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EDITORIAL

Consumer-Driven Care May be Dramatic

The age of consumer-driven care is upon us and cannot be ignored. That's the opinion of observers who cite a rising number of examples of insurers that are developing these plans for their employer customers who want them for their workers. Among the major national insurers that have developed these plans are Wellpoint, United Healthcare, Aetna, Cigna, and Humana. These insurers are offering high deductible plans linked to health savings accounts and employers are offering these plans (also known as consumer-directed health plans or CDHPs), along with more traditional HMOs and PPOs. So far, more than one million Americans have chosen to participate in such plans.

Jayne Oliva of The Croes-Oliva Group, a consulting firm in Burlington, Mass., says the changes that are coming as a result of these plans will have a significant effect on physician practices. Patients will seek and evaluate physicians using data available on the Internet to compare one physician against another and to monitor the quality of their care, she says. Also, since consumers will be spending their own money, they will have greater expectations and will demand practice efficiencies such as same-day access, no waiting time, and convenient hours.

The structure of care will change as well because patients will pay using debit cards, and the use of e-mail consults and telemedicine will rise, Oliva continues. Physicians and other providers will develop customized care centers, sometimes called "focused factories," to provide care for patients with chronic diseases. Investments in information technology will be imperative for survival.

While physicians will need to make some changes to accommodate these new plans, many are likely to appreciate some of the aspects of consumer-driven care. Caring for patients under a consumer-driven system, for example, may eliminate many of the burdens of pre-authorization and other forms of health-plan sponsored micromanagement. Also, health plans and banks are developing cards that contain information on each patient's health savings account (HSA) fund reserves and electronic health record, meaning physicians may see improved cash flow if they get paid at the point of care.

To take full advantage of such sophisticated technology, physicians would need to invest in information systems capable of managing electronic medical records, swipe cards, and allowing for communication with patients over the Internet.

Like any of the other major shifts in care processes that have occurred over the past 20 years, the change to a consumer-driven system is likely to be fraught with challenges for physicians and office staff. Fortunately, the resulting changes are likely to be mostly positive from a physician's point of view even if difficult and challenging during the transition from what we have now to what will be in place in the future.

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Program Recognizes Care Quality

Cardiologists who deliver quality care can earn recognition through the Heart Stroke Recognition Program (HSRP). A voluntary program based on accepted, evidence-based clinical guidelines, HSRP formally and publicly recognizes physicians for the quality of their care. Several payers use such recognition to promote high-quality care among enrollees and in pay-for-performance programs.

The National Committee for Quality Assurance (NCQA) in Washington, D.C., in collaboration with the American Heart Association and the American Stroke Association, both in Dallas, has created the program to recognize physicians who deliver high quality care to cardiovascular and stroke patients. Launched two years ago, the program to date has bestowed HSRP recognition on some 130 physicians nationwide.

Promoting Improvements

The goal of HSRP is to promote improvements in quality of care among cardiologists, neurologists, and primary care physicians who treat patients with cardiovascular disease and have had a stroke. "HSRP is part of a larger NCQA strategy to expand our measurement of quality at the physician level," says Linda Shelton, NCQA's assistant vice president of product development, who is responsible for all NCQA recognition programs.

More than 60 million Americans have cardiovascular disease or have suffered a stroke; the two conditions combined are the leading cause of death in the United States, NCQA says. Despite widespread dissemination of clinical guidelines defining optimal care of patients with these conditions, most patients do not receive such care.

"There are well accepted, evidence-based measures of quality in the care of cardiovascular disease and stroke," Shelton explains. "Through the HSRP, we have taken those measures and operationalized them. NCQA has developed a way of collecting data consistently across practices and a method of scoring that allows us to determine with excellent validity and reliability which physicians or practices meet the standards of care embodied in the HSRP measures."

HSRP is modeled after a successful NCQA program that rewards physicians who provide high quality diabetes care: the Diabetes Physician Recognition Program (DPRP), operated in collaboration with the American Diabetes Association. Instituted in 1997, the DPRP has recognized 2,500 physicians to date and fostered improved performance on measures of diabetes care.

Proven Processes

"NCQA recognition programs validate the health care industry's growing commitment to quality of care in the ambulatory arena," says Thomas Knight, MD, an internal medicine physician and Medical Director of Quality Improvement and Disease Management with Forsyth Medical Group, a 185-physician multispecialty group with 31 practice locations in and around Winston-Salem, N.C. "They measure adherence to a proven process of care for a specific population. We pursued recognition as part of our overall goal of moving beyond excellence in acute care toward the management of a population of patients with chronic illnesses." Forsyth Medical Group physicians began achieving DPRP recognition in 2002 and HSRP recognition in 2003.

HSRP is a positive step for cardiology, says Joel J. Rubenstein, MD, a cardiologist with Newton-Wellesley Cardiologists and chief of cardiology at Newton-Wellesley Hospital, in Massachusetts. "It is quite difficult for office based physicians to know exactly how well they are performing," he explains. "Physicians are inherently motivated to provide excellent quality of care, and a mechanism to convey information to them about their performance, such as HSRP, can be very useful for driving improvements.

"I have had a long interest in guideline development and implementation," Rubenstein continues. "One of the key elements of implementing a guideline is feedback to the physicians. In general, while such feedback has been ongoing in the hospital setting, it has not been common in the outpatient setting. Since HSRP was our first opportunity to obtain feedback about our performance in our practice, we decided to participate."

Setting Goals

While many physicians believe the purpose of public quality measure-

(Continued on page 4)

"We have been able to differentiate ourselves from our competitors by emphasizing that we care for patients beyond their acute events," says Thomas Knight, MD, Forsyth Medical Group.

HSRP Linked to Bonuses

One significant reason to participate in the Heart Stroke Recognition Program (HSRP) may be the link between such recognition and pay for performance, says Linda Shelton, assistant vice president of product development at the National Committee for Quality Assurance. "In the last year, a number of pay-for-performance programs have been developed based on our recognition programs," she says, adding that payers use NCQA recognition as a criterion for conferring financial rewards on physicians.

The most prominent example is Bridges to Excellence, a coalition of large employers including General Electric, Ford Motor Co., Procter & Gamble, UPS, and Verizon.

"Bridges to Excellence employers pay bonuses to high-quality physicians as a way of ultimately controlling their own costs," Shelton says. The Bridges to Excellence pay-for-performance program tied to HSRP, called "Cardiac Care Link," pays as much as $160 annually for each eligible cardiac patient a physician treats.

A growing number of health plans are rewarding recognized physicians in several ways: showing NCQA recognition seals next to provider names in the provider directory; helping practices with data collection efforts; paying rewards or application fees to recognized physicians; and actively steering patients to recognized physicians, Shelton says. "All the major health plans (such as Aetna, United Healthcare, Cigna, and several Blues plans) now get data feeds from us regarding recognized physicians and they distinguish these physicians in their provider directories," she adds. In addition, several payers, such as Oxford Health Plans of New York, encourage enrollees to seek care from recognized physicians or offer providers assistance with chart review and data collection. —DJN

(Continued from page 3)

ment is to indict them or pressure them to change their practices, the NCQA programs recognize physicians who have adopted systems that enable them to hit certain goals.

Physicians can more easily meet the standards of care set forth by clinical guidelines if systems and processes exist to support their efforts, Rubinstein explains. "Cardiologists, like all physicians, want to do the right thing," he asserts. "But guidelines typically embody a variety of complex requirements. Clearly, the development of systems that place guideline specifications easily at hand and that track the response to those guidelines will be helpful to physicians."

Before participating in HSRP, the Forsyth Medical Group had been measuring quality indicators related to cardiac care each quarter. "But HSRP stimulated the creation of an infrastructure to support our physicians such that we now have systematic ways of ensuring that all our patients are getting the preventive care they need," Knight says. "We don't just measure physicians' performance and tell them to improve. Rather, we make it easier for them to fulfill all the routine components of preventive care in an efficient manner."

Participation Requirements

The nature of the HSRP program encourages participation because it is non-punitive, Shelton explains, adding that only the names of physicians who achieve HSRP recognition are publicized.

To participate, physicians purchase a license to use NCQA's Web-based HSRP survey, Shelton says. The survey includes the specifications for selecting a sample of patient charts (25 or 35 charts per doctor, depending on practice size) and abstracting data to compare against the standards for five quality indicators:

1. The percentage of adult patients with documentation of a blood pressure test and whose average blood pressure is less than 140/90 mm Hg.
2. The percentage of adult patients with a lipid profile that includes total serum cholesterol, serum triglyceride, high-density lipoprotein (HDL), and low-density lipoprotein (LDL).
3. The percentage of adult patients with an LDL of less than 100 mg/dl.
4. The percentage of patients who have documentation of aspirin or other antithrombotic use.
5. The percentage of patients with ischemic vascular disease (IVD) who have notation of smoking status and, for those who are smokers, documentation of referral for smoking cessation counseling or treatment.

These five indicators were chosen because improvements in these measures are associated with better patient outcomes for a number of conditions collectively grouped under the term IVD: coronary artery disease (acute myocardial infarction, stable angina); peripheral arterial disease; and cerebrovascular disease (ischemia, stroke, and atheroembolism).

Physicians can earn as many as 10 points for each indicator, depending on the percentage of patients in the sample. To be recognized, physicians must earn 40 out of a possible 50 points.

"Following the self-assessment, physicians who meet the standards submit their data to us," Shelton explains. "We review and validate

Group Learns Hard Lessons

Physicians who participate in the Heart Stroke Recognition Program (HSRP) may find that the chart review involved be revealing, says Linda Shelton, assistant vice president of product development at the National Committee for Quality Assurance.

"HSRP creates a teachable moment that prompts improvements in care quality," Shelton asserts. "Physicians have told us that going through the exercise of pulling a sample of charts and looking at the care they are actually providing is the best educational event they have ever participated in. HSRP prompts a real awareness of what they are actually accomplishing with their patients. All physicians want to provide the best care possible, and most honestly believe that they are following evidence-based guidelines carefully and thoroughly. So it can be sobering, but enlightening, if they determine that they are not perfect."

A large physician practice in the Midwest, for example, inquired about HSRP participation because the region's Blues plans were offering rewards for recognized physicians. "Unfortunately, after the physicians reviewed their charts, they found that they did not pass the standards," Shelton says. "That exercise then prompted them to pursue quality improvement activities geared toward the provision of optimal quality ischemic vascular disease care." —DJN

the data and confer a recognition on those participants who pass within 30 days of submission." HSRP recognition is valid for three years.

Rewards for Recognition

Physicians who are recognized are sent an NCQA certificate and a template press release they can use to publicize their achievement in their communities. They are also listed on the NCQA Web site (www.ncqa.org) in the "Recognized Physician Directory."

"Certainly, an important motivator for many physicians is a desire to differentiate themselves from their competitors based on quality, thereby expanding their practice," Shelton says. "For example, some physicians who have achieved recognition have taken out full-page advertisements in local newspapers highlighting their NCQA recognition."

Knight agrees, saying, "Recognition has been a powerful marketing tool in our efforts to demonstrate our long-term commitment to patients with chronic conditions. We have been able to differentiate ourselves from our competitors by emphasizing that we care for patients beyond their acute events and into the future by controlling their risk factors through systematic preventive care."

Furthermore, recognition helps promote practice integration, Knight adds. "We are geographically diverse, and these programs have helped us promote group identity by representing the achievement of a goal that is professionally appealing to all of us: high quality care," he asserts. "NCQA recognition confirms that we are making an important contribution to the health of our communities."

"Our practice has been recognized by insurers, our own hospital administration, as well as the Partners Health Care System for our HSRP recognition and the high quality of care implied by that recognition," Rubenstein says. "We believed we were providing high quality of care to our patients, and participation in the HSRP program has allowed us to confirm it. My experience with guideline implementation has indicated that for many physicians and many practices, feedback on performance is crucial to improving care. No matter how excellent a practice is, it can always do better."

Recognition has not directly affected payer negotiations for Forsyth Medical Group, because the practice already had a strong negotiating position, Knight observes. "But quality is a topic of keen interest to employers, who are concerned about health care costs as well as productivity," he says. GE, IBM, and other employers are attempting to organize groups such as Bridges to Excellence (www.bridgestoexcellence.org), in North Carolina, he adds. "When payers try to ratchet down their networks, HSRP recognition will be a good bargaining chip because employers will not want to lose access to high-quality physicians."

Forsyth physicians have not yet earned any direct financial rewards as a result of HSRP recognition. "HSRP fits in with our quality-oriented philosophy, and we have participated out of a motivation to improve care," Knight says. "Any pay-for-performance funds that may eventually come our way will be nice, but our primary goal has been and will continue to be quality measurement and improvement for the benefit of our patients."

Forsyth is one of 11 physician groups in the nation participating in the pay-for-performance physician demonstration project of the Centers for Medicare & Medicaid Services that began April 1. "The selection process was very competitive," Knight notes. "The number of physicians in our group that had received NCQA recognition certainly contributed to our selection."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on the Heart Stroke Recognition Program is available from NCQA (at www.ncqa.org/hsrp). More information on physician practice strategies is available on our Web site (see page 8).

Employment Contracts Need Scrutiny

By Andrew T. Hahn, Sr., and Rosemary Joyce

Upon graduating from medical school and completing his residency and fellowship, Richard Kildare, MD, (a fictional character) joined the Marcus Welby Medical Group of Gotham County as an otolaryngologist. As a condition to his employment, he was asked to sign an employment agreement that contained a number of restrictive covenants (see sidebar).

After working for the group for two years, Kildare wanted to start his own practice and found an office in the next town, Smallville. For the next several weeks, on his free time, he purchased equipment and furniture. The night before he submitted his resignation to the group, he gathered his patients' files and took them to his new office. He also copied a patient list containing the names, addresses, and phone numbers of all of the patients of the group. This list was locked in a cabinet in the group's office, but Kildare knew where the key was kept. After Kildare copied the patient list, he returned the original list to the cabinet and copied his appointment book of scheduled patients for the next year. The next day, he submitted his resignation and informed his colleagues to forward his mail and any phone calls from his patients to his new office. In addition, when he arrived at his new office, he mailed all of the group's patients an announcement informing them of his departure and new office.

Three days later, Kildare got a letter from the group's attorneys demanding that he cease and desist from practicing otolaryngology in Smallville. Attached to the attorneys' letter was a copy of the employment agreement he had signed two years earlier. Kildare tossed the letter in the trash. Three days later, he received a court order temporarily restraining him from practicing otolaryngology in Smallville. At this point, Kildare called a lawyer, who said the court order was enforceable.

***Andrew Hahn** is a partner in the litigation practice group and **Rosemary Joyce** is an associate in the labor and employment practice group in the New York office of Seyfarth Shaw LLP, a national law firm with more than 625 lawyers in 10 offices in the United States and Europe.*

Limiting Factors

In the context of an employment agreement, a restrictive covenant, also known as a non-compete provision, is defined as a clause in a contract, which limits the contracting party after the termination of the contract from performing similar work for a period of time and within a specified geographical area. The laws on restrictive covenants vary by state. While restrictive covenants tending to prevent a person from pursuing his or her vocation after the termination of an employment relationship are disfavored, they will generally be enforced if they are:

1. Reasonable,
2. Necessary,
3. Not harmful to the public,
4. Not unduly burdensome.

Covenants restricting physicians from competing with a former employer are common and generally acceptable in many states, so long as certain requirements are met. Many states recognize the different considerations affecting the enforceability of non-compete provisions in the medical profession. Indeed, some states impose strict and specific criteria for an enforceable restrictive covenant with respect to physicians. Texas, for example, requires that such a covenant must not deny the physician access to a list of his patients whom he has seen or treated within one year, must not prohibit the physician from providing continuing care to specific patients during the course of an acute illness, must provide access to certain medical records, and must contain a buy out provision for the physician. Several states, such as Colorado, have enacted statutes prohibiting restrictive covenants among physicians.

Most states, however, have declined to find restrictive covenants among physicians to be unenforceable, and the overwhelming majority of states have ruled that restrictive covenants among physicians are enforceable if found to be reasonable. In certain jurisdictions, such as New York, where the restrictive covenant is included in an agreement between doctors, the interests of the employer have enjoyed careful consideration. The courts have enforced restrictive covenants against the departing doctors if the four-prong analysis has been satisfied.

Courts will consider four factors regarding the enforceability of restrictive covenants.

Reasonable Protection

The more restricted the time and geography, the more likely that the courts will enforce the restrictive covenant. A six-month time restriction has better chances of enforceability than a five-year restriction. Likewise, a 15-mile radius restriction has better chances of enforceability than a statewide geographic restriction. The restrictions should be care-

Flexibility Restricted

Here's the restrictive covenant that Richard Kildare, MD, signed when he joined the Marcus Welby Medical Group in Gotham County.

"The physician acknowledges that, as of the date of this agreement, he has no substantial sources of patients or referral sources. Physician further acknowledges that the medical group has been materially induced to enter this agreement in reliance upon the physician's express agreement to be bound by the restrictive covenant as set forth below. The physician also agrees that under the circumstances of this transaction, the following restrictive covenants are reasonable in extent, duration, and geographical scope. Accordingly, the physician agrees that in the event of the termination of the physician's employment with the medical group for any reason, the physician shall not, for a period of two years following the termination of his employment, without the written consent of the medical group, engage directly or indirectly, as principal, agent, or employee, in the practice of otolaryngology within Gotham County."

fully and specifically defined. Phrases such as, "the Smallville metropolitan area," as the geographic restriction can lead to unnecessary disputes as to whether a town falls within the scope of that location.

Assuming the covenant is reasonable in time and geographic scope, a court must further consider whether the covenant is necessary to protect the employer's trade secrets or confidential information including patient information and protect the employer's relationships with its patients that was developed over time and with expense.

A New Jersey court found that the employer had a legitimate interest in protecting himself "from erosion of his patient base resulting from the departing physician's practice at hospitals located in the restricted area." A recent decision from New Jersey's Supreme Court reaffirmed the hospital's legitimate interests including the protection of patient lists, patient base, referral base, and investment in the doctor's medical training while working at the hospital.

In Kildare's case, Kildare took patients' files to his new office. Because doctors, medical groups, and hospitals generally maintain such files with a high level of confidentiality, courts do not challenge the employer's interest in this regard. With respect to patient relationships, courts are divided. On the one hand, the employer devoted substantial time and resources to develop its patient base. Moreover, as in the case of Kildare, some doctors did not bring any patients with them. If a doctor did bring a group of patients, he or she would most likely be allowed to take such patients to the next practice. This is informally referred to as the "What's mine is mine" rule. On the other hand, the patient should be able to select the doctor that he or she prefers. In other words, the patient cannot be forced to stay with a particular doctor. If the patient preferred to stay with the Gotham Medical Group, Kildare should accommodate the patient's wishes.

Courts will not enforce a restrictive covenant if some harm to the public results. In the context of medical professionals, the argument has been made that enforcement of the restrictive covenant would limit patients' choice of a physician, especially in a medical area that is deficient of physicians generally or includes physicians specialized in a particular field. The federal government can designate certain areas as a Medically Underserved Area (MUA) or as a Health Professional Shortage Area (HPSA). Such designations can be evidence of public harm if a physician could not practice in an area where he or she is the only specialist. However, the availability of nearby specialists can be sufficient to alleviate any possible public harm that could be caused by the enforcement of the restrictive covenant, even in some cases where patients would be required to cross state lines for treatment.

In the recent New Jersey Supreme Court case, the court considered carefully the public interest, specifically the negative effect of the 30-mile restriction that would preclude the restricted doctor from becoming one of two neurosurgeons available to provide emergency coverage at the new hospital, hereby "dangerously compromising" neurological treatment and evaluation in the emergency room there."

Undue Burden

The final prong of the analysis involves whether the enforcement of the restrictive covenant would be unduly burdensome to Kildare. The restrictive covenant prohibits him from practicing otolaryngology within Gotham County. Courts would not likely find undue burden if he had to move his practice to another county.

A medical practice is a business, and one of its most important assets is the goodwill that it enjoys with its patients. Such goodwill must be protected, and a detailed agreement with in-coming physicians can offer enormous protection. Conversely, if a doctor is required to sign an employment agreement he or she should review the restrictions carefully, and, if necessary, consult with an attorney familiar with the law of the relevant jurisdiction.

—More information on physician practice strategies is available on our Web site (see page 8).

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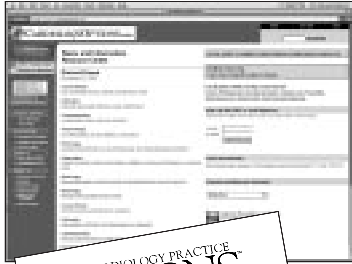

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