Ideal Medical Practices

A new model lets physicians reclaim autonomy and control. But is it for everyone?

By Delia O'Hara

IT WAS 11 A.M. on a Wednesday morning at the Roscoe Village Family Practice, a storefront on a corner in an affluent family neighborhood on the North Side of Chicago. The radio was playing light classical music, and the small waiting room was deserted, because Wednesdays are paperwork days. Two staff members were working in the office, but the atmosphere was relaxed.

"Listen," said Lawrence Lindeman, MD, the only full-time physician in the practice, raising a finger to his ear. "Do you hear it? You've been here how long? Twenty minutes? How many times has the phone rung?" Not once.

"That's right," Dr. Lindeman said, and smiled. "We do everything possible so the patient doesn't ever have to call."

Dr. Lindeman has an "ideal" medical practice, which he opened as a solo practitioner in 2006, the kind of small, lean primary care practice described by L. Gordon Moore, MD, and John Wasson, MD, in a 2007 paper in *Family Practice Management*—a low-overhead, high-technology blend "wrapped around an excellent physician-patient relationship." It's the only practice identified as an Ideal Medical Practice (IMP) in the city of Chicago. There are, however, a few other official IMPs in northern Illinois, plus an unknown number of "micropractices," often solo or two-doctor offices that rely on technology to make up for the fact that they have no staff, or small, often cross-trained staffs.

Bucking the Employment Trend

Medical practice is definitely going in the other direction. While more than half of physicians in 2012 were still self-employed, 29% either worked directly for hospitals, or were in practices owned wholly or in part by hospitals, up from 16% in

2008, according to a survey by the American Medical Association. In 2012, only 18% of doctors were in solo practice, down 6% from 2008, according to the survey. Even though working for a large practice may promise respite from the hassles of running their own businesses in the present environment, many doctors don't relish giving up their autonomy.

Wanda Filer, MD, president-elect of the American Academy of Family Physicians (AAFP), said that many members of her organization are feeling the tension between

Distinguishing Features

An "Ideal Medical Practice" marries the feel of an old-fashioned solo practice with the latest technology. Here are some of the identifying characteristics:

- Patient satisfaction is the top priority.
- The practice relies heavily on technology other than telephones for communicating with patients—online scheduling, patient portals and email.
- Patients have round-the-clock access to their doctors.
- Electronic medical records are essential.
- Overhead is low, with one to two staff members per doctor.
- Physicians see 12 to 18 patients per day.
- Same-day appointments are routine.

Dr. Lawrence Lindeman opened his "ideal" medical practice as a solo practitioner in 2006, following the model of a small, lean primary care practice that blends low overhead with high technology.

productivity and quality.

"We want to take care of patients in a manner that's driven by the patient's desires, by quality, evidence, compassion," Dr. Filer said. However, "payments have been lagging behind the value we give." The pressure is on to see several patients each hour in the office, but "ethically, we know there are patients we can't do that with."

In response to such concerns, interest is on the rise among AAFP members in the direct-care model, which moves away from "fee-for-service" into a system in which physicians collect a retainer for a period of time, and deliver comprehensive primary-care services in return, Dr. Filer said.

Unlike direct care, the IMP model doesn't fiddle with the way patients pay for care. Instead, it aims to cut overhead. The IMP model has solid outposts in the Northeast, where Drs. Moore and Wasson both started out, and in the Northwest, where Pamela Wible, MD, of Eugene, Ore., practices. Dr. Wible is possibly the best known proponent of the Ideal Medical model right now.

"It's the human rights movement for doctors," she said.

"It doesn't get spoken of very often, but essential qualities for physicians are a sense of autonomy, a sense of purpose, a sense of mastery, the ability to work always to be better. In a small practice, you can do that."

Giving Patients What They Want

Before she opened her own IMP 10 years ago, Dr. Wible held nine "town hall meetings" with potential patients and collected 100 pages of testimony, she says, to find out what they thought about what an "ideal" doctor's office should be like. It all boiled down to this, Dr. Wible said: "They want real health care from a doctor who cares, at an affordable price, in their neighborhood."

John Brady, MD, president of the board of Ideal Medical Practices, agreed. "It doesn't get spoken of very often, but essential qualities for physicians are a sense of autonomy, a sense of purpose, a sense of mastery, the ability to work always to be better. In a small practice, you can do that. When you are employed, when you give up your autonomy to avoid the mundane stuff," the productivity demands can be daunting, said Dr. Brady, a solo family practitioner in Newport News, Va. "Over about 20 patients a day, you start losing empathy; that's my gut feeling. You'll be worn out emotionally."

An IMP offers "a wonderful way to practice medicine," said Dr. Brady. His group, Ideal Medical Practices, is a nonprofit umbrella organization that works to demonstrate the efficacy of the IMP model, assist practitioners and improve quality.

It's good for patients, too, he said. According to a recent study, practices with one or two physicians had 33% fewer preventable hospital admissions than larger practices, especially large hospital-owned practices, Dr. Brady noted.

The Pendulum Swings Back

Sakina Bajowala, MD, owner and sole physician at the Kaneland Allergy and Asthma Center in North Aurora, Ill., learned about IMPs from a urologist-heavy online practice management group, and thinks it could work for at least some other specialists like her. "People told me I was completely nuts when I was starting out," she says about her debut in a solo IMP four years ago.

"It's true, the pendulum is swinging in the other direction," Dr. Bajowala said. "But when everything is under the control of large hospital systems, and [other people have] a lot of control over how doctors work, and they realize what that's like, it's going to swing back hard." Meanwhile, "if there is a choice between being a number and being a person, I'm going to choose being a person every time."

Dr. Bajowala, an allergist, worked in a large practice for three years at the beginning of her career. She had five or six support staff, but still often wound up handling things herself, she said, because she wanted her practice to be a particular way. "I realized I didn't need a ton of people to do it for me all day long. That's what led me to think

of this model," she said.

She had no staff at all for the first 18 months in her new practice, and she is proud of the fact that at Kaneland Allergy and Asthma, "I am truly the one person who knows how to do absolutely everything. I can change the toner, take out the garbage and check the mail."

About 18 months into running her new practice without a staff, she found "personal satisfaction" going down. "I couldn't handle my clinical responsibilities and the front office, too." She has a physician's assistant now, and three additional part-time staffers.

Dr. Lindeman agreed strongly that some staff is critical. While it often makes sense to start out with a staff-free office, buying virtual reception and other services as needed, he is convinced that, long-term, "the people who are successful all have staff."

Hands-on Personalities Best Suited

Dr. Lindeman and Dr. Bajowala have some things in common. First, they want to have that "family doctor" experience, even in the 21st century. They both love technology and they have friendly "hands-on" personalities. Both say they'll roll up their sleeves and do just about anything, if the need arises and they have the time.

Dr. Lindeman took a course on how to use his practice's new billing software right along with his staff. "They told me I was the only doctor who had ever taken the billing course," he said.

Before opening his own practice, Dr. Lindeman was the medical director at a family practice residency, which had "lots of doctors" and about 30 staff people. In that job, he said, he "mostly learned what not to do. My biggest goal for my own practice was simplicity. I wanted it to be calm."

Dr. Lindeman shares his office with Lois Miller, MD, who works roughly half-time. They provide each other coverage for vacations and other absences. He is in the office about nine hours a day Monday through Friday, typically sees 15 patients a day (his patient panel is about 1,800), and earns more than the median income for a family practitioner, he said. His patients all have his cell phone number, but he said, "I never get called unless somebody really needs me." Same-day appointments are routine for sick patients, and everyone who has an appointment is seen, no matter how

Dr. Sakina Bajowala is proud of the fact that at her solo practice, Kaneland Allergy and Asthma Center, she is the one person who knows how to do absolutely everything.

Physicians Most Likely to Succeed

THE COMMON thread doctors share who thrive in the Ideal Medical Practices model is "a sense of entrepreneurialism and problem solving," said John Brady, MD, board president of the nonprofit Ideal Medical Practices umbrella group. Two Chicago-area IMPs agree. They enjoy those aspects of their practices, and they say the IMP model probably isn't for everyone.

Sakina Bajowala, MD, whose allergy practice is in North Aurora, Ill., said, "The IMP was for me, really, because it satisfied my need to stay on top of quality control. I have to have my finger on the pulse of everything. If I had to wash my hands [of the day-to-day operations] and hope the practice was running well, I would be ill at ease."

"At the end of the day, IMP doctors are not above doing anything that needs to be done, even opening up the office or mopping the floors. It's not like a practice where a doctor is saying, 'That's not my job.'"

Lawrence Lindeman, MD, who practices in Chicago said, "Practice management is really important. A lot of doctors don't want to get into the nitty-gritty of practice management."

However, he said, "It's important to look at everything from the patient's point of view."

"If the patient isn't comfortable with something, we don't do it. We don't do tests—well, strep tests, yes, things that make sense. But we only have something if it's to the patients' benefit. If I had something around," like an EKG machine, for example, "and I was making money, I would want to do [the tests]. So we don't have them."

Dr. Wanda Filer, president-elect of the American Academy of Family Physicians, notes increased interest in direct care, where physicians collect a retainer. The IMP model, in contrast, aims to cut overhead.

long it takes.

Dr. Lindeman is proudest of "our clinical outcomes." The practice is a Level 3 Certified Medical Home, affiliated with Advocate Illinois Masonic Medical Center, where Dr. Lindeman said he is not only among the top performers, but also gets high marks in patient-satisfaction surveys. "We spend a lot of time with our patients," he said.

Lean and Efficient Staff

Embracing technology has been key in succeeding with the ideal medical model, Dr. Lindeman said. The practice belongs to several large insurance plans, and files for patients, but sends out virtually no bills, simply charging balances owed to patients' credit cards kept on file. (Someone will call a patient if a big charge is about to hit, though, he said.) The practice encourages patients to book appointments online, which saves "tons of money," he said, and steers them hard to the patient portal for lab results and other communications—though about 3% don't use the patient portal at all, Dr. Lindeman said. "We're like a regular doctor's office, but we try to be very efficient," he said.

The three staff nurses, including office manager Leticia Sandoval, who has been with Dr. Lindeman since the office opened, take blood, administer vaccines, and handle insurance and billing matters at the front desk. "We all know how to do pretty much everything," Sandoval said.

"We don't have many people, but they're really good," Dr. Lindeman said.

The office keeps track of chronically ill patients, and sends out emails and makes follow-up calls to diabetics overdue for a visit. Once a week, the staff meets to brainstorm ideas on how to improve efficiency. The practice tries a lot of things. Some work, some don't, like the free pedometers the practice handed out once in hopes of getting diabetics to exercise more. "Not a single one used it," Dr. Lindeman said.

Dr. Bajowala sees 15 patients on a really busy day, more typically 10 or 11. Technically, she works part-time, two full days, two half-days, plus every other Saturday. Dr. Bajowala spends an hour on each initial appointment, and schedules half an hour for each follow-up. Her patients, too, have her cell phone number.

"Allergy is a cognitive specialty. You have to be a bit of a detective. I spend most of my time taking a high-quality history, listening to the patient, teasing out the relevant information to see what is causing the problem. It is a specialty that does benefit from more time spent with the patient," she said.

Getting More Face Time with Patients

Dr. Bajowala has a patient panel of 1,600, though she notes, "many of those got what they needed on the first visit." The primacy of the doctor-patient relationship, the keystone of the IMP model, helps in a specialty like hers, where "a cure on the first visit" is not uncommon. "People are pleasantly surprised to find a practice where they feel listened to. You get a lot of word of mouth [referrals]." She said she loves being "the allergist for my subdivision, my kids' classmates, and doctors down the hall."

Dr. Bajowala tries to do all her paperwork while she is in the room with a patient. "I explain to them I will be typing on my laptop. I'm very upfront. I tell them it's to increase efficiency and make it easier for them to access their records." She keeps her EMR on her phone. "When patients call, I don't have to wonder who they are," she said.

"I take from the IMP model what makes it so good, spending time with the patient, being accessible, addressing more than a single concern" during a visit, she said. "When I am able to demonstrate to my patients that I have taken an interest in who they are, they trust me more and they are more likely to take my recommendations, and that leads to higher quality care," she said.

Delia O'Hara is a Chicago-based freelancer who frequently writes about health care and science topics. She was previously a longtime features reporter for the Chicago Sun-Times.