

## Title: The Pro's & Con's of Joining a Multi-Specialty Group

Size does matter, but being part of a large group is not for everybody.

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One of the more dominant principles governing the practice of podiatry is the recognition that podiatrists exist as members of the healthcare team. Evidenced at every venue where this profession is practiced, podiatrists have always emphasized their role in the comprehensive management of the patient. However, the nature of traditional practice has at times forced many podiatrists to remain separated from other fields of medicine.

Yet today a new trend seems to be emerging that is bridging the divide. Podiatry groups, as well as individual podiatrists, are merging with larger multi-specialty groups that consist of other types of physicians. Facing pressures like managed care and costly practice overhead expense, podiatrists are choosing to join forces with other medical groups, including orthopedics. In fact, most podiatrists in multi-specialty groups are finding their rapport with orthopedists to be cooperative, friendly and productive. Podiatrists also appear to be heading towards these practice arrangements despite sacrificing independent business autonomy, a criterion that was once the high mark of a podiatric career. While some podiatric physicians have experienced difficulties along the road to merging with these larger practices, most state that once the deal is completed, they are far better able to contribute towards providing broad-spectrum healthcare to their respective communities.

"There are many advantages in working for a large multi-specialty group practice if the other doctors are very busy," says Eric Feit, DPM of San Pedro, CA, who has written extensively on group practices and managed care. "It is comforting to a patient to know that their primary doctor is affiliated with you and that the podiatrist can easily communicate with him or her."

Podiatrists also understand the pressure of managed care. As Feit points out, "Managed care has influenced the way IPA's contract with specialists in one's community. The larger groups sometimes have an advantage in obtaining contracts with IPA's."

John Guiliana, DPM of Hackettstown, NJ, a leading lecturer and author on topics pertaining to practice management, agrees. He

says, "Historically, managed care organizations have been attracted to the cost-effectiveness of negotiating with and managing a large, integrated group. Through limiting access, these organizations have influenced the propagation of both multidisciplinary as well as single specialty groups."

"Managed care companies will bend over backwards to retain the multi-specialty practice because they can contract a greater number of physicians through one contract over the single specialty or solo physician," adds Neal Frankel, DPM of Chicago, IL, president of a sixty-member podiatry IPA.

#### Cornerstone Healthcare

One such successful venture can be found in North Carolina, where a multi-specialty group by the name of Cornerstone Healthcare has been in operation since 1995.

"Over the course of the past seven years we have grown our original group to a 120-provider group with comprehensive medical specialty services including internal medicine, family practice, pediatrics, general surgery, vascular surgery, urology, otolaryngology, ophthalmology, cardiology, gastroenterology, pulmonology, and critical care medicine, hematology, oncology, obstetrics and gynecology, pharmacology, and laboratory and imaging services," says Grace Terrell, MD, Internist and Chief Executive Officer of Cornerstone Healthcare.

"Within this context," she continues, "we felt that the addition of podiatry services would add to our strategic plan to be the premier provider of comprehensive health care services in our market."

Cornerstone's search successfully culminated with its merger with Family Foot and Ankle Specialists of High Point, NC. This podiatry practice with origins dating back to 1959 started with the private practice of Harvey Tilles, DPM. It is itself a product of a merger of two former practices: Tilles Foot Care Associates and Family Foot Health Center. The latter one was founded by Richard Weinbaum, DPM. United since 1998, today they maintain a primary office in High Point and have satellite offices in Thomasville and Asheboro, NC.

"In 1998, when we completed the merger process of our two practices, several doctors in Cornerstone that referred patients to us encouraged us to talk with the CEO of Cornerstone to see about the possibility of podiatry services. From our understanding, our practice was getting the most specialty care referrals from primary care outside of Cornerstone. So at that time, discussions began," says Steven Tilles, DPM, son of Dr. Harvey Tilles and one of the principals involved in the merger. "Cornerstone recruited two orthopedic physicians in 1999 and wanted to make sure that whoever they got would be in favor of

podiatry services. In July 2001, we officially joined Cornerstone Healthcare."

Prior to joining the multi-specialty group, the Family Foot and Ankle D.P.M.'s had attempted to get on staff at their local hospital, High Point Regional, and had encountered vehement opposition from one independent orthopedic group. But with the merger they were encouraged to reapply for privileges and ultimately were successful.

Overall, by joining forces with Cornerstone, these podiatrists had positioned themselves within a multi-specialty group of substantial magnitude. Originally formed by the merger of sixteen separate medical practices encompassing 42 physicians eight years ago, this organization served over 90,000 individual patients in 2002 in over 400,000 individual clinical encounters, according to Terrell.

Of course, pursuing an arrangement of this nature should be conducted cautiously. In this case, the podiatrists enlisted the services of an attorney who had helped merge a primary care practice with Cornerstone. Cornerstone also had its own attorney in the process. According to Tilles, financial information was exchanged and pro formas developed. Interestingly, in North Carolina, where this deal was consummated, podiatrists are not allowed to be stockholders in a multi-specialty group, forcing the deal to differ from other ones. Cornerstone purchased the assets to the podiatry practice in lieu of transferring stock. Tilles notes that the podiatrists are treated the same as shareholders but do not own shares of stock, as do the other providers. As a result, they cannot legally hold a seat on the board of directors and cannot vote.

"Knowing your state's podiatry statutes will help in deciding whether you would be able to become a 'partner' of the group legally if the opportunity arises," advises Frankel.

"A concern that we had during our discussions with Cornerstone was giving up our autonomy," Tilles says. "Cornerstone has treated us very well and fairly."

Guiliana recognizes this important point. He says, "As physicians, we tend to place great value on our autonomy. The benefits of a multidisciplinary group must be weighed against the varying loss of this autonomy."

Logistically, the move was not difficult. The podiatrists were not forced to relocate their practice. At the main office, the podiatrists own their building. Each site is considered its sole expense site, meaning that these D.P.M.'s continue to pay their employee payroll, physician payroll, supplies, utilities, etc., as before. However, the business checking account is managed through Cornerstone.

Early on the podiatrists recognized that Cornerstone was not going to micromanage their practice. While they do suggest certain guidelines, according to Tilles, they do not enforce any rules concerning office management unless they learn of some serious detrimental situation.

" They do not tell us who to hire, how much to pay our employees, who to let go, how much supplies to order, what supplies to order, etc.," Tilles notes.

The podiatrists' staff was given every incentive to move with them into the new partnership and Cornerstone, in fact, assisted them in developing an improved benefit package that is both comprehensive and competitive. Although many of the business office tasks have been assumed by Cornerstone, the podiatrists still maintain previous staff levels. While employee decisions ultimately rest with the doctors and practice manager, Cornerstone advertises for personnel, screens applicants and provides candidate resumes. Tilles adds, "Cornerstone is a desirable place for healthcare employees to work."

Behind the scenes, affiliation with Cornerstone has proved valuable to Tilles and his associates. Doors are opening to larger hospital facilities where access had been previously denied. Cornerstone files all hospital, surgical center and managed care applications forms. Computer billing software has been changed and hardware upgraded upon integration with Cornerstone. The podiatrists do enter charges on site, but the rest of the billing process is managed by Cornerstone, and, as Tilles reports, the collection rates remain high. The doctors, however, are involved in handling past due accounts on an individual case basis. On the plus side, the podiatrists do get a share of collections obtained from the use of Cornerstone lab and imaging services.\*

On issues of compliance with respect to mandated programs such as OSHA and HIPAA, Cornerstone has an officer who provides training and performs audits. This keen regimen helps to ensure that the entire practice always remains compliant.

But it is up front where joining the multi-specialty group has been the most beneficial. Prior to the merger, Tilles claims his practice did see more of Cornerstone's patients than any other podiatry group. And those numbers have increased. "Since joining them, we continue to see several referrals a day from the group. The referral base of primary care and other specialists has increased as well as our visibility in our community." Tilles stresses also that they are garnering "many referrals from both primary care physicians, as well as general surgeons for diabetic foot care."

The response from the referring physicians within Cornerstone has been favorable as well. "The podiatrists greatly enhance our care of a rapidly growing segment of our surgical

practice and that is the diabetic patient with foot ulcers," comments Thomas Walsh, MD, General Surgeon. "We now offer an enhanced clinical package of services with, I believe, better outcomes."

"They lead in our patient satisfaction surveys and contribute at every level to our goals of comprehensive care for our patients," adds Terrell. "We are proud that they have joined our group."

As a result, Tilles states that the podiatrists are averaging 30-35 patients each day per provider. With the addition of the newest D.P.M., there are presently four of them in the practice, with the elder Tilles still working one day a week in one of their two satellite offices. Accordingly, their income has increased since joining Cornerstone.

However, before joining a larger, multi-specialty group, Tilles warns that much research and investigation needs to be done to determine the true benefits. Even in this particular case, Tilles admits that although his podiatrists continue to get referrals from other doctors outside the group, that portion may have diminished somewhat.

Feit says frankly that "In order for it to work the group needs to be able to refer you at least five new patients per day. This is very important because other primary care doctors and specialists outside the group are very apprehensive about referring a patient to a podiatrist who is already associated with other doctors. They are afraid that they may lose a patient to your group."

Frankel agrees. "The podiatrist in a multi-specialty group risks not getting any referral sources other than from the doctors within the group."

Tilles says he is also aware of several multi-specialty group arrangements where poor administration and infrastructure have led to failure. As Feit describes, the collections may increase each year but other doctors in the group may lose money depending on the office expenses and growth of the patient base. Overall, the group may not be run well and poor management could result in a loss of income even though the practice seems busy.

But for Tilles and his associates the experience has been thus far very positive. "Our exposure to our community, referrals by primary care, and involvement in our medical community has been expanded dramatically," Tilles confirms. "It has been a wonderful move for us."

#### Foot and Ankle Clinics of America

Sometimes, in contrast, podiatrists find themselves in the leading position. Such is the case of the Foot and Ankle Clinics of America that has been in existence since 1981. This group,

directed by Fortunee Massuda, DPM consists of eight podiatrists and an internal medicine specialist. It has twelve clinics, eight in Chicago (including one at the William M. Scholl College of Podiatric Medicine) and four in northwest Indiana.

"We did not join a multi-specialty group. Instead we've taken some steps to form our own group, while keeping medical and surgical treatment of foot and ankle disorders the main thrust of our business," says Massuda. "In 2001, we brought in a board-certified specialist in internal medicine to our practice."

This arrangement, according to Massuda, has helped to strengthen the view of podiatrists as fully trained and educated physicians. In fact it has been so successful that Massuda says they'll be looking to bring in orthopedists and sports medicine specialists in the future.

### Core Health Services

In New Hampshire, James Dolan, DPM has been working with Core Health Services for three years. It is a group consisting of forty primary care providers and fifteen specialists. Dolan joined this group, he says, because he personally did not enjoy the business of podiatry and felt isolated as a solo practitioner. "I had no problem giving up the autonomy of private practice. I was very happy to have others responsible for hiring, firing, billing, rent, etc.," Dolan says. He acknowledges, however, that in his current position, the providers have no ownership interest.

Again the importance of good legal awareness is illustrated in Dolan's experience. Upon exiting private practice, Dolan was required to purchase a tail for his malpractice insurance. He happened to overlook this costly item during the negotiation and thus ended up responsible for the bill.

"Other 'contractual risks' are rather complex and, as always," warns Guiliana, "should be thoroughly reviewed by qualified accountants and attorneys. Break up clauses, termination clauses, restrictive covenants, and death and disability are among the concerns."

But that and some other negatives mainly related to patient scheduling issues are greatly outweighed, according to Dolan, by the many advantages.

Additionally, he says he has never experienced friction with the orthopedists within the group and feels they have been the biggest advocates of his profession.

Feit observes that this co-operative spirit between D.P.M.'s and orthopedists is a common phenomenon. He says that rivaling specialists who practice in a group setting often compliment each other very well as long as there are certain practice patterns established from the beginning. "Most orthopedists who work in the same group with a podiatrist co-exist

without difficulty and provide a higher level of care to their community," he asserts. "Most orthopedists do not want to perform routine podiatric surgery or diabetic wound care. They do not want to perform procedures that they do not perform often. They prefer to concentrate on what they do best: trauma, and other orthopedic sub-specialties such as shoulder, knee or hip surgery."

Guiliana echoes that sentiment. "Through open dialog, education, and a patient-focused mission, orthopedics and podiatric medicine, by nature, should be great allies."

"A steady paycheck, benefits, paid vacation and education opportunities, collegial interaction with other members of the group, what's not to like?" Dolan concludes. "I would really struggle with a return to private practice."

### Not Always Smooth

Getting started in his multi-specialty arrangement did not go as smoothly for Gary Whittier, DPM of Queens, NY. In 1988, this new podiatrist eagerly entered into a co-op sharing space with his landlords, a chiropractor and a psychologist. On this smaller scale, he was looking forward to reasonable rent and shared overhead expense. However, he soon learned that poor advice from his attorney had left him vulnerable to comparatively high rent and exorbitant rent increases.

Trapped by a concern that moving his practice would be costly both in terms of expense and lost patients, he stayed reluctantly through a second lease term. Then, as his landlord colleagues were preparing his next lease renewal, a medical office was opening across the street. The office was to be a new location for a pair of internists who already were practicing in another section of Queens. This time Whittier prepared for the opportunity.

"After learning the hard way," he says, "I did my research this time. I hired an attorney familiar with the leasing of professional office space, and I was ready to go."

"As with any major decision, fact finding is imperative," adds Guiliana.

At this new group, called Family Medical Health and Urgent Care, originally formed in 1993, he found himself working with not only the two internists, but also a pediatrician, a part-time gastroenterologist, a urologist and an ophthalmologist. Within two years his income doubled and he says that he impressed his new colleagues with his overall knowledge of medicine. He has even been asked to work part-time in the physicians' other office.

"Again, I cannot overemphasize enough how much working in such a Multi-Specialty Center has worked to my advantage, not only financially, but most importantly, professionally," he says.

Deciding to join a large group can depend on other factors as well. For David Deeney, DPM of Iowa, the decision rested on his desire to spend more time with his family. "As a solo practitioner, I was spending more and more time with the paper work, helping with the billing, supply ordering and the running of the business, which was leaving me less time for my family," he says.

Eventually he received a call from the vice president at his hospital, Mercy Medical Center, inviting him to a meeting, at which he was tendered an offer to join Mercy Care Community Physicians, a multi-specialty group practice. Prior to agreeing, he spoke to physicians who were both in and outside the group and spent some time with some of the management involved with running the group. This group, formed about six years ago, now has 44 members, including physicians, physician assistants and nurse practitioners. Deeney is the only podiatrist in the group. There are thirteen practice locations, consisting of eleven offices and two immediate care clinics. He reports the group is very stable, and continuously has grown over the past five years.

"All of the physicians have an equal vote on the issues that arise, and during my second year I was elected as one of eight physicians on the quality council which reviews and determines the direction and policies that the group has," he says.

Ironically, being the only podiatrist in the group has once again put his time on a premium. He is forced to be on call much of the time, though other doctors in the practice do cover for him when he is out of town. He hopes that, because the volume of work he performs for the practice is substantial, the group will soon bring in another podiatrist. "They were honest that it wasn't in the immediate plans, but they thought possibly within three-to-five years, depending on the need," he says.

#### Not Always Positive

Unfortunately, not all multi-specialty arrangements turn out as positive. Such appears to be the case for one podiatrist who wished to remain nameless. Five years ago this D.P.M., who we shall call Dr. B, was considering joining a 40-year-old multispecialty group. Dr. B's perception was that that managed care was becoming more prevalent in his area and he felt the alignment with the group would be to his advantage. He was not concerned about giving up the autonomy of his own ten-year old practice, so he joined and became an owner on the same terms as the other members of the group and was able to buy in immediately.

"I did get busier and my practice did benefit as a result of being with them," he says.

He began to observe a lot of tension between the primary care physicians (family practice and internal medicine) and all the specialists. In this group the specialists comprise sixty percent of the practitioners. He says the primary care doctors had serious problems with the specialists because the specialists would generate more income than they did. So the primary care doctors made it hard on the specialists, and consequently the group was and is still is being torn apart by those more concerned with individual interests rather than the benefit of the entire group.

"This situation is leading to a lot of problems," Dr. B notes. "We've lost some of the higher-producing specialists from different fields including orthopedics, and we've lost some of the primary care doctors as well."

"Multi-specialty groups are prone to this. This is a problem that multi-specialty groups face," he says, "because of the disparity between the income generated and the income distribution."

As a result, the group is having serious financial problems and he is considering leaving. Also, to make matters worse, those doctors who do want to leave may be restrained by a non-compete clause for two years or more. Some doctors who have left the group have had to leave the community as well because of signing this clause.

"If you are in your mid-forties to early fifties, it's not that easy to leave the community, especially if you have been there for over ten years," Dr. B says.

"Make sure you research the dynamics of the group and what implications would occur if for some reason you left the group," warns Frankel.

For those considering joining a multi-specialty group, Feit cautions to first discuss everything in the open prior to working there and make sure the contract covers all of your needs in writing. Also, be sure to discuss who will pay for all office and business expenses. These should include rent, staff salaries, insurance and taxes, office supplies, DME supplies and instruments. Also included are other annual expenses, such as licensing fees and taxes, hospital dues and provider fees for some plans. Finally, always discuss the opportunity for partnership in the group. But beware that this is not always a good option, as the value of the practice may change from year to year.

"If the group is busy," he says, however, "and can provide a significant number of new referrals, then it may evolve into a terrific situation for a podiatrist."

\* Editor's note: Such arrangements must comply with the "safe harbor" provisions of the Stark laws.