

The History of Integrated Practice

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I hope that many of you were able to attend the most recent annual meeting of LUGPA, held traditionally the first week of November in Chicago. We enjoyed record attendance this year by both physicians and administrators, and despite the pressures of groups being purchased by integrated hospital systems, the organization continues to grow.

If you are reading this piece and are part of a group that is a member and you have not taken the time to attend the meeting, I would encourage you to speak with your group leadership and put the meeting date on your calendar for next year. If you are reading this and are part of a group with five or more urologists and are not a member of LUGPA, I encourage you to join (www.lugpa.com). In either case, you will find this to be one of the better investments of time and money as we face continued challenges to the survival of integrated and independent practice.

Over the past few years, not only at our annual meeting but as I have had the opportunity to speak with other urologists across the United States, questions about the organization invariably come up: How did LUGPA start? Why don't we have our meeting concordant with the AUA in May? Why do we even bother being members of AUA, AACU, and LUGPA?

The Large Urology Group Practice Association (LUGPA) was the brainchild of key members of The Urology Group in Cincinnati. In the late 1990s and early 2000s, Gary Kirsh, Earl Walz, and Bill Monnig recognized that there were many urology groups consolidating across the United States and thought it would be a good idea for the leadership of those groups, both physicians and administrators/CEOs, to network with each other to compare business models, recognizing that larger practices face many different hurdles and challenges than their smaller cohorts and those in academic medicine. TAP, a joint venture between Takeda and Abbot and the maker of Lupron, at the urging of Bill and Earl, funded the meeting and paid for a physician and administrator to fly into Chicago. As attendees, we discussed how our markets were different, what strategies we were employing, what service lines were being offered and developed, etc. What started out as a dozen or so groups getting together soon became a very hot ticket as more groups started to consolidate in various

cities. Everyone wanted to come to the “TAP meeting.”

In 2007, as I was walking into the hospital one morning, I received a call from my good friend Gary Kirsh. For many of you who know Gary, he can be quite persuasive, to say the least (the growth of UROPAC can be attributed to his powers). Gary informed me that the number of groups wanting to attend the “TAP meeting” was becoming unsustainable for TAP to solely fund. He and Earl, working in conjunction with Wendy Weiser and her team in Chicago, wanted to start a not-for-profit organization, dedicated to the preservation of independent and integrated urology practice. They believed it was time for us to have a formal entity due to the groundswell of groups merging across the country, and that we needed a vehicle that addressed the issues and questions that many of these newly formed groups had. Gary inquired about my interest in being on the initial board of the organization that would continue our tradition of having both physician and administrative leadership as part of the board.

The rest, you can say, is history. In LUGPA’s first year of existence, 41 dues-paying groups joined. Today, I am happy to report that the membership continues to grow and now totals north of 120 groups, representing close to 2300 urologists across the United States. Depending on what figures you wish to use as the denominator, that is about one-fourth of the urologists in the country. Not too shabby for an organization that has only been in existence for 5 years.

The number of minefields that we as urologists have to navigate continues to grow. LUGPA does have to work with the AUA and AACU to present a united front in providing the best care for our patients, especially to the decision makers on Capitol Hill. As we move away from the traditional fee-for-service model and into performance- and value-based payment systems, our business practices need to be dynamic and morph in order for us to survive and still provide optimal patient care, which should always be our number-one priority.

Cancer management is a significant portion of any group’s total revenue. It is imperative that we continue to recognize that fact and embrace the newer therapies and modalities of diagnosis and treatment. We are the last bastion of independent and integrated practice.