

# CARDIOLOGY PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Guidelines Calling for Statins at Discharge Improve Outcomes

**C**linical evidence has proven that lipid-lowering medications are highly effective in reducing the risk of recurrent myocardial infarction and in improving the survival of patients following MI. Despite such evidence and the promulgation of guidelines, these medications are dramatically underprescribed, resulting in poor quality care and adverse outcomes.

A recent study led by Gregg C. Fonarow, MD, of UCLA Medical Center, found that less than one third of heart attack patients were taking lipid-lowering medication when they were discharged from the hospital, and less than half of patients with a prior history of heart disease or heart attack risk factors were prescribed these drugs.

### Proven Benefits

In contrast, a UCLA quality improvement program directed toward the proper use of lipid-lowering medications has achieved remarkable results, showing that the vast majority of heart attack patients are being treated with these medications both at hospital discharge and at one-year follow-up.

"Effective therapies are available for high-risk patients, but they are not being fully implemented," says Fonarow, the director of the Ahmanson-UCLA Cardiomyopathy Center and associate professor of medicine in

the division of cardiology at UCLA. "If these therapies were applied widely, they would have a phenomenal impact on the health of patients with cardiovascular disease nationwide."

"Statin drugs are the most frequently prescribed, the safest, and the best tolerated cholesterol-lowering medication," Fonarow continues. "Statins very effectively lower LDL cholesterol levels, lower triglycerides, and raise HDL cholesterol levels."

In many clinical studies of lipid-lowering medications, most—and possibly as much as 95% by Fonarow's estimates—of the medications prescribed are statins. "Research has unequivocally shown that statin drugs lower the risk of recurrent cardiovascular events, including unstable angina, MI, and stroke," he states. "They lower the risk of both cardiac mortality and total mortality, and with a side-effect profile that is largely comparable to a placebo. As higher doses have become available for some of the older statin drugs, and as newer, more potent statins have been developed, the majority of patients on these drugs are able to reach the goal of an LDL cholesterol level of below 100 mg/dL. In patients with established atherosclerotic vascular disease, these agents unequivocally allow them to live longer and healthier lives."

Research has further shown that the effectiveness of statin drugs com-

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**Who Should Judge the U.S. Health System?**

The patients' rights bill passed this summer by the U.S. Senate is a ridiculous diversion of political energy, says Uwe E. Reinhardt, PhD, an expert on health economics and professor at Princeton University. The bill diverts attention from the truly shocking problems of the U.S. health care system: the large numbers of uninsured, the elderly who need drugs but can't get them, and the large numbers of medical errors, he says.

Michael Millenson, another health care expert and a consultant in Chicago with the benefits consulting firm William M. Mercer Inc., in New York, believes the problem of medical errors needs to be addressed immediately. He says that "the biggest threat to life and limb comes from what happens to you once you reach the doctor's office and the hospital."

In a World Health Organization report, the United States was ranked last in overall health system performance among 17 industrialized nations. Yet American patients praise their own doctors, foreigners flock to this country for diagnosis and treatment, and foreign doctors come here for postgraduate training.

Why these sharp discrepancies in opinion about the U.S. health system? The answer may be embodied in the word "responsiveness," an important value in the market-driven health care system in this country.

WHO recently introduced responsiveness as a new criterion to judge health systems. WHO surveyed 1,791 "key informants" (or approximately 50 or more experts in 35 countries). The informants evaluated their health systems based on seven elements of responsiveness: dignity, autonomy, confidentiality, prompt attention, quality of basic amenities, access to social support systems, and choice of care providers. By the responsiveness criterion, the United States ranked first among 35 industrialized nations.

In May, the Institute of Medicine said that the first rule for improving health system quality is that "the health system should be responsive at all times (24 hours a day, every day)."

This focus on responsiveness is also evident in the recent name change of the agency that runs Medicare and Medicaid. Formerly known as the Health Care Financing Administration, in June it became the Centers for Medicare and Medicaid Services (CMS), and promised to be more responsive to patients, physicians, and hospitals administrators.

Being more responsive is a good start, but it shouldn't hide the stark reality that more needs to be done—reducing the high cost of care for the elderly, providing greater access to care for the uninsured, reducing errors, and providing the latest scientific evidence at the point of care.



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# Ignoring Compliance Issue Is Ill Advised, Says Federal Attorney

**S**ome physicians have recommended that doctors take no action to comply with the government's reimbursement compliance guidelines. But an attorney who prosecutes these cases for the government says ignoring the compliance issue could lead to fines and imprisonment for physicians who do not comply.

Such recommendations are an indication of how exasperated physicians have become with the idea that billing irregularities can lead to penalties, fines, exclusions from federal health programs, and in some cases a trial and prison time. But ignoring the compliance guidelines could leave physicians open to an investigation, says Jim Bickett, an

assistant U.S. Attorney with the federal Department of Justice. Bickett prosecutes cases against physicians in Akron, Ohio, and says that his views do not represent the formal position of the Justice Department.

**Physicians complain that complying with the guidelines is difficult and costly, but failing to do so can have serious consequences that outweigh the difficulty of implementing an effective compliance plan.**

**—Jim Bickett, U.S. Department of Justice**

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## Severe Penalties

The AMA's House of Delegates voted last year to recommend that physicians nationwide ignore the Voluntary Compliance Guidelines issued last fall by the Office of Inspector General (OIG) of the federal Department of Health and Human Services. The delegates said that the guidelines are cumbersome, that the nature of com-

pliance regulation in the United States is currently too punitive, and that many doctors would not follow the guidelines anyway. The OIG's document, *Compliance Program Guidance for Individual and Small Group Physician Practices*, is available on the Web at [www.dhhs.gov/progorg/oig](http://www.dhhs.gov/progorg/oig) under Compliance Tools.

Physicians are at risk in two distinct areas: criminal and civil infractions, Bickett says. In either case, the financial penalties could be so severe that physicians would be well advised to consider carefully the potential ramifications of ignoring the OIG's compliance guidelines.

"When it comes to compliance, there are two separate tracks of concern for physicians: the criminal

track and the civil enforcement track," Bickett says. Criminal offenses involve breaking a federal law (or possibly a state statute) and include actions related to kickback violations and false claims being submitted to a payer with the specific intent to defraud.

If a judge or jury determines that a physician is guilty of criminal acts, the physician can be excluded from Medicare and other government-funded programs, such as Medicaid, for five years. Also, the physician can be fined, be required to make restitution, and "may be incarcerated—not in executive prisons—but rather in

prisons that house mainstream criminals," Bickett says.

## Patterns of Conduct

"I've never seen a criminal case where there was only one incident of misconduct," Bickett explains. "Instead, it's an extensive pattern of billing for care that was not provided, and paying or receiving kickbacks. Criminal conduct would include a doctor telling a billing manager to bill \$40 for a procedure, which he knows should be billed for only \$10, because Medicare doesn't pay enough. That's a conscious decision to overbill, and it's illegal.

"In civil enforcement, the government will sue for treble damages; in other words, the government will

assess triple the amount of money that was received improperly," Bickett continues.

"Of far greater concern to physicians is the per-claim penalty, which can be from \$5,500 to \$11,000 per false claim submitted," Bickett adds. Even on the low end, a penalty of \$5,500 per false claim can add up quickly, meaning the total in fines easily could exceed a practice's annual revenue. In these instances, the Justice Department may reduce the amount of the penalties.

One hospital system billed 139,000 false claims for procedures related to taking blood. "Do the math," Bickett

*(Continued on page 4)*

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says. “The penalty was more than the hospital system had.”

### Problems When Delegating

One area of particular concern to physicians involves delegating compliance tasks to staff who may be

unaware of the legal and financial ramifications of errors. “When doctors rely on untrained people to do their billing and put pressure on them, implied or otherwise, to maximize billing for everything the doctor does, the result is a practice rife with

overbilling,” Bickett says.

While Bickett sympathizes with the concerns of physicians, he says that they miss the point of the legal ramifications of actions that run counter to existing law, and thus severely underestimate their personal risk. “When I’ve spoken at seminars of private practitioners,” Bickett says, “their first comment is always the same: ‘I’m a doctor. I ought to be able to practice medicine and treat patients. This billing stuff is threatening and doesn’t help the patient, so why are you bothering us?’”

“I look them in the eye,” Bickett continues, “and say: ‘If you’re asking for money, you have an obligation to ask for money only for what you did. If you buy a Volkswagen, you aren’t billed for a Cadillac. So, if you are going to treat patients and bill the federal government for the care you provided, you have to set up a system to ensure you’re following the rules and provide proper training to your staff.’”

### Bitter Complaints

While physicians complain that complying with the guidelines is too cumbersome, failing to do so can have serious consequences that outweigh the difficulty of implementing an effective compliance plan, says Bickett. In fact, the cost-to-risk ratio does not favor the physician who fails to comply. Physicians regularly say that complying is too difficult, cumbersome, costly, or unproductive, Bickett says. “My response is: ‘If you don’t comply, you run the risk of inappropriate billing and the results thereof,’” he explains.

Charles E. Colitre, who oversaw Medicare fraud investigations while serving for 14 years as a senior supervisory agent for the FBI in northeastern Ohio, agrees that physicians are wrong if they believe a compliance program is too expensive. “Particularly in a group practice, a compliance program is likely to cost far less than what it would cost if the government comes

## Physicians Fail To Get the Government’s Message

**M**any physicians have ignored the government’s advice to draft and install a reimbursement compliance plan, even though developing a plan and putting it into action has few drawbacks, some experts say.

Having a compliance plan in place will help to protect a physician from being investigated, says Jim Bickett, an assistant U.S. Attorney with the federal Department of Justice. “I disagree with those who say having a compliance plan in place is a bad idea,” Bickett says. “The very existence of an effective compliance plan acts as a shield against charges of misconduct. In my definition, a compliance plan provides for basic education, training, and review of the billing system in a given practice.”

A compliance plan serves as a shield because it demonstrates that the physician group is acting in good faith, Bickett says. “This not only counts in court; it’s listed in the Justice Department internal guidelines to all U.S. health care attorneys as something to be heavily weighed in decisions on who to aggressively pursue for potential misconduct,” he says.

Also, implementing a compliance plan minimizes the problems for which the physicians in a practice could be held accountable, Bickett continues. For example, if the group uncovers a compliance issue while it is putting a plan in place, simply having the plan shows that the issue is being addressed, he says. When a group can show that it has an operational compliance plan, the group has significant protection, Bickett explains. “It’s harder for the government to win a case then because the physicians can show they have made an effort to comply with the guidelines. Juries understand this, and tend to rule in the physicians’ favor,” he explains.

In fact, Bickett reports that no action has been taken against groups with compliance programs in place. “Of all the physicians who have had plans in place and returned monies that were inappropriately received from payers in the last two years and that needed to be returned, none were pursued after initial investigation,” Bickett says.

Putting a plan in place does have one serious drawback, Bickett concedes. If a physician group uncovers misconduct while implementing a plan and makes no effort to fix it, the physicians have then collected money with the specific intent to defraud the government, he says. “Suppose you have a compliance program and find a problem but say to the office manager, ‘Bill it wrong anyway to increase our income,’ with full knowledge that you’re defrauding the government.” Bickett explains. “That’s another—potentially bigger—problem.”

—DK

after you for illegal conduct,” Colitre says. “Just the legal and accounting fees alone will exceed the cost of a compliance program.”

### Acquiring Targets

The process of identifying targets to investigate is much easier today than it was years ago, Bickett says, because information systems have dramatically improved the government’s ability to find billing irregularities.

“In the past, if we wanted to see if a practice had a pattern of inappropriate billing, we had to hand manipulate data,” Bickett explains. “Now, I call a carrier and say, ‘I want to see these codes and these claims on this practice, and I want to see how they compare with those of the practice’s peers.’ Boom, it’s done. It is easy for us to determine who has the potential for aberrant billing, and thus who we may want to investigate.”

Bickett’s office is handling about double the number of cases it handled in the past as a result of improved efficiencies brought on in part by the use of information systems. This factor alone increases the risk of audit. But another factor that is contributing to the increase in numbers has to do with the trend for physician consolidation. “The number of physicians affected by an investigation is higher today because doctors are consolidating their practices, often with 20 or more physicians in one group,” Bickett says. Thus, consolidation among physicians has significantly increased the total number of physicians being audited, Bickett adds.

Physicians who hold on to the simple belief that they will not be audited are taking a larger risk today than they would have years ago. Moreover, the government is concluding its actions against several major hospital systems, and it is looking more closely at group practices, Bickett says. In other words, the chances of being audited have grown significantly, putting more

## Past as Prologue: The Future of Compliance

**P**hysicians concerned about reimbursement compliance may benefit from looking to the past for possible predictions of what could happen in the future, says Jim Bickett, an assistant U.S. Attorney with the federal Department of Justice.

In the mid-1990s, the federal Department of Health and Human Services (DHHS) was concerned about reimbursement fraud among some U.S. hospitals. In 1994, the government issued guidelines for hospitals seeking reimbursement for health expenses under the federal Medicare and federal-state Medicaid programs. At the same time, fraud investigators from DHHS and the federal Department of Justice conducted extensive and intensive audits of the reimbursement practices of dozens of U.S. hospitals. During that time, the government brought a number of civil and criminal cases.

By 1998, most hospitals had effective compliance plans in place. One factor contributing to hospitals achieving compliance may have been the high level of sophistication of hospital management, Bickett says. Unfortunately, physician offices have less experienced staff, which means that it may take physician groups longer to comply, he adds.

“I anticipate that the experiences with compliance issues that physicians have will be similar to the experience hospitals had,” Bickett explains. “In other words, there will be criminal prosecutions for kickbacks, damages and penalties paid, and exclusions from federally funded programs. Then doctors will start to read newsletters, go to seminars, and address the issue. But there will always be those who will get the message and ignore it, and there will always be some who will take the risk regardless of the consequences.”

Physician groups that make an effort to comply, however, will find the government unlikely to pursue an investigation. “For the government to pursue those who are making a good-faith effort at compliance makes no sense, and it sends the wrong message,” Bickett says. “It’s important from a program perspective to send the right message. If physicians are trying to comply and are repaying what was incorrectly received, those efforts need to be recognized and rewarded. The physicians who are working hard will not be targets. Not only would it not be fruitful, but also people should not be punished for doing the right thing.”

Charles E. Colitre, a former senior supervisory agent for the FBI, who has overseen Medicare fraud investigations, agrees that physicians need to make an effort to comply. “The federal guidelines may be voluntary, but the laws they are based on are not,” says Colitre, a consultant with Med-Management Group, in Akron, Ohio. “Physicians may choose to ignore the guidelines, but they do so at their own risk.”

—DK

physicians at risk if they ignore the  
OIG’s recommendations.

—Reported and written by David Kettlewell,

in Cleveland. More information on physician  
practice strategies is available on our Web site  
(see page 16).

# Developing a Group Practice

By John W. McDaniel

**M**any physicians today are seeking to start or build group practices, and it is important for them to understand the many factors that can help them to succeed in this endeavor. In a past issue, we discussed the feasibility and development phases of starting or building a group practice. In this issue, we continue discussing practice development and address implementation issues as well.

One of the first operational issues to address in developing a group practice is to identify the physicians or executives who will be members of the management team. For this task, group members should seek candidates who have the experience, education, and personal skill to lead effectively.

## **Legal Issues**

After members of the management team have been selected, one of the first issues the team must address is the legal structure the practice will use. Will it be a sole proprietorship (not likely, if there is more than one physician), a partnership, or a corporation? For this task, the team is best advised to retain an attorney to help form the partnership or corporation and to help the new group with physician contracts, office equipment leases, collections questions, representation in hospital matters, and employment issues.

*John W. McDaniel is president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. For a copy of a checklist related to starting a group practice, readers may contact McDaniel by phone at 800/764-2633 or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).*

Once the management team is in place and the physicians have settled on a legal structure, the physicians should review call and coverage issues by analyzing the existing call groups and establishing new ones if needed.

Early in the development process, a new group also needs to address issues related to office space and design by reviewing existing leases and current practice sites. A real estate agent may be able to assist the group in selecting the best location for the practice, but the group also may need the expertise of a physician practice consultant in order to evaluate the needs of the market involved. To do so, the physicians

the physical needs of the group, they should review the capability of the security system of the existing or new building and contact system vendors for information or for bids on installing a new system, if necessary.

When considering new office space, physicians should also pay particular attention to ensure that the office is designed so that patient flow is optimized.

## **System Requirements**

Every group today needs an effective and efficient medical management system. Therefore, the physicians should review existing systems and

**One of the first issues for the management team to address is the type of legal structure the practice will use. Will it be a partnership or a corporation?**

or a consultant should collect demographic information on the areas under consideration. They should also analyze competitors in the region by evaluating how the competitors are serving the market. In this way, the physicians can identify potential opportunities for providing new or enhanced services in that market.

Determining whether it would be better to build a new building or to lease office space is another decision that many new groups must make. If the group decides to build a new office, the management team will need to get preliminary plans, draft construction documents, negotiate construction contracts, and supervise the contractor. If the group decides to lease space, the group members should be thoroughly familiar with the type of lease and the requirements of the leaseholder. While reviewing

contracts to determine whether it is better to upgrade the current hardware and software or whether buying or leasing a new system makes the best business sense. Any new system must be able to help the group comply with the new requirements under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Also, the group will want to ensure that a new system can help speed billing and payment.

If the physicians decide to buy or lease an information system, they may want to consider a system that is capable of storing medical records electronically. In the past, many physician groups had electronic systems for billing and kept paper files on all patients. Today, however, patient medical record systems are being used for billing purposes. Therefore, physician groups should carefully consider

## An office manager may be able to help with personnel issues such as job descriptions, benefits, procedures, and hiring.

getting one system to do both. To do so, physicians will need to determine which format they will use and obtain samples from vendors. Also, the physicians should determine whether they will need dictation machines because some medical records systems eliminate or minimize the need for such equipment.

In any case, physicians will want to develop policies and procedures for patient record maintenance and for billing and collections before soliciting price and performance information from vendors. Also, physicians should consider what other office equipment the group will need (such as a copier) because many pieces of ancillary office equipment can be linked to compatible office equipment.

Determining a group's hardware and software needs in order to enhance practice efficiency is a complex and arduous process. In fact, the physicians may want to consider hiring an adviser. As medical office systems become more sophisticated, they are being used in so many functions that most physicians need advice when considering patient records and billing systems and when designing a financial reporting system and appropriate software. The physicians and their consultant or accountant will want to design an income statement and balance sheet, develop procedures for tracking managed care and capitation contracts, and create appropriate accounting systems for payroll and accounts payable. Also, the physicians will need to establish new bank accounts.

The accountant also will develop a chart of accounts, accounts payable procedures, and a fee schedule. He or she will prepare an operating budget, income and cash-flow projections, and a first-year estimate that includes

percentages for collections, overhead, and the approximate number of projected patient visits, gross billings, and expenses. The accountant also will address banking issues, such as the types of accounts that will be needed.

### **Policies and Procedures**

Once the required systems are chosen or in place, the group should consider hiring an office manager to help complete many of the steps that will follow. The office manager can do a staffing assessment, develop a staffing plan and salary projections, and create a new organization chart. Also, the manager may be able to help the group with such personnel issues as job descriptions, benefits, personnel policies and procedures, and advertising for and interviewing applicants. The office manager can help the group find best-practice policies and procedures and meet these as closely as possible. The office manager also can get copies of federal and state regulations relative to employment law.

At this point, the group should determine the licenses, permits, and registrations it will be required to obtain and other administrative duties it must complete. For example, the group will need occupational licenses from the city and county, and it will need to inform the state medical licensing board of its new address. The group also will need to determine state requirements relative to narcotics licensing and determine which requirements under CLIA it will need to meet and submit an application, if necessary. Also, the group will need to apply for federal and state employer identification numbers.

Each physician member of the group also will need a provider number and credentialing applications for affiliated hospitals and health plans.

The group will need to apply to the federal Centers for Medicare and Medicaid Services in Bethesda, Md., for provider applications.

In addition to personnel policies, the group will need clinical procedures and a fee schedule for each service it will offer.

### **Ancillary Services**

While developing policies and procedures, the group must consider issues related to insurance. The office manager and accountant can assist the group in choosing an insurance broker and review policies for general and professional liability, for general and business insurance, and for service contracts and vendors.

The group also may need vendors for general office services, such as waste management (regular and biohazardous), janitorial and pest control services, landscape maintenance, telephone answering, transcription, and laundry. It is also important to consider marketing services at this time.

### **Completion**

Upon the completion of the feasibility and development phases, the practice should set forth a reasonable and achievable implementation timetable. Indeed, many of the activities in the development phase of this process will take time for physicians to consider both individually and collectively.

Still to be resolved are some of the major issues in the implementation phase, including a physician and executive compensation plan, and a retirement plan.

While the rewards of group practice can be extraordinary, careful attention to detail and extreme due diligence in the early practice development stages are crucial to later success. ■

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pares favorably with the effectiveness of beta-blockers and ACE inhibitors in terms of improving the risk of recurrent MI and reducing the rate of mortality from a heart attack.

“After the first few days following MI, the magnitude of the benefit of the statins exceeds that which is achieved with beta-blockers, ACE inhibitors, or aspirin,” Fonarow says. “As to pure relative risk reduction, the statins are among the most potent therapies we have. Also, statins add to the benefits that can be achieved with the other agents.”

Given such strong evidence of their effectiveness, the use of statin drugs for heart disease patients constitutes a standard of care. “All physicians should assess whether statin drugs are being appropriately prescribed for their

Unfortunately, adherence to the guidelines has been disappointing, Fonarow says.

### Improving Statin Use

An innovative UCLA quality improvement program, called the Cardiovascular Hospitalization Atherosclerosis Management Program (CHAMP), was implemented in 1994 to improve the institution’s low utilization rates of drug therapies for heart disease patients.

“In the early 1990s, when we examined the treatment rates of UCLA patients with established cardiovascular disease, we noted the marked underutilization of the therapies that clinical trial evidence had shown were beneficial,” Fonarow explains.

Recognizing the logistical difficulties

blockers, ACE inhibitors, and lipid-lowering therapies,” Fanarow says. At discharge, statin use for patients following MI increased from 6% of patients before CHAMP to 86% after CHAMP. Also, the medications initiated at the hospital were continued over the long term. At one-year follow-up, 91% of patients with established cardiovascular disease were being treated with statin drugs; total mortality rates fell from 7.0% to 3.3%; and risk of recurrent MI fell from 7.8% to 3.1%. Results of this study were published in the April issue of the *American Journal of Cardiology*.

### Suboptimal Use

When implementing the CHAMP program, researchers noted that the use of statin drugs nationwide was

**If the effective therapies were applied widely, they would significantly improve the health of patients with cardiovascular disease.**

**—Gregg C. Fonarow, MD, UCLA Medical Center**

patients with established atherosclerotic vascular disease,” Fonarow says. In 1993, the National Cholesterol Education Panel created guidelines setting a target LDL cholesterol below 100 mg/dL in patients with known coronary artery disease. In 1995, the American Heart Association, in Dallas, and the American College of Cardiology, in Bethesda, Md., set forth guidelines addressing the secondary prevention of heart disease, stating that all patients with established cardiovascular disease should achieve an LDL cholesterol below 100.

“In effect, the AHA/ACC guidelines indicate that 95% or more of heart attack patients should be on a lipid-lowering medication, since only between 2% and 5% of patients with atherosclerosis have an LDL below 100,” Fonarow explains. Few patients can achieve this goal through diet and exercise alone, he adds.

of implementing all of the steps in the secondary prevention guidelines in individual physician offices, the UCLA physicians hypothesized that initiating drug therapies in the hospital would offer greater chances of success.

“We believed that a system that would initiate the essential drug therapies before patients left the hospital would improve our treatment rates,” Fonarow explains. “This, in turn, would favorably impact patients’ long-term use of the medications, since initiation of the therapies in inpatients would underscore their importance. Also, it would allow better coordination of care between the cardiologists at the hospital and the primary care physicians who would be following the patients postdischarge.”

CHAMP was an astounding success. “In a short period we markedly improved the use of evidence-based therapies, such as use of aspirin, beta-

suboptimal. Fonarow says, “When we looked at data from other medical centers, as tracked by the National Registry of Myocardial Infarction, we saw that the use of statin drugs around the nation was continuing at a very low rate.” The National Registry of Myocardial Infarction 3 (or NRMI 3) is a prospective, observational study of patients admitted to hospitals in the United States with a diagnosis of acute MI. NRMI 3 has been ongoing since April 1998.

Fonarow and a research team analyzed data from NRMI 3 to determine the use of lipid-lowering medications in acute MI patients. The study was published in the Jan. 2/9 issue of *Circulation*. “In this study, we examined the use of statin drugs for all MI patients discharged in 1999 and 2000 from the 1,470 hospitals participating in the registry,” Fonarow says. While other studies have exam-

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ined lipid-lowering medication use, this study was remarkable for its scope: Overall, it included data on 138,000 patients, accounting for approximately 8% of the total MI discharges in the nation.

The study indicated that less than a third of MI patients—31.7%—were being discharged on lipid-lowering therapy.

### Identifying Underuse

Several factors played a role in the underuse of these drugs, researchers found. Patients aged 75 to 84, for example, were 40% less likely than patients younger than age 55 to be on statin drugs at hospital discharge. Also, women were less likely than men to receive statin drugs. Patients in teaching hospitals were more likely to be so treated than were patients in community institutions. Patients undergoing catheterization were also more likely to be treated with statin drugs. Furthermore, patients undergoing bypass surgery were half as likely to be treated.

Understanding why statins are underused is a complex issue, Fonarow says. “Several possibilities exist,” he adds. “First is that physicians focus largely on acute problems, rather than on prevention. Second is the relatively poor communication between cardiologists and PCPs as they try to coordinate care.”

Third, national guidelines recommending statin use include many different steps, options, and timeframes, and suggest that the initiation of the medication begin after, not before, hospital discharge. “Instead, a simpler focus and a hospital-based algorithm can improve treatment rates,” states Fonarow, suggesting that physicians initiate statin drug therapy prior to hospital discharge. “The key is recognizing that atherosclerosis is a chronic, progressive disease. Physicians should understand that the best way to ensure long-term clinical benefits is to prescribe the full comple-

ment of proven therapies at the time the patient presents.”

Finally, prior guidelines suggested that patients first try to lower their cholesterol through diet and exercise, before initiating medication. “This suggestion led physicians and patients to view lipid-lowering medications as an ancillary benefit,” Fonarow observes. “But in fact, statin drugs in conjunction with diet and exercise outperform diet and exercise alone in every study.”

### Implications for Physicians

All physicians who treat heart disease patients—including cardiologists,

keeping heart disease patients alive is providing them with immediate and thorough treatment before discharge.

Fonarow’s research provides the scientific foundation for the AHA’s new hospital-based Get With the Guidelines quality improvement program, which seeks to replicate CHAMP’s successes in other U.S. hospitals, Smith explains.

“A hospital-based program can dramatically affect the treatment rates, not just at hospital discharge but during longer term follow-up,” Fonarow says. “Applied nationwide, the program could save as many as 80,000 lives a year.”

**The key is providing thorough treatment before hospital discharge.**

**—Sidney Smith, MD, American Heart Association**

surgeons, PCPs—should focus on improving statin use in appropriate patients, Fonarow says. “It is every physician’s individual responsibility to apply these treatments,” he adds.

For physicians in capitated health plans, using statins appropriately could help to contain costs for the group. Prescribing these medications properly could help to prevent a catastrophic claim such as would be filed in the case of a heart attack. What’s more, physicians can realize benefits in terms of increased efficiency by ensuring that they deliver proper preventive care and avoiding adverse events. Practices vary in their strategies to ensure guideline adherence, and ideally, computer software can prompt physicians to use statins properly by generating notes for charts. Some practices may adopt a system of flagging patient charts to ensure appropriate use. Such systems allow physicians to incorporate guidelines efficiently into their practices.

Sidney Smith, MD, chief science officer of the AHA, says the CHAMP study shows that the key to

“The development of hospital algorithms is key to statin drug initiation,” Fonarow says. “A hospital stay is the best time to ensure that patients start taking the medications that will ensure their long-term survival.”

As in the CHAMP program, Get With the Guidelines simplifies the protocol to make it easier for physicians to incorporate into practice. “When guidelines are 90 or 120 pages long, physicians find it difficult, if not impossible, to absorb all the algorithms,” Fonarow notes. “Also, they have to know many different guidelines to treat many different conditions,” Fonarow adds. “This complexity contributes to low rates of guideline adherence. The CHAMP guidelines fit on one page and are simple to follow.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on CHAMP can be found at [www.med.ucla.edu/champ](http://www.med.ucla.edu/champ). Information on Get With the Guidelines can be found at [www.americanheart.org](http://www.americanheart.org). More information on cardiology practice strategies is available on our Web site (see page 16).

# Direct Contracts Offer Alternatives to Adversarial HMO Agreements

By Howard "A.J." Lester

**E**liminating the middleman is a very old business idea, affording the buyer and seller direct access to each other, without the usual costs, interference, or ulterior motives of an intermediary. Yet, when it comes to managed care, commercial HMOs, PPOs, and insurers control most of how doctors and employers do business together.

Managed care middlemen first dangle huge memberships in front of physicians, and then pull out the adversarial contracts that contain reduced reimbursement rates and many practice restrictions. Physicians often have little choice but to sign. Meanwhile, managed health plans offer huge physician networks to employers, saying that participating in these networks is the best way to achieve savings and allow access to care for employees and their families.

## Seeking Lower Costs

Benefits executives and physicians are starting to take a closer look at cutting out the middleman and doing business directly with each other. For physicians, direct contracting represents the chance to regain control over their practices. For employers deeply concerned about rising health costs, direct contracting represents the chance to regain control over health plan

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expenditures and improve employee satisfaction.

Direct contracting offers many distinct advantages. Direct agreements are generally short, readable, and protect both parties' interests, and they fully disclose all financial and contractual terms to both parties. What's more, direct agreements compensate physicians fairly without compromising potential savings for employers. Reimbursements can be based on reduced fixed fees or simple discounted

fee arrangements. Since there is no fee to pay a middleman and no fees for monthly network access, overall costs are typically lower than what commercial networks offer. Therefore, direct contracts typically have lower administrative costs and reduced claims expenditures, and provide higher physician reimbursement rates than are offered in managed care networks.

## Gaining Leverage

By contracting directly with a network and controlling the health plan, employers can more effectively steer employees and family members to network providers. Direct networks are designed to meet specific employer needs in designated locations. Therefore, physicians and providers can anticipate prospective patient volume more accurately and can count on the employer's support. Conversely, managed care companies build networks first and then try to fit employers into them, disregarding

the conflicting needs of various employers, thereby creating inconsistencies and service problems.

Under conventional managed care agreements, health plans include some cost-containment and strict administrative requirements. To contain costs, commercial networks use restrictive contract requirements to micromanage the delivery of medical care. Direct agreements generally have fewer limitations on what doctors can and cannot do, as long as

**Many benefits executives and physicians are seeking to do business directly with each other.**

they use sound medical judgment, meaning there is less second guessing of physicians' treatment decisions. For employers and physicians operating under direct contracts, the goal is always optimum patient health.

Since direct contracts typically are based on simple and self-funded plan designs, they contain fewer rules, restrictions, and filing requirements than the conventional contracts of HMOs and PPOs. Therefore, the physicians' office staff do not waste time determining what treatments and procedures are covered and whom to call when problems arise. Direct access to employers usually facilitates problem resolution and helps to establish a productive working relationship between the physicians and the employers.

Physicians considering contracting directly with employers should begin by reviewing all of their current managed care contracts and decide which ones are financially or

administratively disadvantageous. The willingness to cancel, or not renew, detrimental contracts is an important impetus, especially when the self-insured employers represented under those contracts can be approached directly.

### **Contract Review**

So many different agreements are used that each party to a direct contract should carefully review the specific terms. Some agreements have restrictive covenants that may prohibit a physician from contracting with employers nor are existing clients of an MCO. Other agreements may prohibit contracting with any local employers or even soliciting employer business. Some agreements may prohibit employers from contracting with other physician groups. Neither employers nor physicians should sign restrictive agreements of any kind.

Also, physicians should consider as prospects local self-insured employers that offer managed care benefits, but are dissatisfied with the service or have little or no access to physician networks. Employers generally welcome establishing direct agreements with physicians, especially when doing so would help solve service or access problems. Also, direct contracts may allow employers to offer coverage to employees who otherwise might not have it.

It is impractical to replace all existing managed care agreements with direct contracts. Well-run commercial networks that offer reasonable physician contracts, reimbursements, and service, while providing employers with adequate savings and service, should be retained. But direct contracting should always be considered as a replacement for and an alternative to agreements that are not serving the physicians' best financial or professional interests.

Any physician or physician group that pursues direct contracting is likely

to find resistance from managed health plans, such as commercial HMOs and PPOs. Most insurers and managed care middlemen are too busy to pay much attention to direct agreements but those that do notice will tend to oppose such ventures and resist them. Resistance may take a number of forms.

**Direct agreements generally have fewer limitations on what doctors can do as long as they use sound medical judgment.**

Insurers, for example, may refuse to process claims for any networks outside their own or may impose heavy fees for loading, maintaining, and adjudicating claims from direct contracts.

### **What To Expect**

Since commercial managed care agreements are written to protect the interests of HMOs and other managed care plans, they may include clauses that prohibit physicians from contracting directly with employers. Physicians should never sign an agreement containing such a clause, or else they should negotiate the clause out. The employer's HMO or PPO agreement also likely prohibits direct contracting with physicians contracted to the HMO or PPO, even after the agreement is terminated. Employers should be discouraged from signing such agreements as well. Employers and physicians always should retain the right to contract directly with each other, regardless of other arrangements in place. If such contract restrictions are in place, however, physicians and employers will have to wait until the contracts expire or seek to revise them.

Other than contractual restrictions, there's no reason why a physician, group practice, or IPA should not approach local employers with the offer of a direct contract. From a practical standpoint, however, contacting employers directly may

appear to be a conflict of interest with other managed care arrangements. Insurers, HMOs, and PPOs may be contacting the same employers as potential clients that the provider is contacting. It's always preferable for the employer to initiate direct contracting through a compa-

ny representative or experienced direct network consultant.

By showing that they are willing to contract directly with employers, even for a few employees, physicians send a message that they want to maintain control of their own interests while helping to serve the needs of businesses. The decision to contract should not be based solely on potential patient revenue, but should focus on whether the concept of direct contracting makes good business sense.

The revenue may not be significant at first if only a few employees are involved, but there's virtually no downside to a direct agreement either. Even in captive patient markets in which doctors get the patients with or without managed care, the only way employers can offer employees managed care benefits is through a network of contracted physicians. For doctors who disdain commercial managed care, the direct agreement guarantees that the employer will not have to turn to a commercial network to gain managed care access for employees.

### **Contract Terms**

While it's impractical to outline here all the necessary contractual terms, physicians should look first and foremost for balance and mutually beneficial financial terms in the agreement. The best direct contracts are short (five pages or less), concise, and

*(Continued on page 12)*

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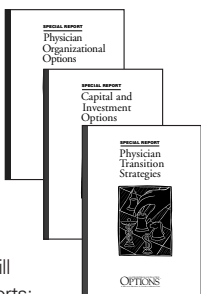
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## Eliminating the middleman requires employers and physicians to pursue each other as business partners.

(Continued from page 11)

establish a strong working partnership between the parties. They clearly acknowledge the health of the patient as the ultimate concern of both the employer and physician. A direct "win-win" agreement provides written assurance of the reimbursement, timeframe for payment, and exact terms for the provision of plan benefits and processing of provider claims.

Sometimes, a local employer may express interest in a direct agreement, yet decisions on such matters may be made at a corporate benefits department located elsewhere. Many employers assume that if an MCO does not already have networks in certain areas, none are available. Where networks are available, the employer may be oblivious to physician dissatisfaction with these networks and their subsequent receptiveness to direct contracting. Most corporate benefits executives have no experience with direct contracting and may be unaware that direct contracting is a viable alternative.

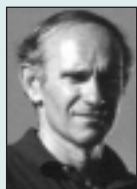
HMOs, PPOs, and insurers wield an enormous influence over their employer clients and physician networks. Eliminating the middleman to gain the advantages of direct contracting requires employers and physicians to pursue each other actively as business partners.

### Becoming Aware

Direct contracting is a little known and often misunderstood area of opportunity for most physicians. The fact is that commercial HMOs and PPOs are not the only way that physicians can gain access to employers, especially when direct agreements with community employers can be negotiated reasonably, at fair terms, and with a great likelihood of a stable and advantageous relationship.

With so many MCO contracts in place, middlemen may always be a big part of the commercial managed care picture. But by remaining receptive to direct contracting, being willing to replace disadvantageous middleman agreements with direct contracts, and supporting and encouraging local employers to contract directly, physicians can do much to balance their managed care involvement and control their destinies. This opportunity will grow as more employers realize that contracting with HMOs, PPOs, and other conventional insurers is not the only way to provide managed care access, especially when so many physicians will readily do business under mutually beneficial direct agreements. ■

# Book Offers Instruction, Advice for Expert Trial Witnesses



**Steven Babitsky** is an attorney in Falmouth, Mass. He graduated from Boston College Law School in 1972, and practiced personal injury

law until 1992, focusing on issues surrounding personal injury, workers' compensation, Social Security, and disabilities. As a trial lawyer, Babitsky was involved in medical and legal issues. In 1980, he started the National Organization of Social Security Claimants Representatives, and founded Seak Inc., a company in Falmouth that provides education on medical-legal issues through seminars, distance learning programs, videos, publications, and other resources. In this interview, he discussed his book for physicians who serve or seek to serve as expert witnesses, *The Comprehensive Forensic Services Manual: The Essential Resource for All Experts* (Seak Inc., 2000), with Richard L. Reece, MD, editor-in-chief.

**Q:** Why did you write your book on forensic services?

**A:** The book's other co-authors, James Mangraviti Jr., and Christopher J. Todd, and I are attorneys. After providing resources for physicians and other experts in preparation for trials, we realized that a comprehensive text on medical-legal testifying for physicians did not exist. To satisfy that need, we created a book that allows physicians to understand most, if not all, of the aspects of being a medical-legal witness or an expert in court. The book, which was published in 2000, has become a leading book on forensic medicine and is being incorporated as a textbook at some colleges.

**Q:** What topics do you cover in the book?

**A:** The book covers all aspects of forensic medicine for physicians: why they become involved in lawsuits, what happens during the discovery phase of a suit, what to expect when testifying in a deposition, what to expect during a trial, how to connect with a jury, and how to present evidence. It also discusses how to become qualified as an expert, curriculum vitae, how to express opinions, how to deal with questions on methodology, and how to write and defend an expert report. Liability, marketing, fees, billing and collections, and other practical areas are covered as well.

Although the book can be used by physicians who are being sued (because they will be witnesses in their own cases), it is mainly designed for physicians who are serving as expert witnesses in other cases, are writing reports on medical cases at the request of attorneys, or are being deposed.

**Q:** What is the scope of the medical expert witness "industry"?

**A:** At least 50,000 physicians regularly testify in court. Many others are involved in the medical-legal arena because they are answering subpoenas or writing reports. Most physicians in the United States will be called on at

some point to testify or to otherwise be involved in a medical-legal case.

**Q:** How can a physician become a medical expert?

**A:** Most, if not all, physicians qualify as expert witnesses based on their education, training, and experience. In order to testify about a particular specialty, the physician must be an expert in that specialty. For example, a family practitioner probably would not be allowed to testify about brain surgery unless he or she could prove some expertise in surgery. Many courts have become more vigilant regarding who will be allowed to testify as an expert and do not permit physicians to testify outside of their area of specialty.

Physicians who wish to serve as expert witnesses should notify local personal injury attorneys that they are available to serve in this capacity. As in all marketing efforts, word of mouth is helpful. Some experts put small announcements in medical-legal journals or in trial magazines; others list themselves in directories. For example, the "Seak National Directory of Medical Experts" is available at [www.seakmedexperts.com](http://www.seakmedexperts.com).

**Q:** Do some specialties have more expert witnesses than others?

**A:** Certain specialties tend to require more physician expert witness activity, such as obstetrics, orthopedic surgery, forensic psychia-

(Continued on page 14)

**At least 50,000 physicians testify in court regularly, and most physicians will be called at some point to testify or to be involved in a medical-legal case.**

(Continued from page 13)

try, occupational medicine, pain management, and physical medicine and rehabilitation. This makes sense, given the nature of the conditions these physicians must address.

**Q:** Are there ethical issues involved in serving as a medical expert?

**A:** Many physicians and others involved in medicine feel that a physician testifying in court is acting unethically, in a sense, serving as a hired gun. Nothing could be further

from the truth. In fact, the AMA recognizes that doctors should testify on behalf of patients when asked to do so. Most doctors who testify in court are highly concerned with doing an ethical job, but many do not understand the law or the legal and ethical requirements involved. They need to develop such an understanding. When doctors act ethically and comply with legal regulations by testifying in court, they are doing a service to the community and to their profession. In fact, they have a legal and moral obligation to do so.

**Q:** Have physicians made being an expert witness a full-time career?

**A:** Some physicians, when they reach age 50 or older, decide they no longer want to practice med-

icine. Another seminar focuses on how to be an effective medical witness, including how to qualify, key medical and legal terms to know, an overview of the civil litigation process, how to testify at depositions, preparing for trick questions, ethics, marketing, and compensation. We also host summits and offer training that we customize for medical societies, such as the training we did for the American Academy of Pain Medicine.

**Q:** How are your seminars organized?

**A:** Our seminars are unusual in that they are interactive. We obtain information, such as CVs and a sample forensic report, from the attendees prior to the seminar. In particular, participants are encouraged to send us their expert witness reports with the patient name and other identifying data eliminated. During the seminars, we critique the reports and put the authors on the witness stand—so to speak—and question them about their mistakes or other things that could have been improved in the report.

**Q:** Do your seminars focus on particular specialties in which malpractice suits may be more common?

**A:** Some areas of medicine are certainly more prone to malpractice suits, and we offer a seminar titled, “Medical Malpractice: Advanced Survival Training for Physicians” dealing with medical malpractice.

All kinds of physicians attend our seminars, but many are from the high-risk specialties, such as surgeons, neurologists, occupational medicine physicians, orthopedists, psychiatrists, and physical medicine and rehabilitation specialists. Also, clinicians who are actively involved

**“We surveyed 266 medical experts across a broad range of specialties and found that the average testifying fee per hour was \$535. This fee varies across specialties in a given geographic area.”**

**Q:** What is the reimbursement for medical experts?

**A:** For the book, we surveyed 266 medical experts across a broad range of specialties and found that the average testifying fee per hour was \$535. This fee varies across specialties in a given geographic area. For example, a primary care physi-

cian might receive \$250 per hour, while an orthopedic surgeon might receive \$500 per hour. Fees also vary by geographical area: Experts in rural areas charge less than experts in an urban area, such as New York or Los Angeles.

**Q:** Does Seak offer seminars for medical-legal witnesses?

**A:** Yes. Among the many courses we offer that focus on medical-legal issues is a seminar on how to be an effective independent medical examiner. It includes roles and responsibilities, compensation, effective report writing, and marketing an independent medical examiner prac-

**“The patients’ bill of rights may open up a new area of litigation. Still, physicians in many states have been supporting the patients’ rights bill because they do not like the practices of HMOs.”**

**“When physicians graduate from medical school, they usually have received no training in practical business matters and are on their own to develop these skills. From a practical standpoint, they are at severe business and legal risk.”**

in treating patients who have been in accidents or have medical-legal problems are more likely to attend than others.

Recently, the malpractice environment has stabilized somewhat. The laws have been tightened up, and now attorneys take only cases in which they feel a very serious injury has occurred.

However, the patients' bill of rights may open up a new area of litigation. Still, physicians in many states have been supporting the patients' rights bill because they do not like the practices of HMOs. In fact, physicians and their patients are on the same side in the sense that they want to be able to force HMOs to give people reasonable medical care.

**Q:** *What type of legal training do you offer to physicians?*

**A:** Because of the threat of litigation in health care, we offer a three-day course in which physicians are taught the legal aspects of providing health care. Topics include the fundamentals of law, intentional torts, defenses to intentional torts, negligence, medical malpractice, defenses to negligence and medical malpractice, damages, workers' compensation, Social Security disability, liability insurance, contracts, and breach of contract, as well as a contract negotiation workshop. Many physician participants have told us that this material should be taught in medical school.

**Q:** *What type of business training do you offer physicians?*

**A:** Our seminars are much broader than just the medical-legal field. For example, we offer

a mini MBA course during which participants receive two days of intensive training using case studies. We cover topics such as financial accounting, computer applications for business, capital finance, risk and leverage, insurance and managed care, human resources management, and marketing services.

We also offer training to help physicians—especially young physicians—in the business of medical practice. For example, we offer a seminar on negotiating skills that physicians should have when being hired by a medical group, as well as skills

because everybody else is.

Business and legal training can help physicians become better doctors because such training enables them to spend less time on medical-legal problems, handling business issues, and dealing with managed care organizations and more time on patient care. The financial aspect of their practices can become more successful as well.

**Q:** *Please tell us about your company, Seak Inc.*

**A:** Seak stands for Steven, Ellen, Alex, and Karen—the names of my family members. This name is

**“Business and legal training can help physicians become better doctors because such training enables them to spend less time on medical-legal problems—handling business issues and dealing with managed care organizations—and more time on patient care.”**

for contract negotiation with managed care companies.

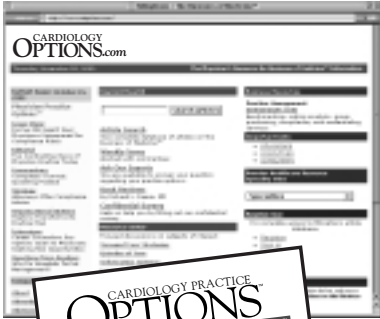
**Q:** *Why is it necessary to have such training program?*

**A:** When physicians graduate from medical school, they usually have received no training in practical business matters and are on their own to develop these skills. From a practical standpoint, they are at severe business and legal risk. But physicians are starting to learn that they have to treat some aspects of practicing medicine as a business,

appropriate because Seak was and still is a family business. We started Seak in 1980, and it has grown from one simple newsletter to an organization that provides multiple newsletters and seminars on medical-legal and expert witness issues, impairment evaluation, workers' compensation, disability management and occupational health and safety.

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

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