PHYSICIAN PRACTICE
OPTIONS™
May 30, 2000
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# Single- or Multispecialty? Many Factors Drive the Structure of a Group

Managed care is designed to offer "one-stop shopping" to large health care buyers. Purchasers are supposed to be able to contract with one health plan and get many services for workers, dependents, and retirees. As a result, physicians and other providers have formed organizations designed to make them attractive to large payers and to give them increased negotiating leverage.

This practice significantly influences physician group formation and development. It leads specialists to join multispecialty groups to reduce overhead costs and to give them access to a referral base. On the other hand, in some markets, specialists join single-specialty groups to enhance their clinical focus and to strengthen their bargaining position when negotiating with managed care organizations (MCOs). Which structure specialists choose depends on many factors. Payer preferences, leadership and governance issues, and ease of compensation and referral relationships all play into which type of group structure specialists will form.

### Profiling Group Practice

The 1999 edition of *Medical Group Practices in the US: A Survey of Practice Characteristics*, published by the AMA, offers a profile of group practices, based on a survey of 10,471 medical groups.

According to the survey, 71% of groups consider themselves to be single-specialty, 22% multispecialty, and 7% are family or general practice. While the great majority of groups are in a single specialty, more physicians practice in multispecialty settings than in any other setting. Approximately 87,000 physicians practice in single-specialty groups, while more than 111,000 physicians are in a multispecialty practice.

Common specialties in single-specialty group practices include pediatrics, obstetrics-gynecology, orthopedic surgery, internal medicine, and anesthesiology. In addition, hospital-based specialists and many surgical specialists are more likely to practice in single-specialty groups. The specialties most commonly represented in multispecialty groups are family practice and internal medicine. General surgeons, plastic surgeons, neurologists, psychiatrists, and pulmonary disease specialists also are likely to practice in multispecialty groups.

Most groups are small: 46% have three or four physicians, and 35% have between five and nine physicians. Small groups account for only 15% of physicians who practice in group settings, however. While groups of 100 or more physicians account for only 1% of all physician groups, they account for almost 30% of all physicians. The average single-specialty group, at 6.4 physicians, is one-fourth the size of the average multispecialty group, at 23.4 physicians.

While many factors guide group structure, the most significant factor, regardless of physician specialty, is the contracting preferences of health plans in the local market.

"The most salient factor driving group structure is the willingness of health plans

*(Continued on page 8)*

# EDITORIAL

## Clinical Trial Resources Available for Physicians

In our article, "Top Ten Trends for 2000," (Feb. 15), we predicted that pharmaceutical manufacturers would continue to contract with physicians for clinical trials. The search for new pharmaceuticals will mean manufacturers will retain and may expand the practice of outsourcing clinical trials, we said, adding that this work could become an important source of revenue for many physicians.

Our predictions, particularly the one about clinical trials, generated phone calls from readers who wanted to know how they could participate in such trials. A number of resources are available, including the following: The Pharmaceutical Research and Manufacturers of America lists drugs in development (phrma.org); CenterWatch Clinical Trials Listing Service compiles information on more than 7,500 clinical trials actively recruiting patients (centerwatch.com); and Medscape offers a searchable database of current clinical trials actively enrolling patients (medscape.com).

In February, the federal government opened a database of all clinical trials for serious illnesses. The site is available on the Internet (clinicaltrials.gov) and it offers simple explanations of how the trials work and what questions patients should ask before enrolling.

"This is a single place you can go where the most important information will be available to everybody," says Donald Lindberg, MD, of the National Library of Medicine, in Bethesda, Md., which is running the database of information on 4,000 studies.

One way to begin your research would be to read what we have written about clinical trials. In the Nov. 15 issue, we published "Physicians Find Profits in Clinical Trials," for our Capital Ideas column. In the June 15 issue we published an interview, "Clinical Trials Research Offers Physicians Potential New Ways To Increase Revenue." Both of these articles are available at the *Practice Options* Web site (mdoptions.com).

A fierce competition exists among pharmaceutical companies seeking patients for drug trials. The companies usually need about 4,000 people to test an experimental drug and will pay physicians for every patient recruited. As with any endeavor, there are caveats. The government is investigating some trials for fraud and abuse, some trials may carry risk for patients, toxic side effects are unknown, and a reorganization of the practice may be required to conduct such trials rigorously. What's more, you may need to add staff to run the trials, and some may be double-blind studies, meaning some patients receive placebos only.

But there are benefits for physicians as well: a new revenue stream, new intellectual challenges, an entree into the growing field of chronic disease management, and a chance to provide cutting-edge care to uninsured patients who otherwise might not be able to afford care.

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# Steps Required for a Practice Repurchase

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

A few years ago, physician practice management companies (PPMCs) were heralded by physicians and investment analysts alike as a beacon of hope for an industry plagued by escalating costs. Assuring physicians that both practice efficiency and managed care contracting success could be enhanced by delegating administrative and management responsibilities, PPMCs seemed an attractive practice option for physicians seeking to increase revenue. Many physicians sold their practice assets to PPMCs and entered into contracts to manage the physician group in exchange for cash, notes, or equity in the PPMC.

At its peak, the PPMC industry had about 50,000 doctors under contract to its major public and private companies, such as PhyCor Inc., in Nashville, Tenn., and MedPartners, in Birmingham, Ala., (two public companies focusing on multispecialty practice management).

As physicians and investors well know, many PPMCs have under performed with regard to the services they promised their physician clients. In most cases, lower costs and operational enhancements never materialized, and managed care negotiating leverage did not significantly improve. As a result, many physicians that are affiliated with PPMCs are seeking to disassociate themselves from these companies, often through a repurchase of their practice assets.

## Steps to Termination

Reacting to the acquisitions PPMCs were making, many hospitals also began acquiring physician practices. Approximately half of all U.S. hospitals have acquired practices involving about 100,000 physicians. When the hospitals found they lost money on the acquisitions, however, they too began to divest themselves of their physician practices. As a result, physicians in many markets have been learning how to repurchase their practices from these entities.

Before discussing the steps necessary to repurchase their practices, Tim Schier, a vice president in the Houston office of Cain Brothers & Co., LLC, a health care investment banking firm in New York, says physicians should perform a financial analysis in which they project the finances and economics of their group both under the larger entity's umbrella and as a separate company.

"When the business relationship between a PPMC and a physician practice does not seem to be beneficial for the physicians, it is important for the physicians to determine how the group would perform financially if it were outside of the control of the PPMC," he says. "Such an analysis provides guidance for two reasons. First, an analysis provides information as to whether a practice repurchase is, in fact, a better option than continuing the status quo relationship. Second, assuming that the analysis proves that practice re-purchase is a good strategy, the financial projections for the practice will drive the estimate of the amount of capital that would be needed to repurchase the assets of the group from the PPMC.

**A financial analysis will tell whether a practice repurchase would be a better option than continuing with a larger entity.**

"In effect, therefore, the analysis gives the physicians a sense of their ability to buy themselves out of the contract," Schier explains. "As a result, physicians should go through this financial process before making any type of overt offer, and certainly before negotiating any financial terms with the PPMC."

Once the medical group has performed the financial analysis—but before it presents any financial proposal to the PPMC—the physicians should solicit and arrange financing to enable them to implement the practice asset repurchase, Schier says. "Potential sources for capital that physicians can explore might include local banks, national health care financial investors, and hospitals that can provide either equity or debt financing to the group," he adds. "Equity from the physicians is sometimes required by the lender. If it is not, then the lender might require a guarantee."

The next step is to pursue the idea of disassociation with the PPMC administrators. "In effect, disassociations with PPMCs can proceed in one of two ways," Schier says. "The PPMC and the physicians can have a contentious, drawn-out legal battle in court, or they can have an amicably negotiated settlement."

Not surprisingly, Schier notes that entering into litigation to force the PPMC to terminate the agreement is a difficult method of getting out of these relationships.

In pursuing an amicable end to a contract with a PPMC, Schier counsels physicians to ask the PPMC to consent to a termination. "For example, MedPartners was exiting the PPMC business and therefore was a willing seller," Schier explains. "However, some of the PPMCs are not willing sellers and would prefer that the groups remain aligned with them under the existing economic model or even, potentially, under some revised economic model."

PPMCs are most receptive to contract terminations when at least one of four factors are involved:

1. The relationship between the group and the PPMC has deteriorated considerably
2. The physicians are departing the clinic in substantial numbers
3. The growth of the clinic and its ability to recruit have been impaired
4. The economics of the agreement are not beneficial to either the physicians or the PPMC

*(Continued on page 4)*

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The final steps for the physicians are to negotiate both the terms of the repurchase with the PPMC and the terms of repayment to the entity serving as the source of capital.

### Communication and Education

No matter how smoothly the negotiations proceed, a practice repurchase can be a confusing and stressful event. Therefore, Schier asserts that a thorough communication and educational process is necessary for physicians when severing a relationship with a PPMC, just as communication and education were needed when the relationship was being developed.

"In a disassociation, it is critical for the doctors to have a complete understanding of the process and the status of negotiations, " Schier states.

"Physicians also must clearly understand what the effect of the repurchase will be on several fronts, including the physicians' personal finances, group economics, and operations," Schier says. "To preserve the stability of the group after the repurchase, all of its physicians need to support the disassociation fully, and they can only do this if they completely understand the terms of the dissolution of the agreement."

Each of the group's physicians should understand, for example, whether he or she is incurring any debt, and if so, how much and what repayment terms are required. "We have found that in many practice repurchases, physicians' finances are affected negatively," Schier says. "As a result, the physicians are even more interested in the details of the deal than they were when they first affiliated with the PPMC. Accordingly, the group's administrative team, leadership, and legal and financial advisors should educate the physicians on the process and terms of the contract termination."

### Negative Consequences

Even in those cases in which the financial implications are not altogether positive for physicians, Schier says, the group members tend to be positive about a practice repurchase. "We find that a number of groups, after proper education, are invigorated by the process of regaining their practices—and, in effect, their freedom—even in the face of some negative financial consequences," he says.

Like PPMCs, hospitals also are divesting themselves of physician practices, but there are some important differences between hospital-owned practices and practices affiliated with PPMCs, Schier explains. "First, the main purpose of practice acquisition differs between hospitals and PPMCs," he says. "PPMCs have generally purchased practices as a financial opportunity, hoping for a high return on investment."

In contrast, hospitals have tended to purchase practices as a defensive strategy designed to boost market share. "Hospitals are not in the business of managing physicians, but they saw many of their local practices being gobbled up by a PPMC or a hospital competitor," Schier says. "These practice acquisitions led hospitals to acquire practices to protect their market share. Therefore, hospitals might be more likely to view an acquisition as a successful business strategy, even if return on investment is not as high as hoped."

A second difference is in the size and type of group acquired. "PPMCs tended to target large single-specialty or multispecialty groups for acquisition, since these were the groups that were most likely to yield opportunities for significant operational and contracting enhancement," Schier says. "Hospitals have largely purchased numerous smaller practices, particularly primary care practices, in order to solidify their relationships with the local physicians and, therefore, their market share."

Some hospitals—particularly large integrated health systems—are losing money on their acquired practices and are seeking to divest. Last year Ernst & Young, CPAs and health care consultants in New York, reported that 96% of integrated delivery systems had lost money on acquired practices.

"The physician practice management business is difficult for hospitals," Schier says. "Given the demise of the PPMC industry and a lower level of competition over practice acquisitions in general, hospitals are under much less pressure to acquire practices than they were in

## Unexpected Events Led to a Decline

The decline in the physician practice management market is a result of PPMCs focusing on practice acquisition at the expense of operations, mixed with unexpected market events, says Tim Schier, a vice president in the Houston office of Cain Brothers & Co., LLC, a health care investment banking firm in New York. At Cain Brothers, Schier is involved in advising clients on many facets of medical practice, including physician group practice management, information technology, managed care, mergers and acquisitions, and raising capital. Cain Brothers also has extensive experience in guiding doctors through practice repurchases.

"The early PPMCs had very high hopes for their ability to improve the efficiency and cost-effectiveness of medical practices and, at the same time, to negotiate favorable managed care contract prices and terms," Schier adds. "The venture capitalists were excited about PPMCs because they seemed to represent a health care model that could potentially drive costs down while incorporating more business discipline into the provision of medical services in both multispecialty and single-specialty medical groups."

But in fact, those operational and contracting benefits largely did not occur. "Managed care organizations did not penetrate as deeply into some geographical areas as was predicted, so the need for a negotiating leverage tool to affect practice income was not as great as expected," Schier says. "Not surprisingly, physician behavior with regard to administrative and practice patterns can be difficult to change; as a result, the implementation of new operational practices developed by the PPMCs—practices that were intended to drive cost-effectiveness—did not always occur to maximum benefit." These two factors meant PPMCs were unable to deliver much of the value they had promised to practices.

**"We are seeing select hospitals enter into practice purchases because hospitals are, in many cases, the natural strategic or capital partners for physician groups."**

***—Tim Schier, Cain Brothers & Co.***

the past. As a result, some hospitals and health systems—after having experienced severe financial losses, sometimes in the range of $100,000 per doctor—are beginning to divest these practices." Physicians face a similar type of negotiation when re-purchasing their practices from hospitals as from a PPMC.

Despite the overall trend of hospital divestiture of practices, some hospitals continue to acquire practices. "We are seeing select hospitals enter into practice purchases because hospitals are, in many cases, the natural strategic or capital partners for physician groups," Schier notes. "Hospitals also tend to be much closer to practices geographically and emotionally, because they are members of a shared community. So, the practice purchases are sometimes viewed as building a kind of partnership in the care delivery system."

Occasionally, a hospital will acquire a physician group after the practice has left a PPMC. "In this case, the hospital could be either an equity or a debt investor, or it could provide a guarantee or some other sort of financing support on a fair-market-value basis," Schier says. "The hospital can act as the practice's management services organization, owning the clinic's assets and providing it with administrative services."

## The Aftermath

Physicians who either elect to repurchase their practices from PPMCs or hospitals, or who are jettisoned by these organizations, sometimes feel at loose ends, Schier notes. "This feeling can be particularly acute for physicians who were in smaller groups or solo practice before being bought by or affiliated with a hospital or PPMC," he says. "Being released into the market without the security of a capital partner can be daunting. The business discipline, as well as some of the management services provided by PPMCs are still needed in the practice."

In the next several years, it is likely that other entities will be developed to assist physicians in enhancing revenue and managing their practices, Schier predicts. It could be that Internet-based services and a la carte management services from consultants will fill the void left by PPMCs and hospital partnerships, he says.

*—Additional reporting and editing by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available at mdoptions.com.*


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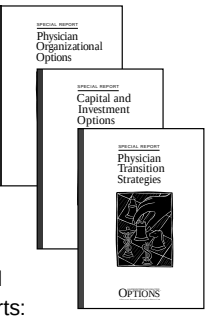


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# Four Ways To Build Patient Volume

*By David Kettlewell*

As a physician, you are probably mystified and intrigued by medical marketing. Mystified because you, like all Americans, have been fed a daily dose of the savviest consumer advertising corporate America can conjure. Intrigued because you also recognize the potential value that awareness of your practice among existing patients and the general public can bring. But you also may believe that medical marketing is unnecessary today.

Neil Baum, MD, a urologist in New Orleans who also is a medical marketing expert and author of many books including *Take Charge of Your Medical Practice Before Someone Else Does It for You* (Aspen Publishers, Gaithersburg, Md., 1996), strongly cautions fellow physicians against accepting the pernicious myth that marketing is unnecessary in a managed care environment.

**The idea that under managed care physicians are guaranteed a certain patient volume and thus no longer need to market their practices is simply a myth.**

The misconception that once physicians have managed care patients and are paid on a capitated basis, they are guaranteed a certain number of patients and no longer need to market their practices is "absolutely and unequivocally false...a myth to ignore," writes Baum. His patient-friendly ideas are designed to ingratiate your practice to patients.

The four following strategies can help physicians retain current patients, attract new ones, and increase the image of your practice among potential patients. These strategies require no additional staff to implement. Three are fairly simple in scope; one is more complex. Each idea is professional, has proven to be successful in many physician practices, and does not cost a lot.

The four strategies are:

1. Keep in touch with your patients, inexpensively.
2. When physicians or patients refer a new patient to you, take the time to thank them.
3. If you must make patients wait, then make the wait enjoyable.
4. Organize seminars for the public to provide you and your practice with exceptional top-of-mind awareness.

1. **Keep in touch with your patients, inexpensively.** Forget expensive ad campaigns unless you have a budget of at least $100,000, not including Yellow Pages ads. Instead, focus on existing patients. Utilization of your services increases as patients' awareness rises about what you offer.

Tell patients about the new physicians in your group and new treatment modalities that protect their health and make them more comfortable. Make it friendly, informal in style, and do it three to four times a year.

Don't worry that your communications aren't full-color. Communication with your patients is similar to giving or receiving a gift. The expense of the gift is less important than the fact that you were thinking of them.

A standard sheet of paper printed on one side is fine. All you have to do is sign it. If you use 6-by-9 postcards with a printed message, you can benefit from bulk postage rates. The post office will provide details on how to secure lower rates, or a local printer can discuss bulk mailing.

2. **When physicians or patients refer a new patient to you, take the time to thank the referred source.** When a physician or someone in your community sends you a referral, thank your referral source with a heartfelt handwritten note. Better yet, find out what your referral source likes. It could be a book on history, sailing, candy, or wine. The fact that you (or a staff member) would take the time to select a personal gift will not be forgotten. Gifts should be wrapped and sent with a personal, handwritten note.

One orthopedic surgeon in his 40s in the top 5% of his peers by income, created a software program that told him when referrals from specific area physicians were declining. He responded by immediately mailing all wayward physicians a thank you letter for their most recent referrals.

Another surgeon in the same group identified the top 20 physicians referring to his practice, and asked his secretary to call the secretary of each of these physicians to get small gift ideas. One received a photo album; another received a bottle of wine.

The tangible benefit is more referrals, and it requires nothing more than extending good manners.

3. **If you must make patients wait, then make the wait enjoyable.** Many patients strongly resent being asked to wait more than 10 minutes for anything today. If you are asking your patients to wait for 45 to 90 minutes, consider the following ideas being implemented by a six-physician ob-gyn practice in Ohio.

Have a staff member go to the local shops in your area and tell them that occasionally, a patient must wait more than 30 minutes to see a physician. Ask the proprietor if he or she would be willing to give your patients a 20% discount on goods, so patients can shop while they wait. Doll stores, coffee houses, bookshops, and clothing stores can be approached. Type all offers on a sheet of paper, provide a map,

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and a pager to let patients know when to return.

Acquire several small embroidery kits to allow patients to embroider a heart-shaped mat for a photo or some other decorative item. Let patients embroider in your office while waiting. You can also:

- Put cookies in your reception area and provide coffee and milk.
- Purchase 20 quality books for your patients to read while waiting.
- Provide a telephone for patients to make local calls.
- Provide a computer with Internet access in your reception area.

4. Organize seminars for the public to provide you and your practice with exceptional top-of-mind awareness. It may be a challenge to organize such seminars, but the results are likely to be well worth the effort.

A leading ob-gyn practice in Ohio recently had been approached by one of the local hospitals and strongly and repeatedly encouraged to sell the practice. The physicians resisted, believing that selling would not be in their best interest. In the face of such strong resistance, the hospital decided to establish its own ob-gyn practice that would compete directly with the Ohio group. Seeking to increase visibility of their practice in the community, the leading physicians decided to offer a series of highly visible public seminars on topics of interest and to use nationally known physician authors as speakers.

Making your practice the source of definitive medical information in your community will raise public awareness of your practice and help you attract more patients. Among the other benefits of this strategy are the following:

- Local newspapers likely would cover the events or provide free publicity before each seminar.
- The group could invite its existing patients and physician friends in the area, helping it to solidify existing relationships.
- The seminars provide a service to the community in synch with the mission of the practice.

## Getting Results

The Ohio ob-gyn practice found the seminars brought excellent results. Every two to three months, the group paid for a different physician speaker to fly to Ohio to speak at a local facility. The speakers' fees averaged $700 plus expenses, which included airfare, hotel, and car rental. The practice invited all speakers to sell copies of their books and provided them the opportunity to hold a book signing before and after their talk. Pharmaceutical manufacturers willing to serve as sponsors of these events paid for some of the speaker fees, defraying costs for the ob-gyn practice. The practice invited all patients to attend the seminars and several area radio stations ran public service announcements.

**Making your practice the source of definitive medical information in your community will raise awareness of your practice and help you attract more patients.**

For some of the seminars, the major daily newspaper ran half-page articles about the featured speaker, and the radio stations interviewed speakers on the air by phone before some events.

The result of all the pre-event exposure helped attract 120 attendees to the first seminar. More than 450 attended the final event in the series. A physician from the practice introduced each speaker, and the talks lasted 60 to 90 minutes. Wisely, the ob-gyn physicians left at least a half hour for questions and answers each night. If attendees are encouraged to write their questions on index cards, you can edit them beforehand and a moderator can read them into a microphone for everyone to hear.

Before each presentation, all members of the ob-gyn group came to the front of the audience to greet the guests, and afterward, all physicians stayed to visit with patients. Events were held on weekday evenings from 7 to 9 p.m. Coffee, tea, soda, cookies, and other refreshments were available for each event.

Among the several significant benefits that resulted from the seminars was an increase in patient volume. Former patients returned, the group had an increase in referrals from other practices, and individuals who had heard about or attended the seminars signed up as new patients. Another benefit was the success of the seminars themselves. Surveys showed attendees valued the seminars and wanted more, meaning the group had achieved an increase in positive public awareness.

Another significant result was a new relationship the group developed with the local media. After publishing one seminar-related article, the editor of the major daily newspaper printed several other stories that the practice provided on health-related topics of interest to the general public. In reviewing what worked, the ob-gyn practice decided that there were several keys to the success of the seminars program:

- Selecting speakers of national reknown who had authored books
- Pursuing aggressively public service announcements and other media coverage
- Selecting topics of interest to the public
- Holding seminars over many months
- Marketing the seminars to patients, the public, and area physicians

## Planning Required

Getting results in marketing is similar to getting results in any endeavor. It requires planning, a commitment to complete the job, and continued activity over time. Many practices do nothing to market themselves, sometimes because no one on staff has the background, or because no one knows the questions to ask, or because physicians believe medical marketing uses the same methods and techniques used in consumer advertising—techniques that may not be held in high regard. In truth, medical marketing is a specialty, and you must keep the need for professionalism at the fore at all times. Remember that techniques that provide value will work in marketing. ■

*(Continued from page 1)*

to contract with a particular kind of group," says Thomas Gorey, president and CEO of Policy Planning Associates, health care consultants in Crystal Lake, Ill. "One of the main reasons to form a group is to enhance attractiveness to payers as well as to gain contracting leverage. In some markets, single-specialty groups are very popular with payers, and specialists can maximize their attractiveness by forming this kind of group. In other markets, payers prefer contracting with multispecialty groups, which offer payers the ability to contract with a single group for all care for a defined population of patients." Particularly in markets heavily penetrated by managed care, specialists should determine payer preference to maximize the likelihood of contracting success.

## Contracting Preferences

While plan preferences vary among markets, MCOs traditionally have preferred contracting with multispecialty groups because such groups offer a wide range of services under a single capitated contract, says Walter Unger, founder of Walter J. Unger & Associates, consultants in Laguna Niguel, Calif., who advise physicians on group formation. "Having to negotiate only one contract for a range of services is an efficient way to conduct business," Unger explains.

Other market considerations affect group formation as well. "In addition to the demands and practices of local payers, circumstances of the local environment that affect group formation include the attitudes of the physicians with whom one is affiliating, the pre-existing referral relationships, and the attitudes of any potential investors," Unger says. "The main concern for specialists should be the effect such a relationship could have on their current practice and referral patterns."

The need for patient referrals from primary care physicians often leads to the decision to form multispecialty rather than single-specialty groups, says Unger. This fact is especially true in markets dominated by managed care plans, which often use PCPs as gatekeepers. As a result, some specialists have seen the number of referrals from PCPs decline as managed care market penetration has grown.

**"Specialists have to consider whether affiliation with one group will mean losing referrals from others."**

***—Walter Unger, consultant***

To counteract the loss of referrals, many specialists have affiliated with PCPs in multispecialty groups, thus aligning their financial incentives with those of gatekeepers and allowing them to share profits. This strategy allows specialists to offset a decline in per-case income with an increase in net income through profit sharing.

"Specialists have to consider whether affiliation with or membership in one multispecialty group will mean losing referrals from other groups or solo practitioners," Unger explains. "But such relationships also can mean an expanded geographical base and an increased ability to handle managed care contracts."

Another factor that helps to foster the formation of multispecialty groups is patient preference. In recent years, consumers have been demanding broader access to specialists. "Multispecialty groups enjoy the ability to market the fact that a full range of medical care is available from that one group," says Gorey. "This can be extremely attractive to patients."

Multispecialty groups also offer significant financial advantages, and specialists should consider those advantages when deciding whether to affiliate with such groups or form their own, says Kenneth Abramowitz, a health care analyst with Sanford C. Bernstein & Co., an investment research firm in New York. "Multispecialty groups offer a continuum of care, and that can result in cost savings attractive to managed care," he says. "As a result, they are better able to handle capitated contracts and manage outcomes."

Despite the advantages inherent in developing multispecialty groups, there are two trends prompting the development of single-specialty groups. Increasingly, health plans are allowing enrollees to use specialists without a referral from a PCP. In addition, specialists are becoming more comfortable dealing directly with MCOs. "More and more specialists are forming or joining single-specialty groups," notes Unger. "They usually do so for lifestyle reasons, to gain more freedom over their schedules, and to protect their incomes."

Furthermore, a multispecialty group has significant disadvantages, which are obviated by forming a single-specialty group. "Physicians of different specialties have different orientations in terms of their training and perspective," Gorey explains. "They often exhibit different practice patterns, different ways of approaching the patient, and different ways of providing care. These differences, while they can be synergistic, can also result in many challenges to forming a cohesive group."

## Ease of Operation

Single-specialty physicians may simply prefer to be among others within their specialty, explains Jason M. Rosenbluth, MD, a managing director with Volpe Brown Whelan & Co., investment bankers in San Francisco. "Once you get into the larger multispecialty groups, there are differing perspectives and goals among, for example, the high-revenue-generating orthopedic surgeons and the high-volume PCPs. Rifts can develop early in those relationships."

A strong proponent of single-specialty groups, Rosenbluth says, "The multispecialty model is a conglomerate-based approach, which is not as focused as the single-specialty model. Thus, those using it cannot allocate resources efficiently—it takes longer to make decisions in terms of allocating resources because of competing interests. When looking at guidelines, for example, groups that have a smaller single-specialty focus and whose members are not competing for resources are much more likely to effect change."

As a result, political issues surrounding leadership and governance are often simpler in a single-specialty group. "It's harder for multispecialty groups to have a small core group of leaders, because some specialties will not be represented," says

*(Continued on page 9)*

**"Once you get into the larger multispecialty groups, there are differing perspectives and goals among the high-revenue-generating orthopedic surgeons and the high-volume PCPs."**

***—Jason M. Rosenbluth, MD, Volpe Brown Whelan & Co.***

*(Continued from page 8)*

Gorey. "This makes governance issues more difficult. Physicians in each specialty feel nervous about whether their interests will be fully represented within the group's leadership, administration, board, and committee structure. In a single-specialty group, the specialty representation issue does not exist."

## Compensation Complexity

Another reason specialists consider single-specialty groups rather than multispecialty affiliations is the complexity of compensation arrangements. Since specialists receive most of their income from single, expensive procedures and PCPs generate income by seeing many patients for a relatively low fee on each one, compensation issues can produce considerable tension in multispecialty groups. An interventional cardiologist, for example, may perform four angioplasties and generate revenue of $1,500 from each in a day. A PCP may see 30 patients in office visits a day, and generate revenue of $100 for each. Thus, a cardiologist may generate twice the fee income as a PCP. The income disparity results in complicated and often controversial compensation schedules.

"The issue is usually handled through constant debate in multispecialty groups," Unger explains. "Some group practice leaders say they have three compensation packages going at the same time: last year's, this year's, and next year's."

Gorey concurs. "Creating the compensation system is a difficult hurdle for a multispecialty group," he says. "Even some multispecialty groups that have been operating for a number of years are still struggling with compensation issues, because there are wide differentials among many of the specialties, and there is no simple way to address that problem. The compensation system must be fair to the lower-paid physicians, but you can't transfer so much income from the higher-paid specialties that those specialists become disenchanted and leave the group."

Compensation differentials are especially wide in multispecialty groups that include PCPs. "Specialists like to work with people who think like they do and have the same financial goals," says Abramowitz. "A lot of specialists look down on primary care physicians. They believe that they, the specialists, carry the multispecialty group financially and don't receive their fair share of the compensation."

Another financial consideration is operating cost. "Most of the major overhead items are the same whether groups are single-specialty or multispecialty," says Gorey. "The one difference, however, is that some specialties require more expensive equipment than others. Specialists who do not require expensive equipment for their practices may not want to contribute to the overhead of those physicians who do. In a similar vein, some specialists, such as radiologists and anesthesiologists, are hospital-based and might not even need an office. So these specialists often prefer to form single-specialty groups because they can control their overhead costs better that way."

While administrative issues may be more difficult in a multispecialty practice, so too are clinical issues. One multispecialty group, for instance, cannot possibly represent all the ranges of subspecialties, since there may be dozens within any given specialty, says Rosenbluth. "Radiology has almost 20 subspecialties," he says. "Because most multispecialty groups don't have that depth, they have to contract for it, internalize it—which they won't do because they generally won't have the volume to support it—or forgo it. In other words, they'll have a general radiologist reading a head scan that a neuroradiologist ordinarily might read. So their level of expertise will be shallower."

Although payers may value a clinical focus, many are still reluctant to undertake the administrative burden of contracting with many single-specialty groups. One way single-specialty groups can handle risk-based contracts and develop relationships with MCOs is to affiliate with a physician practice management company capable of providing the expertise and information systems necessary to make such contracts profitable.

## Single-Specialty Success

Another trend involves forming single-specialty physician networks. Specialists seeking to contract successfully under managed care and to maintain and expand their patient base are forming these networks. They tend to be started with little capital and are usually led by one or two physicians who have strong business skills and experience with managed care, says Gorey. Moreover, physicians in these networks often share the financial risk of delivering care, a developing trend among specialists in many disciplines.

"If the measure of success is getting managed care contracts, these entities are working," Gorey explains. "The success of these networks appears to demonstrate a sense of specialist empowerment that was not evident in the market 10 years ago."

Such networks often precede group development, notes Gorey. "Physicians sometimes begin organizing in a network," he says. "Then, once they establish some relationships and a certain level of trust, they feel comfortable moving to the next level and formalizing the relationship by creating a group practice."

*—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on practice strategies is available at mdoptions.com.*

# A Market-Based Theory for HMOs

*By Douglas W. Emery*

The U.S. health care system is a complex economy. The global theory of managed care advocates taking stock of the most primal, elementary forces shaping the economics of health care and harnessing them. That means all activities involving health care and its payment must be sorted and puzzled together according to the multidimensional nature of risk. The entire universe of medical treatments must be organized into a robust taxonomy of clinically homogenous episode product lines.

A market-oriented solution to the social inefficiencies inherent in traditional managed care would be driven by three values: risk bifurcation, polycentrism, and consumer sovereignty. These three values can be contrasted with the three values that dominate traditional managed care: risk conflation, monopolism, and paternalism.

## Risk Bifurcation

The overarching problem that traditional managed care faces involves pricing two unrelated bodies of risk: probability risk and technical risk. A genuine market approach would recognize that one category of institutions should manage probability risk and another should manage technical risk. Though managed care—and particularly capitation—has the potential to achieve cost efficiencies unheard of in a traditional indemnity, fee-for-service context, those gains are inherently limited, and at some point, turn back on themselves. The current savings from capitated managed care flow primarily from price compression, reduced hospital admissions, shorter lengths of stay, and some efficiencies in managing patients.

Even greater savings and leaps in optimal health care technology will occur when, as happens in other markets, providers managing technical risk compete on the basis of global fees for acute care or maintenance fees for chronic care. The only way to accomplish such point-of-service price competition in health care is to organize the delivery of care by episode. The episode of care is the natural unit of analysis identifying and categorizing all relevant types of human behavior and resource consumption in the delivery of care. Furthermore, it is the only way to measure quality and outcomes in the delivery process of care meaningfully.

Globally priced episodes of care act as a lens to focus clinical decisions regarding appropriate levels of resource utilization. Commenting on participating in Medicare's experiment with globally priced cardiology episodes, Richard Shemin, MD, chief of cardiothoracic surgery at Boston University Medical Center, said the challenge was to alter protocols to fit within the global payment system without compromising the care physicians provide. The cardiologists canceled all standing orders for bypass patients, which forced them to think twice before ordering any procedure, he said. Shemin found global payments to be vastly superior to several alternatives and much less onerous than such options as capitation.

Shemin's team has been saving almost $100,000 annually just by substituting less expensive but equally effective anesthetics and other pharmaceuticals. The team also cut back on the use of ventilators in postoperative recovery, which speeds the patient's convalescence and cuts costs. Left alone to manage technical risk, surgeons were freed from the additional burden of having to manage the probability risk of capitation. Note also Shemin's observation that the challenge was to adjust the factor inputs just to the point that patient care was not jeopardized. The reason a globally priced episode of care is attractive is that it is the only incentive-oriented payment modality that actually centers on the patient. By comparison, capitation centers on an abstract aggregation of total population resource utilization adjusted to the needs of payers and providers. By organizing health care delivery around episodes of care, health systems would encourage price competition.

**The reason a globally priced episode of care is attractive is that it is the only incentive-oriented payment modality that actually centers on the patient.**

By organizing the delivery of care around episodes of care and paying for them with global fees, health systems create two markets: one for insurance and one for health care itself. Price competition is encouraged to operate in both markets.

## Polycentrism

Polycentrism is defined as a diversity of competing episode providers and competing payer systems all vying for market share under robust price competition. In a polycentric system, health care insurers would sell premiums and health care providers would sell episodes of care. Under the current system, however, provider entities that integrate and manage episodes of care have the awesome task of delivering care and ensuring that premiums are sold at rates sufficient to cover the actu-

*Douglas W. Emery is the editor of* Global Fees for Episodes of Care: New Approaches to Healthcare Financing *(New York: McGraw Hill, 1999). More information on episodes of care is available at mdoptions.com.*

**At no time should consumption of medical care at the point of service be free, unless the managers of probability risk are trying to entice patients to consume, as with preventive care.**

al and foreseeable costs of care.

In a polycentric world, these provider systems could be physician-hospital organizations, management service organizations, IPAs, or small boutique operations that specialize in one area of delivery expertise, such as carpal tunnel release, for example. Each provider system would offer its discrete globally priced products of episodic care to consumers.

But because they cannot specialize under the current market, as every other healthy market can, provider systems today are frustrated by the task of attempting to be all things to all people. This is one of the reasons that integrated delivery systems are doing so poorly.

In a polycentric world, integrated episodes would put physicians back in control of the delivery system by giving them a sovereign voice in management to design optimal care processes, making them financially and clinically accountable for the performance of the integrated organizations to which they belong and by providing all health care providers with the incentive to collaborate. Under the current system, physicians and other clinical professionals have had socially perverse incentives to resist collaboration in a team-oriented, collegially cooperative manner.

Polycentrism means that consumers shop premiums from discrete, competing health care insurers who help them protect their assets from future catastrophic medical expenses by ensuring robust global fee competition for acute episodes and maintenance fees for chronic episodes. It also means structuring real-time, user-friendly information when patients need it, and making easily accessible care available that is designed to help prevent illness. Once a risky event or medical consumption becomes a certainty, then consumers enter the market to purchase care from discrete, laterally integrated provider groups. In a polycentrist market, a patient needing surgery would have the opportunity to shop for his or her care from a menu of competing, discrete provider groups with minimal regard to his or her insurer.

## Consumer Sovereignty

The truth about traditional managed care is that, because consumers do not have true choice, the real consumer is the HMO, and, therefore, the HMO is sovereign. Since consumers have largely been forced to surrender their ability to respond individually to market information, the HMO is forced to develop paternalistic strategies toward patients and providers. Therefore, the HMO compels patients to consume according to its preferences for risk. This fact may be one of the unstated reasons managed care supporters oppose medical savings accounts and, at times, global fees. To the extent that the patient's preferences are sovereign in the choice of care delivery, HMOs and other managed care payers lose their base of power.

It is important to stress that as consumers are empowered to make decisions regarding allocation of their own resources, the more likely it is that they will be prudent. Consumer sovereignty means that, at some level, there must be consumer risk. Uwe Reinhardt, a noted economist and health care expert at Princeton University, has been quoted as saying, “I’d remind patients that they make economic trade-offs in their own lives. They take a chance in buying a car to save some money; why shouldn't they take a similar chance to save some money in health care?”

Such trade-offs bring reason to any competitive market. People must be able to compare trade-offs by balancing what they would spend against what value they would receive in return. Since health care is a service produced by many organizations working together, patients must become managing partners both with their insurers and their providers, eschewing risky behavior and complying with physician advice. HMOs do little to motivate patients to invest in their own health. Therefore, health care cost control must come from the bottom up: from patients to doctors to payers to government, not the other way around. If such cost control cannot be accomplished, excess health care inflation will never be tamed.

There are, however, strategies for getting consumers to become partners in ensuring their own good health. Health systems need to define episodes of care and assign them global fees, and then eliminate care that appears to be free (or nearly free) at the point of care. At no time should consumption of medical care at the point of service be free, unless the managers of probability risk are trying to entice patients to consume, as with preventive care. It should be clear that $5 copayments for office visits and $3 copayments for prescriptions are about as close to free care as one can get. When cost at the point of service is made meaningful (as opposed to onerous), consumer choice will become the sovereign power in the market.

When health care systems are organized around these three values—risk bifurcation, polycentrism, and consumer sovereignty—the result will be a decentralized structure in which consumers shop in one competitive market for health care insurance, and once insured, shop in another competitive market for health care. This structure does not preclude traditional managed care. A robust market in health care should encourage a rich system of competing organizations. In fact, if a truly vibrant market were to develop, it would probably strengthen the vertically integrated systems by generating the information they need to price their products more effectively—if they're still around. ■

# Niche Programs, Careful Marketing Help Seasonal Practice Succeed

*Victor Gong, MD, is the medical director of the 75th Street Clinic, in Ocean City, Md., and has been practicing family and emergency medicine for 15 years. He attended medical school at the State University of New York at Downstate Medical Center. He completed his internship and residency in internal medicine at Rutgers University in New Brunswick, N.J., and completed an emergency medicine fellowship at Johns Hopkins University Hospital in Baltimore. Gong is the author of two books on AIDS:* Understanding AIDS: A Comprehensive Guide *(Rutgers University Press, 1985) and AIDS: Facts and Issues (Rutgers University Press, 1986). Richard L. Reece, MD, editor-in-chief, conducted this interview. More information is available at mdoptions.com.*

**Q.** *How big is Ocean City, Md., and how much does the population swell in the summer?*

**A.** Ocean City is the only resort town on the Atlantic Ocean in Maryland. The population varies from a year-round average of 20,000 up to 300,000 in the summer. We are about a three hours' drive from the nearest big cities, which would be Baltimore, Washington, D.C., and Wilmington, Del. Our closest hospitals are Atlantic General Hospital, about 15 minutes away in Berlin, and Peninsula Regional Medical Center in Salisbury, about 40 minutes away. Tourism is the main business here, making medical practice a challenge. We have to be able to handle higher patient volumes in the summer and be successful and profitable during the off-season.

**Q.** *You have adopted a number of niche marketing strategies to help support your practice. What is niche marketing, and why did you pursue this strategy?*

**A.** Niche marketing is a strategy whereby physicians can differentiate their practice from others to attract additional business. Because of a certain specialized focus or program, practices may attract new patients, who then return when they need general medical care. Because our business is seasonal, we needed to develop some services that were in demand but were not being provided in our area. This need prompted our niche marketing strategies.

**Q.** *Would you describe the various niches that you have developed and why?*

**A.** In looking through financial and medical news reports, I noticed that there were several "cash cows" left in medicine: occupational medicine, weight control programs, wellness programs, and nutritional supplements. For example, weight control is a $40 billion industry. These are all big industries, but none of the practices in our area were providing any of these services.

We were already providing a significant amount of occupational medicine in terms of work-related injuries. To enhance this aspect of our practice, we purchased more equipment such as audiometry machines and blood alcohol testers, and became involved in other aspects of occupational medicine such as drug testing, wellness programs for our occupational medicine clients, and other specialized examinations.

Our other niche programs—weight control, wellness, supplements, and anti-aging—were a little more challenging. Like most of the physicians in America, we had not focused on learning about these topics. But patients desire these services, and when they find someone of reputable standing to guide them, they are happy to pay that individual for assistance. Patients pay out-of-pocket for our weight control and other niche programs. Often they pay cash. So I recognized the potential of these areas and decided to move our practice in that direction.

We instituted the weight control program in 1995. A year later we started providing a general wellness program and a vitamin program. This year, we started an anti-aging program.

**Q.** *Why should physicians consider developing a weight control program?*

**A.** First, a weight control program can be very profitable. Our program had about $90,000 in gross revenue in the first year, and we were profitable.

Second, physicians can truly help patients lose weight with a program that is comprehensive and addresses obesity as a disease. Most physicians in America know about the negative consequences of obesity, but they don't know enough about it to treat it as a disease. Most physicians have patients with weight problems; he or she will tell them to lose weight, and they come back next year having gained even more weight. But when people seek out a weight control program, they have to pay money for it; so they are more motivated.

**"Patients pay out-of-pocket for our weight control and other niche programs. So I decided to move our practice in that direction."**

Third, the weight control patients usually are women, and women typically make the health care decisions for their family. So when they join the program and get results, they become a patient of the practice and bring the rest of the family in too.

**Q.** *What are the components of your weight control program?*

**A.** Participants come in for an initial health evaluation, or pre-screen, requiring 20 minutes. During the pre-

screen, participants complete a questionnaire, receive a free body fat analysis, and hear about which program options we think are best for them.

The actual program components include nutrition evaluation, exercise evaluation, behavioral evaluation, and a regular medical evaluation that includes an EKG and a comprehensive blood panel. Participants also receive specialized written material and videos about weight loss. Then, they have a series of follow-up visits during which we check their health and their weight loss progress. As part of the program, we include counseling, a medication regimen, a nonmedication regimen based on the use of nutritional supplements to help control appetite, and a maintenance program.

We also incorporate technology into the program, to highlight that we are a high-quality and technologically advanced practice. We have a computerized body fat analysis machine that analyzes electrical impulses to determine body fat and muscle and water content levels. It's like a scale: A patient stands on it and the computer generates readings for amount of body fat, percentage of body fat, amount of water, and muscle mass. This information is important to know, because when a patient loses weight we want to document whether the weight is coming off of muscle or fat. We put all this information into a database.

In addition, we purchased an imaging system, so that when potential clients come in we can take a picture of what they look like now and generate a digital picture of what they'd look like if they lost, say, 30 pounds. Because they can see a before-and-after image prior to the start of the program, they get motivated to lose the weight. They can visualize their success. That picture is a great marketing tool. If they look at that picture every day, they eventually join the program. We also promoted that technology to all the local newspapers. We wrote articles that the newspapers published and got ourselves on a few television programs talking about the new technology of weight control.

**Q.** *Why did you develop nutritional supplements as a niche?*

**"The weight control patients usually are women. So when they get results, they become a patient and bring the rest of the family too."**

**A.** Nutritional supplements can seem like alternative medicine to physicians because of our training, which is focused on the treatment of acute conditions rather than wellness. But it's impossible to ignore vitamin supplements because patients are taking them, and we as physicians are responsible for their care. We need to know what they are taking and how it will affect the treatments we suggest, because it's a risk management issue if we don't. Furthermore, if physicians address topics such as supplements, they will build their patient volume because patients want to be treated by someone who will not reject supplements out-of-hand.

In addition, we should be sharing important information about supplements with our patients on a regular basis. Researchers have published more than 35,000 articles on the role of nutritional supplements and health. We need to promote folic acid for pregnant women, for example, given the results of an important study published two years ago. Another study analyzed the use of antioxidants for heart attack patients and found that these patients had a 50% to 60% reduction in reinfarction rates. Still another study of 20,000 nurses found that colon cancer rates were reduced by 60% in patients who take high potency multivitamins with extra folic acid. This information should be highlighted for patients for whom it is relevant.

**Q.** *As you know, there's controversy in this topic. Many physicians and physician organizations believe that peddling nutritional supplements in the office is unethical. What do you think?*

**A.** That's a complex question. First of all, we provide products to patients if they want them, but we don't actively solicit purchases. There is a large market out there that wants to learn about and take supplements, so we need to provide leadership and assistance. For example, a majority of the nutritional supplements on the market are low quality. They have a lot of fillers and binders. There's no quality assurance. It's not like a medication where the federal Food and Drug Administration will guarantee quality and monitor it. It's up to physicians to educate patients on what to take, what's a quality product, and what's not.

**Q.** *What does anti-aging mean, and can you tell us what your anti-aging program involves?*

**A.** The term "anti-aging" is like "wellness" in that it means different things to different people. What it means to me is helping patients not only live longer, but live stronger. People who maintain their health can be active and feel good as they age. The purpose of anti-aging is to maximize quality of life, to ensure that when people are in the 50-to-70-year age bracket, they are in optimal health, they are still active, their minds are intact, their bones are strong, and they feel energetic. Anti-aging is not just keeping people looking healthy. It's not a fountain of youth.

Anti-aging involves nutrition and exercise physiology: Certain foods and exercises are better for anti-aging than others. Other aspects of anti-aging include nutritional supplements such as antioxidants, stress reduction, and hormone rebalancing.

**Q.** *What other preventive measures are part of your approach?*

**A.** We pursue many common preventive measures but try to be creative in how we execute them. For example, in promoting flu shots, we did a weekend drive-through-flu-shot program, which was covered on television, over the radio, and in newspapers. We had a lot of people who were not our regular patients come for the flu shot because we offered the shots in a convenient way. We have a banner that we put on our office saying 'Flu Shots,' and that brings a lot of people in.

We're also developing more specific programs. We are currently organizing an osteoporosis program. The program is a

*(Continued on page 14)*

**"We accommodate ourselves to the needs of the media. We look for topics that will be of interest to newspaper readers or television viewers."**

*(Continued from page 13)*

little more comprehensive than most programs of its kind. In most such programs, patients get a bone density scan and the physician tells them to take some calcium, and many physicians suggest an over-the-counter medication. But different types of calcium preparations are superior in building bones. In our program, we will give patients a bone density scan, and then put them on a nutritional and exercise regimen. Also, we will incorporate some new diagnostic testing in determining levels of the breakdown of the calcium in the bone. Then, we can monitor the bone formation before the follow-up scan.

**Q.** *In addition to niche marketing, you advocate a philosophy called guerrilla marketing. What is it and where did you learn about it?*

**A.** Guerrilla marketing entails low-cost strategies that enhance the reputation of a business and make it more profitable. It's a great strategy for small businesses that don't have significant marketing and advertising budgets.

I learned about the technique in a book, *The Guerrilla Marketing Handbook*, by Jay Conrad Levinson (Houghton Mifflin Co., Boston, 1995). The guerrilla marketing strategy impressed me because it is geared toward small businesses and how they can compete with bigger competitors that might spend millions of dollars on marketing. Guerrilla marketing is especially relevant to physicians in private practice, who can feel that they are not big enough to compete with integrated delivery systems.

**Q.** *What are some guerrilla marketing strategies you use?*

**A.** One of the common-sense strategies we have adopted is calling our patients, just to see how they are doing. This is a good strategy for several reasons. It enhances quality of care, because we are checking in on our patients' health and can determine how, for example, a change in medication has affected them. It also helps us with risk management, because we can monitor the health and reactions of our patients and might possibly avoid a crisis. Generally, it's good for business because patients remember that we called, and come back to us because they know we care about them. We call patients back whether they're local or out-of-state.

As another example, when patients send us letters thanking us for our care, we hang the letters up in the office. This is a good marketing tool. It validates the work we're doing and offers comfort to new patients, especially tourists, who are seeking care far from home and want assurance that the physicians are high quality. When they come in and see the letters, it helps alleviate their concern and sets a more positive context for care.

We also do other things to build personal relationships with our patients. We send out birthday cards hand-signed by all the doctors in the practice. We personalize the Christmas cards we send out with notes to the patient. We send thank-you notes to patients who refer others to us. When we see a notice in the newspaper about one of our patients receiving a promotion or another achievement, we send a congratulatory card. Those little touches mean a lot to the success of a practice, because they enhance patient loyalty and physician reputation.

**Q.** *What unusual advertising and public relations techniques do you use?*

**A.** We try to pursue inexpensive advertising techniques. For example, we distribute refrigerator magnets to our patients. The magnets are brightly colored, and have the names, addresses, and phone numbers of our offices. Many patients, particularly the tourists, put the magnet on the refrigerator in their rental property. As a result, subsequent renters see the magnet and come directly to us if they need a doctor. We distribute 20,000 magnets each year, so many of the rental properties in the city have one of our magnets on the refrigerator.

Since 1996, we have pursued public relations marketing, where news reporters can interview us and we can be perceived as experts in the field. We started by submitting articles on different medical topics to three local newspapers, and then our relationships with reporters helped us bounce to television. We would show television producers these newspaper articles and started to make ourselves available. Most doctors either are shy, don't want to take the time, or won't take the initiative to generate publicity. On the other hand, we not only pursue these relationships but we accommodate ourselves to the needs of the media. We look for topics that will be of interest to their readers or viewers.

**Q.** *Do you use the Internet as a marketing tool?*

**A.** We have a site on the Internet (75thstmedical.com), which we plan to start this spring. The site includes information about our practice and its services. We also have references and articles that can be downloaded for free, and we have links to other major health care sites. Eventually, we plan to add a chat room so patients can talk to each other about their conditions, forming a sort of support group. We will probably restrict the ability of patients to ask us medical questions via e-mail because of risk management issues.

**Q.** *What final comments can you offer to our readers regarding your marketing strategies?*

**A.** When physicians embark upon some of these ventures and publicize them, they are perceived as promoting these ventures just to make money. That's not what drives us. Physicians can always make money. We do it with the goal of optimal care for the patients.

We want to keep patients healthy so they can live long and strong, and so they don't have to come back and see us or go to the hospital. Patients like to hear that. The only thing we are trying to sell is good health.

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

# Provider-Owned Health Plans Struggle

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

Sales of health plans in the past year have yielded considerably lower valuations than they have in previous periods. The figure, "Health Plan Transactions" shows transactions occurring last year that generated about half of the purchase price per member as those occurring in the preceding year. Provider-owned health plans have suffered a more severe devaluation, receiving valuations 25% below non-provider-owned plans.

The lower market valuations have not inhibited the divestiture of provider-owned health plans, however. The number of transactions involving provider-owned health plans increased 21% last year, even though the total number of health plan transactions remained unchanged.

Lower valuations, coupled with rising divestiture rates, reflect the significant operating losses and capital reserve deficiencies that have recently characterized provider-owned plans. Companies that partner with provider-owned plans frequently have been regional or national HMOs that already have a local market presence and have been able to realize significant administrative synergies and enhanced contracting clout with providers.

## State of the Industry

Two factors have exacerbated the financial instability of provider-owned health plans. One significant factor is the effect the Balanced Budget Act of 1997 (BBA) has had on health care providers, particularly hospitals, but health plans as well. The other factor is the ongoing effect managed care has had on limiting inpatient utilization.

As a result of these two factors, an increasing number of hospital systems reported a significant decline in profitability of both their core institutional assets and ancillary business units, such as health plans, physician groups, and home health centers. The trend is projected to continue.

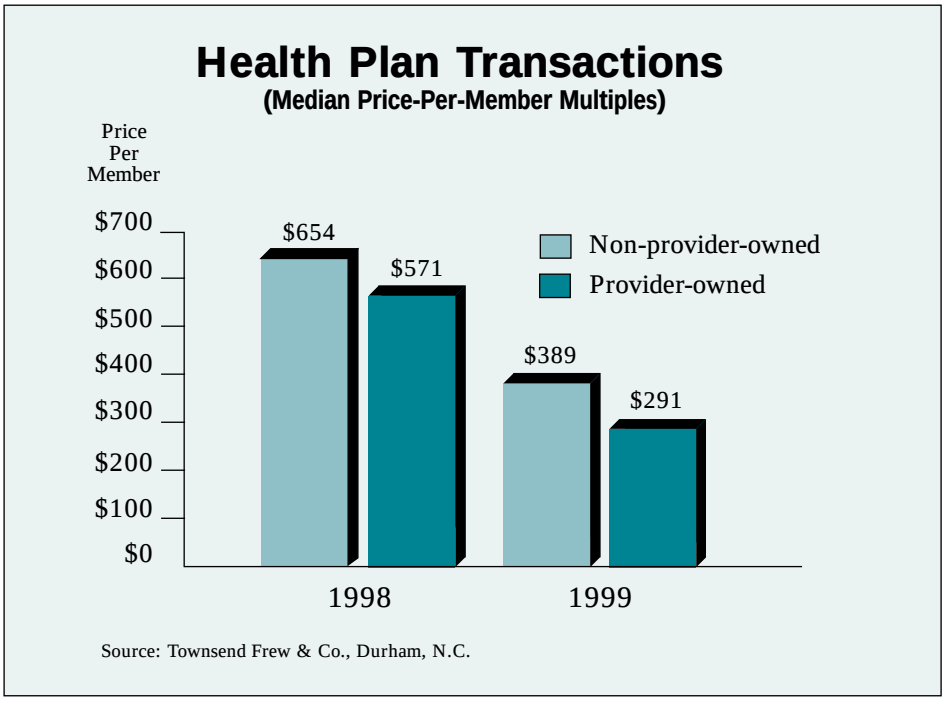
Continued deterioration in hospital system financial results has led one financial analyst to report 62 credit downgrades so far this year, compared with 12 upgrades last year. The BBA refinement legislation passed in November 1999 should offer providers modest relief of approximately $15 billion over five years, but that legislation is likely to have only a limited effect in curbing short-term operating losses.

Ownership of physician practices has diluted the profitability and management focus of integrated hospital systems. Last year, hospital systems lost an average of $111,000 per employed physician, according to estimates by Ernst & Young, CPAs and health care consultants in New York. The combined effects of lower reimbursement, increased administrative and technological demands, rising capital costs, and declining compensation have made the business of running physician groups extremely difficult.

As physician practice management companies end the relationships they have had with physicians and as hospitals shy away from making equity investments in medical groups, many physicians are fleeing larger practices and seeking refuge in smaller groups or solo practices.

In previous years, hospital systems were willing to accept modest losses in their ancillary businesses as long as their core hospital assets were profitable. The current market has changed, however, and hospital systems are now reexamining their strategy of acquiring physician groups. Deteriorating financial conditions are forcing hospitals to make difficult decisions.

The merits of integrated health care delivery systems continue to be debated. The consistent and profitable management of hospitals, HMOs, and physicians has yet to be demonstrated. ■




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

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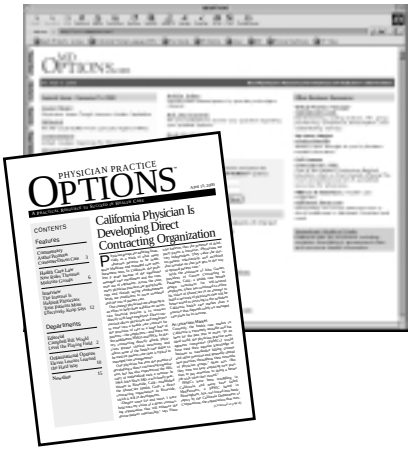


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