

PHYSICIAN PRACTICE OPTIONS™

September 30, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Strategy
“Goodwill” Complicates
Buy-In Pricing 3

Interview
Author-Consultant Says
Physician Groups Need
Both Medical and
Business Leaders 12

Departments

Editorial
Improving Patient
Access Is a Long-Term
Investment 2

Commentary
Physician Report Cards
Gain Favor 6

Managed Care Theory
What Is an
Episode of Care? 10

Capital Ideas
Two Specialists Seek
Greater Productivity 15

Emerging Trends Signal Opportunities for Improving Patient Access

For the past decade, health care purchasers and payers have been working to improve access to health care for all patients. In a report issued earlier this year, *Practice Access: Five Emerging Trends to Protect Physician Practice Profitability in the Future*, the Croes Oliva Group, practice management consultants in Burlington, Mass., has examined strategies physicians can use to improve access. The report contains the findings of a survey Croes Oliva conducted last year of practice administrators from 64 physician groups in the United States. Altogether, 43 practice administrators completed the survey, for a 67% response rate.

In its report, Croes Oliva acknowledges that physicians may feel overwhelmed by credentialing standards and other expectations from purchasers and health plans. The report also points out, however, that improving access for patients can also mean improved provider satisfaction and increased practice profitability.

“A six-week wait time for patients to get appointments also adds six weeks to a practice’s accounts receivable wait time,” says Jayne Oliva, a principal with Croes Oliva. “From a profitability standpoint alone, it behooves practices to clear out their patient backlogs.” Providing expeditious treatment once a patient is diagnosed can sometimes make a significant difference in outcomes, Oliva adds. “Good outcomes are important both to patients and physicians,” she says.

The report notes that improved practice access can offer a number of other rewards, namely:

- Increased patient ease and convenience. Patients interpret access as being able to obtain care quickly, easily, and at a convenient time and location. Practices that remove barriers to care and focus on health care delivery from the patients’ perspective tend to garner higher patient satisfaction marks. Increasingly, practices that build and distinguish themselves with increased patient satisfaction and patient loyalty are rewarded with financial incentives and contracts.
- Greater practice efficiency. Delays in service not only are inconvenient for patients, but also are symptomatic of costly inefficiencies within a practice. Moreover, ensuring that sick patients are treated promptly can prevent unnecessary treatment costs.
- Reduced provider stress. While improving access usually requires changes in the way staff work, it does not necessarily mean staff members must work more or harder. Truly improved practice access means systems and practices are structured and designed to support providers as well as patients.

Emerging Trends

Drawing on the results of its survey of private, hospital-owned and university-affiliated physician practices as well as on its own experience working with physician practices to improve operational and financial performance, the Croes Oliva Group suggests that physician practices seeking to improve access for patients examine their

(Continued on page 8)

Improving Patient Access Is a Long-Term Investment

In a recent report, the Croes Oliva Group, physician practice management consultants in Burlington, Mass., addressed the issue of how physicians can make their practices more accessible to patients. In the report, *Practice Access: Five Emerging Trends to Protect Physician Practice Profitability in the Future*, Croes Oliva examines strategies physicians can use to improve patient access and explains why doing so will be important to practice profitability in the years to come. The report details five trends affecting physicians in their practices and the steps they can take to respond to those trends.

"We believed it would be helpful to survey physician practices that are seriously working toward improving patient access," explains Jayne Oliva, a principal with the Croes Oliva Group. "Therefore we surveyed practices that have set aggressive access standards for themselves and who view it as a preeminent goal within their organization."

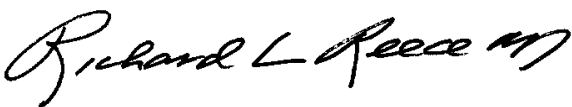
Interestingly, the report shows that improving practice access cannot be left to chance. It requires identifying what patients want, setting aggressive customer service standards, and implementing innovative strategies to reach those goals. "After all, a large care delivery network staffed with dozens of physicians in multiple locations is only as accessible as its ability to connect patients with providers easily, quickly, and in a culturally appropriate manner," Oliva says. "Nonetheless, study respondents reported that while they recognize the importance of developing aggressive practice access guarantees, tactical execution is extraordinarily challenging."

Not only is it challenging, but improving access requires a long-term investment of both time and money, says Howard Trietsch, MD, managing partner of Baystate Ob-Gyn Group Inc., in Springfield, Mass. "Adding nurse practitioners and midwives to our staff was expensive and far from immediately profitable," he says. "It takes some time for the flow of patients to change and for patients—and providers—to get used to a new way of operating." It took the practice two years to profit from the addition of mid-level providers, he says.

To survey the physician practices, the Croes Oliva Group and Pathfinder Research Group, a market research company in Acton, Mass., used the computer-assisted personal interview (CAPI) method. Altogether, 43 medical practice administrators completed the interviews (a response rate of 67%), representing a mix of private practices and those owned by hospitals or affiliated with a university. Among respondents, 70% were single-specialty groups and 30% were multispecialty.

Despite the challenges inherent in attempting to increase patient access, top physician organizations are taking concrete, systematic steps to improve in each of the five areas, Oliva says. By reducing the barriers to care, whether they are language, transportation, or a lack of care coordination, some physician practices are raising the bar for what patients will expect—and even demand—from their health care providers in the near future.

For a copy of the report, readers may write to Croes Oliva at 111 S. Bedford St., Burlington, MA, 01803, or call 781/272-5055.



Richard L. Reece, MD
Editor-in-Chief
Toll-free phone: 888/457-8800
E-mail: Rreece1500@aol.com

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President, Director
Center for Clinical Innovation
Premier, Inc.
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley
Chairman
Personal HealthMaps
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Ernst & Young
Washington

Richard Liliedahl, MD
Health Care Consultant
Milliman & Robertson Inc.
Seattle

Lee Newcomer, MD
Chief Medical Officer
UnitedHealth Group
Minneapolis

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Brooks G. O'Neil
Managing Director
Piper Jaffray Inc.
Minneapolis

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Carl Schramm
President
Greenspring Advisors, Inc.
Towson, Md.

Jacque Sokolov, MD
Chairman
Sokolov Schwab Bennett
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher
Premier Healthcare Resource, Inc.
888/457-8800
E-mail: phrinfo@worldnet.att.net

Publishing Address: Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

Editor
Joseph Burns
508/495-0246
E-mail: joeburns@capecod.net

“Goodwill” Complicates Buy-In Pricing

By Daniel M. Bernick, JD, MBA

Physicians in private practice traditionally have been the ones on the purchasing end of practice buy-ins, meaning they were buying their way into a practice. But over the past decade, the tide turned, and many found themselves facing hospitals, physician practice management companies (PPMCs), and other institutions on the opposite side of the bargaining table. Selling their practice equity, these physicians believed, would rid them of time-consuming management and co-ownership issues.

Now, the situation has come full circle. An increasing number of buy-outs are crumbling because organizations that previously purchased practices incurred significant financial losses. As a result, many physicians are being thrust back into independent practice. Willing or not, they face the question of how to negotiate buy-ins with associates who typically are younger and newer to practice and are seeking to buy their way into a practice.

Issues Affecting a Buy-In

For a practice owner, this is a difficult time to contemplate taking on an associate. Many physicians today emerge from training with a sense of pessimism about the future. They come to the negotiating table worried about negative trends affecting medicine, such as falling reimbursement levels, slow or no payments from HMOs, and increasing regulation such as the Stark laws, new Medicare rules regarding fraud and abuse, and state restrictions on referrals. Added to their concerns may be the burdens of large educational loans to pay back and the personal financial pressures common among young families.

Counteracting these trends is the fact that private practice is beginning to look

more desirable once again, now that many institutional buy-outs are failing. Selling out to an institution is not the professional panacea that some physicians had once hoped it would be. Uncomfortable as private practice can be, with its administrative burdens and financial risks, no hospital, PPMC, or

Components of a Buy-In
How, then, should a buy-in be structured? There are three basic components of practice value:

1. Hard assets, such as equipment and leasehold improvements
2. Accounts receivable
3. Goodwill

Physicians are negotiating arrangements with younger associates who are seeking to buy their way into a practice.

other institution is likely to offer a better environment. As a result, both existing and prospective co-owners are focused on private practice as their future and not just as a way station on the road to a big-dollar buy out by a hospital or PPMC.

Still, owners of existing practices are left in an uncomfortable position. Demanding anything other than a “book value” buy-in, they worry, might antagonize aspiring associates. How can they ask for a traditional buy-in, complete with goodwill, when the conventional thinking is that goodwill is non-existent?

There is no denying, certainly, that the days of full-fee indemnity payments and unrestricted access to medical services are gone. Physicians are under pressure because of declining reimbursement by government and commercial payers, HMO limitations on patient access to care, and burdensome regulations. Yet most are still well-compensated, and public sentiment is turning the tide against onerous managed care practices. Prospects are good for repeal of such regulations as the Stark laws, which severely limit the ability of physicians to profit from ancillary services, such as x-rays, ultrasounds, lab tests, and physical therapy. By sharing this positive perspective, senior physicians can help dispel the pessimism that some junior physicians may bring to the negotiating table.

While there are many definitions of the term *goodwill*, regarding physician practices it means all of the intangible assets of a practice that contribute to its ongoing success, including:

- An established patient base
- Referral sources
- Practice phone numbers
- Charts and records
- Established location
- Established, familiar practice name
- Established, experienced work force
- Established, smoothly running office systems and protocols
- Valuable contracts

In general, younger doctors do not object to paying for the cost of equipment because the value of these items is indisputable. A physician group can arrive at an accurate buy-in figure for hard assets in one of two ways: by hiring a professional appraiser to assess the equipment or by calculating it, using a formula based on book value with adjustments.

Younger doctors usually also understand the need to buy into receivables, although some of them may question the fairness of buying into their own production. Physicians can answer this concern by explaining that while some of the practice’s income will be attributable to the new associate’s prepartnership efforts, he or she has no equity in the prepartnership

(Continued on page 4)

Daniel M. Bernick, JD, MBA, is an attorney and consultant with The Health Care Group, health care consultants in Plymouth Meeting, Pa.

(Continued from page 3)

receivables. A reasonable way to calculate the value of the receivables is to take their face value at the outset of co-ownership, deduct any older deadwood that will never be collected, and multiply the result by a factor that reflects expected contractual disallowances and bad debts.

The major point of contention in a buy-in is not equipment or receivables, but goodwill. Some would-be partners react angrily to the idea of paying for goodwill because they believe it no longer exists in an age when HMOs control physician selection by patients. On the surface, this argument appears to be reasonable, but it is self-serving because younger doctors naturally want to minimize the size of their buy-in. Goodwill may be difficult to value, but it does exist.

Not every practice deserves a high goodwill payment from a new co-owner. A physician will have a problem justifying a significant goodwill value if the practice generates low physician income, is in a bad location, or has operational or personnel problems. The reverse is true of a practice that is profitable, properly situated, and operates smoothly.

The best way to demonstrate the value of goodwill is to consider the obstacles that a young physician would face in establishing a new practice. He or she must attend to patients while scrambling to assemble all of the equipment, office space, personnel, and systems needed to practice. His or her income would take a drastic hit and cash flow initially would be nonexistent as fresh receivables build up. Meanwhile, capital costs for new equip-

ment and improvements and ongoing overhead costs for rent, malpractice, and payroll would accrue beginning from day one. Further, the physician's appointment book is not likely to be filled that first day.

A young physician who declines a buy-in and leaves the practice with which he or she is currently employed will likely also need to build a patient and referral base from nothing. Typically, a noncompete clause restricts a young physician from opening a practice in the immediate vicinity. A nonsolicitation clause bars him or her from removing or using the practice's patient list to contact patients. Even without these restrictions, a physician who rejects a buy-in offer may face stiff competition from the former practice, particularly in a geographic area that has no shortage of physicians.

Factors to Review When Considering a Buy-in Arrangement

	Positive	Negative
Practice profitability	Physician compensation exceeds national norms or is attained with lower than average work effort, rising revenue and profit.	Physician compensation is lower than national norms or attained only with excessive effort. Falling revenue and profit.
Location	Nice place to live, access to metropolitan area, amenities, and transportation, good weather. For specialty practices, proximity (such as in the same office) to referring physicians.	Less desirable place, rural or inner city.
Competition	Moderate competition.	Too much competition can reduce profitability. Not enough competition may mean there's no need to buy an existing practice to get started.
Managed care penetration	Low penetration.	High managed care penetration, tight referral controls, low reimbursement rates, closed panels, insurers control patient choice of provider.
Reimbursement trends	Fees stable or rising.	Significant fee cuts.
Patient demographics	Growing population, increasing in target age bracket, high employment and income levels.	Population loss, reduced population in target age bracket, high unemployment and low income.
Payer mix	Strong commercial component, good diversity of payers.	Too much Medicare or Medicaid, overdependence on a few key payers.
Work force	Experienced, loyal staff, competitive salaries.	High staff turnover rate.
Range of services	Good breadth of services, ability to profit from ancillary services or non-MD providers.	Loses profit by needing to refer out many services.
Practice systems	Up-to-date computer, patient recall protocols, effective billing and collection routines.	Older computer, lack of recall protocols, poor collection procedures.
Other	Local hospitals in bidding war for practices, practice has dominant position in the area.	Hospital offering income guarantees to new practitioners, adverse legal developments.

Source: The Health Care Group, Plymouth Meeting, Pa.

All of these financial hardships can be avoided by buying into an existing practice. Such a practice has all of the systems in place to practice medicine efficiently. Most important, it offers immediate patient flow: All of the doctors are busy and productive. If an existing practice is profitable, a new associate almost surely will take home more money, after the buy-in payment, than if he

For a new physician, it is better to pay top dollar to be part of a great practice than to pay less to join a mediocre one. It may also be better to pay a reasonable buy-in to a good practice than to bear the financial risks of starting a new one.

or she was to start a new practice. The question is not whether the buy-in is big; it is whether it is reasonable given the expected returns. It is better to pay top dollar to be part of a great practice than to pay less to join a mediocre one. It may also be better to pay a reasonable buy-in to a good practice than to bear the financial risks of starting a new one.

The question for both sides in this negotiation is how does one place a value on a practice's goodwill? There are many approaches, but the most reliable is the market or comparable sales approach. This method uses a database of other buy-in transactions, or comparables. As with residential housing, the price for goodwill is based in part on actual prices paid in prior months and years for similar "property" in the same geographic area. Prices in the database serve as a baseline, and characteristics of the practice either add to or detract from its assessed value.

The median goodwill value for a family practice is currently 30% of annual receipts, for example, according to the Health Care Group's Goodwill Registry, a database of medical practice buy-in and sales transactions. A particular family practice's situation, however, may dictate a higher or lower value. A large, well-run practice that dominates in a competitive area may command a higher value, whereas goodwill may have little or no value for a practice in an area in which a hospital is recruiting new doctors with lavish income guarantees.

While the practice of medicine is changing, not all of the changes are bad. Contrary to popular belief, goodwill is not obsolete. Many medical practices continue to have significant goodwill value and underestimating it during buy-in can be a costly mistake. ■

New! Trial Offer

SPECIAL INVITATION TO SUBSCRIBE

PHYSICIAN PRACTICE OPTIONS™

Our articles focus on:

- Marketing and expanding your practice
- Network formation and affiliation
- Looking at practice valuation
- Finding strategic partners

A new 3-issue trial subscription to **Physician Practice Options**, regularly a \$75 value, is for a limited time, only \$19.95.

75% off the regular subscription price

Simply send or fax the order form below to begin your subscription and get the information you need to succeed in health care. There's no need to send payment now; we'll gladly bill you.

PLEASE SEND FORM BELOW TO:

Physician Practice Options

PO Box 3000, Denville, NJ 07834-9218
or, for faster service, please call toll free:
888/732-6735 • Fax orders: 973/316-5989

Yes! Please send me a subscription to **Physician Practice Options** (3 issues for \$19.95)

Name _____

Address _____

City _____ State ____ Zip _____

PLEASE FILL IN THE FOLLOWING INFORMATION:

Bill me Payment enclosed

Medical Specialty: _____

Title: _____

I'm in a: Solo Practice Group Practice

If sending payment, please make check payable to: Physician Practice Options
Expires 9/99 #T01995

 **Physician Practice Options**
A Practical Resource to Succeed in Health Care

Physician Report Cards Gain Favor

In an innovative and perhaps trendsetting move, HealthPartners, a managed care organization in Bloomington, Minn., is paying bonuses to more than 80% of its medical groups. Groups that meet or exceed one or more clinical performance and patient satisfaction measures as determined by HealthPartners have been getting cash bonuses this summer.

"Our program is a pure bonus program, with no negative ramifications," explains Maureen Reed, MD, the HMO's medical director. "It rewards superlative performance, but there is no slap on the wrist if a group doesn't achieve our targets."

Many health plans have long used profiles to record scores on physician performance in meeting specific cost-saving goals, usually related to specialist and hospital referrals. Some plans, such as PacifiCare Health Systems Inc., in Santa Ana, Calif., have publicly reported on the aggregate clinical performance of their medical groups. Even through PacifiCare said it has no plans to link bonuses with performance, other MCOs have said they intend to do so. HealthPartners is among the first to pay actual bonuses to physicians for meeting specific clinical performance targets, such as mammography rates and pediatric immunizations.

The bonuses come from a pool of about \$2 million, and payments to individual groups averaged in the tens of thousands of dollars, Reed says. The amount of bonus relates to how many HealthPartners patients a group serves, the percentage of a group's patients who are HealthPartners members, and how many of its four targets were met: rates for mammograms, pap smears, the number of patients in smoking cessation programs, and pediatric immunizations.

Clinical Criteria

This is the second year HealthPartners has paid bonuses based on physicians meeting clinical criteria. Last year the company paid clinical criteria bonuses to 13 medical groups. This fall, it will pay clinical bonuses to physician groups, but as of July, it had not determined the num-

ber of bonuses it would pay. What's more, HealthPartners has paid bonuses this year and last to six physician groups that have met certain patient satisfaction criteria. Patient satisfaction bonuses are paid in the summer, and clinical bonuses are paid in the fall. The health plan will continue paying bonuses for reaching clinical quality and patient satisfaction goals next year, Reed says.

The health plan set its targets above the national averages determined for health plans by the National Committee for Quality Assurance (NCQA), in Washington, D.C., Reed says. "That is

But Health Net, like other HMOs, is rethinking its use of performance measures, plan officials say, and wants to tie a higher level of physician compensation to meeting clinical targets. Late last year, it began issuing report cards based on clinical criteria to its medical groups on their care of asthma patients, and plan officials hope to increase the level of compensation tied to performance as their physicians become familiar with the HMO's measurements.

Health Net used data on 18 indicators gathered from surveys of asthma patients, who reported on their functional status and

HealthPartners paid bonuses to 17 physician groups from a pool of about \$2 million.

—Maureen Reed, MD, HealthPartners

the best way to work with our physicians to achieve the best care," she says. "It is telling that of our 21 medical groups, 13 hit one or more of the clinical quality goals last year." HealthPartners's patient satisfaction bonuses require that 47% or more of a group's patients say they were "very satisfied." A total of 17 of HealthPartners's 21 medical groups received either a clinical or patient satisfaction bonus last year. "That's a high level of achievement, which we believe translates into quality care," says Reed.

Moreover, Reed says, the HealthPartners bonus plan does not pay physicians from withholds. Many health plans withhold money from physician payments throughout the year and make payments based on meeting certain cost-related targets, such as lowering specialist referral rates and reducing hospitalizations. Such withhold plans have been widely criticized. Health Net in Woodland Hills, Calif., ties a percentage of compensation to meeting nonclinical performance goals, but does not issue bonuses. The money for meeting these nonclinical performance goals comes from the withhold pool.

use of recommended treatments, such as the percentage of a group's asthma patients who used peak-flow meters daily and who were counseled on ways to prevent severe asthma attacks. Success was judged both by patient reports of their physical functioning and absentee rates from work or school, and their avoidance of hospitalizations and emergency department visits.

Under Health Net's program, between 3% and 5% of a group's compensation is linked to cost-saving performance measures and patient satisfaction, says Antonio P. Legorreta, MD, vice president of the quality initiatives division of Foundation Health Systems Inc. in San Francisco, Health Net's parent company. Within five years, Health Net plans to link 15% of a group's compensation to how well it meets Health Net's clinical performance measures, says Legorreta. In that time, Health Net will issue physician report cards on how well its medical groups treat patients with diabetes, cardiovascular disease, depression, and breast cancer.

Richard O'Connor, MD, the head of quality management and chief of the asthma division at the Sharp Rees-Stealy Medical Group, in San Diego, believes

report cards will help improve patient care. The Sharp Rees-Stealy Medical Group contracts with Health Net. "Report cards are going to be effective by providing stimulation to medical groups that do poorly to look internally at their own processes to determine what they can do to provide better care," O'Connor says. "But you can't use those report cards in a punitive way. Doctors are competitive; if they see their group at the bottom of the list, that will be enough to cause change."

Improving Patient Care

The nation's largest managed care organization, UnitedHealth Group in Minneapolis, is in its second year of issuing standardized reports to physicians on clinical performance. It issued patient-specific report cards to 21,000 of its internists and cardiologists last fall. The report cards contained information gleaned from medical and pharmaceutical claims records. The data came from six specific measures: the use of ACE inhibitors, anticoagulation therapy, beta-blocking therapy for cardiac patients, blood level testing for diabetics, mammograms, and potassium screenings for patients on diuretics.

The second round of United report cards was issued this summer to 42,000 physicians. This time, the reports went to cardiologists, internists, family practitioners, and pediatricians. United does not issue performance bonuses based on its report cards, but Lee N. Newcomer, MD, United's senior vice president for health policy and strategy, says UnitedHealth Group eventually may create "positive financial incentives" for meeting specific performance targets. "It's definitely something I would like to see us do once we are certain our measurements are completely accurate and physicians have enough time to respond to the data we provide," Newcomer says.

United has seen progress in each of the six categories it used in the 1998 reports, Newcomer says. "I thought we'd meet with greater resistance than we have, but we've been very encouraged," he adds. "About 10% of our doctors have said 'I don't like this,' but what we're hearing from the other 90% is more

"About 10% of our doctors have said 'I don't like this,' but what we're hearing from the other 90% is that it's the first kind of valuable information they've ever gotten from a health plan."

—Lee N. Newcomer, MD, UnitedHealth Group

along the line that it's the first kind of valuable information they've ever gotten from a health plan."

While the use of report cards to gauge individual physician performance appears to be growing slowly, it is not without its critics. "Increasing professional accountability is a laudable goal, but profiling can be expensive to health plans and potentially harmful to patients through a distortion of physician incentives," says Timothy P. Hofer, MD, a practicing physician with the Department of Internal Medicine at the University of Michigan, in Ann Arbor. A researcher with the Veterans Affairs Center for Practice Management and Outcomes Research in Ann Arbor, Hofer co-wrote an article, "The Unreliability of Individual Physician 'Report Cards' for Assessing the Costs and Quality of Care of a Chronic Disease," in the June 9, issue of JAMA.

Process Versus Outcomes

Hofer and his colleagues studied 3,642 patients with type 2 diabetes, cared for by 232 physicians who worked at a large staff-model HMO, an urban teaching university, or a private medical group. They concluded that physician report cards based on clinical records couldn't accurately measure outcomes performance, primarily because they generally are not adjusted for case mix factors, such as age and income levels. Only a 4% variation existed in the practice styles of the physicians, regardless of whether they received feedback on performance goals.

The authors also concluded that incentive payments based on performance might lead physicians to shuttle sicker patients to other physicians in order to protect their profiles and thereby receive bonuses or avoid being deselected by a MCO.

But the JAMA study missed the point

of report cards, Newcomer says. "It focused on outcomes, not processes, and studied a chronically ill population, not a general patient base," he says. "In any case, United does not use its performance reports to punish physicians. We have not deselected anyone as a result of our first pass through, nor have we for the second round. We see this as a joint effort to improve the quality of care."

United and HealthPartners chose their measures based on opinions from their physicians, Newcomer and Reed say. Health Net used criteria developed by physician groups and by such national organizations as the NCQA.

"We asked our doctors what they would like to measure," Newcomer says. "The response was that they wanted information about treatment processes, such as data on cholesterol levels after heart attacks, not outcomes measures. They also wanted information that doesn't require statistical significance, that had no bearing on the number of patients involved, data on whether patients were receiving necessary immunizations, for example, not numbers related to the percentage of patients referred to specialists."

Process performance measures can indeed be used to increase the quality of care, and even to reform health care, says Beth Gallup, MD, a family practitioner and medical director of New Century Health, an IPA in Kansas City, Mo. She also chairs the board of directors of the National Association of Managed Care Physicians in Glen Allen, Va. "We wouldn't even have performance measures if it weren't for HMOs," says Gallup. "They will be used more and more by consumers, and the market will determine which providers will prosper and which will fail based on performance."

—Reported and written by Martin Sipkoff, in

(Continued from page 1)

performance in these five areas:

- Visit planning
- Neighborhood care
- Seamless navigation
- Cultural competence
- Information technology

Visit planning. Not so long ago, preparation for a patient's visit commonly consisted of a staff member pulling the patient's chart so the physician could take a quick glance through it moments before the patient's arrival. Today, visit planning requires a much more sophisticated process, the report says. In addition to assessing what resources are needed for each patient visit, effective planning includes sophisticated triage, deciding how quickly a patient should be seen, and what level of provider—a physician, physician assistant, or nurse practitioner—is appropriate for the care each patient needs.

Of the practices surveyed, 88% use mid-level providers. All but one practice cited "making better use of support staff and clinicians such as physician assistants and nurse practitioners" as a strategy for improving practice access.

"Patients like to have choices, especially about who their provider is," says Howard Trietsch, MD, managing partner of Baystate Ob-Gyn Group Inc., a multiphysician practice in Springfield, Mass. "To provide our maternity patients with more choice, we set up a collaborative midwifery service alongside of our practice, so that they can choose a physician or a nurse midwife as their routine care provider. This allows our physicians to spend more time seeing patients with complex medical needs, while the midwives provide a significant portion of the usual care we deliver."

Baystate Ob-Gyn also offers early morning and evening appointments for patients. "These hours are especially convenient for working women who can stop by on their way to or from work," Trietsch says, explaining that the practice uses staggered shifts. "Many of our midwives work from 3 to 8 p.m., so that we have sufficient coverage when patient demand for appointments is highest."

Survey respondents noted other strategies for improved visit planning that included implementing a designated time for parents to bring sick children to the

office without an appointment; providing after-hours telephone advice using nurses; and using automated telephone systems that allow patients to access results of laboratory tests 24 hours a day.

The report notes that practices are

one. "The nurse practitioners are kind of a steady influence there," explains Trietsch. "If a patient's physician is unavailable or at another satellite office, the nurse practitioners are available to provide coverage, answer patient questions, and help in

"Some young teenagers would not necessarily have come to see me, but by offering appointments before or after school near their homes with young female mid-level providers, we have attracted those patients to our practice."

—Howard Trietsch, MD, Baystate Ob-Gyn Group Inc.

moving toward more comprehensive visit planning; however, survey responses indicated that the organizational science behind their efforts is still developing.

Neighborhood care. As health care organizations have become larger and more integrated through mergers, acquisitions, and consolidations, health care has gained many of the efficiencies of other large industries. However, ties to local communities have often been the casualties of such reorganizations. As health care organizations have centralized operations, patients often have been forced to get care outside of their own communities; others have encountered barriers such as inadequate parking in urban medical office locations, or a shortage of transportation.

Due to patient demand, community-based care is making a swift comeback, the report notes. The majority of survey respondents indicated that most of their patients live in close proximity to their primary office location, and that 84% of respondents have established satellite clinics in surrounding communities to increase their geographic reach.

"After examining where our patients live, identifying geographical regions of our area where there were no ob-gyn providers, and asking patients about their preference for alternative office locations, we decided to open two satellite offices in suburban areas," Trietsch says. Two of Baystate's five physicians rotate between the satellite clinics, while a nurse practitioner is permanently stationed at each

emergencies," he says, noting that patients also have a choice of selecting a nurse practitioner as their routine provider.

Not only does offering care near the patient's home reduce stress and improve patient access, it also can be a lucrative financial strategy for the practice, the report notes. For example, satellite offices located strategically in surrounding communities can serve as feeder sources for the primary office location where more intensive procedures and services are offered. Further, physician practices that can increase their geographic reach may also increase their attractiveness to health plans and hospitals.

"Our strategy was to attract patients who would not have ordinarily come to us in the first place," Trietsch explains. "Some young teenagers would not necessarily have come to see me, but by offering appointments before or after school near their homes with young female mid-level providers, we have attracted those patients to our practice. Then if they have a problem that requires a physician-level intervention, they're very easily transferred to me. It's an easy transition for the patient and the providers."

Within five years health care organizations—even academic medical centers—will be staking out territory within patients' communities, predicts Croes Oliva. By doing so, they will be well positioned to serve patients' health care needs most appropriately. Positioning triage specialists within neighborhood clinics will

(Continued on page 9)

(Continued from page 8)

funnel patients with routine needs and minor illnesses to on-site primary care physicians, while patients with more complex needs will be routed to regional centers for specialty care, Croes Oliva says.

Seamless navigation. “Health care organizations are becoming more integrated from an internal perspective, but from an external perspective—namely the patient’s—it’s still a heinous chore to access care,” Jayne Oliva says. Patients are stymied by unfamiliar administrative and bureaucratic hurdles, such as utilization review or referral processes, she says. Focusing primarily on expanding their size and service offerings, few integrated health care organizations have considered how to deliver services to the patient, Oliva says. Instead, most rely on informal, unstructured communications between patients and physicians, placing the burden of traversing the health care system on the patient. Physicians (or their office staff) must then advise patients about how to navigate the system.

Croes Oliva recommends physician practices help shift the responsibility for navigating the health care system from the patient to the system itself. This strategy is challenging for independent physician practices and applies more readily to practices owned by hospitals or health plans. Nevertheless, the report cites a variety of innovative initiatives currently underway at some of the practices that responded to the survey. Some practices:

- Provide an on-site pharmacy (42% of respondents) or lab services (28%)
- Offer a prescription mail-order program
- Schedule patients for visits with specialists on-site one day per month
- Coordinate referrals to specialists
- Offer transportation to appointments
- Provide knowledgeable patient care representatives, such as reception room greeters, to answer patients’ questions and to guide them as needed
- Use clinical care case managers who are experienced with utilization and reimbursement systems and familiar with other community services

Cultural competence. Noting that the increasing ethnic diversity in the United States is making cultural competence an imperative for health care organizations,

the Croes Oliva survey asked respondents how they are preparing their practices to serve minority patients. Among respondents, 79% reported providing a translator for non-English-speaking patients and 47% had a physician on-site fluent in patients’ native language. The survey also showed that the majority of practices offer little else in the way of culturally competent programs or services.

Physicians should work to become culturally competent by assessing ethnic diversity within a community and implementing specific strategies such as having signs and patient education materials prepared in patients’ native languages, Croes

Oliva says. Doing so will help practices to stay competitive and will thereby reduce stress on patients and providers alike.

Another aspect of cultural competence that should not be overlooked is patient use of alternative medicine. Many ethnic minority cultures use non-Western medicine, such as acupuncture for pain relief, to promote health or treat illness. Increasingly, patients who have historically relied solely on allopathic medicine also have been turning to alternative therapies. Despite the popularity of alternative medicine, 74% of physician practices polled in the survey reported that their practices currently do not provide alternative healing services, nor do they have any plans to incorporate them in the future. The most common reason respondents cited for not offering such services was that physicians were dedicated to practicing only evidence-based medicine.

“Practices do not necessarily need to offer alternative medicine,” says Oliva, “but physicians should be aware of what alternative forms of treatment their patients are utilizing.”

Information technology. To some degree, almost all improvements in practice efficiency require increased use of computers. Information technology facil-

itates automation of tasks, has the ability to improve speed and accuracy, and usually reduces labor costs. Many practices currently use information systems to produce reminders for patients who need immunizations, for example. Computers also can be indispensable tools for measuring performance and providing useful data quickly so that practice administrators know what areas need improvement.

Despite the recognition that information technology holds great promise for improving practice access, implementing such systems has become a stumbling block. Affordability is an issue for independent practices, while nearly every

“From a profitability standpoint, it behooves practices to clear out their patient backlogs.”

—Jayne Oliva, the Croes Oliva Group

practice faces the challenge of implementing new systems while concurrently conducting business as usual and remaining accessible to patients. In addition, few practices have access to the support required when physicians and staff start using sophisticated new systems.

“We’d love to have an electronic medical records system to facilitate information exchange between our office sites,” Trietsch says. “But the initial investment required is a significant hurdle for us.”

Only 29% of survey respondents reported that they use computerized systems for medical record keeping. Of these practices, many reported that they could not access records from all office locations. Yet when asked to name the most critical issue for physician practices seeking to improve access and customer service, 21% of physician practices offered “use of technology and computers” as their response.

“As the health care delivery system continues to integrate and physician practices become affiliated with larger organizations, implementing information technology—such as electronic medical records systems—not only becomes imperative but also more cost-effective,” Oliva says.

—Reported and written by Laura M. Northup, in Mashpee, Mass.

What Is an Episode of Care?

By Douglas W. Emery, MS

Even to experienced observers, health care often appears as a chaotic collection of unrelated events rather than an orderly sequence of interventions designed to achieve distinct clinical goals. The episode of care is an analytical construct designed to bring order to the complex profusion of activities, technology, and data that characterize modern health care.

The episode of care rests on three basic premises:

1. The development and progression of disease is governed by underlying, discernable laws of pathophysiology.
2. Medicine is based on knowledge of these laws and of how clinical interventions promote health and cure disease.
3. Medical practice is an organized sequence of processes that can be described and managed.

According to the first premise, health and disease are subject to fundamental laws of physical reality. The human body is an integral part of the physical universe and the laws that govern that universe also govern our physicochemical existence. However much individuals may appear to differ, they are remarkably similar in their organic functioning and their bodies' responses to external interventions. Furthermore, the laws that govern the formation, life, and dissolution of the human body can be discovered and understood.

The fact that many of the diseases of modern civilization are byproducts of nontraditional pathogens, such as one's attitude, emotional conflicts, stress, and culture, as much as they are of traditional pathogens, such as germs, carcinogens, genetic mutations, and biochemical abnormalities, does not invalidate the premise that illness can be explained in

scientific terms. Instead, these nontraditional and traditional pathogens expand the frontiers of science, challenging medical practitioners to consider many etiologies and pathophysiological processes.

To be effective healers, medical practitioners not only must understand disease; they also must translate that understanding into effective interventions. Thus, the second premise underlying episodes of care is that, whatever behavioral idiosyncrasies may mark patients, their families, and their diseases, therapeutic outcomes are, in general, predictably circumscribed by the laws of nature. With appropriate knowledge, illness and injury can be treated and human

examinations and blood gas analyses, for example, and therapies, such as immunizations, chemotherapy, and surgery, for instance, with psychosocial diagnoses and behavioral modification, such as biofeedback, relaxation therapy, and family counseling. In this context, stress and intimal vascular injury both are viewed as important contributors to the pathogenesis of atherosclerosis, and behavioral modification and revascularization both are considered appropriate therapeutic interventions that may be combined to avoid or ameliorate this condition. This broader definition of medical diagnosis and therapy has enriched rather than detracted from the

Episodes of care are based on a premise that when diagnosing and treating patients, care givers follow logical sequences that can be measured, analyzed, and systematically altered.

suffering relieved. Medicine may never succeed in ensuring disease-free immortality, but it does provide patients with a reasonable expectation that prior successes can be repeated in similar circumstances. These reasonable expectations govern courses of medical treatment. As a result, it is expected that intervention X will produce outcome Y given disease state Z, based on the current body of knowledge derived from scientific medicine. As researcher Susan Horn, has said, "Within a well-defined, similarly ill patient group, one would expect that care processes of equal effectiveness would result in similar outcomes of care."

Despite many exceptions, complications, and medical misadventures, if this second premise is rejected, then all of modern medicine could be abandoned without great loss to society.

Increasingly, modern medicine is recognizing the multifaceted nature of disease and is expanding its diagnostic and therapeutic armamentarium to supplement traditional diagnostic techniques, with x-ray

optimistic medical paradigm that increasing knowledge of human pathophysiology will enhance the effectiveness of medical interventions.

Finally, episodes of care are based on the third premise that when diagnosing and treating patients, caregivers are guided by clinical objectives and follow logical sequences that can be measured, analyzed, and systematically altered.

Episodes of care encompass the flow of related medical activity to create a single construct that fully expresses clinical reality. In this regard, episodes of care serve as containers that organize diverse clinical processes into a unified, intelligible whole. Or, as defined in a definitive paper on episodes of care in the Fall 1985 issue of *Medical Care Review*:

"A 'health care episode' is the period of time during which a specific disease process, illness, health care problem, or treatment process is present. It is characterized by an onset, or beginning, and a resolution, or ending, between which the health problem state applies. It may per-

Douglas W. Emery, MS, is president of Zoadigm Health Systems Inc., in Salt Lake City. He is also the editor of Global Fees for Episodes of Care: New Approaches to Healthcare Financing (New York: McGraw Hill, 1999).

tain to an acute illness such as appendicitis; to a chronic illness such as diabetes mellitus; to a preventive activity such as immunization; to a course of treatment for cosmetic purposes such as a face-lift; to a demand for information and advice such as whether to take oral contraceptives for birth control; or to administrative imperatives such as court-ordered treatment of alcoholism or physical examination required for participation in intramural sports. A health care episode is a higher-order concept that deals with all reasons for contact with the health care system.”

Thus, the full array of modern health care, including both traditional and non-traditional modalities, can be incorporated into a finite set of discrete, self-contained, all-inclusive episodes of care.

Six Defining Features

If episodes of care are to serve as overarching constructs that unify all aspects of health care delivery, they must be capable of incorporating other constructs designed to characterize important dimensions of clinical care. Terms and concepts related to constructs such as evidence-based medicine, disease management, clinical practice improvement, practice guidelines, clinical integration, pathways, global fees, and outcomes measurement all must be related to the basic building blocks of episodes of care.

As such, it is useful to define the aspects that encompass an episode of care. The six features that define episodes of care are as follow:

1. Subject of care (the patient)
2. Underlying conditions requiring care
3. Objective of care
4. Clinically homogeneous parameters of care
5. Duration of care (time)
6. Complete domain of care

Subject of care. As stated earlier, individuals seeking care are vital elements in the definition of episodes of care. Whether described as individuals, as clients, or as patients, subjects of care initiate episodes by consulting health care practitioners, such as physicians, pharmacists, and others, interact with the health care system throughout each episode, and benefit or suffer from successes or failures

associated with each episode. The subject of care may sound a little abstract when patient will simply do, but think about an episode of marriage counseling in which two people are receiving care, and the patient or subject is the marriage. Or, to demonstrate the general flexibility of the concept, consider an episode of veterinary care, in which the subject is not human.

Underlying conditions requiring care. While patients define episodes of illness, clinicians define episodes of disease. Complaints or concerns patients bring to clinical encounters are important in defining and directing episodes

Episodes of care can serve as overarching constructs that unify all aspects of health care.

of care. However, these complaints and concerns must be translated into a diagnostic hypothesis specified in terms of etiologic agent, pathophysiological manifestations, natural history, and expected response to treatment.

Objective of care. The objective of care is the principal force guiding all clinical activity and resource consumption. Without a clear objective, it is difficult to formulate a rational clinical strategy. The objective of care stems naturally from the needs of individuals seeking care and the nature of the underlying conditions diagnosed. Thus, the objective of care pervades all aspects of an episode.

Clinically homogeneous parameters of care. Parameters of care define the processes available to caregivers to diagnose and treat disease and to preserve health. These parameters are clinically homogeneous when they separate classes of providers' activities with respect to underlying illness and thereby generate clinical responses from physicians that are similar in terms of the cognitive processes involved, diagnostic tests ordered, and class of therapies used. Clinically homogeneous parameters of care result in comparable consumption of resources by different providers caring for the same condition. Although clinical objectives, like bookends, form the strategic beginning and end of episodes, clinical-

ly homogeneous parameters of care, like the books themselves, provide the content of the episodes.

Duration of care. Episodes of care have clearly identifiable beginnings and ends. The duration of an episode is defined either as a fixed period of time, such as one year of routine care of a chronic disease; as the completion of a defined process of care, such as a diagnostic evaluation for ischemic heart disease; or as achievement or failure to achieve specific objectives of care, such as resolution of a wound infection. Clearly defined temporal boundaries are essential components of episodes of care. Without them, clinical

homogeneity becomes illusory, outcomes monitoring is impractical, and global pricing is unmanageable. The failure of capitation to provide realistic boundaries for episodes of care severely limits its ability to direct health care activity effectively.

Complete domain of care. The episode of care has been designed to integrate all the processes required to accomplish a clinical objective. Thereby it permits: meaningful analyses of the content and value of health care, determination of the cost and price of medical services, and the efficient allocation of risk. To accomplish these tasks, an episode of care must encompass the complete domain of care elements that comprise a clinically comprehensive package of interrelated services designed to meet well-defined clinical objectives.

Synthesizing these six defining features into episodes of care resolves the complexity of health care delivery into focused product lines that render the delivery of medical care as a service for which providers can set a price, manage the service, and be held accountable for results. Defining episodes of care in this way places physicians in the center of managed care leadership. After all, what other party is more competent to organize integrated episodes as a institutionalized means of care delivery? ■

Author-Consultant Says Physician Groups Need Both Medical and Business Leaders



Sandy Lutz is a health care practice manager in the Dallas office of PriceWaterhouseCoopers, CPAs and health care consultants. She is the author of four books: *The For-*

Profit Health Care Revolution, (McGraw Hill, 1995), *Columbia HCA: Health Care on Overdrive*, (McGraw Hill, 1998) *Med Inc.* (Jossey-Bass, 1998), and *Physician Group Management at the Crossroads: Developing, Operating and Growing Medical and Dental Groups* (McGraw Hill, 1999). Before joining PriceWaterhouseCoopers, Lutz spent 10 years as a journalist for Modern Healthcare and a year as a hospital analyst for an investment bank in Dallas. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q. Why is your most recent book, *Physician Group Management at the Crossroads*, particularly relevant to today's physicians?

A. The timing is good because we see many doctors trying to figure out how to manage their practices efficiently. We have seen, and will continue to see a huge divestiture of practices by hospitals at the same time physician practice management companies (PPMCs) are divesting physician practices. Obviously some hospitals will still purchase physician groups, but not all physicians want to be part of a hospital system. And many hospitals are having difficulty running the practices they own. As a result, many more physicians will need to consider what is the best practice management option for them.

Q. How are physicians reacting to practice divestiture?

A. Physicians are pretty disillusioned right now, but once they get over that, they'll realize that they have the power to improve the management of their practices, as well as to help deter-

mine the cost and the quality of care. For example, given that HMOs in Texas lost \$500 million in the last two years, they need the physicians on their side to help keep costs in line. But physicians tend to view their relationship with HMOs as adversarial. In general, the options for physicians are the same options that were out there a few years ago. They can either be part of a hospital system, stay independent in a small group, or join a PPMC. There will still be large medical groups out there, and they're going to need the tools to operate effectively.

Q. Why has the effort to organize and consolidate physicians been a financial failure for so many HMOs, hospitals, PPMCs, and even large medical groups?

A. Many organizations have consolidated physicians and continue to be profitable, but most have lost money. It's a complex business, and physicians can't be organized in an efficient, economical package. The biggest problem in the organization of most physician groups is a lack of clear leadership. Physicians in a group will recognize that they need a business manager, so they hire a CEO and

the physicians in the group. A lot of successful physicians have done that. For example, Ron Anderson, the CEO of Parkland Hospital, a huge public hospital here in Dallas, is a doctor. But that's a pretty unique trait, to be a good business executive and run a large organization while keeping up with medical knowledge and practices.

Q. What is the role of hospitals in managing physician practices?

A. Running a hospital and running a physician practice require two different sets of competencies. That doesn't mean that hospital administrators can't hire the right set of competencies, but in some cases they have failed to hire the right people to manage the physician practices they own.

Many hospital administrators will admit that they bought physician practices because of what's called the fear factor. Everybody else was buying; PPMCs, such as MedPartners and PhyCor, were coming to town; and they got caught up in the bidding wars for these physicians group. They didn't sit back and evaluate their criteria for physician practice pur-

"Given that HMOs in Texas lost \$500 million in the last two years, they need the physicians on their side to help keep costs in line."

they think the CEO works for them, while the CEO thinks the doctors work for him or her.

The best organizations have a tandem structure with both a business leader and a medical leader, because frankly a lot of physicians won't listen to anyone who's not a physician. Some experts have advised physicians who want to be medical directors to maintain at least part of their medical practices—even though it makes for a demanding career—because it helps them to maintain credibility with

chases or consider whether those physicians' referrals would come to them regardless of who owned the practice. Also, the valuation of physician practices has often been based on assumptions of future profits and future referrals that never happened.

Q. Why have PHOs been considered such a failure by many managed care observers, and yet the Health Care Financing Administration wants to use PHOs as the structure for introducing global fees for episodes of care?

A. In many instances, HCFA is behind the curve when it comes to trends. So many PHOs have failed because they were just loosely pasting an organization together for the purposes of negotiating managed care contracts, and not focusing on managing the cost of care.

Q. *Why do many more tightly organized organizations fail as well?*

A. Management in any industry is an art. Managing physicians is probably one of the toughest business problems that exist today because of a confluence of factors: They've been schooled to practice autonomously, they are high achievers, and they tend to be high-income individuals. Therefore, sometimes they are prey for questionable financial schemes. The many forces at work that have driven their culture do not welcome tight management. For physicians who are in their 40s and 50s, some of the attraction of medicine was that they could work for themselves. But to some degree that culture is changing. Physicians coming out of school now have a different attitude about working for an organization.

Q. *How will PPMC strategies change in the coming years?*

A. We'll still see PPMCs but not necessarily the kind we saw before in which they're buying groups all over the country, putting dots on the map. We'll see more controlled growth, and more regional players. Many PPMCs failed because growth was their top priority. They became physician recruitment organizations rather than management organizations.

Q. *Why is MedCath, in Charlotte, N.C., likely to succeed when other PPMCs have failed?*

A. Right now, MedCath is focused on just one segment of the cardiology business: the ancillaries that they incorporate into the system. MedCath is a cardiology physician management company that expanded into building heart hospitals. It's a practice management organization, hospital provider, and outpatient provider all in one. All of the hospitals MedCath owns benefit because they can be involved in the whole spectrum of car-

diac care, not just inpatient services.

By mid-1998, MedCath was operating 33 cardiac catheterization laboratories or diagnostic centers as well. Each MedCath hospital is a joint venture with physicians, who like the idea that they can own part of the hospital in which they work and that they can help control the quality of care in that hospital. But this is not a strategy for everyone, because it's very capital intensive. MedCath spent \$40 million to build each of its hospitals.

Q. *What features of ProMedCo, the multispecialty PPMC in Fort Worth, will make it a successful model?*

"So much capital is required to become a PSO that many physician groups can't take the financial risk. They'd have to put up so much in capital reserves that they will probably lose money at least for a while."

A. Their chief ingredient for success is that ProMedCo has targeted non-metropolitan areas. ProMedCo enters areas without significant managed care penetration, and then buys the biggest group in town. It's then likely that some of the other physicians will see the success of this group and approach ProMedCo on their own. ProMedCo might pay a lot for the physicians on the front end but then the successive practice purchases won't cost them as much. It's the same philosophy some of the hospital chains have taken, in which they enter small non-urban markets and become the major game in town because health care is such a local business. PhyCor also started out with this strategy but then expanded beyond this strategy into metropolitan areas. It's hard to get any kind of clout in a big market. As a result, PhyCor has begun a downslide.

Q. *Will many physician groups be starting PSOs?*

A. I doubt it. So much capital is required to become a PSO that many physician groups can't take the financial risk. They'd have to put up so much in capital reserves that they would

probably lose money at least for a while. A lot of hospitals aren't willing to take the risk either.

Q. *You mention in your book that the bar has been raised for a new generation of management companies. Who's going to step in to fill the void? Is it going to be the hospitals or another organization?*

A. There could be another model, although sometimes in health care we just see existing models go through a metamorphosis into something that has a new and different name, but it's still the same model. Some physician organizations that can demonstrate strong leader-

ship, technological savvy, geographic restraint, and specialty focus will be the new model of physician organization. Disease management organizations will enjoy a comeback also.

Q. *How hard is it for physicians to raise capital these days?*

A. It's almost impossible to raise capital on the public market right now. There are still organizations that are attracting venture capital, however, so that area is not completely dry. Venture capital firms are still interested in putting money into physician organizations, but they have to be the right physician organizations. Multispecialty groups are having difficulty attracting capital. On the other hand, single-specialty groups with a proven track record of collecting ancillary revenue still are attractive to venture capitalists or other private capital sources.

The health care pendulum swings: Something that is out of favor will eventually swing back into favor, and that will happen with physician organizations to a certain extent. But it will be awhile before the public market comes back to these organizations because they have not been financial winners.

(Continued on page 14)

(Continued from page 13)

Q. *Is there a common formula to follow in valuing a practice?*

A. In terms of practice valuation, there is no cookie-cutter formula for the best acquisition deal. Physicians simply must exercise extreme due diligence in each case. Both the physician

collecting. If you look at the write-offs that organizations take, you can see it's a continuous problem in health care. We haven't seen this recently, but for awhile many of the PPMCs were writing off bills that they hadn't collected and if an organization is publicly traded, it can't afford

"Toward the end of this year many physicians will find out if they have a problem, because their patients will be trying to make appointments into the year 2000, and they'll see whether their computers will accept the data."

group and the buyer of the physician group should complete their own independent valuations, which in some cases in the past has not happened. Sometimes just one side could afford to pay for a valuation and so the other side accepted that value.

Q. *In your most recent book you discuss many issues regarding the management of physician practices. What is the link between operational efficiency and practice size?*

A. Very large practices seem to be dysfunctional and overburdened by politics and bureaucracy. After a certain point, maybe about 20 physicians, groups get less efficient as they get larger. That doesn't mean you can't have an organization that has several hundred physicians, but they need to be organized in smaller pods that can work together. Within these pods, the physicians feel like they have a culture of their own, and they can focus on their patients rather than the bureaucracy of their practices.

Q. *One of the most important chapters in your book concerns billing and reimbursement. Why is this a crucial issue for physicians?*

A. If the money is not coming in, you're just not going to succeed. It's crucial to have excellent billing and collections systems. It's funny how people get so caught up in other things that they forget the basics of this business. All health care organizations, even hospitals and HMOs, have problems with billing and

to do so on an ongoing basis.

Q. *One significant decision health care managers face is the purchase of an information system, which can consume as much as 10% of a practice's revenue. How are physicians to choose between the 300 to 500 products that are currently on the market?*

A. They almost invariably are required to enlist some outside help, because they can't learn it all themselves. A consultant can assess their needs, help them do a request for proposal, and choose a vendor. But once they select a system, it doesn't end there: They need somebody to help them as they go through the installation and training processes.

Q. *Should physicians be concerned about Jan. 1, 2000?*

A. The average physician office has a five-year-old computer, and those computers are probably not Y2K compliant. Toward the end of this year many physicians will find out if they have a problem, because their patients will be trying to make appointments into the year 2000, and they'll see whether their computers will accept the data. In some sense, the Y2K issue is a wake-up call for physicians. Maybe this problem is actually a blessing for health care in that everybody is going to have to spend the money to reach a certain standard of computerization.

Q. *How will the Internet affect physician practices?*

A. We're going to see a huge revolution in how physicians use the Internet. Health care organizations have expressed enormous interest in Web technology so they can be more connected to their physicians. Physicians will be overwhelmed by how easy and fast it will be to use the Internet. Because the connections are becoming so fast, physicians will use Internet communication as a time-saving tool. Physicians will use the Internet for billing, medical education, communicating with patients, ordering prescriptions, collecting outcomes data, and compiling patient satisfaction scores.

Q. *Are we on the road to the paperless office?*

A. We're still a long way from that, but we'll get there. One of the problems has been a lack of standards for forms and processes, but that will come once the focus shifts away from the Y2K problem. Some firms are using a paperless medical record and a patient swipe card with medical information. The momentum will build to the point that we'll have the entrepreneurs that can get us there.

Q. *What's the best way to compensate physicians?*

A. We'll see much more performance-based compensation for physicians. During the recent physician practice buying frenzy, physicians wanted guaranteed salaries, and you can't blame them. They were joining organizations that had no track record of managing physicians. As a result, last year's physician salaries may have been based on inflated contracts. This year's compensation may be more true to form, as the contracts are being reexamined.

The worst thing an organization can do is drastically alter physician compensation, because it will have a rebellion on its hands. Hospitals and physician groups this year will look hard at those contracts and put some benchmarks in. Contracts should not incorporate dozens of different benchmarks, or they will be ineffective, because physicians can't focus on addressing a half a page of benchmarks. Contracts should only have three or four benchmarks that organizations want to use to affect physician behavior. ■

Two Specialists Seek Greater Productivity

By W.L. Douglas Townsend Jr. and Jill S. Frew

Two physicians called recently regarding the issue of productivity, although each one addressed the issue from a different point of view.

The first caller was a faculty member in a large group practice at an academic medical center. He found pressures by managed care plans on groups operating in academic medical centers were making his working environment intolerable. Rather than continue to work under these conditions, he believed he could be more productive, generate more income, and have a more efficient practice outside of the academic setting.

The physician was in his mid-40s and had practiced in the medical center for more than 10 years. He had established a large following in the community and anticipated little problem in starting a solo practice. He wanted to know what advice we would offer to a physician in his position just beginning a solo practice.

This physician is not unusual among those who practice in large groups in academic medical centers. His belief that he could leave the medical center and do well in a solo practice is common among doctors in such settings and is a source of constant consternation to those who provide physician consulting services.

Before they leave a big group practice, all specialists should first assess the reasons they initially joined a group practice. Most specialty physicians join large groups for one or more of four reasons:

1. To avoid the hassles of dealing with administrative chores
2. For professional camaraderie
3. For professional prestige
4. To get referrals that the group has from

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Practice Options.

Jill S. Frew is managing director of Townsend Frew & Co.

within or through long relationships with other physicians in the community

Regardless of their professional reputations, physicians generally find value in the first two reasons no matter what the current status of their particular market. As physicians gain experience and a record of delivering quality medicine, however, the latter two tend to fade as reasons for continuing to function in large group practices. The break point generally comes when a specialist reviews his or her annual take home pay as a percentage of gross billings at the end of a year. The specialist will begin to ask: How much am I willing to pay for these values when my personal income could be much greater if I worked

A physician cannot let the emotion of the situation drive his or her decision. The hard facts of the risks are all that matter, especially if he or she has limited years left to practice medicine.

Hiring a Nurse Practitioner

The second question came from an interventional cardiologist in a group practice in New York. The cardiologist wanted to know if it would be prudent to hire a nurse practitioner to help him increase his productivity.

As is the case in such endeavors, the physician's profession offers certain intellectual stimulation along with the routine necessary to complete daily tasks. In the

A specialist in a large group may become disenchanted with group practice after reviewing his or her annual take home pay as a percentage of gross billings.

in a solo setting with an overhead rate (as a percentage of revenue) much less than what my group currently charges me?

We are strong proponents of the group model and believe it to be the one operating structure that will allow physicians to compete with other large health delivery systems. We also recognize, however, that individual physicians' specific circumstances can lead to a desire for different practice arrangements. Therefore, the issues to consider before leaving a large successful group are several: If you want to be successful in your new setting, you will need to convince yourself that you can increase your take home income by at least 50% because the savings on overhead are indeed substantial. This increase must be net of the lost productivity you project due to:

- More involvement in administration
- Lower fees from a weakened position as a solo practitioner negotiating with managed care payers
- Reduced volume if group referrals are sent to another specialist

practice of medicine, the routine generally requires less professional expertise. The physician makes the best use of his or her time by combining the art and science of medicine to make complex diagnoses for which others are not trained. In a perfect world, the physician would work only on complex cases in which the need for experience and training is paramount. The revenue opportunities in these areas also tend to be the highest.

Employing a physician assistant or nurse practitioner is a wonderful way to increase the revenue capacity of an individual physician or a group. A physician assistant or nurse practitioner can bill out at rates that generally exceed the salaries they are paid, creating positive cash flow. In addition, if the physician is billing greater charges on a more consistent basis due to the complexity of the cases he or she sees, revenue, margins, and contribution also will improve. Therefore, purely from a business standpoint, the use of such extenders makes sense. ■



MDOPTIONS.COM

has just been launched to serve your business-of-medicine needs

Visit us for a **FREE ON-LINE SUBSCRIPTION** to *Physician Practice Options* and get "online" the type of quality information you have come to expect in each issue.

MDOPTIONS.COM includes:

- Archived text of all past issues
- Search by keyword, subject, or topic
- Hot links to other important business-of-medicine sites
- Reviews of business books for physicians
- Forum—interact with Dr. Reece, editor-in-chief, and others who may have already experienced the issues facing you.

New!

- Special Reports available
- Resource Center
- Select areas of interest and we'll contact you with relevant updates

Visit **MDOPTIONS.COM** to find answers to your pressing questions.

TOLL-FREE LINE FOR PHYSICIANS

888 /457 -8800

PHYSICIAN PRACTICE OPTIONS is a practical information resource for physicians seeking to succeed in health care.

Physicians are asking a variety of questions, including:

- What is my practice worth?
- Should I sell my practice and to whom?
- How can I run my business more efficiently?
- What are my career options?
- What is the right information system for my practice?
- How do I evaluate my organizational options?
- Where should I go to get capital?

We are available to answer all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will help to locate the appropriate expert.

To reach us, readers are invited to call toll-free: **888/457-8800**. The service is *free* to readers.

Richard L. Reece, MD
Editor-in-Chief
PHYSICIAN PRACTICE OPTIONS

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

September 30, 1999



Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

BULK RATE
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

