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To keep their independence—and offer quality care—a group of physicians charts a new course.

by Burton Schwartz, M.D., F.A.C.P. and Timothy F. Signorelli, F.A.C.M.P.E.

In Minnesota the tide of health care reform is moving ahead of that in other states—driven by many of the state's major employers that have formed large organized coalitions to purchase health care and supplemented by an active state legislature. The local health care community has responded to this trend through consolidation of hospitals and HMOs, and, more creatively, through the formation of physician-directed organizations or IPAs (independent physician associations). Minnesota Specialty Physicians (MSP), formed in 1993, is one of five such organizations in the Minneapolis/St. Paul marketplace. MSP has successfully launched what is now a thriving multispecialty health care delivery system that comprises 25 shareholder specialty groups representing more than 230 physicians, 15 specialty areas, and 75 practice sites.

BUILDING AND MANAGING THE SHIP

The original concept and process for forming MSP were logical, but implementation was far from rational—not unlike building a ship in a driving rainstorm. Five physician groups came together in response to the tremendous change occurring in the health care community, each having been successful in its own right. The question then became what these groups could do collectively to make a difference. Through initial discussions, a consensus was developed on what this new organization would look like and how to develop a physician-driven organization that could be effective in a time of changing alliances, consolidation, and rapid reconfiguration of the market.

Members from the charter member groups, including physician and administrative representatives, developed a mission and a set of values: MSP would deliver continuous improvement in the quality of patient care and manage medical costs to achieve optimum value for patients, buyers, and the larger community. MSP would bring together the highest quality specialty medical groups, combine them with excellent management capabilities, and hence deliver a value-added approach to specialty care not yet seen—even in the innovative Minnesota marketplace.

MSP recognized early the need for outside help to make its vision a reality, and selected an outside health care consultant and a law firm to assist with its development. MSP received funding from the original physician associations, with many clinic administrators and physicians volunteering their time. Eventually outreach was initiated to add key specialties—a significant step, given most prospective groups' existing associations with major hospital systems. This selection of member groups represented a philosophical change in thinking: MSP selected groups based on the criteria of quality, coverage, and management capability rather than solely on past relationships.

SIGNING THE CONTRACT AND SETTING SAIL

As awareness of MSP spread throughout the health care community, hospitals, payers, and others began voicing concerns about MSP's formation. At times it was difficult to sustain the enthusiasm, participation, and support of members to commit to the MSP concept. Ultimately, these challenges sparked a renewed MSP focus to provide the highest quality care and value for its patients and the health care community.

To better position itself as a legitimate organization, MSP negotiated a contract with its first payer, Prudential. Signing a contract with such a well-known insurer helped demonstrate to physician members, the local health care community, and others interested in how health care delivery is being shaped that the MSP concept was valid and capable of delivering something of value to the marketplace.

In March 1993 MSP became "official" with the signing of its articles of incorporation and the inclusion of seven medical groups, including Oncologic Consultants, P.A. Committees were established within MSP to pursue key objectives, including credentialing and recruitment; finance; a medical information system; primary care linkages; quality, regional outreach; and shared services committees. Then, in the fall of 1993, after six months of management-by-committee, an executive was hired to oversee all aspects of MSP development, including recruitment and payer relationships.

A NEW AND BETTER MODEL

From these beginning stages, MSP developed specific strategies to achieve its vision of improved health care quality and managed costs. These strategies revolved around the goal to unify the previously

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autonomous specialty organizations to develop a single, responsive, integrated health care delivery system that provides a comprehensive set of specialty medical services—and functions with a high degree of information sharing and communication.

MSP's strategies included:

• *Setting practice guidelines for appropriate medical conditions.*
Seven MSP groups have developed and implemented MSP-sponsored guidelines. The goal of the guidelines is to reduce variability in physician recommendations. For example, MSP had great success in the area of follow-up of neoplastic lesions found at colonoscopy. With a guideline in place, its Digestive Healthcare group reduced by more than 30 percent the number of physician recommendations that varied from guideline criteria. Colonoscopy exams were reduced by more than 50 percent, and charges for colonoscopy decreased more than $600,000 in one year—all while maintaining a high standard of quality patient care.

• *Measuring outcomes, including patient satisfaction, clinical results, and costs.*
An MSP patient satisfaction survey was conducted among all member clinics as part of MSP's quality management efforts. The survey provided valuable feedback on member clinics, including areas for improvement and areas where they excel in terms of the entire care process, from administrative and service issues to quality of care. MSP will be implementing additional outcomes measurement initiatives in the next year.

• *Sharing clinical data among members.*
MSP's goals for a medical information system include centralized electronic claims submission, e-mail, common patient registration, referral magnets, and a next-generation clinical data system. MSP is partnering with various information technology providers to achieve these goals.

• *Eliminating redundancy by integrating administrative systems to drive down cost.*
As a whole, MSP clinics incur millions of dollars in annual expenses in areas such as supplies, laboratory, transcription, and others. Realizing that it could derive efficiencies in everything from the joint purchase of legal services and accounting to general medical supplies and insurance, MSP is pursuing opportunities for shared services. Through integration of these administrative areas, MSP is able to reduce overhead, provide a higher level of service, and offer services through a management services organization (MSO), a structural vehicle established in May 1994 to link specialty groups more closely together and provide opportunities for generating revenue for any products MSP may develop.

• *Recruiting the highest quality partners.*
MSP's credentialing and recruitment committee evaluates and considers prospective partners for the MSP network and has developed a formal credentialing policy and membership criteria.

• *Establishing effective working relationships with primary care physicians and hospitals.*
Given the dynamic nature of the market, MSP is looking for a new model for how it interacts with local primary care physicians. Developing relationships with primary care physicians will help establish a network for referrals, allow MSP to better market the organization to buyers and payers as a comprehensive service network, and help participating primary care groups maintain their independence. In addition, an outreach committee is charged with establishing relationships with communities statewide.

As MSP approaches its two-year anniversary, these strategies continue to guide its course as a physician-directed organization committed to developing a new and better model for the delivery of health care.

CHARTING THE COURSE—IN RETROSPECT

It is clear that physician networks are forming across the country. MSP has learned lessons along the way that may help other physician groups wishing to remain independent and focused on delivering the highest quality medical care.

First, make the investment. Organizations like MSP cannot succeed on a shoestring budget.

Second, ensure that strong physician leadership guides the organization. Create a solid infrastructure and establish a sound mechanism for information collection. Go to the market (i.e., buyers, payers, customers) early and listen to what the market wants—this provides momentum and perspective for moving the organization forward.

Third, do not lose control of the process. Consultants work for you, not the reverse. Maintain control over your own development and stay focused. Anticipate that the headaches and struggles of being involved in one PA will be more than multiplied when more than 10 are brought together. (In retrospect, MSP found that in the formative stages, it is best to get commitment and control of the process from member groups to avoid overreliance on outside guidance and counsel.)

Finally, *remain focused* on improving the delivery mechanisms of care and the patient experience. All initiatives of the organization should add value, not bureaucracy. In a system where physicians, not insurers, set the standards for care, patients will receive the highest quality, most cost-effective care available. ■