Interview With Therese M. Mulvey, MD: Growing a Community Practice

*Therese M. Mulvey,
MD*

Therese M. Mulvey, MD, is a medical oncologist with Commonwealth Oncology, a private practice of 30 physicians headquartered in Quincy, Massachusetts. She also serves as an Associate Editor for the Journal of Oncology Practice and is chair-elect of ASCO's Clinical Practice Committee. Dr Mulvey agreed to share her personal story as well as a snapshot of the reality of operating a medium-sized community practice in 2007.

Some of the physicians interviewed for this column came from medical families. Was that true in your case?

Yes and no. My father was a truck driver and janitor, and my mother was a nurse who worked primarily in business. But being a physician was something I always wanted to do, from grade school on.

I went to college at Holy Cross in Worcester, Massachusetts, and found myself in classes with kids from private schools or better public schools who were much better prepared. The whole pre-med thing was overwhelming, so I majored in history. Sometime during my junior year, I took a comparative anatomy class from a visiting professor who took an interest in me and encouraged me to think of a career in science or medicine. That's when it all took off. I finished pre-med classes after graduation, worked in a lab for a year, then applied and was accepted at Tufts Medical School. I started there as my husband was finishing law school.

I did my internship and residency at Tufts New England Medical Center, started a fellowship, and then had two children 15 months apart. So I took a year off, which was an unusual thing to do during a fellowship. I worked at a community health center as a primary care physician, and really gave serious thought to not going back and finishing my oncology fellowship. I didn't want to go back to a National Cancer Institute-funded research facility, because in those days you either chose community oncology and went to a program that wasn't research based, or you did a research fellowship and followed the path of a physician-scientist. Had I chosen community oncology, my program's funding would have been in jeopardy, because their funding was contingent on producing physician-scientists. As much as I enjoyed the lab, I enjoyed taking care of patients more. So, I finished my oncology fellowship at Mass General [Massachusetts General Hospital, Boston, Massachusetts], which at the time was more clinically based.

I was offered a job on the faculty at Mass General, and anticipated staying. There was an oncology practice literally 5 minutes from our home, and they were advertising for an oncologist. I offered my services part-time, which again, in the late 1980s and early 1990s, was not the norm. But my future partners were great; they said I could work part-time if I agreed to take full-time call. After 2 years they offered me a full partnership, and it has been a great relationship since. I was the fourth person to join that group, and next fall there will be 30 of us. Many things in life are just being in the right place at the right time.

How did the practice grow?

It started with the four of us in the Quincy area. We found that we had a shared vision with a group a few towns over. By the late 1990s, managed care was penetrating Massachusetts, and it became clear that we couldn't adapt as a small group; we needed economies of scale and greater ability to negotiate with contractors. So we joined with the other local group to form Commonwealth Oncology. Over the next 3 or 4 years, other groups joined, and we grew to about 20 physicians. We now hire physicians directly rather than joining with other established groups.

We serve eastern Massachusetts from the New Hampshire border out to central Massachusetts and south to Cape Cod. In the spring, we'll open our first radiation center, hopefully with others to follow.

And the other services?

Every site is a little bit different. One of the sites has an integrated cancer center. Some offer social work and financial counseling, and some have nutrition counseling. It's not homogeneous. We do what works in any given situation. Some of the staff service several sites, such as the financial counselor.

I understand you offer financial and dietary counseling and translation for patients who don't speak English?

I spend 50% of my time at Carney Hospital, an inner-city hospital, which serves a large, immigrant population. Many of those people don't speak English. The hospital is wonderful about providing translators, and over the years we've worked with several interpreters who are interested specifically in cancer patients. This has worked phenomenally well. We have translators who work in Vietnamese, Haitian-Creole, and Spanish; although the Spanish we can do generally on our own. This particular hospital also provides dietary counseling in the patients' native language. Many of the interpreters we work with are active in community organizations, and this helps bridge the culture and language gaps.

As for financial counseling, the practice employs two counselors to travel to the sites and help people negotiate the financial issues that come along with having cancer, such as when to apply for social security disability, how to use sick time, how to negotiate short- and long-term disability, and so forth. This alleviates a tremendous amount of anxiety for patients who are worried about providing for their families. It also alleviates some of the anxiety for the practice, and lets us deliver the best evidence-based medicine regardless of the financials. Financials are an unfortunate reality for both sides.

And do you have electronic medical records?

We're working toward a full EMR [electronic medical record]. At this time, we use automated computer chemotherapy-ordering software that's integrated with our billing and scheduling system. But only approximately 10% of our practice actually has EMR records. It's been one step forward and two back. One size doesn't fit all. What works at one of our hospital-based sites may not work at an office-based site. We're 30 doctors at six different sites. How can we be interoperable with every hospital and still protect patient privacy? It's very complicated. I personally admit patients to three hospitals, and they are just not that excited about sharing all of their patient data with my computer system, knowing that it will all appear in one patient's chart. Those are technological issues we haven't yet overcome.

Speaking of other hospitals, you practice in the vicinity of large university-based cancer centers, some of which have international reputations. How do you interact with them?

Yes, indeed—Dana-Farber is 8 miles away! I was worried when I came into private practice, and wondered why a patient would come to see me in Quincy when Dana-Farber, Mass General, New England Medical Center, Beth Israel were so close. But oncology is a small world, and the reality is, we can't see patients fast enough. The demand is so high, and number of people dedicated to purely clinical practice is finite. I feel very fortunate to have some of the best and brightest minds in the country so close. I'm grateful that the patients who need the services of an academic institution, the specialized care, surgery, radiation therapy, or phase I or II trials we may not be set up to run in our own office can have access to these services. The biggest downside to having world-renowned institutions is, frankly, fundraising. It is very hard to compete for philanthropic dollars for a community cancer center with the development department resources and reputations of large institutions close by.

Let's talk for a moment about Massachusetts' universal coverage program for state residents. How has that affected you as a provider and an employer?

It hasn't affected us either way very much yet, and it's not likely to affect us as an employer, because we offer health insurance to our employees.

Under the new program, which is called the Commonwealth Connector, everyone has to have health insurance by a certain date. People at just above of the poverty level, traditionally the Medicaid population with large spend downs, will be the first to be enrolled. So far it looks for all the world like regular old Medicaid. They get their primary care physicians through the traditional Medicaid primary care base in the community health centers. The fee schedule looks like Medicaid, so far.

The next group to be enrolled will be the 100% to 300% of the poverty level, people who are working, but can't afford health insurance. It will be interesting to see how that shakes out. People who don't take the health insurance will be penalized on their state taxes. It's similar to Medicare Part D, in that it will be more expensive if they don't enroll during the initial period. I believe the plan is for everyone to have health insurance within the next 2 years. Employers are going to fund this with the state. A business with 50 employees, which doesn't offer health insurance, will have to kick in a certain amount of money per person per year. But so far it just looks like we've got more Medicaid patients. The plans for people not close to poverty levels may include low premiums and high deductibles. This could be problematic if say it were like Medicare with an 80/20 plan. Most folks who choose this don't expect to get sick and choose these plans to have more cash on hand. A cancer diagnosis could be catastrophic financially.

One problematic issue has been immigrants living in Massachusetts for less than 5 years. They cannot get Medicaid or the new Commonwealth Connector insurance, even with a green card, due to the strict residency requirements.

Now, back to your practice for a minute: how do you make decisions like capital allocation, and what do you look for in new associates?

Our CEO [chief executive officer] was the founder of the Quincy group, and we have a board of 10 physicians. The board handles strategic planning and plans for capital allocation. Recent expenses have included the radiation site and hiring a nurse to oversee quality and safety. Two or three times a year we have all-physician meetings to make sure everyone agrees with the plan and recommendations, and people pretty much do. We're fortunate to work with solid, cooperative people.

For new hires, we look for people who are bright and well-trained. They must be willing to work hard. We have to address this directly. Many bright people are coming out of programs where they've had limited hours and a lot of protected time—nights, weekends, things like that. There has to be an understanding that when you join our group and begin to build your own practice, it's hard work. Each physician in our group sees an average of six to 10 new patients a week. This is often a big change for folks coming out of fellowship. We want people who are cooperative and

easy to get along with, and share our goals of patient-centered quality care. We're neither a research institution nor a factory. We want to take good care of the folks who come through our doors, participate in clinical trials that make sense for us and our patients, and support both the patient and their families through the illness.

Do you find the practice of oncology much different now from when you started 16 years ago?

There is an enormous change in our ability to do what we want as quickly as we can. The administrative burdens are immense and increasing yearly. We are held to the fire daily by payers to justify our mere existence. Every year codes change and unfunded mandates increase by private payers, such as increased prior approvals, so there's a learning curve just to do the same thing each year and bill it correctly. This is only in the office. Add to this the vagaries of inpatient billing and six different insurers all with different rules and pharmacies. It is the same everywhere.

One thing that has changed our lives has been the immediacy, which we all take for granted. I have a cell phone, PDA, computer with e-mail and Internet, as do many of my patients. If my pager goes off and I do not call back in

5 minutes, I am paged with a "second call" message. Patients want e-mails answered immediately, as do colleagues, pharmacies, and home care agencies. There is less time to sit back and reflect about a case or problem because everyone, including myself, wants a quick and immediate answer and plan. I think this is one of the biggest challenges facing oncology as a "cognitive" specialty. There must be time to consider the plan and the alternatives, seek others' opinions, and read. With the push to see more and more patients, this can easily get lost.

Many job offers come across my desk for HMO [health maintenance organization] staff-type positions, pharmaceutical or academic positions, and some days I wonder whether remaining in private practice is worth the harassment. But the science keeps moving forward, and we've seen the great positive impact of new drugs and technologies. Cooperative trials keep us charged up and interested, and patients who need our care keep coming through the door. In the end, it is definitely different but no less rewarding today than when I started 16 years ago.

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