The Focused Musculoskeletal Factory

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BACKGROUND

The development and formalization of the practice of rheumatology has been a relatively recent development in comparison with most other areas of medical specialization. Board Certification in Rheumatology was not offered until 1972 and Fellowship in the American College of Rheumatology did not exist until 1986. Up until the turn of the 21st century, rheumatology was practiced overwhelmingly by small groups of 1 to 3 physicians in academic or community-based settings. Occasionally, some academic centers might have larger numbers of rheumatologists seeing patients, teaching, doing bench research, and participating in clinical trials. Larger numbers of rheumatologists practicing together was certainly the exception to the rule. Multiple factors have combined over the past 20 years, which have had a profound impact on how medicine, in general, as well as rheumatology, specifically, has been practiced. The revolution in our understanding of the immune response and our ability to impact on immune function gone wrong has literally revitalized the specialty of rheumatology since 2000. At exactly the same time, the “businessfication” of medicine has made the practice of a cognitive medical specialty increasingly more challenging, especially for the traditional model of the small rheumatology practice. This issue of Rheumatic Disease Clinics is focused on various aspects of rheumatology practice and this particular review focuses on one approach to successfully dealing with the complex environment of 21st century rheumatology practice.

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Successful medical practice remains, hopefully, centered around the relationship between the patient and his or her physician. However, there are other critical relationships that have come into play, which also must be navigated for a practice to prosper. Insurance companies and other payers, benefit management companies, hospital systems, state and federal government agencies, and employee relations all need to be competently addressed for a practice to grow and for its patients to be successfully treated. All of these additional players in medical care see their services as deserving of reimbursement and profitability and have no problem in generating those profits at the expense of the patient as well as the treating physician. To a certain extent, the growth of “medical business” has occurred in the relative vacuum of business expertise on the part of the traditional practicing physician. In the past 20 years, the explosive growth of the insurance industry, the consolidation of hospital systems nationwide, and the availability of extremely effective and extremely expensive treatments with the resulting bonanza of unheard of profitability for big pharmaceutical companies have all placed increasing financial pressure on doctors’ practices. In addition, the business acumen accumulated over the past 25 years has enabled hospital systems, insurance companies, pharmacy companies, and private investors to become involved in the practice of medicine, sometimes leaving practicing physicians in the dust of limited time, resources, and strategic vision.2

As these major shifts in the finances and management of medical practice have occurred, the public’s relationship with its medical care and doctors has also undergone seismic, and not necessarily positive, change. Increasing competition, decreasing physician reimbursement, expansion of marketing, and ever-increasing consumer expectations have placed medical practice under the same microscope as any other retail business. People want what they want when they want it and those practices that cannot deliver are finding that the traditional doctor–patient relationship does not always carry the day.

In the past 10 years physicians have been caught in the potential death spiral of decreasing reimbursement and increasing expenses. Employee salaries and benefits, the rent, the costs of equipment and furnishings, as well as professional liability insurance have not stood still. The government mandate for the electronic medical record, Health Insurance Portability and Accountability Act (HIPAA), insurance preauthorization for medications and procedures, and marketing are just a few examples of significant practice expenses that literally did not exist as recently as 10 years ago. So, doctors are being squeezed. This financial pressure is a root cause of the deterioration of the sacred relationship between the doctor and patient.3 Doctors are no longer at the center of what has become a very complicated system of medical care. Others have seized this opportunity and we have paid for it.

NEW STRATEGIES FOR NEW CHALLENGES

In 1997, Regina Herzlinger, Professor of Business Administration at the Harvard Business School, authored Market Driven Healthcare, which was her attempt at addressing the increasingly competitive and increasingly consumer-driven world of health care and medical practice.4 She expanded on the idea of finding the right “niche” in services and focusing on delivering the best possible care which would, of necessity, ultimately be the most cost-effective care as well. She referred to the “focused factory,” a term that had been introduced in the mid-1970s and referred to manufacturing processes that focused on only one or a very few products and did it as well and efficiently as possible. She suggested that the focused medical factory could concentrate on one area of increasingly specialized medical care and do it better than others. In
this way, such a practice could not only survive but flourish. There were already several well-known examples of these focused medical factories. The Mayo Clinic was established in the late 1880s when a small group of doctors combined their resources to provide comprehensive medical and surgical care, in one setting, to their patients. In the subsequent 135 years, the Mayo Clinic remains the prototypical large group practice, whose size and scope provide the resources for good patient care, physician education, and ongoing research.\(^5\) The Hospital for Special Surgery in New York has a long and proud history of providing focused care specifically in the area of orthopedic care, research, and teaching. Since the Second World War, The Hospital for Special Surgery has also developed a successful and sophisticated rheumatology program, which, together with other musculoskeletal specialists, provides multidimensional care to people with musculoskeletal and autoimmune disease. But rheumatologists and orthopedists are acutely aware that close collaboration between the specialties is the exception, rather than the rule.

In the 1970s, Dr Daniel McCarty was the Director of Rheumatology at the University of Chicago and one of his faculty was Dr John Skosey. Dr Skosey has recalled that Dr McCarty frequently would comment on the positive impact on patient care that might ensue with close collaboration between orthopedists and rheumatologists. Dr McCarty suggested that close proximity of rheumatologists and orthopedists in the clinics would expedite and improve care (Dr John Skosey, personal communication, 2017). Dr Skosey kept this in mind when he arrived at the University of Illinois as Chief of Rheumatology in 1978. Within a few years he established multidisciplinary clinics with both dermatology and orthopedic surgery. In these combined clinics, patients with overlapping clinical issues would be seen simultaneously by the needed specialists. It was my good fortune to attend these multidisciplinary sessions as a rheumatology fellow and junior attending between 1979 and 1982. An additional participant in some of those years was an orthopedic resident, Dr Wayne Goldstein, who subsequently took additional training in joint replacement at the Brigham Hospital with Dr Clement Sledge.

**PREDECESSORS TO THE “FOCUSED FACTORY”**

Thereafter, I practiced rheumatology in a hospital-based multispecialty practice in the Chicago area. Our rheumatologists had active practices, interacted on a daily basis with medical students and residents and conducted clinical research, as a matter of routine. At the same time, Dr Goldstein returned to the Chicago area after his joint replacement fellowship in Boston and joined an orthopedic practice that was, coincidentally, at the same hospital where I was a hospital-employed physician. Dr Goldstein and I renewed our old collegial relationship and actively referred patients to one another. We were, however, in separate locations and in separate practices. By the early 1990s, Dr Goldstein had refined his vision for comprehensive orthopedic care and recruited the first of several orthopedic subspecialists in hand as well as sports medicine. Over the next several years, spine, trauma, foot, and ankle were added to the practice roster. Dr Goldstein and his orthopedic partners were establishing a large and successful subspecialty orthopedic practice.

In the meantime, the hospital-based rheumatology practice I was part of grew from 2 to 6 rheumatologists and we expanded our scope of services to include not only traditional rheumatic disease, but osteoporosis as well. We were “given” a DXA machine in 1990 that had been underutilized in the hospital setting. In addition, 2 of us learned how to do epidural steroid injections for our older patients with lumbar stenosis. We were active teachers at the hospital and in the community and developed a
reputation for delivering state of the art care. We ultimately convinced the hospital to allow us to establish a practice site, which was well removed from the hospital campus, where access was easy and rheumatology patients would not face the various inconveniences that came with visits on the hospital campus. This outpatient facility would have X ray, bone densitometry, laboratory services, and physical therapy, all in one setting. Office hours were expanded and we were the only rheumatologists in the area offering evening and Saturday office hours.

A lot of this changed when the hospital that employed us made some poor business decisions and found itself in financial stress in the mid-1990s. The hospital ultimately sought a partner in the Chicago area with which to merge and with that came a new and less physician-friendly atmosphere. There is no question that competition was ramping up amongst nascent hospital systems at that point and doctors were being referred to as “cost centers” and “profit centers” in meetings I personally attended. On top of that, it rapidly became clear that hospitals at that point were not good at managing doctors’ practices. The close attention to nickels and dimes that had always been the hallmark of successful practice management was initially lost on the hospital systems that saw doctors and their practices as a marketing device and gateway to inpatient hospital care. The doctors, themselves, were at arm’s length from the practice’s financial performance, which they viewed as a “black box.” One of the last straws for us was when hospital management closed the small outpatient physical therapy department we had developed at our office. We were told it was a “money loser.” For me and my rheumatology partners, it was time to find a better way. (In an ironic twist, when the rheumatologists did leave the hospital’s employ, the hospital sold the building where we had practiced, several miles away from the hospital campus. The building was torn down and replaced with a huge privately owned physical therapy facility!)

REALIZING THE MODEL

Although the hospital-based multispecialty practice had provided some outstanding advantages, compared with the smaller private practices in our area, none of us was interested in simply moving to another hospital system as employees. Our collegial relationship with Dr Goldstein and his partners had matured over the years. Dr Goldstein and I both recalled the combined ortho/rheum clinics we had attended almost 20 years earlier at the University of Illinois. Dr Goldstein proposed, and we accepted his suggestion, that our rheumatology practice fully merge into the orthopedic practice that was already known as The Illinois Bone and Joint Institute (IBJI).

I pause for a moment and ask the reader to do the same. For what I have just described was an extraordinary occasion. Dr Goldstein, who already had demonstrated the vision required to develop an orthopedic subspecialty practice (common now, not common then) had enthusiastically endorsed the idea of rheumatologists and orthopedists practicing together and using their combined skills to efficiently and successfully treat people with musculoskeletal disease. I submit that having an orthopedic champion for this model of care was the single most important factor in establishing this kind of practice. If not for his drive, I am doubtful that the merger would have been undertaken. There are now more than 100 physician members of IBJI and most of them take the presence of rheumatologists as a given, if not a true asset to their practice. Twenty years ago, however, there was plenty of doubt.

I was the first rheumatologist who joined IBJI in January of 1999 and was joined by 5 of my former group partners over the next 18 months. In another twist, we were ultimately joined in our practice by Dr John Skosey who, not surprisingly, found our model
of practice extremely attractive! Working with my former chief has been a highlight in my career.

Conceptually, having rheumatologists and orthopedists working closely together with patients in common makes a lot of sense. As usual, the devil was in the details. How could we merge a high income, procedural specialty such as orthopedics with a lower income, cognitive medical specialty such as rheumatology? This model was almost unheard of in community-based, private practice. Although many university centers employed both orthopedists and rheumatologists, they rarely worked together, in the same space, on the same patients. University centers, especially in years past, maintained rigid silos where rheumatologists and orthopedists occupied very separate turf.

Although our long-standing collegial relationship initially launched the merged enterprise, it would ultimately be driven by the advantages offered by the group practice model. Group practice allows its physicians to develop ancillary services and to maximize negotiating leverage. If a group is big enough, services that are traditionally associated with the hospital can be offered to patients and those services can be offered at a price and level of convenience that simply cannot be met by a hospital system. Ask any insurance company and they will agree. If a group is large enough and offers expertise in an area, such as musculoskeletal care, it is difficult, if not impossible, for payers to circumvent reasonable contracting terms with such an entity.

In respect to ancillary services, the rheumatologists already had experience with X-ray, bone densitometry, laboratory services, and physical therapy. We had just begun infusion services for a year or so before our merger and had a vigorous clinical trials program. All of these services were brought to our new situation at IBJI. The orthopedists, of course, had x-ray services already. But these other ancillary services were new to them. Subsequently, IBJI has added MRI, occupational therapy, durable medical equipment, diagnostic and procedural ultrasound, and C-arm fluoroscopy for injections. It was our good fortune, and our patients’ good fortune, that infusion therapy exploded at exactly the time that our practice merger took place. It remains an important patient service as well as an important ancillary activity.

There are certainly vibrant single specialty rheumatology practices that have developed some or all of the ancillary services mentioned. If the number of rheumatologists is large (compared with most rheumatology practices) this can be done. Having multiple orthopedic partners does, however, change the financial picture and allows the scale of the ancillaries to increase substantially. At this time, IBJI ancillary volume is considerable.

A NEW CULTURE

Having looked at other practice options at that time, we found the potential for multidisciplinary musculoskeletal care to be irresistible. The first question to be answered was whether the 2 “cultures,” rheumatology and orthopedics, would be compatible in the private practice setting. The rheumatologists were initially most concerned that we would be looked down on by our orthopedic colleagues as someone less valuable than they. Income disparities between the 2 specialties were universally acknowledged, and the traditional hospital “pecking order” placed orthopedists at the center of the hospital universe with rheumatologists somewhere beyond Pluto. In our particular regard, the rheumatologists’ clinical maturity and the simultaneous evolution of the medical environment from the hospital to the outpatient setting was helpful in leveling the playing field somewhat. All 6 of the rheumatologists who initially joined IBJI were very experienced clinicians with recognized expertise and large, established
practices. A couple of us had served significant administrative and academic roles in our previous practice setting. By that point, we clearly understood the difference between being hospital/system employees and private practitioners and we were confident we could bring added value to the practice that would help differentiate IBJI from other orthopedic practices, both in the private and academic settings.

The question, of course, was whether our new orthopedic partners would see it the same way. In this way, we were clearly benefitted by the presence of Dr Goldstein, who was the president and founder of IBJI, as well as a seasoned clinician. He was, and remains, a respected voice amongst his orthopedic partners and pushed his partners, at that time, to see the bigger picture. Rightfully, several of the orthopedists at IBJI at that time were concerned that bringing in rheumatologists would be a drag on overhead. Rheumatologists spent all their time in the office, they did not operate, and they did not earn as much. How could they support the overhead of a large, orthopedic practice? How would having rheumatologists in the practice effect referral patterns? In addition, there were questions about personality fit. Fortunately, we were known entities to one another. On the balance, that was a positive situation, but there was still some hesitancy, from both sides, as to whether the 2 sides in the equation would match up.

Some of the nuts and bolts of the relationship would need to be answered immediately. The rheumatologists insisted, from the start, that the merger would result in full partnership after a reasonable period of time had passed. This turned out to be 2 years. Although it was true that our income potential was lower than our orthopedic partners, there were forces at play that were blunting the disparity. Procedural reimbursement was decreasing. Orthopedic practice was moving from the hospital to the outpatient surgery center and to the office. Income from office visits was an increasingly important factor for many orthopedists. We felt that rheumatologists in the practice could offset some of the fixed orthopedic overhead. When our ortho partners were in the operating room, the rheumatologists would be using empty office space to see patients. Infusion therapy, unknown to orthopedists, supplied a constant stream of patients to the practice. Not only was infusion therapy remunerative, but many of these same patients would choose to use IBJI orthopedists when surgical questions arose. Indeed, the whole notion of rheumatologists and orthopedists working together was predicated on timely and appropriate referrals between the 2 specialties that would optimize care and outcomes.

In addition to the increase in interaction between the 2 specialty groups, the other strong argument in favor of the pairing of the 2 groups was that it would make IBJI more distinctive than it had been previously. There was no practice in our area where a patient with any musculoskeletal question could get it answered in one place. We proposed that we were truly a “one-stop shop.” We wanted our new orthopedic partners to embrace this; we wanted our other referring physicians to know this; we wanted chiropractors and other alternative health practitioners to know this; we wanted the payers to know this. But, most of all, we wanted the public to know this. The idea was that if you have a bone and joint question or problem, you just needed IBJI. It was the beginning of the era of decreased access to one’s primary care physician and this message could have universal appeal.

**COMPENSATION FORMULA**

After initial negotiations, the compensation arrangements were clarified and agreed on. Compensation would be based on professional productivity. One’s office collections would be the main driver of income, which would vary with volume. Ancillary
income fell into 2 buckets. Rheumatology ancillaries were defined as those services used exclusively, or almost exclusively, by the rheumatologists. These included infusion, DXA, laboratory, and rheumatology clinical research. Each of these services would pay its overhead out of collections, with the remaining profits (or losses) split amongst the rheumatologists. The other ancillary bucket derived from those services used by rheumatologists and orthopedists, alike, and ultimately came to include physical/occupational therapy and MRI. Over the past 20 years, additional services have been added and the attribution of ancillary income has been modified from time to time, but the basic formula has remained unchanged.

Determining group overhead (indirect expenses) is complex in any practice organization and IBJI is no exception. Rent, front desk, billing, “back office,” answering service, and scores of other everyday expenses are allocated evenly across all members. Clinical staffing, liability insurance, and educational expenses were variable for each group member and were considered direct expenses. Overall rheumatology overhead was calculated at a fixed percentage above the indirect orthopedic overhead, because all rheumatology expenses and collections were generated in the office, whereas a significant percentage of orthopedic collections were generated in the operating room, with relatively less practice overhead. It seemed fair, from everyone’s point of view, that completely office-based physicians should have an overhead percentage higher than physicians who generated some income elsewhere. The fact that rheumatology and orthopedic overhead were directly linked gave both groups “skin in the game” to keep expenses controlled.

Thus, a rheumatology compensation formula was derived, which was identical for all the rheumatologists, tied to our ortho partners’ overhead, and driven, in the main, by our individual productivity. It has remained an agreement that most of us find acceptable.

In discussing the compensation formula, the office-based nature of rheumatology has been emphasized. This has remained true over the last 20 years. Although we do see inpatients in consultation as well as our own patients when they are hospitalized, the yearly income derived from inpatient care is approximately 1% of total income for the rheumatologists.

GOVERNANCE AND ADMINISTRATION

With a compensation plan in place, next steps involved fully integrating our rheumatology practice into the governance of the merged musculoskeletal practice. To be frank, we understood that we were a half dozen rheumatologists merging with a much larger group of orthopedists. However, the 6 of us had significant involvement in group and hospital politics and group practice governance. We felt strongly we had something to contribute to the culture of an evolving musculoskeletal practice. Early on, we had intuitively identified a small number of our new ortho partners who saw themselves as individual practitioners who did not depend on or require the support of any of their partners, orthopedic, rheumatologic, or otherwise. The evolution of IBJI’s culture remains a work in progress to which the rheumatologists, despite our relatively small numbers, have contributed with gusto. Beyond clinical collaboration, the rheumatologists sit on the practice management committee, as well as other governance committees, such as marketing, ethics, operations, and others. Over time, our orthopedic partners have not only accepted our presence but also have ultimately welcomed it.

The rate of change in the practice of medicine continues to accelerate. Declining reimbursement; competition from systems; competition at the local pharmacy (I recall
seeing a flyer from a local pharmacy “doc in the box” advertising screening for Lyme disease); the need to be HIPAA compliant; electronic medical records; prescription and procedural preauthorizations; and marketing in the press, radio, television, and social media have changed, in a fundamental way, how doctors practice. These modern realities play more easily into the group practice model. It is difficult, if not impossible, for many smaller medical practices to maintain themselves in this increasingly expensive atmosphere. Some practices have the wherewithal to charge its patients a premium, or membership, to support these onerous expenses. In some situations, physicians have opted out of the insurance rat race altogether and are run as cash businesses (such as your grocery store or your plumber). More power to the physicians who can do it. But, as one of my partners said to me, about 10 years ago, “Who will take care of our parents? Who will be around to take care of US?”

Large group practices will likely be around. They are more nimble than large systems that are accountable to a lay board or investors. The administrative structure that reports to a board or investors is, itself, an interest group that may consider physicians and even patients, secondarily. By definition, physician group practices are owned and directed by their physician members. That does not mean that they are necessarily figuring the budget or adjusting the heat, but they sign the checks and had better have significant input into strategic planning, major spending, the patient experience, the employee experience, and the wellbeing and retention of the physicians themselves. Who better than the doctors in the office seeing their patients to make these decisions?

These days, successful practices require all manner of administrative expertise to advance ambitious practice agendas. This starts with strong office management. The office administrator should ideally view her/himself as working for 2 bosses; the patient and the doctor. An effective administrator is able to communicate clearly, yet with empathy, with both parties, multiple times a day, while still dealing with staff who is late, supplies that do not arrive, medical emergencies that disrupt the best laid plans, and other daily drama. An effective administrator is an essential complement to physician governance, but does not replace it. Beyond the front desk, telecom, and clinical office support, a large group must support an increasingly sophisticated back office. At IBJI this includes a COO (nonphysician) who coordinates and implements group strategy as well as a CFO responsible for budget, prompt payment of group bills, and helping doctors to allocate limited financial resources. A good CFO is absolutely invaluable in clarifying for the physician members, in financial terms they can understand, just what is going on in their practice. In a group with many employees, human resources is occupied to a great extent by the usual comings and goings of employees, in-house health maintenance programs, employee satisfaction and grievances, and all manner of insurance questions. Risk management deals with group legal issues, medical liability, HIPAA, compliance, and contracting with payers. For the past 10 years our group has had fulltime information technology support in the office as well as remotely available to deal with our large electronic medical record, imaging picture archiving and communication system (PACS), and telephone issues. The practice supports a large billing function, which deals not only with billing and collections but accurate coding and documentation, as well.

Having real contracting expertise is a critical piece in making sure that the payers recognize the value of a skilled and large musculoskeletal practice. Payer contracting for a group with orthopedists, rheumatologists, podiatrists, psychiatrists, as well as physical and occupational therapists is complicated. None of these groups will get top dollar for their services from the payers in every instance. It is the job of the person negotiating the contract to make sure that the group, overall, gets the best deal
possible; this means close and cogent conversation with physician members to explain the overall impact of a contract. I would certainly not accuse insurance companies of being particularly obsessed with patient convenience, but having multiple services available in one outpatient setting for people with musculoskeletal disease is an attractive and increasingly cost-effective approach for payers and patients alike.

SIZE DOES MATTER

Hospitals have merged and formed systems that have purchased medical practices. Pharmaceutical companies have merged and merged again. Pharmacy companies have purchased insurance companies (and vice versa). Insurance companies have contracted with benefit management companies, then devoured those same benefit management companies. This has all been done to accomplish that elusive economy of scale and increase profitability. It is probably not coincidental that these same steps have reduced competition amongst these various entities.

So, it turns out that size does matter. A small practice can be ignored or marginalized by payers. It is unfortunately not rare for hospital systems to approach small specialty practices (cardiology is one good example) and make it “an offer they cannot refuse” to become hospital employed. The (usually) unspoken alternative is that the system will hire someone else, steer referrals to the new specialists, and put strong financial stress on the preexisting practice. The emerging practice expenses already sited, by themselves, can be enough to sink a small practice. In the Chicago area, several small rheumatology practices found that the expense of converting to an electronic medical record was an extreme financial pressure.

The migration of medical care from the hospital setting to the outpatient setting has the attention of the payers and the hospital systems. It is one of the major reasons that large, musculoskeletal group practice is increasingly more attractive. If there is enough volume, rheumatology patients can receive almost all of the care they require in the office, without the huge overhead of a hospital structure. Even joint replacement surgery is rapidly moving to the outpatient setting at a pace no one would have foreseen only 2 or 3 years ago. IBJI now has more than 15 office sites and offers rheumatologic care at 7 of them.

Economy of scale is not automatic, however. If costs and reimbursement are not carefully tracked, it does not take long to see margin disappear. This means that physician partners must be acutely aware of their own charges and collections and that relatively esoteric collection issues are not lost in the shuffle. In addition, there must be “group think” that allows for more global awareness of the ebb and flow of the larger practice. An example of this is infusion therapy. The cost of infusion drugs is one of IBJI’s largest expenses. Yet, there is no margin to speak of on the medications, themselves. We essentially provide a “pass through” of the medication to the patient, at no profit, given our costs and reimbursement for infusion drugs. Initially, our orthopedic partners were nonplussed that IBJI was spending 7 figures yearly on drugs with no profit margin. Careful explanation from their rheumatology partners, however, showed how the infusion business worked and that there were substantial charges and collections for the professional services associated with the delivery of the drug, even if the expenses and profit on the drug itself was a wash. There is now universal understanding in our group that infusion therapy is good for patients and good for IBJI, as well.

From time to time, issues arise about the cost-effectiveness of providing a service. Reimbursement may fall so low that the costs of providing that service simply are not covered. In the last 5 years, reimbursement for bone densitometry, for example, has steadily fallen to a point where it may not be sustainable in some practice settings.
Keep in mind that insurance companies will typically reimburse a hospital 3 to 4 times as much as a physician’s practice for the identical service. The system may say that the charge differential is related to the fact that the hospital has much higher overhead, provides charitable care, and takes care of a sicker patient mix than does the doctor’s office. Although all of this is true to some extent, it is certainly true that this differential is also related to a system’s clout with politicians and insurance companies who determine reimbursement.

However, a multispecialty musculoskeletal practice may find that providing a marginal service, such as DXA, has benefits to the practice, as a whole, that become obvious when you scratch below the surface. Abnormal DXA results lead to rheumatology referrals for diagnosis and treatment. Treatment may lead to infusion therapy. Osteoporosis may lead to the need for orthopedic intervention, such as kyphoplasty, fracture repair, or joint replacement. Imaging such as MRI may be required and follow-up services such as physical therapy are common. So, there builds up a certain “momentum of care,” which makes the provision of DXA services integral to what we do.

**FOCUS ON THE PATIENT**

Medical care is becoming more and more patient/consumer focused. If a practice cannot keep up with this evolution, it really does not matter how big it is. My patients who have been seen at the Mayo Clinic routinely rave about the care they receive there. They have no idea whether the actual care they have gotten is medically superior to what they would have gotten closer to home, but Mayo’s attention to patient needs and convenience is almost never off the radar screen. It makes traveling to Rochester, Minnesota in January not only a worthwhile endeavor, but downright efficient and satisfying. As we all know, the Mayo Clinic has had the wherewithal and vision to actually go to where their patients live in Arizona and Florida to make it even more convenient.

An ongoing challenge at IBJI is to find ways to make our services comfortable and convenient for our patients. Certainly, providing multiple services in one place and at one time is attractive. A readily available patient portal, federally mandated, has helped. E-mail accessibility and other simple communication devices bring us closer to our patients. We have recently begun offering urgent services every day of the week. This is a less expensive alternative to emergency room care and specifically aimed at people with bone and joint problems. This is just the kind of service that is good for the patient, good for the payer, and good for the practice. It is only one step, however, in making our services readily available. We wrestle with other access issues, such as long waits for nonurgent appointments. With 8 rheumatologists, we offer immediate appointments to all of our new patients. However, that may mean seeing someone other than the rheumatologist to whom they were originally referred, at a different location than they originally may have anticipated. It is then the patient’s choice. Once a patient is in the office, what can be done to avoid prolonged waiting time? This remains a bedeviling problem for a practice where 12 physicians on a typical day at one IBJI office may see more than 400 patients with their X-rays, laboratory studies, billing and insurance questions, etc. In some cases, it will certainly involve a change in physician mindset that a patient’s time is as valuable as the physician’s time. Like many practices, IBJI has instituted on-line previsit registration and gradual elimination of time-consuming forms that can be handled more efficiently with electronic tools. For many of us, this frequently feels like a Sisyphean task; for every form we eliminate or shortcut we create, there is a new federally mandated consent or insurance hurdle our patients and we must overcome.
We have looked at other opportunities provided by our multispecialty model. Fracture patients are routinely referred by their orthopedist for bone densitometry and rheumatology referral. Overweight patients with osteoarthritis as well as patients with fibromyalgia and sleep disturbance can benefit from a physical therapy program that includes dietary advice and sleep evaluation. We are seeking opportunities to provide bundled care for various disease states at reduced cost with the potential for gain sharing with payers.14

OTHER OPTIONS

Can other models of musculoskeletal care provide the “high tech/high touch” that sits at the sweet spot of the most comfortable, convenient, and efficient care (Box 1)? There are pros and cons to all models, although my bias is already disclosed.

A practice involving a single practitioner certainly provides control. The corollary is that the single practitioner has to take the time to exercise that control, both administratively and, increasingly, clinically. Many solo practices have hired extenders to provide education and “routine” care. This can result in a certain amount of loss of the high-touch component that made solo practice so attractive to begin with. The additional layer of care extenders requires clinical supervision to make sure sound decisions are being made with patients who are frequently medically complex; doable, but no cake walk. Provision of ancillary services, as already mentioned, is volume dependent, so certain services may need to remain outside of the practice or are scaled to the smaller volumes of patients. Contracting terms for solo practitioners may be less attractive, on the theory that small practices can be circumvented if they do not concede more readily to payer terms. Issues such as practice coverage, sudden illness, or loss of a key employee are additional stressors. Many of these same challenges face the somewhat larger (but still small) group of 2 or 3 doctors.

Working as an employed physician for a hospital system or insurance company is certainly seen as attractive in some respects, especially by younger physicians just out, or recently out, of fellowship. The idea of a “9 to 5” job with a “guaranteed” salary sounds a lot like fellowship. There are others in the organization who do the administrative work of contracting, practice management, charges, and collections. Initially, all that the physician, her/himself, must do is simply “see the patient.” Were this

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<th>Box 1 Benefits of musculoskeletal group practice</th>
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<tr>
<td>One-stop shop model</td>
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<td>Enhanced cross-specialty consultation</td>
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<td>Ancillary services development</td>
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<td>Better contracting leverage</td>
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<td>Maintains/requires ongoing physician governance</td>
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<td>Better able to accept risk and bundling</td>
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<td>Supply pricing</td>
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<td>Depth and breadth of administrative expertise</td>
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<td>Better market access (locations, referral sources)</td>
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actually the case, it is not a bad set-up. Left unspoken is the fact that the physician is an employee with relatively little say-so in the practice management, let alone the strategic direction of the entire enterprise. Although there will be an initial salary guarantee, be assured that the guarantee will not last forever. In fact, it will last 2 or 3 years and then be readjusted to the realities of the practice (and here’s the really important part) as perceived by the system management. That perception may not be shared by the involved physician and the actual facts that drive the administrative perception may not be fully shared with the doctor. The employed physician is putting a great deal of faith in a system and people that may change with each fiscal year.

Large, multispecialty group practice is yet another option. I have spoken rather glowingly about the Mayo Clinic, which is certainly the prototype of multispecialty group practice in the United States. Very few other multispecialty group practices even remotely approach the Mayo’s renown and size. In most multispecialty group practices, the primary care physicians drive the group referrals and the specialists use some of their income to support primary care. There is the constant give and take between these 2 camps. If the culture is strong, the give and take becomes part of that culture and how the group does its business. If the culture is not strong, the specialists, such as rheumatologists, may perceive that they are being “penalized” to help support primary care. In addition, there is a constant tension for the resources necessary to support practice initiatives. If oncology or cardiology is a major part of the practice, it may be difficult for a rheumatologist to get her/himself heard and get the resources sought.

These comparisons obviously reflect my biases that are based on my experience not only in a focused musculoskeletal factory for the past 20 years but also in my participation in a hospital-owned, multispecialty group medical practice for almost 20 years before that. It does not mean that one cannot derive immense satisfaction and personal financial success with any of these models. Indeed, each of these models does just that on a regular basis.

GOING FORWARD

Any physician who has been involved in a strategic planning process has undoubtedly been frustrated and humbled by our inability to predict where the practice of medicine is going. There are, however, several themes that are playing out now and will remain important goals for a successful private practice (Box 2). The focus on the patient as the center of concern, rather than the doctor, is probably the paramount challenge. Can access and communication be facilitated to the point that patients become fully engaged partners in their care? At IBJI, we are working hard to take advantage of current technologies and are looking forward to emerging technologies, such as telemedicine, to help answer simple questions quickly and triage more serious concerns in a timely manner. We are actively engaged in proactive care that anticipates patient needs, whether it is bone density evaluation on every appropriate fracture patient seen in the practice, preoperative physical therapy for total joint patients, or sleep, dietary, and psychosocial evaluation for all patients with fibromyalgia.

It is not yet entirely clear what the total impact of customized medicine and genetic analysis will have, but it is safe to say that over the next several years rheumatologists will be diagnosing disease at a much earlier stage (even before the disease develops!) and selecting medications on the basis of the genetic components of the immune dysfunction and the specific properties of the disease modifying medication. In our lifetime, it is likely that genetic manipulation will enable physicians to stop disease
before it has occurred and to reverse disease after it has begun. More and more of this kind of diagnostic and therapeutic intervention is likely to occur in the outpatient arena, in care settings that require a multidisciplinary approach.

As already mentioned, growth of any practice remains a key goal. Without growth, a practice is at risk of being eclipsed by competitors (the “Grow or Die” maxim). The members of IBJI consider our practice a true medical center, prepared to deal with any musculoskeletal problem that presents. We are martialing our resources to provide sites of care, with appropriate specialty expertise, that are nearby and easily accessed throughout our catchment area. This means controlled but ongoing growth, not only of the services we provide, but the settings in which we provide those services. We are partnering with various payers, including Medicare, in a variety of experimental models, to provide high-value services. Some of these projects, we understand, will not be successful, but most will move the needle forward in providing better outcomes at reduced cost.

The question, going forward, is what model of practice will be best for rheumatologists, their patients, and other interested parties, such as payers. Which model will best satisfy all of these unrelenting masters? Beyond compensation, physicians are likely to do their best work and feel best about themselves when they can maintain maximum control over their practice environment. Of course, their patients must do well. A practice setting that provides comprehensive care for all musculoskeletal concerns and questions, in one place and at one time, is theoretically very attractive to patients, physicians, and payers alike. Beyond that, however, is the additional imperative that patients actually feel good about the care they receive. What will they tell their family and friends when they leave the office? What message will they send out into cyberspace? Not feeling well is difficult enough, without having additional stresses added by a practice model or philosophy that does not put the patient first.

The deciding issues will be the same for all practice models: the shift from physician focus to patient focus, the evolution from reactive to proactive care, and the best outcomes at the lowest cost (the definition of value). The focused musculoskeletal factory provides the framework to meet these challenges, while maintaining a high level of professional satisfaction for the practicing rheumatologist.

<table>
<thead>
<tr>
<th>Box 2</th>
<th>The focused musculoskeletal factory in 2025</th>
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<tbody>
<tr>
<td></td>
<td>Customized appointment slots based on previous appointment experience</td>
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<tr>
<td></td>
<td>Thumb print/voice recognition registration</td>
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<td></td>
<td>Telemedicine “walk-in clinic” for urgent advice (24/7)</td>
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<td></td>
<td>Daily urgent care/routine care office hours for rheumatology</td>
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<td></td>
<td>Genetic screening for at-risk patients for premorbid or early stage diagnosis</td>
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<td></td>
<td>Tailored medication for specific genetic defect</td>
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<td></td>
<td>Full-risk contracting for rheumatoid arthritis, psoriatic arthritis, systemic lupus erythematosus, and ankylosing spondylitis</td>
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<td></td>
<td>Full-risk contracting for osteoarthritis care, including disease modifiers, and surgery</td>
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<td>Expansion of sites of care, scope of services determined by demographic data</td>
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<td></td>
<td>Rheumatology Fellowship Training</td>
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<td>Expansion of clinical research</td>
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REFERENCES