

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Atlanta Physician Mines Patient Outcomes Data

By collecting health status information, solo practitioner does what many large health care providers have failed to do

Four years ago, Atlanta physician Dwana M. Bush, MD, faced a scenario common in primary care practice under the constraints of managed care: too many patients, too little time, and not enough reimbursement for the services she provided. To "bring sanity back" to her practice, Bush began experimenting with an outcomes tool called the SF-36. The experience has paid off in more effective patient encounters and substantial, useful data on the effect of the care she is providing.

"The SF-36 lets me know how my patients are doing, what they need, and if they are getting better," says Bush, who has been in primary care practice for 12 years. Available since 1988, the SF-36 is a 36-question health assessment survey that measures health status and outcomes from the patient's point of view (see sidebar). The questionnaire can be given by an interviewer, self-administered, or taken on a computer, but whatever the method, the result is a quick but compelling "snapshot" of a patient's well-being.

Developed by the Health Institute at the New England Medical Center (NEMC), in Boston, with support from the Henry J. Kaiser Family Foundation, a philanthropy in Menlo Park, Calif., the SF-36 yields a health profile and self-reported assessment of change in health status. The survey covers physical functioning, overall health, bodily pain, vitality level or energy level, social functioning, and emotional and mental health; areas that are relevant across age,

disease, and treatment groups. One of the instrument's strengths is the availability of documented normative data for the general U.S. population and from representative samples collected in Denmark, Germany, Sweden, and the United Kingdom. A physician can compare a patient's SF-36 profile with what is "normal" for a person who is considered healthy or for one who has a particular disease or condition.

Using the SF-36, Bush has collected data on more than 4,000 patients since 1994, and she now is using the aggregate data to create "group portraits" of certain subpopulations in her practice, Atlanta Family Medicine. Two groups she has studied are HMO members being treated for depression and employees of a company that was experiencing three times more disability claims than health claims. Armed with the SF-36 reports, she convinced the HMO that the care she provided to its patients was working and the company that a stressful work environment was the cause of a high incidence of injuries and low back pain among its employees.

As Bush's story shows, physicians can achieve two key goals by using a simple but thoroughly tested assessment tool in primary care: efficient and consistent tracking of patient progress, and documentation of outcomes, which is becoming a necessity for leveraging participation in managed care plans. Her story also shows that one physician armed with enough of the right data

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A Simple Approach to Measuring Patient Satisfaction

Success in practice, says Neil Baum, MD, a urologist in New Orleans, starts and ends with satisfying patients. Dissatisfied patients, on the other hand, can destroy a practice. Since one dissatisfied patient usually talks about that dissatisfaction to at least 12 people—friends, relatives, co-workers, and referring physicians—such broadcasting of bad news can have dire consequences. Negative patient reports can be especially problematic if a health plan determines that your patient satisfaction rates are lower than average and deselected you from an HMO network.

Baum, who helps physicians market their practices and has written on the subject in his book *Take Charge of Your Medical Practice* (\$66, Aspen Publications, Frederick, Md., 1996), says that physicians can avoid such trouble by measuring patient satisfaction and acting on the results. Physicians who seek to follow this strategy have many systems to choose from, but even a simple one, Baum suggests, can be useful.

When patients enter your office, Baum says, hand them a form with the following seven questions and ask them to complete it before they leave the office:

1. Were you able to make an appointment in a timely fashion?
2. Was the staff helpful and cordial?
3. Did the physician see you within 20 minutes of your appointed time?
4. Did the physician answer all your questions?
5. Would you recommend our practice to your family?
6. Do you have suggestions for how we can improve the services we provide to you?
7. What three questions did you want to ask the doctor today?

Simply by asking these questions, you are:

- Showing that you care about your patient's concerns
- Leaving no major concerns of the patient unanswered
- Setting up an early warning system that identifies the "big six" problems (in the first six questions) that turn patients off
- Building patient satisfaction that may spread to other patients
- Collecting positive data to share with managed care companies

In our story on page 1, "Atlanta Physician Mines Patient Outcomes Data," we report on the efforts of Dwana M. Bush, MD, a primary care physician in Atlanta who uses a more sophisticated tool than Baum's simple form to improve patient encounters and collect data on the effect of the care that she provides. For physicians seeking a simpler approach than hers, a single form—like Baum's—that addresses major patient issues is a good way for physicians to begin seeking rudimentary patient satisfaction data.

In our Sept. 15 editorial, "A Simple Approach to Information Systems," we wrote about Dallas internist Bruce Landes and his use of a two-sided summary of pertinent patient information. By using this "gold sheet," Landes dramatically reduces duplicative testing on his patients and cuts the time other physicians need when they meet with his patients. The concept behind Baum's form is similar to the idea behind the gold sheet, only simpler.

Whether you use a simple approach or a more complex system, the point is that physicians need effective ways to collect information from patients. In fact, to build a successful practice, the need for patient satisfaction data is becoming more important every day.



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Physicians Find Partnerships Don't Last

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

Some of the large health systems that created organizations over the past several years to achieve better integration between physicians and hospitals are now unraveling those organizations.

"Right now, the overall state of integration between hospitals and physicians is shaky," says Daniel Beckham, president of The Beckham Co., physician and hospital consultants in Whitefish Bay, Wis. He should know. Since 1983, when he started his consulting firm, Beckham has been doing market-based strategic planning for hospitals and group practices. In addition, he is past chairman of the board of the American Marketing Association.

"Some health care systems are trying to spin off their primary care business because they feel they are losing too much money on their investments," says Beckham. But spinning off physicians is not easy. Not only are there contracts to be dealt with, but there aren't many investor-owned organizations eager to pick up these spin-offs, says Beckham. But he does see a solution: spinning them off into a for-profit company in which the hospital assumes a minority ownership position and turns over the management, governance, and ownership of the organization to physicians. By taking this approach, hospitals would not be dominating physicians, but rather assisting them to become independent.

"Hospitals are actually being forced into that minority ownership position," says Beckham. "The nonprofit organizations have savvy businessmen on their boards who are asking tough questions about all the red ink on the physician side of the business. They receive two typical responses to their questions on how to deal strategically with the problem. One is: 'We'll cut costs.' But with primary care groups, there aren't a lot of costs to cut because they were shoestring operations to begin with. The other response is: 'We'll get rid of the organization.' That leads to the spin-off option."

But that option isn't easy either. "What do you, as CEO, say when your board members ask you about the millions of dollars invested up to the point that you spun off the orga-

nization?" asks Beckham. "Toward what end did you make that investment? It would be ironic if it were simply to cut the doctors loose, leaving them to fend for themselves. That leaves the doctors feeling that they have been betrayed or misled, and what will you have done? Essentially, you will have spent millions of dollars to disaffect what

In many relationships, hospitals have been on the defensive, says Beckham. "They acquired the practices to begin with purely for defensive purposes, thinking that if they didn't, someone else would," he says. "But the 'losses' they are experiencing are important investments because the relationship between the hospitals and the

Physicians need to say, "You're not going to dictate the terms of this contract; we are, because we're in the driver's seat."

—Daniel Beckham, The Beckham Co.

remains the most important constituency for your hospital—the physicians."

But if cost cutting and spinning off the organization are not the solution, what is? Beckham answers: "It's showing some *chutzpah* by saying to health plans, 'We control 40% of the primary care delivery capacity in this market and you cannot do business in it without us. So, it's going to be our deal, not your deal. You're not going to dictate the terms of this contract; we are, because we're in the driver's seat.'"

This solution, Beckham says, requires pressuring health plans for higher reimbursement and attacking the problem of revenue losses from the income—not the cost—side. In other words, "this is not a problem that can be solved in any sustainable way by reducing the expenses from physician practice operations," he says.

That leads to the next question: Must a strong organization originate in the hospital setting or can it be led by a large physician group? Beckham believes the proper posture can come from physicians. "In a large physician group owned and controlled by a hospital, the leadership obviously is going to emanate from the CEO of the hospital or health system," he says. "But a group practice of significant size can take the same attitude and the same stance, and some of them have. It takes courage, however, and most people who could do it, haven't been demonstrating much courage."

physicians is absolutely critical. It's a question of how the relationship is structured."

It is best for hospitals not to assume controlling ownership positions, Beckham says. Rather, they should assume minority ownership positions and let the physicians continue to have responsibility for their own profitability and productivity.

Problems Among PPMCs

While hospitals and physicians have been struggling in their efforts to work together, physician practice management companies have been experiencing problems of their own. On Wall Street, the stock prices of many PPMCs have declined dramatically over the past year. Since PPMCs currently take management fees of 15% to 20% from physician practices under 40-year contracts, Beckham says these companies will need to create significant value for the affiliating physicians. "The problem with these companies," says Beckham, "is that they probably aren't bringing enough to the table to justify the management contract."

"There are two ways in which PPMCs can bring value," Beckham continues. "One is managed care savvy, which is simply experience with managed care and with the necessary infrastructure, particularly the information systems needed to allow a group to be effective. The second area is revenue. Many physicians hope that PPMCs will bring a deeper business sense to

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COMMENTARY

Beckham has adopted a “wait-and-see” attitude on PSOs, saying it may be unwise to enter a market in which major HMOs have failed.

(Continued from page 3)

the practice, including the ability to identify and develop new services that generate new revenue. That's where the value was expected and probably where it hasn't been delivered.”

Many PPMCs promise to install ancillary services and siphon off some of the income from the hospital for these services, but they haven't developed these services sufficiently to justify the management fee, says Beckham. As a result, physicians have become impatient and frustrated, and, as their income drops, they have become disillusioned and revolted against PPMCs. In fact, some physicians are attempting to walk away from those relationships.

In addition to hospitals and PPMCs, provider-sponsored organizations offer a new opportunity for physicians, especially those seeking to participate in the Medicare program. PSOs are new organizational structures created by Congress in the Balanced Budget Act of 1997 as part of the Medicare+Choice program. Experts argue that PSOs will have a significant effect on health care. Beckham, however, has adopted a wait-and-see attitude. In particular, the recent exit of many health plans from Medicare may mean many providers will not participate in PSOs, he says.

In general, consumers, physicians, and hospitals are feeling stung by managed care, says Beckham. But if HMOs are successful in their recent efforts to pass along to employers premium increases of 8% to 10%, he predicts that many health plans may be more inclined to continue to participate in the Medicare program.

While only three organizations filed new applications to become PSOs, more than 50 organizations have applied for licensure as Medicare-risk HMOs. This development raises the question of why has PSO development been so slow while provider-owned HMOs are gaining a significant presence in the market. The reasons are many and varied: HMO development is a known process while PSO development is not; PSO solvency requirements are steep, forcing providers to put up \$1.5 million in net worth and \$750,000 in cash; and developing a PSO could take 12 to 18 months.

In the midst of these developments, major HMOs are finding Medicare-risk to be unprofitable and, as a result, they are leaving many markets.

It's no wonder, then, that Beckham has a “wait-and-see” attitude toward untested PSOs. He correctly senses that it would not be wise to enter a market in which major HMOs have failed.

Physicians considering which partner is best may be well served simply to do as Beckham suggests:

- With hospitals, form a large primary care base and persuade the hospital to offer you a larger premium share
- With PPMCs, do more extensive due diligence in examining the credentials of the management team and ask for cash rather than stock if your group is being acquired
- With PSOs, proceed with caution and consider the more tested alternative of a provider-owned, Medicare-risk HMO. ■

(Continued from page 1)

can solve problems that have vexed much larger organizations. She can show, for example, changes in her patients' health status over time, something few—if any—health plans can do. Also, by using the SF-36 to identify depression in patients, she is doing what behavioral health care experts have been asking larger provider organizations to do for years: identify and treat appropriately those patients whose mental health problems present as physical illnesses.

Putting the SF-36 to Work

In May 1994, Bush stumbled on the SF-36 when she met outcomes specialist Harry Wetzler, MD, who was working for Response Healthcare Information Management Inc., then of East Greenwich, R.I., and now part of HCIA, a health care data analysis firm in Baltimore. Wetzler showed her the survey and demonstrated an accompanying scanner that could generate uniform scores in the form of bar graphs. Bush was intrigued with the idea of surveying her patients and eventually realized that the scanner would allow her to analyze aggregate data from groups of people rather than data on just individuals.

Clinically, the way Bush uses the SF-36 in practice is straightforward. When patients come into her office, a receptionist or clerical assistant routinely gives them the questionnaire to complete and a sheet to sign granting permission for the data to be used in the aggregate for Bush's personal research. Patients complete the health survey by simply filling in circles on a card. This "answer sheet" is run through a scanner, which reads the answer "dots" to plot bar graphs on a scale from 0 to 100. Reviewing the resulting patterns, Bush can quickly gauge a patient's physical, mental, and emotional well-being. If she's seen the patient before, she can compare the current and previous surveys to determine whether the patient's condition is improving.

Two case studies from Bush's files show how effective the SF-36 can be as a diagnostic and treatment adjunct. The first involves a 49-year-old woman with a history of depression for whom SF-36 data were obtained four times between September 1995 and April 1997. At different times during the survey period, the patient was placed on physical and psychiatric disabili-

ty, and her SF-36 scores showed corresponding declines. The mean survey score is 50, and the woman's scores dipped to 24.1 and 34.9, respectively. The second patient

"Using the SF-36 helps me to screen for depression earlier, do fewer tests, and make fewer psychiatric referrals than I would if I weren't using it," Bush says. In fact, Bush

"Using the SF-36 helps me to screen for depression earlier, do fewer tests, and make fewer psychiatric referrals than I would if I weren't using it."

—Dwana Bush, MD, Atlanta Family Medicine

had a history of chronic shoulder pain and depression, and her initial scores were 43.9 for physical health and 23.3 for mental health. The former mark dropped to 36.4

compared SF-36 outcomes on 21 depressed patients who had visited her twice within a year with a control group of 118 depressed patients who participated in an outcomes study conducted by Blue Cross and Blue Shield of Georgia. Of Bush's patients, 71.4% (or 15) had improved, only one had gotten worse, and 23.8% (or 5) showed no change, whereas only 42.3% of those in the Blue Cross study had improved, 17.9% got worse, and 39.8% stayed the same. (See table.)

"The SF-36 results let me feel more confident about my treatment decisions," Bush says. "Based on the functional measurements the survey provides, I can tell who needs more attention." For Bush, such data have been a key to improving practice efficiency because she can now schedule appointments knowing which patients will require the most time, and more quickly reach the correct diagnosis. "The biggest hidden cost of medicine is the under-functioning of good clinicians who suffer from professional burnout," she concludes. "They can't find a way to be supportive of their patients."

Beyond the Patient Encounter
Besides helping her to improve her patients' health significantly, the nearly five years' worth of aggregate data Bush has collected are a powerful economic leveraging tool when dealing with employers and insurers.

Bush helped the company with the disability problem, for example, by comparing data on depression, workplace injuries, and low back pain in its employees with reports from her other patients. The employees were experiencing a high level of stress, Bush found, and she's working with the company to determine what's causing the problem and to identify ways of making the

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Comparing SF-36 Outcomes (Percentage)

	Bush's patients (21)	Control (118)
Improved	71.4%	42.3%
Got worse	4.7	17.9
No change	23.8	39.8

Source: Atlanta Family Medicine, Atlanta, 1998

when her shoulder pain worsened. After surgery and treatment with antidepressants, her mental health score improved to 64.4 and her physical health score to 44.2.

By using the SF-36, Bush learned that one-third of her patients are at risk for significant clinical depression. Since many experts believe depression is widely undiagnosed, a sophisticated quality of life measurement instrument such as the SF-36 would identify many more cases of depression than would be possible in a practice that does not use such tools. Her medical training had prepared her for the extent of the problem in the overall population, but she was surprised by the types of patients who have a tendency toward depression. Without the survey, Bush says, making the diagnosis in some of them might have entailed several visits or extensive testing. She has found that questions 23 through 31 on the SF-36—which ask about energy, fatigue, and general emotional states—are reliable indicators of depression.

(Continued from page 5)

employees feel less stress at work. She believes the company's experience with the SF-36 may translate later into a value-based buying decision about insurance because the company now knows what it's getting for its health care dollar: improvements in employee health. Many employers have long been frustrated by the lack of data on the health status of workers.

When it came time for Bush to renew a contract with one HMO, SF-36 data showing the level of care and the extent of the services the plan's 700 participants required put her in a position to negotiate more favorable capitation and utilization rates. She used SF-36 results to prove to another HMO that treatment of depression was effective in its patient population. In that

depression are overlooked, and many patients are not treated long enough for it," he explains. "The science does not match practice. If every patient enrolled in our plan got an SF-36, I would certainly know a lot more about the population."

The Medical System

Despite positive assessments of the SF-36 from Hoffman and Bush, most physicians probably have not even heard of the survey, according to its principal investigator, John E. Ware Jr., PhD, director of the Health Assessment Laboratory at NEMC's Health Institute. A veteran of the Rand Institute, researchers in Santa Monica, Calif., with more than 30 years' experience in outcomes measurement, Ware believes the lack of

comes and measures," he says. "If they don't, the bean counters and managers will know more than the doctors know about medical practice—and that's a bad situation."

Ware also believes that Bush's use of a general health assessment tool for measuring outcomes puts her far ahead of her peers in terms of caring for patients. While the SF-36 may appear to lack sophistication and precision in this era of medical technology, training, and specialized care, the opposite actually is true. For physical functioning, the survey agrees with other clinical performance tests and, compared with a much more expensive and risky study, such as a treadmill test, Ware says, it gives a much clearer picture of daily functioning.

As further evidence of the SF-36's validity, Ware points out that its application is not limited to general or primary care practice. Orthopaedic surgeons, for example, have told him that the survey is useful for determining physical functioning, which is a necessity in their practice. In a cardiovascular practice, the SF-36 can be used to determine whether a patient's surgery can proceed on schedule.

The SF-36 also is a powerful tool for medical research, a point illustrated by a study led by Ware and published in 1996 ("Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems," *JAMA*, 1996; 276: 1039-1047). The report documents the survey's use in comparing physical health outcomes in HMO patients and in fee-for-service patients. Data collected with the SF-36 showed that, on average, nonelderly patients participating in HMOs fared better physically than did their counterparts who were covered by fee-for-service plans, whereas the reverse was true for elderly patients.

While using the SF-36 has helped her practice tremendously, Bush cautions that the SF-36 is by no means a panacea for a busy PCP. Because of continuing economic pressure, she has cut back to two examining rooms from four and is operating with just two staff people: a clerk and a medical assistant. When finances permit, she plans to hire a family nurse practitioner.

Perhaps the most important lesson Bush has learned by tracking the general health of her 4,000 patients is that physicians'

"The SF-36 results let me feel more confident about my treatment decisions. Based on the functional measurements the survey provides, I can tell who needs more attention."

—Dwana Bush, MD, Atlanta Family Medicine

case, she tracked 382 patients whose mental health scores were less than 60 points (out of a possible 100) on the survey. The scores of these patients, who had been under her care for more than a year, increased by an average of 20 points each.

Wayne Hoffman, MD, medical director of the HMO of Blue Cross and Blue Shield of Georgia, one of the HMOs whose members Bush has tracked, is a firm believer in the SF-36. He considers the survey a valid tool for screening a patient's ability to function on a daily basis. Similar tools, he says, measure only processes and are based solely on claims data and not on patients' self-reported data. "Other tools don't give results on how patients feel or how satisfied they are with their symptom complex," Hoffman says.

Outcomes studies show that stress, depression, and substance abuse are common in patients who have been to a PCP five times in a year or who have claims totaling more than \$5,000, Hoffman says. All three conditions would be readily apparent on the SF-36. "Lots of cases of

knowledge of the SF-36 among PCPs is unfortunate for several reasons. "The SF-36 reflects topics that good doctors have always talked about with their patients, and measuring and tracking the data add another dimension," he says. "Health care data should not be measured casually, and the SF-36 gives reproducible, measurable results, not just talk."

Substantial, useful data are important today because health plans increasingly are incorporating outcomes measurements into reimbursement schemes. In fact, as much as one-third of a physician's bonus under managed care may be based on his or her performance measured against quality criteria, according to Linda Peeno, MD, chair of the ethics committee at the University of Louisville Hospital in Louisville, Ky. But most quality evaluation systems measure processes in physicians' offices and not outcomes or health status.

Ware believes physicians should become familiar with tools such as the SF-36 even if they don't want to make their patients complete the surveys. "Doctors need to know out-

Understanding the SF-36 Health Survey

The SF-36 has its roots in hundreds of existing patient surveys, many of which have been in use for longer than 20 years. It was developed and validated by the Health Institute at the New England Medical Center, Boston, with support from the Henry J. Kaiser Family Foundation, in Menlo Park, Calif. The principal investigator, John E. Ware, Jr., PhD, director of the Health Assessment Laboratory at the Health Institute at the New England Medical Center, Boston, is a nationally recognized expert in outcomes measurement.

Released in 1988, the SF-36 is a comprehensive short-form with only 36 questions, which yields an eight-scale health profile as well as summary measures. The profile reflects function and dysfunction, distress and well-being, objective reports and subjective ratings, and both favorable and unfavorable self-evaluations of general health status. Well-known instruments on which the SF-36 is based include the Psychological General Well-Being survey developed by psychologist Harold Dupuy of the National Center for Health Statistics and the physical functioning

measures developed by Sydney Katz, MD, of Brown University in Providence, R.I.

The SF-36 can be self-administered, given via a computer, or administered by a trained interviewer in person or by telephone in only 5 to 10 minutes and it is suitable for use by people ages 14 and older.

Translated into 45 languages, the SF-36 has been administered successfully in general population surveys in the United States and other countries to both young and old patients. Published SF-36 data exist for more than 100 diseases or conditions, and results from the survey have been compared with more than 225 generic and disease-specific instruments. The tool has been used in research reports published by more than 500 researchers.

Next year, a shorter version of the SF-36, known as the SF-12, will be a part of the membership satisfaction survey of the National Committee for Quality Assurance (NCQA). Since 1991, the non-profit organization in Washington, D.C., has fully accredited 168 of the approximately 650 managed care plans in the country. A random sample of 2,000 mem-

bers from each of the plans accredited by the NCQA will receive the SF-36, according to the NCQA. Another version of the SF-36—the Health of Seniors Survey—is being used by the federal Health Care Financing Administration to survey Medicare patients about their satisfaction with managed care plans. HCFA recently hired a company to send the questionnaire to 1,000 Medicare enrollees chosen at random from among managed care plans.

In the past 10 years, the Medical Outcomes Trust in Boston, Mass., has received more than 20,000 requests for the SF-36 and more than 10,000 manuals have been distributed to a wide variety of health care providers. The 320-page *SF-36 Manual and Interpretation Guide* and a reproducible survey, which can be used royalty-free, are available from the trust for \$295. More than 20 vendors offer the scanner hardware and software necessary to score the questionnaire, at a cost of \$3,000 to \$5,000. For more detailed information on how to obtain and use the survey, visit the SF-36 Internet site at <http://www.sf36.com>.

—HAH

results, not their level of activity, are what should be rewarded by health care plans. “The right question to ask is ‘How many patients can my staff and I manage well?’ rather than ‘How many patients did I see today?’” she concludes.

And therein lies the real problem, according to Wetzler, the man who jump-started Bush on outcomes measurement. Now an outcomes consultant for the American Medical Group Association in Washington, D.C., he believes that the health care system is stacked against the use of an instrument such as the SF-36. Despite the survey’s demonstrated usefulness, he would be surprised if more than 20 physicians in the country are routinely and regularly using it for patient care.

“The bottom line is that what is paid for is doctor and hospital visits. The incentives are stacked against us,” Wetzler says. “If your goal

is to produce office visits, the SF-36 will hamper your practice. If your goal is to produce better health, it can play a critical role in that. I’ve analyzed Bush’s data and I’m convinced that the SF-36 is helping her to do a better job. Can I prove it? No. It all comes back to the real difficulty—the incentives.”

Another barrier that Wetzler sees to wider adoption of the SF-36 is, ironically, one of its strengths: the ability to use the survey to uncover mental health problems. PCPs may be reluctant to diagnose behavioral health conditions because of the social stigma that lingers and because of reimbursement constraints. In many managed care plans, reimbursement for mental health care is limited or available only on a carve-out basis, meaning the physician would need to refer the patient to another professional who would be paid to provide care while the PCP may get nothing. “With the SF-36, psychosocial

problems can be uncovered, but they can’t be dealt with in 15 or 20 minutes,” Wetzler says. “The incentives are to see patients on a conveyor belt, but they are not conducive to dealing with root issues.”

The final obstacle to use of the SF-36 is a technical one. Data from the survey can be reported in a variety of formats, but Wetzler says, the bar graphs that Bush uses are most appealing to physicians because they tend to be adept at pattern recognition. Touch-screen technology, introduced in 1995 and designed to be easier for patients to use, was more expensive and never caught on with physicians. There also is considerable variation in the mechanisms available from outside vendors to score the SF-36. As Wetzler warns, “The key is to look at the report produced for an individual patient and be sure that it makes sense to you.”

—Reported and written by Harriett A. Hiland, in Atlanta

New IPAs Aim to Accept More Risk

A new generation of independent practice associations is emerging—and thriving—under managed care. These IPAs are successfully functioning more like medical groups that accept risk than loose affiliations of physicians. Also, they aim to retain enough income to build information systems and to purchase administrative expertise, say proponents of this emerging model.

“We represent the next evolutionary step in IPAs,” says Michael Abel, MD, the CEO of Brown & Toland, a 2,000-member multi-specialty IPA in San Francisco. “We think of ourselves as an IPA-plus, functioning more like a large group practice.”

IPAs are defined by the federal Health Maintenance Organization Act of 1973 as confederations of individual physicians and group practices that negotiate capitated, or prepaid, contracts with payers for physician

director of the National IPA Coalition, also in Oakland, Calif., says NIPAC has found it difficult to determine an exact number because “so many different types of organizations call themselves IPAs, and so many are doing so little business it is problematic to even call them a functioning organization.” NIPAC has about 240 IPA members, of which about half are in California, and the rest are spread evenly throughout states in the Mid-Atlantic and Southeast. TIPAAA President Albert Holloway says his group has 500 IPA members in 28 states.

Dixon and others say many traditional IPAs are weak because their nonexclusive membership feature and lack of single-authority contracting mean they are too loosely structured to be attractive to payers. Historically they have lacked the financial resources to manage care successfully through the purchase of costly management

rather than physicians being reimbursed through an HMO, Dixon explains.

“New generation IPAs have to have the capacity to pass all billings and charges through their own management information system,” Dixon comments. “They have to be able to write checks for the care they manage. It means nothing if an IPA accepts risk but another entity is paying for the care it manages.” New IPAs control risk by retaining enough capital to develop medical management expertise, utilization controls, and shared information systems.

Brown & Toland, for example, serves as the provider network and contracts on a prepaid, risk-assuming basis with HMOs in California. It has retained enough cash to purchase an information system, allowing the IPA to integrate its physician network effectively, Abel says. “We operate as a virtual medical group with standardized protocols and reduced hospital utilization across the board,” he says. “That’s made possible by our investment in an information system that allows us to integrate nearly all of our members by linking our offices through the Internet. Our physicians maintain their own practices and clinical independence, but we are able to coordinate care and reduce costs through electronic integration.”

Its information system also allows Brown & Toland to manage a budget for the entire IPA and for its individual members, says Abel. “We set up operating budgets for all of our members, and everyone operates under those budgets,” he says. “Therefore, we can control our reimbursement costs and retain a surplus to reinvest in the IPA.” Brown & Toland has exclusive contracts with many of its PCPs, who are reimbursed principally through a modified fee-for-service system, adjusted for the age and sex of patients. “We hope to move our PCPs to capitation as soon as possible,” Abel says.

To enhance its ability to budget successfully, Brown & Toland has developed a “contact capitation reimbursement plan” with two types of specialists in its network, ophthalmologists and podiatrists. Under contact capitation, these physicians are paid based on the number of referrals they receive not

Physicians often enter into capitated contracts without fully understanding the risks of capitated pricing.

— Jeffrey P. King, attorney, Haynes and Boone

members, who in turn are usually compensated on a fee-for-service basis. IPA members remain individual practitioners and retain separate offices. Traditional IPAs have nonexclusive contracts with their members, which means their members are free to work for other HMOs. These IPAs also lack single-contract authority, so their members are free to accept or reject a specific contract if they believe reimbursement would be too low. That degree of autonomy is attractive to many physicians. In fact, the percentage of physicians affiliating with an IPA grew from 20% in 1990 to about 50% in 1996, according to the AMA’s *Socioeconomic Characteristics of Medical Practices 1997-98*. In 1996, about 11% of physician income came through an IPA affiliation, says the AMA.

The IPA Association of America (TIPAAA) in Oakland, Calif., estimates that about 4,000 IPAs are operating nationwide. But Richard Dixon, MD, medical

expertise and information technology.

“An IPA is inherently unwieldy because it is made up of a large number of independent physicians whose only commonality is contracting,” says Peter Kongstvedt, MD, a health care consultant and partner with Ernst & Young, health care consultants and accountants in Washington, D.C. Kongstvedt also is a member of the editorial Advisory Board of *Physician Practice Options*. “An IPA’s ability to preserve private practice also means an inability to leverage resources, achieve economies of scale, or change physician behavior,” he says.

Risk Without Control

The new, emerging IPAs have the ability to accept financial risk and control that risk. “Taking risk without being able to control risk is the way too many IPAs have done business for too long,” Dixon says. The most important element of the new model of IPA is the capacity to pay its physician members,

Pitfalls to Avoid When Forming an IPA

Forming an IPA raises legal issues and failing to resolve these issues can jeopardize the IPA's success, says Jeffrey P. King, a partner in the health care section at Haynes and Boone, a law firm in Dallas.

Antitrust. Since practitioners participating in IPAs are competitors, they are prohibited from engaging in what could broadly be described as anticompetitive behavior. Defining anticompetitive behavior involves a detailed assessment of the IPA's activities. Such activities as price fixing, group boycotts, and division of markets are deemed to be violations of antitrust laws.

Licensure and choice of entity. Many states have laws forbidding the corporate practice of medicine, making it unlawful for an entity that is not owned by physicians to render medical care. They also prohibit persons who are not physicians from employing physicians to provide medical care to the public for a fee.

Remuneration. Federal and state laws prohibit the payment of compensation for health care referrals. Any arrangement to refer patients to other physicians within an organization must be analyzed in connection with broadly written federal and state prohibitions to determine if an exception applies.

Self-referral. Federal laws, known as Stark I and Stark II, prohibit physicians from referring Medicaid or Medicare patients to entities with which physi-

cians have financial relationships for the provision of designated health services. There are exceptions, however. If an IPA is formed with the involvement of other health care organizations, perhaps in conjunction with the formation of a physician-hospital organization, it is necessary to determine whether Stark laws apply and if an exemption is available.

HMO regulations. If an IPA offers services on a capitated or other prepaid basis, its activities must be analyzed under state insurance regulations and statutes regulating HMOs. If the organization is deemed to be an insurer or an HMO, regulatory requirements will be imposed. A state insurance code or HMO act may include an any-willing-provider statute that requires an HMO to permit any provider within its service area to participate if the provider wishes to participate and is willing to meet the insurer's terms.

Utilization review. A state insurance code may regulate utilization reviewers by imposing significant burdens on their operation, including appeal procedures, standards for personnel, and physician supervision. A utilization reviewer, for example, might be defined as an entity that conducts utilization review for employers having employees covered under a health benefit plan or a health insurance policy.

Securities laws. Under federal and state laws, securities offerings are general-

ly subject to registration and disclosure requirements. Promoters of IPAs and other entities should therefore consider financial interests in the entity to be securities subject to registration and disclosure requirements, unless an exemption is available. But even if an exemption from registration is available, disclosure often is required in order to avoid fraud liability.

Benefit plans. Laws applicable to benefit plans present thorny and often overlooked issues in IPA formation, King says. Under certain circumstances, these laws could consider an IPA an affiliated service group and require that the benefit plans of each member of the affiliated group comply with certain requirements or risk losing the tax-deductible nature of contributions to those plans.

Liability. Practitioners may be concerned that the assets and revenue of a practice could be at risk if a member of the group is sued for malpractice, King says. In general, an IPA is liable for the malpractice of its employees and independent contractors directed by it or under its control, but providers not involved in a malpractice incident should not have personal liability unless they contributed to the malpractice in question. Physicians who participate on utilization or peer review panels can expect to be the target of claims and may be held liable if found negligent.

—MS

on the number of times they see a patient. Each physician receives the same reimbursement whether he or she sees a patient once or 10 times. For other specialists, Brown & Toland maintains withholds and then reimburses them on a modified fee-for-service basis. Under the withhold, a percentage of reimbursement is held back and paid if the specialists meet utilization targets.

Since this new model of IPA is designed to link clinical autonomy with utilization control, it is attractive to physicians. "Physicians today are forming all kinds of organizations," Dixon says, "but in doing so, the question is whether they know what they're getting themselves into."

In fact, IPA formation is fraught with legal and financial risks, experts say. "It raises a number of legal issues," says Jeffrey P. King, a partner in the health care section of Haynes and Boone, a law firm in Dallas. "Physicians often contemplate forming IPAs and entering into capitated contracts without fully understanding or appreciating the risks of capitated pricing and appropriate ways of dealing with those risks," he says.

Among the issues that need to be addressed are those involving licensure, antitrust laws, self-referral, and regulations.

Some IPAs, such as the 2,700-member Rochester Community IPA in Rochester, N.Y., see financial opportunity in global cap-

itation, a reimbursement system that covers all medical expenses, including professional expenses and facility fees. RCIPA is also developing a self-insured health plan that it plans to sell to employers in the region.

"These moves will allow our members to gain control over their financial future," says Michael O'Connor, RCIPA's chief operating officer. "HMOs generally do not like to share in the profits that are possible to achieve by controlling facility fees," O'Connor explains. But if physicians contract for all professional expenses and facility fees, they will earn those profits.

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

In a New Book, Medical Director Sees Tremendous Opportunities for Physicians



Derek Van Amerongen, MD, is national medical director for Anthem Blue Cross Blue Shield, a managed care organization in Cincinnati. He is also the author of *Networks and the Future of Medical*

Practice, published in July by the Health Administration Press in Chicago. Formed from the mergers of health plans in four states, Anthem is the Blue Cross plan in Connecticut, Indiana, Kentucky, and Ohio. It has 5.5 million members and revenue of approximately \$8 billion. An obstetrician and gynecologist by training, Van Amerongen is responsible for Anthem's women's health initiative, transplant activities, and programs addressing depression, osteoporosis, heart disease, nutrition, and cancer. This interview was conducted by Richard L. Reece, editor-in-chief.

Q: Dr. Van Amerongen, you received an MS degree from the University of Wisconsin-Addison. How did that experience influence your career and prepare you for your current position?

A: I have been involved in administration management since I began my career. Early on, when I realized that there was only so much I could learn by reading and self-education, I enrolled in a program at the University of Wisconsin that would prepare me as a physician executive and give me the background I needed in health care administration.

I came to Anthem after about seven years at Johns Hopkins University, where I was on the faculty of the department of gynecology and obstetrics of the medical school and chief of ob-gyn for Johns Hopkins' managed care organization (MCO). Prior to that, I was a staff physician at an HMO in suburban Chicago for about seven years.

As I moved from a community setting to an academic inner-city setting to a health insurer, it became apparent to me the direction medical care was headed under the

influence of managed care. The traditional medical delivery system—which consists of the hospital at the center of the medical universe around which rotate the physicians and their office practices and the other ancillary providers in the community—was being remade.

In the new managed care model, the hospital is still at the center of the activity, but it is through the creation of integrated delivery systems. That model is not what the new paradigm of medical care demands. Every physician in the country has been affected by the recent changes in the health care system, and they all have doubts about their future autonomy in medical decision-making and what role they will play in 10 years. I see in these changes a tremendous opportunity for physicians to take control of the direction that the medical delivery system is going in and to dramatically increase their autonomy to a level of control that they have never before had in that system.

We're moving beyond the hospital-dominated model of care in a way that creates opportunities for physicians to develop large, efficient, competitive organizations that shift the emphasis of medical care to the physician provider side so that physicians are not at the mercy of hospitals and large health care organizations as they have

U.S. hospitals were run by physicians who made the management and business decisions as well as the medical decisions. After the war, probably because medical practice became so incredibly lucrative, physicians lost interest in that role.

The imperative now is for physicians to take back that control, not by excluding health care executives but rather by sitting next to them at the table so that physicians are also executives at large organizations and are actively involved in medical decision-making. As I point out in my book, in situations in which physicians have not participated in the important decisions that these organizations have made, the results have been less than satisfactory, if not downright disastrous.

Q: Your book expresses your extreme optimism about the future of physicians in the managed care environment. How do you explain this optimism?

A: A lot of my optimism has to do with the fundamental changes going on in medical care right now, which are overwhelming for many doctors. The example that I mention in my book concerns what happened in the early 1960s with the advent of Medicare and Medicaid. At that time, physicians looked at the changes Medicare would bring as causing an end to American

"We're in a time of tremendous change that presents opportunities for physicians much like the advent of Medicare did."

been for the last 50 years.

Q: Will physician networks, using management and business skills to operate outside of the hospital and contracting directly with payers, be the wave of the future?

A: Yes. And I would add that there's a tremendous need for physicians to become the leaders of these organizations.

I don't mean to cast aspersions on health care executives, but prior to World War II,

medicine. The levels of depression, frustration, and anxiety they were experiencing then were likely as high as what physicians are feeling today. Yet today, if we took Medicare away, most doctors—except those who don't treat many Medicare patients—would not be able to survive.

We're in a time of tremendous change that presents opportunities for physicians much like the advent of Medicare did.

Medicare, and later Medicaid, made it feasible for the first time for physicians to treat elderly and poor people, which was a huge step forward.

Managed care will soon be creating the opportunity for physicians to provide the same level of service that hospitals and big organizations are providing. One factor that can never be overlooked is that medical care is a service provided by a doctor to a patient. As managed care continues to be refined, physicians will be able to take off the shelf the various things a patient needs at various times. If, for example, the patient needs to go to the hospital, the doctor can send the patient to a hospital; if the patient needs outpatient care, the doctor can provide that service as well; the same will be true for diagnostic services, ancillary services, and so on. This new system will replace the traditional system in which physicians are linked to a hospital that defines how health care services are provided and essentially takes control once the patient gets there.

Q. *Are you saying that these seismic paradigm shifts, such as Medicare and managed care, have unintended positive consequences for physicians?*

A. Every change has positive and negative consequences. I'm sure there were physicians in the early 1960s who said, "There's no way I'm going to be an employee of the government. I quit." There are physicians today who say the same thing.

But I'm a firm believer in evolution as a positive force. In the early 1960s, we could not continue with a health care system in which the poor and the elderly had no medical care. Today, we're at another point in the evolution of health care in which we cannot perpetuate a system that is sucking up so much revenue and so many resources without imposing some type of organization and rationale upon it. Even with managed care, everyone is still making out quite well; the money is still there. The question is: How do we organize the use of the resources and the dollars in a more coherent fashion? And that is where physicians have a wonderful opportunity.

Q. *In your book, you criticize hospitals as being the center of health care, and you point out that hospitals operate under a defunct business model that carries substantial cost baggage. Would you comment on that?*

A. Basically, here is how I see physician-hospital organizations (PHOs) and the integrated delivery systems: In the early 1990s, the leaders of these organizations faced huge changes; everything was up for grabs. Suddenly, the issue was: How do we make medical care relevant to the patient rather than to the institution? One issue concerning medical care has always been whether it addresses the patients' needs or whether their needs are being made to fit the medical delivery system.

"Managed care will soon be creating the opportunity for physicians to provide the same level of service that hospitals and big organizations are providing."

When I was an ob-gyn resident, patients were in the hospital for four or five days. We did surgery on day one, and by day four or five they were ready to be discharged. At that point, our involvement with them—as well as our interest in them, quite frankly—dropped off. Certainly, we'd see them in a few weeks or months for follow-up, but essentially once they left the hospital, we were done with them.

But from the patients' standpoint, what is relevant to them is not just what happens during those five days but also six months or a year later. They ask: "Will I be able to go back to work? If I can't, what resources will I need to have at home? How will this affect my family?" All of these concerns are important life-long issues. And these issues underlie the current shift in the focus of health care.

So, executives in the hospital boardrooms of the early 1990s tried to figure out ways to jury-rig the system so that they could address more of these long-term patient-centered issues. Of course, when you have a hammer, everything looks like a nail, and if you have an institution made of bricks and mortar and filled with people, the answer is to make that institution bigger and to provide more services, which leads to a lot of hospital consolidation. But that strategy leads to systems that are grafted together without redesigning their mission—and that's where my criticism of integrated delivery systems comes in. So many resources are devoted to simply maintaining

the institution that attention is not paid to what the institution is supposed to be doing in the first place.

Any hospital system in just about any city in this country consists of three or four hospitals that have merged and yet the system still has three ob units, three ERs, and three cardiac units. The hard decisions involving this overlapping of services—which would be made if the system were being designed from scratch—are just not being made. Simply merging several organizations to

make one bigger organization does not bring about the changes that result in true progress.

Q. *Your book contains a diagram that shows how hospital-based organizations took off in 1992, peaked in 1996, are now in decline; in essence, it graphically depicts how these hospital-based systems haven't worked. Doesn't this situation rattle the hospitals that have acquired these physician practices and are losing \$100,000 per physician per year?*

A. I'm sure it has, and most hospitals are probably seriously rethinking that entire strategy. Simply because you buy a practice does not mean that the practice will continue to be profitable or that practitioners will continue to work at the same level of motivation that they had before their practices were purchased. For example, the University of Pennsylvania found a dramatic drop in the productivity of the physicians whose practices it purchased. It also found that the physicians with practices in distant suburbs weren't diverting all of their patients to the university's hospital but rather continued to send their patients to the local hospitals as they had done for years. Such a situation reflects the unrealistic expectation that simply buying practices is the solution. What is required is a fundamental change in philosophy, and that has not happened in many of these hospital organizations.

What's more, you need to have physicians in the forefront of these organizations. One of the major failings of managed care is

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the failure to get physicians to do what everybody else wants them to do. One of the principal causes of the financial difficulties of the large MCOs is their failure to control medical costs. And this results from the fact that it's not enough to say, "Here's a guideline on treating asthma that we're going to send to all of the doctors in our network," and then to assume that the physicians will read it, memorize it, and do everything it says. Physicians' behavior is far more complex than that.

Without an effective way to get at how physicians practice, the variation in practice can never be reduced, which is a major driver of the increased cost and the lack of improved outcomes. It's critical that physi-

for comfort? We do such analyses every day with everything we buy. Physicians need to understand that people do similar analyses when they buy health care and will be doing it more and more in the future. So we need to be comfortable with that concept and understand how the various factors involved interrelate.

Q. *Would you agree that the purpose of managed care is not to reduce physicians' salaries but rather to decrease variations and unnecessary care and to foster innovation and population health, but that most doctors don't quite agree that these ideas are what managed care is about?*

A. Yes, I would agree. But part of the problem is that managed care has made major changes in how health care is

the "P" stands for. Does it stand for "provider," that is, the hospital, or for "physician?" The basic concept is that organizations initiated, organized, managed, and led by physicians are the wave of the future.

Q. *You give in your book a list of what it takes to make physician-led organizations successful. Among those requirements are visionary physician leadership, a unity of purpose, and an awareness of the importance of service. Will those criteria make these organizations work for the betterment of American health?*

A. Absolutely. My point is that we need physicians at the forefront. We need them to be looking to the future and to understand how we can make changes that are positive for physicians and patients, as well as for the system. And we need to move the focus of health care out of the corridors of the hospital and into the community because that's really where the emphasis is. The focus needs to be on making our services attractive to people, on making them happy that they've selected a particular practice or health plan, which in turn will be accountable for their health care. We need to take responsibility for the outcomes and to address the needs that patients have, not just what we think their needs are.

Q. *A recurring phrase in your book is "thinking outside the box." Could we conclude by your explaining what you mean by that phrase?*

A. As physicians, from the day we start medical school, our entire frame of reference involves people coming to us. But to be a leader, to do something different and meaningful, we've got to break out of the frame of reference. We've got to ask, "What if I go to people, rather than wait for them to come to me? What if I am concerned not only about whether my patients leave the hospital alive in five days but also about how they are doing a year from now? And what if I'm concerned about my patient not just as a woman lying in a hospital bed, but also as an employee and a mother and someone who has hobbies and likes to be active? How does my care fit into the important aspects of her life?" In other words, to deliver the best care for our patients, it is necessary to think outside of the traditional framework and to empathize with our patients. After all, as doctors, that's what each of us would want if we were a patient. ■

"We cannot perpetuate a system that is sucking up so much revenue and so many resources without imposing some type of organization and rationale upon it."

cians instigate those kinds of changes because only then will other physicians be receptive to them. This situation, in fact, presents a wonderful opportunity for physicians. Many companies today are interested in hiring full-time physicians to advise them and to analyze medical care. In other words, they are seeking a doctor whose job would be to serve as an internal consultant on the medical care given to their employees.

Q. *You also focus in your book on the concept of "value," which you define as quality care plus quality service plus a reasonable price. I'm sure that's what value is in the eyes of corporations, but is that how physicians see it?*

A. No, they don't. And that is one of the philosophical changes that physicians have to go through, which won't be easy for them. As doctors, we're trained from day one that whatever we do is of value, that all care is good care, and that more care is better than less care. We need to understand that these ideas are not necessarily true, and that in fact there is a trade-off between service and price. We use value equations whenever we purchase anything.

When we buy a car, for example, we decide how much it is worth to us in both monetary and nonmonetary terms. Are we looking for basic transportation? for status?

paid for, and if money were not an element in this, managed care would probably be much easier for physicians to understand. With time, physicians will move beyond the money, reimbursement, and salary issues and begin to realize that managed care involves bigger issues than "how much am I going to be paid for doing a Pap smear?"

Q. *One issue high on the political horizon right now involves physician-sponsored organizations. What do you see as the future of PSOs?*

A. PSOs have not done very well. In fact, every week, I read about another PSO that is in the red and is closing down. However, that phenomenon is simply due to the fact that the concept behind PSOs is new to physicians. As they gain more experience with them and come to understand the subtleties behind them, physicians will find that PSOs present a tremendous opportunity for them. Ten years from now, we'll see how important organizations that are led by physicians have become to the delivery system.

Q. *But is there a danger that PSOs are simply an extension of hospital-sponsored networks?*

A. Absolutely, and that's why it is important to be careful about what

Factors That Make Practice Mergers Work

By Thomas M. Gorey, JD

Physicians across the country have found that there is strength in numbers. For this reason, one of the most popular practice management strategies today involves merging existing practices into a larger group. Last month, this column summarized some of the major findings from a case study of physician practice mergers conducted by Policy Planning Associates on behalf of the AMA and other medical societies. This column, the second article in the two-part series, looks at the remaining key findings from the study: office staff, strategic development, group culture, market response, group leadership, and merger partners.

Office Staff

Office staff face a formidable challenge in adapting to the changes brought on when two practices merge. Physician practice mergers typically create high levels of anxiety among office staff. In addition to being concerned about job security and loss of autonomy, staff may find it difficult to accept the consequences of a merger if they have not had a voice in decisions that affect them. The levels of concern and anxiety among staff often are directly related to the amount of communication that has taken place regarding the merger. For this reason, some physicians who are merging their practices take steps to ensure that staff are involved throughout the process.

Office managers and other staff may be assigned, for example, to work on committees charged with gathering information and resolving such operational issues as employee benefits, information systems, and personnel policies and procedures. Such committees can serve as a link between the physicians and the office staff and as a vehicle for building relationships among the staffs of the merging practices.

Many newly formed groups experience significant turnover in office staff in the year or so immediately following a merger.

Although it often is emotionally difficult for all involved when long-time employees leave a group, ultimately the departure of these individuals benefits the physicians by allowing them to hire staff who support and are comfortable working in a group practice environment.

Strategic Development

Mergers are works in progress that usually take years to accomplish. The formation of a merged entity is just the beginning of a long process of creating a medical group. Physicians who participate in practice mergers soon find their work does not end when the merger is completed.

Physicians sometimes are surprised at how long it takes after a merger for a new group to

formed groups sometimes are more willing to enter into collaborative contracting arrangements with hospitals, to take on risk-based contracting arrangements, or to form a management services organization (MSO).

Group Culture

The success of a merged practice hinges on its ability to create a new group culture.

Physical consolidation of practices may be the strongest force in building a group culture and in creating a psychological sense of being a single medical group. Physicians find it difficult to feel part of a unified group while they are physically housed in separate offices.

Physically merging practices, however, may be difficult when physicians own their office

Some hospitals perceive a physician practice merger as a threat, but others understand that if the new group makes the physicians stronger, the hospital will become stronger too.

gain a sense of identity. The “us and them” mentality that sometimes arises when two or more groups merge dissipates over time as new physicians and staff join the group. One of the groups we studied said it took 10 years for a new identity to fully emerge.

The merging of practices is an educational process for physicians that makes them more aware of the business side of medicine. Consequently, physicians involved in mergers sometimes experience a change in perspective. They become more aware of and open to the possibility of other potential strategic alliances.

After having learned the lesson of “strength in numbers,” some new groups are anxious to take it a step further, by exploring strategic alliances with physicians in other specialties or in other geographic areas. As a result of their new market strength, newly

buildings or have long-term leases. When groups cannot physically consolidate their practices, they usually work to build group identity and culture through such simple steps as designing new signs and stationery, publishing a group newsletter, and holding frequent physician and staff meetings.

Creating a group culture, however, takes a long time—even when the physicians are housed in one office building. For this reason, it is important that new groups address group culture issues actively and continually. Creating an active committee structure provides opportunities for physicians to interact with new partners, and implementing uniform policies and procedures makes it easier for them to provide cross coverage by moving from one practice site to another.

Market Response

Such mergers can produce varying reactions from other players in the market—including physicians, hospitals, and payers. Many times, health plans will welcome practice

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Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development.

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mergers because they simplify contracting issues and offer the potential for broader geographic coverage.

The widest range of reactions often comes from local hospitals: from strong support to vehement opposition. While some hospitals perceive a physician practice merger as a threat, others are more pragmatic and understand that if the new group makes the physicians stronger, the hospital will become stronger too.

Similarly, the reactions of physicians in the community who are outside the merger

group formed. In at least two of the groups we studied, a nonphysician administrator with experience in a group practice environment in another market played a lead role in moving merger discussions forward.

Unfortunately, physicians who play lead roles in practice mergers often find themselves overwhelmed with administrative responsibilities once the group is formed. Many physicians involved in mergers assume that the newly formed group will reduce the hassles of running a medical office, thereby allowing them to concentrate fully on providing medical care. To the

ions on the involvement of nonphysician investors—in those instances in which the medical group elected to organize a separate management company. One group has benefited from its financial link to a major health system, but this link is viewed negatively by some of the physicians it has tried to recruit. Another group took the opposite stance, deciding not to seek a hospital or an HMO as a financial partner because of a desire to remain independent.

Yet another group advised that physicians need partners with similar goals and interests and cautioned that nonphysician partners, such as hospitals, might have different goals. One group had considered an asset merger with a hospital but decided that the cultures and strategic focus of the two organizations were quite different.

The financial benefits of having a nonphysician capital partner, however, are evident. Building the administrative infrastructure for a medical group can require a substantial amount of capital. Absent a financial partner, physicians contemplating a practice merger need to develop a realistic plan for capital development that will enable them to hire experienced administrative staff, implement a sophisticated information system, and acquire adequate, professional office space.

Like all practice options, group practice is not for all physicians. Nonetheless, many of those who decide to merge will find considerable benefits can result. Paying careful attention to what can be learned from physicians who have merged can be an important step in making the merger and postmerger process as painless as possible.

One group believes that if it had developed financial ties to a third party, its contracting freedom would have been compromised.

also vary. Soon after its merger was consummated, one practice found itself competing with another physician group in recruiting primary care physicians. Another group encountered difficulties with other physicians in its community because of the group's strategic decision to limit the number of physicians participating in the merger.

Because of the strong potential for opposition to a merger—from physicians, office staff, hospitals, and professional advisers—some groups recommended that physicians keep merger plans confidential.

Group Leadership

Strong physician leaders are needed to merge physician practices successfully and, once a new group is in place, a new generation of leaders must be groomed to assume leadership responsibilities. Visionary physician leadership is needed to build a strong medical group. Since many physicians tend to resist change, especially when there is no outside threat, it is important to have strong physician leaders who can articulate the opportunities available from a merger. One of the important roles physician leaders play in the early stages of merger discussions is to convince colleagues that while they may have busy, successful practices, there nevertheless are good reasons to merge.

In addition to the important role physician leaders play, nonphysician leaders can sometimes be instrumental in getting a new

contrary, new groups require a substantial amount of physician time.

A common problem in new groups is the reluctance of other physicians in the group to assume leadership positions. New leaders are needed to relieve the physicians who did the intensive work of forming the new group and to assume additional responsibilities, such as forming an MSO, which require ongoing physician oversight.

To meet this need, some groups have begun to create leadership tracks to groom new physicians to take over some of the leadership responsibilities. Other groups are struggling to convince their members of the value of administrative work.

Merger Partners

It is important that physicians choose their partners carefully. The groups in this study used a number of criteria to select physician partners. Most often, new partners were physicians whom the merging physicians knew from previous work or from residency training. The clinical reputation of physicians in the community also was mentioned frequently as an important factor.

A key factor in selecting prospective members is "cultural fit." Successful groups include like-minded physicians with a shared commitment to the group's goals and a common understanding of what it will take for a merged practice to succeed.

The groups in the study had strong opin-

Editor's note: The report, *Case Study Analysis of Physician Practice Mergers*, was sponsored by the AMA, the American Academy of Dermatology, the American Academy of Pediatrics, the American College of Radiology, the American Society of Plastic and Reconstructive Surgeons, the Michigan State Medical Society, and the South Carolina Medical Association. To obtain a copy, readers can call Kristen Sabec at the Michigan State Medical Society at 517/336-5769. The cost is \$25 for physician members of one of the sponsoring medical societies and \$95 for nonmembers.

Market Needs Second-generation PPMCs

By W.L. Douglas Townsend Jr.

Criticizing physician practice management companies has become easy. This year, PPMCs have reported falling share prices and drastically lower earnings compared to previous years' earnings, and one PPMC even filed for bankruptcy. Such events have cast a large shadow over the industry's prospects for growth.

The sad irony in this turn of events is that to remain competitive, physician groups need—now more than ever—partners with business acumen and capital. We are, in fact, in the midst of a “classic market dislocation,” in which demand, measured by physicians' partnering needs, is totally outstripping supply, which is the ability of PPMCs to satisfy this need. It is likely that a second-generation of PPMCs that focuses on physician practice operations will surface to take advantage of this need. But if such a model is not developed soon, independent physician groups as we know them may cease to exist.

Changing Valuations

Already PPMCs are moving away from an acquisition focus and toward an operational focus. This shift is evident in the changes we have seen in the way PPMCs arrive at the purchase price for a clinic. Historically, PPMCs have paid a clinic a multiple of their first-year management fee. That fee was typically defined as 15% of the clinic's pre-distribution pool, which is clinic revenue minus expenses and excluding physician compensation. Often, this purchase price would offset the compensation physicians gave up to affiliate with the PPMC.

But lately we have seen PPMCs reduce their purchase prices for clinics. Although many also are lowering their management fees, the new purchase prices don't always cover the compensation the physicians must give up. As a result, the pressure is on PPMCs to prove that they can increase the predistribution pool at a higher rate than the physicians could attain independently. In

other words, the emphasis on value is shifting toward what a PPMC can do after it affiliates with a clinic and away from the amount of money it can pay a clinic up front. Since

PPMCs seems to be moving sideways, at least for now. PhyCor, in Nashville, announced that it was taking a \$92 million one-time charge in the third quarter, lower-

If a second-generation practice management company is not developed soon, independent physician groups as we know them may cease to exist.

purchase prices are declining, PPMCs must show that they can add value to a clinic's operation to “make up” for the value they are subtracting by paying a lower purchase price.

A Mature Industry?

Many physicians may be wondering whether the PPMC industry is in its twilight. While the pressure is on PPMCs, the industry is not about to collapse. It is, rather, in a state of purgatory awaiting final judgment. When a PPMC finds a way to deliver services that unquestionably allows affiliated physician groups to be competitive in their markets, we will see the resurgence of the industry.

Meanwhile, investors are rightfully skeptical about the ability of current PPMCs to deliver such services and are unlikely to provide capital on a promise to do so. Nor are physicians in independent groups—which will drive future growth—likely to step into such relationships based solely on a promise.

This predicament could be called a “PPMC riptide,” in which PPMCs are caught in swirling waters, uncertain of their ability to swim to the safe shoreline of investor and physician confidence. Most lifeguards advise that when you are caught in a riptide, the best way to swim to safety is to swim sideways, or parallel to the shore. Given the growth in PPMCs in recent years, proceeding sideways is not necessarily a direction public PPMCs have found necessary to try in the past.

Already, however, one of the largest

ing its third-quarter earnings, and lowering earnings growth expectations for 1999. Moreover, it doesn't expect to acquire any physician groups next year. Despite losing significant growth from acquisitions, PhyCor says it will achieve 15% growth in earnings next year, mostly by focusing on the operations of its affiliated physicians and its IPA activities.

While this step and other previous news have had a negative effect on PhyCor's stock, focusing on acquisitions may be the only way to drive its future growth. The stock was trading at \$5.25 on Oct. 19, down from \$32.88 on Oct. 22 of last year.

Looking Ahead

The current turmoil among PPMCs raises the question: What strategic alternatives are now available to independent physician groups? Since we hear this question so often from physicians, we have concluded that the management and operational needs of these groups are substantial and growing. At the same time, our experience has taught us that most physicians are fiercely independent by nature and are unlikely, given the negative publicity, to enter a 40-year arrangement with a PPMC unless there is tangible evidence that the PPMC has significant expertise in managing physician practices.

If PPMCs are unable to create the true operating expertise required to make groups competitive, independent medical groups

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Over time, a lack of growth will cause the physician delivery system to move toward an employment model, and the most likely employer would be hospitals.

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as we know them will slowly disappear. If such groups are unable to remain competitive in their markets, their growth and recruitment of new physicians will cease. Over time, this stagnation will cause the physician delivery system to move toward an employment model, and the most likely employer would be hospitals. Many physicians over 40 years of age readily admit that young physicians coming out of medical school today are content under employment arrangements. If independent medical groups, including those affiliated with PPMCs, are unable to remain a viable practice alternative for new physicians, it is likely that the balance of local market physician control will shift toward hospitals.

The physicians who have long held that PPMCs are a foolish idea may indeed be correct. However, those who believe capital- and management-starved physician groups will survive in the long term may be equally guilty of foolish thought.

Editor's note: This article was adapted from Townsend's presentation at the National Physician Practice and Practice Management Symposium in New York, in September. Readers may view the accompanying slide presentation on the Internet at <http://www.townsend-frew.com/>.

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