

# PHYSICIAN PRACTICE OPTIONS™

October 30, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Web Links Physicians to Patients, New Technology

Physicians are tapping into consumer interest in the Internet by creating their own practice Web sites. Experts say physicians are expressing increased interest in making information about their practices available online. What's more, physicians are finding that the Web offers much more than a way to attract patients.

Given that many components of health care are being computerized and that the Web is a vital ingredient in almost all computerization efforts today, it follows that physicians should become thoroughly familiar with the Web, says Brett Trusko, executive management consultant at Superior Consultant Co. Inc., a nationwide health care information management and technology company in Detroit. Having a Web site will pay dividends in terms of exposing physicians to the technology and will allow them to become familiar with technological innovations that are critical to doing business today, experts say.

The services that are being computerized today include referrals, risk assessment, health education, treatment option selection, case management, family support, care planning, and self-help, says Trusko, who consults on Web site development for physicians and other providers. "While we don't have the technology to do many of these things yet, I encourage physicians to get their feet wet by developing a Web site," Trusko says. "This technology will be coming soon. It doesn't hurt to get some experience with it, even if the initial venture is simply providing information to patients."

Two years ago, Frank Jackson, MD, president of Jackson Gastroenterology in Camp

Hill, Pa., opened a site on the World Wide Web ([www.gicare.com](http://www.gicare.com)). "I thought a site would be a good way to offer information to patients and tell them about my practice before they came here," says Jackson. The site has become one of the most popular gastroenterology sites on the Internet. When doing a recent search for the word "gastroenterology" on America Online and the Microsoft Network, Jackson's site appeared in the top three according to the search engines' determination of relevancy.

### Business Benefits

One of the main purposes of physicians' Web sites is patient education. "Physicians often find that a Web site improves communication with patients," says Douglas Munn, a systems consultant with Superior Consultant Co. Munn assists health care professionals with Web site development. "With a site, physicians can easily share a wealth of information with current and prospective patients," he says. "People generally like to use the Web. In fact, many physicians tell me that even their older patients will ask if they have a site."

Furthermore, a Web site can help build a patient's confidence in the physician and reduce treatment anxiety. "Getting to know the physician through the Web site raises a patient's comfort level," says Munn. "Patients feel more familiar with the physician, and they are more prepared when they come to the office because they have a better understanding of the specialty and medical treatments."

Jackson agrees, saying, "Our site provides important information to patients about their diseases, appropriate diets, and what to expect from endoscopy pro-

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## The Internet Is Helping To Improve Practice Efficiency

A Harris Poll done in July indicates that 70 million Americans now use the Internet to look for health care information, an increase of 15% since January. A Healthcon Poll released in July shows that 85% of U.S. physicians are now using the Internet to get information, an increase of 42% in the last three months, a jump of 87.5% from 1997. More than 64% of physician surveyed use e-mail daily and 33% have used e-mail to communicate with patients. Physician-patient communication by e-mail has risen by 200% in the last year, the Healthcon survey shows.

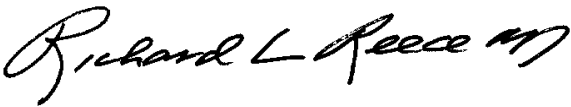
Recently, a newsletter produced by the Medical Group Management Association listed many of the qualities of e-mail for physicians. Primarily, as we have reported, it is asynchronous, meaning a physician can reply when time allows. It is also informal and long lasting in that e-mail files remain on computers. At the same time, it can never replace direct patient contact, and physicians who use it to communicate with patients should copy their e-mail comments and make them a part of the patient record. Since the written word can lead to legal difficulties, physicians should use e-mail only after first developing written policies on ways to minimize legal liabilities.

Since it is such a powerful method of communication, the Internet can be used successfully to help physicians build their practices, says Robert B. Connery, a consultant with the Health Care Group, consultants in Plymouth Meeting, Pa. In an article on marketing a physician practice on the Internet, Connery says, "The information superhighway can deliver your message to thousands of people, including your current and potential new patients. If you do not already have a Web site, establish one and make sure your Web site is easy to find."

In another article on the topic, Paul Weigel, administrator at Citrus Cardiology Consultants, a cardiology group in Inverness, Fla., says that before the Internet became widely available, many projects in physicians' offices languished undone due to lack of communication. Typically, employees felt uninvolved and unimportant and were left "in the dark" about many important topics. Implementing new policies and procedures faltered and failed due to lack of effective follow-up. Telephone tag frustrated employees and slowed productivity and it was difficult to keep staff up to date on rapidly changing managed care plans. Often, physicians and other staff members would complain—sometimes falsely—that "I never got the message," as an excuse for not implementing new policies, Weigel says.

After e-mail communication became widespread, however, it helped the group to coordinate the efforts of each team member on projects and improved accountability, Weigel says. Morale improved because staff members had a new way to present good ideas. E-mail provides an efficient means to gather the opinions of staff members and to make adjustments in projects underway. Questions are answered quickly and succinctly. Urgent messages are delivered promptly and usually generate a quick response.

Obviously, e-mail and the Internet offer new ways to improve practice efficiency and are helping to make physicians more productive. In this age of managed care, any increase in efficiency is welcome.



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# Physicians Need Unconventional Ideas

By Richard L. Reece, MD, editor-in-chief

Under managed care, many physicians want to reconfigure their practices, but want to know how they can do so both effectively and inexpensively. The answer to this question often requires a significant shift in the way physicians address the practice of medicine because unconventional approaches today may be the most likely to succeed.

One reason unconventional solutions may be most effective is that health care is in the midst of a rapid and radical transformation. The Internet is transforming health care and medical practice. Armed with unprecedented clinical and medical information, patients are becoming powerful consumers, according to published reports. Governmental and managed care payers are driving down reimbursement. Practice expenses are rising significantly. To cope, physicians are merging into larger groups, forming single specialty networks, and forming and joining unions.

To be sure, many of the traditional approaches to medical practice should be continued. Physicians should attempt to gain more market share by negotiating new managed care contracts and seeing more patients. Cost reduction strategies should be identified and pursued. But doing these things, even doing them well, may not be enough. Reputation and experience alone will not guarantee patient volume, solid reimbursement levels, or favorable managed care contract terms.

## First Tentative Steps

Instead, current challenges call for unconventional thinking in assessing practice structure and revenue opportunities. At some point, physicians must recognize that the practice of medicine has changed irrevocably, and they must change as well. Once they make this realization, physicians begin to be more receptive to new ways of doing business. But refocusing ideas that were formed through years of training, experience, and meeting public expectations may be difficult. Typically, physicians begin their first steps toward unconventional thinking by

seeking to gain an understanding of the new environment through reading.

In their classic 1982 book, *Megatrends*, and later in *Megatrends 2000* (New York: William Morrow), John Naisbitt and Patricia Aburdene identified several broad trends that illustrated how the United States was evolving. Using a technique

mined to participate actively in their own health care decisions.

- Hierarchies to networking. Patient networks offer something no health care bureaucracy can: patients with common diseases linked together on the Internet or in local and regional support groups. Patients in these groups

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called content analysis, Naisbitt and Aburdene examined the content of newspapers across the country and found that American society is transforming from:

- An industrial to an information society. Power is gravitating to those with information, such as Internet-savvy health care consumers.
- A national to a world economy. Physicians often must adjust to new cultures, by learning to speak other languages in areas with large non-English-speaking communities, for example.
- Short to long term. Attention is shifting from daily, operational concerns to developing strategies to meet tomorrow's business objectives.
- Centralization to decentralization. The Internet and other economic forces will overcome such traditional power pyramids as academic medical centers and staff-model HMOs as well as the traditional barriers between patients and physicians.
- Institutional to self-help. A recent Harris poll showed, for example, that 70 million Americans now use the Internet when seeking health care information. Many Americans use this information to treat themselves.
- Representative democracy to participatory democracy. Patients are deter-

sometimes trust each other more than they trust their physicians.

- North to south. Most significant health care trends have not started in the Northeast, but rather in large states such as California, Texas, and Florida, where much of the for-profit entrepreneurial health care activity—in hospitals, in physician management companies, and in HMO growth—has occurred.
- Either-or to multiple options. Increasingly, consumers want to be able to choose their own physician, hospital, and health plan, and they want to shop for comparative value among those choices.

## A Second Primer

A more recent book addressing shifts in society is *The New Pioneers: The Men and Women Who Are Transforming the Workplace and Marketplace* (Simon & Schuster: New York, 1999), by Thomas Petzinger. A former reporter for *The Wall Street Journal*, Petzinger cited examples from a variety of industries to explain some of the shifts occurring in society today.

At one time, society was dominated by discussions about optimum design and consistency of operation; today, experts aim for adaptation and continuous improvement, Petzinger says. As a result,

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medical groups, no matter how well-structured, are learning to adapt. Petzinger points out that for many years, the command-and-control model of management was popular. Today, employers are giving more autonomy to employees and encouraging them to articulate their visions for improvement. For medical staffs, this shift means it is time to train office personnel to use their judgment.

Petzinger points out that in the past, industries were built on land, energy, and materials. Today, businesses need information and information management systems. For physicians, this shift means success in medical practice will hinge on information physicians can provide to patients. The economy has shifted from one dominated by producers to one dominated by consumers. For physicians, this shift means the source of economic authority will be health care consumers, not payers or physicians.

#### Unconventional Ideas

While experts can identify shifts in society and work to define trends in business and industry, physicians need practical ideas about how to build a successful medical practice today and in the future. For physicians, we recommend the following:

1. Foster physician communication
2. Develop your office staff
3. Use e-mail to communicate with patients
4. Widen your revenue streams

**Foster physician communication.** Conventional wisdom says that each physician in a practice must have his or her own office. These offices may please egos, but they can constrict conversations and inhibit group efficiency and innovation. A six-physician group of ear, nose, and throat specialists in Minnesota has thrived under managed care because it encourages productivity and efficiency. According to the group's founder, one of the main keys to its success is that physicians' desks are in a large open room in the center of a group of offices. The physicians sit back-to-back in swivel chairs. This configuration allows them to discuss issues and settle matters quickly and efficiently, without any intervening, time-consuming bureaucracy.

## Hand-Held Computer Captures Physician-Patient Data

One physician who is using technology to develop unconventional approaches to solve problems is Lloyd Hey, MD. Four years ago, this spine surgeon and assistant professor of surgery at Duke University Medical Center, founded a company, Clineffect System Inc., based on six simple observations.

1. The heart of the health care system is the patient-physician encounter.
2. Encounter data account for more than 75% of the information that supports billing charges and clinical information used in patient care.
3. Almost 20% of data generated by physicians must be reworked and resubmitted for payment, a costly consequence of not getting it right the first time.
4. Expensive and unwieldy health information systems control collection and use of data throughout the treatment process—except at the point of care, where less than 2% of all physicians collect data electronically.
5. Physicians can collect these data at the point of care, using a hand-held device and download the data at their convenience using a personal computer and Internet software. In this way, physicians can capture data accurately from all patient encounters, without interrupting their work processes.
6. Some 25% of all physicians own hand-held computers and 85% use the Internet, making the Clineffect system useful for many clinicians.

Hey realized that these observations have far-reaching implications. Since 1995, 115 Duke surgeons have used hand-held computers, personal computers, and Internet software to document more than 700,000 patient encounters. Each year, Duke estimates Clineffect's data system saves \$8 per encounter, \$15,000 per physician, and \$1 million for the department of surgery. Duke has signed a contract with Clineffect to extend the system for all of Duke's clinicians.

An orthopedic surgeon, Hey, 37, has an electrical engineering degree from the Massachusetts Institute of Technology, a medical degree from the Harvard Medical School, and a master's degree in clinical epidemiology from the Harvard School of Public Health. From his previous work as a resident trying to measure orthopedic surgery outcomes, Hey recognized that health care involves three separate and distinct areas: clinical medicine, administration, and outcomes. Physicians participating in each of these three separate areas operate in the absence of information about the other two areas. The only binding event is the patient-physician encounter.

Hey's system is a vivid example of a significant shift at work. The shift is occurring from information managed in a back office to being available as physicians meet with patients. Hey's system shows how the creative use of the technology can solve problems that may have been previously unsolvable. —RLR

Petzinger believes physicians do not necessarily need to reorganize their practices to increase efficiency. Often they can improve effectiveness simply by speaking openly with one another. For example, a group of heart surgeons in five New England hospitals dropped mortality rates by 24% in one year by simply observing each other in practice and holding meetings to discuss their work processes with each other. Gastroenterologist Steven

Morris, MD, of Atlanta, provides another example. He runs the Network for Gastroenterology Communication and Research, a loose affiliation of specialty physicians from across the country who meet regularly to share ideas.

**Develop your office staff.** Obviously, the office staff, even in a solo practice, can significantly enhance practice revenue by working together with physicians as a team. Two family practitioners, one in

California and one in Michigan, provide examples. Each has a staff of 10 to 12 medical assistants who have been trained to perform multiple tasks, such as recording patient histories, drawing blood, taking vital signs, preparing patients for x-rays, answering patients' questions, and arranging refill prescriptions for the doctor's signature. The physicians, meanwhile, perform physicals and address the most pressing of patients' questions.

These physicians have learned to excel at leading their teams and to become more productive by asking staff members at periodic meetings, "How can we do things better? What can you do to help me do my job better? In your opinion, what are we doing wrong?" Showing humility and asking for help from staff members can result in heightened practice efficiency.

Marshall O. Zaslove, MD, a psychiatrist and physician productivity expert in Napa, Calif., says physicians can build a successful team by sponsoring staff educational activities, requiring staff members to cross-

## Physicians have become personally more productive by asking staff members, "How can we do things better?"

train each other, asking each person on the team how others do their jobs, training staff members in efficiency-enhancing techniques, and encouraging each one to handle problems without being asked.

Two excellent sources of information on this topic are Zaslove's *The Successful Physician: A Productivity Handbook for Practitioners* (Aspen Publishers Inc.: Gaithersburg, Md., 1998), and *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients* by Susan Keane Baker (Jossey-Bass Publishers: San Francisco, 1998).

**Use e-mail to communicate with patients.** At first, this idea may seem risky, but to Tom Ferguson, MD, publisher of *The Ferguson Report*, an online newsletter for health care professionals, it makes perfect sense. "Providers who choose not to

respond to their patients' growing demand for online communication will lose customers to online competitors," Ferguson says.

**Widen your revenue streams.** There are many ways to widen a practice's revenue stream by introducing new services. For example, some physicians have expanded their practices by introducing a nutritionist or a pain relief specialist. Other physicians have started to offer ancillary services or perform office-based procedures to allow the collection of facility fees as well as professional fees.

In sum, these ideas might seem unconventional, but in the new practice environment, they might mean the difference between a moderately successful practice and an exceptional one. ■

# Physician Finds New Career Invigorating

By Kent Bottles, MD

Physicians in increasing numbers are finding it necessary to reinvent themselves and transform their careers. Some realize after years of practice that they made the wrong choice of career to please a parent or some other family member. Others simply want to change their career to enjoy continued professional growth. Many are dismayed by the changes attributed to managed care and restrictive cost-containment measures in health care. The last group has tired of what the practice of medicine has become and yearn for simpler and more fulfilling work.

The projected oversupply of physicians in the United States contributes to the feeling of anxiety and loss that many physicians are experiencing. The estimates range from 100,000 to 300,000 American physicians who will be forced by the global economy or who by personal choice will elect to try a nonclinical career. In 1998, the Medstat Group, consultants in Ann Arbor, Mich., conducted a study of 30,000 physicians in 22 cities and found that 46% of American doctors often think about leaving clinical practice.

## Management Material

Just as telling but less quantifiable are numerous indications that American physicians are not satisfied with the practice of medicine. Many are flocking to MBA programs; others are filing for disability claims in numbers that make insurers stop underwriting such policies for physicians, according to published reports. Some physicians are selling herbs and cleaning products out of their homes to supplement their incomes. Members of the AMA and physicians in Los Angeles County voted last summer to form unions.

*After a 20-year career in academic pathology and administration, Kent Bottles, MD, of Narberth, Pa., now consults and writes about physician careers, the Internet, information technology, medical education, and medical marketing.*

My own story reflects many of the trends described above. After nearly 20 years in academic pathology, I found myself professionally restless and willing to take on new administrative roles. At the University of Iowa, I served as interim head of pathology and reengineered a department. Also at the university, I served as medical director of UICare, the gatekeeper managed care plan for faculty and staff, and UISelect, the point-of-service managed care plan for faculty and staff. I also served as medical director of managed care, and corporate operations officer for ambulatory services at UI.

responsibility and salary. I assumed I would end up as dean of a medical school or medical director of a large integrated delivery system. To say the least, it was disorienting to think of other possibilities.

I was lucky. My saga had a happy ending. Earlier this year, I was able to convince Judith von Seldeneck, the founder and CEO of the Diversified Search Cos., of Philadelphia, to take a chance on me. She hired me as the first physician managing director of this national executive search firm. I also assumed management responsibilities at Manchester/Diversified, a company in

**After defining the job one desires, research must be done to identify both the organization and the person in that organization who has the power to create a new position to use one's skills and interests.**

When the Allegheny integrated delivery system based in Philadelphia and Pittsburgh offered me the chance to become professor and chair of the Department of Pathology and Laboratory Medicine, I took the opportunity to leave an immature managed care market and test my mettle in the tough Philadelphia marketplace. About a year after arriving in Philadelphia, I found myself on administrative leave from a bankrupt American medical school. A national job search revealed several possibilities for interesting physician-executive positions, but none was located in the Delaware Valley. The family conference that I thought would endorse my plan to move to Chicago, instead culminated in a family decision for me to do something useful in Philadelphia so the family would not have to relocate again.

At 46 years of age, I embarked on the first job hunt in my life. In the past I had never had to look for a job. My career had been one of positions of increasing

Philadelphia that does executive coaching, training, and career development consulting.

## Lessons Learned

These jobs gave me an opportunity to learn some of the idiosyncrasies of corporate life. At the same time, I got an education in how the job-search market in America during the information revolution works. I had to become familiar with a new language; I had to package myself to attract the attention of employers in the private sector; I had to change my resume and interviewing techniques; I had to learn how to network and promote myself. I had to accept that my transferable skills were attractive to employers, but I had to start all over and prove myself even though I had been a tenured full professor and someone who had a good national reputation in cytology. I accepted a decrease in salary with incentive payments tied to productivity.

It turns out that reinventing one's

career is likely to be most successful if one takes the time to try to figure out what one likes to do, what one wants to do, and where one wants to do it. In my case, I knew I wanted to teach, write, and work with other professionals, and my family demanded that it be within commuting distance of Philadelphia.

Although I did not go through a formal assessment process during my job search, I wish I had. I have since learned that assessment in the career world includes a battery of tests that can be taken on a computer and that reveal clues to how each of us learns, relates to colleagues, thinks, leads, and manages. I have since taken the Meyers Briggs psychological test, the Strong Interest Inventory, and the Life Styles Inventory, and I am surprised at how useful the results are in understanding what makes me happy and successful in the workplace. These tests revealed that I would be happiest in a position that involves public speaking, social service, writing, art, and nature; they indicated I would be least successful and fulfilled in the military, accounting, and mathematics.

#### Research Required

After defining the job one desires, research must be done to identify both the organization and the person in that

then used all my personal and professional contacts to meet with insiders in these two industries.

Creating a position that is tailor-made for you will make human resources departments nervous. In my experience, HR professionals will want to fit you

**Creating a position that is tailor-made for you will make human resources departments nervous. In my experience, HR professionals will want to fit you into existing job openings, not create a new position that will benefit both you and the company.**

into existing job openings, not create a new position that will benefit both you and the company.

For this reason, you should seek in your research and networking to meet the person who has the power to create a new position. In small companies, this person may be the president and CEO. In larger companies, it may be a senior executive but not the president or CEO. Getting a face-to-face meeting with that executive is the key to reinventing yourself into a position that will be satisfying and that will make you successful. Let's face it: von Seldeneck offered me a job

Can Transform Themselves and Their Careers in June in Philadelphia. The presentations were divided between career counseling experts and physicians who had already transformed themselves into physicians who specialize in being medical directors,

doing home visits, working on Internet projects, working as television or radio reporters, pharmaceutical investigators, and consultants. The evaluations indicate that the many attendees found the information on physician discontent and career management useful and timely. Future conferences are scheduled for Boston (Nov. 12 and 13), Philadelphia (Nov. 19 and 20), and Washington, D.C. (Jan. 14 and 15). In reaction to the overwhelming response to the conferences, I have set up one-day sessions in the Philadelphia area for physicians who cannot get away for a two-day CME course.

When Manchester/Diversified decided not to pursue the continuing education niche, I amicably left these companies to go out on my own to continue to provide assistance to physicians who want to reinvent themselves and better understand how they can fit into the new landscape of medicine created by the information revolution and the Internet.

The varied fields that physicians are occupying in the American workplace astound me. *Careers in Medicine: Traditional and Alternative Opportunities* (Garrett Park Press, 1990) has the most extensive list of positions held by physicians; it lists more than 1,000 jobs for physicians.

While my own career has taken an unexpected direction, I am happier now than I have ever been professionally. ■

**"I had to start all over even though I had been a tenured full professor and had a good reputation in cytology."**

organization who has the power to create a new position to use one's skills and interests. This research can be done by using the Internet, by networking with personal and professional contacts, and by seeking out leaders in the field. I was surprised at how many individuals were willing to meet with me for 10 minutes to offer advice about the field I was targeting. My research revealed that I would best fit in an executive search or consulting firm. I

because she liked me and thought I could be of use to her company.

Since many of my friends and colleagues in medicine are finding consolidation of hospital systems, new owners, and new bosses are making reinvention of careers more attractive, I convinced my new employers that a continuing medical education conference to help physicians deal with these trends was needed. We held the first Chrysalis Conference: How Physicians

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cedures. We prompt new patients to look at the site prior to their appointment by sending them a description along with new patient forms that highlight the site and ask them to check it out. Patients are reassured when they can reference the site prior to a procedure such as endoscopy, which can cause some anxiety. Then, patients can look back at the site after the appointment to reference information when they need it."

Through providing information and enhancing patient comfort, Web sites also can serve as a time-saving strategy for physicians and office staff members if information that is repeatedly shared with patients can be posted on the Web. "A physician who finds a way to encourage patients to self-educate leverages his or her time," says Munn. "Visits become more efficient, because repetitive questions, as well as the patient's anxiety level, are reduced."

#### Practice Marketing

A second purpose of physician Web sites is practice marketing. The AMA conducted a survey of 1,905 physicians in 1997 and found most (89%) were using the Web and that of this percentage, 17% had a Web site. Of those who had a site, 62% reported that their primary reason for site development was to advertise and promote their practices. Undoubtedly, the number of physicians who have Web sites has grown substantially in two years.

Munn points out that consumers select physician practices as a result of what they learn from the Web. "When people are new to a community, they might use the Internet to find a physician," says Munn, who has sought physicians for his family on the Web. "Also, people might look at their insurer's site to find links with provider Web pages."

Jackson indicates his practice has generated patient referrals as a result of the site, although this new volume is not quantifiable. "We do get some local referrals, and our four-week wait time for new appointments increased a bit after we implemented the site," Jackson says. Moreover, Jackson has received calls from consumers in Western states who thought he had the only practice that could help them. "That wasn't true, of course," Jackson says.

"They were going to good physicians and were just frustrated because their problems were resisting treatment. But obviously the site generated a degree of patient interest." Still, Jackson didn't develop his site to gain new business. "I was busy enough," he says. "I just wanted to enhance the quality of the practice, and tell people what we were about."

#### Features to Consider

When considering what to provide to patients on a Web site, physicians should offer as much information about the practice as possible. Pictures of the physicians and staff and a list of the

helpful sites as a service to patients."

In addition to webmd and drkoop, other popular health sites on the Web are AMA Health Insight ([ama-assn.org/consumer.htm](http://ama-assn.org/consumer.htm)), [nih.gov](http://nih.gov), [thriveonline.com](http://thriveonline.com), [betterhealth.com](http://betterhealth.com), [intelihealth.com](http://intelihealth.com), [mayohealth.org](http://mayohealth.org), [mediconsult.com](http://mediconsult.com), [onhealth.com](http://onhealth.com), and [ahn.com](http://ahn.com), according to *USA Today*.

Patients typically want to know more about a physician than specialty-specific information. "The most appealing Web sites will be those that make the patients feel connected to the practice," says Munn. "Pictures and biographies of the physician and the staff, including personal information, such as hobbies and inter-

**"Overall, I feel that a Web site adds prestige to a practice. It gives a feeling of completeness to the practice, and shows that we've really gone the extra mile for our patients."**

**—Frank Jackson, MD, Jackson Gastroenterology**

physicians' society affiliations and memberships can be included. Several methods of contact should be included as well, such as office address and telephone numbers, directions and maps to the office, and links to enable the user to send an e-mail message to the staff.

Also, physicians should discuss their services in detail. "Patients are most interested in their illnesses," says Munn. "So, the site should have complete descriptions of the illnesses and treatment options that fall under the physician's specialty."

Sometimes, patients are not even sure what services a specialist physician will offer. As a result the practice should describe all services the practice provides and describe what these services entail for the patient, Trusko says.

A number of medical Web sites publish information for consumers and encourage other Web sites to provide links to this information. "Sites like [webmd.com](http://webmd.com) and [drkoop.com](http://drkoop.com) encourage consumers to use their drug interaction databases and other information on their sites," says Munn. "Physicians should try to tap into these resources and could provide links to these

ests, show them as real people."

Similarly, the best physician Web sites reflect the practice's mission and the physicians' perspective on patient care. "Before developing a site, a physician should reflect on his or her philosophy of practicing medicine and the message he or she wants to convey, and incorporate that message into the site," Trusko says. "For example, if a practice stresses personal service, the site should emphasize that characteristic."

Jackson's site includes an extensive amount of information on the gastroenterology specialty and services such as endoscopy. It also includes sections with Jackson's personal thoughts on good health and longevity, and a section on marathon running. "I included items that reflected my personal interests," Jackson explains. "I wanted patients to see me and my staff as real people who had opinions and interests." The site includes pictures of Jackson and his staff.

Regardless of content, one of the most important characteristics of any Web site is clarity. "Users should be provided with clear instructions, so that they can easily negotiate the site," Trusko says. "Information

(Continued on page 9)

(Continued from page 8)

should flow logically, and links to subsections should be unambiguous.”

Jackson concurs. “The site should be clean, not fussy,” he says. “The designers can tell you 50 things they can add to the site, but maybe only a dozen make sense for you. Overall, the site should be simple to use in order to offer the best service to the public.”

Before developing the site, physicians may want to determine patients’ information needs and interests. “Physicians who want to develop a truly useful site should ask patients what they want included,” Munn explains.

The actual creation of a simple Web site can be relatively straightforward. Since most physicians probably do not have the time or the expertise to develop their own site, Web design studios can assist in developing sophisticated sites, designing the flow, and helping to write the content. Site design can take anywhere from one month to one year, depending on the complexity of the site. Likewise, site development can cost anywhere from a few hundred dollars to tens of thousands. The cost to rent a Web site location on the Internet depends on the server, and can range from about \$30 a month for a site of limited capacity to more than \$150 a month.

Despite hectic schedules, physicians should participate in every step of site development. “Physicians should meet initially with the designer to describe what they are trying to accomplish and what information they would like to include,” Trusko says. “Then, they should approve all prototype screens. Physicians should ensure that their message is clear, that all of the links are operational, and that they like the aesthetics.”

Before Jackson Gastroenterology developed its site, Jackson met with the designers and his staff and sketched a rough model of what he wanted on the site. “I knew I wanted two sections,” he says. “First, I wanted a description of the practice, and second, I wanted to offer patient education, including some personal interest items.” Given these content guidelines, the designers produced a variety of ideas for the design. “We batted those back and forth until we came to an agree-

ment,” Jackson explains.

Most important, physicians should ensure that their sites reflect the quality of their practices, Trusko advises. “If the site is sloppy or otherwise poorly done, patients might associate those negative qualities with the practice,” he says.

As a result, physicians would be well advised to keep their sites current. “Otherwise, the site becomes a waste,” Munn says. “Nothing is as bad as outdated information. If material is outdated, people will not look there again. Furthermore, an outdated site reflects sloppiness, lack of precision, or lack of care, and this impression may lower patient confidence in the

the site. “I wanted the name of my site to reflect its content,” says Jackson. “Then, people interested in “GI care” would be more likely to check it out.”

#### Measuring Effectiveness

As with any marketing or advertising effort, physicians will want to ensure that consumers and patients are visiting the site. “Various tools can be used to determine how many visits a site receives and how long users tend to spend in the site,” says Trusko. Many Internet service providers that host pages produce periodic reports listing the number of hits, (downloaded files), number of pages viewed, and number

**“People generally like to use the Web. In fact, many physicians tell me that even their older patients will ask if they have a site.”**

**—Douglas Munn, Superior Consultant Co.**

practice. Amend the site whenever there are changes in staff, hours, services, or insurance.”

What’s more, posting inaccurate or out-of-date information can leave a physician open to possible legal liability.

Jackson revises his site regularly. “You just can’t walk away from your site; you have to put time into it,” he says. “I try to do my *GI News* section every three months, and I add interesting articles every six months.”

#### Advertising the Site

Once they develop a site, of course, physicians need to make sure patients and consumers know about it. “The Web address should be added to business cards and letterhead,” Trusko says. “It can be included in advertisements, and within the sites of the hospital and payers with which the physician is affiliated.”

The physician group should register the site with many various search engines, and add the Web addresses to physician indexes, general medical sites, and specialty-specific sites, Munn says.

Trusko suggests that physicians include descriptive words in the name of the site, so that users will be more likely to enter

of unique visitors, among other statistics.

Munn also suggests that physicians consider distributing comment cards to patients, and that a site should let users send comments and suggestions to the practice via e-mail. “Being proactive in soliciting user feedback promotes the site, maintains user interest, and can provide information because patients may have visited other sites and can point out interesting improvements,” Munn says.

At the end of each patient visit, Jackson asks patients for their comments about the site. “I ask them if they found it useful and interesting, and if they learned anything,” he says. “We get compliments on the site over the e-mail every week from all over the world.”

“Overall, I feel that a Web site adds prestige to a practice,” Jackson explains. “It gives a feeling of completeness to the practice, and shows that we’ve really gone the extra mile for our patients. Beyond that, I have gained a personal sense of satisfaction in developing a quality product on the cusp of the information age when I did not know what the ultimate payoff would be.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

# Episodic Care of Simultaneous Conditions

By Douglas W. Emery, MS

An episode of care can be viewed from three perspectives: the patient's episode of illness, the clinician's episode of disease, and the financial system's episode of medical services. It follows an orderly sequence beginning with diagnosis, proceeding through therapy, and concluding after a period of follow-up.

An episode consists of six interrelated components:

1. A subject of care around whom the episode is constructed
2. An underlying condition that requires care
3. An objective of care
4. A set of clinically homogeneous processes that can be combined in pursuit of the objective of care
5. A well-defined duration of care
6. A unique circumscribed domain of care that is complete, permitting analytical discernment, global reimbursement, and the efficient allocation of risk.

## Complex Episodes

In its most basic form, an episode of care is a complete, self-contained sequence of interactions between a patient and providers of health care services in pursuit of a defined objective over a specified period of time. Episodes of care can be relatively straightforward when they occur as isolated responses to illness. But if they are to serve as an organizing principle for all of managed care, episodes also must describe the care of complex patients with multiple diseases and comorbid conditions. This can be accomplished by dividing episodes into three types of episodic categories that are related to simultaneous conditions. These would be episodes that are: additive, polymorbid, and polymorphic.

**Additive episodes.** Not infrequently, a patient will present with multiple illnesses or injuries, or new illnesses will occur before old ones have transpired. These are

additive episodes, so called because they overlap one another in time. For instance, a pregnant mother injures her ankle during the second trimester of her third pregnancy. Or a 35-year-old factory worker being treated medically for a herniated disk develops strep throat. In each of these examples, an individual experiences simultaneous episodes of care for two clinical conditions that are unrelated etiologically. The two distinct episodes can be managed and priced independently. If the global fee for an episode of routine obstetrical care is \$5,375, and the global fee for an episode of care for a fractured ankle is \$3,850, then the additive

terms of treatment are influenced by the presence or absence of other diseases in such a way as to raise the combined level of resources required to treat all diseases, for example, diabetes in the presence of obesity, or hypertension and obesity."

The best method of classifying polymorbid episodes is to begin with basic episodes of care, such as a discrete condition in an otherwise healthy person, and then adjust for morbidities that complicate the episode. Analytic methods used to risk adjust patients' outcomes are ideal for this purpose. In this way, empirical data can be used to derive algorithms that adjust basic episodes to account for

**Episodes of care must describe the care of complex patients with multiple diseases and comorbid conditions.**

amount for the two episodes should be \$9,225, whether they are delivered to two individuals or to a single person, simultaneously or sequentially.

**Polymorbid episodes.** In modern medicine, simple self-limiting illnesses in otherwise healthy patients are the exception rather than the rule. Unlike additive episodes, polymorbid episodes encompass conditions related in numerous, sometimes extremely complex ways. Defining each set of interactions as an all-encompassing, circumscribed, unique episode of care is a challenge, but one that is not beyond the limits of current technology.

There are two varieties of polymorbid episodes of care. In potentiating polymorbid episodes, coexisting conditions make the whole more than the sum of its parts. In inversely potentiating polymorbid episodes, efficiencies of scale make the polymorbid episode less costly to treat than the sum of its individual components would be if they were treated separately.

Experts have defined potentiation among simultaneous episodes as "two or more coexisting morbidities in which pat-

increases in a patient's severity and clinical complexity when each episode begins.

The advantage of severity-adjusting basic episodes is that resource consumption can be tracked and reimbursement can be determined using a manageable number of distinct episodes. Operationally, the addition of specific components to polymorbid episodes may alter optimal approaches to their management. Identifying and implementing these optimal approaches are essential in providers' management of technical risk.

Purchasers of health care, however, need only to determine appropriate levels of payment for different combinations of comorbid conditions. This latter task is far less daunting than developing individual algorithms for the care of all possible combinations of patients and conditions. Furthermore, accomplishment of this task will create a market environment that encourages providers to obtain and use information about clinical processes and outcomes to improve the effectiveness and efficiency of their management of polymorbid episodes of care.

*Douglas W. Emery, MS, is president of Zoadigm Health Systems, in Salt Lake City.*

## Systems designed to support performance monitoring and global reimbursement based on episodes of care must incorporate mechanisms to adjust for severity.

Recognition of polymorbid episodes of care also acknowledges the primary importance of individual patients in episodes of care. Carving what a patient views as a single problem into multiple discrete episodes, each addressing a single coexisting condition, encourages fragmentation of care. In some circumstances, designations of basic episodes may vary with clinical judgment. On the other hand, polymorbid episodes constructed for similar patients with similar conditions will become strikingly similar regardless of the basic episode that generated them. For example, whether pneumonia in a patient with metastatic cancer is treated as an episode of care for pneumonia in a setting of metastatic cancer or as an episode of care for metastatic cancer complicated by pneumonia will have little effect on the episode's ultimate resource corridor or its optimal clinical management.

Occasionally a polymorbid episode requires fewer resources to manage than do its components when they are distributed among several different patients. For instance, the simultaneous treatment of otitis media and bronchitis in a single patient may be more efficient than the treatment of each in different patients. In this example, if the combined treatment of bronchitis and otitis media improves patient compliance so that recovery from both is quicker, costs may be reduced significantly. These inverse potentiating polymorbid episodes may be less frequent than potentiating episodes, but they provide a splendid opportunity to profit from increased efficiency by bundling services.

**Polymorphic episodes.** If the course of clinical management were always completely predictable and complications and unexpected deterioration never occurred, equitable fixed global prices could be derived to cover all clinical situations. Unfortunately, even episodes that seem routine can become

extremely complicated rapidly.

This tendency for clinical episodes to degenerate into worst-case scenarios creates a genuine concern among clinicians about assuming technical risk. They may view many of these clinical nightmares as unavoidable acts rather than as avoidable sequelae of technical miscalculations or blunders. Although most analyses of clinical outcomes demonstrate that outliers are relatively rare, episodes of care must recognize the dynamism of polymorphic episodes. Episodes also must make provisions for the more frequent, less catastrophic complications that are a part of daily clinical practice.

Although traditional risk adjustment centers on severity of illness at the beginning of an episode of care, additional adjustments may be required during an episode. At the beginning of an episode of total hip replacement, adjustments must be made for a 70-year-old woman with osteoporosis that are not required for a 27-year-old athlete experiencing necrosis of the hip due to a poorly healed fracture. In both cases, however, outcomes and resource consumption are expected to be consistent with projections, whether these projections are based on polymorphic episodes or on basic episodes. Problems arise when either of these two patients develops post-operative pneumonia or a wound infection with gram negative sepsis.

When does a complication that occurs in the course of an episode of care become an outlier, meaning a catastrophe that is reimbursed as a separate occurrence? Or, in terms of technical risk, what events are incorporated in the technical risk borne by providers and what events constitute new occurrences that are separately insured and reimbursed?

Systems designed to support performance monitoring and global reimbursement based on episodes of care must incorporate mechanisms to adjust for severity, not only at the onset of an episode but also as the episode progresses.

They must provide information about expected clinical outcomes for basic and severity-adjusted episodes and about expected severity-adjusted resource consumption for routine care, for routine care plus the care of noncatastrophic complications, and for routine care plus the care of catastrophic and noncatastrophic complications. Global fees are established based on reasonable reimbursement rates for severity-adjusted routine care and for the routine care of episodes of catastrophic complications.

Therefore, performance monitoring and the establishment of global reimbursement rates must be based on sound empirical data. These data must mirror clinical practice and must be adequate to support required analyses. Two good examples of systems designed to capture needed clinical data for these purposes are Clinical Practice Improvement Methodology created by researchers at ISIS Inc., in Salt Lake City, as part of the comprehensive severity index and the risk-adjustment methodology created by Michael Pine and Associates Inc., in Chicago, and used by Anthem Health Plans of Ohio to evaluate competing episode providers in its coronary services network. The Mayo Clinic in Rochester, Minn., also is developing a sophisticated electronic medical record and decision support system based on the episode of care.

Creating an infrastructure to support the application of episodes of care is a formidable undertaking, but the health care system is gradually evolving to such a structure. Perhaps one of the best arguments in support of adopting an episode of care paradigm (as opposed to an insurance paradigm) for managed care is that it is an incremental approach, requiring iterative feedback and constant physician input. As is becoming evident, the process of health care reform will likely take several decades, and even then must be seen as a continuing work in progress. Integrated episodes form the spokes of the wheel that will get us there. ■

# CEO Believes the AMA Needs to Be an Advocate for All Physicians' Interests



*E. Ratcliffe Anderson, Jr., MD, the executive vice president and CEO of the AMA, directs AMA operations and is often the voice representing the AMA's views on health care issues and policy. Anderson spoke candidly with Richard L. Reece, MD, editor-in-chief, regarding his career, the AMA's plans to establish a national negotiating organization for employed physicians, and the future of the AMA.*

**Q.** Dr. Anderson, please tell us a little bit about your background.

**A.** I was born in Baton Rouge, La., and received my undergraduate and medical degrees from Louisiana State University. I served as a rotating intern at Philadelphia General Hospital in 1964 and 1965 and then I spent two years as a flight surgeon in the Air Force. Afterward, I was a resident in general surgery at Boston City Hospital and was planning to move on to a urology program at Cornell University. But I had always had an interest in airplanes and flying, so I started flight training with the Air Force in 1969. My last flight as a pilot was in September 1996 in the Air Force. Overall, I served in the Air Force for just over 30 years.

**Q.** How did you arrive at your position as the executive vice president of the AMA?

**A.** One of the members of the AMA's search committee called me in January 1998 and asked me if I would be interested in the position. I was extremely honored to receive the call.

**Q.** Why did you take the AMA position?

**A.** I thought it was a great opportunity to lead a great association at a pivotal time for both the association and the medical profession. There's no question that the medical profession is under

assault from some elements of the managed care industry, as well as the federal government. In addition, patients have become acutely disenchanted with the way their health care is being delivered. As for the AMA, we are reversing the gradual decline in membership we've seen over the past 10 years. It is a tough time for all associations. Association membership declines are occurring across the board, but we expect to change that. I think we are going to be very successful.

**Q.** What do you hope to accomplish as head of the AMA?

**A.** The thing that concerns me is helping to connect America's physicians with their patients. I believe strongly that the AMA and organized medicine in general do so much more good for both patients and physicians than is generally realized or acknowledged. So right at the top of the "to do" list is to convey, in clear terms, to physicians and the general public the priorities and accomplishments of organized medicine as well as what our goals are for the future.

If we have had a failing, lack of communication has been a major one. With prop-

**Q.** How do you plan on highlighting that message?

**A.** One thing we've just done is hire a new, talented senior vice president for communications. We've supported him in his efforts by encouraging him to work with outside consultants who are experts in the field of communications. Together, they are developing a strategic communications plan, the highlights of which I recently presented for the first time. The crux of the initiative: A core question, "Is it good medicine?" We intend for that to be not just a rallying cry but a cultural assessment against which we will weigh every single decision we, as physicians, and others in the health field make in the service of caring for our patients and in serving the public good.

**Q.** You were one of the recipients of the AMA's Nathan Davis Award. Why did you receive that honor?

**A.** Nathan Davis was the founder, 152 years ago, of the AMA. The award is given annually by the AMA for significant contributions to the public health. I received the award in 1996 for my service as the surgeon general in the Air Force

**"The medical profession is under assault from some elements of the managed care industry, as well as the federal government."**

er communication of our accomplishments and our goals, membership will follow. Clearly, one of the most tangible markers of success is membership, so I certainly am encouraged to see that improved.

At the same time the AMA has to be the steward of standards and ethics for the entire profession. Only the AMA has the capability to speak for all of America's physicians and patients, across geographical boundaries, across specialty boundaries, across ethnic boundaries, and across gender boundaries.

and, in general, for serving a public health function in the federal service.

**Q.** I noticed that you've been giving a series of "Lectures on Leadership" semi-annually for the United States Air Force Medical Service.

**A.** Yes, I've been doing that since 1986. This is a leadership forum for up-and-coming Air Force leaders. I give basically the same speech with variations on the theme since that time. When I first gave the speech, it was very well received, and after that I was invited to

give the speech on an ongoing basis. The point of my comments is that the traits of leadership transcend the kind of institution you're in. These traits are equally applicable to a fighter squadron in a combat zone and to running a hospital or even the AMA.

**Q.** *I've talked to physicians who are disenchanted with the AMA and feel it brings no tangible value to them. How do you plan to win these physicians back and generate interest among physicians? What concrete actions do you intend to take to show them that you do indeed offer a value-added product?*

**A.** In every encounter with physicians we ask, "What do you want from your AMA?" The word that resonates is advocacy. Physicians want to be represented. They want to be represented by a highly ethical, completely professional organization. Demonstrating this kind of advocacy is the strongest action we can take. For example, we've stepped in and challenged the Aetna merger, and that's unprecedented. Also, we are very much involved in assisting physician groups that have been dealt with in a heavy-handed way by managed care organizations. We have been working on Capitol Hill for many months to get a sound Patients' Bill of Rights passed. We are also leading the drive for antitrust relief. These are just a few of the ways in which we are serving our advocacy role.

Second, we are constantly involved in addressing federal government actions, for example, dealing with the Health Care Financing Administration on issues that threaten the patient-physician relationship and quality patient care. The

get a meaningful comprehensive bipartisan Patients' Bill of Rights this year in Congress. The AMA has led that effort from the beginning.

Third, we are involved on the physicians' behalf in negotiations with large payers. For example, we have challenged Aetna on some of the language in its physician contracts. We have been successful in getting Aetna to eliminate offensive clauses that limit what doctors can tell patients about their coverage.

**Q.** *I would like to discuss several issues that have received a lot of press within the last year. First, several months ago you challenged Aetna's acquisition of Prudential Insurance in a letter to the U.S. Department of Justice. What is your reaction to the outcome of that case?*

**A.** We view our challenge as a success. For the first time, the Department of Justice acknowledged publicly that bigger is not always better when it comes to health care insurers. While the Justice Department is allowing the acquisition, our challenge did force Aetna to make some concessions that should bode well for patient care. For example, in Texas, Aetna agreed to divest part of its commercial HMO business in Dallas-Fort Worth and Houston. This should lessen their potential stranglehold on both these

patients and physicians, and restrictions of certain heavy-handed contract provisions.

Beyond these specific gains, however, our greatest success was the public attention we brought to the issue. We made patients aware of some of the concerns associated with a consolidating health care marketplace, and we put plans on notice that the AMA is not going to stand idly by when they pursue actions that threaten patient care.

**Q.** *Another issue is physician unions. The AMA House of Delegates voted at its annual meeting this past June to form a union. How does the AMA respond to critics who say that unions are bad for physicians, or that unions have no real power in the absence of the ability to strike?*

**"The AMA and organized medicine in general do so much more good for both patients and physicians than is generally realized or acknowledged."**

**A.** The fact that physicians feel the need to organize is a reflection of the desperation and distress in the medical market today. Physicians are unable to advocate for their patients without fear of reprisals, including antitrust threats from the health insurance industry. The AMA is in the early stages of setting up a national negotiating organization that will be affiliated with us, but still be a separate entity. It will represent employed physicians and eligible resident physicians. We will not be affiliated with traditional organized labor, we will not strike, nor endanger patient care. We will be faithful to the AMA Code of Medical Ethics.

**Q.** *In general, among both the public and people in the medical profession, there seems to be an overwhelmingly negative view of managed care. Where is that leading us?*

**A.** It's leading us to a recentering of our focus—a swing of the pendulum back toward the patient-physician relationship. What's happened here over the course of the last generation is that the business interests in medicine have

**"If we have had a failing, lack of communication has been a major one. With proper communication of our accomplishments and our goals, membership will follow."**

most obvious example of this involvement is that we were the first to champion patients' rights about four years ago, and we're confident that we're going to

markets considerably. In New Jersey, state officials are allowing the acquisition only if Aetna meets certain conditions during the transition, including protections for

*(Continued on page 14)*

(Continued from page 13)

moved in and captured the clinical practice of medicine to a degree, making employees of physicians to the real detriment of patient care. Now, let me be quick to say that neither the AMA nor its leadership believes managed care is all bad in and of itself. Clearly, there are efficiencies and economies in managed care that we would all do well to emulate. However, there are clearly those plans whose main focus, and it appears in some cases the only focus, is on the bottom line and quarterly stock dividends rather than on taking the best care of their patients. The AMA is vehemently opposed to business practices where quality of care is compromised.

**Q.** *Outgoing AMA President Nancy W. Dickey, MD, spoke of the new "cultural competence initiative" during her keynote address at the annual meeting. Can you explain what this is?*

**A.** Physicians need to communicate effectively with all of their patients. They can do so only if they understand the unique cultural background of those they are treating. This is especially true in today's rapidly changing and increasingly diverse society. We've just published a massive resource guide, the *Cultural Competence Compendium*, to help physicians understand the needs of all cultures, whether they are treating the economically disadvantaged in Appalachia or recent immigrants from Southeast Asia.

**Q.** *What are other current concerns of the AMA?*

**A.** Those outside of the AMA probably do not know that we have more

meet the needs of patients at the end of life. We spent several years putting together an extensive curriculum to help physicians meet this challenge. Over the past year, we trained more than 250 physicians at four separate conferences across the country. We were pleased by the effusive praise from the participants.

**"The AMA has the capability to speak for all of America's physicians and patients, across geographical, specialty, ethnic, and gender boundaries."**

These physicians subsequently go back into their communities and, using our materials, train other physicians in this important work.

**Q.** *How do you view the future of the AMA?*

**A.** I view the AMA as the relevant leader of organized medicine in the United States, one that touches every physician in every specialty. The AMA is here to represent the best interests of physicians and their patients. I'd ask all physicians to look at what organized medicine is already doing for them every day in many ways, and consider how, together, we can achieve organized medicine's important goals.

**Q.** *You mentioned earlier that you spent 30 years in the Air Force. Was the Vietnam experience a big part of your life?*

**A.** It certainly was. I was over there five different times. After I finished flight training, I was posted to a fighter

1971 to 1973, I went back to being a flight surgeon for a fighter squadron at MacDill Air Force Base in Tampa. After that, I was getting ready to start a residency, but the Air Force asked me if I'd run a hospital for a couple of years because they needed commanders. So I assumed the role of hospital commander, in part

because it gave me the opportunity to continue flying for a few more years.

I served as the hospital commander at Seymour Johnson Air Force Base in Goldsboro, N.C., from 1975 to 1977. That hospital had 35 beds and approximately 250 staff members. It was a general hospital, covering medicine, surgery, pediatrics, obstetrics, flight medicine, and family practice. I served as a hospital commander at Langley Air Force Base, in Hampton, Va., from 1983 to 1984 and at Wilford Hall Medical Center, in San Antonio, Texas, from 1990 to 1994.

**Q.** *You eventually became the surgeon general of the Air Force. What were your responsibilities in that role?*

**A.** I had oversight responsibilities for 87 medical facilities and 52,000 people and an annual budget of \$4.5 billion. My staff and I were responsible for all medically related Air Force operations, including staffing, resource allocation, quality measurement, and ensuring the health care of people on active duty, and their dependents, as well as retirees.

**Q.** *In the military, you had extensive experience both on the medical side and the management side. What did you take away from that 30 years of experience?*

**A.** I gained some understanding of what it takes to succeed as a leader and what I believe to be some rock-solid principles of leadership that are based on a foundation of integrity, courage, loyalty, and commitment.

—Edited by Deborah J. Neveleff, in *North Potomac, Md.*

**"The fact that physicians feel the need to organize is a reflection of the desperation and distress in the medical market today."**

than 1,200 employees, almost all of whom work directly on projects related to improving the health care of all Americans. One of our latest undertakings is the EPEC project—Educating Physicians on End-of-Life Care. We determined that many physicians did not feel that they were adequately trained to

squadron in North Carolina, which was sent into combat. I flew about 100 combat missions.

**Q.** *I know you served as a hospital administrator for the Air Force as well. Can you please tell us about that?*

**A.** After flying for a two-year operational tour with the Air Force from

# Hospital-Based PPMCs Show Strength

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

Despite the downturn this year and last among physician practice management companies (PPMCs), merger and acquisition activity has remained strong for hospital-based PPMCs. Most PPMCs have had large declines in their stock prices (table). But in this period of turmoil for PPMCs, hospital-based PPMCs that provide services in fields such as anesthesiology, emergency medicine, neonatology, and radiology have continued to pursue strategic affiliations to capture market share and expand ancillary capabilities.

Pediatrix Medical Group Inc., a hospital-based PPMC in Fort Lauderdale, Fla., that specializes in neonatology, has recently been contending with an investigation of the company's Medicaid billing practices. The investigation and the stagnant PPMC market conditions have caused the company's stock price to drop from above \$50 per share to below \$15 this year. Nevertheless, the company has maintained its growth strategy, sup-

plementing its network with 16 new neonatologists and 12 new perinatologists since April 1999. Most recently, Pediatrix acquired neonatal intensive care units (NICUs) in Greenville, S.C.; Topeka, Kan.; and Baltimore. It also acquired neonatal and pediatric intensive care units (NICUs/PICUs) in San Juan, P.R. Currently, Pediatrix has more than 140 NICUs, nine PICUs, and three pediatric departments in 25 states and Puerto Rico.

Coastal Physician Group Inc., in Durham, N.C., has acquired the operations of FPA-owned Sterling Healthcare Group Inc., in Coral Gables, Fla., for approximately \$85 million in cash and assumed liabilities. Sterling provides emergency medical practice management services to 124 hospitals in the southeastern United States.

Coastal Physician Group provides physician practice management services primarily to emergency rooms. FPA Medical Management, a national physician practice management company in San Diego, has slowly unraveled since filing for bankruptcy reorganization last year. Coastal's acquisition of Sterling substantiates its continued strategy to refocus on emergency medical management services. Coastal recently changed its name to PhyAmerica Physician Group Inc.

American Physician Partners Inc, a company in Dallas that develops radiol-

ogy and imaging service networks, has recently announced the acquisition of Questar Imaging Inc. for \$44.6 million in cash and assumed debt. In the past, American Physician Partners has managed radiology networks and provided services that have been outsourced by hospitals. The transaction added 27 centers in 14 states and made APPM the largest operator of radiology centers in the United States with 134 centers in 18 states.

Sheridan Healthcare Inc., in Hollywood, Fla., has been taken private in a financial acquisition by a subsidiary of Vestar Capital Partners Inc. for \$9.25 per share in cash. A hospital-based PPMC that employs and manages specialists who provide anesthesia, neonatology, obstetrics, pediatrics, and emergency services, Sheridan is affiliated with approximately 240 physicians at 38 hospitals and 28 office locations nationwide. Vestar Capital Partners is an investment firm with more than \$1 billion in equity capital under management. It specializes in growth capital investments and has succeeded as a result of investing in middle-market companies.

In the uncertain PPMC market today, it is not easy to maintain the pursuit of an unchanged business model. However, if market activity is any indication, companies in certain health care sectors will continue to find growth opportunities. ■

*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.*

## Recent Activity Among Hospital-Based PPMCs

Company	One-year total return*	Recent activity
Pediatrix Medical Management, Inc. (Neonatology PPMC)	-69.7%	Acquired 12 perinatal and 16 neonatal physicians
American Physician Partners, Inc. (Radiology and imaging services)	-3.1%	Acquired Questar Imaging's 27 imaging centers
Sheridan Healthcare, Inc. (Ambulatory surgical facilities)	-43.0%	Acquired by Vestar Capital Partners
PhyAmerica Physician Group Inc. (Hospital-based PPMC, specializing in ER management)	-50.0%	Acquired Sterling Healthcare

\* Recent change in stock price over the past 12 months

Source: Townsend Frew & Co., Durham, N.C. 1999.



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

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