

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Cutting Overhead Raises Net Income, Helps Groups Work Smarter

Under fee-for-service reimbursement systems, revenue was directly proportional to the number of patients a physician had seen or the number of procedures performed. A physician who worked harder was almost guaranteed an increase in practice revenue.

But no more. Discounted fee-for-service contracts, fee-schedule limits, capitation, and other measures designed to limit reimbursement have forced physicians to spend more hours just to maintain revenue from year to year. From 1996 to 1997, compensation increased only 0.86%, while production rose 2.56%, according to the most recent physician productivity and compensation survey of primary care physicians conducted by the Medical Group Management Association, in Englewood, Colo. These figures reflect a marked change from an earlier survey that showed an increase of 7.47% in compensation from 1992 to 1993, despite an increase in production of only 2.92% for the same period.

As physicians struggle to maintain revenue, the costs of rent, staff salaries, equipment upgrades, and other business expenses continue to rise. So what can physicians do to balance revenue and expenses? "It's hard to give up the little family or leisure time left after a 10- to 12-hour day to maintain a practice's income," says Keith Borglum, principal, Professional Management and Marketing, consultants, in Santa Rosa, Calif. "A better alternative may be to reduce overhead costs." Reducing overhead also is the most expeditious way to increase net income.

"If, for example, 60% out of every \$100

goes to overhead, then saving \$4 translates to a 10% increase in net income," he says.

Getting Started

A common misconception among physicians is that supplies and staff salaries are the most costly expenses in a medical practice, Borglum says. In fact, the percentage of revenue required for physician compensation (not including profit) is the largest expense (see table, page 5). "It's not prudent to worry about what you're spending on, say, legal and accounting costs, when physician costs are fully 40 times greater," says Borglum. Since potential cost savings are directly related to the total expenses in a particular area, he suggests medical practices set priorities for cost-cutting efforts in this order:

1. Physician costs
2. Staff costs
3. Facility costs
4. Supply costs

Physician Costs

For Sumana Reddy, MD, keeping overhead costs low is a priority for the recently opened two-physician family practice, Acacia Family Medical Group, in Salinas, Calif. Reddy and her partner (who made no initial financial investment in the practice) had no space, staff, equipment, or a guarantee that patients would follow them when they decided to establish the practice in March of last year. Nonetheless, they opened for business two months later. Without a sure source of revenue and with no external funding, their strategy for financial success involved being frugal.

(Continued on page 5)

E-mail Improves Physician-patient Communication

Can e-mail help you serve your patients better, attract new patients, and assist you in budgeting your time? Thomas Ferguson, MD, thinks so. The editor and publisher of *The Ferguson Report: The Newsletter on Consumer Informatics and Online Health*, in Austin, Texas, Ferguson says, "Soon you won't be able to practice medicine without e-mail."

Newspapers and magazines frequently carry stories about enthusiastic physicians who have embraced e-mail for communicating with patients. Last fall, the entire Oct. 21 issue of JAMA was devoted to articles about e-mail and the Internet. In one article, Alissa R. Spielberg, JD, MPH, a member of the faculty of Harvard Medical School, reported on physician use of e-mail and how it creates new expectations, new practice standards, and new potential liabilities. In her article, Spielberg points out some hidden hazards of e-mail, including the fact that most e-mail is not secure unless a message is adequately encrypted.

In the same issue, Ferguson wrote an editorial about the opportunities and challenges in electronic patient-physician communication. E-mail helps physicians to communicate with current patients better and more quickly, attracts new Net-savvy patients, and allows physicians to budget their time more effectively, he says.

The Growth of Technology


Recent surveys show that physicians are finding the Internet and e-mail are useful tools to help them provide patient care, do research, and to communicate with colleagues.

In one such survey, "The Benchmark Study on Physicians' Use of the World Wide Web," researchers for the AMA conducted interviews with 1,905 physicians. Among responding physicians, 42% said they use a computer either at home or at their office. The survey also showed that:

- In a typical week, the respondents using computers spent five hours on the computer.
- Physicians who used the World Wide Web, spent an average of nine hours at the computer in a typical week.
- Among respondents who use computers, 45% expect their computer usage to increase in the next six months.
- Approximately 17% of physicians who use the Web have their own Web site. Among this group, almost two thirds (62%) use their Web site to advertise or to promote their practice.

As physicians seek to become more efficient and productive and try to please savvy patients, e-mail and the use of the Internet are likely to increase. As you weigh the use of e-mail in your practice, keep in mind that approximately 41 million people ages 18 or older used the Internet to gain health information in 1997 and patients rank "information from my physician's office" as the online health information they want most, according to researchers.

Based on these statistics and my own use of e-mail as a fast and powerful communication tool, it is clear that e-mail is creating new ways for physicians seeking to build their practices.



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Merger Partners Look Back 10 Years Later

By Thomas M. Gorey, JD

When the Quincy Clinic and the Physicians and Surgeons Clinic merged in 1987 to form the Quincy Medical Group in Quincy, Ill., some of the physicians and administrators may have thought the toughest obstacles were behind them. To the surprise of many, the process of forming a fully merged group out of two previously independent and well-established group practices took over 10 years and presented an array of ongoing challenges.

One of the first challenges involved administration. As the group increased in size, new administrative needs emerged. One significant change implemented about five years ago was the creation of the administrative position of medical director. The hiring of a physician for an administrative position was controversial at first. Older physicians in the group, for example, were concerned about a younger physician telling them how to practice medicine. The medical director, Richard Schleppehorst, MD, was in his 30s when he took the position.

To help ensure his success, the group provided Schleppehorst with educational opportunities during his first years in the position. Being a member of a regional medical directors' group that meets periodically to discuss cases also has proved to be a useful learning experience for Quincy's medical director.

Schleppehorst meets with all new physicians joining the medical group and is involved in addressing problems that arise involving physicians. The group has found that having a physician, rather than a lay administrator, deal with the physicians on clinically related issues has provided an important measure of credibility that often is lacking when nonphysician administrators address clinical issues.

The most significant staff-related problem that emerged as a result of the merger

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involved differences in salary structures between the two groups that merged. As a result, the group found it necessary to develop a new salary plan that included new job classifications and pay ranges. The new plan involved salary freezes for a number of years for employees who were at the top of the new pay ranges.

Financial Strategy

As might be expected, the group's financial strategy has been extremely important to the group's evolution. First, the group instituted a simple buy-in/buy-out policy, which provides physicians joining the group the opportunity to purchase stock for \$10,000. If they leave the group, the buy-out amount is \$10,000.

The group's physician leaders believe that generous group practice buy-out arrangements have their origins in an era when retirement plans were uncommon, and that they are unnecessary if a group has a good retirement plan. Also, the group wanted to

directors. The group has had as much as \$1 million in retained earnings in a year. Over several years, these retained earnings, which are used mainly for capital investments, have enabled the group to build a new office building without requiring the physicians to sign a loan guarantee.

The group's financial strategy also involves a working capital loan fund. The group withholds 15% of physician income and places it in a fund for capital projects. Over time, the money plus a low rate of interest is repaid to the physicians.

Contracting

In 1993, the group and Blessing Hospital, in Quincy, formed a managed care contracting company called Quincy Health Care Management. The medical group and hospital each have a 50% interest in this entity. The goal of QHCM is to facilitate joint contracting in managed care for the physicians and for the acute-care hospital center. The group handles all of its managed care

The group's compensation program emphasizes productivity, but includes other components to ensure that PCPs are paid at the market rate.

have a buy-in amount that would encourage young physicians, coming out of residencies with substantial debt, to join the group. The physician leaders believe strongly that the \$10,000 buy-in has contributed to their success in recruiting new physicians. The number of physicians in the group has increased from approximately 40 in 1987 to more than 70 today.

Another key component of the group's financial strategy involves retention of earnings. Each year, administrators compute the group's debt-to-equity ratio and review the group's future plans. Based on this information, the group's finance committee suggests an amount of earnings to retain for future use and this amount is subject to approval by the group's board of

contracting through QHCM. Community physicians who are not members of the group also participate in QHCM contracts, and an independent, community physician is a member of QHCM's board of directors.

QHCM has partnered with Health Alliance Medical Plans, a physician-owned HMO in Urbana, Ill. This arrangement allows the medical group to use the health plan's HMO license and to be part of a consortium of clinics in a managed care network owned and operated by physicians.

Physician Payment

Following the merger, the group began using a standard fee schedule. First, the group standardized the levels of care assigned to a procedure within the medical departments.

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Next, the group established one fee for each procedure within each specialty. Finally, the group established uniform coding across departments, so there is now a single fee, by code, that applies regardless of which specialist is providing the service.

In the past 10 years, the group has revised its compensation formula several times. At the time of the merger, the founding medical groups had different approaches to compensation. One group based compensation entirely on productivity, while the other placed a cap on compensation to help balance pay levels between specialists and primary care physicians.

The group's current compensation program emphasizes productivity, but includes other components to ensure that primary care physicians are paid at the market rate. The group uses market surveys to ensure that its compensation plan is on target and then holds meetings of all physicians to explain the plan and any changes that are made over time.

Since the medical group has one benefit structure for everyone, employees and physicians are in the same retirement plan. Similarly, physicians and employees have the same health plan and benefit levels.

Governance

Each director on the seven-member board of directors is elected by physician shareholders to serve three-year terms. During the group's first few years, there was a gentlemen's agreement that the position of president would rotate between a physician who had been with the Physicians and Surgeons Clinic and a physician who had been with the Quincy Clinic. The physicians now believe that since they are electing a president, where the president practiced previously is no longer an issue.

Resolving governance-related issues has been somewhat of a struggle for the group. While the group's leaders have worked hard to run the medical group as a business, some older physicians have had difficulty accept-

ing the loss of individual decisionmaking. The chief administrator for the group, William Sullivan, comments that in some ways governance is a tougher issue than compensation. "If you have a working governance model that everyone accepts, you can solve the problems the compensation plan presents," he says, "but if you don't have a good governance model, it doesn't matter what compensation plan you have."

Physician Practice Management

In January 1997, the group and several other medical groups formed Stratum Med Inc., a physician practice management company. Stratum Med's goal is to help physician groups control costs and develop more efficient practice operations.

Each medical group that purchases stock in the company is issued a certain number of Class A shares, based on the number of physicians in the group. Some of the physicians in the Quincy Medical Group have said that since Stratum Med is 100% physician-owned, they have considerable trust in the organization. Currently, more than 800 physicians have ownership in Stratum Med, through their respective medical groups.

Because of the number of physicians involved, Stratum Med has negotiated favorable pricing terms on a number of purchases, including professional liability insurance and x-ray film.

Looking back, the group believes that it has been able to recruit high-quality physicians because of its strategies for growth and its ability to negotiate favorable managed care contracts. The group strongly believes that its expanding strategic partnerships and new enterprises would not have been possible without the merger.

Editor's note: The Quincy Medical Group is one of six medical groups profiled in *Case Study Analysis of Physician Practice Mergers*, a study recently released by Policy Planning Associates. For a copy of the study, physicians may call the Michigan State Medical Society at 517/336-5769. The price is \$25 for physician members of one of the sponsoring medical societies and \$95 for others.

Seven Lessons Learned From a Merger

In the 10 years that the Quincy Medical Group has been in operation, the physicians involved have learned seven significant lessons about mergers:

1. Find partners with similar goals, styles, and interests. A merger involving physicians whose professional or personal styles differ significantly will fail.
2. Build a base of physician support for change. To get physicians to support the idea of a merger, the group will need visionary physician leaders who are willing to champion the idea among others.
3. Get support staff involved in merger planning. Keeping employees informed and involved throughout the process helps alleviate fear and distrust.
4. Tackle the compensation issue directly. Since compensation is the make-or-break issue in merger discussions, physicians in merging groups should not avoid it.
5. Relocate after a merger into a single facility. Doing so is the best and quickest way to build a new group culture. If physicians continue in their original offices, with their original staff, melding organizational cultures and creating a feeling of being a single group can be difficult.
6. Remember that the formation of a merged entity is the beginning of a long process of creating a medical group. It took 10 years for the physicians and staff of the Quincy Medical Group to feel as if they were working for one entity. Part of the shift in perception occurred as long-time employees and physicians left or retired and new individuals joined the group.
7. Be open to other new strategies after the merger. A practice merger is an educational process that instills a greater awareness and appreciation of the business side of medicine. As a result, physicians often experience a change in attitude that makes them more open to other potential strategic alliances with hospitals, health plans, and others.

(Continued from page 1)

"The practice is funded entirely by my personal savings, and if that doesn't motivate me to contain costs, I don't know what does," says Reddy. "I've had to invest a lot of money upfront to build our practice, and I have leveraged every cost-containment strategy possible to minimize the risk."

One strategy that has been especially beneficial for the Acacia Family Medical Group is to ensure that physicians delegate as many tasks as possible that do not require their training or expertise. "We have found that it is very effective to hire and staff adequately so that our physicians' time is best spent seeing patients and dealing with those aspects of the practice that only physicians can do," Reddy says.

Borglum agrees with this strategy, saying, "Don't do something you wouldn't pay another physician to do." This idea is a good rule of thumb when deciding which tasks to delegate to others. "I wouldn't pay someone \$200 per hour to open the mail, for example," he says.

Staff Costs

Not only does Reddy delegate as many tasks as possible to her staff, but she encourages staff members to delegate as well. Her management philosophy is to ensure that the least qualified staff member of her practice takes on as much as his or her level of expertise allows. "We've found that hiring high school students at minimum wage in the afternoon to do mundane paperwork, such as photocopying and filing, frees our receptionist to do more complex work," Reddy says. "It's also a great opportunity for students whose long-term goal is to work in health care."

Small practices may be inclined to use clinical or other highly paid staff to work an extra hour or two rather than hire an entry-level staff person. If the practice pays time-and-a-half rates for overtime, this strategy may be needlessly costly. In such cases, "a nurse who is paid \$14 an hour then turns into a \$21-an-hour expense, which is fine if she's doing something that it takes a nursing license to do," Borglum says. "But what's more likely is that she's filing charts or filling out paperwork, both of which could be done by an entry-level person for about \$7 an hour. For the same \$21, would you rather have a file clerk for three hours or a nurse for one?"

Expenses as a Percentage of Collections or Revenue

(Family practice median)

Physician salaries	41.0
Support staff salaries (nonproviders)	26.2
Facility and occupancy costs.....	7.3
Medical and surgical supplies.....	3.7
Administrative supplies	2.2
Insurance	1.8
Outside professional fees.....	0.9
Marketing.....	0.4
Other (such as staff benefits, laboratory costs, information services)	16.5

Source: Medical Group Management Association, Englewood, Colo., 1997.

"It's not prudent to worry about what you're spending on legal and accounting costs, for example, when physician costs are fully 40 times greater."

— Keith Borglum, Professional Management and Marketing

Delegation of more complex duties requires the hiring of highly qualified staff, of course. "One of the best ways to get the right person for the job is to test his or her skills before hiring," says Borglum. "If a candidate says he or she knows how to give an injection, make the candidate do it. For positions that require nonclinical knowledge, such as working with computerized billing systems, which may be unfamiliar to physicians, Borglum recommends administering a written skills test, or enlisting the help of a colleague's billing clerk or a medical billing company to assess candidates' knowledge and skill level.

"The cost of an incompetent staff person is enormous," Borglum says. A consultant who works with many physicians, Borglum has seen several physician practices that had attributed losses in revenue—ranging from \$100,000 to \$1.4 million—to reduced reimbursement from managed care contracts, when in fact incompetent bookkeep-

ers had failed to bill claims correctly, he says. He recommends paying more for quality staff members. A practice that elects to pay 20% over the market rate for an exceptional staff person who works 50% faster than other staff members, for example, can net the practice the difference paid in salary, Borglum says.

Even practices on a tight budget can attract high-quality employees. "In the start-up phase of our practice, we have been able to contain costs by offering a lot of job satisfaction, not necessarily high salaries," says Reddy. "We looked for people who were really interested in the challenge of the position."

What's more, at weekly staff meetings Reddy apprises her staff of the practice's approximate financial situation. "I don't keep secrets from them," she says. "I tell them how much it has cost for start up, what our monthly expenses are, where we're headed, what our construction costs

(Continued on page 6)

“When it comes to cost containment, it very much depends on the types of investments that work out long term, and I view my staff as a long-term investment.”

— Sumana Reddy, MD, Acacia Family Medical Group

(Continued from page 5)

are for a planned renovation, at what point we're going to break even, and what I expect to be able to do for them when we do.” By sharing this information, Reddy has instilled cost-consciousness in her staff.

Another cost-saving measure is to hire a nurse practitioner or a physician assistant rather than another physician, says Borglum. “An NP or a PA can save the practice 30% to 50% on provider costs per patient,” he says. In addition to Reddy and her partner, Acacia Family Medical Group's clinical staff includes a PA and six medical assistants, two of whom are part-time. “In our area, it has not been traditional for practices to use registered nurses,” Reddy says. “So, we've hired experienced medical assistants who are interested in learning new skills and enjoy the challenge of new responsibilities.”

“When it comes to cost containment, it very much depends on the types of investments that work out long term,” says Reddy. “I view my staff as a long-term investment. How you take care of your patients is also reflected in how you take care of your staff. I judge my success just as much by how my staff views me as an employer who is interested in them and their careers, as by how many patients come to see me. The two are very closely tied together.”

Facility Costs

Just as big salaries are not necessarily required to attract high-quality staff, a large, new office building is not a prerequisite for attracting patients, says Borglum, who advises against building or buying office space. “Given the current changes in the marketplace, especially with respect to group formation, a practice may not have sufficient time to amortize the cost of purchasing a building,” he says.

Currently, Reddy has located her practice in an office building that, despite being in a prime location, had been unrented for two years and needed remodeling. “The building owner agreed to rent us an older, abandoned

portion of the building until we finish remodeling our office,” she says. While the current office space is not ideal, she says, the practice is paying little rent while waiting to move into the new space. At the same time, the practice has increased the number of patients each month by 20%. “What's been a tremendous benefit is that we've been able to design our future space while we're in this very rapid growth mode,” says Reddy. With the cost savings Reddy gained from this strategy, Acacia Family Medical Group planned to move into its new office space in the first quarter of this year.

While sharing office space with other physicians is a good cost-cutting strategy, merging other aspects of medical practices usually results in increased expenses, not cost reductions, says Borglum. “Many people believe that practice consolidations result in economies of scale, especially with respect to amortization of costs,” he says. “In truth, the costs are higher for practices with more doctors,” Borglum says. More complex organization requires more labor, equipment, and supplies to operate. “As the num-

ber of people in an organization increases arithmetically, the relationships and problems increase geometrically,” he explains.

A common problem when it comes to expenses is that group practices often fail to assign responsibility for purchasing, leasing, or hiring decisions to a specific individual. In a prior position as an employee physician in a large, primary care group practice, Reddy witnessed the effects of a lack of centralized decisionmaking. Because none of the partner physicians was responsible for selecting a phone system for the practice, an inadequate system was installed and the practice lost a large number of patients who were frustrated when they could not get through to the doctors.

“When costs begin to spiral out of control, physicians can become intimidated and lose the confidence to manage their own practices,” Reddy says. “Then they start to make decisions, such as merging their practices with others or hiring an external management company, out of desperation rather than choice.”

Part of Reddy's vision for her practice is to

Two Ways to Cut Costs

Physician consultants suggest that two ways physicians can cut overhead costs involve buying in bulk and using a payroll service.

1. To cut the cost of medical supplies and equipment, join a physician purchasing coalition. Most coalitions require each member practice to make a certain percentage of purchases through the group. Another option is to shop online at Internet sites that specialize in medical supplies.
2. Use an outside payroll service. If your group has five or more employees, an outside payroll service will prepare weekly payroll, quarterly reports, conduct benefits analyses, and track sick and vacation time. Using such a service is likely to be less expensive than employing a bookkeeper. If your practice uses an external billing service, someone in charge should closely monitor the service's performance to ensure that it provides timely, complete access to accounts payable data. “Locally, practices have floundered based on their choices of billing services,” says Sumana Reddy, MD, a partner in the Acacia Family Medical Group, in Salinas, Calif. “It's not always the quality of the service, but sometimes simply the service's failure to communicate with the practice or provide it with information,” she comments.

SPECIAL INVITATION TO SUBSCRIBE

Another Goal: Be More Productive

In addition to cutting overhead costs, Keith Borglum, principal, Professional Management and Marketing, consultants, in Santa Rosa, Calif., recommends that physicians seeking to increase net income also should work to improve productivity and efficiency. They can do so by

- Spending more time in the office seeing patients. "Travel and time spent out-of-office on surgeries and assists usually lose money for doctors," Borglum explains. Physicians in group practices should assign one physician to all hospital patients or rotate hospital on-call duties.
- Having staff and patients fill out forms whenever possible. Utilize checklists that patients can use to supply information about themselves and comprehensive forms that physicians could use when taking a patient's history or making notes. Such forms should be designed to reduce the time physicians would spend writing, but increase the quality of time they spend with patients.
- Taking practice management courses as part of continuing medical education requirements. "Physicians tend to spend all or nearly all of their CME on clinical issues, and very little on management courses," says Borglum. "As a result, most physicians experience relatively few clinical problems, but they don't tend to be as successful in business matters."
- Starting patient appointments on time because the more patients a physician sees, the more he or she will earn. "The cost of starting late is about \$2 a minute," says Borglum, based on an average 50-hour physician work-week and approximately \$300,000 in collections each year.
- Scheduling an hour a day for administrative duties and paperwork. "Much of staff efficiency depends on what the doctor does," says Borglum. A patient's chart left sitting on a physician's desk for several days is not readily accessible to the staff who may need it to resolve billing questions, respond to a call from a specialist, or file lab results. As a result, they spend time looking for missing charts, which reduces their efficiency.

prove that practicing medicine and being successful in business are not mutually exclusive. "I hear physicians say all the time, 'I'm not a business person,'" Reddy says. "A business person is somehow seen in negative terms. I believe that one can be a very ethical business person and a good physician."

Borglum acknowledges that implementing proactive measures that have the most potential to reduce overhead in a practice is difficult. "It's difficult for the same reason that preventive health care isn't a best seller with patients," he says. "Most people don't get help until it hurts."

— Reported and written by Laura M. Northup, in Mashpee, Mass.

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Physician Report Cards Get Mixed Reviews

Reports issued to the public by health plans and private organizations about the performance of medical groups offer health plan members an informed choice and allow providers an opportunity to improve the quality of care. But some physicians ask whether these reports reflect accurately the quality of their work and whether the data collected are useful to consumers.

"Physicians are like anyone else," says Marvin Gordon, MD, chief medical officer of Monarch Healthcare, an IPA in Mission Viejo, Calif. "They don't like to be judged." Three Monarch medical groups have been publicly profiled in the Quality Index, a report card produced by PacifiCare of California, a 1.2-million member HMO in Cypress. PacifiCare published the data in September on the Internet (www.pacifi-care.com) and sent copies through the mail to its members. The Quality Index shows how 118 of its larger medical groups rate on

a variety of clinical, administrative, and patient satisfaction measures. (See "Index Rates Medical Groups on Quality.")

In several clinical areas the Monarch groups achieved "best practice" results—defined by PacifiCare as being in the top 10% in any given category—and did poorly in several service measures. "We're not happy with all the results, but they point out areas for improvement," says Gordon. His response was typical of several physician leaders, who usually reacted based on how well they scored.

"We're generally very pleased," says Patrick O'Brien, MD, president of Matrix IPA, a 900-physician medical group affiliated with Saint Agnes Medical Center in Fresno, Calif. "It's a good idea for physicians to receive report cards," he says. "It tells you where you need to improve." His group did well in most categories because "we took the time necessary to accurately report our results," he says.

Offering physicians an opportunity to improve their performance was a goal of the PacifiCare initiative, says Sam Ho, MD, PacifiCare's medical director. "Our first reason for doing these reports was to provide credible and relevant information to consumers so that when they select provider groups, they have the information they need," says Ho. "The second objective was to give physicians information so that they can continue to improve performance. The index also fosters a healthy competition among physician groups, competition that will ultimately lead to higher quality throughout our network." In August, Brown & Toland Medical Group, a 2,000-physician group in San Francisco, released a report card on its own evaluation of the quality of care its physicians provide. This effort is an example of the utility and growing acceptance of report cards among physicians, Ho says. (See "Group Produces Its Own Report Card.")

But some physicians question whether performance reports are accurate enough to foster meaningful competition. Moreover, physicians say the data required are difficult to collect and report. Keith Richman, MD, is a physician with Lakeside Medical Associates, which is part of Lakeside Medical Group, an IPA in Burbank, Calif., with 200 primary care physicians and 800 specialists in the Los Angeles area. Lakeside did poorly in several PacifiCare measures. "The distribution of this report is premature and misleading," says Richman. "The clinical measures do not reflect the care we provide to our patients, but are more reflective of any group's ability to collect data and submit it in centralized form."

Report cards do not adequately reflect the types of patients a medical group or hospital is serving, says Henry Anderson, MD, chief quality officer of Swedish American Health System in Rockford, Ill. SAHS has been profiled by several reporting organizations, including Healthcare Report Cards Inc., a company in Lakewood, Colo., that posts hospital mortality ratings for various procedures, such as cardiac bypass surgery, on the Internet (www.healthcarereportcards.com). "As long as the statistics used in these reports are meaningful, that's one thing," says Anderson.

Index Rates Medical Groups on Quality

PacifiCare of California, a 1.2-million member HMO, in Cypress, has published a quality index of 118 of its medical groups. The index was mailed to all PacifiCare members and posted on the Internet in September. It will be updated twice a year, and includes clinical, administrative, and service measures.

In its data collection effort, PacifiCare includes medical groups with more than 1,000 PacifiCare members, and those with more than 500 Secure Horizons members. Secure Horizons is a Medicare-risk plan. The most recently available 12 months' worth of data were collected from member surveys, phone calls, and correspondence. PacifiCare converted the clinical and service indicators into a performance rate for each participating group. The rate is a percentile ranking relative to that of all other groups. In other words, the best group gets the highest score and all others are ranked against the best group. Administrative data, such as the number of times a patient visits a physician, reflect absolute scores.

Beginning in 1995, PacifiCare began a two-year process of soliciting provider feedback. In 1998, it spent six months correcting errors in an effort to ensure that the data submitted by provider groups were complete and accurate. PacifiCare asked focus groups of brokers, consultants, and providers to help develop the Quality Index.

In the rankings, physician groups are listed alphabetically. Therefore, groups are not listed according to performance. Those that performed in the top 10% of a specific measure receive the "best practices" designation. In the next two years, PacifiCare's parent company, PacifiCare Health Systems, in Santa Ana, Calif., plans to release quality indices for medical groups in Arizona, Colorado, Nevada, Ohio, Oklahoma, Oregon, Texas, and Washington.

—M.S.

Quality Index Measures

Some of the measures in PacifiCare's Quality Index are:

- Cervical cancer screening rate for women ages 21 to 64
- Breast cancer screening for women ages 52 to 69
- Rate of admissions for congestive heart failure per 1,000 members
- Access-related complaints
- Medical group transfer rate
- Voluntary disenrollment
- Benefit appeals
- Member satisfaction with participating provider group
- Member satisfaction with PCP
- Number of procedures
- Inpatient hospital days

"But sometimes we see statistics that are not meaningful. For example, some of the best physicians are referred the worst patients, so their length of stay or cost per case may be higher than that of other physicians."

Healthcare Report Cards bases its reported data on Medicare statistics gathered from the federal Health Care Financing Administration. Using a narrow population for reported data can cause problems, says Michael A. Cohen, MD, a radiologist and medical director at the Memorial Sloan-Kettering Guttman Diagnostic Center in New York. "The problem is that statistics can be very misleading. If you put a lot of thought into collecting data and analyzing the statistics, and if you have a good statistician, you could generate statistics that look very favorable to you," says Cohen. "For example, the statistics of a provider that has a large population aged 60 to 70 will look much different than those of a provider that is handling a lot of younger people because old people get more diseases."

PacifiCare asks that its groups report such data as the rate of cervical cancer and breast cancer screenings, and the rate of admissions for congestive heart failure. Physicians do not always recognize the value of reporting such data completely and accurately, says Sam La Blue, senior vice president of Lakeside Healthcare, the company that

Group Produces Its Own Report Card

Recognizing that the public wants such data, the 2,000-physician Brown & Toland Medical Group in San Francisco released its own report card to the public earlier this year. The data report on preventive care and patient satisfaction. "We believe that by publicly reporting on our efforts, we will demonstrate our commitment to quality improvement and the importance we place on providing excellent care," says Tom McAfee, MD, Brown & Toland's chief medical officer. "We use these statistics for internal evaluation and improvement, and the public should be able to use the same information in deciding on their health care providers."

Brown & Toland has been collecting data on its physicians' practices since 1995, tracking five screening measures: immunizations, mammography, Pap tests for cervical cancer, retinal exams for diabetics, and prenatal care in the first trimester. These data were collected by reviewing claims information and medical records. The results showed slight improvements from 1996 to 1997 in the all five screening measures, McAfee says. The statistics are most meaningful as a baseline for future evaluations, he says.

Brown & Toland also compiled data on patient satisfaction by mailing surveys to patients. From the 40,000 surveys that were mailed out, 22,000 patients responded. The surveys showed an increase in the percentage of patients reporting overall satisfaction with their physicians; access to routine, urgent, and specialty care; member services; and interaction with their physicians. The surveys covered more than 500 physicians, including all of the group's primary care physicians and all of the specialists who saw more than 100 patients.

Brown & Toland links an undisclosed portion of primary care physicians' compensation to the percentage of patients receiving preventive care and the level of satisfaction among these patients, McAfee says.

"We are an organization led by physicians that is committed to providing quality health care and to having members who are satisfied with the care they receive," says McAfee. "Report cards offer the opportunity to demonstrate our effectiveness and to improve our service. We believe it is important that our group be committed to measuring data, intervening to make improvements and then re-measuring our results."

—M.S.

manages Lakeside Medical Group. "We encourage our physicians to send in complete encounter data on a timely basis," says La Blue, "but they are busy people, and sometimes don't understand the importance of these reports."

Responding to consumer demands for information on provider performance, PacifiCare began its Quality Index initiative in 1995, says Tyler Mason, PacifiCare's director of public relations. "Managed care has a bad reputation with the public," says Mason. "People say to us that the collection of data on things like C-section rates is one thing that we can do well, so why not report our results to the public? We've kept our reporting mechanisms as fair as we possibly can by giving our groups more than two years' notice and by allowing them more than six months to correct for errors before issuing our first report."

Consumer response to the PacifiCare Quality Index has been "very positive," Mason says, explaining that the Quality Index data were downloaded about 15,000 times in its first three months of operation. The Healthcare Report Cards Web site had approximately 6 million hits in its first 10 weeks of operation, company officials say.

Regardless of consumer popularity, report cards are likely to remain controversial among physicians, says Joseph L. Francis, vice president of Cooper Research Inc., a health care marketing research firm in Cincinnati. "You're going to see a constant battle between providers and payers because one is never going to trust the other," he says. "When this information is made public, it becomes a very tenuous situation between the two parties."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Lawyer Explains How Physicians Can Negotiate From a Position of Strength



Steven Babitsky is president of SEAK Inc., a legal and medical information systems company in Falmouth, Mass. A lawyer, Babitsky received his law degree from Boston College School of

Law and is the coauthor, (along with James Mangraviti, a lawyer and vice president of SEAK) of *The Successful Physician Negotiator: How to Get What You Deserve*, which SEAK published last year. The book is the focus of this interview. Physicians interested in SEAK Inc.'s programs or products can call the company at 508/457-1111, fax to 508/540-8304, or visit its Web site at www.seak.com. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

their training, doctors are told to be cooperative and friendly, to assist people, and to downplay their own desires and needs. So, when it comes time to be assertive, they are at a loss as to how to proceed. We have found that an underlying resentment exists among many doctors, especially regarding managed care and related issues. That's because after all the education and training they've gone through to become a physician, many are underappreciated and grossly underpaid.

On the other hand, physicians who have some training or some experience in business and negotiation have been able to negotiate fair salaries, fair agreements, and fair relationships for themselves. These physicians are happier than the doctors who have to carry a pager all day and can't be more than two miles from the hospital.

they are involved in a negotiation. They need to get the necessary training before they get a letter telling them to be someplace at a particular time to negotiate a contract.

Q. You point out in your book that negotiations can start almost anywhere—over the telephone or in a casual conversation—and that physicians should be sensitive to that fact.

A. That's a very important point. Often, a physician who is not experienced in negotiation believes that negotiation starts when you sit down with attorneys and try to hammer out an agreement. But many times that's not what happens. Rather, a physician may receive a phone call from someone asking him or her to write a chapter in a book or to give a presentation. That phone call is the beginning of the negotiation. If the physician is not aware of it as such, he or she might agree to something

Q. Let's begin with a discussion of what led you to write this book.

A. We have been working with physicians for about 20 years and have been struck by the fact that although physicians are highly intelligent and highly educated, they do poorly in many business situations because they lack training in negotiation skills. Because we did not presume to know all of the issues and concerns physicians face, we talked with many of them before writing the book. Then, we added our 20 years of experience in dealing with and negotiating for physicians to write a text that is easy to read and that addresses the issues physicians face.

Q. Physicians from across the country often call me on our newsletter's toll-free phone line about issues you address in your book, such as: *To whom should I sell? How can I bring in a new partner? How do I negotiate a managed care contract? But doctors, as you point out in your book, are uncomfortable negotiating. Why is that?*

A. Our experience has shown that the training physicians receive is counter-intuitive to negotiation skills. In much of

"The best time to negotiate is when the other party needs the deal the most and you need it the least."

There are doctors who have very little family life, are constantly called in to do emergency procedures, and get paid \$29 for coming in on Sunday. Those doctors are not happy and probably rightfully so.

Q. It seems that physicians are facing many new negotiating situations: *Hospitals are buying primary care practices; practice management companies are acquiring practices; and physicians are dealing with multiple managed care contracts every day. It's common for doctors to be in situations that require negotiating skills.*

A. That's true. In fact, when our book came out, many physicians asked for it to be shipped to them overnight—which tells us that they have something imminent coming up and that they want to be prepared. Even though we are glad they want our book, we stress in it that physicians who do not have the training or the skills for negotiation often don't even know when

without giving it too much thought, thereby marking the beginning, the middle, and the end of the negotiation. So, it's important for doctors to recognize when a negotiation is taking place and to be able to say "no" at an appropriate time and in an appropriate way. And if they do agree to do something, to make sure what they're agreeing to doesn't interfere with their practice or their family life or anything else.

Q. You caution against "ambush negotiations"—that is, being forced into making a decision. You suggest a delaying technique: *Request that whatever is being asked for be put in writing. Would you say more about that?*

A. Often, physicians find themselves in a situation in which an experienced negotiator tries to force them to answer quickly. The approach in such a situation—where they are essentially being ambushed because they are not ready to make a decision—is to buy additional time by asking to

see the proposal by fax or to weigh the decision overnight. It's usually the precipitous answers that come back to haunt you.

Q. *Tell us more about who has the authority in making decisions.*

A. We have included a fair amount about the topic of authority in our book. When physicians are negotiating, they need to make sure that the person they are negotiating with has the authority to make a decision, otherwise that person is simply gathering facts, perhaps to report back to someone else who may negotiate later.

It is equally important for physicians to be able to say to the person being negotiated with, "I don't have the authority to do that," or "I have to check with someone else about that." This type of response gives physicians time to think about the negotiating points and to come up with other proposals if needed.

We recommend that physicians go in to negotiations with a reason for not being able to make immediate concessions. We also recommend that physicians do not conduct negotiations in their offices, where they have staff, office equipment, records, and everything else that could possibly be needed during a negotiation. For example, during a negotiation, the other side might say, "I just saw your partner walk by, why don't you ask him to come in here so we can resolve this right now." By not negotiating in their offices, physicians leave open the option of being able to say, "I have to check my records (or with my partner, or my attorney, or my bookkeeper) first and then I'll get back to you." Physicians should always buy additional time to weigh their options carefully before giving a response.

Q. *Is it true that, as you say, "Everything is negotiable?"*

A. To a certain extent, I believe that. Very few business situations are not negotiable. But a lot depends on the parties involved and the particular situation.

Q. *Could you explain the timing of negotiations and how to use deadlines to an advantage?*

A. Perhaps the best way to do so is to start with an analogy. Most of us wait until the day of a snowstorm to put snow tires on our cars. Some of us even wait until then to buy the snow tires. Well, the day the first snowstorm hits is not the best day to buy snow tires. Likewise for negotiations.

The best time to negotiate is when the other party needs the deal the most and you need it the least. By waiting until you absolutely need it, you're in the weakest possible negotiating position.

As for deadlines, most negotiators have deadlines and then they have other deadlines. For example, if I need a client to get a document to me by Dec. 31, I certainly am not going to make that date the client's deadline because, human nature being what it is, chances are I won't get it until sometime in January or February. Instead, a good business negotiator would give an advanced

use to better your other offers.

Q. *Your use of frequent examples throughout your book is effective. One is about a young doctor who is asking for a salary of \$150,000 from a group he is considering joining. The group, however, says that it can afford to pay him only \$130,000. Tell us about the concept of "linkage" and how this young doctor could negotiate a higher salary.*

A. Young physicians are probably in the worst negotiating position. They're concerned about getting their first job. They're also concerned about their reputation and their relationship with the practice.

"The worst thing doctors can do is to squeeze in crucial calls involving hundreds of thousands of dollars in the few minutes they have between patient visits."

deadline of say, Dec. 5, to buy additional time in case of delays.

Q. *I often receive calls from solo practitioners who have been approached by three different parties to acquire their practices. They are bewildered about how to handle this situation and whether to bid one against another. What should they do?*

A. I recommend that they first set aside time to take the calls and think about the proposals outside of a busy office. The worst thing physicians can do is to squeeze in crucial calls involving hundreds of thousands of dollars in the few minutes they have between patients. When negotiating with multiple parties, many different negotiation strategies and tactics can be used. For example, it's not unusual to use one company's bid against another company's bid as a negotiation tactic.

If you are trying to sell your practice, the key is to get a firm offer, even if it isn't the best possible offer. Thus, a firm offer from company A puts you in a stronger position when dealing with companies B and C because it gives you a figure to compare with the other offers. If company A's offer is the best of the three, you can tell the other two companies that you already have an offer that is better than theirs without telling them exactly how much it is. The key here is to have a firm offer that you can

frequently, a group or other organization will take advantage of these physicians by talking them into poor contracts, offering long-term employment without sufficient raises, and requiring that they pay large sums of money out of their salary to buy into the practice, which will tie them up indefinitely.

The technique of linkage is basically this: If you're going to give something up, get something in return. In terms of salary, it's important to know what the going rate is in order to make your argument. If, for example, the practice says to you, "The most we pay anybody to start is \$120,000, and you must be on call three days a week." You might be able to counter with, "If I sign now for two years and agree to some of your terms and you agree to some of mine regarding coverage, insurance, bonuses, or other benefits, will you increase my starting rate?" In essence, what you're doing then is saying, "I'm giving something up and I would like something in return. If and when I get that, then I'm in a position to sign."

Q. *Would you comment on other techniques—such as flexibility?*

A. There are a number of techniques that we talk about in our book, and it's remarkable how effective some of them can be. For example, people will often give you an offer—or make a demand—saying, "The most we can offer ...," or "The most

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we can pay ... is \$20,000." If, however, they continue to talk when you suggest other options, you can ask a simple question: "How much flexibility do you have?" Most of the time, their response will be something like, "I have some (or not too much, or a little) flexibility." Any of these words are buzzwords to listen for.

Our book devotes an entire chapter to the importance of listening because careful listening alerts you to situations where there is

HMO, Harvard Pilgrim Health Care, says, "Here's our standard contract, take it or leave it." How would you respond?

A. Usually it's not presented that way, but rather as, "Here is the standard contract." Even so, it's up to the doctor to say, "We need to make a few changes." The situation depends on the strengths and weaknesses of the various parties: Does the physician have alternatives? Is he or she in other HMOs or is this the only one in town?

strength, you can take it.

Again, it depends on timing. If three of your partners demand that the practice be sold by the end of the year and it's Nov. 25, you can't take that approach. But if you have other options, if you're not in a rush to sell, and if the other person needs what you have more than you do, you can take a hard and direct approach.

Q. Also if you have superior knowledge, you can take the direct approach.

A. Absolutely. The key is to position yourself with the superior knowledge by doing the necessary preparation before the negotiation begins. Many times a physician is the only one in a small town, which is a situation he or she should exploit. For example, if you are either the only person or one of the few people to offer a service, you do not have to value that service based on traditional methods.

Q. In closing, tell us briefly about your company, SEAK Inc., and what it does.

A. SEAK helps physicians in the business and medical legal arenas. We offer a three-day seminar that teaches physicians about the legal issues that affect them, and a two-day mini-MBA seminar.

Q. In your business seminar, how is it possible to cover the essential curriculum of an MBA program in two days? That must entail a heavy concentration of firepower.

A. We've been in the education business for 20 years, and one thing we've seen is that our physician attendees are smart and willing to work hard. Both the law seminar and the business seminar

"If you're going to give something up, get something in return."

still negotiating room after what seems to be a bottom-line offer. The traditional negotiating technique is not to make your best offer immediately but rather to start low and negotiate up. That's what happens in most cases. So, the answer to that simple question, "How much flexibility do you have?" often indicates that there's more to be put on the table than there initially seemed to be.

Q. Physicians also need to negotiate when confronted with a boilerplate managed care contract. If these contracts are presented as a take-it-or-leave-it proposition, What negotiating strategies do you recommend?

A. What usually happens with these contracts is that the company is relying on the "force of legitimacy" to make people sign them just as they are. Such contracts are either standard contracts or are preprinted with only the date, the name of the practice, and the name of the doctor left to be filled in. They don't have any blank spaces for the dollar amounts to be filled in; those amounts are preprinted in the contract. So, for example, if you're to get \$100 for an office visit, that amount and whatever terms go along with it will be preprinted in the contract. Most people assume that they can't negotiate terms in preprinted contracts. In fact, 95% of the contracts people sign—whether they come from an insurance company, a finance company, or an attorney—are not negotiated, but rather are standardized contracts. The reason: The company doesn't want to negotiate over these terms.

Q. Let's say you are a doctor in Massachusetts, and the state's largest

When a doctor has contracts with other providers, and receives a fair amount of business from them, the physician will be in a stronger negotiating position than he or she would be without those contracts. But as doctors get smarter, which is happening more and more, even those who seem to be in weak negotiating positions may be able to strengthen their positions by joining together—even against the only HMO in town. One of the major premises of the book is to negotiate from a position of strength. And that requires preparation.

Q. One amusing technique you discuss is the Brooklyn approach. Would you explain, please?

A. Sure. The Brooklyn approach involves a situation in which you're negotiating and you want to be very direct.

"In fact, 95% of the contracts people sign are not negotiated, but rather are standardized contracts."

Let's say you're selling your practice. Conventional wisdom dictates that you start at the higher price and let the other side negotiate it down until you reach an agreement. The Brooklyn approach cuts to the chase. You say to the other side, "I've talked to my six partners. Our bottom line is \$5 million, and if you want to purchase the practice for that price, let us know." Often, people are caught off guard by an approach like this, and if you're in a position of

use detailed course books, which we mail to the physicians before the seminars begin. We expect them to read the books—which they do—and to be well prepared—which they are—when the course begins. It's amazing to see the transformation they go through after these two- or three-day courses. When they complete the courses, they are talking about what is legal and what can and should be done. In many respects, they are thinking like lawyers. ■

Match Contract Systems to Group Needs

By Brett R. Trusko

Participating in managed care plans demands accurate and timely information. Therefore, the ability to capture, retrieve, process, manipulate, analyze, and share information effectively is essential for physicians seeking to remain successful in markets in which managed care has a significant presence.

Many contract management systems are designed specifically for certain practices. Some systems are best for solo practitioners and small-group practices; others are best suited for mid-size and larger groups. Each system has strengths and weaknesses. Deciding which system is right for your practice is a matter of identifying your needs and the types of contracts you typically sign. The few simple rules and guidelines that follow will help you to analyze the various contract management systems and decide which will work best in the practice you manage.

Initial Analysis

A physician does not need to be technically sophisticated to make a good choice of systems. The skills you use as a successful medical practice manager are the same skills you will use to evaluate the strengths and weaknesses of the systems you review. You will also use the same skills to ensure that your staff and any consultants who help you with the technical aspects of the installation are doing their jobs properly. Your role in the process of purchasing and installing a contract management system will be that of researcher and investigator, project manager, and team leader.

You will need to understand the basic concepts of information technology; that is, what that technology can and cannot do, how it is being used in health care and other industries, and what you believe it should be able to do for you. By coupling

your understanding of technology deployment with these guidelines, you will be prepared to analyze managed care information systems and make decisions that will help you to manage your practice more effectively.

The first step in preparing to acquire managed care software is to examine your payer mix and the processes you currently use to administer the managed care dimension of your business. By examining and documenting your current managed care business processes—what works, what needs to be improved, and what can be

ments will serve as a shopping list when you meet with managed care information system vendors.

The final step is to establish what might be called your system philosophy. This step involves determining what you believe a contract management system should accomplish for your practice. If your practice is in the early stages of managed care and your approach to a managed care system calls for a simple product focused on billing and business office functions, you are looking for technology that is relatively straightforward. If your expectations

The physician's role in purchasing and installing a contract management system will be that of researcher and investigator, project manager, and team leader.

automated—you will see clearly what you need to look for in a managed care contract management system. If your practice currently reviews coding appropriateness manually, for example, you will want to purchase contract management software that will provide you with the ability to automate that procedure.

The second step is to identify the data you want to capture, manipulate, analyze, and share. Examples of these types of data might include demographics and social characteristics of your patient population, morbidity and mortality rates, performance of the individual providers in the practice, measures of health status, and patient satisfaction and quality measurements.

Keep in mind that computers are efficient tools for collecting data, which is then processed into information. To manage your contracts successfully, you must be able to access and assess the appropriate data effectively. By thoroughly assessing and identifying your information needs, you will be able to prepare a comprehensive checklist of your minimum information system requirements. This list of minimum require-

ments include providing access to computerized patient records, scheduling, or clinical management of chronic conditions, you are looking for an entirely different system. Modern managed care information systems have evolved beyond mere claims processing, and now are capable of providing sophisticated data analysis, population analysis, market segmentation, disease management, outcomes reporting, and greater personalization of services for patients.

Keep in mind that some systems work well in solo practices or small groups while others seem better suited for large practices that employ dozens of physicians. Some information system vendors will argue that their system works as well in a small focused practice as it does in a large multispecialty practice. To make an apples-to-oranges analogy, one could argue that a hammer seldom does as good a job as a screwdriver. This is not to say that either the hammer or the screwdriver is inferior, just that each works best when used for the job for which it was designed.

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Brett E. Trusko is a director of the physician practice management services division of Superior Consultant Company Inc., Southfield, Mich., and a certified Fellow in the Healthcare Financial Management Association (FHFMA).

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Managing Risk

Any managed care system you purchase must fully support your practice's risk-evaluation and risk-minimization processes, including contract analysis and evaluation of need, also known as population management. Risk sharing involves transferring risk from one party to another. In health care, risk is transferred, in varying degrees, from payers to providers. Contract evaluation involves examining the numerous types of managed care contracts that payers will present to your practice. Some of these contracts will involve capitation (in which the financial risk is shifted to physicians), while others will involve payment systems that are similar to fee for service (in which physicians have little financial risk).

Some systems do a reasonable job of processing a variety of contracts, while others can process only one type of contract well. Therefore, if possible, it will be advantageous to determine what types of contracts the practice will be most likely to sign in the future and buy the system that manages those contracts most effectively.

Evaluation of need means examining the makeup of the patient population you serve. An effective demographic evaluation should include determining the health status of your local and regional patient population, identifying the services that will meet the typical needs of that populace, and

A System Buyer's Checklist

When searching for a managed care system that will provide your practice with the ideal combination of features, functions, and benefits, you should use a systematic method of evaluation. To do so, you might want to follow a checklist such as the following:

1. Assess your market and your strategic plan.
2. Review your current method of performing managed care processes.
3. Involve those who do the work in the selection process. Have them check the system you are evaluating to confirm that it will fully support the way your practice processes patient information and the related paperwork.
4. Assess the product's functionality by making site visits and working with the vendor's product if possible.
5. Test the system with a sample of your typical workflow. Confirm with those who will be using the system that it performs up to their standards.
6. Ask the vendor to draw up a sample contract. Submit the contract (along with the vendor's product marketing materials and proposal) to a qualified attorney for review. Make sure that the attorney includes wording in the contract that will protect you if either the system or the vendor fails to perform as specified.
7. Plan and schedule the conversion to the new system. The vendor can typically supply its own specialists or recommend some who can help you with any and all technical aspects of the installation.
8. Be sure that the new system is working properly by testing it with office data before allowing the vendor to leave.

meeting those needs with the appropriate services, thereby helping to minimize risk.

You now have the selection guidelines that information system professionals have used for years. These guidelines are easy to learn and use. By using this simple

methodology (of analyzing your current procedures, identifying your needs, and outlining the steps required to meet those needs), most of your information system selection issues will be more easily identified and resolved. ■

Questions to Ask When Evaluating Systems

When evaluating managed care information systems, many physicians forget to consider their practice's short- and long-term business plans and strategies. Important strategy issues to address include:

- Will you or your practice join a group in the near future? If you are planning to join another group, find out if that group has a contract management system. If so, make sure that the system you purchase will be compatible, or at a minimum, that your data can be easily converted to the format of the other group's system.
- Will you be in a position to rent a

colleague's business office staff and system? A nearby provider who is somewhat overstaffed and has the system capacity to do so may be willing to consider processing your practice's managed care claims for a fee. Or, in a twist on this scenario, you could pay a portion of the salary of the individual who would handle your paperwork. Either way, this proposition could be mutually advantageous to the contract management area in both practices.

- Will your practice generate enough complicated contract-related business to warrant the acquisition of a sophis-

ticated system? Analyze the types of contracts your practice typically signs because contracts with a fee schedule demand an approach to information management that is completely different than the approach full-risk capitation contracts require. If you anticipate that your practice will have just a few scheduled contracts, it would be unnecessary—and ridiculously expensive—for you to purchase a system designed for 250,000 capitated lives. You would be paying for system capacity and functionality that would never be tapped, an error a small practice cannot afford to make.

Is Unionization a Viable Option?

By Katherine A. Nino, JD

Widespread consolidation in health care has enabled some managed care plans to amass enough market leverage to virtually dictate the terms of the contracts they offer to physicians. Physicians often complain about the onerous provisions in these contracts, including those that restrict their fees.

In response, many physicians are expressing an interest in forming unions or joining existing ones to gain leverage through collective bargaining with large managed care plans. But before exploring the option of joining a union, physicians must understand that the federal antitrust laws and the National Labor Relations Act (NLRA) greatly restrict what unions can do on their behalf. In particular, they must be aware that the rights of physicians to bargain collectively differ dramatically, depending on whether they are considered employees or independent contractors under the law. (See “Are Physicians Independent Contractors or Employees?” page 16.)

Stated simply, the federal antitrust laws prohibit competitors from “bargaining collectively” with payers. Self-employed physicians are considered independent contractors, and therefore competitors, under these laws. Consequently, it is illegal under these laws for self-employed physicians to bargain collectively through a union or any other entity with health plans. Violation of the antitrust laws can result in severe penalties, both civil and criminal. Moreover, the individual physician members of the union—not just the union itself—may be subject to penalty. Therefore, independent, self-employed physicians should not join a union with the expectation that it can negotiate better fees with health plans, and, in fact, such bargaining is fraught with legal risk. The U.S. Department of Justice, for example, recently filed complaints against the Federation of Physicians and Dentists on the grounds that it engaged in illegal bargaining activity with

health plans on behalf of independent, self-employed physicians.

Physicians who are employed and non-supervisory may bargain collectively with their employers. In other words, the right to bargain collectively is contingent upon an employment relationship. In addition, some state laws provide specific rights for public employees—including physicians—to organize. In fact, unions have played a role in bargaining collectively on behalf of publicly employed physicians for years. Of the 3% of physicians in this country who belong to unions, most are employed by public hospitals or other government entities.

National Labor Relations Act

For employed physicians seeking to bargain collectively with a common employer, the NLRA provides important protections. First, an employer must recognize and negotiate with unions certified under the NLRA. Second, the NLRA restricts the tactics employers might use to break up unions, such as retaliation against indi-

In the past two years, the National Labor Relations Board, the federal agency that oversees the certification of labor unions, has recognized three bargaining units composed of physicians employed by private institutions. Critical to the NLRB's finding that the physician members were nonsupervisory was the fact that the institutions' department heads were not in the bargaining units.

Other Roles of Unions

Although the antitrust laws and the NLRA leave little room for independent physicians and physicians employed in supervisory roles to bargain collectively, these physicians are not necessarily prohibited from joining unions. In fact, these physicians may do so as long as they do not participate in the union's collective bargaining efforts. Ironically, the prospect of collective bargaining is what most physicians who express interest in joining a union find most enticing. Therefore, self-employed physicians interested in joining a union should look into what

Physicians must be aware that their rights to bargain collectively differ dramatically, depending on whether they are considered employees or independent contractors under the law.

vidual members who join the union.

Employed physicians who organize into a bargaining unit will not qualify for NLRA protection if the physician members are in supervisory positions. Because having the protection of the NLRA is so crucial, the definition of “supervisory” is important, but the law is unclear as to whether physicians are appropriately classified as supervisors under its provisions. In finding that physicians are supervisors, some courts have pointed to their role in directing other members of the health care team, thus making them unable to benefit from NLRA protection. Other courts, however, have found physicians do not have a supervisory role, and, as such, do qualify for NLRA protection.

benefits other than collective bargaining the union offers.

Aside from collective bargaining, union roles may include advocating on behalf of physicians before state legislatures and the courts. But many observers question the propriety of physicians joining traditional trade unions, which represent a wide array of constituencies, because unions often take positions contrary to the interests of physicians on legislative issues, such as tort reform. In deciding whether to join a union, physicians should consider whether their interests are more likely to be represented by national, state, and specialty medical societies that represent the interests of physicians exclusively.

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Are Physicians Independent Contractors or Employees?

The courts look at the following criteria to determine whether a particular worker is an employee or an independent contractor:

1. The extent of control which, pursuant to the agreement between them, the alleged employer may exercise over the worker. The greater the amount of control, the more likely it is that the individual is an employee.
2. Whether the worker is engaged in a distinct occupation or business. If so, that fact is more indicative of independent contractor than employee status.
3. The kind of occupation and whether the work involved is usually done under the direction of the employer. If the occupation is normally done by self-employed individuals, that fact indicates independent contractor status.
4. The skill required for the work involved. The higher the degree of skill, the more likely it is that the individual is an independent contractor.
5. Whether the alleged employer supplies the person's tools and the place of work. If so, that indicates employed status.
6. The length of time for which the worker is hired. Indefinite and long-term relationships are more indicative of employed status.
7. Whether the pay is by time period or by the job. Payment of fees for individual services is more indicative of independent contractor status.
8. Whether the work is part of the regular business of the employer. If so, then the person is more likely to be an employee.
9. Whether the alleged employer and the worker believe that they have created an employment relationship. ■

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