AMERICAN HEALTH CONSULTANTS®

MANAGED CARE STRATEGIES™

Tactics for provider success

INSIDE

NOVEMBER 1998

VOL. 6, NO. 11 (pages 121-136)

American Health Consultants® is A Medical Economics Company

MD practice purchases by hospitals seem to be slowing down, experts say

Your MSO will profit from smart decisions

Hospital purchases of physician groups may not be a dead concept, but it's certainly a candidate for the intensive care unit. The question remains as to whether there is a cure for the illness.

Many hospital-owned medical group practices lost millions this past year, and experts interviewed by *Managed Care Strategies* say this has doused most of the enthusiasm hospitals had for buying these groups and forming management services organizations (MSOs).

MSOs often are the vehicle hospitals use to manage their physician practices. And both MSOs and physician-hospital organizations (PHOs) have helped hospitals increase their integration with physician groups.

Hospitals are not alone in having financial problems with physician practices. Physician practice management (PPM) companies fared as poorly or even worse in 1998.

This year has been a time of turmoil for organizations that own physician practices, says **Michael J. Eberhard**, president and chief executive officer of Medical Pathways Management Corp. in Torrance, CA. Medical Pathways is a managed care consulting and management company that manages medical groups, MSOs, independent practice associations (IPAs), and HMOs.

Both MSOs and PHOs have been losing a lot of money, sometimes as much as $1 million to $2 million a month, Eberhard says.

"The hospital-owned MSOs and PHOs that are managing medical practices have been sustaining substantial losses; and the question is 'Why? And what can you do to stop it?" Eberhard says.

At least one survey of hospital-owned MSOs suggests the anecdotal

EXECUTIVE SUMMARY

■ Many hospital-owned medical group practices lost millions in 1998.
■ Although the boom days of these purchases are over, some experts say hospitals will continue to buy physician practices at a more cautious pace.

evidence of hospitals losing money.

Only 13% of hospital-owned MSOs made a profit in 1997, according to a recent study conducted by New Health Management of Cleveland, and AmeriNet of St. Louis. The study analyzed survey results of 95 hospitals, including 19 that have MSOs.

The study showed that 13% of the MSOs broke even, and 74% lost money.

"A lot of [MSOs] are looking at what they should do in terms of fixing it, restructuring it, or getting rid of it," says **Tom Hardy**, director at New Health Management in Cleveland. New Health Management, which cosponsored the study, is a consulting firm that focuses on health care provider integration. The company also has an office in Denver.

Some experts say these types of problems are widespread.

The PPM industry has changed so rapidly that it's difficult to predict where it will head next, says **Robbe Rygg**, executive vice president of UniMed Management Co. in Burbank, CA. UniMed is a large for-profit MSO that was formed by UniHealth, a non-profit integrated health care company also based in Burbank.

Rygg says he realized how fast things had changed when he recently cleaned off his desk and found a year-old brochure reporting positive PPM industry growth.

"The industry is at one of those nexus, where it can go a couple of different ways," Rygg says. "You have an industry that has not done well for a variety of reasons, but expectations of physicians, hospitals, and other capital sources have become more realistic as well."

Hospitals and PPMs will analyze their failures and change what needs to be changed, Rygg asserts. "Physicians are still key to the health care delivery system and the correct formula will emerge."

Physicians who have built up a distrust of PPMs in recent years might be more inclined to sell their practices to hospitals in the future, says **Mark Moser**, MPH, chief executive officer of City of Hope Medical Group in Duarte, CA. The medical group is a 125-physician, multi-specialty medical group that is affiliated with City of Hope Medical Center.

But do hospitals still want to own physician practices?

Some experts say hospital executives are changing their minds about the value of owning doctors' practices.

"We think there has been a real slowdown in the acquisition of physician practices by hospitals," says **Stephen Hatch**, a partner with Arista Associates in Northbrook, IL. Arista Associates provides consulting services to the health care industry.

"At least here in the East, the interest in purchasing physician groups has declined considerably," states **Nellie O'Gara**, president, First Health Associates Inc. in Avon, CT. First Health Associates is involved in multi-specialty medical group development, physician-hospital integration strategies, and interim management of HMOs.

Hospitals lost interest mainly because many of the quality physician practices have already been acquired, Hatch says. That reason is overshadowed by the more obvious problem, Hatch adds. "The whole world knows that managing these practices on a profitable basis has been a real disaster."

Meanwhile, some providers are trying to fix their MSOs and make them profitable.

Medical Pathways Management Corp. has had some experience in making MSOs profitable, having turned four MSOs from financial black holes into profitable ventures, Eberhard says.

One key to making an MSO profitable is to make the physicians accountable for results, Eberhard says. "Doctors must be involved in the day-to-day medical management." **(See story on how to succeed with MSOs, p. 123.)**

Experts say another reason MSOs have lost money is because the investment cost is so high.

COMING IN FUTURE MONTHS

- Find PHO model that works best for you
- Check out these risk contracting strategies
- Develop disease management partnerships
- Prepare for future of post-acute care
- Learn legal strategies to prevent fraud and abuse

The hospital-owned MSOs featured in the New Health Management survey showed an average first year investment of $930,850; with an average investment per physician of $39,700 in 1997. Losses per physician for 1997 averaged $24,000. That figure, multiplied by 30 (which is the average number of physician participants), totaled substantial losses in 1997.

"This survey gave us a baseline," Hardy says. "We're going to continue the survey to look for revenue trends."

Interestingly, the New Health Management survey showed that hospitals in 1997 continued buying physician practices. About 36% of the hospitals not having MSOs (64 respondents) said they have plans or are considering forming an MSO. The survey has not yet followed up to see if the hospitals' plans had changed near the end of 1998.

One reason why some hospitals continue to be interested in forming MSOs is that hospital executives believe physician employment is the most effective model for increasing integration with physicians, according to a recent Arista Associates survey that was cosponsored by *Modern Healthcare*. The survey included responses from chief executive officers (CEOs) of 61 multihospital systems.

Ironically, the same survey also showed that hospital CEOs believe direct physician employment is the least profitable model in increasing integration with physicians, Hatch says.

"There is going to have to be a change because the boards of these organizations will be patient for only so long," Hatch says. "While I think these systems can operate their own practices at a slight loss and tolerate that, there's no way they're going to continue to tolerate the huge losses now being experienced." ■

Some MSOs are making money; here's how

Follow the wizards down the yellow brick road

It may seem like magic, but it's really just a little old-fashioned common sense — combined with psychology and organizational skills — and voila! You have turned around an unprofitable hospital-owned physician practice.

By now, everyone is familiar with the huge losses some physician practices can sustain when owned by hospitals and other organizations. But, perhaps no one bothered to tell you why they failed. *Managed Care Strategies* asked five people who have first-hand knowledge about medical group management to explain why the industry has done so poorly, and how hospitals and others can successfully manage these practices.

Physician practices may operate under a variety of models and be owned by many different organizations. But if they are to succeed, they must have the ability to control utilization and consumption of resources, says **Michael J. Eberhard**, president and chief executive officer of Medical Pathways Management Corp. in Torrance, CA. Medical Pathways helps MSOs and hospitals improve unsuccessful physician practices.

"You need to know how many patients you have in the hospital, how long they've been there, and what is the plan for getting them out; and this needs to happen in real time," Eberhard says.

They also need to have managers who can stay within a budget and still facilitate good quality health care, Eberhard adds.

New Health Management of Cleveland also consults with providers, MSOs, and others to find solutions for failing physician practices.

Physician practice owners sometimes call New Health Management to ask the company to investigate why they're losing money on a physician practice. Typically, they theorize that the problem is that physicians have lowered their productivity, says **Tom Hardy**, director of New Health Management.

"So we may go in and look and find that the doctor's activities haven't dropped," Hardy says.

The doctor may be working as hard as ever, but the practice is losing more revenues in its laboratory work because the hospital or MSO has taken over that area. Or, maybe the new owners have changed the office staff, and patients are less satisfied with the new employees, Hardy explains.

"Or you relocated the doctor and haven't taken into account the loss of practice volume that the move will generate," Hardy adds.

So finding the exact problem with any particular physician practice group may not be simple. However, the troubleshooting experts offer this guide to some of the more common problems and their potential solutions:

PROBLEM: The organizations that buy-physician practices often put too much distance between physicians and the management.

"When managed care organizations (MCOs) own doctor practices they have a very difficult time getting the doctors involved in day-to-day medical management, and I think that's a fundamental error," Eberhard says.

Solution: Doctors need to trust management, and the best way to do this is to make sure they're a big part of the management structure, Eberhard says.

"They need to feel it's their financial responsibility and have the budget to manage it," Eberhard adds.

Physician leadership also is essential.

"The single thing that you cannot succeed without is the quality of the physician leadership of the medical group," says **Robbe Rygg**, executive vice president of UniMed Management Co. in Burbank, CA.

"A leader is not someone who is anointed, and that's what usually happens," Rygg adds. "Leaders are people who other people respect and follow."

PROBLEM: Physicians may grow disillusioned with the practice if the partnership or shareholder model isn't equitable.

Some of the medical groups formed in the mid-1980s in southern California had sole proprietor owners or a limited number of owners, and they didn't make partners of the physicians they hired, says **Marc Moser**, MPH, chief executive officer of City of Hope Medical Group in Duarte, CA.

Some of the partners were making a lot more money than the hired physicians, although the hired physicians were expected to generate a lot of the patient visits, Moser says.

This type of model creates resentment in the non-owner physicians, who feel exploited, and could lead to higher turnover and lowered productivity.

Solution: Moser was the CEO of a medical group that did very well financially, partly because it had a much more fair partnership model, he says.

Any doctors who met the group's specific criteria were eligible to become shareholders. They had to complete a three-year internship and invest $35,000 in 100 shares of stock, which would be returned to them when they leave the company, Moser says.

"Then they'd make the same as a shareholder who had been there 25 years, with the only differential being that senior doctors had more vacation time," Moser says. "It was a very egalitarian model."

About 95% of the doctors who had been there three years became shareholders, and the organization remained vital and successful, Moser adds. "We received superior performance out of the physicians because they were motivated, and we got the pick of the crop of new doctors."

Physicians look at the entire package, including equity, compensation, and bonus plan; and they're very sensitive to that entire package, Eberhard says.

PROBLEM: Physician group managers often accentuate the negative and eliminate the positive, causing physicians to become frustrated and less productive.

"They may have a great practice manager, but the only time they see the head of the MSO is when he comes in and says, 'You're not producing enough,' or 'We have to cut your employees' pay,'" Hardy says.

Then the doctor might tell the practice manager that they cannot get the hospital to order a certain supply, and the manager replies, 'Sorry, that is the way the hospital purchasing office works.'

"So doctors feel they don't have any clout, and all they hear from anybody who has clout are negative messages," Hardy says.

Solution: Become positive from the top down, Hardy says. "I believe the ability of the management to be positive and to encourage a productive environment is as important as the doctor's pay incentive, given you're paying doctors a reasonable amount," Hardy says.

The top MSO directors and the practice manager should be visible in the practice, and should communicate support to physicians to create a productive and organized environment.

PROBLEM: Physicians sometimes are not given the tools and information they need to increase their efficiency. Or, the MSO has unrealistic expectations about how much money will be saved on economies of scale.

Hospitals often bought these practices mostly to build their base of primary care physicians in their networks. This way they could offer physician contracts as part of a bargaining chip with MCOs, says **Nellie O'Gara**, president of First Health Associates Inc. in Avon, CT.

Since profitability was a secondary concern, hospitals often failed to invest in training and

technology that would enhance efficiency and create economies of scale.

The other issue is that MSOs might think they're going to save a lot of money on consolidating billings and office management for individual practices, but the expected savings do not materialize, O'Gara says.

Sure, it makes sense if you put many physicians on one billing and collection system, it will save money. "But, then you find out that the person who was doing the doctor's billing and collection for his practice was his wife, and he never charged his practice for her work," O'Gara explains.

"So then you take this person out and start charging the business for it, and it costs more money," she adds.

Solution: Hospitals will have to plan on spending even more money up front to modernize information management systems and modernize physician offices, O'Gara says.

Once this is done, physicians will have the tools they need to increase their efficiency and can take advantage of economies of scale.

PROBLEM: The group's primary care physicians (PCPs) make referrals to a specialist when the PCPs can take care of the problem.

Solution: Incentive should be aligned in a way that encourages PCPs to manage patient care, including handling all cases where it's necessary for a specialist to become involved.

The incentives can be in the form of a cap on specialist services, or a bonus pool in where MSO doesn't give out bonuses whenever referrals exceed expectations. "If you overspend your budget, there's nothing left over; so, there's no participation excess earnings,"Eberhard says. ■

EXECUTIVE BRIEFINGS

NCQA releases health plan rankings

Health plans continue to have wide variances in measures of clinical and patient satisfaction, according to data released in the National Committee for Quality Assurance's (NCQA) 1998 Quality Compass Report.

On the average, New England's health plans continue to outperform other plans in the country when ranked in terms of member satisfaction and clinical quality measures reported to NCQA's Health Plan Employer Data and Information Set (HEDIS) in 1997. New England plans as a group typically performed between 10 and 40 percentage points higher than plans from the lowest performing region on each measure, NCQA reports.

The worst performing were in South Central states, such as Alabama, Lousiana, Mississippi and Texas, and mountain states such as Arizona, Colorado and Wyoming.

The gap between top and bottom performing plans is evident in measures such as beta blocker treatment rates, which range from 52% to 92%, according to the *Quality Compass* report. The report includes data from 292 health plans that voluntarily submitted information. These plans collectively cover 40 million people.

Trends that emerged from the report include:

The industry's overall performance was essentially unchanged from 1996 to 1997, with the exception of one measure: how frequently physicians advised patients to quit smoking (up from 61% to 64%).

Plans that reported performance data two years in a row improved more quickly and outperformed the industry as a whole.

Publicly-reporting health plans outperformed plans that were unwilling to make their results public in every category of measurement.

For a copy of the report, contact NCQA at (202) 955-5197. ▼

Prudential exits Medicare risk in some markets

Prudential HealthCare, based in Roseland, NJ, has exited the Mediare risk business in northern and southern California, Maryland, Washington, DC, New York, New Jersey and parts of metro Jacksonville,.FL (Baker County and parts of St. John's County), the company announced late September.

The decision impacts approximately 25,000 seniors who are customers of the company's Medicare risk product.

However, the company will remain a player in the Medicare risk market in parts of Jacksonville, Orlando, Miami, and Tampa, FL; Houston and San Antonio; and Cleveland, where it serves 100,000 members.

According to a company statement, the company decided to pull out of some markets where it could not offer a competitive Medicare risk product. ▼

HMO medical appeals often overturned

Patients of your practice who are leery of appealing a denial of coverage from their HMO can take heart at a new study released by Georgetown University researchers for the Kaiser Family Foundation.

The study found that when people have sought independent reviews of HMO medical decisions, one-third to one-half of the decisions are overturned.

Georgetown researchers said in a recent *Dallas Morning News* interview that it is hard to compare external appeals processes around the nation because of various state laws. One trend, however, is that most consumers stop fighting after they have been turned down the first time. ▼

Federal court upholds malpractice law

A federal judge has upheld an unprecendented Texas law that allows patients to sue their health plans for malpractice. The law means that consumers in Texas can sue to collect damages in state court against health insurers and employer health plans that deny them medical treatment.

A state law called the Health Care Liability Act holds that HMOs could be liable for damages caused by their "failure to exercise ordinary care when making a health-care treatment decision."

Aetna US Healthcare immediately filed suit last September challenging the law after it was enacted, arguing that it improperly sought to circumvent the Employee Retirement Income Security Act (ERISA), which prevents nearly 125 million Americans from collecting damages for denial of medical treatment that results in death, injury or economic loss.

The *Fort Worth Start-Telegram* reported that Aetna is working with state officials about how to alter the independent medical review process (which asks an outside party to review a carrier's decision regarding coverage) required by law to avoid conflict with federal law. One suggestion has been to make the review process nonbinding.

As part of the federal court ruling, the judge ruled that ERISA pre-empts the review process for most members of health insurance companies in Texas. However, the judge did not order the state to stop its independent review process.

Since the process began last November, 253 cases have been reviewed. Of the 244 reviews that have been completed, 114 rulings were in favor of the HMO in question and 110 in favor of the patient. ■

Gatekeeper products losing favor in many markets

But victory may lead to headaches for capitated practices

"If it sounds too good to be true, it probably is." This adage is particularly appropriate when it comes to analyzing the impact of the latest marketing effort intended to regain the trust of wary or disgruntled HMO members: the open-access HMO plan.

Peter Kongstvedt, partner in Ernst & Young's Washington, DC, office and a national expert on managed care, says he has seen increasing consumer interest in open-access products because they offer direct access to specialists. Both United Healthcare and Oxford Health Plans are offering open-access products, Kongstevdt says, although both companies have recently written off tremendous financial losses in terms of systems problems. "I'm not sure I see them [open-access products] going anywhere" because of the financial problems involved in managing them, he says.

Open-access plans are slightly different from point-of-service products, which have been around for years. Open-access products require enrollees to use physicians within an HMO's

(Continued on page 131)

(Continued from page 126)

network (which is typically quite narrow), but do not require enrollees to get a referral from a primary care physician before visiting an in-network specialist. Point-of-service plans, on the other hand, allow HMO members to seek care outside the managed care plan's provider network and even access specialists directly without a referral from a primary care physician. The out-of-network option usually involves greater out-of-pocket costs.

Although no data are available on open-access products, there are figures to show the increasing popularity of open-access health products that emphasize choice of providers.

A 1997 study released in the Hoechst Marion Roussel *Managed Care Digest* series reports that more than two-thirds of HMO plans (67.9%) offered point-of-service products in 1996 (the latest year data are available), compared to 54.1% in 1995. **(See chart on p. 132 for specifics on point-of-service enrollment among the country's 25 largest HMOs.)** Among the HMOs surveyed that did not provide open access in 1996, 22% said they planned to provide the service in 1997. In addition, enrollment in POS plans rose 43.2% to 14.2 million members in 1996, from 9.9 million in 1995, the *Managed Care Digest* reports.

A 1997 William M. Mercer Inc./Foster Higgins survey of 4,000 employers with 500 or more employees found that 13% of companies surveyed offered an open-access product. When the data were expanded to cover companies with 10,000 or more employees, the report found that 24% of companies surveyed offered open-access products.

Although the Mercer/Foster Higgins survey does not have comparison data for open-access products (the question was included for the first time in 1997), the firm says anecdotal data from its clients reveal that open-access products are an increasingly popular option.

In the past, clients east of the Mississippi were willing to pay more for open-access products; although cost flexibility sometimes determined if the company was globally competitive and local economy health, says William M. Mercer principal **Bob Coburn**.

Primary care practices that aren't careful can be held accountable for out-of-network costs that get out of control, say practice leaders and consultants interviewed by *Physician's Managed Care Report*. Although open-access products have not become popular in the New Orleans market, "we try not to participate in point-of-service [networks] . . . there's very little way to control risk when patients have the accessibility to go where they want to go," says **Robert Goldstein**, chief administrative officer for Browne-McHardy Clinic, a Metairie, LA-based 50-physician multispecialty group with about 50% of its patient base in capitated contracts.

But Goldstein has one or two point-of-service contracts in place out of competitive necessity, and he considers the contracts problematic for two reasons:

- They can be "an unending drain" on finances when there is no control over out-of-network costs.
- Practices are at the mercy of managed care plan administrators who decide when not to hold a primary care physician or internal medicine physician accountable for medical expenses related to his or her patient panel.

Because of this concern, Goldstein insists that language limiting the practice's liability be included in Browne-McHardy's point-of-service contracts with managed care organizations. The agreements call for a 5% to 10% withhold from the per member per month payments that are designated to cover out-of-network costs incurred by a plan's point-of-service members who designate a Browne-McHardy physician as a primary care physician.

"You have to be cautioned against going into a contract and having an open-ended potential expense that you have no control over," he explains. "When we take risk, I know if a patient will need a lot of services. So if I'm responsible for a patient who needs a transplant, I know going into [the contract] that I need to get a certain amount of money to cover those services. I'm able to find the best place to have it done. [But] when patients have the ability to opt out of network and access a myriad of other physicians who may refer patients to other physicians . . . you lose the ability to control utilization management on tests and other things. My group should not be responsible for that [cost]."

Other medical groups have yet to feel the effects of the open-access trend, but have concerns about the future. "We haven't seen it much in our market yet," says **James L. Walker**, MD, medical director of Seton Medical Management, a physician-owned medical group affiliated with Providence Hospital in Mobile, AL. "The dominant player is Blue Cross Blue Shield, and they are promoting a gatekeeper product. But I am concerned about it for an [upcoming] Medicare risk product."

POS Enrollment in Nation's 25 Largest HMO Plans

PLAN	12/31/96 Total Enrollees	12/31/96 OE Enrollees	% of Total Enrollees in OE	12/31/96 POS Enrollees	% of Total Enrollees in POS
Kaiser Foundation Health Plan-N. Calif.	2,528,603	0	0.00%	1,898	0.08%
Kaiser Foundation Health Plan-S. Calif.	2,447,843	0	0.00	2,902	0.12
PacifiCare of California	1,417,289	0	0.00	91,689	6.47
Health Net	1,260,657	0	0.00	71,131	5.64
Keystone Blue	1,148,926	0	0.00	786,703	68.47
Oxford Health Plans-New York	1,142,800	28,500	2.49	0	0.00
Harvard Community Health Plan	1,078,000	0	0.00	22,000	2.04
CaliforniaCare	939,655	0	0.00	77,137	8.21
PacifiCare/FHP Health Plan of Calif.	927,600	0	0.00	15,517	1.67
HMO Blue-Boston	876,845	267,880	30.55	0	0.00
HIP of Greater New York	817,828	14,545	1.78	17,545	2.15
U.S. Healthcare-Southeastern PA	788,038	0	0.00	171,100	21.71
Medica Choice	754,765	0	0.00	402,550	53.33
Foundation Health-California	740,434	0	0.00	8,480	1.15
HealthPartners	702,034	159,720	22.75	0	0.00
Group Health Cooperative of Puget Sound	681,406	55,885	8.20	0	0.00
U.S. Healthcare-New Jersey	680,397	0	0.00	146,834	21.58
Keystone Health Plan East	657,798	0	0.00	359,450	54.84
U.S. Healthcare-New York	657,192	0	0.00	152,949	23.27
Tufts Associated Health Plans	625,877	0	0.00	138,606	22.15
Health Options	599,108	0	0.00	67,906	11.83
NYLCare Health Plan-Mid Atlantic	587,140	0	0.00	73,884	12.58
Humana Medical Plan-Florida	564,874	0	0.00	0	0.00
Kaiser Foundation Health Plan/Mid Atlantic	559,149	0	0.00	11,170	2.00
HMO Illinois	552,000	0	0.00	0	0.00
TOTAL/AVERAGE	**23,736,202**	**526,530**	**2.22%**	**2,619,451**	**11.04%**

Open-ended options allow members enrolled in an HMO plan to use the plan's provider network or to go outside of the network to any physician of choice.

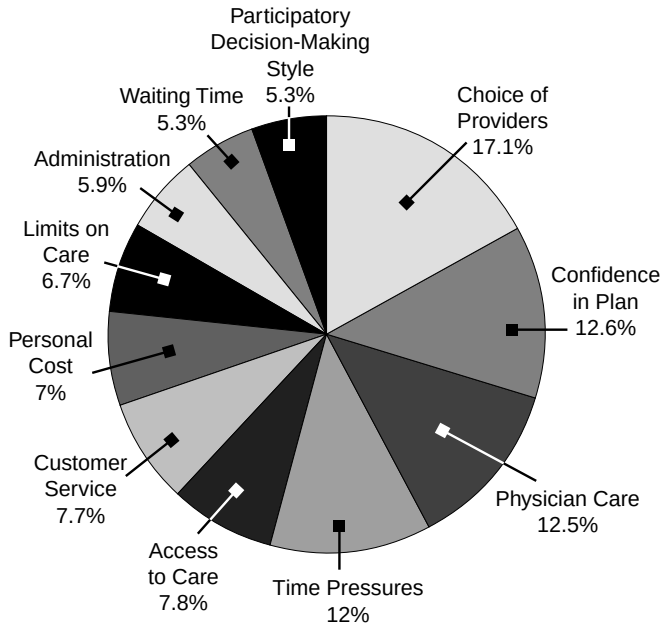
Point-of-service plans may be separately licensed HMOs by a state department of insurance that allow HMO members to use the plan's provider network or to go outside the network to obtain services. Both types of hybrid plans generally assess a higher fee to the HMO member for going outside the provider network.

Source: Hoechst Marion Roussel. *Managed Care Digest.*

Seton plans to launch its own Medicare risk product to compete with a current marketplace product, that must have a good handle on utilization and costs. Walker's main concern is finding an information management system to track whether patients are utilizing their primary care physician or going directly to specialists or outside the network, he says.

The increasing popularity of open-access plans actually is part of the managed care backlash that has simmered among consumers during the past several years, says **J. Leonard Lichtenfeld**, MD, FACP, a former practicing internal medicine physician who is now a health policy consultant and national capitation expert. "The original plan [among managed care organizations] was to get

Factors Influencing Overall Plan Performance
The MEDSTAT *Quality Catalyst* Program
1998 Enrollee Study



% = Importance in influencing overall plan performance

Source: The MEDSTAT Group, Ann Arbor, MI.

people into PPOs, then move them into point of service to increase their comfort level with managed care, and then move them into an HMO. But exactly the opposite of that has happened; people are moving away from HMOs due to consumer dissatisfaction," he says.

A 1998 study of 81,000 health plan enrollees by The MEDSTAT Group and J.D. Power and Associates found that the largest factor influencing how consumers rated health plan performance was provider choice **(see chart above)**. This item was ranked ahead of areas such as physician care, personal cost, and customer service.

But managed care organizations' efforts to keep current members and draw in new ones by increasing provider choice has come at a cost, Lichtenfeld says. "It's the old law of unintended consequences. The good news is open access is increasing. And the bad news is open access is increasing," he says.

In some cases, capitated providers or the patients themselves may be held responsible for cost overruns, Lichtenfeld says. For example, a point-of-service contract may state that the plan will pay 70% of allowed costs incurred when a member sees a provider outside the network. But the key phrase is *allowed costs* – which may be as low as $400 for a $1,000 service. "A lot of times, there is no way for someone to find out what that allowable rate is ahead of time," he points out.

But there are solutions to the open-access dilemma. Lichtenfeld suggests that primary care practices need to be more proactive in reaching out to patients. "If a patient comes into your panel on Sept. 1, you need to have someone call the patient and screen them with regard to health risk. If you find out that the patient has congestive heart failure, get them in to see your physician."

A nurse or a nonclinical practice employee can make this call with some guidance, Lichtenfeld adds (although a nonclinical person obviously cannot give clinical advice over the phone). Some practices contract with call centers to perform this activity.

Coburn of Mercer says the open-access trend may even be an opportunity for savvy practices in some markets. "There will be an employer backlash against the costs of big HMOs and [employers] will look for alternatives," he says. "The best-functioning plans on an ongoing basis will be integrated systems owned and run by physicians. I'm defining them as better plans based on patient satisfaction, physician satisfaction, clinical excellence, and low costs." ■

Internet gets fast results for outcomes project

Centers receive weekly reports, on-line training

Talk about quick turnaround: When surgery centers send data to the Surgical Outcomes Monitoring System, they can retrieve comparative reports *within a week* for 10 outcomes indicators and nine procedures. They can send instant comments to the project director or ask for help with their outcomes management.

The key to this rapid feedback: the Internet. The American Association of Ambulatory

Surgery Centers (AASC) in Chicago is among the first to base its outcomes program on the Internet. Members can download software, receive updates and reports by e-mail, and communicate with colleagues around the country.

"Our goal is to be real-time," says **Louis Rossiter**, PhD, co-principal investigator for the AAASC Surgical Outcomes Monitoring System. "You collect your data and *click*, it will recalculate it for you. The technology is available to do it."

The benefits of rapid feedback extend beyond the data and analysis. Participants, who pay no fee but must be members of the association, can "talk" and receive support through the Internet as well.

Rossiter has experience teaching via the Internet; for 10 years, he has taught a course on health economics as part of the executive master's program in health administration. Rossiter is professor of health economics at the Williamson Institute for Health Studies at the Medical College of Virginia of Virginia Commonwealth University in Richmond, which is a partner in the outcomes project.

"What really makes our program unique is the use of the Internet, not only for data collection but for training and communication," Rossiter says. "We have been applying some of the things we learned there [in teaching] to bringing these centers on-line."

What you'll need to get started

The Internet also brings a certain technological ease to outcomes management. Participants need only a Pentium personal computer with the Windows 95 operating system, a 28.8 kbps telephone modem, an Internet service, and the FileMaker Pro Version 3 or 4 database management software. Participants can download additional software from the project's World Wide Web page, which gives step-by-step directions.

"It really is as easy as going to [a computer store], getting off-the-shelf hardware and software, and plugging it in," says Rossiter. "We have considered other, more complex Internet software and rejected it because the beauty of this program is the accessibility for everybody."

When comparative reports are ready, participants receive an e-mail notice. Surgery center staff also can enter the information on-line. They fill out a medical abstract form to collect clinical information from the medical record, and nurses use a patient telephone interview form to ask a set of questions during the standard follow-up phone call after discharge. While Rossiter recommends the on-line method, at some centers, nurses conduct the interviews then give the forms to clerks to input the data. Either method is not difficult or time-consuming, says **Stephen E. Zimberg**, MD, MSHA, an obstetrician/gynecologist who is secretary of AAASC and vice president of the Lakeview Medical Center in Suffolk, VA, one of the first centers to join the outcomes project.

"It takes about seven minutes to do the survey," says Zimberg. "That's the time you're spending when you call the patient anyway."

The center's own cumulative data are available immediately. "When you're finished [with the survey], you can [determine] the percentage that are most satisfied, the percentage that had pain, and you can analyze all that data," says Rossiter.

The same-day surgery project is designed for flexibility as centers conduct their own quality improvement efforts. They can add several parameters that are unique to the center. For example, the project doesn't provide comparative data by physician, but centers can use physician identifiers to pinpoint variation among their surgeons.

"This was designed for the sites, not for the individual physician," says Zimberg. "We want the sites to be able to say 'I've got great patient quality, and I can prove it.'"

That demonstration of quality becomes more important as the Joint Commission on Accreditation of Health Care Organizations in Oakbrook Terrace, IL, and the Accreditation Association for Ambulatory Health Care in Skokie, IL, prepare to add requirements for performance assessment that would apply to ambulatory surgery centers. The same-day surgery project began with just two procedures, but now centers may send data on the following procedures: breast biopsy, bronchoscopy, carpal tunnel, cataract removal, cystoscopy, gastrointestinal endoscopy, hernia repair, laparoscopy, and knee arthroscopy. Or they may submit data on all procedures at their facility and receive reports that are not procedure-specific.

The 10 indicators include perioperative complications, longer than expected recovery time, and effectiveness of pain relief. As the AAASC project evolves, it will include an auditing function to ensure the integrity of the reported data, he says.

For example, the project may verify that centers are reporting data on all cases within the procedure codes they have chosen for participation, he says. The project also will refine its case-mix adjustment to account for differences among patients. Currently, the database is adjusted for

Group offers support in outcomes management

Sharing solutions by e-mail or regular mail

Are you in search of solutions to a vexing outcomes management problem? Do you need some advice as you launch your outcomes program? You may find answers from a new user's group that has formed to allow an exchange of ideas, questions, and advice among health professionals involved in outcomes management.

Currently, the 60 members of the user's group are mostly nurses, with job titles such as case manager, nurse clinician, practice coordinator, or clinical nurse specialist.

But the user's group is open to physicians, practice administrators, and others who are trying to monitor outcomes in a clinical setting, says **Chris Arslanian**, PhD, RN, director of research for the Tucson (AZ) Orthopaedic Institute.

Arslanian distributes comments and questions to the group via e-mail and regular mail, giving access to those who are not yet connected to the Internet.

"Everybody's struggling at different points of the process," says Arslanian, who says she formed the group to share what she had learned through the development of an outcomes program for the 17-physician group practice.

"Someone at the very beginning can learn from the mistakes we made," she says. "Let's help everybody get over the hurdles and collect meaningful data."

While group members may be in different medical specialties, they share the difficulties of collecting and analyzing data in a busy, clinical setting, says Arslanian. "The barriers to doing research are still the same no matter what group you're talking to," she says.

[Editor's note: For more information on the outcomes user's group, contact Chris Arslanian, Director of Research, Tucson Orthopaedic Institute, 2424 N. Wyatt Dr., Tucson, AZ 85712. Telephone: (520) 324-3900. E-mail: arslanphd@aol.com.] ■

age, comorbidity, and time in surgery.

Eventually, the project could become a network for clinical trials for drugs and devices, Rossiter says. "That would mean that if a pharmaceutical company wanted to try a new drug, each of these sites would be signed up as clinical investigators," he says. "The physicians would agree to use the drug and report the results back to our system. Each ASC would receive compensation for its participation."

But the primary motivation will continue to be quality improvement, he says. "This provides an opportunity for the industry to show the value of ambulatory surgery," he says.

[Editor's note: For more information on the Surgical Outcomes Project of the American Association of Ambulatory Surgery Centers, contact Kari Dabrowski, AAASC, 401 North Michigan Ave., Chicago, IL 60611-4267. Telephone: (800) 237-3768. Fax: (312) 321-6869. E-mail: aaasc@sba.com. World Wide Web: http://come.to/outcomes/.] ■

Managed Care Strategies (ISSN 1086-1378) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Managed Care Strategies**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (custserv@ahcpub.com)

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $249 per year; 10 or more additional copies, $149 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $48 each. (GST registration number R128870672.)

Editor: **Melinda Young**.
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Hours of operation: 8:30 a.m.-4:30 p.m. EST

Editorial Questions

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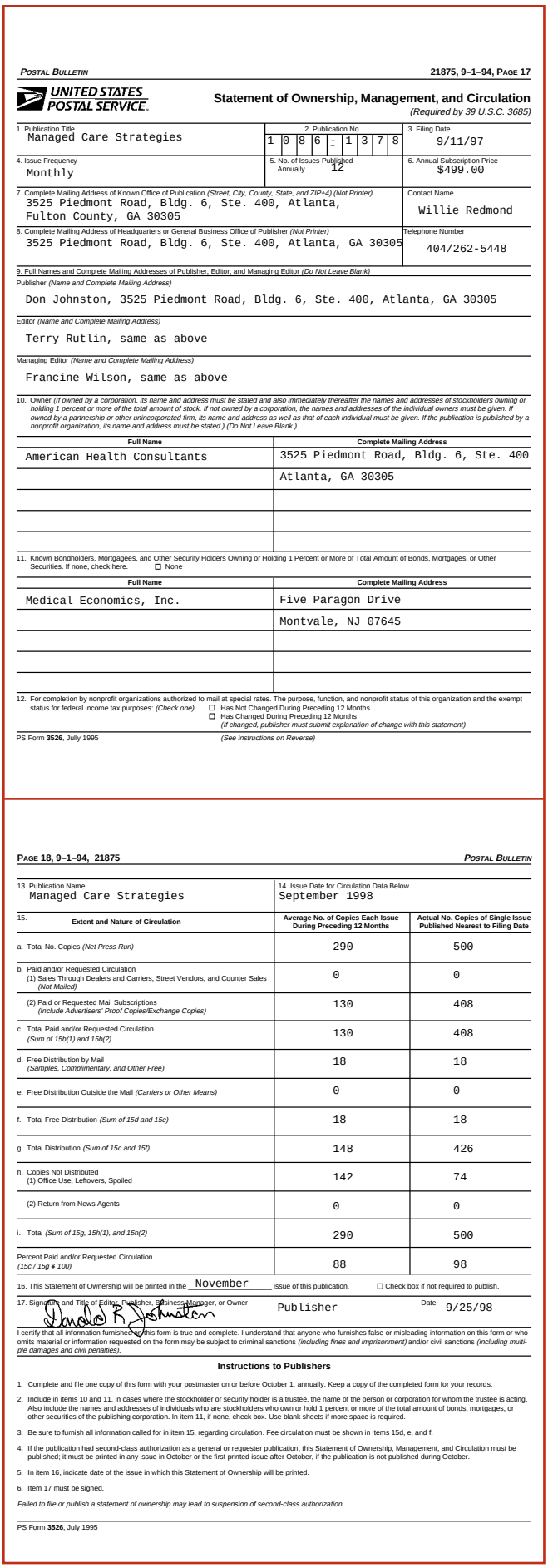

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UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation
(Required by 39 U.S.C. 3685)

1. Publication Title	2. Publication No.	3. Filing Date
Managed Care Strategies	1 0 8 6 - 1 3 7 8	9/11/97
4. Issue Frequency: Monthly	5. No. of Issues Published Annually: 12	6. Annual Subscription Price: $499.00

7. Complete Mailing Address of Known Office of Publication *(Street, City, County, State, and ZIP+4) (Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305 — Contact Name: Willie Redmond

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305 — Telephone Number: 404/262-5448

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*: Don Johnston, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*: Terry Rutlin, same as above

Managing Editor *(Name and Complete Mailing Address)*: Francine Wilson, same as above

10. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank.)*

Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste. 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☐ None

Full Name	Complete Mailing Address
Medical Economics, Inc.	Five Paragon Drive
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PS Form **3526**, July 1995 *(See instructions on Reverse)*

PAGE 18, 9–1–94, 21875 POSTAL BULLETIN

13. Publication Name	14. Issue Date for Circulation Data Below
Managed Care Strategies	September 1998

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*	290	500
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not Mailed)*	0	0
(2) Paid or Requested Mail Subscriptions *(Include Advertisers' Proof Copies/Exchange Copies)*	130	408
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*	130	408
d. Free Distribution by Mail *(Samples, Complimentary, and Other Free)*	18	18
e. Free Distribution Outside the Mail *(Carriers or Other Means)*	0	0
f. Total Free Distribution *(Sum of 15d and 15e)*	18	18
g. Total Distribution *(Sum of 15c and 15f)*	148	426
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	142	74
(2) Return from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2)*	290	500
Percent Paid and/or Requested Circulation *(15c / 15g x 100)*	88	98

16. This Statement of Ownership will be printed in the November issue of this publication. ☐ Check box if not required to publish.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Donald R. Johnston, Publisher — Date: 9/25/98

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