

# PHYSICIAN PRACTICE OPTIONS™

November 30, 1999

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Physicians Develop PSO To Gain Control Over Delivery of Patient Care

A group of 300 New York physicians is developing an innovative provider-sponsored organization (PSO) in the hope of regaining control of medical and financial decisionmaking for their practices and enhancing patient care.

"A PSO is an alternative for Medicare patients who want to join a managed health care plan that is operated by physicians," says Robert Aquino, MD, a primary care physician and president of Universal Medical Associates, the PSO under development in the borough of Queens in New York City. The developers hope to open the PSO next spring.

### Medical Decisions

Aquino and his colleagues were interested in the PSO concept because they wanted to maintain control over the medical decisions affecting their patients, about 60% of whom are covered by Medicare and Medicare-risk HMOs. "We felt that managed care plans were dictating policies on how to treat our patients," says Aquino, whose group practice, New York Physicians Network in Astoria, N.Y., includes 35 primary care physicians. "Under managed care, of course, we were subject to utilization review and preauthorization requirements, and other clinical directives. Furthermore, we were subject to restraints on care access, as we were told what facilities, specialists, and hospitals to use, even though some of these choices did not provide continuity of care for our patients."

Such fragmented care was affecting the quality of care negatively, says Aquino.

"Physicians are the front line, and we understand our patients' medical needs," he continues. "We want control over our ability to provide and access care in the way we see fit."

Aquino believes that a PSO is the best structure under which to organize his group and an associated IPA of more than 200 primary care physicians and specialists. "A good portion of our patients are Medicare patients," Aquino explains. "And elderly patients are the ones who use the health care system the most, so it becomes important to manage their care efficiently and effectively. As owners and managers of Universal Medical Associates, we will control all policy and financial decisions. Our physicians will decide where to spend the funds Medicare provides to cover care, whether it's pharmacy, tertiary care, specialty care, or diagnostics."

Richard Richel, executive director with Superior Consultant Co. Inc., in Southfield, Mich., agrees that physicians are attracted to the PSO concept because they want more control over medical decisionmaking. "As owners of the PSO, they can provide or control the distribution of medical services appropriately to members, and can contract only with those facilities with which they want to work," he says.

Allowing physicians to control the processes of care has wide-ranging implications for patients and for physicians, Aquino says. "For example, now, if we are unhappy with the service our patients receive at a hospital, we can contact the medical director but we basically have no

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## Practitioners Have Their Reasons for Going Solo

One day recently, a physician's wife called me. She had read an article we had published about a physician who was seeking advice on starting a solo practice.

The reader was pleased because we had described a number of advantages of solo practice. "My husband is in solo practice," she said. "He absolutely loves it. It's the best thing he has ever done. I'm so glad to see a positive article on it. There should be more positive articles. There is so much propaganda nowadays encouraging doctors to join larger and larger groups. It just doesn't need to be that way."

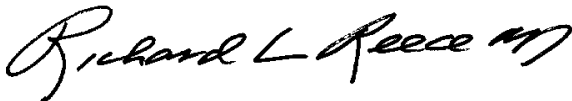
Indeed, there are many benefits to being a solo practitioner. As we reported, most solo practitioners enjoy complete control over their practices and their overhead may be much lower than that of a physician in a larger group. Of course, there are a number of serious drawbacks, as well, as we pointed out. The solo practitioner's schedule can be demanding because there's no one else to help meet the workload. There may be limited access to managed care contracts, and insufficient volume to create profitable ancillary services.

Despite these drawbacks, the physician's wife has a valid point. For many physicians, the pleasures of practicing simply for the professional gratification of serving patients may be worth all the trouble of working alone. In fact, the death of solo practice may have been greatly exaggerated. According to the most recent edition (1997/1998) of *Physician Characteristics and Distribution in the United States*, which is published by the AMA, the number of group practices has grown by 30.4% over the past six years but the number of solo practitioners has declined by only 2.2%. Today, more than one third of physicians are practicing alone or in two-person groups. Among practicing physicians, only 25% work in large groups of more than 10 physicians.

While group practices are growing and will continue to grow given the presence of managed care, solo practitioners still represent a significant portion of the physician work force. What's more, if the number of calls I receive is any gauge, then there is renewed interest in solo practice.

Many of the phone calls I receive are from solo practitioners or those interested in learning how they might succeed in solo practice. Few of these callers are acting out of desperation. Some of these calls are from older physicians who want to know how they can sell their practices and retire. But most calls are from physicians interested in leaving a group or hospital practice or they are from young doctors just getting started. I also get a number of calls from physicians in their prime who want to re-enter solo practice after being divested by hospitals or physician practice management companies. Many of these physicians have experience working in group practices and did not enjoy it.

The point is that medical practice remains a very personal business, and solo practice may be the most personal of all patient-physician encounters. It, therefore, may be among the most gratifying.



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# The Medical Director's Role Evolves

By Richard L. Reece, MD, editor-in-chief

In any dynamic industry, executives must be willing and able to alter their roles to meet the needs of their organizations as the business environment changes. This fact is especially true for physician executives, who face the difficult challenge of managing changing health care systems when costs are rising and reimbursement is falling.

Elizabeth Gallup, MD, knows firsthand the problems physician executives face. The president and medical director of New Century Health Quality Alliance, a nonprofit multispecialty risk-bearing IPA in Kansas City, Kan., Gallup is a board-certified family physician. She also serves as executive director of North American Medical Management/Kansas City, a subsidiary of PhyCor, a physician practice management company in Nashville, Tenn., that maintains a management contract with the IPA. Gallup holds a medical degree and has earned a JD, an MBA, and an environmental engineering degree. She is the author of a book, *How Physicians Can Avoid Surrender and Lead Change: Gaining Real Influence in Your Own Health Care Organization Before It's Too Late*, published in 1996 by The American College of Physician Executives, in Tampa, Fla.

## An Educational Role

As a result of varied experience, Gallup believes the position of medical director has been changing in recent years. "The role of each medical director obviously depends on both the job description and the organization," she says. "But the traditional role of the medical director is changing. The role of monitoring clinical performance and serving as the last word in decisionmaking—which often means

serving as 'Doctor Denial'—is evolving into more of an educational role. Today's medical directors are focused on developing data so physicians can manage their own practice patterns and alter their practices based on that data. Also, medical directors are now much more involved in monitoring costs than they were in the past. Years ago, the medical director's role was purely clinical. He or she didn't participate much in the economics of the practice. Today, medical directors have a business as well as a clinical role."

The shift in role from clinical to business administrator is beneficial for both the medical director and the physicians in the practice. Medical directors who deny treatment, and thus contradict the physicians at the bedside who deem a procedure to be medically necessary, face significant legal liability. "That's one of the reasons provider organizations are evolving away from encouraging medical directors to deny procedures," she says. "When a procedure is denied, that increases not only the medical director's individual liability—for which he or she would have liability insurance, of course—but also the liability of the organization as a whole."

Furthermore, denying procedures isn't effective in changing physician practice behavior, Gallup reports. "Denials alienate the practicing physician from the medical director, whose role is to help the practicing physician," she says. "The only time in our organization that I ever deny a procedure is when the practicing physician refers the patient to an out-of-network provider. Our physicians must have a good clinical reason to refer outside of the network, but usually their reason is that they didn't realize that the provider

was not in our network. Instead of denying procedures, my job is to supply the information and data to help the physician make some practice adjustments."

## Building Credibility

Gallup asserts that the medical director, who is considered a member of the administrative team, can build his or her credibility with the physicians under his or her purview through education. "If the medical director doesn't educate the physicians about proper clinical decision-making, physicians won't understand the reasoning behind decisions," Gallup says. "As a result, the physicians will be frustrated and angry any time the need for a procedure is discussed."

Future changes in the medical director's role may occur as a result of legislative developments, some of which may make the medical director's educational and oversight role more difficult, Gallup says. "For example, while it's well-meaning, the patients' bill of rights actually may hurt patients more than help them," she says. "Yet under the legislation, the patients can get everything that they demand without understanding that some of the tests, drugs, and specialists they might want aren't appropriate or may even be harmful or unnecessarily risky. Therefore, physicians may lose their ability to help guide patients to the appropriate care.

"In some ways, the legislation returns us to one of the problems with fee-for-service medicine," Gallup continues. "There was, and still is, a tremendous number of procedures, medications, hospitalizations, and office visits that are clinically unnecessary. The legislation won't help rein in

(Continued on page 4)

**"The traditional role of the medical director...of monitoring clinical performance and serving as the last word in decisionmaking—which often means serving as 'Doctor Denial'—is evolving into more of an educational role."**

**—Elizabeth Gallup, MD, New Century Health Quality Alliance**

(Continued from page 3)

medical care costs, and it actually could tie the hands of physicians more than they are tied now through managed care. It also ties the hands of the medical director, who is trying to manage health care costs and promote efficiency as well as educate physicians to develop clinically superior practice patterns."

#### Practice Management

No matter what managed care legislation Congress passes, the old rules will still apply to medical directors. The responsibilities of a medical director to gather and review data on the costs and quality of care will remain, for example. Gallup notes that physicians tend to respond positively to such data and usually tend to improve once they realize where they stand. "Physicians are inherently competitive, and they don't like to be on the bottom," Gallup explains. "Showing them where they stand helps prompt behavioral change."

Gallup believes that collecting and reporting data on costs and quality is one key to the success of IPAs such as hers. "In contrast, HMOs may not track data appropriate to the medical director's task of effectively managing risk," she says. "The HMO is usually more interested in costs. Also the HMO medical directors often may be too far removed from the daily practice of the physicians to have much of an influence. That's one of the reasons that HMOs haven't really been able to manage their medical loss ratios as well as some IPAs."

#### Using Leverage

"While an average HMO can get its medical loss ratio down to 85%, highly functioning IPAs can get their medical loss ratios down to about 65%," Gallup continues. "This is because the IPAs, if they have an appropriate management partner, such as PhyCor, can generate data that physicians then use as a basis to change their practice patterns."

Only those groups that work hard to be cohesive and highly efficient will succeed at reaching such a low medical-loss ratio. Acting as a group, in fact, is crucial for physicians who want to have real influence in the health care organizations in

## Physician Offers Perspective on Decline of PPMCs

As executive director of a subsidiary of PhyCor, the large physician practice management company (PPMC), in Nashville, Tenn., Elizabeth Gallup, MD, has an interesting perspective on the decline of the PPMC industry over the past year.

"PhyCor has two strategic initiatives: one is practice acquisitions and management, and the other is IPA management, which involves physician practice management contracts as opposed to practice ownership," says Gallup, executive director of North American Medical Management/Kansas City, in Kansas. "The mere fact that PhyCor is still around demonstrates that it has been managing physician practices better than its competitors, most of whom are now defunct. PhyCor also had the foresight to move into IPA management and is deriving a growing percentage of its revenue from IPA management."

Inherent difficulties exist any time an external organization tries to manage physician practices, Gallup says. "The medical directors in physician practice management companies have to work hard to get the different practices to start thinking and acting like a group,"

she says. "This must be accomplished whether the physicians are employed by a hospital, an insurance company, or a practice management entity—and PhyCor assists in this regard."

PhyCor has survived when so many others have failed because the company has kept its focus on serving physicians. Gallup has found that the best medical organizations have credible and useful data and she praises PhyCor because its data are invaluable to her in her role as medical director.

"PhyCor is extremely helpful, because it allows me to provide the physicians, both individually and on a small group level, with a number of data points," Gallup says. "Such data include number of referrals, pharmacy costs, admissions per thousand, bed days, and average length of stay. This is a significant amount of important comparative educational information to help lead physicians to change their practice patterns. Our IPA has been in existence only five months and we're already showing these physicians data about their practices that they have never seen before, even though some of these physicians have been involved in managed care for 10 or 15 years." —DJN

which they participate, Gallup says.

Given that Kansas City is one of the most competitive markets in the country in terms of number of physicians, strength in numbers is even more important. "If the physicians in Kansas City want to take a stand against a payer, their mass must be sufficiently large," Gallup explains. "Otherwise, the payer will just move its business to other physicians. This characteristic of the market decreases the physicians' ability to have much leverage with the HMOs. Also, Kansas City physicians have historically received low reimbursement rates, which is one of the reasons the physicians formed this IPA."

"Our IPA has been extremely fortu-

nate, however, in that we're partnering with Humana to share a risk contract both for Medicare and commercial enrollees," Gallup continues. "We are the first IPA in the city to form and acquire a risk contract. It took three years to accomplish this, and all the while the hospitals have continued their consolidation and their ability to negotiate with the HMOs. What we have now is essentially a two-hospital town, with the Health Midwest System and the Shawnee Mission/St. Lukes System. The hospitals have not been willing to negotiate prices down, so in the face of rising premiums the HMOs will try to take their money out of the physicians' pockets." Conversely, a risk contract offers the

physicians the opportunity to share in any savings that are generated.

But such contracts may become increasingly rare since so many large payers, such as Aetna and Prudential, have been consolidating recently. These mergers put physicians at a disadvantage. Such consolidation is beneficial, however, in that it allows large payers to amass giant pools of patient data so they can sort patients by risk.

Just as health care payers are getting larger in order to become more efficient, physicians need to do so as well, Gallup says, adding that the future of solo practitioners may be limited. “The individual physician as a stand-alone entity does not have a future,” she says. “Physicians can still choose to operate in small practices, but if they really want to exert any sort of negotiating power, they need to become a member of some form of group—defined for independent physicians and small practices as an IPA or IPO, an independent practice organization.”

Such loose affiliations are easier to form

than combining many independent physicians into a group with a single taxpayer identification number, Gallup explains. “Frankly, physicians can achieve more of the benefits in terms of negotiating power and the ability to educate each other from an IPA than from a formal physician group practice,” she says.

When forming a group practice,

greater chance of group cohesion and group education. Furthermore, practice patterns tend to evolve to a similar level, which simply won’t occur in a larger group.”

Despite the more complicated environment in which physicians practice today, Gallup remains optimistic and says physicians should as well. Her

**“When a procedure is denied, that increases not only the medical director’s individual liability—but also the liability of the organization as a whole.”**

**—Elizabeth Gallup, MD,  
New Century Health Quality Alliance**

Gallup believes small groups may be optimal. “Basically, it’s easier to get five people to agree on how to manage a practice together than it is for 10, 15, or 20 physicians to do so,” she says. “In a five-person group, the physicians have a

advice to physicians and physician executives is simple: “Keep the faith, work hard, and never forget the patient,” she says.

—Additional reporting and writing by Deborah J. Neveleff, in North Potomac, Md.

# Group Links Guidelines and Outcomes

By Peter Schock, MD

Physicians are concerned that as managed care proliferates they may be forced to shift their focus from patient care to cost control. It is not surprising, therefore, to find that the physicians in the Cascade Healthcare Alliance (CHA), a 200-member physician group, in Bellevue, Wash., were concerned that the process of managing care would take them away from providing the best care to their patients.

Seeking to continue delivering quality patient care, the physicians developed protocols aimed at ensuring that patients got timely and appropriate treatment. One of the protocols was an asthma initiative that focused on defining, measuring, and providing a financial incentive for producing good outcomes. Within three months of the program's outset, the initiative reduced inappropriate prescriptive behaviors, spawned creative patient education programs, and increased the professional gratification of practitioners. The initiative's attainable goals centered on reducing the use of bronchodilators and increasing the use of anti-inflammatories.

## A Flourishing IPA

CHA is the product of three different affiliations with various integrated delivery systems in the area. After struggling and reforming itself a number of times throughout its 10-year history, the group has evolved into a successful IPA. Formed in 1995, the IPA is governed by a board of physicians and is wholly owned by its 200 physician members, about half of whom are PCPs.

The group generated more than \$1 million in revenue in each of its first two years, and has grown from 5,000 covered lives and monthly gross revenue

of \$290,000 in 1995, to 40,000 lives and \$1.4 million in monthly gross revenue this year. Cascade Management Inc. (CMI), a corporation formed and funded by CHA, processes the entire group's managed care business. For CHA, CMI handles claims processing, referral authorization, utilization management, physician education, practice guideline development, and quality improvement.

Since 1995, the group has revised its physician payment system several times, and this system continues to evolve. Currently, the IPA pays its PCPs under a capitated system and uses fee-for-service to pay specialists. This payment method

risk only for that over which they have control," says Mulloy Hansen, MD, a family medicine physician and a co-founder of CHA. "Having control and risk for patient care will prove to produce better outcomes."

## Risk and Reward

The group members believed that being in control of and at risk for the costs of patient care also should result in financial rewards. Therefore, the founders of CHA developed a financial incentive program designed to reward appropriate performance and to attract and retain the best providers in the area. A primary care bonus

**The physicians hope that following the guideline will keep patients out of the hospital and the ER.**

is designed to stabilize specialty reimbursement until the volume of covered lives grows large enough to support a subcapitated system for specialists. Four years ago, the group used outside information sources to determine capitation payment rates, but CHA now uses its own accumulated data to create a capitation system adjusted for the age and sex of the patients being served.

As the physician group has changed and grown over the past 10 years, the members have decided that physicians must be in charge of their own destiny and they must take the lead in determining what is best for patients. As a result, the current group—CHA—has been founded and governed by practicing physicians who work together as collaborative partners.

Members of the IPA believe, for example, that the best way to deliver care is to follow fundamental business principles, such as concentrating on what one does best and contracting for the rest. As a result, the CHA physicians view hospitals and insurers as resources rather than the organizations that are driving the delivery of patient care. "Physicians can assume

pool derived from savings on hospital costs is designed to reward positive changes in clinical behavior. Of course, the program has the added advantage of helping to foster improved patient outcomes.

Rather than introduce a financial incentive program for all conditions, the group members believed the program should be phased in slowly.

So, in the summer of 1998, the physicians decided to introduce practice guidelines for the treatment of patients with asthma and if positive patient outcomes resulted, the group eventually would pay a financial incentive for appropriate treatment. The specific criteria for the asthma program included patient access to care, patient satisfaction, work volume, patient outcomes, and compliance with practice guidelines. The physicians decided that if the asthma initiative was successful, they would expand the program to other high-cost conditions.

The physicians chose asthma as the first condition because in a capitated group practice, 20% of all patients can generate 80% of the group's costs if asthma treatment is not managed aggressively and appropriately. What's more, the

*Peter B. Schock, MD, is the medical director of Cascade Healthcare Alliance and is the primary founder of Bellevue Family Medicine, in Bellevue, Wash.*

annual cost of treating a high-cost asthma patient can be 200 times higher than the cost of treating a low-cost asthma patient.

Moreover, national asthma statistics have shown that patients clearly need all physicians to manage the care of patients with asthma more effectively. The medical literature shows hospital admission rates for children with asthma have doubled over the past 20 years. The use of beta agonists, or bronchodilators, had been leading to unnecessarily high hospitalization rates. Conversely, the use of inhaled corticosteroids, or anti-inflammatories, had led to lower admission rates.

### Selecting Guidelines

Before implementing the quality improvement initiative, the group appointed a committee to select the most appropriate guidelines. In making their selection, the committee members had three goals. The guidelines should:

- Meet the needs of the patient
- Foster professional gratification for physicians
- Create a business opportunity

Many of the group's physicians had made significant contributions to the family practice guidelines (Volume Five, *Outpatient, Pharmaceutical, and Primary Care Guidelines*) of Milliman & Robertson (M&R), actuaries and consultants in Seattle. Recognizing that M&R's *Healthcare Management Guidelines* (HMGs) were based on suggestions from area physicians, the committee decided these guidelines would be appropriate.

CHA was committed to ensuring that the initiative would not overwhelm practitioners or have them so absorbed in the process of meeting the guidelines that they would lose their passion and devotion to patient care. Asthma was a relatively easy guideline because it required physicians to make only a single practice change of prescribing anti-inflammatories over bronchodilators. The committee members reasoned that the asthma guideline would be relatively easy to implement and results could be recorded in a relatively short time. Treatment patterns would be measured monthly, emergency room and hospital visits quarterly, and the total cost of care annually.

## "Physicians can assume risk only for that over which they have control."

—Mulloy Hansen, MD, Cascade Healthcare Alliance

Defining, measuring, and rewarding desired practice behaviors meant focusing on just two key features: precise diagnostic categories and pharmaceutical treatment guidelines for anti-inflammatories. The diagnostic categories for asthma are mild-intermittent, mild-persistent, moderate-persistent, and severe-persistent. The primary treatment for patients in all of the persistent classifications is an anti-inflammatory.

Currently throughout the United States, PCPs and specialists are prescribing two bronchodilators for every anti-inflammatory over any measured period of time. This behavior is inconsistent with new asthma guidelines. The medical literature shows that a full canister of anti-inflammatory medication should last one month while bronchodilators should last much longer and be used only rarely to prevent disease exacerbation.

After reviewing their own data, CHA physicians believed the statistical, financial, and patient outcomes literature were clear and decided they needed to prescribe at least twice as many anti-inflammatories as bronchodilators to treat their asthma patients most effectively. To follow the success of its practitioners, CHA adopted what it calls an anti-inflammatory (A-I) ratio. This ratio is the total number of canisters of anti-inflammatories prescribed, divided by the total number of anti-inflammatory canisters plus bronchodilator canisters. If a physician prescribes three times as many bronchodilators as anti-inflammatories, the A-I ratio would be 0.25 and if he or she prescribes two times as many bronchodilators as anti-inflammatories, the A-I ratio would be 0.33. CHA set the ideal A-I ratio at 0.75, which means that three times as many anti-inflammatories as bronchodilators would be prescribed, and set a benchmark goal of 0.67 as an appropriate A-I ratio for the group. Data on the A-I ratio will be followed at least through next year.

Since patients get their prescriptions

filled at hundreds of pharmacies over a broad area, CHA decided that collecting these data would be expensive and labor-intensive. To offset some of the cost, CHA established a partnership with First Choice, an insurer in Seattle that is contracting with a large pharmacy data clearinghouse to study the prescription patterns of all PCPs in Puget Sound.

When scoring began, the highest A-I ratio of any CHA physician was 0.47 and the group's average was a surprisingly low 0.14. After three months, the physicians had increased the ratio by an average of 4% and by the second quarter of this year, had raised it by an additional 3%. What's more, individual physicians showed improvements as well. Initially, the best physician's A-I ratio was 0.54. After the first quarter, it was 0.59, and after the second quarter it was 0.89.

To measure the results of the initiative, CHA is collecting data on the frequency of office, emergency room, and hospital visits for asthma patients. Before the program started, CHA collected baseline data on the corresponding number of patient visits last year. The physicians hope that following the guideline will keep patients out of the hospital and out of the ER.

As of the end of last year, the asthma initiative had been adopted successfully by CHA physicians who developed a number of methods to educate patients in the use of an anti-inflammatory medication as a "preventive measure" and to use a bronchodilator as a "rescue measure."

As a result of the initiative, CHA found that the PCPs were working as collaborative partners and were realizing more professional gratification in their jobs. PCPs learned that the more they teach each other about being successful, the better they believe they will be at both the business and the practice of medicine.

—Additional reporting and writing by Jan Odell, in Santa Rosa, Calif.

(Continued from page 1)

power to make changes in service," he says. "They bill Medicare, and Medicare pays the bill. With a PSO, we will be paying for patient services directly, so if we are displeased the hospital will be more responsive. As another example, our Medicare fee-for-service patients tell us that the biggest concern they have is pharmaceutical costs. Most Medicare patients are on multiple medications, which cost them a hefty amount each month. But as owners of the PSO and designers of our plan, we can decide to cover a greater percentage of pharmacy costs and potentially attract some of these patients."

In contrast, says Aquino, physicians who form a network to contract with payers have little control over policy decisions or patient access to care. "Maybe if your network represents 100 physicians, it can have some leverage in negotiating favorable contract prices and terms and deciding what facilities to use," Aquino says. "But at the end of the day, the payer can always find another group of physicians with which to contract."

### Monday Meetings

Developing Universal Medical Associates required almost two years of planning. First, Aquino and his colleagues defined the area of PSO coverage to be the area of Queens that includes Astoria and Long Island City. Next, they determined which providers to invite to participate in the PSO. They sent invitations to 50 primary care physicians, 200 specialists, seven hospitals, approximately 10 outpatient centers, and 12 diagnostic centers.

"Actually, a lot of the planning time was spent on physician education," Aquino explains. "The physicians have met every other Monday night for two years, and we've brought in consultants and experts to talk with us about PSO development. We wanted to be sure that all the physicians understand the nature of the PSO: They are at risk clinically and financially, but they have control over how care will be provided and accessed."

Start-up costs for Universal Medical Associates total about \$6 million. For PSO administration, Aquino and his colleagues hired 15 staff members with administrative expertise from HMOs to

**"We believe we can manage care efficiently because we're good physicians, and because we'll be empowered to understand the financing of care."**

**—Robert Aquino, MD, Universal Medical Associates**

perform all back-office services, including billing, collections, precertification, and claims adjudication. Administration will require a \$1.5 million annual budget. Additionally, New York State requires the PSO to hold approximately \$2 million in reserves to cover claims, based on projections for PSO enrollment.

Universal Medical Associates also is developing a sophisticated medical information system, which will cost almost \$2 million. "The key to managing health care is managing information," says Aquino. "For example, if we admit to two equally good hospitals but one is double the cost, I need to know that information if I am to manage the costs of care. Quarterly, we will evaluate where dollars are being spent, and determine if we are getting appropriate value for our money." In addition, the information system will handle admission precertification, physician credentialing, utilization review, quality improvement, and claims processing through analysis of encounter forms.

The remainder of the start-up funds are being used to pay lawyers, actuaries, and consultants who are assisting the physicians in developing the PSO. "We hired experts to ensure that the PSO would be set up properly and that we could manage the risk appropriately," says Aquino. "On the first of every month, we will get that payment check from the Health Care Financing Administration (HCFA), and we have to provide or pay for all the health care services using that amount of money. We are at risk, but our actuaries have run the calculations and we are confident that we can provide excellent care within the reimbursed amount."

To increase their chances of success, Aquino and his colleagues plan to manage enrollment growth closely. "Since the models that failed had an explosion of members, we want slow, methodical

growth," he explains. By the end of the first year, the PSO will be providing care to about 5,000 patients; in about five years, it plans to have 25,000 patients. "That's about half the Medicare lives we normally cover," Aquino says. "We know that not all of our patients will want to join the PSO, although we feel comfortable that many of them will join, since they have been our patients for years." Approximately 20% of the group's Medicare patients are currently enrolled in an HMO.

Universal Medical Associates' PSO application with New York State was still pending as of the end of September. If the application is not approved, the PSO can automatically apply to HCFA, under the rules of the Balanced Budget Act of 1997.

"In terms of income, we think we will fare at least as well as we do under current Medicare managed care reimbursement, and maybe even better if we manage it well," Aquino says. "We believe we can manage care efficiently because we're good physicians, and because we'll be empowered to understand the financing of care. We don't expect to get rich, but we believe we'll get a fair distribution."

One factor supporting the PSO's financial projections is that Queens, N.Y., receives one of the highest Medicare reimbursement rates in the country, at \$685.46 per patient month, which amounts to more than \$8,225 annually for each enrollee in a Medicare managed care plan. The rate is even higher for certain high-risk individuals.

Richel believes a high reimbursement rate is a critical factor for any PSO hoping to succeed. "If the physicians are efficient providers of quality care and can monitor and control the costs of providing that care, while at the same time offering a competitive benefits package within that reimbursed rate, they will be able to hold their own against area competitors," he says.

One factor that makes Universal

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Medical Associates unusual is Aquino's insistence that it include components that will foster preventive and complementary care measures to help the physicians manage the health risk of its population. "We knew that if we were to truly manage care, we needed to add a vital piece," Aquino says. "How many times does a physician call a patient and say, 'You haven't been here in three months. How's your cholesterol doing?' There is little automatic checking in with patients under traditional medical care, and traditional medical services don't work well for certain problems, such as low back pain."

To incorporate illness prevention into its services, Universal Medical Associates established a joint venture with the Gaunya Group, health care consultants in Chatham, Mass., to form a delivery system called World Wide Wellness. World Wide Wellness will create ambulatory care centers that will incorporate traditional medicine and surgery with preventive and alternative medicine services in one location. Depending on the pace of construction, the first World Wide Wellness location—a medical complex of 200,000 square feet—is expected to open in Queens early next year.

"United Medical Associates must be driven to keep their patients healthy, because the PSO is a capitated system," says Steven Gaunya, president of The Gaunya Group. "Preventive and alternative therapies can be crucial components of care that help to minimize illness."

#### Preventive Care

Preventive services offered by World Wide Wellness will focus on musculoskeletal and cardiovascular illness prevention. "Those two areas together represent half the health care costs in the United States—over \$500 billion a year," Gaunya says. The prevention complex, at over 40,000 square feet, will include almost 40 staff members in various medical disciplines. "We'll have cardiologists and orthopedic surgeons on staff just focusing on prevention, and we'll supplement these staff members with exercise physiologists, physical therapists, and nurse practitioners."

About 25,000 square feet will be devoted to complementary alternative medicine

## PSOs Offer Provider Autonomy

The federal Health Care Financing Administration defines a PSO as a public or private entity established by health care providers that deliver a substantial proportion of health care services either directly or through contracting with affiliated provider groups. A PSO can contract directly with HCFA to receive capitated reimbursement for Medicare patients enrolled in Medicare+Choice, HCFA's Medicare managed care plan. In return, HCFA stipulates that the PSO must assume full medical responsibility for these patients, thereby placing itself at risk, both clinically and financially, for care of these patients.

By law, at least 51% of the PSO must be physician-owned, and the organization must be directed by physicians. PSOs also can contract with state governments for the care of Medicaid managed care patients. In an effort to give physicians an opportunity to develop health care provider organizations that would offer them greater autonomy than they have under most systems of care,

Congress passed the law authorizing PSOs as part of the Balanced Budget Act of 1997. But since then, few provider organizations have chosen to develop PSOs as defined under the law.

Only one PSO—St. Joseph's Healthcare PSO in Albuquerque, N.M.—is currently operational under the Balanced Budget Act. After the act was passed in August 1997, HCFA sponsored a demonstration program with 13 PSOs. Two of these—Florida Hospital Health Care System, in Orlando, and Ohio Health Care Alliance, in Columbus—have withdrawn from the program for financial reasons, and the other 11 are operating as HCFA demonstration projects. Therefore, Universal Medical Associates, a PSO under development in New York, offers one of the few examples of physicians taking advantage of the legislation to allow them to develop more physician-friendly organizations than are found in most managed care markets.

—DJN

(CAM) services. "These services will include chiropractors, nurse practitioners, physical therapists, massage therapists, osteopaths, and naturopaths," Gaunya says. "Patients will see these providers in coordination with staff primary care physicians who understand the value of alternative therapies." The CAM staff will include between 30 and 40 providers. The complex also will include a day spa offering stress reduction and relaxation therapies.

World Wide Wellness services will be provided as one element of United Medical Associates' services to its Medicare patients. Primary care physicians will direct the PSO's enrollees to the World Wide Wellness complex for a baseline health assessment. "First, they will complete a health care questionnaire to determine where they fall on the continuum of physical function based on their past medical history and their current health state," Gaunya explains. "Next, they will receive a battery of tests to determine their

physical capabilities. After these assessments, the World Wide Wellness staff will create an individualized program to help the enrollee maintain his or her health." Enrollees will be scheduled for quarterly exams to determine health improvements and compliance with suggested regimens. World Wide Wellness also will include a research component to assess outcomes.

Eventually, Aquino and Gaunya hope to expand the World Wide Wellness delivery system to fee-for-service and managed care populations, and plan on marketing the system to individuals, employers, and insurers.

"We truly believe this is a delivery system that will offer top-of-the-line care to the populations we serve," says Aquino. "Our physicians are in this venture for the long haul. This system will enable us to help our patients maintain their health and get the best care possible when they need it."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

# HMOs Need Scientific Approach to Data

By Douglas W. Emery, MS

Although all physicians are educated in the scientific method, most clinical practice is based on internalized algorithms derived from example and experience. This fact is true in both fee-for-service and managed care environments. The lack of a method to monitor clinical outcomes systematically and relate them to processes of care severely limits the ability of individual practitioners to apply the scientific method in the context of their daily practice.

At the core of the scientific method are hypotheses, which are not merely suppositions based on subjective conjecture but are statements that can be evaluated objectively. The scientific method does not prove hypotheses to be true. Instead, it rigorously challenges hypotheses and elevates them to the status of theories only when they withstand many such challenges. If a hypothesis is not consistent with the results of an experiment designed to test its validity, it is doomed. If it is consistent, then its reward is to be subjected to additional challenges.

## Spending Patterns

As Kerr White pointed out in 1961 (in an article, "The Ecology of Medical Care," in *The New England Journal of Medicine*, 265(18) 1961:885-892), our nation spends huge sums of money on scientific studies of diseases and on the technology needed to confront those diseases, but almost nothing on the scientific study of the clinical processes that direct patient care. In nearly 40 years, spending patterns have not changed much. But a physician-driven episode paradigm could begin to turn this trend. Performance monitoring associated with episodes of care can apply scientific principles to everyday practice. To do so would fulfill White's

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injunction to research not only the natural history of disease but also the natural history of patient care. It also would require a system that allows health care providers to apply scientific principles to data drawn from their own experience and to relate their findings to the clinical processes they employ.

Attempts to use externally derived clinical protocols, guidelines, or algorithms to control clinicians' practice patterns often meet with resistance. In part, this resistance results from concerns that the parameters of care are inflexible and do not apply to the clinical situations and health care settings being addressed. Without the dynamic feedback loops that provide information about actual care delivered and its effect on patients, parameters lose much of their value, even when they are developed and accepted by local clinicians.

**Performance monitoring associated with episodes of care can apply scientific principles to everyday practice.**

Standardized processes of care will replace care based on personal style only when relevant data demonstrate that these standardized processes result in improved clinical outcomes.

## Local Data

An alternative to externally derived parameters of care is to use locally derived data to develop and test hypotheses regarding parameters of care, their interrelationships, the results they produce, and the mechanisms that link them to clinical outcomes. When care is organized episodically, these analyses are greatly facilitated. Analyses may begin by examining processes to explore hypotheses about how they relate to outcomes. They also may begin by evaluating outcomes and then exploring how processes contribute to them. In

either case, hypotheses are tested using clinical data derived from the actual practice settings in which findings will be applied.

## Process Improvement

This analytic process is iterative. Each cycle of discovery and change sets the stage for a new set of hypotheses and analyses. One such model was proposed by Robert Blum in a paper titled, "Discovery, Confirmation, and Incorporation of Causal Relationships from a Large Time-Oriented Clinical Data Base: The RX Project," that was published in *Computers and Biomedical Research* in 1982.

Blum's model consists of a continuous feedback loop running through a series of four modules: a discovery module in which new hypotheses are formulated, a study module in which these hypotheses

are tested, a statistical analysis module in which conclusions are drawn, and a knowledge or database module in which current evidence and conclusions are stored and referenced. Using this model, clinicians can develop and evaluate evolving hypotheses about episodes of care and apply their findings in their everyday practice.

In a recent clinical process improvement study conducted by Susan Horn, PhD, of ISIS Inc., health care researchers in Salt Lake City, a potential relationship between patient-controlled analgesia and extended length of stay was hypothesized, explored, confirmed, and added to an organizational knowledge base. However, since establishing a relationship does not prove causality, the cycle of hypothesis, study, analysis, and dissemination of findings will continue to evolve around this important

issue. These types of studies are designed to integrate research into daily practice by establishing a permanent feedback loop aimed at all clinicians in an institution.

### Feedback Loops

Independent of the modified Blum model above, the Mayo Clinic has been developing a system designed to operate in much the same manner. The whole point of moving to an episode paradigm is to provide feedback loops on individual physicians and on overall system performance. It makes sense, then, that these two approaches would evolve along parallel paths. In the Mayo model, data from real-time episodes as captured by the electronic medical record are fed through several modules (observational data, clinical advice and guidelines, and a clinical database) to be compared with analytic or hypothetical episodes summarized for the decision support system or episode information system. The results of such ongoing studies ultimately culminate as a growing medical database. In turn, these data are fed back into the research loop and the process continues.

Another effective method of evaluating and improving clinical performance is the epidemiological approach described in the manual, *Measuring and Managing Health Care Quality: Procedures, Techniques, and Protocols*, by Goldfield, Pine, and Pine, and published by Aspen Publishers Inc., Gaithersburg, Md., in 1991. This approach begins by formulating hypotheses based on observed differences in risk-adjusted outcomes. It then tests these hypotheses by analyzing risk-adjusted processes and clinical milestones. But no matter how hypotheses are generated—whether from reviews of literature, personal experience, clinical speculation, or analyses of comparative performance—there is a constant commitment to evaluate new data systematically in order to test the validity of even the most widely accepted teachings.

Basic clinical research has had a profound influence on modern medical practice. However, until the advent of inexpensive, high-powered computers, clinical practitioners were unable to create and analyze large clinical databases

to evaluate and improve their daily performance. Today, clinicians can establish closed feedback loops that permit them to combine patient care and scientific research. Organized around episodes of care, the findings of such research are immediately applicable to their practices. Since physicians own

change promises to return autonomy back to physicians inasmuch as they would become the generators of information. Currently, health plans hold the bulk of the information on patterns of utilization.

When episode methodology is pursued aggressively, as it has been in the

**Standardized processes of care will replace care based on personal style only when relevant data demonstrate that these standardized processes result in improved clinical outcomes.**

and operate the entire feedback process, they essentially convince themselves to alter their established patterns of practice. Change is no longer externally mandated. It is merely the logical consequence of new knowledge generated by practicing clinicians themselves. These techniques are not proposed to replace classical medical research, but they will complement published studies, and they will speed the generation and dissemination of new practice- or evidence-based knowledge. Most important, they promise to have a potent effect on behavior modification at the clinical level of medical practice.

### Best Practices

Finally, though good clinicians often may disagree about best practices, they generally can agree about how to convert their convictions into hypotheses that can be tested scientifically. Now these clinicians actually can use clinical databases organized by episodes of care to resolve their differences through scientific study rather than by political maneuvering or by benign neglect. The advent of universally applied, interactive systems that generate continuous clinical feedback about the management of episodes will have a profound effect on the way medicine is practiced. When this alteration occurs, patient care will be managed and the term managed care will become a reality rather than a catch phrase. Moreover, this

Anthem Coronary Services Network project (sponsored by Anthem Health Plans in Indianapolis), movement toward managing care effectively occurs rapidly. After only three years, all parties participating in the Anthem project, including representatives of competing hospitals, are reviewing data about episodes of care and exchanging ideas about how performance can be improved. In this example, a competitive market has stimulated rather than precluded the sharing of information.

### Inexorable Logic

Many changes are required to evolve to a system in which managed care is truly a reality. New methods of disseminating information must be adapted to handle a plethora of important findings from practice-based investigations. New analytical skills and professional flexibility will be required of caregivers who operate under this new microstatistical paradigm. Unfortunately, many medical informatics companies are still focusing on systems designed to support insurance-based rather than episode-based technology, and many consultants still are preparing their clients to compete in mature capitated markets. But the inexorable logic of episodes of care and the systems that surround them will inevitably win favor, marking the opening era of physician-driven, bottom-up reform and the closing era of top-down, plan-driven managed care. ■

# Physicians Should Manage Patients' Expectations, Consultant-Author Says



**Susan Keane Baker** is a practice management consultant in New Canaan, Conn., and an expert on the role of communication in physician practice management. Her background includes

17 years of experience in senior management positions in hospitals in New York and Connecticut. Baker is the author of *Managing Patient Expectations: The Art of Finding and Keeping Loyal Patients*, published in 1998 by Jossey-Bass Publishers: San Francisco. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q:** What led you to focus your career on the role of communication in physician practice management?

**A:** As a hospital vice president responsible for risk management programs for more than 17 years, I saw the heartbreak physicians experienced when they were sued for malpractice. I saw first-hand, too, that patients who sued were often angry about a perceived slight or indifference that the physician had never intended. Even when physicians won the lawsuit, they still lost time, energy, income, and self-esteem. So I began giving risk management seminars on preventing errors in documentation and informed consent, and handling unexpected adverse outcomes.

As time passed, I began to focus on some low-cost, relatively quick approaches to creating rapport with patients, and I found that when physicians began to improve the way they interacted with patients they actually enjoyed their days more. That's why my work is rewarding for me. I tried to make the book realistic and practical. I wanted it to be low on theory and high on communication strategies that physicians could adopt immediately to improve the management of their practices.

**Q:** What message is the essence of your book?

**A:** The opening sentence reflects the book's essence: "Satisfied patients are the key to professional success and the personal rewards of medicine." The book really has two themes: first, if physicians meet their patients' expectations, then patients are more likely to be satisfied with their care, and second, if physicians can anticipate, measure, and exceed those expectations, then they can manage them appropriately.

Here's why managing patient expectations is crucial to a practice's success. Anticipating what experiences will be like is just part of human nature. We form our expectations by our prior experiences and those of people we know. They are

the pain or the outcome is negative. It may be that someone exaggerated his own experience or the patient is thinking of what his mother went through when she had surgery 30 years ago. Managing expectations means educating the patient so that expectations are realistic, and then responding appropriately when those expectations aren't realistic. It's important for physicians to look at things from the patients' point of view.

**Q:** You emphasize the importance of first impressions, saying it's the simple things that count. What are some examples of those simple things?

**A:** It's true that the first 60 seconds are critical. For instance, if you've ever walked into a store or a restaurant, taken a quick look, and walked right

**"If physicians meet their patients' expectations, then patients are more likely to be satisfied with their care, and if physicians can anticipate, measure, and exceed those expectations, then they can manage them appropriately."**

also, of course, created by stories in the media. And they are created by what a physician practice tells patients, both in one-on-one conversations and in brochures or advertising. Finally, expectations are created by promises physicians make. I ask physicians and staff members, "What are the promises you make but can't or don't always keep?" That's a source of unrealistic expectations and disappointments. For example, a surgeon might tell a patient that he or she will be "as good as new," when the surgeon knows that surgery is risky and all outcomes aren't perfect.

Furthermore, unrealistic expectations need to be clarified up front. For instance, a patient might refuse to have a surgical procedure because his expectation about

back out again, you know that your scan of what was important to you said that the organization would not be able to meet your needs. Patients react the same way. They are attuned during that first minute as to whether they expect to be happy in the relationship.

Physicians know that it's the simple things, such as greeting their patients, giving them undivided attention, using the patient's name, sitting if the patient is sitting, that can make a difference, but they forget how important these things are.

As another example, the physician's office reception area is important. I advise doctors to sit in the reception area quietly and consider, "What message does this room send about my practice?" That area is the first part of the practice patients and

**“Patients feel valued when physicians want to know what’s important to them, and they listen sincerely. Medicine is a relationship business, and those loyal relationships are the greatest reward in the practice of medicine.”**

their family members see, and they may spend some anxious time there. So it needs to be as reassuring as possible. One physician in Texas created a very soothing reception area right down to the details of having only magazines that are designed to be esthetically pleasing and help people relax, instead of news or finance magazines, because she doesn’t want anything in that reception area to create any additional anxiety for patients.

**Q.** *How can physicians build rapport with patients?*

**A.** One of the most important things physicians can do to build rapport with patients is to make patients feel they are getting adequate time and attention. For example, a retired internist in Boca Raton, Fla., wrote a letter to me about creating rapport with patients. He wrote, “The trick is to be able to run all day, as fast as you can, while creating the illusion that you were sitting still. The clock on the wall must be behind the patient’s head so that there is no detectable scanning of walls or wrists for time checks. There must be no nervous tapping of pencils or toes or other manifestations of impatience. Sit at the bedside even for a moment and perhaps give the patient a friendly encouraging pat on the shoulder or wrist.” Physicians should show themselves to be human, and that they enjoy practicing the art as well as the science of medicine.

**Q.** *How else can physicians show that they care about their patients?*

**A.** When you ask people to describe their own favorite physician, they will, almost always, describe some act or manner of caring. Patients know that they’re not the physicians’ only patient, but when a patient feels that he or she is the physician’s favorite patient he or she can’t help but respond. Patients feel valued when physicians want to know what’s important to them, and they listen sincerely. As I mentioned before, medicine is a relationship business, and those loyal relationships are the greatest reward in the

practice of medicine. A person who is loyal to a physician can say, “To my doctor, I’m not just a sick sack of enzymes. She cares about me, she treats me with respect, she listens to me.” That’s the physician who’s unforgettable.

A physician in Pennsylvania told me that he had done one thing during his long career in medicine that was particularly rewarding: He noted on the patient’s chart the last thing the patient said at the end of a visit. Then the next time the patient came in the physician would be able to say, “How is your daughter doing at Stanford?” or whatever it was, and his patients felt that he was thinking about them from visit to visit. And it was that sense of continuity and caring that patients remarked on and kept his patient roster full.

It’s also effective to close the encounter by asking, “What questions do you have? Is there anything else I can do for you today? I’m looking forward to seeing you next time,” or “Please call me if you have any questions.” People like to have that sense that the physician wants the relationship to continue, that the physician cares whether the patient is going to come back or not. Some sort of assurance of a continuing relationship is comforting to patients.

**Q.** *What makes a physician a good listener? What are the barriers to being an effective listener?*

**A.** A good listener is someone who pays attention. They don’t just listen; they also look like they’re listening. That doesn’t necessarily mean uninterrupted eye contact, but it means acknowledging the speaker, facing them, asking them questions, and using prompts such as “go on,” or “I see.”

There are three common barriers to effective listening. The first is anticipating, or assuming what the patient is going to say. The physician doesn’t listen, because he or she has heard this said by other patients a million times. But if you stop listening, you may miss some important details as a result. The second barrier

is thinking about your answer while the person is still speaking. Most of us have developed a tendency to do that. The third barrier is interrupting the person. The physician may think, “I’ve heard part of it, so I can infer the rest and move this along.” Then the physician jumps in to finish the patient’s sentence for him.

One specialist told me that he could diagnose patients just by looking at them. He thought when he made those instant diagnoses that he was conveying his superb diagnostic skills. But when he made instant diagnoses, patients felt the need to retell their stories to be sure he had all the facts, or they sought a second opinion, or they called him later with some other information that they hadn’t had the time to give him. So the specialist forced himself to slow down, listen to the patient’s entire story, and ask a few questions. Then when he gave the diagnosis he found that his patients trusted him more and accepted the diagnosis more readily. In the end, he actually saved time and created more positive relationships with patients.

**Q.** *Practicing medicine is unpredictable and full of unexpected emergencies, often causing wait times for patients. What strategies can physicians use to counter patient dissatisfaction caused by waiting?*

**A.** There’s an old saying: “The patient waiting for you is counting your faults.” There are several strategies physicians can adopt. The first, and probably most important, is to be on time so that patients are on time. One practice I know was having significant problems with physicians running late, so patients were coming later and later, and as a result the entire schedule was becoming chaotic. They decided, as a group, that if the physician was more than five minutes late the physician would have to go to the reception area and escort the patient to the examining room. The physicians didn’t like what they saw in the reception area:

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half a dozen or more other patients waiting to be seen, all of them steaming. That exercise helped encourage the physicians to be on time; once they were, patients came on time as well.

There are wonderful scheduling systems and people who specialize in scheduling that physician practices can use so that bottlenecks don't occur. Often it just requires a simple analysis of what types of patients are seen when and leaving enough space for unexpected, urgent needs.

A second strategy is to enable patients to do something else while they are waiting. People feel so overwhelmed by all the responsibilities they have that time is very valuable to them. So practices can make it possible for people to accomplish other tasks while waiting, for instance by having a phone available to patients for local or credit card calls. One practice I know has stationery and stamps available so patients could write letters while waiting.

A third approach is to make the waiting time so relaxing that the patients find it a respite from their busy lives. Reception areas can include soothing music, sound barriers, comfortable seating, complimentary lighting so people feel that they look good. Even if patients have to wait, they know that they're going to at least enjoy the experience of it.

**Q:** You point out that one of the critical modes of communication that is often neglected is the telephone. Why is this important?

**A:** Training your staff to answer the telephone in a certain way is absolutely critical. It's the signal to the patient about how professional the office is. Furthermore, so much of medicine is being handled over the telephone. Staff need to be very adept at telephone triage and at building relationships with patients, because when patients have a relationship with the staff they will then often ask the staff for prescription refills or information that doesn't require the attention of the physician. If patients don't have a good relationship with the staff then they will insist on speaking with the doctor and they'll wait for the doctor to call back. And that just takes more of everyone's time.

Simply using common telephone courtesy skills goes a long way toward building

relationships with people. For example, staff can routinely include with the greeting, "How can I help you?" Also, when patients call, they often want to share something else that is going on in their life. For example, a caller might say, "I can't keep my appointment today because my son, Tom, is sick." It just takes a

**"The savvy practice today has developed a satisfaction survey for their referral sources."**

moment for a staff person to say before hanging up, "I hope Tom is feeling better." Health care is a relationship business, and that type of interaction helps build relationships with people.

**Q:** In your book you refer to "moments of truth." What are those, and how do they pertain to physician practice management and service quality?

**A:** The small things that influence a patient's opinion of a practice can be driven home by what I call moments of truth, points during patient contact when the patient forms a lasting opinion of the practice. A moment of truth is a concept created by Jan Carzon, who headed the SAS airline. He realized that no matter how clean or on time his airplanes were, the reputation of his company and the willingness of people to recommend his airline, came down to every interaction between an employee and a customer. Even if the interaction lasted just 15 seconds, it created an impression. He and his staff defined all those moments of interaction and decided what would make them negative, positive, and exceptional.

For a medical practice, a moment of truth exercise can help quickly define service standards that everyone should follow. Let's consider the moment when a patient arrives in the reception area. A negative impression is created when the patient is not acknowledged right away, perhaps because the employee is busy with paperwork. A positive impression is created when the patient is acknowledged immediately and with a smile. An exceptional moment might be created when the staff person greets the patient warmly and by name (having reviewed

the patient schedule earlier to facilitate name recall) and inquires how the patient is feeling.

It's essential that staff themselves come up with the bad, good, and exceptional possibilities in each encounter, because they can then take ownership of the process. Physicians

have to rely on the discretionary behavior of their employees in those staff-patient interactions, so it's preferable to have staff themselves develop the service standards.

**Q:** How can communication strategies be applied to your referral sources as well as patients?

**A:** It is important to a physician's business to represent a human presence before the referral source. Referral sources have their own needs and expectations and they want to be acknowledged. For example, it's so important to find out how the referring physician wants patients to be treated. Does the referring physician want to be advised about patient care by telephone, e-mail, or in writing? Does the referring physician want a one-page summary of care, or does he or she want copies of notes from every visit and every test report?

Relationships have to be built with both referring physicians and their staff members, because staff members can influence a referral. In addition to building relationships, the savvy practice today has developed a satisfaction survey for their referral sources. They are sending a communication to the practice manager and to the physician that asks, "Are we meeting your needs for information and service? Are you getting the referral reports as quickly as you'd like to get them? What information is essential for you to have? What have your patients told you about their experience with us?"

—Edited by Deborah J. Neveleff, in *North Potomac, Md.*

# Center Struggles Under Managed Care

**Q**uestion: I'm a specialist on the faculty of a large academic health center. We're trying to organize to meet the managed care challenge. Our market share is eroding because HMOs send their referrals to lower-cost community hospitals. In addition, HMOs have little regard for our training and research missions, both of which cost money. Can we appeal to these HMOs on the basis of higher quality? How can we organize to lower our costs?

**Answer:** Clearly, academic medical centers and their faculties are facing unprecedented pressures, brought on in large part by managed care and reduced federal funding, according to Thomas M. Gorey, president and CEO of Policy Planning Associates, physician consultants in Crystal Lake, Ill. "Sustaining revenue and enhancing the competitive position of faculty practice plans in this type of environment calls for creative thinking, innovative strategies, and aggressive marketing," he says. "As always, the unique factors at play in each market will to a certain extent determine which potential strategies are most likely to succeed."

In cities in which managed care has a significant presence, academic medical centers have implemented interesting strategies, Gorey says. "Following trends in the broader market, some of these medical centers have formed PHOs," he explains. "Other academic medical centers have taken a much more aggressive approach, forming their own HMOs,

which allows them to compete with health plans head-on for patients. Undoubtedly, forming an HMO is a costly, high-risk option that carries with it certain downsides, including possibly negative ramifications for relations with other payers in the market. Competitors may decide to channel their enrollees to other providers and institutions."

Another strategy involves collaborating with payers. "Rather than compete directly with health plans by forming an HMO, some academic medical centers have worked with HMOs to introduce

ket itself successfully to employers and to attract—and retain—enrollees. The reason physicians often have been unsuccessful in the past when marketing themselves to HMOs on the basis of quality is that they have lacked data to support their claims."

When payers have no data to the contrary, they assume that all provider organizations provide essentially the same quality of care. Therefore, physicians in medical centers need to generate reliable, credible data supporting their claims of quality. "Many faculty practice

**Academic medical centers may need to market themselves as centers of excellence in areas such as cardiology, transplants, or oncology.**

new managed care products in some markets," he says. This strategy will work, however, only if the parties involved can set aside traditional attitudes of mistrust.

Since academic medical centers have historically been dominated by specialists and have focused on providing tertiary care, they are at a disadvantage in many markets. "To counter this perception, many academic medical centers have taken steps in the past few years to expand their community presence and to strengthen their base of primary care physicians," Gorey says. "Such steps have included opening satellite clinics, recruiting new physicians, and purchasing existing primary care practices."

Given that few organizations seem inclined to pay more for research and graduate medical education, the best strategy may be to focus on emphasizing quality in marketing efforts to HMOs and to institute cost-cutting measures. "Despite what often appears to be a preoccupation with cost on the part of HMOs, they obviously also are concerned with quality," Gorey says. "The quality of a health plan's provider panel is a key factor in the plan's ability to mar-

ket itself successfully to employers and to attract—and retain—enrollees," Gorey says.

Having the necessary data also is important for the many academic medical centers that are pursuing the other strategy—reducing costs. Therefore, information systems may be a key to being successful in managed care markets.

One other area of opportunity may exist in the growing interest in disease management and diagnosis-based treatment centers. For these operations, academic medical centers may need to market themselves as centers of excellence in areas such as cardiology, transplants, or oncology.

In the latest in a continuing series of case studies, the AMA and other physician organizations are cosponsoring a case study of academic medical center faculty practice plans. The study will focus on at least six faculty practice plans and will explore the innovative strategies being implemented at academic medical centers in response to managed care, increased competition, and other trends. A final report is expected by year-end. ■

**Editor's note:** Readers of *Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board. In this column, Advisory Board member Thomas M. Gorey responds to a reader's questions.

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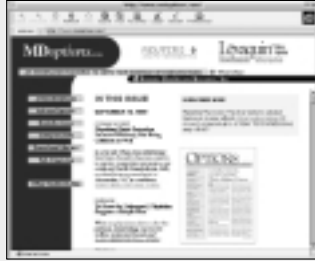
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Editor-in-Chief

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