

## What's a micropractice?

Some doctors are using high-tech to reclaim an older, leaner style of medical practice. Supporters think it's a recipe for better outcomes and lower costs

Dec 1, 2006

By: Wayne J. Guglielmo

Medical Economics

For five years before opening her innovative solo practice in Woodland Park, CO, FP Michelle Eads worked in a very traditional, very busy primary care group. Located in Colorado Springs, it employed lots of doctors, operated with an enormous overhead, and processed scores of patients each day.

"I was forced to crank them through as fast as I could," says Eads, whose panel numbered more than 2,000 patients, most of whom she never got to know very well. "After five years of that, I knew I wanted to do something different."

Then she read an eye-opening article by FP Gordon Moore, who practiced in Rochester, NY, and had had his own disillusioning experience with a traditional high-volume, crank-them-through group practice. Moore's article described his odyssey from that frustrating situation to something that both he—and the patients who followed him—found a welcome change. It's a low-volume, highly efficient solo practice that uses cutting-edge technology to keep overhead low and free up time for more doctor-patient interaction.

Eads liked what she read. And—after hearing Moore speak to other FPs about his experience—decided to emulate his model. Today, she practices out of two rooms, totaling 500 square feet. The only other person in the practice is her medical assistant, who quit the group when Eads did. When not taking vital signs and administering simple labs, the MA serves as receptionist, phone operator, and checkout clerk.

At the heart of Eads' practice is her electronic health record, which has built-in practice management software that, as she says, "makes billing quite painless." With a panel of

only 400 patients who have access to her 24/7, she's able to give many of her patients one-hour appointments.

"The amount of time I spend at work each week is similar to the time I spent in my previous job," she says, "but my satisfaction is so much higher. I'm happy to be a doctor again."

Eads is not alone. Tired of practicing treadmill medicine, doctors across the country have decided to jump off the fast track and use 21st century technology to recapture what Moore calls a Norman Rockwell style of practice. The official term for this approach is the "ideal micropractice," which, as Moore and his colleagues have written, "strips a primary care office to its essential components so that it is capable of delivering patient-centered, collaborative care." (For additional information, go to [www.idealmicropractice.org](http://www.idealmicropractice.org).)

The results to date have been impressive. Not only are doctors happier—and, in some cases, able to earn close to what they could in a traditional practice—but patient feedback has been equally upbeat. In published studies, patients report high levels of satisfaction in areas such as access, efficiency, continuity of care, and doctor awareness of their key concerns.

"Despite passionate dedication and professionalism in primary care, we only achieve what we should be a little over half of the time," says Moore. "And it's this failure at the primary care end that, down the road, drives a lot of very costly specialty and hospital care. I'm after practices that can deliver much better outcomes and help lower the total cost of US healthcare."

We talked to three doctors who, in their small ways, are moving in this direction.

John E. Brady, FP

Newport News, VA

Before opening The Village Doctor in his hometown, John Brady worked in a six-physician family practice located 30 minutes away in Suffolk, VA. It was a fast-paced operation, requiring that he see a new patient every 10 to 15 minutes. But it wasn't just the pace of traditional practice life that bothered him—it was also the sense of being split between two communities, the one he worked in and the one he lived in. His new office, located in a renovated single-family house built in 1919, not only brought him back home but also permitted him to practice a very different style of medicine.

To do that, he's made efforts to keep his overhead low—currently, it's running between \$7,000 and \$8,000 a month, including the cost of paying off his start-up loans. He has one helper, an LPN, whose office used to be the family dining room. He also has an electronic health record, which has charting, scheduling, and billing components built in, as well as a database that serves as a patient registry.

Because he's kept his overhead in check, he's able to limit the size of his practice, which is now capped at 1,500 patients. In an average week (Wednesday afternoons are reserved for administrative chores), he sees approximately 70 patients. New ones get a one-hour appointment; established ones a half hour.

The generous appointment slots permit him to get to know his patients really well. "The woman with diabetes may be less concerned about her illness than about her husband who has dementia," he says. "I can spend time with her and find out what's really on her mind."

To assist him in this effort, he uses a tool that many micropractice doctors now employ. It's a web-based patient medical and healthcare survey called the How's Your Health Quiz (available at [www.howsyourhealth.org](http://www.howsyourhealth.org)), which was developed by John Wasson and his colleagues in the Department of Community and Family Medicine at Dartmouth Medical School in New Hampshire. With information from the survey in hand (patients must elect to share their survey with their doctor), Brady is not only able to assess his individual patients but also his entire patient population.

Basically healthy patients who know how to take care of themselves may require comparatively little extra assistance—what Wasson calls "autopilot care." Patients with serious chronic conditions who aren't self-directed may need greater support, including more frequent and longer visits, telephone follow-up, and more patient education material.

And how has Brady's new style of practice affected his bottom line? "I'm probably making about 20 percent less than I would be if I were employed in a traditional group practice in this area," he says. "But that gap will probably narrow and may even disappear once my start-up loans are paid off."

For now, however, he isn't complaining: "There are probably more than a few doctors out there who would be willing to cut their salary by 20 percent or so to really love what they do again."

Jean M. Antonucci, FP

Farmington, ME

Working a three-quarter schedule, Jean Antonucci expects her micropractice to net approximately \$64,000 this year. Her goal is to gross slightly over \$100,000, which she figures will yield a net income of roughly \$80,000. She could make more, she says, if she put in another day each week, but "my life is important to me, so I've structured my practice so that I can achieve a balance between my life and my work."

Her office—a one-woman affair that operates out of two rented rooms in a standard-looking medical building—also permits her "to practice medicine the way I think it should be practiced."

Her previous experience in medicine did just the opposite.

After residency, she worked for four years in a three-physician, hospital-owned practice in Augusta, ME. On call every third night and facing a grueling pace both in and out of the office, she felt frustrated and unappreciated. "For four years, all I ever heard was that I wasn't doing enough to earn my paycheck," Antonucci says.

Leaving that practice, she went to a rural health clinic, which local patients used when they didn't want to travel to their regular doctor. The discontinuity of care bothered her, and on one occasion, it almost caused her to give a child a medicine she was allergic to.

Her last job before opening up her micropractice was in a VA hospital, which she found a miserable experience, albeit a well-paid one. As she says: "I sat in a tiny room, and most of the patients I saw simply wanted their medicines, which the VA wouldn't give them unless they were examined by a doctor. But I didn't function as a doctor—I functioned as a clerk."

Today, Antonucci has put the bad memories behind her. Armed with cutting-edge technology ("I simply couldn't do what I'm doing without my laptop, cell phone, EHR, and all-in-one copy, fax, print machine"), she's able to do more with less. She finds it especially helpful to book her own appointments, permitting patients to get the time she thinks they need.

She also tries to accommodate her patients in other ways. "Generally, I see patients the day they call. That kind of flexibility is really the 11th commandment for micropractices."

Scott E. Clemensen, FP

Canandaigua, NY

Unlike Antonucci and Brady, Scott Clemensen started his high-tech micropractice straight out of residency training at the University of Rochester Medical Center (in NY)—or practically straight out. For two months while doing start-up research, he moonlighted at a nearby family practice, an experience that convinced him that that wasn't the style of medicine he wanted.

What did interest Clemensen was the chance to put Gordon Moore's ideas to work in his own practice. (He'd known the micropractice pioneer at Rochester, where Moore was on the faculty.) A self-admitted control freak, he didn't want the pressure he'd felt while moonlighting and in residency to see patients in 10- to 15-minute blocks. By controlling his own schedule, he could delve deeply into the compliance issues and other

psychosocial issues that his residency training had prepared him for. "In a micropractice, you're not standing in the exam room with your hand on the doorknob," he says.

Most of his patients like the extra attention. But a small minority, Clemensen acknowledges, "don't appreciate a doctor asking probing questions. Ironically, they prefer the traditional practice model, where they can get their issues rubber-stamped and move quickly along."

Because he doesn't rubber-stamp, Clemensen has had to cap his medical practice at 300 patients—a mark he reached only four and a half months after opening his doors last September. (He practices, alone, in a 110-square-foot room that he leases from a physical therapy office.) He assigns prospective patients to a waiting list, for which he receives five to seven new calls each week.

A licensed acupuncturist (he received his certification this year) and part-time residency instructor, Clemensen limits his full-day office schedule to Tuesdays, Wednesdays, and Fridays. For two-hours on Mondays and Thursdays, he schedules acute visits. Because, like most micropractitioners, he believes in open access or same-day scheduling, he may start his full office days with only a few scheduled patients, but see as many as seven or eight by day's end. Patients have the option of making appointments online.

At present, Clemensen accepts commercial insurance, but limits his Medicare participation to just a couple of managed Medicare programs. (He accepts very few Medicaid patients.)

Clemensen estimates that his current income is roughly "70 percent of what an entry-level job in family practice would be." That suits him for now, given his other interests. But he knows that, when the time comes, he could easily increase his revenue. "Building this kind of practice from the ground up, you learn a lot about the economics of medicine," he says. "It's easy to see how to improve your efficiency and bottom line."

The IMP model—not just for soloists?

The benefits of ideal micropractices—lower overhead, better efficiency, more time for patient visits, enhanced physician and patient satisfaction—certainly make it a model worth investigating. But there are downsides, only some of which can be mitigated at this point:

Most of the doctors we spoke to said they're making less than they could in a traditional practice arrangement. For the model to become attractive to more physicians, the gap between IMP and traditional earnings will need to be narrowed.

Especially for start-ups, certain resources can prove expensive. Certainly, EHRs and practice management software fit into this category, which is why experts advise physicians starting out to lease systems or buy ones with very few bells and whistles. But the cost of telephone counseling and other patient-centered services can also prove expensive for a growing practice.

For this reason, Dartmouth's John Wasson has been testing the idea of a "confederacy of micropractices," which enables IMPs across the country to share resources like patient education nurses, thereby reducing individual practice costs.

A micropractice "isn't for the faint of heart," cautions Michelle Eads, who says that IMP doctors must learn to wear many hats in order to keep their overhead lean. Scott Clemensen agrees, adding, "Cutting overhead is a game you play every day. If you don't want anything to do with administrative duties, this isn't the kind of practice for you."

Besides being a jack-of-all-trades, an IMP doctor must also embrace technology, and not just grudgingly. "If you're not comfortable using a computer or doing some of your own IT management, you either hit a roadblock or you end up hiring people to do it for you, which increases overhead," says Clemensen.

Ideal micropractices are especially well suited to primary care, where open access leads to improved doctor-patient interaction, which, in turn, leads to better care. That kind of open access might be more difficult for specialty practices.

Finally, if the IMP model is going to have a real effect on outcomes and rising healthcare costs, it must expand beyond solo practices. "It isn't viable for every doctor in the country to go out and work on their own, nor is it the model we're proposing," says Gordon Moore. Instead, he'd like to see "larger practices that are aggregations of micropractices." These "micro teams" might be housed under one roof and share resources, but they'd function autonomously, managing their own time, patients, and overhead without the need for middle management.

Talk of "flatter" organizations and reduced overhead is music to the ears of a growing number of businesspersons—including the National Business Coalition on Health.

"Businesses are interested in micropractices not only because they have a positive impact on their bottom lines, but because they encourage more collaborative physician-patient relationships," says Andrew Webber, NBCH president and CEO. "That yields better quality care and healthier, more productive employees."