

# PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Physicians Face More Scrutiny as HMOs Struggle To Be Consumer-Friendly

For many physicians, managed care has made practicing medicine a difficult profession. Over the past 10 years, physicians have chafed at the micro-management of their practice patterns by health plans seeking information on health care utilization rates, costs, and quality. At the same time, managed care has cut into physician income, forcing many to work more hours and to seek new ways to practice more efficiently. It is not unusual, then, to find physicians leading the fight against managed care in state houses and in Washington, D.C. Yet, as the saying goes, they should be careful about what they wish for because it might come true.

As withering criticism from physicians, patients, and legislators forces managed care to make changes, those who practice medicine may find that the new version—or whatever replaces managed care—makes practicing medicine even more difficult than it is now. Indeed, health care is changing, but it is changing in favor of consumers, not physicians.

"The system is becoming centered around consumers," says Lee Newcomer, MD, chief medical officer of United HealthCare Corp. in Minneapolis. "Patient dissatisfaction with managed care is leading to more accountability for the quality of care delivered and for providing access to care, and accountability begins with physicians. Patients are acting as consumers, and they are demanding performance." In other words, physicians will be asked to deliver still more information on utilization and the quality of care they deliver, and be accountable to patients, health plans, and even purchasers.

In the past, health plans have dictated to physicians how care should be delivered and physicians have been forced to step back from their role as patient advocates. But patients are demanding more from physicians today, and they expect their physicians to be their advocates with HMOs, says James Nuckolls, MD, medical director of Carilion Healthcare Corp., a 160-physician medical group in Roanoke, Va.

In a health care system centered around consumers, "physicians are going to have to be prepared to practice medicine based on outcomes and science, not only on their own experience," Nuckolls says. "Patients are demanding results and information, and as more patients enroll in managed care plans, they are forcing those plans and their physicians to provide answers, not just cut costs."

Moreover, patients have learned to negotiate their way through the myriad systems managed care plans have installed. As a result, they now know what to demand of health plans and what to demand of physicians. "Today, patients expect better-quality, outcomes-based treatment from their physicians," Nuckolls says, "just as they expect better access and a broader range of services from their health plans."

Since they have begun to demand substantial changes in health care, consumers have gained political clout. In fact, consumer dissatisfaction has resulted in several significant legislative initiatives in the states and in Congress, says Paul Ginsburg, president of the Center for Studying Health System Change, a policy research firm in Washington, D.C. "The rise in influence of

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## Physicians Are Left to Organize Themselves

Last year was a difficult one for large organizations of physicians. These organizations struggled for a wide variety of reasons, according to many of the speakers at the recent National Congress on the Future of Medical Practice and Practice Management in Nashville.

One industry that had difficulty last year was that of physician practice management companies. About 40,000 physicians are affiliated with PPMCs, and the number is dropping. PPMCs manage physician practices and, in many cases, own the practices or have the rights to purchase them in the future. Experts expect the current number of publicly traded PPMCs—32—to shrink by about a third in the next year or two. At the same time, the number of private PPMCs—currently 200—will also decline as a result of mergers, public stock offerings, and business failures. Last November, MedPartners, the largest PPMC, said it was abandoning its physician practice management business with its 238 clinics and 10,000 affiliated physicians. The trend is sharply downward.

Another example of physicians having difficulties can be found in physician-owned health plans. Most are not doing well, and one, California Advantage, filed for bankruptcy last year. The medical societies of at least 12 states (representing 50,000 physicians) have formed organizations like California Advantage. But many state societies, such as those in Illinois and Florida, have been unable to persuade physicians to invest in physician-owned HMOs.

Hospital-based physician groups also have a mixed forecast. Hospitals are still acquiring primary care practices at a rate of about 5,000 each year, but some hospital-based physician groups are being closed, spun off, or restructured because many hospitals are losing money on these operations. The AMA says 101,470 physicians were employed by nongovernment hospitals last year. Among hospitals with more than 200 beds, 70% either own or have strong affiliations with physician groups, and 20% of hospitals that do not own physician groups plan to add practices this year.

Among the groups that seem to be growing are integrated medical groups, which are group practices of three or more physicians who deliver patient care, share equipment or personnel, and divide income by a prearranged formula. About 380,000 of America's 738,000 physicians belong to groups of three or more. These groups are growing through mergers and acquisitions, but by about 3% annually. Many physicians in these groups also are in independent practice associations, or IPAs.

About 330,000 physicians are in IPAs or in a similar type of organization called a Group/IPA hybrid. These two organizational options are growing by about 10% a year. IPAs allow physicians to do just as the name implies: practice independently. Currently, there are only 1,000 established medical groups with 25 or more members, and only 421 of these groups are capable of assuming the financial risk of delivering care, according to the Health Strategies Group, researchers in Palo Alto, Calif.

The point is: Physicians in general remain in small, unorganized groups and large organizations that have tried to consolidate physicians into larger groups have failed or are struggling. It's obvious, therefore, that physicians should not be looking for a white knight, such as a managed care organization, hospital, PPMC, or other financial benefactor, to organize them into a cohesive group. Simply put, physicians seeking to be part of effective contracting entities will have to organize on their own and find ways to overcome the problems of physician-run organizations.



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# Group Merger Ends Long-running Rivalry

By Thomas M. Gorey, JD

During the early 1980s, two 20-member multispecialty physician groups operated within three blocks of each other in downtown Quincy, Ill. Each considered the other a bitter rival. But by the middle of the decade, managed care was beginning to establish a presence in this small city on the Mississippi River. As it grew, the rivalry began to cool, and in 1987, the two groups merged. Today, the combined entity, the Quincy Medical Group, has more than 70 physicians and about 12 nurse practitioners. Here's what happened.

The first group, Quincy Clinic, was formed in the 1930s, and was among the first group practices in the country. The other group, the Physicians and Surgeons Clinic, was formed in the 1940s. Despite their close proximity, the two groups had historically been arch enemies. "One group had offices on 11th Street and the other had offices on 14th Street. The joke used to be that there was a barbed-wire fence at 12th Street," says Diane Weber, associate administrator for finance for the Quincy Medical Group. At the time, each group referred patients to competing hospitals. Physicians at the Quincy Clinic primarily referred patients to St. Mary's Hospital, while physicians at the Physicians and Surgeons Clinic mainly used Blessing Hospital.

In the mid-1980s, managed care companies saw an opportunity in Quincy. While the city has only 40,000 residents, the multistate, rural market has a population of approximately 250,000. The nearest large cities are Springfield, Ill., about 90 miles to the east, and St. Louis, which is 120 miles south. Managed care organizations approached each of the two clinics separately with proposals to participate in their plans. On occasion, the managed care plans would try to pit one clinic against the other.

At the same time, Blessing Hospital administrators hinted that if the hospital formed an HMO, it would contract only

with one of the two medical groups. This threat became a pivotal event in the evolving relationship between the two clinics. The presidents of the clinics sent a joint letter to the hospital opposing the plan. As a result of the groups' opposition, the hospital backed away from its HMO proposal. These events provided the first inkling of what the two groups might accomplish if they could cooperate, rather than compete.

About this time, a physician in one of the groups attended a seminar and heard speakers discuss the efficiencies and market clout possible when medical groups merge. He returned with a missionary's zeal. Although many of the other physicians were at first

retiring, the boards appointed the two top administrators from the Quincy Clinic to oversee the merger process.

The groups retained consultants from one of the California offices of a national consulting firm to help them through the merger. They chose California-based consultants because they wanted advisers who had substantial experience with managed care. The physicians also used local accountants and attorneys during the merger to provide what they referred to as checks and balances. After the consultants suggested that the groups make a financial commitment to demonstrate their seriousness about merging, each group was asked to contribute \$25,000. According

**The two groups chose consultants from the California offices of a national consulting firm because they wanted advisers who had substantial experience with managed care.**

skeptical of the idea of merging, it didn't take long before the idea began generating interest and support.

About this time, William Sullivan, the administrator of the Quincy Clinic, began to urge the physicians to discuss cooperative arrangements and to encourage group leaders to attend educational seminars to expand their understanding of managed care and other changes occurring in health care. Being from Chicago, Sullivan was familiar with competition in health care. But he clearly recognized that despite his strong encouragement for the physicians to consider merging, ultimately, a physician would need to champion the cause. "Physicians will listen to an administrator for awhile," he says, "but then you have to get physicians out in the lead."

## Planning for the Merger

Given these events and Sullivan's urging, the physicians got more involved and eventually the boards of the two groups began to plan for a merger. Since the administrator of the Physicians and Surgeons Clinic was

to one Quincy Medical Group representative, "That request got everyone's attention."

Issues related to the merger generated discussions for many months. "What sold the physicians was good planning and good discussions," says Sullivan. "We were not in a hurry. So we didn't do it overnight. We had lunch and dinner with the other group for over a year and a half."

## Difficult Issues

Most of the talks centered on financial issues. The administrators and physician leaders planning the merger believed strongly that a well-thought-out financial plan was needed to convince the physicians that the merger would sustain their financial security. Part of the planning involved considering scenarios of what would happen within ten years if the two groups did not merge.

To build support for the merger, market data were generated to show that sufficient growth potential was available in the market to support the merged groups and to improve income. "You have to lead with the financial plan," says Sullivan. "In a

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**“In a merger, each physician is like a CEO of a company. Each has to be involved because each is concerned with his or her livelihood. What brings people together is a feeling of financial security.”**

**— William Sullivan, Quincy Medical Group**

*(Continued from page 3)*

merger, each physician is like a CEO of a company. Each has to be involved because each is concerned with his or her livelihood. What brings people together is a feeling of financial security.”

As in most physician group mergers, compensation was a major financial issue. The compensation plans of the groups were completely different. The Physicians and Surgeons Clinic plan was based almost entirely on productivity. The Quincy Clinic used a formula that capped the income of high producers in order to subsidize primary care physicians. The groups hired a firm to prepare a compensation survey and, eventually, they agreed to a phased-in plan that combined elements of the two groups' compensation plans.

At the time of the merger, the Quincy Medical Group borrowed \$2 million to compensate physicians for the value of their practices. The medical group determined the buy-out amounts at the time, “froze” those values, and adopted a policy that it would pay the money upon each physician's retirement. After the merger, however, the group found it had sufficient cash flow to pay this debt early. The group's administrators believed doing so would help the group attract new physicians without having to explain this unusual debt.

### Consolidating Operations

Immediately after the merger, the group consolidated some administrative departments, including the business offices, and it consolidated two laboratories into a single lab. The group found, however, that its space was too limited to consolidate most of the administrative and medical departments.

Both clinics had been buying property near their offices for future building projects. Therefore, after the merger, the group moved some administrative departments into individual houses the clinics had acquired earlier. This unwieldy arrangement resulted in core functions, such as purchasing, mail and delivery, and accounting, being housed in different

locations. Weber described the situation this way: “It was just a nightmare. We had to run records up and down Maine Street.”

### Creating a New Culture

Reluctant to take on the debt associated with a major construction project, the group did not physically consolidate all medical and administrative offices for a number of years after the merger. Instead, the physicians postponed their building plans until the group had built up its retained earnings. This delay also proved beneficial because the group grew much more quickly than anticipated after the merger, necessitating the construction of an office building twice the size of the one originally planned. In 1994, the group moved all its medical offices into a new office building. Shortly after the consolidation of the medical offices, the group consolidated its administrative offices into an adjacent building.

At the time of the merger, the group decided not to lay off any staff. When this decision resulted in overstaffing, the group relied primarily on attrition to reduce staff size. Still, by 1995, the group needed to lay off some staff after it consolidated its administrative offices. The layoff occurred as a result of physicians' concerns that overhead costs had become unacceptably high.

In some ways, an increase in overhead was inevitable, Sullivan says. “Overhead before the merger was so low, it would have been difficult to get it any lower,” he explains. “Both clinics were lean and mean already.” Although the group has realized savings by eliminating duplicative ancillary services, such as lab and x-ray, Sullivan believes it is a fallacy that operating costs go down after a merger. “If you don't spend money and put money back into your business, you don't have a business,” he says. Following the merger, the group began retaining earnings for future projects, and these projects contributed to increased operating costs.

A typical physician practice merger will

result in difficulties related to the culture of the two merging organizations, and the Quincy Medical Group was no different. Since the groups were similar in size and financial value, the merger was viewed essentially as one of equals. Yet, “everything else was different, from governance philosophy to the way they bought Kleenex and paid for overtime,” says Sullivan. “We had two very different entities coming together. If we had known how different the two corporate cultures were, we may have had more reservations about doing it.”

The group also encountered difficulties with some physicians who were not suited to practicing in a large medical group. Over time, several of these dissatisfied physicians retired or left for other reasons. Those physicians who have been recruited since the merger have joined because they want to be part of a large entity.

“We have a growing pool of physicians who really understand and believe in group practice,” observes Sullivan, “as opposed to ‘accidental group practice physicians’ who found themselves in a group practice without really buying into the concept.”

*Editor's note:* The Quincy Medical Group is one of six medical groups profiled in the Case Study Analysis of Physician Practice Mergers, a study recently released by Policy Planning Associates. The study was sponsored by the AMA, the American Academy of Dermatology, the American Academy of Pediatrics, the American College of Radiology, the American Society of Plastic and Reconstructive Surgeons, the Michigan State Medical Society, and the South Carolina Medical Association. For a copy of the study, physicians may call the Michigan State Medical Society at 517/336-5769. The price is \$25 for physician members of one of the sponsoring medical societies and \$95 for others.

# The Web Is Changing Health Care

## Developing Useful Systems Requires Physician Participation

The race is accelerating to create effective health care information systems that use the substantial power of the Internet. In particular, interest is growing quickly in telemedicine, the nascent science of delivering medical care using remote access through personal computers. These trends are being fueled, in large part, by the ongoing quest to create a comprehensive, cost-effective electronic medical record (EMR) that can be viewed over the World Wide Web.

Some experts believe the Web has the potential to link physicians in many different offices to other physicians and other organizations in the delivery systems, and thereby potentially to reduce the cost of care dramatically and to improve patient care.

Several developers have created Web browser-based EMRs that meet the criteria that health care information systems (HCIS) administrators and clinicians consider important. These systems must be cost-effective, compatible with current systems (such as Windows-based PCs), secure to ensure the confidentiality of patient information, and logical for clinicians. But because physicians are not often closely involved in developing the user interfaces, or visual portions, of these systems, the user interfaces have not always been intuitive to physicians, limiting the functionality of new clinical systems. More commonly, programmers have developed HCIS for other programmers.

Within the next several years, experts estimate that EMRs and other telemedicine tools will be integrated into existing, or legacy, computer systems. So that patients and practitioners can reap the most benefit from these new applications, it is more important than ever, experts say, that physicians become involved in developing Internet-oriented information systems. Two examples of how fruitful such a partnership can be are the diagnostic user interface produced by Diagnostic Information System Co., in Warwick, R.I., and the Careweb EMR, a collaborative effort of Beth Israel Deaconess Medical Center, in Boston; Massachusetts General Hospital, also in

Boston; and Massachusetts Institute of Technology, in Cambridge. (See "Careweb Aims for a Paperless Future.")

### Creating a Sensible System

Robert Coli, MD, a gastroenterologist, is the founder and CEO of Diagnostic Information System Co. Coli believes that the most effective user interface for any new HCIS is a computer capable of browsing the Web. "All that doctors need in order to use our intuitive clinical data interface is Internet access, a Web browser, and an authenticated password," he says. "Internet-literate physicians require no training, and physician groups at all stages of integration can use this

patient care process well enough to design a good, clinically intuitive system," Coli says.

John Glaser, chief information officer at Brigham & Women's Hospital in Boston, says that only clinicians can decide what is the most logical way to satisfy the clinical information needs of other clinicians. "Bold change doesn't come out of committees, hence the need for a user interface developed by clinicians," Glaser says.

Martha Geisler, director of applications at Boston Medical Center, believes that systems developed from a clinician's perspective will be used more widely than other systems developed solely by programmers. "Any system that I consider has to have

**"Bold change doesn't come out of committees, hence the need for a user interface developed by clinicians."**

**— John Glaser, Brigham & Women's Hospital**

new tool to improve patient care and reduce its cost. Anytime something can improve how doctors use their time, especially in a health care market with limited pricing power, it's worth the cost. Doctors instinctively know that good clinical information is not free; it's priceless."

Recognizing that physicians would have an interest in his system, Coli sought the opinions of physicians on how to establish the most effective electronic system for handling medical information. "Of the 40 initial investors I approached, 30 are practicing physicians," Coli says. "It was important to me that this effort not be viewed merely as a business venture, but as an effort that would solve a chronic problem and benefit both clinicians and patients."

In the late 1970s, when Coli started working with the concept of an "open standard" diagnostic system, the idea of EMRs was beginning to emerge. "I became interested in the technology, particularly when I realized that programmers working on mainframe systems didn't understand the

physician buy-in," she says. "I want to know whether my doctors are going to use it. I also know that it's likely that a system will be more useful and well received if practicing physicians have had considerable input into its development and implementation."

As an office-based, practicing clinician, Coli understands that what seems logical to those in medicine may appear anything but that to those outside the field, particularly software programmers. In developing his user interface, Coli says, "trying to find logic among the almost 5,000 different medical tests was a challenge. We wanted the simplest and most logical way to report the results of an infinite number of data combinations involving numbers, text, and diagnostic images, and decided to group the tests according to the two types of testing sites (clinical labs and subspecialty testing facilities), and categorize them by organ system and clinical specialty."

With the advent of new diagnostic technologies, the number of procedures available to clinicians has increased, yet the categories

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of diagnostic tests have not changed much in the last 20 years. Coli has been careful to capitalize on that stability. His integrated and standardized test-results-reporting and test-ordering system—called the Diagnostic

Information System (DIS)—groups diagnostic assays into two overall categories: microchem tests and subspecialty tests. The microchem category includes about 3,500 tests (such as basic hematology, urinalysis,

basic chemistry, special chemistry, and microbiology tests). The remaining 1,500 tests in the subspecialty category cover diagnostics for cardiology, pulmonology, gastroenterology, musculoskeletal and genitourinary medicine, neurology, special senses, endocrine and metabolic disorders, allergy-immunology, and pathology. The Roger Williams Medical Center, in Providence, R.I., is the prototype development site for the system. Use of the clinically integrated and standardized grouping at the medical center has demonstrated a reduction of more than 70% in the number of pages required for cumulative reports and an accompanying improvement in caregivers' ability to spot clinical trends, Coli says.

Despite the promise of the system, Coli finds that most physicians aren't worrying about how legacy systems will be integrated with Web-based EMRs. Those concerns, according to Coli, are still relegated largely to information systems directors and programmers struggling with lines of code. Coli argues that physicians need to understand that information is power, and that power eventually will be used by physicians to do what they do best—care for patients.

#### Security and Confidentiality

"I'm not a programmer," Coli asserts. "I'm just a physician who thinks that we have some unique opportunities to improve the status quo by using standardization and a common user interface approach for our patients' benefit."

BMC's Geisler shares Coli's concern. Whether the group is a freestanding diagnostic lab or a hospital, she says, "institutions are no longer islands of discrete information. It only benefits them to share information. Information systems directors are looking to make information more accessible, and it is likely that many delivery systems will become less expensive with the push toward remote access." Geisler cautions, however, that "I can't endorse a system that will cost me more than a direct line to my diagnostics group. Still, I want to know that doctors are involved in the process, that they've shared information with developers about what works."

If telemedicine applications are to succeed, the two critical hurdles that developers must overcome are security and confi-

## Industrywide Standards Need to Be Set

To compare the writing of computer code to the perfecting of a surgical procedure may seem strange at first, but the two practices have something in common: highly individualized technique. Just as a doctor may develop a personal "trademark" for a specific treatment, a programmer leaves an equally distinct impact on the software he or she creates. Akin to the way health care practices differ from state to state, programmers' styles also differ from company to company. Add to this the variation in health care legislation of 50 states and it's clear that Web-based telemedicine faces a serious obstacle: lack of standardization.

In 1991, standard objectives for electronic medical records (EMRs) were proposed by the National Academy of Science's Institutes of Medicine. An IOM report, "The Computer-based Patient Record: An Essential Technology for Health Care," recommended that future EMRs have these five capabilities:

1. Support and improve the quality of patient care
2. Enhance the productivity of health care professionals and reduce the administrative costs associated with health care delivery and financing
3. Support clinical and health services research
4. Accommodate future developments in health care technology, policy, management, and finance
5. Have mechanisms in place to ensure patient data confidentiality at all times

But now, eight years later, few vendors are familiar with the IOM report, which was revised in 1997. Laments Martha Geisler, director of applications at Boston Medical Center, "Vendors didn't embrace it, and physicians don't even know it exists." Without an agreed-upon standard, even a highly useful system has no chance of gaining a viable market position.

Geisler cautions that lack of federal regulation also may hamper the vision for a seamless EMR and additional modules, such as the test-ordering and test-results-reporting system from Diagnostic Information System Co., in Warwick, R.I. "Remote access has such potential, particularly in underserved rural areas, but I would worry about state-to-state regulation," Geisler says. "It may be that the physician groups interested in bringing this technology forward end up lobbying at the federal level for interstate regulation regarding electronic medical commerce."

Even so, Robert Coli, MD, founder and CEO of Diagnostic Information System Co., is optimistic: "I knew going into this that standardization had to be foremost," he explains. "That is why I spent so much time coming up with a clinically intuitive grouping for the test categories." Today, there is no common output or user interface from clinic to clinic. Traditionally, user interfaces have been flexible and user-defined.

Yet there is precedent in other industries. Many individual companies have developed industrywide standards. In the early 1980s, when the IBM PC became the early standard for all desktop computers, dozens of competing products lost market share dramatically and the companies behind them closed. Likewise, some laboratory companies have developed industry standards as well.

"One common user interface that any diagnostic testing company and any doctor can use with either native Internet or Web-enabled legacy systems is where I'm headed, hence the emphasis on physician buy-in and the clinician-centric orientation in developing this interface," Coli says.

—M.H.

**“Physician groups at all stages of integration can use this new tool to improve patient care and reduce its cost. Doctors instinctively know that good clinical information is not free; it’s priceless.”**

**—Robert Coli, MD, Diagnostic Information System Co.**

dentiality. “Patient confidentiality is vital, particularly when ordering and viewing diagnostics,” says Coli. “Because our system has been developed as a module for an existing EMR, and not as an independent system, security will already exist on the clinic’s own intranet. There is no need for additional protection, which keeps operating costs low. We’re not requiring that more security be added.” An intranet is a local, proprietary network that works like the Internet but is available only to select individuals, not the Web-surfing public.

John Worrall, solutions marketing manager for Security Dynamics Inc., in Bedford, Mass., the company that provided the security for Careweb, shares Coli’s concerns about security and confidentiality. “Without question, health records require a high level of confidentiality, especially when the records are available electronically,” says Worrall. “Our security technology can be extended to the user interface, and as a result, adding this front-end module for diagnostics would not present additional security concerns.”

The security issues related to direct line-proprietary systems—those developed by a hospital or clinic to transmit information directly—remain the purview of the diagnostics laboratory. Creating EMRs or diagnostic systems based on the Web shifts that responsibility—and the costs associated with it—to the physician’s practice or to the clinic’s information systems department. Says Geisler, “I would certainly not want to create an additional opportunity for system break-ins. It would definitely benefit my organization to combine an existing direct line used for diagnostics with a protected Web-based EMR.”

Most experts agree that technology that takes advantage of the Web will play a major role in expanding the way health care delivery systems are integrated. It is just as likely,

however, that no system developed without clinician input will remain useful for long. As a result, physicians need to work closely with information systems departments, programmers, and information systems administrators to ensure that future HCIS are useful, cost-effective, and clinically intuitive.

But being fully involved in the development of information systems does not mean that physicians must become software programmers, says Coli. Rather, they need to create bridges of understanding with programmers to avoid creating yet another expensive, unwieldy, and unnecessary legacy system that uses proprietary software. “Get involved and get curious,” encourages Coli. “There is more going on right now than just an opportunity to ‘surf the Web.’ You don’t have to get a degree in programming or an MBA. You just have to get involved when you look at a computer system and it makes you say, ‘This doesn’t make sense.’”

—Reported and written by Maria Hecht, in Boston.

*Editor’s note:* For a closer look at the potential future of Web-based telemedicine, two companies developing systems for it have sites on the World Wide Web. The Careweb system can be seen at <http://clinquery.bidmc.harvard.edu/people/jhalamka/careweb.htm> and the Diagnostic Information System can be viewed at <http://homecyber.com/webdis/>

## Careweb Aims for a Paperless Future

John Halamka took a circuitous route to his position as executive director of quality and value at Beth Israel Deaconess Medical Center, in Boston. The former CEO of a software company, Halamka later became an emergency room physician. Today, he oversees the Careweb project at BIDMC that is developing an electronic medical record (EMR) to give clinicians direct access to patient data via the Web, through any PC with Internet access.

“Any physician working toward a paperless future, particularly one who is developing modules that replace a proprietary diagnostics line, is headed in the right direction,” says Halamka. “The last thing we need is to reinvent the wheel, and if someone can develop an add-on to a functional EMR, that’s wonderful.”

Halamka shares the sentiments of Robert Coli, MD, the founder and CEO of Diagnostic Information System Co. in Warwick, R.I. Both men believe products like those being developed by DISC and the Careweb project would not have been possible without an unusual integration of medical and systems expertise. “I wanted to do something a little more beneficial for humanity than continuing to run a software company,” Halamka says.

Coli, on the other hand, was “always watching the telecommunications world” and curious about new developments. The user interface for diagnostics he initially developed did not rely on Web-browser technology. Says Coli, “Our first stab at this was based on Windows 3.1. However, the real power in DISC’s design is that its value can be achieved in any legacy system environment that can access the Web. DISC achieves its ‘out-of-the-box’ ease of use by following the logic of the users, not the logic of the operational systems behind it.”

Both Coli and Halamka share the conviction that legacy systems will eventually give way to physician-influenced “complementary” Web-based software. With such tools, any clinician will be able to view patient data, order diagnostics, add clinical notations, and eventually, prescribe medication, all through the Internet. *M.H.*

# System Saves Time, Improves Care

Since an electronic patient charting system was implemented at Carolina Internal Medical Associates, each physician in the practice now has the time to see an average of three or four more patients each day. "We estimate that we have saved about 60 to 90 minutes per day per doctor," says Haywood N. Hill, MD, chief executive officer of CIMA, in Asheville, N.C. What's more, the clinical charting software makes the primary care practice's patient records more accurate and much easier for the eight physicians and their staff to retrieve and review.

But not all physicians are rushing to invest in such systems despite these and other benefits that electronic medical records systems offer. Undoubtedly, the \$20,000 to \$40,000 price tag for a basic system can be a significant hurdle for some physicians. A more daunting hurdle, though, may be the rapid pace of system technology advancement. Many physicians may be concerned that the system they buy today will be outdated next

perform an internal audit of their patient charts—an audit that revealed deficiencies in about 50% of the charts reviewed.

"In essence, we flunked," says Hill. "And we realized that unless we improved our documentation, we would be at risk for significant amounts of money."

## Seeking a Good Fit

For CIMA's physicians, one of the most important considerations in selecting a system was whether it could be integrated with the practice's other information systems. "We didn't want one system for medical records, another for scheduling, and another for insurance billing," Hill says. "We wanted a fully integrated system involving one computer system from one vendor." Many computer system vendors claim to offer integrated products or claim that they can integrate their systems seamlessly with the systems of other vendors. "While they may be able to integrate systems at one point in time, if one system upgrades, which

multiple health problems, for example. About half of CIMA's 25,000 patients are senior citizens on Medicare, and typically they have three or four chronic health conditions. "Many systems are geared to single-health-problem data entry and therefore just wouldn't work for us," Hill says.

In addition to an integrated system to meet the daily needs of the practice, Hill and his colleagues wanted a systems vendor that had an excellent record of customer service. "While support is important for a practice management system, it's even more important for a medical records system," he says. "If the system goes down, you need to be sure that it will be back up in an hour or two because your practice depends on it on a daily basis."

After considering various systems and vendors for about two months, a process that included viewing product demonstrations and visiting other physicians' offices to see various systems in operation, CIMA selected AutoChart in early 1993. AutoChart is an electronic patient charting system from Medic Computer Systems, a health care software company in Raleigh, N.C.

"At the time, we had had about five years of experience with Medic, since we were using its practice management software," says Hill. "We had been pleased with both its support and its updates to that system." Medic was also selected because CIMA's physicians were confident that it would be a viable, financially stable company over time. "We decided to go with one of the largest, most well-known companies because we knew that we would always be updating any system we purchased, and we felt confident that Medic would still be around in 10 years," Hill says.

Once they had purchased the system, Hill and another CIMA physician tailored AutoChart's features to their practice's particular needs, customizing the system's generic templates and text. "As physicians, we are pretty individualistic," says Hill, "and therefore we found that it was important to do our homework up front to ensure that the system fit the way we practiced." While the system allows individual physicians to customize nearly every aspect of

**"We estimate that we save about 60 to 90 minutes per day per doctor."**

**—Haywood N. Hill, MD, Carolina Internal Medical Associates**

year or that an even better system will become available, perhaps with better features, for a lower price.

Delaying the purchase until the ideal system is developed is not the answer, says Hill. "Implementing an electronic medical records system involves a huge change for physicians and their staff, and the longer physicians put it off, the harder it will be," he says.

For Hill and his colleagues, the decision to purchase an electronic charting system resulted from an internal audit of CIMA's patient charts. In 1992, the practice was preparing for the new Medicare reimbursement methodology, the resource-based relative value system. Knowing that the RBRVS bases reimbursement on documentation and incorporates routine reviews of patient medical records, CIMA's physicians decided to

tends to happen every couple of months, then it's usually no longer compatible with the other systems," Hill says.

The ease of data entry was another salient factor for CIMA in selecting an electronic patient charting system. "It is critical that a system allow you to enter data quickly, easily, and intuitively when you're in the exam room with the patient," Hill says. "A lot of the bells and whistles that computer salespeople show off are not very useful. I'm not interested in 'gee-whiz' technology that I rarely need. When I've got three patients in exam rooms and four more in the waiting room, I want a system that saves me time."

While many systems appear to be similar at first glance, there are subtle, but important, differences among them, Hill claims. Some electronic medical records systems are cumbersome to use when a patient has

data entry, Hill and his colleagues decided that the value of documentation consistency outweighed the benefits of individual preferences. "In terms of reporting capabilities or gathering outcomes data on clinical practice, consistency among our physicians is important," he says.

Within a few weeks, all CIMA physicians had been trained to use the new system; but the transition from paper to electronics was more gradual. "Initially, we entered information into the system and then printed it out and filed it in the chart," Hill says. "After about two or three months, we stopped printing our chart notes. Today, all of our patient records exist electronically."

#### With Just a Click

Now, when Hill checks his schedule each morning, he can access medical records for each patient he will see during the day. Then, using a pen-based unit that looks like a laptop without a keyboard, he completes 80% to 90% of his documentation while seeing each patient in an exam room. Because the system uses macros that contain full paragraphs to describe the normal function of various body systems, documentation for a typical two- to three-page history and physical can be completed in minutes. For example, if Hill sees a patient with a normal heart exam, he can simply touch the pen to "heart-normal" and the system inserts a descriptive paragraph that includes such phrases as "normal sinus rhythm," "heart not enlarged," and "valve sounds normal." Physicians can also add, modify, or delete text at any time.

"In our practice, we see patients with hypertension at least five times a day," says Hill. "So, we built in standard questions that we ask these patients, such as "Do you have any swelling?," "Do you have any problems with your medication?," and "Do you have headaches?" In most cases, patients do not report any of these problems, he says. Simply by clicking a box on the screen, Hill can quickly and fully document most aspects of routine care for hypertensive patients. "Since I need to key in only special notes when a patient has a problem," he says, "I can spend my time addressing the exceptions, not the rule."

What do Hill's patients think of a computer in the exam room? "The system is transparent to patients, probably because they're

so used to computers as a part of everyday life," Hill says. Nevertheless, he admits that at first he was a bit self-conscious when using a computer in the exam room. "I felt that I had to give a little demo to each patient," he says.

While the process may be transparent to patients, CIMAs' physicians believe that patients receive better quality care because of the electronic medical records system. The physicians have more time to see patients, and the accuracy and accessibility of their medical information have improved greatly. "We do virtually all of our office notes electronically," Hill says. "We now scan paper records such as x-ray reports and mammogram results, and we've automated most of our nurses' notes so that they can very efficiently keep records of patients' phone calls. We've done this so that we can have immediate access to a patient's medical records, whether we're in the office, at home (via modem), or on call. As a result, we believe that we are able to provide much better patient care."

Having access to medical records is especially important when patients need emergency care, says Hill. "Because I have access to that database 24 hours a day, I can fax a patient's complete medical history to an emergency room physician in just minutes even when I'm not in the office," he says, adding that CIMA was able to do so for a patient who was ill while traveling in China.

#### A Process, Not an Event

CIMA's initial investment in the AutoChart System was less than \$40,000, but Hill estimates that over the past five years the practice has invested nearly \$150,000 in software and hardware of all kinds, and spends approximately \$10,000 for an annual service contract. "Those are figures you might choke on until you realize the efficiencies," says Hill. "If each of our doctors has time to see four more patients each day, it's pretty easy to pay for." In fact, the practice has increased its patient flow and added two physicians to the practice since installing the system, without having to hire additional office staff.

"We'll always be upgrading the system because of the rapidly changing technology," says Hill. In the near future, CIMA will upgrade its system to accommodate:

- Internet transfer of medical records

## Outcome: Improved Efficiency

CIMA's electronic medical records system has not only expedited documentation, it has also helped the practice to reduce costs and improve efficiency in many other ways. For example, the system has helped the physicians to:

- Increase the accuracy of patient medical records
- Scan paper documents, such as lab tests or patient records transferred from other physicians
- Eliminate transcription costs
- Screen prescription drug information for potential harmful interactions or patient allergies
- Have 24-hour access to medical records
- Eliminate searches for misplaced files
- Quicken staff's access to records to resolve billing questions
- Automate letters to patients and other physicians

among health care providers

- Electronic ordering and scheduling of lab tests, such as chest x-rays or blood work
- Databases from managed care plans, which will assist physicians in referring members to an approved specialist

"These are the types of time-consuming tasks in a practice that computers are designed to handle," says Hill.

While it may be tempting to wait for these types of upgrades before investing in an electronic medical records system, Hill says such a strategy will result in an endless waiting game.

"The reality is that no matter when you buy a product, a better model will be available the next year," Hill continues. "My advice is to choose a fully integrated system from a company that has a philosophical and a financial commitment to health care information systems and a good record of customer service and support. And then, get started."

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

# 'Secrets' of Physician Productivity Revealed



**Marshall O. Zaslove, MD**, is director of the Zaslove Group in Napa, Calif., providers of seminars and media to professionals since 1993. Zaslove also co-chairs the

Department of Psychiatry at Northern California's largest hospital. He is the author of *The Successful Physician: A Productivity Handbook for Practitioners*, published in 1998 by Aspen Publishers, in Frederick, Md. The book describes ways for physicians to increase their professional effectiveness and career satisfaction. Zaslove was educated at Columbia University and trained at UCLA School of Medicine and the Neuropsychiatric Institute at UCLA. For the past 27 years, he has practiced in solo, group, office, hospital, administrative, teaching, and military settings. Readers may order the book directly from Aspen at 800/638-8437, or online at [www.aspenpublishers.com](http://www.aspenpublishers.com). This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q:** Dr. Zaslove, when did you become interested in physician productivity and what led you to write your book on that topic?

**A:** For some years now, physicians across the country have been experiencing changes in practice due to the effects of managed care. About five years ago, I also began to feel the pressure of having to see more patients, do more in less time, discount my fees, face more competition, and so on. Seeking some help with these problems, I searched a large computer database and found about 240 books on time management—but not a single one that was written for physicians! I realized this was an area that I'd have to look into for myself, so I started doing extensive interviews and surveys with successful practitioners across the country, asking them to share their personal "secrets" for being more productive. For the past five years, I've been giving seminars in productivity enhancement for physicians—specifically, time management, knowledge management, and relationship management. The seminars are

based on updated surveys and interviews, and my book is based on the seminars.

**Q:** You say in the preface that one purpose of your book is to dissuade doctors from quitting practice because of too much work, too much hassle, too much competition, too much despair, and too little reimbursement. In other words, you seem to be saying, "Don't work harder, work smarter." Isn't that sometimes difficult in today's environment when physicians are often asked to see one patient every 10 minutes and to offer higher quality at a lower price?

**A:** You put your finger on the problem: We're all having to speed up, do more in less time, and increase output with less input. But the solution that doctors usually come up with probably won't work. When things get tough, we doctors always do the same thing: We work harder. The 60-hour work week is now the norm, and a lot of physicians are working 70- and 80-hour weeks, especially if they deal with managed care. But we're stretching the envelope of what we can humanly do. Working longer and harder isn't the right answer. Rather, what we need to do is to take a small amount of time from our busy schedules and invest it in seeing how we can work smarter, more efficiently, and more productively—and with less hassle and more satisfaction.

**"We need to take a small amount of time from our busy schedules and invest it in seeing how we can work smarter, more efficiently, and more productively."**

**Q:** You point out in your book that it's ultimately up to the individual physician to make his or her practice more efficient, despite the speedup and efficiencies that can be achieved with computers and other "systems fixes." Is that right?

**A:** Definitely. In fact, even the multibillion-dollar physician practice management companies now realize that autonomous, independent, highly trained, highly skilled professionals can't be managed externally. It's like herding cats. And

since we have to become more productive as individual physicians to keep up—and as a profession, to go forward and survive—we will have to manage ourselves. The problem is that certain skills—especially time management, knowledge management, and relationship management—are not taught in medical schools and in residencies. We have to learn them on the fly.

**Q:** Your book is divided into three main parts that deal with goal setting and time management, knowledge management, and relationship management. You say the first step in becoming more efficient is to pick a personal professional goal. What do you mean by that?

**A:** As physicians, we aren't used to choosing our own professional goals; they're chosen for us. Throughout our training, we're told what we're going to do, and when and how we're going to do it. But by not setting our own career goals, we have no direction—which is why, after 10 or 15 years of practice, some physicians end up saying, "Is this really what I wanted to do? Did I train 16 years to do *this*?" When you set a goal, and every day do some work toward that goal, you begin to take control of your professional life. That's why choosing a professional goal is the most important single idea in the book—it starts to put you back in control of your career.

**Q:** Another one of your suggestions is to create a goal card that you carry around with you. What does your goal card read?

**A:** My goal card for last year said: "Complete a book called *The Successful Physician*." I made sure I worked on that goal every day. Some days, it meant working on the manuscript at 6 a.m. and sipping coffee all over it, but little by little—despite a full-time hospital practice, a private practice, giving seminars around the country, and seeing my family—it got done.

My goal now is to get the word about this book out to physicians everywhere.

**Q:** *As I was reading your book, I was reminded of the old real estate rule pertaining to “location, location, location.” It seemed to me that you have four rules in which you could repeat three words like that. One of those words is “focus, focus, focus.” That is, focus on your goal and on only what you need to do the job, and no more.*

**A:** That’s right. And to “focus” I would add “analyze” because we don’t examine what we do—to see if we need to do it in the first place, to see if someone else can do it, or to see if there’s a quicker and easier way to do it. Analyzing what we do is a small investment in terms of time, but it can help us to see where we need to make the changes that will allow us to become super-efficient.

**Q:** *Another word that is applicable here is “prune, prune, prune.” In other words, get rid of the nonessential, read only the literature that’s important to your practice, and deal only with the people who have an effect on what you do. Have I got that right?*

**A:** Yes. If you think about it in terms of a bell curve, there is a certain amount of activity on the left side of our curve that is not productive. Everyone has some activities that don’t produce anything—watching television, for example, or starting projects we never finish, or browsing aimlessly through journals. Replacing even a few minutes of unproductive time with very productive time can shift our whole career into high gear.

**Q:** *In the book, you describe one seminar that you gave for physicians’ office managers during which you asked volunteers to shout out the personality characteristics that are typical of physicians and how taken aback you were by their responses. Could you elaborate on your response here?*

**A:** I was not only taken aback, I was embarrassed. The audience consisted of about 160 office managers who work for us and whom we consider our friends. When I asked them to yell out some of the characteristics of physicians, I assumed they would say the ones you and I would expect: trustworthy, hard working, intelligent, caring. Instead, they yelled out words like arrogant, greedy, stubborn, angry, controlling, rude. I filled a whole flip-chart page with

such descriptions and they still hadn’t said anything positive. So I said, “That’s very good. Now let’s have the positives.” I flipped the page and waited. Total silence for a very long time. I was getting embarrassed, so I said, “We’ve got to come up with something positive.” Finally, one of the office managers put up her hand very tentatively and said, “Well, I think maybe doctors are often the patients’ advocates.”

It is amazing that so many people who work with us daily could come up with only one positive characteristic to describe physicians. By the way, an aside to this story

**“As doctors, we aren’t used to choosing our own professional goals; they’re chosen for us.”**

is that after the meeting I found out that about 30% of the audience were also married to doctors.

**Q:** *You use some powerful language in the book to discuss how physicians can dramatically increase their productivity by listening to the members of their care team and by asking such questions as, “How would you do this?” or “How could I do this better?” In other words, by asking for the advice and guidance of those whom doctors work with every day.*

**A:** I’m a bit of a “doctor-watcher.” Because I work closely with so many residents and staff physicians, I get to see how physicians handle their teams. I’m always struck by how much more productive our work could be if we would share ideas with our coworkers and listen to their ideas. They want to be listened to. So many nurses have told me that they could save physicians a lot of time and trouble—if only the doctors would slow down long enough to listen.

**Q:** *I talked to two family practitioners—one in Southern California and one in Northern Michigan—who both had teams of seven to 12 people whom they had cross-trained. They were using the approach you’re suggesting and reported that it not only speeded up their productivity enormously, but that their patients were more satisfied and their teams were engaged in the whole effort. Is that what you mean?*

**A:** Yes, exactly. The amount by which you can increase your productivity by working with your team in a special way is unlimited. Knowing how to work efficiently with your team is the “hidden secret” of physician productivity; conversely, an inefficient doctor makes the whole team inefficient. I’ve devoted an entire section of the book to helping physicians become more productive in their teams.

**Q:** *You also point out in your book that much of what you learned about productivity was not from management books but rather from members of your seminar*

*audiences, who have been helpful in suggesting to you how productivity can be increased. So, many of the 140 concrete suggestions offered in your book actually come from those who have attended your seminars. Is that correct?*

**A:** Yes. Many of the books advising physicians on how to change their practice or change their ways of working in the new world of medicine are written by people who don’t practice medicine full time, and don’t have a feel for what a practicing physician actually does. All of the information in my book came from physicians. The book was written by physicians, for physicians, and it’s being used by physicians. Now, that doesn’t mean every physician will use all of the suggestions in it; but even using only a few of them can increase a physician’s productivity. For example, a neonatologist from the Midwest wrote me to say that he had increased his efficiency by 10% by using just one of the suggestions.

**Q:** *You’ll have to share with us what that suggestion was.*

**A:** That suggestion involved no longer allowing any interruptions to his work, particularly during rounds. He said that one change allowed him to get an hour ahead each day.

**Q:** *Could you characterize briefly how managers and physicians differ?*

*(Continued on page 12)*

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## INTERVIEW

**"The amount by which you can increase your productivity by working with your team in a special way is unlimited."**

(Continued from page 11)

**A:** The manager's job is to get work out of other people, which is basically why we hire managers. Physicians have to work with teams in a way that is more a form of coworking than it is of managing. That kind of teamwork is a skill that some physicians have and some don't. But it's a skill that every physician can learn; I'm convinced of that.

**Q:** You have some interesting comments on computers. In essence, you say computers aren't for everybody and that physicians shouldn't look to them as a way to reduce paperwork.

**A:** Young physicians finishing medical school now were brought up on video games, so they take computers for granted. As a result, in a few years, we're all likely to be using networked computers. But many physicians manage to have very successful practices and not use computers. Even for these physicians, however, there are one or two "killer" applications that they will have to learn, or else have someone do for them. One involves the MEDLINE database, which is a mountain of useful clinical information that can be accessed efficiently only by computer. MEDLINE is a database produced by the National Library of Medicine that contains references to medical journal articles. The other application is paperless charts. For physicians working in large groups and networks, paperless charts are the only way to move patient information efficiently from site to site.

**Q:** So, are you saying physicians will carry only a hand-held computer instead?

**A:** Hand-held computers are getting very popular, but the ideal hardware and software for physicians hasn't been developed yet. Today's computers are technology-oriented, not doctor-oriented. For maximum efficiency, we need wireless portability, and more versatile and user-friendly machines.

**Q:** Let's conclude by talking about your seminars on personal and professional productivity. You've given more than 500 of these seminars to large hospital systems, to specialty associations, and to others. How do audiences respond?

**A:** Often, physicians in the audience start out thinking that they don't need the seminar. Some physician usually stands up and says, "I'm already very productive. I see patients all day long. How could I be any more productive?" And then we talk about the difference between being busy—which I think almost all physicians are these days—and being productive. In other words, the difference between *inputs*, which is how busy you are, and *outputs*, which is how productive you are. There's a huge difference between the two. Once physicians grasp that concept and go through the seminar or read the book, they realize that—like professionals in almost every field—they are only about 40% to 60% efficient in their work. And that's a revelation. ■

# MedPartners' Physicians Have Choices

By W.L. Douglas Townsend Jr.

Since November, when MedPartners announced it would sell its physician practice management operations, I have heard from many physicians discouraged over the prospect of having to buy back their practices from the troubled physician practice management company in Birmingham, Ala.

Physicians affiliated with MedPartners have no doubt been worried since they learned their practices would be sold, and are now likely to be concerned that they will not have access to the capital required to purchase their practices at a price acceptable to MedPartners. Some may be resigned to the fact their practices will be sold to the highest bidder and that they will need to "make the best of a bad situation."

Yet, there is good news here: It may not be necessary to sell out to the highest bidder. In fact, physicians seeking to regain control of their practices could view Mac Crawford, the chairman of MedPartners, as the current-day Moses. His actions in November are akin to parting the Red Sea and creating a safe passage to the promised land. Getting there won't happen without considerable effort by MedPartners-affiliated physicians, but buying back their practices is the first, positive step on the journey.

Many creative ways exist to acquire capital for such a transaction. For starters, and for some of the funding, physicians could meet with a local banker to see how much the bank might lend on the physicians' personal guarantees. Other sources include subordinated-seller or accounts-receivable financing, and minority investments by local strategic partners.

Depending on the level of financing, limited personal guarantees by the physicians may be required. Physicians selling a practice should also remember that a group

practice is a service business: It has no value if the principals are unable to deliver the service. Thus, any transaction will need strong physician support.

As unlikely as it may seem, capital for physicians who took MedPartners' stock when they initially sold their practices

be sensitive to this issue and may have trouble making a case that it helped its practices reach their maximum valuation, particularly when the stock of the parent company has been trading at historic lows. As a result, many physicians in MedPartners-affiliated clinics will likely try to use this decline in

**Physicians could view Mac Crawford, the chairman of MedPartners, as the current-day Moses. His actions are akin to parting the Red Sea and creating a safe passage to the promised land.**

exists in those very shares. While their value has declined considerably, physicians should not underestimate their ability to use these shares to fund some of the purchase price. What's more, returning the shares to MedPartners creates some value for the troubled PPMC.

Simply because MedPartners has said it wants a "purchase price acceptable to MedPartners" does not preclude physicians from negotiating for the best possible deal. The "buyback provisions" in most long-term service agreements dictate an amount the physicians would have to pay under certain circumstances, such as a breach of the agreement. Such provisions generally suggest a buyback price at the "net book value of assets," which includes goodwill and contract intangibles paid by MedPartners. The net book value of assets generally is a proxy for the original purchase price less any costs for amortization. This buyback price is likely to be greater than the current fair market value of the clinic.

Thus, today's market value is the only appropriate basis for the purchase price. Given how the values of PPMCs have declined over the past 18 months, the market value of the clinic should be lower today than what was paid originally. To negotiate on this basis, physicians must analyze the future prospects of the clinic and current valuation benchmarks and trends.

Since PPMCs are supposed to add value to their affiliated practices, MedPartners will

value to their advantage during negotiations. These physicians could claim, for example, that MedPartners damaged the clinic by breaching its agreement. In essence, clinics will claim that the buyback price should be discounted by the amount of damage sustained.

Strategic investors are another source of capital for physicians to consider. Using this option, the clinic's physicians would act as the "lead investor" in an investment opportunity in the local market. Instead of MedPartners marketing the clinic as a "property" to buyers, physicians in the group should take the lead as investors, inviting strategic health care companies to share the investment in the group. Physicians should keep in mind that any strategic partners on the physicians' list would likely be on MedPartners' list as well.

Put simply, the physicians' investment would be their goodwill toward making the physician group productive over the long term. Once again, that promise of production in a service business has immense value.

MedPartners-affiliated physicians in this situation should look at all their options. Whether the outcome ends up being a sale to another PPMC or to a local health care system, they should consider the merits of controlling their destiny and realize that capital-formation strategies exist that can lead to a successful repurchase of their clinics. ■

*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 Physician Practice Options.*

(Continued from page 1)

the consumer and the reemergence of public policy activity are the most important recent trends in the evolution of the financing and delivery of health care," Ginsburg says. "Consumers are demanding a broader choice of providers, and consumer activism has led to extensive legislative activity."

Regina Herzlinger, professor of business administration at the Harvard Business School and the author of *Market-Driven Health Care* (Addison-Wesley, 1997), agrees that patients are changing health care, and these changes are forcing all providers to be more responsive to consumer demands. "The truth is, consumers are better educated about health care than they used to be and are worried about the quality of the care they receive," she says. "These patients are changing all the rules of the game. The MCOs that can adjust to

these changes will survive. Those that don't will disappear. One of the best parts of all this change is that it reaffirms the importance of the delivery of quality health care."

In the face of such changes, HMOs are trying to become more consumer-friendly. For example, PacifiCare Health Systems of California, a large managed care organization in Cypress, last August published data on the performance of the medical groups that serve PacifiCare patients. The HMO used 14 measures related to clinical care, service, and administrative quality of care, such as cervical cancer screening, member satisfaction, and professional encounter data. Known as the Quality Index, the information was published on PacifiCare's Web site ([www.pacificare.com](http://www.pacificare.com)), and the MCO said it will update the data twice annually.

Margaret O'Kane, president of the

National Committee for Quality Assurance, an HMO accrediting organization in Washington, D.C., says the report allows "consumers to vote with their feet for higher quality and better service so that quality becomes a business issue." But not everyone is pleased with the PacifiCare initiative. One critic is Keith Richman, MD, chairman of Lakeside Healthcare, which manages Lakeside Medical Group in Los Angeles, a group that fared poorly in the PacifiCare rankings. The report does not reflect the group's ability to practice medicine, but rather its ability to gather data, Richman says. The PacifiCare initiative does, however, "tell us that we need to work a little bit harder to put in place systems that will enable us to pick up data."

Another HMO that is expanding services as a result of consumer demands is Harvard

## Changes Are Coming to Managed Care

Recognizing that dissatisfaction with managed care is high, physicians and politicians want to "look beyond managed care" as quickly as possible, says Peter Kongstvedt, MD, a partner with Ernst & Young, CPAs and health care consultants in Washington, D.C. "They have a variety of motives for wanting to do this. Some simply want managed care to go away, and by 'looking beyond,' they see the past. Some see the continual evolution of our health care system and want to project the future for business or personal reasons. And some are fidgety about the present and want to move rapidly into the future."

The drive for change is so strong that the label "managed care" may disappear. "If the term 'managed care' becomes a sufficient liability in the public's mind, another term or set of terms may eventually replace it," Kongstvedt says. "But even if a new term comes into use, the need to balance rising costs with the need for quality care will continue to grow in importance. The economic and social forces that have led the American health care and insurance markets to develop and refine managed care remain at play."

Lee Newcomer, MD, chief medical officer of United HealthCare Corp. in Minneapolis, agrees. "HMOs as we know them now may disappear, but all of health care's problems won't disappear with them. In fact, some of the coming changes may make health care unaffordable to more people."

Consumer discontent, legislative initiatives, and information technology are powerful forces that are compelling the health care industry to evolve, says Kongstvedt. "And there are certain aspects of that evolution that we can reasonably predict," he says. He and other experts predict the following six trends will be prominent in the future:

1. Movement of risk to providers
2. Increased importance of physicians
3. More accountability
4. More regulatory and legislative initiatives
5. Continued consolidation
6. Increased use of electronic information

**Movement of risk to providers.** "Risk has been slowly moving from the insurer and MCOs to providers," says Kongstvedt. "This trend will continue." In some cases, MCOs genuinely desire to get out of the business of micromanaging medical care, says Kongstvedt, for several reasons. "First, a provider's knowledge of the health needs of his or her patients means the provider should, at least theoretically, be able to do a better job of managing risk. Second, there is less liability for both the MCO and the providers if the providers are managing costs while applying highly trained clinical judgment. Third, by delegating risk as well as management of medical cost, the MCO is exposed to less volatility in costs. And last, the administrative costs are lowered by transferring medical management activities to providers."

**Increased importance of physicians.** "As managing clinical care continues to become more closely aligned with managing financial risk, the physician's role will continue to become more important," Kongstvedt says. Therefore, comments Harvard professor Regina Herzlinger, physicians who understand the emerging power of health care consumers will thrive financially. "The health care providers that flourish in this new market-driven system will give customers the convenience and the focused, cost-effective services they want," she says. "And consumers will come to understand that they can manage this care themselves."

Pilgrim Health Care, in Boston, the largest HMO in New England. Over the past year or more, HPHC has been working to deliver more consumer-friendly care, says Glenn Hackbarth, CEO of Harvard Vanguard Associates of Boston, a 500-member multi-specialty group affiliated with HPHC. Addressing the National Congress on the Future of Medical Practice and Practice Management in Nashville in October, Hackbarth said HVA has found that a "new breed of consumer" is seeking a wider choice of treatment, including alternative medicine, choice of geographic locations and physicians, lower costs, information on outcomes, flexible appointment times, no waiting, and no disagreements over HMO bureaucracy. Consumers responded positively when HVA began offering acupuncture, chiropractic, and massage therapy at four of its clinics, Hackbarth says.

### Widespread Dissatisfaction

Being responsive to consumers may help improve—albeit slowly—the relationship between physicians and HMOs, says Jack Lewin, MD, chief executive officer of the California Medical Association in Sacramento. Lewin has begun meeting regularly with the CEOs of the state's largest HMOs to develop collaborative initiatives, such as electronic transfer of patient data to facilitate membership verification, he says. Despite such efforts to improve relations between physicians and health plans and between health plans and consumers, physicians remain "frustrated by managed care," he says.

"The truth is, patients and physicians are linked together, regardless of the delivery system," says Nuckolls of Carilion Healthcare Corp. "In treating their patients, physicians should be prepared to explain to them the positive side of man-

aged care, such as wellness and early intervention programs."

Such advocacy may not come easily. An editorial in the *The New England Journal of Medicine* on Nov. 19, said that "American doctors are unhappy with the quality of their professional lives," citing the Commonwealth Fund survey as evidence that most physicians are unhappy with the quality of care they deliver under managed care plans. A general sense of frustration is reflected in the finding that only one physician in four is very satisfied with the practice of medicine overall, the survey shows. More than a third (35%) of physicians are somewhat or very dissatisfied. Only about two in five physicians (43%) with at least half of their patients in managed care are very satisfied with their ability to make the right decisions for their patients, compared

*(Continued on page 16)*

**More accountability.** "Whether health care plans like it or not, health care financing and delivery systems will be held to increasing levels of accountability for fiscal results, clinical outcomes, and satisfaction," Kongstvedt says. "The market will become ever more demanding and come to expect ever higher levels of service and results, all for the most competitive prices possible." Since markets are demanding more of health plans, it is natural that they would transfer more risk to providers.

To remain competitive, MCOs will need to provide "full systems of care," defined as a broad range of medical services, such as behavioral health and wellness programs, says Kenneth Thorpe, director of the Institute for Health Services Research at the School of Public Health and Tropical Medicine at Tulane University in New Orleans. "The term 'managed care' may or may not continue to have meaning, but it's inevitable that managed care plans will need to become more outcomes oriented and evolve into organizations capable of providing completely integrated care, using the best science available," he says. "Today's better-educated consumer will demand state-of-the-art medicine."

**More regulatory and legislative initiatives.** Since insurance is regulated primarily by the states, lawmakers in state houses nationwide have passed numerous laws to regulate managed care plans. In the five years ending in 1997, there were 1,043 state health mandates nationwide, according to data compiled by the Blue Cross and Blue Shield Association, the national association of independent Blue Cross and Blue Shield plans in Chicago. In the previous five-year period (1987 to 1992), there had been only about 800 such mandates. No figures are available yet for 1998, but association officials say several hundred more were considered by state legislatures last year. The state of Maryland passed a sweeping health care reform law in 1993 and now has 40 health mandates—more

than any other state, the association says. Florida and Minnesota have 37 each, California has 33, and New York and Texas have 30 each. Idaho and Washington, D.C., have the fewest health mandates—seven each, according to "The Backlash Against Managed Care," an article in the July issue of *Nation's Business*.

State mandates, however, don't apply to all persons enrolled in health plans in a state. Under the federal Employee Retirement Income Security Act (ERISA) of 1974, self-insured employers—those that pay their employees' health claims directly from company funds—are exempt from state health mandates. These companies would be covered, however, by proposed federal legislation.

The American Association of Health Plans (AAHP), in Washington, D.C., the managed care industry's largest lobbying organization, has criticized federal and state initiatives as unnecessary and costly. "Changes in health plans should be market driven, not mandated," says Karen Ignagni, AAHP president. "That approach will stifle innovation and increase costs for working families, employers, and taxpayers."

**Continued consolidation.** "Large insurers and MCOs will continue to merge and become larger and more powerful, although it is not likely that the industry will soon be dominated by a few large, national companies," says Kongstvedt. "There is plenty of room for strong regional carriers, although these could be acquired by national companies simply for the economic value."

**Increased use of electronic information.** "To continue to achieve greater levels of quality, efficiency, and satisfaction, MCOs and providers will need to engage in increasing amounts of electronic commerce and data exchange," Kongstvedt says. "These exchanges of data will be a part of the increasing use of information to manage the health care delivery and financing systems."

M.S.

## COVER STORY

**"Consumers are changing all the rules of the game."**

**— Regina Herzlinger, Harvard Business School**

*(Continued from page 15)*

with over half (54%) of physicians with no managed care patients.

Perhaps as a result of this dissatisfaction, many physicians are consolidating into groups capable of accepting risk and learning to manage care themselves, says Jayne Oliva, a principal in the Croes Oliva Group, physician practice management consultants in Burlington, Mass. "Physicians are just beginning to understand their own power," she says. "They are beginning to organize into groups big enough to purchase the technology capable of accepting risk, and to dictate terms to payers. They are regaining their autonomy."

Just as physicians are working to survive, the delivery and financing systems are continuing to evolve as well, says Kongstvedt. "Evolution is not always pretty," he comments, "but it certainly is effective. For managed care, the forces of competition result in greater efficiencies and control of costs, while dealing with greater demand for clinical results and satisfaction in service." Physicians seeking to be an equally competitive force clearly need to operate in larger organizations simply to have the market expertise and clout to survive and so that they can have the revenue to purchase the necessary information systems and to hire management talent.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

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