

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

March 15, 2001

CONTENTS

Features

Strategy
ASC Focuses on
Convenience,
Quality 3

Case Study
Group Automates
Workflow 10

Interview
Career Expert Offers
Suggestions to
Physicians Leaving
Patient Care 13

Departments

Editorial
Will Fees
Facilitate Online
Consultation? 2

New Technology
Systems Help
Standardize
Coding 6

California Group Failures Offer Several Lessons

Physicians around the country have lamented the fate of their colleagues in California: poor compensation and widespread practice failures, leading to physician relocation, retraining, and retirement. Such failures have occurred as a result of a confluence of factors: low reimbursement, poor financial management, and indiscriminate consolidation among medical groups.

Many physicians in other states have questioned whether such wholesale physician group failures might occur in their own markets as well. But health care experts believe that the widespread practice failures experienced in California are unlikely to occur in other areas of the country, citing peculiarities of the California market.

Seeds of Discontent

"Due to extremely low reimbursement from health plans, the revenue earned by many medical groups in California has been insufficient to cover their operational costs and to meet the expectations or obligations of group physician compensation," says Michael Guthrie, MD, MBA, executive vice president in San Diego for Premier Practice Management, a division of Premier Inc., an alliance of health care providers.

The California Medical Association estimates that 143 physician groups have closed or gone into bankruptcy since 1996 and bases its estimates on physician and media

reports. Among the failures are some of the largest groups in the country.

"The primary reason so many physician group failures have occurred in California is that large primary care groups have taken on high levels of full capitation, which typically means that they have nearly full responsibility for all health care services for these patients," says R. Brett Ringler, principal with Physician Practice Consulting Group in San Diego. "If the patients use more services than predicted based on the negotiated capitation rate, the group loses money. This is an even more important issue where groups have taken on Medicare patients under capitated contracts.

"Such widespread failures are less likely in areas of the country where capitation is not as prevalent," Ringler continues. "In addition many plans are moving away from onerous utilization review programs. Some are even moving back to discounted fee-for-service in primary care areas."

Bruce Swartz, vice president of practice operations at Premier Practice Management, says the group failures in California offer several lessons. First, the growth of physician groups occurred too fast, preventing some from acclimating to the more complicated operational requirements of a larger group. "In addition, the growth of groups has been opportunistic, rather than strategic," Swartz says. "Many physician organizations in California seemed to be trying sim-

(Continued on page 8)

Will Fees Facilitate Online Consultation?

First Health Corp., a national managed care company in Downers Grove, Ill., that covers 10 million enrollees, is paying \$25 to physicians for online consultations. First Health says it is the first company to do so. Physicians in its network who treat any of the more than 300,000 enrollees and dependents with asthma, diabetes, and hypertension are eligible for the payments.

The question is whether a \$25 consultation fee will be sufficient incentive for physicians to use the Internet more frequently. We doubt that this fee will be the factor that motivates physicians to embrace the Internet. More likely, physicians' increasing comfort with e-mail communication will be a factor.


To date, e-health companies and HMOs have miscalculated physicians' acceptance of electronic technologies. Elliott Masie, an Internet authority who founded the Masie Center, an e-technology consulting firm in Saratoga, N.Y., says managed care and e-health companies have misunderstood physician behavior, although their attitudes may be changing.

These companies are beginning to understand, for example, that physicians want to spend less time—not more—in front of a computer screen. Many physicians believe that typing e-mail messages to patients has not been a productive use of their time. Many, but not all, consider such work to be clerical in nature and best for a secretary or other assistant. Also, Masie says, physicians prefer portable handheld devices and face-to-face meetings with patients.

But a recent Harris Survey showed that 89% of physicians have access to the Internet, and most use e-mail routinely for personal purposes. In addition, consumers want more direct interaction with physicians, including the ability to communicate with doctors online, according to *The Wall Street Journal*.

Masie believes physicians want to use the Internet to solve problems quickly. In other words, physicians want to use e-mail and the Web for a specific purpose using prepared templates that require only minor changes to modify.

Therefore, we conclude that First Health's plan to pay for e-mail consultations might be successful. It requires less work on the physicians' part because the focus is on specific diseases with a limited number of variables. It lets the physician be a medical adviser to sick patients seeking specific information. It offers a fee so the physician is reimbursed for his or her time spent on patient care. And it involves a medium with which patients and physicians are becoming more comfortable. If the program does work for First Health, then we hope the idea of paying for e-mail consultations spreads widely.



Richard L. Reece, MD
 Editor-in-Chief
 Phone: 860/395-1501
 E-mail: rreece@premierhealthcare.com

- Neil Baum, MD
Urologist
New Orleans
- Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.
- Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.
- Michael B. Guthrie, MD, MBA
Executive Vice President,
Premier, Inc. and
Premier Practice Management
San Diego
- Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis
- Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego
- Paul H. Keckley
President and CEO
webEBM
Nashville, Tenn.
- Peter R. Kongstvedt, MD
Partner
Cap Gemini Ernst & Young
Washington
- Richard Lilledahl, MD
Health Care Consultant
Milliman & Robertson Inc.
Seattle
- Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.
- James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.
- Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.
- Jacque Sokolov, MD
Chairman
Sokolov Schwab Bennett
Los Angeles
- W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

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

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

Publisher
 Premier Healthcare Resource, Inc.
 Suite 300, 99 Cherry Hill Road
 Parsippany, NJ 07054
 888/457-8800
 Fax: 973/316-5989
 publisher@premierhealthcare.com

Editor
 Joseph Burns
 508/495-0246
 editor@premierhealthcare.com

ASC Focuses on Convenience, Quality

Physicians seeking greater convenience, higher quality of care, and more practice autonomy have made ambulatory surgery centers (ASCs) increasingly popular in recent years. In particular, urologists and surgeons have opened specialty-specific centers, while other physicians have preferred to participate in multispecialty organizations.

One unusual center seems to be a combination of both. The Oklahoma Surgery and Urology Center, in Oklahoma City, offers various types of outpatient surgeries, yet concentrates on urological surgery. This organization offers participating urologists the ability to position themselves as experts in the fields of urology and urological surgery—and reap the quality and efficiency benefits of a “focused factory”—while at the same time achieving economies of scale and minimizing fixed costs by sharing space with physicians who are not urologists.

Growth Factors

“The Oklahoma Surgery and Urology Center provides both urological outpatient surgery and other specialty outpatient surgical procedures,” says Marie Lee, the center’s executive director. “More than 60% of procedures handled at the center, however, are urological procedures. The remainder are general, orthopedic, and plastic surgery.” Overall, the center provides care to 4,000 to 6,000 patients each year.

Richard Edward Herlihy, MD, a practicing urologist and the center’s medical director, believes the center is unique. “Other metropolitan areas may have lithotripsy centers or surgery centers, but I have not heard of any urological surgery centers,” he says. “Our center is a fantastic practice option for urologists. Other surgery centers are composed mostly

of general surgeons, podiatrists, and orthopedists. Urologists are the minority in those groups.”

The Oklahoma Surgery and Urology Center grew out of one original group of urologists called Oklahoma Lithotripter Associates, which was formed in late 1986. “Oklahoma Lithotripter Associates was a collaboration of many of Oklahoma City’s urologists who wanted to purchase a lithotripter,”

Oklahoma Surgery and Urology Center in 1998.

Rapid growth is one measure of its success. “We currently have 50 employees, 30 of whom are full time,” Lee says. “We have experienced incredible growth since 1997, when the Oklahoma Surgery and Urology Center was formed. We grew from eight full-time employees treating about 50 patients a month to our current staff of 50 employees who treat

The ambulatory surgery center allows specialists to position themselves as experts in their field while also achieving economies of scale and minimizing fixed costs.

Lee says. “At that time, lithotripters cost approximately \$1 million. Since the hospitals were facing reimbursement and cost cutbacks, most were reluctant to make the investment. The urologists formed their group and approached numerous hospitals in Oklahoma City. They selected and developed a relationship with Deaconess Hospital, the local 200-bed community hospital, that would enable the purchase of a lithotripter to benefit both the physician group and the hospital.”

Over the next decade, Oklahoma Lithotripter Associates grew. In April 1997, the center was renamed the Oklahoma Urology Center with the addition of a second urology group. “In March 1998, we added a group of general surgeons, and in July we added another group of urology surgeons,” Lee explains. “As a result, we currently have four different investor groups of physicians functioning in our facility and operating under the umbrella of our license.” To acknowledge the addition of the surgeons, the center changed its name to

500 patients a month. It is truly remarkable that this growth has occurred in only three and a half years.”

Ownership Positions

The urologists and other surgeons practicing at the Oklahoma Surgery and Urology Center hold equity positions in one of four limited liability corporations, reflecting the distinctions among the four original groups. “The original group, Oklahoma Lithotripter Associates, now includes approximately 50 physicians who are owners, including many rural-based urologists throughout the state,” Lee explains. “These rural physicians use two mobile lithotripsy units, which serve 17 hospitals in Oklahoma and Texas. The second organization, Urological Surgery Center Associates, has 14 urologists. The third group, Deaconess Surgical Associates, represents 19 multispecialty surgeons who work out of the center. The fourth group, Urology Surgery Associates, includes seven local urologists who perform their surgical pro-

(Continued on page 4)

(Continued from page 3)

cedures primarily at the center.”

The volume of 500 procedures per month includes lithotripsy cases, bladder tumor removal, prostate biopsies, and implantation of radioactive seeds into cancerous prostates, orthopedic procedures such as arthroscopic surgery, and general surgical procedures such as laproscopic gall bladder surgery, hernia repairs, and podiatry cases.

Few diagnostic procedures are done at the center. “We do some lymph node biopsies, but as an ambulatory surgery center, we have to be very selective about what procedures to do,” Lee says. “Additionally, as a physician-owned ambulatory surgery center, according to the federal regulations governing ambulatory surgery

centers, we do not receive reimbursement for diagnostic procedures. If there is a surgical CPT procedure code for doing a biopsy, then we can do that procedure. Otherwise, those procedures are referred back to the hospital or physician office.”

Physician-Hospital Relations

When starting an ambulatory surgery center, physicians often find some resistance from administrators at area hospitals who fear they may lose patient volume. In fact, the Oklahoma center found some local hospital executives were worried. “Not surprisingly, the hospital’s administrators were initially concerned that their caseload might fall,” Lee says. Despite these con-

cerns, the hospital executives worked with the center and supported the endeavor, she adds. As a result, the hospital’s surgical caseload has increased because the hospital was able to increase its procedure capacity and bring in new physicians when some of the physicians who had been practicing at the hospital moved their procedures to our facility. The development of the center, therefore, has created more growth on the entire Deaconess campus. The relationship between the Oklahoma Surgery and Urology Center and Deaconess Hospital is one Lee calls a “good neighbor relationship that is collaborative and cooperative.”

“We lease space from the hospital in its three-story medical office build-

Equity Arrangement Fosters Efficiency

Each of the physicians who own the four entities that make up the Oklahoma Surgery and Urology Center, in Oklahoma City, has an equity position in the center. The equity arrangement fosters the efficient use of resources.

“The mindset is much different in facilities that are physician-owned versus a hospital,” explains Marie Lee, the center’s executive director. “Historically, physicians have gone to hospital administrators and said, ‘We want this latest piece of equipment and whatever else we need for our patients,’ without great concern for cost. While our physicians are progressive and interested in the latest technology, however, they also want proof that these technologies can improve care. They are cautious about incurring expenses and they try to keep the cost of medical care down. The physicians want proof of return on investment and a proven clinical track record prior to any technological purchases. Physician ownership makes the center a responsible and accountable environment.”

As executive director, Lee, a registered nurse who has been in nursing administration for 20 years, functions as the chief executive officer, handling hiring, overseeing contracting with insurers, marketing mobile lithotripsy services, handling accreditation, and monitoring cost efficiency, among other duties. Lee has worked for the center since 1991.

“I have a surgical background in nursing,” Lee says. “At one time, I worked for a major health plan as the director of health care review. Because I worked for an insurance company, I understand how health plans operate and how managed care works. As a result, I can serve as an advocate for the physicians when negotiating managed care contracts.”

Each of the four entities that make up the center maintains its own board of directors, which meets monthly to make decisions regarding each particular organization.

“In addition, the center maintains an operating committee comprised of representatives from each of those entities, and the center’s medical director serves as chairman,” Lee relates. “This central operating committee, which meets monthly, discusses policies that affect the center, whether it be employee benefits, medical records, or billing. This structure allows all physicians to maintain autonomy in their individual groups, yet collaborate and disseminate information to their respective boards. They all work together to make the center operate efficiently.”

Richard Edward Herlihy, MD, has served as the center’s medical director for three years. “As the medical director I help decide what equipment to purchase, settle conflicts in scheduling, and make decisions about physician responsibilities as related to center operations and strategy,” he says.

—DJN

ing that is adjacent to the hospital itself," Lee explains. "In fact, the medical office building and the hospital are connected by a hallway. The center occupies the first floor of that building, about 22,000 square feet, and purchases additional services from the hospital, such as laboratory and housekeeping services. This relationship is a 'win-win' for both the hospital and the center."

The physicians prefer the arrangement with Deaconess because they have the benefits of an ambulatory surgery center and an adjacent, supportive hospital facility in which they can perform more intensive procedures.

Patient Satisfaction

Partly as a result of such efficiency, patient satisfaction at the center is extremely high, Lee notes. "We monitor our satisfaction rate via follow-up phone calls and mail-outs," she says. "For the most part, we get very few complaints, probably fewer than 1%. On the other hand, we get many compliments, most of which come in the form of cards or notes. We've even had patients send flowers to our nurses. Our patients tell us that this is the place they want to be, that they're treated better here than they are in any other facility, and many of them ask to come back."

Herlihy agrees, saying, "The staff members are very friendly, and the admission and discharge processes are extremely smooth. These factors all drive high patient satisfaction."

What's more, the center's patients get wonderful care, says Jon Axton, MD, a practicing urologist in Oklahoma City who uses the Oklahoma Surgery and Urology Center frequently. "We get very positive comments from our patients who utilize the center," he adds.

Payers have responded positively to the center as well, Lee says. "We have contracts with all the major payers in the market," she says. "We

Centers Offer Specialized Care

Many physician specialists today are carving out niches for themselves in an effort to attract patients and to secure a modicum of independence. Also, some of these specialists recognize that patients may value specialized, high-quality care.

"A lot of health care today is everything for everybody," comments Regina Herzlinger, a professor of business administration at the Harvard Business School and author of *Market Driven Health Care* (Addison-Wesley: Reading, Mass., 1997). In her book, Herzlinger explained her theory of consumer-driven specialized care and why physicians and other medical providers should be more focused on serving consumers in the future.

"Consumers understand everything for everybody is not as good as somebody who specializes in meeting a need," Herzlinger says. Savvy patients may prefer physicians who have achieved a level of expertise in their specialty that allows them to provide insight into patients' problems that patients may not get elsewhere.

Working in specialty-focused centers has advantages for physicians as well. Jon Axton, MD, a urologist in Oklahoma City who uses the Oklahoma Surgery and Urology Center frequently, says participating in the center has been a positive experience for urologists. "The center facilitates the performance of outpatient procedures in an efficient manner," he explains. "Because the center focuses primarily on urology, all the staff members, including the nurses, become very good at their individual jobs. This focus creates process efficiency as well as high-quality care. In addition, scheduling is so efficient that the cases are completed on time. The center maintains all the needed instrumentation that the physicians use. Even those urologists who do not have offices on the Deaconess Hospital campus still schedule their patients so that they can have the procedures done in the center." —DJN

are Medicare certified and contract based upon surgery-payment groups. Payers like contracting with the center because we provide quality care at a lower price than most hospitals."

Looking Forward

Axton estimates that he spends five to 10 hours at the center weekly, performing endoscopies, lithotripsies, prostate ultrasounds, biopsies, and implantation of radioactive seeds for prostate cancer. The remainder of his time is spent on office visits or in the hospital, where he performs transurethral resections, bladder operations, and prostatectomies.

"The arrangement between the center and Deaconess has made med-

ical practice easy for me and for many area urologists," Axton says. "I can handle all of the options for prostate cancer treatment in one setting. Deaconess is one of the smaller hospitals in town, yet it handles the vast majority of urology procedures in the area. The center has enjoyed a real commitment to the urology profession on the part of the hospital, and I think urologists appreciate it and are, in turn, supportive of the hospital. Overall, the urology center has captured the urology market in the Oklahoma City area."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Systems Help Standardize Coding

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

For physicians seeking systems that will help them get paid faster and more equitably, a number of companies are developing technology to improve documentation and standardize coding in an effort to speed up claims handling.

The efforts by these companies are important because reimbursement policies for Medicare and managed care companies are written by lawyers. "In the minds of lawyers, if it isn't recorded, it isn't done," says Allen Wenner, MD, a family practitioner and founder of Primetime Medical Software Inc., a company in Columbia, S.C., that automates and documents medical histories. "What you record and write down is absolutely critical for payment," he says.

Increasing Revenue

These systems also will cut the time it takes physicians to document care. Most physicians can dictate about 150 words a minute and can scribble about 30 words per minute, but these notes are often illegible and not in complete sentences. To improve performance, physicians can enter all the information they need into electronic templates of varying lengths in less than 30 seconds. And, consultants advise that the more complete the entry, the better the payment.

"When it comes to getting paid, doctors who dictate receive more than those who write, and those who use electronic entry do even better," says John McDaniel, president and CEO of Physician Management Group Inc., physician advisers in New Orleans. "In other words, faster is better. It is simply a matter of progression to better methods of entry."

But coding properly also involves the vagaries of human nature. "Because of the time involved, those who carefully

document what they do by handwriting feel they deserve more and they tend to overbill," says McDaniel. "But those who provide a service without documenting it tend to underbill, even though they did the work."

Standardized entry is extremely important to the federal Health Care Financing Administration (HCFA) and to health plans nationwide. What payers look for is not the length of the handwritten note or dictation, but the standard entry of key required components. Efficient coding is about routinely addressing a checklist of items payers are seeking.

"Clinical documentation is usually insufficient for billing and results in lost revenue for the physician, hospital, or practice setting."

—David Grayzel, MD, Catalyst Medical Solutions

"The important thing is the mental and habitual process of systematically organizing the data," says McDaniel. "Hit the high points every time, and your reimbursement will automatically increase without a change in staffing, without adding overhead, and without changing what you do. Coding appropriately is the quickest method to increasing reimbursement that a physician can make."

To code effectively and quickly, physicians need practical tools, which a number of companies offer, and some of these companies are founded and run by physicians.

Technology Solutions

One company, for example, is the Digital Physicians Network (www.dpnx.com), an enterprise in Providence, R.I., that was founded by James Weintrub, MD, a surgeon and

systems analyst, and Gregory W. Brownell, a senior software architect. In June, Digital Physicians Network released version 2.1 of its Paladin software for evaluation and management coding compliance. DPNX says Paladin can accurately assign CPT codes for E&M services, help physicians educate and train staff members, and perform practice audits. The system helps physicians avoid government audits and fines.

Another company in this field is Orthocodermd.com, in Winston-Salem, N.C. Orthocodermd (www.orthocodermd.com) offers the

Compliant Coder System, a program that simplifies dictation, explains HCFA guidelines, helps prevent undercoding, and helps physicians do chart audits. Orthocodermd also offers the Surgicoder System, which teaches surgeons to code for surgical procedures and chooses ICD-9 and CPT codes for surgery. It helps increase surgery revenue by aiding physicians in understanding coding more fully.

One company, mdeverywhere.com, in Durham, N.C., uses a system that allows physicians to capture data at the point of care. Mdeverywhere (www.mdeverywhere.com) says its systems help physicians increase productivity, reduce paperwork, and deliver better patient care. Its handheld systems require no initial investment, mdeverywhere says. The initial concept on which mdeverywhere is built, was developed in 1989 by com-

Software Increases Hospitalists' Efficiency

The role of the hospitalist is to bridge the gap between the primary care and in-patient settings, says David Grayzel, MD, a co-founder and CEO of Catalyst Medical Solutions in Cambridge, Mass. For physicians at Massachusetts General Hospital (MGH), bridging the gap between the main campus in Boston and the hospital's satellite clinics in Everett, Quincy, and Revere can be difficult.

"These sites are many miles away and yet these physicians refer their patients to MGH for admission when medically necessary," Grayzel says. "The physicians at these satellite clinics find it difficult to commute into Boston to the hospital to take care of their inpatient population, which may be six patients at a time, and then get back to their clinics to see other patients."

As most physicians know, patient care and procedures are often performed in a hectic environment, meaning work may go unbilled or undocumented. "Somewhere between 20% and 70% of procedures are not billed and reimbursed, depending on the institution, the specialty, and the practice setting," Grayzel

explains. "This problem is not limited to busy inpatient or critical care settings. Busy offices for family practice, dermatology, and others lose revenue on procedures they perform every day due to inadequate documentation and charge capture."

Even when a procedure is recorded, it may not be documented adequately to meet the guidelines of the insurer or the federal Health Care Financing Administration. In these cases, payers may reject the claim. "Once a claim is rejected, it is unlikely that a physician will take the time to go back into the chart and rewrite by hand the lengthy note that would allow for reimbursement," Grayzel says. "Unfortunately, the government and most insurers have equated more documentation with the right to get paid, as opposed to the quality of the care that's given."

In contrast, full documentation at the point of care can have significant consequences for revenue. "Technology today is such that physicians can provide third-party payers with extensive detail quickly and easily," Grayzel says. —DJN

pany founder Lloyd D. Hey, MD, while he was working with the department of orthopedics at Children's Hospital in Boston.

Another company, Catalyst Medical Solutions in Cambridge, Mass., (www.cmedsolutions.com) provides Internet-based applications for physicians that increase efficiency, document procedures, and maximize revenue in all practice settings through customized note writing and data capture for HCFA compliance. David Grayzel, MD, is the co-founder and CEO.

"Catalyst Medical Solutions uses Web-based information technology to speed workflow, save time, and help doctors care for patients," Grayzel says. A graduate of Harvard Medical School, Grayzel completed his residency in internal medicine at Massachusetts General Hospital (MGH) in Boston. Today, he practices part-time as a hospitalist at MGH. All of the founding members of Catalyst are medical doctors.

Procedure-Focused Software

Catalyst's programs are for physicians in many areas of medicine that require procedures to be performed outside of the operating room, such as on the ward, and in surgical care and ambulatory care settings. The software is designed to include all specialty procedures and aims to streamline documentation.

"Our tools can save physicians time via customized note-writing and charge capture that guarantees HCFA compliance, increases revenue, can be deployed for any specialty, and that has been proven in the field," Grayzel says. "We currently offer procedure note-writing and charge capture for ophthalmology, dermatology, ICUs, day clinics, family practice, and pain clinics, among others."

The software addresses procedures because these are the focus of most specialty work. "Standard practice in most hospitals today requires doctors to document medical procedures manually, a wasteful, inefficient

process that causes universal aggravation and is prone to error," Grayzel says. "Physicians perform a given procedure dozens of times, and yet they still must write the same pages of notes required by HCFA in order to receive Medicare reimbursement. The clinical documentation is usually insufficient for billing and results in lost revenue for the physician, hospital, or practice setting."

In conclusion, Grayzel believes new technology means an exciting future for medical systems. "Some in the industry say that e-health companies have failed to live up to expectations," Grayzel says. "But that failure has occurred because not enough physicians are thinking about how to solve technological problems and how to apply simple solutions. Once we start seeing that happen, e-health will live up to expectations."

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on practice strategies is available on our Web site (see page 16).*

(Continued from page 1)

ply to get more dots on a map, rather than looking to acquire groups in contiguous service areas and trying to consolidate services strategically.”

Despite their size, these physician organizations never reached sufficient scale to afford them the leverage needed in negotiations with plans, a second factor that led to group failures. “Physician groups never achieved the status of being

Despite financial pressures, many groups simply refused to cut physician compensation.

Many of the largest groups have failed as a result of these mistakes. One management organization bought the former MedPartners Southern California network and agreed to assume MedPartners’ existing payer contracts, Swartz says. Realizing that the contracts were

“California health plans focused heavily on trying to buy market share through low premiums,” Swartz explains. “In driving down health care premiums, they severely cut compensation to professional and institutional providers.” The health plans should have been wary when physician groups were willing to sign such low-priced contracts, he adds. “They should have recognized that this deal was too good,” he says. “If a physician group had been willing to take a contract priced below market, the health plans should have questioned how that group was going to sustain the provision of care to enrollees.”

While premiums were falling, the health plans passed more financial risk to the medical groups than physicians could handle. “For example, most physician groups do not have the infrastructure to support pharmacy risk, but they were forced to accept this risk if they wanted to obtain the contracts,” Swartz notes. “Compounding the problem was that the health plans required open access, making it harder for the physician groups to control their medical costs.”

The actions of hospitals and physician practice management companies (PPMCs) also were a factor. “The PPMCs, like many of the physician groups, pursued growth indiscriminately,” Swartz says. Hospitals also focused too heavily on acquiring physician practices.

Finally, federal and state legislatures have mandated services—such as two-day stays for maternity patients—but failed to recognize either the economic effect or the care quality implications of such decisions. “Governments mandate more coverage for HMO patients without fully appreciating the pricing constraints on the health plans and professional and institutional providers,” Swartz states.

While these failures have caused significant turmoil among physicians, Swartz believes the worst is over.

(Continued on page 9)

While premiums were falling, the health plans passed more financial risk to the medical groups than physicians could handle.

indispensable to the plans,” Guthrie explains. “They could never negotiate with the health plans in the context of a real business partnership, as opposed to a kind of vendor relationship. Therefore, there was nothing to stop health plans from cutting provider payments.”

Third, physicians tried to assume the full risk of care, both institutional and professional risk, Swartz adds. “The assumption of full risk put these groups in the insurance business, a business they did not fully understand,” he says. “Compounding the problem was that the majority of groups assuming full-risk contracts did not have the depth of management experience necessary to successfully administer multiple full-risk contracts.”

Unreported Claims

A fourth reason for the California medical groups’ failure was undercapitalization. “They simply did not have the capital required to successfully accommodate growth, administer multiple plans, and keep up with the daily operations of a complex multi-site risk-based provider organization,” Swartz says. Many groups were significantly underfunded for claims that had been incurred but not reported, known in insurance as IBNR.

priced below market, the company believed it could compensate for the low reimbursement through leverage with hospitals, other providers, and vendors, and that the payers would give the network higher rates, he says. It failed to win higher rates and even when more favorable contract terms were put in place, the company could not manage the contracts, and closed last fall, Swartz says.

A family-based medical group in Ventura offers another example. “The group grew too fast and expanded into areas that have not traditionally been friendly to managed care,” Swartz says. “The local hospital wouldn’t accept managed care contracts, and the local specialists would not adopt managed care processes. A medical group simply cannot provide managed care coverage in a market in which the cooperation of the local specialists and hospitals is not assured.” Even as revenue was falling, the group did not cut physician compensation and closed in November.

Multiple Errors

The failure of many of California’s physician groups was caused not just by the groups themselves, however, but by the actions of many other health care constituencies as well.

(Continued from page 8)

“Following many group failures, the strongest group practices have successfully survived and are growing as a result of the wreckage,” he notes. “These medical groups never had to approach the health plans for a bailout. They were able to survive on the lower premiums. They will be stronger than ever, and as a result of the shake-out of competition, they will continue to grow and receive a higher premium dollar.”

At the same time, physicians are getting smarter about which contracts they choose. “Rather than trying to contract with 15 different health plans, groups will limit the number of risk-based contracts they assume,” Swartz notes. “Each contract requires a lot of administration. This added overhead means that groups have to weigh which contracts are worth the effort and walk away from those in which the rates are too low.”

Consolidation among physician groups continues, but in a more thoughtful manner. “Consolidation is becoming more strategic, and groups are added only if there is a good cultural fit,” Swartz explains.

Ultimately, the behavior of health plans may change as well. “Health plans are beginning to realize that they are weakening the system through unchecked reductions in reimbursement,” Guthrie says. “They realize that if enough groups go out of business, they won’t be able to rely on a solid infrastructure for the delivery of medical care under risk contracts.”

Another hopeful sign is the newly established state Department of Managed Care, which began operations last year. “The state of California has awakened somewhat late to the role of regulation of managed care organizations,” Guthrie notes. “The new department will oversee the activities of managed care organizations and promulgate requirements for medical groups that want to accept risk.”

Despite these few positive signs,

Will the Trend Move East?

Experts do not believe that the widespread physician group failures that have been common in California will occur across the rest of the country, in part because the health care market in California has several unique features.

A primary difference is the presence of capitation. “Managing risk requires sophisticated financial and medical information systems,” says Bruce Swartz, vice president of practice operations at Premier Practice Management, in San Diego. “This adds significant overhead to a group’s operational costs. Fully delegated risk-bearing compensation models simply didn’t materialize across the country, despite predictions that capitation would become common elsewhere.”

“Most of the rest of the country is characterized by discounted fee-for-service in managed care, with utilization management and other controls,” says Michael Guthrie, MD, MBA, executive vice president at Premier Practice Management. Many large national payers, such as Blue Cross Blue Shield and Aetna-US Healthcare, contract with physicians and other health care providers directly.

“These payers, which are big players in many markets around the country, contract with physicians individually and really don’t pass down the risk to the physician,” Swartz explains. “Enrollees may be paying for a pre-paid insurance product, but from the physician’s perspective the reimbursement is more like fee-for-service.”

In addition, California—and particularly Southern California—has an unusually high number of large medical group practices and risk-bearing IPAs, Swartz says.

Finally, California is unique because of the extremely low premiums, which have contributed to group failures. “While California medical groups were receiving premiums in the low \$30s per member per month, Houston medical groups were receiving premiums in the mid \$50s,” Swartz says. “The health plans in California have been exceptionally aggressive. The bottom line is that they simply drove down the premiums too far.”

—DJN

the implications for most California physicians have been severe. “Physicians in California have faced instability and unpredictable income,” Swartz says. “When these physicians completed their education, they believed they had a job for life. Now they face situations where they don’t get paid or where they don’t have a job. It’s very disheartening. Many physicians are now looking for new jobs with some of the established group practices here. But many physicians have left California and tried to open practices elsewhere. Some have left medicine altogether.”

As a result, a significant challenge exists for managed care organizations. “The HMOs face a lack credibility on behalf of the public,” Swartz says. “They must work hard to regain the trust of their members and health care providers. They must also be creative in developing new models of acceptable reimbursement that ensure the continuation of long-term stable systems capable of delivering high-quality care.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Group Automates Workflow

By Francis Rhie, MD, FACP, MBA

By the late 1990s, Gregory Pecchia, DO, had been in practice for more than 10 years, and his medical office was getting busier by the day. He came to believe that more time was spent pushing papers than on actual patient care. As one of four physicians and a physician assistant with Family Practice Physicians Inc., in Orange, Calif., he and his colleagues had a full panel of patients. Each one had 3,000 to 4,000 patients and three administrative staff members. With mounting paperwork and administrative tasks to accomplish, the physicians soon realized that something had to be done to improve their office operations.

Managing Processes

In 1999, Pecchia's medical group decided that to meet future and current needs, they needed a practice management system that provided

- An integrated workflow system including unified communication
- Billing and financial management
- Computerized patient records
- A Web site
- Open system compatibility to accommodate future technological innovations.

An open system is one that does

Francis Rhie, MD, FACP, MBA, is the chief medical officer for Alteer Corp. (at www.alteer.com), a company in Irvine, Calif., that provides Web-based workflow management systems for physicians' offices. Before founding Alteer, Rhie was a practicing physician in Orange County, Calif. He is board-certified in internal medicine, endocrinology, and geriatrics. More information on office automation is available on our Web site (see page 16).

not have a proprietary operating system or database, meaning it is easily compatible with other products and can work with Web-technology programs. Having an open system could be important later if physicians want to add other programs or system enhancements.

Although Pecchia wanted his office to adapt to the electronic age quickly, he realized that his practice would not be transformed overnight. Other physicians in the group preferred a slower pace than he wanted to pursue. Therefore, he needed a migratory path, one that would use older technology with

Previously, refill requests took 10 to 15 minutes to authorize. Now, the automated process takes a few seconds and greatly reduces the risk of errors.

newer systems, giving physicians in the group some level of comfort while they acclimated to the newer methods. As a result, he recognized that the ideal system would integrate technologies currently in use—such as phone, fax, and handwritten chart notes—with new technologies—such as scanners, e-mail, and the Internet.

While the advent of e-health has created a number of technology and Internet-based systems, the major appeal of the practice management system Pecchia's office selected was that it integrated all fundamental aspects of his office operations. With everything under one roof, practice efficiency improved by eliminating office bottlenecks, such as searching for and filing paper charts, handling faxes, and dealing with handwritten messages.

One example of the difference between using the pre-existing paper-based charts and using the new computerized system was the improved process of handling pharmacy refill requests. In the paper-based system, if a patient with a chronic condition needed to refill a particular medication, the patient's pharmacy would call Pecchia's office and leave a voice-mail message. Administrative staff members would transcribe these messages into handwritten notes, including the patient's name, pharmacy name and number, name of the medication, dosage, and instructions. A

poor voice-mail message or illegible handwriting, however, could add to the risk of transferring the wrong information, and thereby increase the chance of medical errors.

Streamlining Care

Once a request was transcribed, the paper medical record was located and the specific medication history was confirmed and charted. The requests were placed on Pecchia's desk for authorization. At the end of the day, he reviewed the stack of charts and messages, and approved or denied refill requests. His office staff would then place a return call to the pharmacy.

Using the workflow management system, pharmacy callbacks were streamlined. Now Pecchia's office receives all pharmacy requests via fax. Since the new system stores

pharmacy fax numbers, the exact pharmacy is identified via caller ID. The request is routed to the pharmacy callback module. The patient's computer-based file is selected and the medication history is automatically listed. With full access to computerized medical records, Pecchia can make decisions quickly to grant refill requests and can even authorize a refill directly via an immediate fax-back system. The whole transaction is documented and time stamped in the patient's medical record.

Previously, refill requests took Pecchia's office 10 to 15 minutes to authorize. Now, the entire process takes a few seconds. In addition, this automated process greatly reduces the risk of medical errors. By bringing together different communication tools such as the Internet, e-mail, faxes, and phone calls into one integrated communications platform, office productivity improves, and each communication is documented in the patient's medical record for future reference.

Pecchia described the introduction of this fully integrated workflow solution as "a near magical event."

"Once we moved to an integrated solution it was a quantum leap in efficiency and goodwill among my colleagues, our vendors, and other physicians," Pecchia says. "Suddenly, all of the data needed was at our fingertips. Most important, the data was attached to, and integrated within, the same data network where the e-mail was received allowing us to integrate patient e-mail with the patient record."

Computerized Records

The ability to locate all vital patient information quickly is critical for medical offices today. Statistics show, however, that a patient chart is available only 25%

Physician Offers Advice on Automating a Practice

Automating a physician's office practice requires some careful planning if the job is going to maximize efficiencies. For those physicians who may be considering such an endeavor, Gregory Pecchia, DO, of Family Practice Physicians Inc., in Orange, Calif., has some recommendations.

Physician administrators should select information technology that adapts to the current office and work processes, and not the other way around. Also, physicians should look for a workflow management system that manages communication and information efficiently, helps to accomplish office tasks in the order of priority, and easily routes documents to computerized patient files and to outside care partners and other health care specialists.

Physicians should ensure that the system chosen provides adequate customer service and support. To accomplish this goal, it may be best to seek a Web-enabled system that offers ease of use, flexibility, the ability to create computerized patient records, and strong security.

Perhaps most important is finding a system that can quantify its ability to provide a return on investment. While specific savings will vary, a good system should be able to save physicians 10% to 20% or more over current spending.

Also, physicians should remember that in the future, the most advanced Web-based workflow management systems for physician offices will offer Web sites that physicians can use to make patients' medical records available to them. These sites will provide secure access to confidential information contributed by physicians. Patient advocates view the access of patient records to be a right patients should have. Plus, such access offers tremendous benefits to patients. For example, parents needing to see their children's immunization records could have quick and ready access to this information. —FR

to 35% of the time that a clinician needs it. Pecchia realized that if he did not have access to this vital information, he could not make the best possible medical decision. He also learned that even if computer-generated information, such as e-mail, is stored as paper, these documents could be as inaccessible as any paper chart and may be unavailable when needed. The solution provided by the new automated system helped his practice to create a computerized patient record (CPR) system that was stored in a centralized database. In addition, all information, whether it was created by fax, e-mail, or on a

handwritten note, was scanned and stored digitally, thus ensuring that it was available anytime to any authorized office staff member.

The CPR system even allows more than one person in Pecchia's office to view a patient's file at the same time. Also, a physician can access records from remote locations, such as the hospital or from home. In this way, the physicians can manage their time more productively and with more control, resulting in a better quality of life for physicians.

Even patients have experienced the benefits of a computerized medical office. "They think of it as a
(Continued on page 12)

Want to make certain that you receive each month's issue?

SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS

OUR ARTICLES FOCUS ON:

- Understanding the dynamics of managed care
- How to strategically position your practice for success in today's health care market
- Effective organizational options
- Maximizing your practice through health care informatics



1 year (12 issues) - \$110

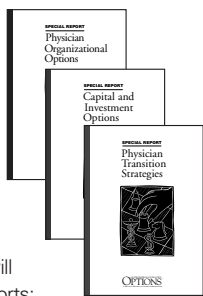
A 50% savings off the regular price. Act now and you will receive one free Special Report of your choice:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES

2 years (24 issues) - \$170

An additional \$50 savings off the special 1 year subscription rate. Act now and you will receive a complete set of three Special Reports:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES



Please call 888-457-8800 to order your subscription now, or fax this order form to 973-316-5989 or mail to:

Physician Practice Options
99 Cherry Hill Road Suite 300
Parsippany, NJ 07054

Name _____

Address _____

City _____ State _____ Zip _____

Email address _____

Payment method: Check enclosed Bill me Credit card.

If paying by credit card, please fill in the following information:

Credit Card (type) _____ Exp. Date _____

Credit Card Number _____

Name on card _____

Billing address _____

Signature _____

Checks should be made payable to: Physician Practice Options

EXPIRES: 12/01

#FSR110.170

(Continued from page 11)

wonderful service that has enhanced their access to our office and helped us become more service oriented," Pecchia says. "It helps to address specific needs patients have, such as information regarding ongoing work-ups, status of current health, and preventive care."

Since patients are encouraged to use e-mail to communicate with Pecchia, he can now send replies with attachments of lab reports or other information as appropriate. As a result of the new system, the communication gap between physician and patient has narrowed significantly.

Practice Advantages

In addition to simplifying processes and facilitating communication, the practice management system offers a number of other benefits as well. First, given that the practice is in Orange County, California, a highly evolved managed care marketplace, two-thirds of its revenue come from capitated contracts. Both the MCOs and the IPAs the office contracts with wanted to be able to send and receive data electronically, such as eligibility lists, bills, requests for referrals, and chart notes. Having these data accessible at the point of care was critical to improving efficiency with the IPA.

In the past, determining the status of referral authorizations would require 10 to 15 minutes on the phone. Today, the office has direct access to the IPA's authorization and referral server, meaning a physician or assistant can look up the status of an authorization quickly and document it in the computerized patient record.

Of all the new system's advantages, the increase in efficiency is one of the most significant. Since Pecchia has direct access to patients' medical records and knows what is going on in the office without leaving his desk, he does not need additional administrative staff for creating, locating, or filing paper medical records. From an administrator's screen view, he can see the status of patients in the waiting room and in exam rooms, allowing him to manage the flow of patients effectively.

Efficiencies have improved in virtually every area of operations, Pecchia estimates, saving his group some 15% per month in expenses and salary when compared with what it spent using the previous paper-based system. As a result of automating workflow, Pecchia has hired two new physicians without increasing administrative staff or the amount of space the practice needs. Paper medical records are now stored off-site, allowing the group to convert the old medical record room into an exam room.

Editor's note: Readers can get more information on Pecchia and his office automation system on the Web (at www.alteer.com/drpecchia/).

Career Expert Offers Suggestions to Physicians Leaving Patient Care



Gigi Hirsch, MD, is the founder and CEO of MD IntelliNet, LLC, a research, consulting, and placement firm in Brookline,

Mass., that focuses on placing physicians in positions nationwide. Trained in internal medicine and psychiatry, Hirsch practiced emergency medicine for nearly five years. In 1992, while on the faculty of Harvard Medical School, she founded The Center for Physician Development, a nonprofit research and consulting firm funded by a grant from Boston's Beth Israel Hospital. In 1997 she launched MD IntelliNet. She is the author of *Strategic Career Management for the 21st Century Physician*, (Chicago: American Medical Association, 2000). Editor-in-chief Richard L. Reece, MD, conducted this interview.

Q: Why did you decide to create MD IntelliNet?

A: In the early 1990s, when I was completing my psychiatry residency at Beth Israel Hospital in Boston, I had the opportunity to speak with many physicians as I offered consultation on their patients. Once we were finished discussing the patients, we would then start talking about physicians themselves. The conversation frequently shifted toward careers, and I noticed patterns in what physicians were saying about careers.

At the same time, I was trying to figure out what I wanted to do with my own career. In holding my own career discussions, I was encouraged by an entrepreneurial physician to leverage my interest in physician careers and try to find funding to launch a new nonprofit research

and consulting organization that focused on physician career issues and the changing medical market. I was fortunate enough to be able to get the strong support of the chief of surgery at Beth Israel Hospital. He arranged for me to meet with the president of the hospital, who himself was a physician, and I was able to get the funding that I needed. Beth Israel gave me a substantial grant to launch The Center for Physician Development in 1992, which evolved into MD IntelliNet.

Q: What were the first research projects you handled?

A: After creating The Center for Physician Development, I traveled around the country and did an in-depth needs assessment of physicians from the career development perspective. I met with a number of individual physicians and offered career consultations. I also did some consulting to malpractice and disability insurance companies, to provider organizations, and to medical associations. But the focus of my work across all

many difficult issues. Some of these were related to managed care, but some were timeless career development issues that had never been discussed openly in medicine before—for cultural reasons. Historically, physicians did not speak openly about issues related to career satisfaction because these were viewed as sensitive, private issues. In some cases, physicians were concerned about being perceived as having difficulty coping, or even being labeled “impaired.”

I was fortunate to get the funding when I did, because managed care was just beginning to touch the lives of many physicians in some compelling ways. Managed care was beginning to cause a lot of pain across the profession and was triggering productive and useful discussions among physicians that had never before been held.

Q: How do you view your position in the medical field?

A: I don't like to think of myself as having quit the medical field. Although I no longer practice

“Physicians should develop at least one additional skill set that leverages their medical expertise but is not applied in patient care.”

of these activities was physician career development and career management in the changing health care environment.

Q: Did your site visits in various places confirm your suspicion that physician career counseling and research was needed?

A: Absolutely. My visits highlighted that physicians faced

medicine, I still continue to contribute to medicine and patient care, but from a slightly different perspective. Some of my early research suggested that some physicians who were unhappy with their medical careers, and who were feeling trapped because they could not find alternative jobs, were at higher risk for making mistakes, for mal-

(Continued on page 14)

(Continued from page 13)

practice and disability claims, and for behavioral problems. As a result, I began focusing on helping physicians diversify and move their careers. No patient wants to be cared for by a physician who doesn't want to be a physician.

Q: On your Web site, you offer a section for physicians in which you describe why the profession is in crisis. Could you elaborate on this crisis and why it has developed?

A: Managed care has imposed fundamental changes on medicine in ways that vastly alter the nature of our work, our professional identities, and almost every aspect of our professional life.

Consider the circumstances of primary care physicians, who, in

internist serving as his or her patient's gynecologist. In other cases, lower cost professionals who are not physicians have usurped roles that physicians sought to play in medicine. For example, social workers and psychologists often provide psychiatric care under managed care. In these and other ways, then, the daily work life of primary care doctors has been dramatically altered by managed care.

Specialists, too, have their frustrations. Many specialists describe devastating declines in reimbursements for procedures that they perform, many of which are associated with high medical and legal risks.

Q: How has the financial crisis in medicine affected physicians?

their careers. Historically, physicians have been given heavy training at the front end of their careers in a narrow area of technical expertise, and we are expected to use those skills and stay in one area for an entire career. That's not a valid model any more. This model no longer serves us well as physicians, given the changes in health care.

I encourage physicians to diversify their talents and develop at least one additional skill set that leverages their intellectual capital and their medical expertise but is not applied in the area of direct patient care. I also encourage physicians to do this as early as possible in their careers. Some examples of that might include involvement in clinical research or medical informatics.

Such skill diversification offers both professional and financial protection. As the health care market has changed, for example, a number of physicians have been laid off and are unable to find work in their geographic area of choice or in their clinical specialty. Another concern is disability. I work with a number of physicians who have become disabled. Disability insurers call me to help move those physicians into new jobs, a task that is extremely challenging if the physician does not have any skill diversification.

Q: Has the increase in physician disability stemmed, in part, from frustration in the profession?

A: On my Web site, I note that the incidence of physician disability claims rose by 60% in the last seven years. As a result, it has become more difficult for physicians to get disability insurance.

Many insurers will assert that most of the disability claims being filed by physicians are fraudulent claims. But my perspective is slightly different. In the past, a physician with a valid disability may not have filed a claim because of the socio-cultural ethic in medicine. Instead

“Many corporations could benefit significantly from greater physician input into their products and marketing strategies.”

some ways, have been hit the hardest by the changes brought about by managed care. Even something as basic as their relationship with patients has been fundamentally changed by managed care.

Primary care physicians must play the role of gatekeeper, which often places them in an adversarial position with their patients, by forcing referral decisions to be based on the cost of care as well as medical necessity. This type of role is not what physicians wanted when they entered primary care medicine.

Many primary care physicians also tell me that they are intellectually bored with their work. They have become high-level triage agents who must refer their most interesting cases to specialists. Other primary care physicians tell me that they are being asked to serve in roles that they do not feel adequately prepared for, such as an

A: Obviously, physicians are affected greatly. Consider California, for example. Approximately 90% of physician organizations in California are poised for bankruptcy or closure. These physician group failures are certainly cause for alarm, and have had great impact on the medical profession. Some experts have referred to the “deprofessionalization” or “corporatization” of medicine, in which physicians are now confronting some of the same issues that all employee groups have faced for years. Lack of job security and lack of control over reimbursement are now major concerns that relate to a physician's financial well-being.

Q: What is the best way that physicians can protect themselves?

A: The current lack of stability in the health care market is one of the reasons I'm a strong proponent of physicians diversifying

of filing claims, we would find some other type of work within medicine. But that's changed now. Many physicians who have been paying a lot of money for their premiums for many years are taking advantage of a valid disability to exit clinical medicine.

There has been a dramatic increase in the incidence of physician suicide. Fortunately, most physicians do not get to that point. But there are real signs of morbidity that result from physician frustration that affect their bottom line in ways that are not really being tracked. On some level, physician frustration relates to the increasing incidence of malpractice claims, disability claims, suicide rates, and even medical error rates.

Q: MD Intellinet also assists health care corporations that need physicians' skills in finding physicians to help them. Could you describe this aspect of your organization?

A: My research indicates that many corporations could be benefiting significantly from greater physician input into the products that they're developing, into their marketing strategies, and even into the evaluation of the potential investment opportunities in health care. For a variety of reasons, physicians are not necessarily being used, or perhaps the best physicians for various roles are not being identified or selected for those roles. MD IntelliNet works with companies to understand how to utilize physician intellectual capital in ways that make their businesses more successful.

Q: Why hasn't physician intellectual capital been leveraged?

A: Many companies, particularly the e-health companies, haven't stopped to research physi-

cian culture and needs. About \$3 billion of venture capital was invested in e-health companies between January 1999 and January 2000. The vast majority of those companies are going to fail. The majority of those companies did not have any substantial physician input into the strategy that would underlie the company or the business model. They didn't use physicians for marketing or for sales. Yet at the same time, a number of physicians were approaching me who were extremely eager to become involved in those new ventures.

Frankly, I have been struck by the way e-health companies refer to physicians as if we are a homogeneous mass of protoplasm. Technology firms in general do not do a good job of segmenting the physician market on a number of levels. They may segment physicians in traditional ways—in terms of specialty, for example—but when it comes to technology, it is important to segment physicians in other ways in terms of their behavior, attitudes, or practice setting.

All these things make a big difference. The fact that two physicians are cardiologists does not necessarily define everything about them. Companies cannot use the same approach for all physicians. There will be some exciting new levels of sophistication that we're going to be seeing in health technology firms, particularly with respect to the use of Internet-based technologies, and those levels will be essential for success.

Q: Why are physician-industry relations so difficult?

A: As part of the research for my book last year, I interviewed a number of industry executives

about their perception of the physician market. Unfortunately, physicians have a terrible image problem with industry. In the many anecdotes I heard from industry executives, I noted that these executives believed physicians were afflicted by what I call "cultural impairment syndrome," a term I coined to describe industry's perception of physicians: somewhat arrogant, with a sense of entitlement, an inability to be real team players, and an inflated sense of financial worth in the marketplace. None of these factors serve physicians well in terms of facilitating our transition to other industry sectors.

Q: How are we going to bridge this gap?

A: It will take a multipronged approach. First, physicians who move to a career in industry need to understand that when they enter into their new role and new work culture, humbleness and a willingness to learn and accommodate other approaches are essential attitudes for success.

In addition, industry will be required to do a better job of understanding what its needs are from the physician market and then creating clearly defined and strategic roles for physicians. Once they select the best physicians to fill those roles, then the industry must offer physicians a better orientation to the organization's culture. Physicians, as a group, are extremely bright, incredibly motivated and achievement-oriented. If they understand the rules of a new game, they'll play it well.

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

“When it comes to technology, it is important to segment physicians in terms of their behavior, attitudes, or practice setting.”

MD
OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: _____
E-Mail: _____

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

March 15, 2001



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

PSRST STD
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

Supported by
an unrestricted
grant from

Aventis Pharmaceuticals

MD
OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: _____
E-Mail: _____

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

March 15, 2001



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

PSRST STD
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

Supported by
an unrestricted
grant from

Aventis Pharmaceuticals

MD
OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: _____
E-Mail: _____

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

March 15, 2001



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

PSRST STD
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

Supported by
a grant from



MD
OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: _____

E-Mail: _____

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

March 15, 2001



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

PSRST STD
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

Supported by
an unrestricted
grant from



U.S. Pharmaceuticals