How Are Physicians Returning to Private Practice?

The healthcare industry has gone through a lot of change very quickly in the past five years, with still more to come. Independent practices and smaller physician groups have a lot of reason to “seek higher ground” in mergers, partnerships, and buyouts by larger groups and hospitals that have the resources to better deal with lower reimbursement and increasing regulation. Still, just as we are seeing the crest of the wave of physicians selling their practices to hospitals, we are also beginning to see a lot of the reverse trend – physicians leaving hospital employment and starting their own practices.

We have a number of new solo physician practices among our clients and each of these practices can make the numbers work for the three reasons outlined below. Their new practices may look much different from the practices they once had, but they now can bypass the crushing financial burden of start-up costs and find ways to cut expensive overhead. As hospitals ratchet down physician salaries and present new hoops from them to jump through, more and more physicians will look to these new tools for independence and financial viability.

Free EMR

In 2008 I was living in Seattle and I attended a conference at Microsoft in Redmond, Washington. It was there that I met Dr. Bill Crounse, the Senior Director of Worldwide Health for Microsoft. He was kind enough to sit down for a few minutes and talk to me about the future of physician practices. He told me something at the time that I didn’t really understand. He said, “Something is about to happen that will be game

changer for physicians.” At the time I didn’t understand what he meant, but today I believe he was hinting of the pending launch of **Practice Fusion**, the first free electronic medical record (EMR.)

The free EMR has indeed been a game changer for physicians. The ability to e-prescribe and report PQRS to avoid Medicare financial penalties and to collect the EHR Stimulus money (aka Meaningful Use) without the typical $25 -$30K outlay per physician has been a boon for many practices. How can an EMR be free? With advertising and the agreement that they blind and sell your data to third parties. (Have EMR companies been doing this all along and not telling you? A topic for another post.)

Physicians still need a billing system to run their businesses, but today software vendors are bundling billing packages with practice management and/or EMR software. For anywhere from 2.9% – 5% of net revenue, physicians can use the software and receive insurance billing services as a package. The two largest vendors providing this service are **Athena** and **eClinical Works.**

Social Media

The second reason physicians can start a private practice is the replacement of traditional (quite expensive) traditional marketing with social media. For a fraction of the cost of a direct mail campaign, a physician can use social media to establish a digital presence via a website, blog, YouTube and Facebook. These mediums are not free, but they are long tail, meaning that they will continue to drive patients to the practice long after a direct mail postcard has been thrown in the trash.

New Practice Models

Physicians and other care providers have a choice of self-employed practice models today. Here are a few choices they have:

- **Concierge** – concierge can mean different things to different people, but I am using it to describe a practice that accepts insurance and also requires an additional fee from all patients on top of insurance payments.
- **Medicare Subscription** – similar to concierge, but applies the additional fee for Medicare patients only to pay for additional services not covered by Medicare, particularly an annual physical examination.
- **Direct Pay** – this is a primary care model where patients pay a monthly fee each month that covers unlimited primary care (sick and well visits) and some in-house laboratory services. This model also includes direct-contracting with employers.
- **Telemedicine** – gaining popularity for more than just rural specialty care, telemedicine is seeing patients via a secure video connection.
- **House Calls** – this model is coming back as a pure practice model because physicians and other care providers do not have to invest in a brick and mortar office. Coupled with the ability to accept payments via their smartphones and the influx of baby boomers, this model is gaining popularity quickly.
- **Nursing Home** – Another “rounding” type of practice like the House Call practice, physicians spend 100% of their time in nursing homes seeing patients.
- **On Call Specialty Practice** – specialty physicians, typically surgeons, see patients pre and post-

surgery in the office of the referring physician and have no brick and mortar office.

- **Cash Practice** – this is a 100% cash model with no insurance payments accepted. Typically, physicians will provide patients with what they need to be reimbursed from their insurance plan. Because insurance is not filed, the practice can afford to discount their prices.
- **Co-op Practice** – this is a time-share-type practice where one practice or a non-physician owner leases space to physicians, providing everything for one fee except billing, EMR and a medical assistant.
- **Micropractice** – an even skinnier form of the co-op practice, the physician works without any assistants and does everything him/herself with just a computer, utilizing one exam room. Micropractice physicians see on average 8 to 10 patients a day.

For more information on different practice models, see our posts **Yes, You Can and Should Start a Solo Medical Practice in 2013!**, **How Physicians Can Offer Direct Primary Care to Employers: An Interview with Dr. Samir Qamar of MedLion**, **The Direct Pay Physician Practice Model: An Interview With Scott Borden** and **Physicians are Leaving Hospital Employment and Starting New Practices on Their Own Terms.**

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The CommonWell Health Alliance: Can The Private Sector Push Interoperability Over the Finish Line?

The HIMSS13 Conference in New Orleans, one of the biggest gatherings of Health Information Technology professionals of the year, was host to speakers, panel discussions, and one pretty large announcement from some of the big names in the electronic health record industry.

Allscripts, AathenaHealth, Cerner, Greenway, and McKesson have announced the founding of the CommonWell Health Alliance, a non-profit trade group designed to implement standards around some of the most difficult problems with interoperability between systems. CommonWell will focus on working to standardize three areas: patient matching, patient access consent, and record location. Once standards are set for these areas, they can be made public and licensed at a "reasonable cost". The Alliance's formation was inspired in part by a Bipartisan Coalition meeting, and especially a comment from National Coordinator for HIT Farzad Mostashari. The conversation was recalled by David McCallie, vice president of informatics at Cerner, in an interview with HealthcareITNews:

> *"…everyone was sort of complaining to Farzad: "You've got to go solve this identifier problem, it's killing us." And Farzad said, "Look, it's against the law! I can't do it. You guys have to solve it." I came back and literally quoted that*

> *– "you guys have to solve it" – I sent an email to Arien and he said, "We think the same thing. Let's talk about it." And within a week, we knew this was what to do."*

Interoperability is the principle that patient information that is shared between two different software packages should work seamlessly. Think about the interoperability of the Internet. A web page can be read on any brand of computer, any browser, and with any internet service provider. It just works. Interoperability between EHR software would look very similar. Anywhere a patient needs care, their records could be transferred and read electronically, without having to worry about the different software formats. It's important to distinguish between interoperability, which allows different software packages to understand each other, and Health Information Exchange, which is simply a means of communication between locations and providers. To extend the analogy, a telephone can connect two people, but if they speak two different languages, you will need a translator between them.

The founders of the CHA have extended an open invitation for other vendors to join the alliance, but one big name was conspicuously absent from the list of participants: Madison, Wisconsin's Epic Systems, who serves almost half of the US market. Epic founder and CEO Judith Faulkner was dismissive of the announcement:

> *"We did not know about it. We were not invited," Faulkner said. "It appears on the surface to be used as a competitive weapon and that's just wrong. It's wrong for the country."*

Epic COO Carl Dvorak was even more to the point, calling CommonWell a "marketing opportunity." Epic System made a collaborative announcement of their own during HIMSS, introducing the DRIVE program to test Epic software in virtualized environments with the help of Dell, Red Hat, Intel and VMWare. The program would be especially useful to

facilities looking to bridge older, closed software installations, with more modern and open systems.

Whether or not CommonWell will be a net win for patients or just an opportunity for vendors to make up ground with Epic remains to be seen. Proponents argue that CHA is a step in the right direction for the industry to achieve real interoperability, even if the gains are only modest. The skeptical take, articulated very well by Adrian Grooper, MD at TheHealthcareBlog says there is no real difference between giants like Epic and coalitions like CommonWell.

> *"The shame is that another program with opaque governance by the largest incumbents in health IT is being passed off as progress. The missed opportunity is to answer the call for patient engagement and the frustrations of physicians with EHRs and reverse the institutional control over the physician-patient relationship. Physicians take an oath to put their patient's interest above all others while in reality we are manipulated to participate in massive amounts of unwarranted care."*

So what do you think? Is CommonWell a good step for interoperability, or just another excuse for big software players to control the marketplace? Let us know in the comments!