

# PHYSICIAN PRACTICE OPTIONS™

November 15, 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Lack of Funds, Poor Timing Help Explain the Failure of a Physician-run Health Plan

By forming their own health plans, physicians have been launching what one consultant calls a "hostile takeover" of health care. Like many new businesses, some of these ventures have been unsuccessful, and one of the most prominent examples of failure is California Advantage.

The California Medical Association (CMA) started Cal Advantage two years ago as a physician-run and physician-owned point-of-service (POS) plan that aimed to give physicians a haven from managed care and allowed patients to get care directed by physicians. Beset by problems from the outset, the plan filed for bankruptcy in June and closed. It is, however, honoring any outstanding contracts through termination. While the physicians involved say they will not start another venture like this one anytime soon, they believe nonetheless that the endeavor was worthwhile despite the failure. In the time since it closed, those involved have had a chance to reflect on the failure and say that what happened offers important lessons for any physician-run health plan.

### Factors in Failure

"What is most ironic about Cal Advantage is that it demonstrated that the idea behind it is sound," says Jack Lewin, MD, executive vice president of the CMA in San Francisco. "In many ways, Cal Advantage was going right when we closed it. So now we ask why."

Among the many reasons for the plan's failure, the most striking are these five:

1. The plan lacked sufficient capital.

2. The plan was overly ambitious.

3. The organizers did not ask for enough money from investors.

4. The plan could not meet the state's solvency test.

5. The CMA board was unwilling to relinquish control when investors wanted more say in governance before giving more money.

In addition to these five factors, the plan also attracted a mix of patients who were sicker and more costly than those of most other health plans. Critics say it overpaid its physicians, and it was the victim of bad timing because it opened when health insurance rates were dropping (see sidebar).

*The plan lacked sufficient capital.* "Cal Advantage was undercapitalized from the beginning," says Lewin. "It shouldn't have been rolled out until there was at least twice as much capital. It started out in January 1996 with \$7 million. It really needed \$15 million or more for a state as big as California. Another alternative would have been to roll it out in a small region with the amount of money we had raised. Politically speaking however, that was not an option for us because the board members and the stockholders were widely distributed across the state. The board acted on faith that it would get the additional capital over the next two years. In fact, three out of four CMA members told us, 'Don't worry; we'll put our money in. As soon as you prove it's viable.' In retrospect, that was an absurd proposition."

*The plan was overly ambitious.* "If we had started the company say, in Los Angeles

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## Physicians' Interest in Salaries Never Wanes

On our toll-free telephone line, I periodically get questions about salaries such as the following:

- "I'm a salaried internist with five years of experience. My contract is coming up for renewal, and I want to renegotiate. What salary should I aim for?"
- "I'm an obstetrician with 20 years of experience and have decided to become a hospital employee. What salary should I expect?"

For answers to questions about salaries, I recommend "The Physician Starting Salary Survey," compiled by the Health Care Group, consultants in Conshohocken, Pa. This 153-page report, which provides details on more than 1,000 physicians hired since 1994, is arranged by specialty and describes each participant's base salary plus bonus for years one, two, and three. It also describes co-ownership arrangements; whether a restrictive covenant is in place; the state in which the practice is located; and whether it's a rural, suburban, or urban setting. For more information or to order the survey, write to or call Advisory Publications, 15 East Ridge Pike, Suite 510, Conshohocken, PA, 19428, 610/941-4488. The price is \$165.

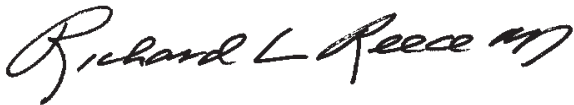
Salary information for more experienced physicians can be found in *The Business of Medicine*, a 387-page book edited by Julie K. Silver, MD, a practicing physician who also is a member of the faculty of the Harvard Medical School. The book shows, for example, the median salaries of invasive cardiologists as follows: those with less than two years of experience earn \$241,465; with three to seven years—\$344,919; with eight to 17 years—\$385,707; and with more than 18 years—\$380,361. Family practice physicians without obstetrics and gynecology have a median salary of \$110,312 in the first two years; \$123,500 in years three to seven; \$137,922 in years eight to 17; and \$135,688 after more than 18 years.

This book also contains information on running a solo practice, organizational options, compensation arrangements, practice marketing, opportunities in alternative and complementary medicine, business and management for physicians, and personal financial planning. To order the book, write to or call the publisher, Hanley & Belfus, 210 S. 13th St., Philadelphia, PA 19107, 800/962-1892 or send a fax to 215/790-9330. The price is \$25.

I also get questions from callers about physician recruiters. Typically, readers ask where they can find physician recruiters who will tell them what parts of the country need specialists like them. To answer such questions, I have collected the names and phone numbers of firms that specialize in recruiting entry-level and experienced practicing physicians and physician executives. Interested readers are invited to call me on our toll-free number, and I will send by fax a list of names and phone numbers of recruiting firms.

### Introducing a New Column

In this issue, our new column, "Organizational Options," begins on page 13. In this column, Thomas M. Gorey, JD, will write about how physicians organize their practices. Since Gorey has done four reports on physicians' organizational options, his work complements that of our newsletter nicely. In addition, Gorey has joined our editorial Advisory Board. We look forward to a long and successful collaboration.



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*Physician Practice Options* is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

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Subscription Price: \$299, 12 issues  
Issue Price: \$25 each

# Questions Surround Alternative Medicine

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

The use of complementary and alternative medicine (CAM) is growing rapidly. So is the controversy about the effectiveness and safety of some practices associated with CAM.

Many physicians offer CAM therapies, such as acupuncture, chiropractic manipulation, biofeedback, and herbal medicine, along with traditional treatments, according to the federal Office of Alternative Medicine (OAM), a division of the Institutes of Health, in Bethesda, Md. As CAM therapies become more popular, HMOs are starting to pay for them and many medical schools have started teaching them as well. But some medical experts say that the use of CAM is unsafe, arguing that most of the treatments—especially the use of herbal medicines—are untested and could be deadly.

Even so, CAM is a big and growing business. In 1993, about one in three Americans used CAM therapies, according to OAM estimates. "The Landmark Report on Public Perceptions of Alternative Care," a study by Landmark Healthcare Inc., a company in Sacramento, Calif., that specializes in providing alternative medicine, shows that in 1997, 42% of all Americans had used some form of alternative treatment.

Americans spend at least \$14 billion annually on CAM, according to a widely cited 1992 study by the Harvard Medical School that was reported in an article, "Unconventional Medicine in the United States" in the Jan. 28, 1993, issue of the *New England Journal of Medicine*. The study is the most complete conducted to date of spending on CAM. Since then, estimates of the amount spent on alternative medicine have reached as high as \$20 billion in 1997, according to *The Boston Globe*.

## Testing Needed

Nearly 20% of all physicians use some form of CAM—mostly relaxation techniques and nutritional therapy—and more than 80% refer patients to other practitioners for these treatments, mostly chiropractic and relaxation therapy, according to the OAM.

Yet, the use of CAM worries some physicians. "What most sets alternative medicine apart, in our view, is that it has not been scientifically tested and its advocates largely deny the need for such testing," wrote Marcia Angell, MD, NEJM's executive editor, in an editorial on Sept. 17. "Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatment."

Wallace Sampson, MD, is also highly skeptical of the effectiveness of CAM treatments and questions the morality of using untested therapies. Sampson, 68, is a retired internist in Los Altos, Calif., and chairman of the National Council Against Health Fraud, in Loma Linda, Calif., a nonprofit agency of about 1,500 health professionals, educators, researchers, and attorneys. The

traditional therapies, proponents argue. A report, "Why Patients Use Alternative Medicine," in the May 20 issue of JAMA, states that most people who use CAM do so because the treatments fit with their "values, world view, or beliefs regarding the nature and meaning of health and illness"—not because of a dissatisfaction with conventional treatments. The 1992 Harvard study states that more than 80% of the people who use CAM also use conventional medicine, and the Landmark study states that 74% of people who used CAM did so in conjunction with traditional care.

"There is no such thing as a single, complete system of medicine that cures all conditions and diseases," says Rob Gleser, MD, 52, an internist in Denver, who owns

**"Traditional and alternative care complement each other. Using both systems allows us to help more people, and allows me to feel like more of a healer than I ever had before in my career."**

**—Rob Gleser, MD, HealthMark Inc.**

council denounces what its members perceive as health care fraud, misinformation, and quackery, including many forms of alternative medicine.

"Our purpose is to provide objective information on the value, or lack of value, of many these alternative treatments," Sampson says. "People believe what they read in the newspapers and physicians accept what they read in journals much too easily, and most of what is published about alternative medicine is written by people with something to gain from selling these so-called therapies. The truth is there's a lack of readily available, reliable information about the efficacy of these treatments. It's unethical to provide unproven treatments."

Proponents of CAM call the NEJM editorial and Sampson's views shortsighted, even ignorant. Patients believe CAM is effective, especially when it complements

HealthMark Inc., a clinic offering traditional and alternative care. "Traditional and alternative care complement each other. Using both systems allows us to help more people, and allows me to feel like more of a healer than I ever had before in my career." Many forms of CAM have been shown to be effective with Gleser's patients, especially chiropractic care and nutritional and massage therapy, he says. About half of HealthMark's patients are treated with some form of alternative treatment. The practice includes three physicians, a physical therapist, a nutritionist, a psychologist, and two massage therapists. The primary benefit of offering alternative treatments is "watching people with chronic conditions, such as cluster headaches and allergies, respond to alternative medicine after traditional medicine has failed them completely," Gleser says.

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The 1992 Harvard study motivated Gleser to practice alternative medicine. "It drove many of us to look at alternative treatment differently and with more acceptance," he says. "It showed that people wanted and accepted these kinds of medical care."

But others, such as Sampson of the anti-fraud council, say the effect of the Harvard study has been pervasive and harmful. "The result of that study has been that many unproven types of care are being treated as though they have been well established," Sampson says. "Medical schools are reacting to popular demand, not to science." He claims that the creation of the OAM in 1992 is an example of mainstream acceptance of unproven therapies.

Some members of the medical community dismiss alternative medicine out of ignorance and fear, Gleser says, and many of his peers regard his work with skepticism. "I talk with a lot of physicians who are critical of what we do," Gleser says. "What it comes down to is fear of change. They don't want their belief system challenged, and a lot of what we do is contrary to what is taught in medical school. But integrating our practice with alternative medicine allows us to practice as more effective physicians. And I believe we make a better income than if we were concentrating only on traditional care."

#### Managed Care Acceptance

In a November 1996 report, "Health Maintenance Organizations and Alternative Medicine: A Closer Look," Landmark said that 70% of the 100 HMOs it surveyed reported an increase in requests for alternative care therapies from plan members. The three most popular treatments were acupuncture, chiropractic, and massage therapy. In response to this consumer interest, 58% of the HMOs surveyed said they would start covering acupuncture and chiropractic treatment.

Landmark primarily manages chiropractic care, and its business is growing. It has 3.5 million members nationwide, and recently signed contracts to manage such care for HealthCarePlan (HCP) in Buffalo, N.Y., and Prepaid Health Plan (PHP) of Syracuse, N.Y. Landmark CEO Marla Orth says HCP and PHP were complying with a state law requiring all health plans licensed in New York to offer chiropractic by Jan. 1,

1998. "Consumers are demanding more benefits options," says John Walker, HCP's associate director for business development. "The Landmark contract reflects our interest in providing these options."

Oxford Health Plans, in Norwalk, Conn., began an alternative medicine program in January 1997 when it established a credentialed network of acupuncturists, chiropractors, massage therapists, nutritionists, naturopathic physicians, and yoga instructors. Oxford has 1.9 million members in Connecticut, New Hampshire, New Jersey,

es," says Bill Jenkins, president of Aurora's alternative delivery and community programs unit.

The HealthEast Healing Center in St. Paul, Minn., an alternative treatment clinic owned by HealthEast, a health care system in St. Paul, has had what medical director Christopher Foley, MD, calls an astounding response from the public. The year-old clinic was created in response to patient demand. "We thought it would take two years to recoup the initial investment, but already we're almost there," Foley says.

**"We feel that our members should choose their own path to wellness. That means providing choice in the type of care our members receive, even nontraditional therapies."**

**— David B. Snow Jr., Oxford Health Plans**

New York, and Pennsylvania. Before being admitted into Oxford's alternative medicine network, providers are reviewed by advisory boards of practitioners in their specialties. They also must meet state licensing requirements, receive specialty certification where applicable, and commit to continuing education in their discipline.

Oxford's program was a marketing decision, company officials say. It resulted from a 1995 Oxford survey showing that 75% of its members were interested in obtaining alternative care, that 33% had used some form of alternative care in the previous two years, and that 85% of benefits administrators were interested in offering coverage of alternative medicine. "We feel that our members should choose their own path to wellness," says David B. Snow Jr., Oxford's executive vice president of marketing. "That means providing choice in the type of care our members receive, even nontraditional therapies."

Like managed care plans, health care systems are also developing alternative care programs. In Milwaukee, Aurora Health Care, the largest health care system in Wisconsin, began opening alternative medicine clinics in 1996. "We're currently reviewing all of our operations for ways to expand beyond Western medical approach-

Some health care systems specialize in delivering alternative care and hire traditional physicians to run these programs. Complete Wellness Inc., in Washington, D.C., had \$8.8 million in revenue last year, an increase of almost sixfold from its revenue of \$1.5 million in 1996. Complete Wellness manages more than 100 clinics nationwide, all of which offer traditional medicine and alternative care, including chiropractic. The company owns eight integrated medical centers in Florida, Illinois, and Virginia that offer traditional and alternative treatments in one setting.

Enough physicians are considering alternative treatment as a practice opportunity that more than 30 medical schools offer courses in alternative medicine, says Aurora's Jenkins.

But NEJM's Angell says physicians should move cautiously in adopting CAM. "It is time for the scientific community to stop giving alternative medicine a free ride," Angell wrote. "There cannot be two kinds of medicine—conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work."

—Additional reporting and writing by Martin Sipkoff, in Gettysburg, Pa.

(Continued from page 1)

County, and had gotten it to viability, we would have gotten the other \$7 million or \$10 million, because the physicians would have seen the viability and they would have said, 'Do it in my county,'" says Lewin. "So, the hindsight is great.

"We have a lot of respect for those who have succeeded in the health insurance business," Lewin adds. "It wasn't as tough 10 years ago to start out. And it would be a lot more viable if you tried this same idea, say, in the Northeast, where global capitation rates can go up to \$150 per member per month (PMPM) compared with California at \$70 PMPM. That's a big difference, and Cal Advantage was working at that \$70 level."

*The organizers didn't ask for enough money from investors.* More than 30,000 physicians were on the panel of Cal Advantage, but only 7,000 made the requested \$1,000 investment. Lewin acknowledges that they weren't asked to give enough. "A painful bit of hindsight for us is the fact that of the 7,000 physicians who did contribute, most would have given \$2,000, or even \$3,000. So, if we had asked for \$2,000 from that pool of stockholders, the company would still be going, with \$5 million in reserves right now."

*The plan could not meet the state's solvency test.* Cal Advantage had approximately 10,000 enrollees, which was less than 10% of the California market. But in April, Cal Advantage (along with the California Hispanic Health Care Association) won state contracts to provide care for 180,000 uninsured children in 31 of California's 58 counties. This program was to begin on July 1. Cal Advantage closed on June 1. The reason: The plan did not meet the state's solvency test. "It needed to have \$3 million in reserves, and, frankly, it was not able to demonstrate that," notes Lewin. Cal Advantage had spent the initial \$7 million from investors and then borrowed \$3 million. At the time of the reserves test, the plan had only \$2 million.

*The CMA board was unwilling to relinquish control.* When the solvency test was being conducted, CMA was negotiating with other physician-owned companies as potential partners. CMA decided to work with the Doctor's Co., a physician-run IPA in Napa, Calif., which earlier had contributed \$500,000 in loans. But, says Lewin, "the Doctor's Co. told us at the last minute that it wanted to have a controlling amount of stock. Now, it was not investing, it was making a loan, and it wanted control of the company to even issue the loan. That was unacceptable to our board for three reasons: The first is called Blue Cross of California. The second is Blue Shield of California. The third is Foundation Health Plan. All three plans were undercapitalized and had to give up controlling interest to other entities to stay afloat. The Doctor's Co. was willing to come in if it could get enough stock options to assure its investment," Lewin adds. "I have no hostility toward the company; it was at least willing to play. From its point of view, it needed to have more of a controlling interest, but that ran into the barrier of our board's initial commitment of never giving up controlling interest. So we quit this company at a time of its most likely viability and success, for a matter of principle."

#### Management Problems

Matters of principle and capital aside, Cal Advantage had other problems as well. The plan had three CEOs in three years, leading many in the state to question the company's ability to honor its commitments. "Each time a new CEO came in, there was turbulence and a lack of confidence in the market," says Jim Hall, president of HCM Benefits, in Torrance, Calif. As one of CMA's marketing partners for Cal Advantage, HCM was the general agent that promoted and marketed Cal Advantage to the state's insurance distribution system.

Lewin acknowledges that Cal Advantage

## The Short, Eventful History of California Advantage

Early 1995

The California Medical Association raises \$7 million for California Advantage by selling shares at \$1,000 per share to physician members.

October 1995

John Gray is hired as Cal Advantage CEO

January 1996

Statewide enrollment begins

March 1997

John Gray leaves Cal Advantage; John Ramey is hired as new CEO.

October 1997

John Ramey leaves Cal Advantage; Kenneth Reuter is hired as new CEO.

April 1998

Cal Advantage wins state contract to cover 180,000 lives with California Hispanic Health Care Association.

June 1998

Lacking \$3 million in reserves, Cal Advantage fails to meet the state's solvency test, files for bankruptcy protection, and closes its doors.

did have its share of management problems and made mistakes. But he maintains that they were the type of mistakes that any

(Continued on page 6)



**"If it [Cal Advantage] could have gotten the message out now—to take advantage of the current backlash against managed care—where people would see a physician-owned, physician-friendly company, it certainly would have a place in the market now."**

**—Jim Hall, HCM Benefits**

(Continued from page 5)

newly formed health plan would make. "Due to the undercapitalization, we didn't have the ability to carefully roll out," Lewin explains. "But we were also attracting bad risk at the beginning, so we had to change management simply because the initial

favorable now for physician-run health plans. "If it could have gotten the message out now—to take advantage of the current backlash against managed care—where people would see a physician-owned, physician-friendly company, it certainly would



**"You had what was basically an anti-managed care organization of physicians trying to compete in a highly evolving managed care marketplace."**

**—Larry Keller, Healthcare Resource Associates**

management wasn't managing the patient care well. But that was in the first year.

"By the time we closed the program, Cal Advantage was paying its physician claims faster than any HMO in California," Lewin says. "The patients in the program were happy with the care. The physicians and brokers in the state felt it was the most attractive new plan in the market even though the brokers were worried about selling it, for fear it didn't have enough reserves to last through the contract year.

"And," Lewin adds, "Cal Advantage offered a POS plan that was between an HMO and a PPO, precisely where Californians say they would like to see health plans move. So we were well positioned, had a great product, a great benefit package, an excellent claims system, and a wonderful panel of physicians. There was tremendous opportunity for success."

#### Bad Timing

Not all observers agree with Lewin's assessment, however. Another possible misstep was the timing, says Hall. In early 1996, HMO premiums were declining in California. "The big insurers and HMOs were engaging in competitive pricing," Hall explains. "Employers and payers were not looking for new partners. They were saying, 'Rates are going down; I'm not even going out to the market this year.'"

Lewin responds that the apparent rush to bring Cal Advantage to market was in response to CMA members' enthusiasm to begin marketing the plan.

Since rates have been rising throughout this year, Hall believes the market is more

have a place in the market now," Hall says. "People would say, 'I want to go to a plan where the decisions are made by the doctors, not by financial people.'

"But it didn't get that message out," Hall adds. "It tried to get it out to the brokerage community with people like us. We understood, but it's difficult to say to a client, 'Instead of going with a Blue Cross, Prudential, Aetna, or any of these household names, you should go with Cal Advantage.' That's a hard sell."

#### Keys to Success

Was CMA's venture simply too hard to sell or was it a flawed idea? Are physician-run and physician-owned plans doomed, particularly in a saturated, competitive market such as in California? Not necessarily, says Hall, who believes good management, appropriate pricing, and a solid infrastructure will help any plan succeed. "The key components of good management, good pricing, and good systems have more to do with your chances of success than the plan's concept," Hall explains.

Larry Keller, president of Healthcare Resource Associates, consultants in Ventura, Calif., believes that success will come to organizations that have the best services and most effective management. "The ascendant players will be those who are well organized, effectively managed and operated, and are far-sighted enough to move beyond marketing to the creation of superior products and delivery infrastructure," says Keller. "They will have a strategy that migrates over time with the evolution from managing care to managing health."

Another key for physicians seeking to develop a successful health plan is to understand how to manage the financial aspects of delivering care. Physicians aren't necessarily ready to hear that they have something to learn before they can run a health plan effectively, says Vincent Miller, PhD, MPH, president of Berkeley Economic Research Associates, economists and consultants in Berkeley, Calif. "In order to have an organization run by and controlled by physicians, you need physicians in that organization who know how to do things like risk adjustment, financial planning, accounting, and perhaps marketing," Miller says. "You can't call it a physician-owned and physician-controlled organization when its financial health depends on outsiders."

Among all physicians in the United States, Miller estimates that only about 5,000 (or less than 1%) are qualified to run a medical practice of any size in which all care is fully capitated. "If 100,000 or even 50,000 physicians knew how to do the job, then they could make what I call a 'hostile takeover' of the whole health plan business," Miller says. "A hostile takeover in the sense that the health plan business wouldn't want to be taken over, but it would be good for everybody else if it were taken over by physicians."

When Miller leads seminars on health care financial management, he asks physicians to imagine being a medical director of a 25-physician multispecialty group practice. A health plan asks the group to take a number of enrollees on a capitated basis. To do so, the physicians must determine a fair capitation rate based on their experience with their own patients, the standard fee-for-service billing rates, and some information from the health plan about its enrollees. "Over and over again, I get physicians who are completely flummoxed by this problem," Miller says. As a result, physicians should seek physician-centered intensive courses on financial management or seek seminars conducted by consultants on the subject, he says.

Also, organizers must recognize that running a managed care organization requires a commitment to the tenets of managed care. With Cal Advantage, "you had what was basically an antimanaged care organization of physicians trying to compete in a

# Would More Money Have Made the Difference?

California Advantage's major problem was lack of capital, and this lack of funds was the root cause of many other problems. As a result of a lack of money, "it never got any momentum going," says Jim Hall, president of HCM Benefits, the company in Torrance, Calif., that marketed the plan to health care purchasers.

If Cal Advantage had waited 36 months and amassed \$23 million, as its consultants had advised, the plan would have been launched this year in a market that might have been more favorable to a physician-run plan and one in which health insurance rates are rising and may go higher still. These factors may have led employers and payers dissatisfied with other offerings to look for new insurance partners.

But some experts believe that neither better timing nor better capitalization would have made much difference in the outcome of Cal Advantage's fortunes. Vincent Miller, PhD, MPH, a health economist and president of Berkeley Economic Research Associates in Berkeley, Calif., says that while Cal Advantage was undercapitalized, that fact simply begs the question of how much capital would have been needed to succeed. The answer to that question is unclear, he says.

"It's extremely unusual—in fact, I can't name a case in the last five years—in which anyone has started a health plan from scratch," Miller says. "This suggests that the amount of capital needed is prohibitive, and that's why it hasn't happened. What you see is health plans buying each other. There may have been some new entrants into this industry in the South over the past five years because the South has had a very low managed care penetration. So, there were lots of opportunities in that region."

## California Dreamin'?

Existing health plans are being sold for at least \$1,000 per enrollee, which does not include start-up costs for enrolling or selling to new members or recruiting physician or hospital vendors. To start a new plan from scratch, Miller estimates an organization would need to enroll at least 100,000 members quickly in a competitive managed care market such as California, and the cost for that number of enrollees would be at least \$100 million.

Even in a more favorable market, Cal Advantage was likely to fail, some observers say. "Cal Advantage would have had only the slightest and insignificantly better chance this year than it had in 1996," Miller says. "The market environment is not that different now and there are just too many other key factors" that contributed to its demise, he explains.

Managed care consultant Larry Keller agrees. "Had Cal Advantage had more money, it would have only postponed the inevitable," he says. Its structural weaknesses were too significant to overcome, he adds.

The president of Healthcare Resource Associates in Ventura, Calif., Keller says the plan's marketing strategy was too aggressive. The plan tried to "explode statewide onto the scene in a highly saturated market instead of growing into it," he says.

Moreover, Jack Lewin, MD, executive vice president of the California Medical Association, which sponsored the plan, believes poorly designed and priced benefit plans also were a significant factor in its demise. "Its out-of-network product attracted sicker members, and grew to represent more than 50% of its enrollment," Lewin says. This point is important because, he says, "physicians need to understand that there are some value issues that will cause physician-owned companies to take a longer time to get to viability. By putting patients first, we will attract the highest risk, most costly patients. We are here to take care of sick people and not compromise that care. From an insurance business perspective, that is not a means of achieving profitability."

Another unbreakable insurance rule is that an insurer cannot pay out more in claims than it receives in premiums from payers, says Keller. Cal Advantage's rate of claims payments to premium income (its medical loss ratio) was too high, "indicating excessive provider compensation—even if the providers don't think that's the case—which left little to cover administrative and marketing costs," Keller explains. As a result, as premiums were dropping in 1996, it was even more important for Cal Advantage to manage utilization effectively, especially in ambulatory settings, and some critics believe Cal Advantage did not manage ambulatory utilization effectively.

—M.M.

highly evolving managed care marketplace," Keller says.

Miller agrees, saying one reason Cal Advantage struggled was that it was at the opposite end of the spectrum from the rest of the California market, which has had a long history of heavy managed care enrollment. Such heavy enrollment means a substantial proportion of the medical profession has made compromises to succeed under managed care. "Relative to their non-CMA colleagues in California, the physicians who attempted Cal Advantage were behind the curve more than their similarly

situated counterparts in other states," Miller says. "And in a market like California, that can have more dire consequences than it would in other parts of the country."

## The Leadership Mantle

Physicians have shown that they are willing to take on the mantle of leadership by forming their own health plans. "But to do this completely, physicians will have to take on a role that they've never been willing to take on before: Drawing a line for their patients, saying, 'There is a limit to how much you can have,'" Miller says. "Will this

clash with the caring culture of physicians?"

In part, Lewin concurs. "Owning a health insurance company is not necessarily the best course of action for physicians today," he says. "A better course, in my view, is to develop evidence-based quality and outcomes systems—owned and operated by physicians—to improve physician contracting capabilities with health plans, government, and employers and demonstrate real value in the management of patient care, where only physicians can lead."

—Reported and written by Margaret Mulligan, in Cleveland.

# Software Enhances Patient Relations

Those who worry that computers in medical practice threaten to erode the doctor-patient relationship should visit the family practice of Charles Burger, MD. For managing almost every aspect of his practice in Bangor, Maine, Burger uses computers for appointment scheduling, medical record keeping, telephone triage, and diagnostic and treatment support. The result, he says, is improved efficiency, higher staff satisfaction, and, most important, better care for his patients.

What's more, Burger is enjoying his practice more because the system helps streamline processes that were time-consuming and helps alleviate nagging worries about inconsistent or uninformed decision-making affected by the limitations of human memory. His patients also seem to appreciate that his way of practicing medicine is efficient and results in more collaborative shared decision-making between doctor and patient, he says.

In practice since 1971, Burger is part of Norumbega Medical Specialists, a 22-provider primary care group practice in

patients to share many responsibilities that, in more conventional practices, would be his alone.

## Telephone Triage

Using computer software that Burger has been fine-tuning over the past eight years, highly trained front-office staff manage all incoming telephone calls. The system makes it possible for even nonclinical staff to handle calls that range from routine to serious. Responses to a series of questions posed to the caller allow staff to determine whether home-care instructions are sufficient or whether the patient should be seen; if so, how soon and by whom; how much time should be reserved for the visit; and whether the patient should go for lab tests before the visit. Patients with serious complaints, such as chest pain, are instructed to go directly to the emergency room.

Triaging phone calls in this manner requires slightly more time with each caller (3.9 minutes on average versus 3 minutes in a comparable practice), but the efficiencies gained are worth it, Burger says. Staff morale and confidence are high,

tools: a computerized medical record and a clinical decision support system called Problem Knowledge Couplers. PKCs are Windows-based programs that aid health practitioners in clinical decision-making. The coupler system gives Burger and his staff access to a vast storehouse of up-to-date medical knowledge to support diagnosis and treatment decisions during patient encounters.

PKC was created by Lawrence Weed, MD, founder of PKC Corp., a company in Burlington, Vt., that develops clinical software for health care providers to use at the point of care. Using the PKC, Burger and his clinical staff enter relevant clinical information, including the patient's history, results of physical exam and lab tests, and symptoms and complaints. This information is gathered from a questionnaire patients complete at each visit and is integrated with data on the coupler system.

Using the patient data, the PKC then couples, or matches, the information with all possible diagnoses or management options for the patient. Recognizing the value of both the physician's and the patient's opinions, Burger said in the Winter 1997 issue of *Healthcare Information Management* that "the provider's judgment and the patient's values and preferences are then applied for a final selection of a diagnosis or management option(s)." The publication is the journal of the Healthcare Information and Management Systems Society, in Chicago.

The computer then presents the clinician and patient with a list of diagnostic possibilities, organized into broad categories. Serious or life-threatening conditions are presented first, even if unlikely, so they can be ruled out. Then, within each broad category, the diagnoses and treatment options with the best match appear. Pros and cons of each option are presented, and contradictory or ambiguous issues are highlighted rather than obscured. All the information is documented from current literature.

George Mathias, director of marketing and sales at PKC Corp., says the PKC covers about 75 medical and psychiatric prob-

**"Patients should see that sometimes there is uncertainty. They need to share some of the burden of that uncertainty and insert their own values into our decisions."**

**—Charles Burger, MD, Norumbega Medical Specialists**

Bangor. He is the sole physician in his office, which he runs with his own staff of two nurse practitioners, two medical assistants, one registered nurse, and 7.5 (full-time equivalent) support staff. Effective systems, highly competent staff, and shared responsibility allow Burger and his staff to serve effectively a patient panel of nearly 4,000, he says. "The hardest thing for physicians to do is to give up control over every aspect of the practice," says Burger. While he maintains an appropriate involvement in all clinical decision-making, Burger counts on both his staff and his

sound decisions are made without interrupting Burger, and visits are appropriately scheduled (some with lab tests already completed).

## Computers in Exam Rooms

Encouraged by the success of the telephone triage software, Burger, who also has a degree in business, decided about five years ago to re-engineer his practice to bring computers into every aspect of care. Today, a terminal in each exam room makes it possible for a clinician to enter information about the patient using two

lems, ranging from anemia to vertigo. "These topics cover about 80% to 95% of cases that most primary care physicians see," Mathias says. The company updates the coupler semi-annually (or more often if necessary), and is working to double the number of topics so that it can cover 100% of cases. While the programs depend primarily on "medical professionals culling through all the current literature," the company regards feedback from users as its most important information source, Mathias says. By making recommendations to PKC Corp., Burger has contributed to the improvement of several couplers, Burger says.

### Improving the Practice

The PKC, says Burger, improves his practice in several ways. First, he says, his nurse practitioners and medical assistants, who have had extensive training in the use of the system, can conduct sophisticated patient assessments with the coupler. As a result, says Burger, "When I see a patient, most of my time is spent talking with the patient, analyzing information, and making decisions. I don't spend much time gathering information."

Second, the system promotes consistency and thoroughness. "The complexity of what we do means we're always going to miss something," says Burger. "You can't solve that problem by studying harder. If I took a test, I could probably get the right answers. But under the pressure of daily practice, I may not always get it right." He cites as an example a patient he treated before he began using the PKC. "I had a patient with a chronic cough," he explains. "Chest x-rays were negative, there were no signs of congestive heart failure, it wasn't postnasal drip, and a bronchodilator didn't help." After finally referring the patient to a pulmonary specialist, Burger learned the patient had a history of heartburn and regurgitation. "Do I know that gastroesophageal reflux can cause cough?" he asks. "Yes, I do, but I forgot to ask the right questions." The respiratory coupler would have helped him make the right diagnosis on the first visit, he explains.

Third, Burger says the technology enables him to involve his patients more intimately in decision-making. "Together, we look at the screen, review the diagnosis and the treatment options, and create a treatment plan," he says. Often, he prints the coupler's response and sends the

lished. He also has very open access: He can see people the same day that they call to schedule an appointment. He and his staff can provide a lot of care over the phone, not in a cavalier manner, but in a way that provides high-quality care to his patients."

**"How do you take the best knowledge and deliver it at the right time to the patient in the exam room? That's the way we will ultimately bring the best care to the patients."**

**—Charles Kilo, MD, Institute for Healthcare Improvement**

patient home to study it. "You can't have truly informed consent without a tool like this," Burger explains. "I want patients to read the discussions on some of the finer points, and to be aware of the pros and cons. They should see that sometimes there is uncertainty. They need to share some of the burden of that uncertainty and insert their values into our decisions."

### Total Commitment

Bringing a system like the PKC into a practice involves more than simply buying computers and signing up for training. It involves a significant culture change. "We coupled the technology with a total quality management approach to our practice," Burger says. "Everyone had to be committed to this way of practicing. We don't have separate administrative and clinical teams; everyone is highly cross-trained. People are self-managing because they're very process-oriented." It also helps, he says, that members of his office staff have been working together for a long time.

Charles Kilo, MD, MPH, director of the Breakthrough Series at the Institute for Healthcare Improvement in Boston, is familiar with Burger's practice. "His practice is quite impressive," says Kilo. "He has systems that are advanced compared to how most offices function. He has quite a large patient panel, and is able to manage it well due to the systems he has estab-

Indeed, Burger is pursuing one of the "holy grails" of medicine, says Kilo: delivering knowledge at the point of decision-making. "That's the big challenge," Kilo says. "How do you take the best knowledge and deliver it at the right time to the patient in the exam room? That's the way we will ultimately bring the best care to the patients."

The system Burger uses does not supersede the clinical judgment or experience of the physician, Kilo adds. "Charlie relies on his own excellent clinical judgment, but he uses the system to support that judgment," Kilo explains.

"I don't discount experience," Burger says. "The more you've seen a condition, the better you'll be at recognizing it." But the system can serve to reinforce his opinion and the available information is useful for patients seeking to know more about their illness, he says.

For Burger, improving his practice has been a career-long pursuit, but one that is paying off in ways that are both measurable and intangible. "I enjoy my practice so much more," he says. "We have a group of highly competent people who are fun to work with and we're all pulling in the same direction to provide better care. We have gotten back to having more fun in medicine."

—Reported and written by Ann B. Gordon, in Wayland, Mass.

# Is It Possible to Create a Patient-centered Information System That Physicians Will Use?



*Ellen B. White, RN, MBA, is president and CEO of Velocity Healthcare Informatics Inc., Minneapolis, a subsidiary of Object Products, a company in San Francisco that develops*

*software for health care providers. White is nationally recognized as a leading expert in outcomes and clinical decision support systems. She has over 18 years of management experience in health care, in both hospital and multispecialty physician group practice settings. Before joining Velocity, White was vice president for patient care services at Dean Health Systems in Madison, Wis., from 1982 to 1997. She managed several departments, including nursing and clinical staff, transcription, and medical records. She also directed Dean's outcomes management program. White is a registered nurse and earned her BS and an MBA from Cardinal Stritch University in Milwaukee. This interview was conducted by Richard L. Reece, MD, editor-in-chief.*

**Q.** Tell us about your experience at the Dean Clinic, a 400-physician group in Madison with 40 locations, and how that experience led to your present position.

**A.** Among my many administrative responsibilities at Dean, I was responsible for the outcomes management programs as well as medical records, medical transcription, and telecommunications. My work at Dean consisted of constant efforts to reduce administrative costs within physician practices. We wanted to help the physicians make their efforts more efficient and more effective. Along the way, I learned what physicians need from information systems: They need systems that increase their access to clinical and patient information, but without adding time and work to their practice.

As a long-time client of Velocity, and as a board member, I worked closely with the

company to bring patient-centered outcomes forward as a practical component of clinical practice. When Object Products acquired Velocity at the end of 1996, I was offered the opportunity to become Velocity's CEO.

**Q.** There are different approaches to defining and measuring quality and outcomes. What do practicing physicians need to understand, and what are the implications for them?

**A.** Because of their different vantage points, purchasers, managed care plans, physicians, and patients understand quality and outcomes differently. Purchasers are interested in the value they receive for their health care dollars. Managed care plans focus on the appropriateness of services and efficiency of service delivery. Physicians think about quality and outcomes technically in terms of the effectiveness of care based on clinical results. Patients are concerned about how their medical conditions affect their quality of life and whether specific treatments will improve their health and functional status.

No single view takes in the whole picture. That's probably the most important point for physicians to understand. The distinct views are like pieces of a puzzle that need to fit together to form a com-

pleted whole.

So, when we think about measuring quality and outcomes in health care, we need to think about the types of information required to give us an accurate and complete picture. We also must think about what to collect and how to structure the information so that it is retrievable and use-

ful for clinical decision-making. Additionally, we want to make sure that the process used to collect and structure this information is not redundant and can, for instance, be efficiently used for documentation and other basic administrative and financial functions.

In sum, we have to enable physician groups to collect data that give a comprehensive picture of quality, make the information available and useful to physicians at the point of care, and do so in a practical way that makes the entire clinical and administrative process in the physician's office more efficient and effective. It's a tall order, but that's the challenge.

**Q.** How do you bring the patient's experience into information systems?

**A.** To measure the health of an individual, we have to assess changes over time in the person's ability to function at full capacity. To determine the effects of care on the health of the patient, we have to ask the patient directly and keep good data on the findings. Standardized, validated survey instruments from organizations such as the Health Institute, at the New England Medical Center, in Boston; the Health Outcomes Institute in Minneapolis; the Foundation for Accountability in Portland, Ore; and the American Medical

**"We have to enable physician groups to collect data that give a comprehensive picture of quality, make the information available and useful to physicians at the point of care, and do so in a practical way."**

Group Association, in Alexandria, Va., provide the tools to measure outcomes based on changes over time in patient-reported health and functional status. There are general health status questionnaires, as well as condition-specific instruments.

**Q.** You use the word "instrument" to describe patient information-gathering

tools. Describe, if you will, two of these instruments: the SF-36 and the Health Status Questionnaire, or HSQ.

**A.** The HSQ is a general health and functional status survey from the Health Outcomes Institute. The SF-36 is a similar instrument from the Health Institute. There are some differences between them, but both include a set of validated questions, and a patient's responses are scored with a standardized algorithm into a set of eight scales: physical functioning; role limitation due to physical problems; bodily pain; mental health; role limitations due to emotional problems; social functioning; energy/fatigue; and general health perception. Each of these dimensions of health is scored on a scale of 0 (poor health status) to 100 (best health status). Bar charts display patient's scores on the eight scales, indicate how they change over time, and show how the scores compare to age- and sex-adjusted reference data. Thus, physicians can get a quick assessment of how the patient is doing.

**Q.** You have said you lean toward the HSQ because it is in the public domain and because it contains three questions relating to accurately screening for depression. Why is it so important to know if the patient is depressed?

**A.** Patients with undiagnosed depression tend to be high users of medical services. Outcomes data have shown that this group generally does not do as well after surgery and other treatments. It is, therefore, important to identify and treat the depression in order to manage overall costs and improve outcomes.

The key to treating depression is access and follow-through. Successful depression management hinges on patients being identified, then being allowed the therapies or medications that can help them, as well as the processes that make sure they aren't left behind. The three questions in the HSQ on depression have proven to be useful to primary care physicians in identifying patients with potentially undiagnosed depression. If you gather the information at the point of

service, it can be used immediately to improve care. We certainly found this to be important in our outcomes management programs at Dean.

**Q.** In this case, "point of service" for the physician is the examining room. How do you bring these outcomes to bear during the actual clinical encounter?

**A.** In a typical scenario, depending on the particular protocols physicians establish for their outcome initiatives, the

patient fills out the HSQ in the waiting room or brings in a previously mailed instrument that he or she has completed at home prior to the office visit. Office staff then scan the form in the outcomes system to produce a report, which is then given to the physician or affixed to the outside of the patient's chart so that the physician can use the data as part of the exam process. In this way, the physician gets timely, relevant information for assessing the patient.

look at the results until after they had already developed a treatment plan. After reviewing the HSQ, the doctors noted that their plan of treatment would have changed due to the information. The percentage of changes in treatment plans was striking and significant.

**Q.** Is this information useful for assessing the quality of physician performance? Is it useful in impressing payers so you can gain managed care contracts?

**A.** In health care today, the emphasis is on competition and accountability. Employers in their role as health care purchasers demand value, which simply stated is the best quality at the lowest reasonable cost. They want quality to be based on outcomes. To respond to their requirements, health plans and physicians have to measure and manage outcomes. In addition, consumers are taking a much more active role in their own health and health care, and patient-centered outcomes enable plans and physicians to take the patient's experience into account.

So, yes, it does improve patient satisfaction. And, more and more, it will be impor-

**"Physicians significantly improve their own performance after being given comparative information regarding such data as complication rates within a department."**

**Q.** Once you've captured this patient-centered outcomes information and given it to the physician, how is it used? Is it useful to physicians at the time of the patient encounter?

**A.** Patient-reported data are used to complement clinical data. Consider a physician who has ordered a new type of inhaler for an asthma patient. The physician uses a clinical measure of expiratory volume and flow to determine if the inhaler is having a beneficial effect. If we then add to that clinical measure some patient-reported data that summarize the effect of asthma on the patient's daily living activities, we put together the pieces of the outcomes puzzle to get a total picture

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tant for physicians who want to maintain and grow successful practices.

The best use of this information as it relates to physician performance is actually with the physicians themselves. I've watched physicians significantly improve their own performance after being given comparative information regarding such data as complication rates within a department. In this example, the cost of doing the procedure was also reduced because once complications went down so did the length of time spent in the operating room, along with the number of supplies used.

**Q.** Can you summarize the main lessons you learned about implementing outcomes programs at Dean?

**A.** In doing outcomes programs at Dean we learned several lessons. First, in a large practice, you have to get physicians and top management involved, and it certainly helps to have a well-respected cham-

do things today, but then you are stuck with that process and the information generated from it. Traditional systems require tremendous time and expense to change.

Health care information systems must be flexible enough so that physicians can change things for the good of their practices and their patients. These systems must easily support much needed clinical information and process evolution. This requires software technology that adapts to change.

**Q.** You have also stressed how important it is for information systems to be "scaleable." What is "scaleability," and how essential is it in a physician practice?

**A.** Scaleability refers to the capacity for having a single user on the system as well as to "scale up" to the demands of a large organization with multiple users and sites, like a physician group practice with several office locations. Systems must be able to scale from single-user configurations to enterprisewide, multi-user arrangements

that person wherever he or she goes in the system. Let's say, for example, that a clinic is using scheduling, billing, and clinical decision systems based on our technology. Imagine a patient calling to schedule an appointment, and he informs the receptionist that his phone number and insurance have changed. If the receptionist makes the changes in the scheduling system, the updated, correct information is immediately available to all other applications with no additional data entry needed.

**Q.** Can you elaborate on your ultimate aim, which I understand is to create an "organic clinic" to offer clinic support systems that make life easier and more objective for physicians?

**A.** The aim of our system is to provide just-in-time, relevant information based on patient-reported health status, and clinical information to physicians at the point of care. This information will guide and support physicians as they formulate a plan of care for each patient.

Based on patient-specific clinical and health status data, this system will present to the physician alternative guidelines—including medical care protocols and patient education information—along with a summary prediction indicator about which guideline would likely yield the best improvement in outcomes for the patient in the most cost-effective manner.

Then, based on the physician's decisions, the software will generate and share the data required for essential business functions, such as scheduling, documentation, and billing. Thus, the software eliminates duplicate data entry and makes the physician's office more productive.

**Q.** Finally, how do you win over physicians on the notion that your information system is good for them and for the patient?

**A.** You have to make the data useful to physicians in the context of one-on-one patient care. Physicians need quick feedback and comparative information that will make it interesting and useful to them at the point of care. You have to help them see how it will support their clinical decision-making and allow them to spend time more effectively with their patients. Most importantly, you must provide a system for them that improves their work process and effectiveness instead of making more work for them. ■

**"Health care information systems must be flexible enough so that physicians can change things for the good of their practices and their patients."**

pion on board to be an advocate. Second, regardless of the size of the physician group, you have to set clear goals, centered on how the outcomes information will actually be used. Third, we found that the key to securing physician commitment is to incorporate outcomes into the actual process of care so that the physician has health and functional status information on individual patients at the time of the patient's office visits. Fourth, you simply have to create practical ways to collect and report the data without creating more work for physicians.

**Q.** You have said it is important to build information systems that are changeable and flexible. By that, were you referring to the problems of rigid computer architecture, and how essential it is to be able to tweak the system anyway you want as you go without massive reprogramming?

**A.** Physician practices should not be limited by their information systems. Health care in general needs to be able to evolve and change. You can purchase an information system that supports how we

over wide area networks, based on client-server technology, or the Internet.

**Q.** One thing that intimidates physicians about information systems is the endless permutations and combinations and interminable variables inherent in a comprehensive system.

**A.** In Object Products' core model, essential data elements, such as patient demographics, are created once and shared instantly by all applications for an integrated solution. Because different modules share a common underlying data model, combined with the scaleable concept mentioned earlier, it makes it easy and practical to start incrementally one application at a time without making things more complex as more functionality is added.

**Q.** In describing the Object Products' concept of "object-oriented technology," is it useful to think of the patient as an "object" around which all data converge?

**A.** Yes. To explain it in nontechnical terms, you can think of the information and attributes of a patient moving with

# Lessons Learned From Group Mergers

By Thomas M. Gorey, JD

Increasing competition and the growth of managed care have led physicians to pursue a variety of career strategies in recent years. One of the most popular strategies involves merging existing practices into a larger group. Policy Planning Associates recently completed a study of physician practice mergers. We visited each organization and conducted telephone interviews in which practice administrators and physician leaders shared their experiences about merging, building a group culture, and planning for the future. The physicians reflected on their merger experiences, shared their thoughts on approaches that had been successful, and offered advice on what they would have done differently.

The study examined six groups formed through mergers of existing physician practices: Medical Clinic of North Texas, PA, in North Richland Hills; Mid-Michigan Physicians, PC, in Lansing; Spectrum Medical Group, in Portland, Maine; Quincy Medical Group, in Quincy, Ill.; Carolina Multispecialty Associates, PA, in Greenville, S.C.; and Pediatric Healthcare Alliance, in Tampa, Fla.

In future issues, we will address all of the key findings from the study. This article addresses the key findings that pertain to merger goals, overhead, compensation, governance, and administration.

## Merger Goals

Physicians who merge their practices achieve an enhanced competitive market position that allows them to contract more effectively with payers. By merging, physicians usually hope to improve their negotiating power, preserve their autonomy, increase administrative efficiency, and experience fewer practice "hassles." Market realities, however, are typically the major impetus for most practice mergers. Physicians merge their practices to improve their posi-

tion in a market that is changing or that they anticipate will continue to change.

For the physicians in this study, full integration of their practices—rather than a looser network arrangement—was the answer to challenges in their markets. Practice mergers generally improve the practices' positions in the market by giving them the size, geographic coverage, and infrastructure necessary to compete effectively. The administrative infrastructure of a group practice offers advantages in contracting because it enables the physicians to develop and sustain mutually beneficial

port new and expanded activities, including more experienced, more highly paid staff to manage business affairs, and more sophisticated information systems to track practice costs and utilization more efficiently.

One way to reduce overhead is to reduce staffing levels following a merger. But doing so is not easy for many groups largely because of the loyalty and concern that physicians have for their office staffs. At least in the first two years after a merger, new groups usually do not interfere with physician-nurse relationships or with other office-staffing arrangements, relying instead

**The increased clout gained when groups merge can influence hospital relations positively.**

payer relationships.

The increased size and clout gained when medical groups merge also can influence hospital relations positively. Soon after forming a group through a merger of existing practices, for example, one group of physicians forced a hospital to withdraw its plan to require physicians to contract exclusively through the hospital's HMO.

## Overhead

Contrary to popular belief, practice mergers typically increase—not decrease—physician overhead. Most of the physicians in the practices we studied anticipated that by merging they would reduce overhead by achieving new efficiencies. In reality, while the mergers made the groups more competitive in their markets, none saw a decrease in administrative costs or overhead and some had an increase in overhead.

The groups in the study cautioned that physicians should not underestimate the administrative cost of running a group practice. Merged groups typically require a broader and more expensive infrastructure to sup-

port new and expanded activities, including more experienced, more highly paid staff to manage business affairs, and more sophisticated information systems to track practice costs and utilization more efficiently.

Several of the groups studied said they allocate staffing costs back to individual physicians or divisions within the group to make the physicians more aware of the effect staffing decisions have on overhead and practice profitability.

For a few groups in the study, increased overhead costs coupled with reduced payment levels from health plans created substantial pressure to increase physician productivity. These groups established standards related to productivity or payment incentives to increase productivity levels.

## Compensation

When merging practices, compensation and benefits are the most formidable issues physicians face and present continuing challenges to newly formed groups. The make-or-break issue in most mergers is physician compensation because money is the only commodity that is sacred in practice mergers.

While it is impossible to have all the details of a merger worked out on the day the new entity is established, physicians merging their practices need to resolve major financial issues and at least have an initial com-

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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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pensation plan in place. In the period immediately following a merger, when overhead increases are common and finances are tight, compensation disagreements can become magnified. Even after agreement is reached on a compensation and benefits plan, group leaders recognize that their compensation formulas likely will change.

To raise the comfort level of physicians joining a new practice, some groups are structured by divisions (typically equivalent to the pre-existing practices) to provide physicians with a considerable degree of autonomy while practicing within a group structure. Such groups may allow divisions to continue to establish their own compensation formulas.

Most groups fashion a compensation plan that promotes equity among their physicians. Multispecialty groups, in particular, are inclined to have a wide variation in physician revenue—usually related to specialty—requiring them to address the compensation equity issue head-on. Groups in this position often implement a model based on productivity and make some adjustments for primary care physicians, who might otherwise believe they would be receiving less than a fair share. Other groups create compensation systems that take into account such factors as patient satisfaction, relative value units, adherence to protocols, involvement in administration, physician-patient ratio, and days off per week.

The merged practices in this study generally created new benefit packages for physicians and staff that often were more generous than those they had previously.

### Governance

Physicians who merge their practices in an effort to maintain autonomy often find that while they protect their clinical autonomy, they give up much of their operational autonomy. Physicians who merge often find that they are sharing decision-making and control for the first time in their professional careers. In their previous individual or small group practices, such physicians are like other small business owners, fiercely independent and accustomed to making all decisions. For these physicians, losing independent control over their practices following a merger is difficult.

Recognizing that control is a major issue

for most physicians, group leaders in newly formed groups that do not centralize practice operations have tried to let individual practice offices make some decisions. Physicians in new groups that have multiple practice sites often say billing and collections is a focal point for control-related issues. A number of groups have attempted to centralize billing, but have run into strong resistance from individual sites. In response to concerns over loss of control

skills to succeed, many physicians make this mistake because they are comfortable working with existing staff. Several physicians commented that a staff member's professional limitations may not be apparent until that individual has greater responsibility in a larger group.

In their formative days, all of the groups needed to develop administrative policies and procedures—a new experience for physicians previously in small practices

## The make-or-break issue in most mergers is physician compensation.

over billing, some groups have returned this function to individual practice sites.

At the outset, many groups begin with a large, fully representational board of directors to allay physician concerns immediately following a merger. As physicians become more comfortable with group decision-making, groups begin selecting board members based more on leadership abilities than on political considerations.

### Administration

When physician practices merge, an increase in administrative structure and staffing is almost always required. The importance of management support for a newly formed group cannot be overemphasized. Failing to hire a well-qualified executive director can have a deleterious effect on a new group. Some groups, depending on size, also may need a medical director, a chief financial officer, and information systems staff.

Several groups in the study said they were slow to recognize that they needed to spend the money to hire highly qualified administrative staff. Financial concerns and a desire to keep overhead low mean newly formed groups make the mistake of cutting corners on administrative expertise. When they realize that trying to save money by hiring inexperienced or under-experienced management could be costly over time, most groups hire more qualified staff.

A common mistake following a merger is to move existing office staff into key administrative positions in the new group, assuming that managers of small physician practices can manage a large practice. Although such staff typically do not have the requisite

with informal management structures. Developing a personnel manual often follows soon on the heels of a practice merger. Many groups noted specifically that because of concern with the number of spouses and other family members employed in the small practices that were merging, it was necessary to adopt strong policies regarding nepotism.

Despite the difficulties of building a new practice infrastructure, physicians in the new larger groups were unanimous in their opinion that merging solved a number of difficult problems and positioned them for the future in a way that would not have been possible if the physicians had remained in solo or small-group practices.

Next month, we will examine the findings on the topics of office staff, strategic development, group culture, market response, and merger partners. ■

*Editor's note:* The report, *Case Study Analysis of Physician Practice Mergers*, was sponsored by the American Medical Association, 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.

# Private PPMCs Continue to Prosper

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

The turmoil in the market for physician practice management company stocks is preventing private PPMCs from going public, but many are continuing to grow and prosper nonetheless. These companies are taking new approaches to the physician practice management business, including having a narrower geographical focus, paying more attention to the growth of affiliated practices, focusing a bit less on acquisitions, and being more cautious about accepting broad global capitation for services outside the direct control of the PPMC. These approaches may be the first edge of a trend toward what might be called second-generation PPMCs (see table). In the past few years, the frenzy among health care companies to acquire physician practices has overshadowed these approaches.

One prospering PPMC is Kelson Pediatric Partners, in Hartford, Conn. It started as a primary care PPMC in late 1995 and in January of this year, the company changed its name from Kelson Physician Partners to its current name after it sold its primary care practices. Kelson decided it could build a stronger company and add

**Private PPMCs have a narrower geographical focus, pay more attention to the growth of affiliated practices, focus a bit less on acquisitions, and are more cautious about capitation.**

more practices by focusing on pediatrics exclusively. Kelson accepts capitation, but only for the professional services it offers. In July, Kelson announced that it had signed long-term affiliation agreements with nine pediatric practices in four states. The new practices add 67 physicians in Florida, Massachusetts, New York, and Utah to its operations, bringing the total of Kelson

## Changing PPMC Values

### First Generation

Growth through acquisitions

Rush to go public

Far-flung acquisitions, making integration difficult

Little to no development of ancillary services

### Second Generation

Growth through operational improvements and revenue enhancements at affiliated clinics

Building up of operations before making public offering

Geographical and/or niche focus

Development of ancillary services

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

partnerships to 20 practices of 177 physicians in seven states. The company says it may go public within the next year.

Another company experiencing growth is Women's Health Partners, an ob-gyn

the scope of services and revenue of its affiliated practices. Rather than make acquisitions in disparate markets, the company says it will focus on markets where it already has a presence.

OrthoLink, an orthopedic PPMC in Nashville, also has enjoyed growth. In 1997, its first full year of operations, the company generated \$32 million in revenue and went from managing 35 physicians to 150. As of June of this year, OrthoLink was managing 180 physicians in Colorado, Georgia, Ohio, Pennsylvania, Tennessee, and Wyoming. One of the company's goals is to increase the orthopedic physicians' share of ancillary services. Typically, practices outsource many of these services, such as x-rays and surgeries, because they lack the capital to acquire appropriate equipment. OrthoLink says it will not enter a market unless it can have a dominant position there. It also says it will go public when it has a predictable stream of revenue. ■

PPMC in Nashville. Women's Health Partners is affiliated with 145 physicians in Indiana, Kentucky, North Carolina, and Tennessee. By March 1997, the company had one year in business and revenue of \$80 million. Physicians have a 75% ownership in the company and hold six of the eight positions on the board of directors. The company says it is working to expand

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### Federal District Court Upholds Texas Law Allowing Patients to Sue Health Plans

A U.S. district court judge has upheld a Texas law that allows patients to sue health plans if they are hurt by treatment denials or delays. After the Texas legislature enacted the law last year, the law was challenged in court by Aetna U.S. Healthcare, a large managed care organization based in Hartford, Conn.

To date, managed care plans have avoided lawsuits by patients under the "corporate practice of medicine" laws, which prohibit organizations not owned by physicians from employing physicians. Enacted in many states, these laws have been interpreted by many courts as barring suits against HMOs and other health plans on the ground that HMOs and other corporations cannot be sued for medical malpractice if they are prohibited from practicing medicine.

The Texas ruling is a victory for patients and for physicians. The Texas Medical Association (TMA), which played an important role in getting the law enacted, hailed the ruling. In essence, the ruling says that if a health plan is making medical treatment decisions that affect the quality of care and that result in injury, the health plan should be held accountable for that action, said Connie Barron, a lobbyist for the TMA.

It is expected that the ruling will be appealed, according to *The Wall Street Journal*.

**Comment:** *The case has been closely watched by officials in other states that want to pass similar laws. After the Texas law was enacted last year, Missouri passed similar legislation.*

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