AMERICAN HEALTH CONSULTANTS®

Physician Relations

♦ UPDATE™ ♦

INSIDE

DECEMBER 1998

VOL.7, NO. 12 (pages 133-144)

American Health Consultants® is A Medical Economics Company

Too many doctors or not too many doctors? Depends on who you ask

The question's all about numbers

Talk about a topic that generates conversation around the water coolers! The talk around the hospital and medical school community has turned to employment prospects for new medical school graduates, thanks to a recent article in the *Journal of the American Medical Association* (*JAMA*).[1]

The *JAMA* article noted that about 7% of medical residents in 1996 couldn't find a position, and more than 22% who did find a position had trouble doing so.

Although the writers noted that employment difficulties were greatest among international graduates, there was still a great disparity between what the students themselves reported as their experience and the rosy portraits painted by the reports of medical school program directors. The conclusions reached by the mainstream press have been uniform: There are too many doctors.

But other studies based on more recent data suggest not a decline in the need for physicians, but rather a shift in what practices and hospitals are seeking.

Merritt, Hawkins & Associates, a health care staffing firm based in Dallas, found that in 1997, primary care searches they conducted for practices decreased by some 17% from 1,094 in 1996 to 913 last year. That includes searches for family practitioners, general internists, and pediatricians. Specialty searches, though, increased from 570 to 797.

Phillip Miller, director of communications for the firm, says the reason for the discrepancy between the *JAMA* researchers' findings and his firm's is the age of their information. "Medicine changes on a dime," he says. "Two years ago, the accepted wisdom was that the primary care gatekeeper model would prevail. But that just isn't so. Things change quickly, and if it was hard to find a position then, it isn't now."

Those very changes are affecting who is being recruited, too. While it was difficult to find good primary care physicians in the past and their salaries were going up year after year, now the primary care panels are full, Miller says, and groups are looking to fill specialty voids.

Couple that with the growing clamoring for choice and patient rights,

as well as a strong economy that lets people purchase more specialty care, and you see specialists are more in demand.

For the first time in a few years, says Miller, salaries for specialists are going up, while primary care physicians are seeing flat income. The two big surveys — from the American Group Medical Association of Alexandria, VA, and the Medical Group Management Association of Englewood, CO — which are due out next month will probably show the same thing, he adds.

Even if there is a recession, the trend to fill out panels with neglected specialty talent will continue, Miller says. "The era of the generalist in every profession is at an end. People want specialty talent." What could change in the future is a greater reliance on extenders like physician assistants and nurse practitioners.

JAMA had another story in the same issue on that topic .[2] The authors found that non-physician clinicians — nurse practitioners and physician assistants — are becoming more prominent as health care providers. "I think that they will continue to gain ground," says Miller. "And even physician-run groups will see them as a way to curtail costs if there is a recession. They can do a lot of what primary care physicians do, but at half the cost."

Among the other findings of the Merritt, Hawkins & Associates study:

- About two thirds of the searches conducted were for group or solo practices, a number which has been fairly constant since 1996.
- Three quarters of the searches occur in communities of less than 100,000 — again a number in keeping with the past.
- Most of the packages offered were salary with production bonuses (60%).
- More practices offer signing bonuses — 29.4% compared to 26.3 percent in 1996.

For more details, contact Phillip Miller, Director of Communications, Merritt, Hawkins & Associates, Irving, TX. Telephone: (800) 876-0500.

References

1. Miller RS, Dunn MR , Richter TH, Whitcomb ME. Employment seeking experiences of resident physicians completing training during 1996. JAMA 1998; 280:777-783.
2. Cooper RA, Laud P, Dietrich CL. Current and projected workforce of nonphysician clinicians. *JAMA* 1998; 280:788-794. ■

Salaries not keeping up with production

Three surveys, same results

The theory was sound: Improve production and efficiency, and physicians will have more money to take home at the end of the day. But the reality is different. Three new surveys show that while production among physicians continues to increase, compensation is rising more slowly, if at all.

The American Medical Group Association (AMGA) of Alexandria, VA, released its annual *Compensation and Productivity Survey* last month. While the data from the 242 responding medical groups showed very modest increases in compensation for physicians **(see charts, p. 135.)**, gains in productivity in most cases outpaced salary growth. For example, while internists had a 2% increase in compensation, they posted productivity gains of more than 7%. The largest discrepancy among those included in the chart occurred among orthopedic surgeons, who had a 2.28% compensation increase, but a 18.19% productivity increase.

There were a few specialities that bucked the trend; general pediatrics had a slightly higher increase in compensation than production, as did family medicine. Among the specialists not included in our table, allergists, urgent and emergent care specialists, and diagnostic radiologists also saw compensation rise more than production.

The annual Medical Group Management Association (MGMA) *Physician Compensation and Production Survey: 1998 Report Based on 1997 Data* came to many of the same conclusions as the AMGA survey. However, compensation increases over the previous year among physicians at the 1,736 responding practices were less or nonexistent. For instance, while AMGA respondents in urology had a 7.26% compensation increase, the MGMA respondents in that specialty reported a 3.6% decrease in compensation. None of the specialties listed in the MGMA portion of the tables show increases.

Like the AMGA survey, production among MGMA respondents was up far more than compensation. Most striking are urology practices, which had a decrease in median compensation of 3.6% and an increase in production of 14.5%.

(continued on page 136)

Median Physician Compensation (in dollars)

	AMGA			MGMA		
	1996	1997	% Change	1996	1997	% Change
Family Practice (with OB)	133,126	137,100	2.99	134,500	133,039	-1.09
Pediatrics	127,100	133,000	4.64	132,039	131,803	-0.02
Internal Medicine	134,232	136,948	2.02	140,000	139,905	-0.01
Cardiology (general)	232,250	232,250	—	247,133	259,961	-5.19
OB/GYN	215,000	218,484	1.62	217,549	210,000	-3.47
Orthopedic Surgery	285,566	292,071	2.28	310,475	302,234	-2.65
Urology	219,091	234,995	7.26	222,336	230,339	-3.60

Source: Medical Group Management Association, Englewood, CO; American Medical Group Association, Alexandria, VA.

Median Physician Production (in dollars)

	AMGA			MGMA		
	1996	1997	% Change	1996	1997	% Change
Family Practice (with OB)	332,021	339,011	2.11	306,816	311,546	1.54
Pediatrics	329,193	341,726	3.81	331,453	331,039	-0.12
Internal Medicine	312,023	342,869	9.89	310,663	329,811	6.16
Cardiology (general)	885,773	916,981	3.52	822,183	889,068	8.14
OB/GYN	651,907	679,738	7.03	632,055	636,922	0.77
Orthopedic Surgery	1,1012,518	1,091,712	18.19	1,011,000	1,004,820	-0.61
Urology	767,218	869,799	10.60	721,075	825,392	14.47

Source: Medical Group Management Association, Englewood, CO; American Medical Group Association, Alexandria, VA.

The third survey, Ernst & Young's *1998 Physician's Benchmarking Survey* also found that increases in professional charges were higher than increases in total compensation. The trend was most pronounced for primary care physicians, who saw productivity increase 16% in 1997, while cash compensation rose only 6%. Surgical specialists saw the least pronounced difference — a 3% increase in compensation compared to 4% in production. And procedural specialists actually had a net gain of 1%, or a 7% increase in earnings compared to a 6% increase in gross charges.

The actual dollar figures for primary care physicians and specialists are available only to those purchasing the report.

According to **Sue Cejka**, whose St. Louis human resources firm Cejka & Co. sponsors the MGMA survey, this trend is a further evidence of physicians getting squeezed between rising costs and declining fees.

What could change the trend of flat or no growth in compensation, according to the survey — particularly for primary care practices — is physicians taking on more risk. Once half or more of their practice is at-risk managed care, compensation rises, states the MGMA survey.

Editor's note: For more information on the surveys, contact:

American Medical Group Association, Compensation and Productivity Survey, *$250 for nonmembers and $175 for members. Call (703) 838-0033 ext. 326.*

Medical Group Management Association, Physician Compensation and Production Survey: 1998 Report Based on 1997 Data, *$200 for members, $250 for affiliates, and $300 for nonmembers. Contact (888) 608-5602.*

Ernst & Young 1998 Physician's Benchmarking Survey, *$1,200 for nonparticipants, $600 for those participating in next year's survey. Contact Richard Cederholm at (213) 977-3426.* ■

Waking up from nightmare of reference checks

A quick guide to recommendations

Anyone who has tried to hire someone in recent years has noted a change: Past employers were once willing to give you information on your potential new hire, but now they are shut up like an oyster protecting its pearl. More often than not, the only information you can get is confirmation of employment, date of hire and termination, and if you are lucky, starting and ending salary.

"It's name, rank, and serial number," says attorney **John Gilliland**, JD, who runs a practice that specializes in health care near Cincinnati in Crestview Hills, KY. "Many employers have evolved to that because they are worried about being sued. It's a big deal in health care because of the ramifications of hiring people who may be providing care to others.

Thomas Bender, JD, an attorney with Buchanan Ingersoll in Philadelphia, agrees. His firm has written a white paper on the topic. While it isn't at epidemic levels, there have been more and more cases where potential employees have sued former employers for hindering their job search by giving negative references, the paper states. Even more frightening, some employers are suing past employers of new hires for giving "negligent" referrals, for not revealing adverse information.

The result: confusion. "The threat of litigation, while probably exaggerated," states the white paper, "has silenced employers."

What can you do to ensure that the you get the information you need about new hires and give information that others need about former employees? Here are nine tips:

1. **Know what to ask.** Perhaps the best thing you can do in a situation where you are being stonewalled is to ask a simple question that few people have trouble answering, Gilliland advises. "Ask them if they would rehire the person if given the chance," he says. If the answer is yes, you know you have a good candidate. If the answer is no, you can dismiss that person. And you shouldn't be afraid of answering such a simple question, either, he adds.

2. **Enlist the help of the candidate.** Gilliland says you can tell the candidate that you are having trouble getting a reference and ask them to intercede with the old employer. Some past employers are more willing to talk if the person gives them permission. He says that you can even ask your legal counsel to draft a statement which

the candidate can sign, authorizing release of information and promising not to sue the former employer for any reason.

"Tell the candidate that you will have to dismiss him or her if you can't get any information about past performance," says Gilliland.

Bender says you can even start by asking all *prospective* employees to sign a release that will allow you to give references about them when their employment with you ends. Wording for such a release might be as follows:

"I hereby authorize XYZ to provide information regarding my employment with XYZ to any future potential employer who requests such information as part of a background check. I release XYZ and any person acting on behalf of XYZ from all claims arising from the release of such information."

Coupled with a release obtained prior to the reference check, you have a good defense against a potential claim.

3. Be consistent in your policies. On the giving side of reference checks, you should also make sure you follow certain rules. Foremost, says Gilliland, is to be consistent. Everyone who may be asked for a reference check should know your policy and follow it. For instance, if you only give employment confirmation, then make sure that neither you or any of your staff give off-the-record remarks to someone seeking further information. "You can't let your friendship with Mary at Dr. Jones' office lead you to say more about the old employee than you would for someone you don't know," warns Gilliland.

Bender says that having one person or department in charge of references is a good way to maintain your consistency. In large organizations, it would be the human resources department. But in smaller workplaces, limiting the duties to one person is a good idea.

4. Get requests in writing. The Buchanan Ingersoll white paper suggests that getting reference requests in writing is a good way to document the process and can also help maintain consistency and ensure compliance with your own policy. Ask that those requests be accompanied by a release from the former employee authorizing release of the information. Such a release should state that the company, its employees, and agents are released from all claims which can result from the reference. Your attorney can help you draft such a form.

If you do decide to do a phone reference, the paper advises that you call the requesting party back, since attorneys and investigators often pose as potential employers to get information. "Do not answer any questions until you call the requesting party back and verify the caller's identity," the paper states.

Also, get a faxed release from the applicant, limit answers to specific objective statements, and keep an accurate records of the telephone reference — including the date and time of the call, the questions asked, and the answers given. **(For more on objective statements, see box on p. 138.)**

In *getting* a reference over the phone, keeping good notes is also essential. **(For a sample form and script, see the insert in this issue.)**

5. Use other means of gathering information. In the face of silence, you can also rely on other methods of gathering information about a potential candidate. You can do criminal background checks, credit checks, and state license checks where appropriate, Gilliland says. You should also check with the Office of the Inspector General of the Department of Health and Human Services in Washington, DC, to make sure that no medical staff you hire is on their list of people banned from receiving Medicare or Medicaid reimbursement. Of course, adds Gilliland, those checks will only turn up the worst of the worst, not the people "who just didn't function too well. But it is a start."

6. Don't be afraid to say good things. If the employee was a stellar performer, Gilliland says you can rest easy about giving a good reference. And in a way, knowing that most people are following your mother's advice — if you can't say anything nice, don't say anything at all — will help you in your hiring decisions. "If they are only telling you that the person worked there and when, you can often take that as a statement that they weren't the best employee. Otherwise, they'd say so," he says.

On the other hand, Bender notes that positive statements *might* be used to support a wrongful termination suit. Make sure that what you say is objective and verifiable.

7. Tell the truth. A true statement that isn't misleading is absolutely protected, says Bender. As long as it isn't made in a context that could cause you to believe something that *isn't* true, you are safe. The white paper from Ingersoll has

Objective Answers to Reference Questions

Do not say:	Instead, say:
He performed poorly.	He achieved the company quota 30% of the time. The company average is 92%.
She is not a team player.	On 12 occasions, she was asked to perform an extra task to fill an unexpected need. She refused each time.
She is not dedicated.	She worked one hour of overtime in two years.
He is violent and disrespectful.	He punched a supervisor in the nose.
He came to work drunk.	He arrived at work smelling of alcohol 10 times, and he fell asleep at his desk each time.
She was a drug addict.	She tested positive for cocaine on two occasions.

Source: Buchanan Ingersoll, *Minimizing Risks in References and Employee Discipline*, Philadelphia, 1996.

the following example:

"Bob resigned from his position at XYZ Inc. because he wanted to move closer to his family in Arizona. The day he resigned, XYZ Inc. completed an investigation into a recent theft from the company safe and discovered that employee Charlie stole $1,000. Charlie was fired. When Bob applied for a job at ABC Co. in Phoenix, the company contacted XYZ Inc. to check Bob's references. XYZ Inc. responded with the following statement: 'Bob resigned the day that we completed our investigation into who stole $1,000 from the company safe.' ABC Co. did not hire Bob."

While true, the way the story is told might make you think Bob's resignation was related to the theft. Truth is not a defense in that case.

There are other defenses against litigation, too, such as conditional and absolute privilege, which might apply in certain cases. Again, Bender says you should check with your own attorney if you have a question about what you might or might not be able to say in a specific case.

8. **Check your state law.** Some states — and you will want to check with your own legal counsel to see if you live in one of them — are considering legislation that would protect employers from such suits by giving a form of free speech protection to employee references.

Other differences in state law may regulate what information you can release from personnel files, and whether or not you have to tell the former employee you are going to be giving a reference, says Gilliland.

9. **Above all, check.** "I'm always surprised by the number of people who ask for references, but then don't check them," Gilliland says. Whatever else you do, call those former employers, as what they say or don't say can help you make a hiring decision that could be the making or breaking of your office.

For more information on reference checks, contact:

John Gilliland, JD, Attorney, law offices of John Gilliland, Crestview Hills, KY. Telephone: (606) 344-8515.

Thomas Bender, Jr., JD, Attorney, Buchanan Ingersoll, Philadelphia. Telephone: (215) 665-8700. ■

National campaign gets local twist

'Got Milk?' ads bring notice to ortho practice

Virtually everyone in the country has seen the "Got Milk?" advertisements of the National Dairy Council — pictures of milk-mustachioed famous people talking about the benefits of milk. So imagine the pleasure at Jewett Orthopedic Clinic in Orlando, FL,

when it received permission to sponsor a series of those ads in the monthly publications for the Orlando Magic basketball team and the University of Central Florida, also in Orlando.

"Typically, Jewett doesn't do ads," explains **Andrea Eliscu**, RN, president of Medical Marketing in Winter Park, FL, the consulting firm that assisted Jewett with the project. "But this was a great opportunity for us."

The result has been great exposure for Jewett, even though it was already well known in the community. "This brings us respect in the business community," Eliscu says. "It keeps our name in front of the public monthly, rather than just once, and it solidifies our relationship with the Magic and the university."

The guts to ask

Most people don't realize that the dairy council, located in Rosemont, IL, allows one organization in every community to make use of the "Got Milk?" campaign for local purposes. Eliscu says the reason Jewett was able to do the ad was because she had the foresight to call her local dairy council and ask if they could mimic the ads with local celebrities.

They, in turn, put Eliscu in touch with the national organization, which approved the idea with the proviso that it could approve the copy and the people who would appear in the ads. Jewett also had to promise not to run the ads in any national publication.

Because Jewett has a relationship with the university and the Magic as team physicians, Eliscu found it simple to approach them about the ads. **(For more on getting involved with your local sports teams, see related story, p. 140.)** The contractual relationship with the organizations requires that Jewett run an ad in their publications anyway, and this offered an opportunity to expand that coverage with a nationally known campaign, she says.

Eliscu wrote letters to various Magic players, collegiate officials, and other local celebrities. The letters outlined the campaign, noting that the practice had permission to run the ads locally and assuring them that it would be a fun shoot. "Then we sat back and waited to see who would call," she says. "For the tougher sells, we went to make personal visits."

One such hard sell involved the president of the university, Eliscu recalls. "We told him: Jewett has been a team physician for a long time, we purchase an ad in the team publication every year, and we wanted him to be in it. We promised a prominent art director, photographer, and professional makeup person. We told him he could select the photograph and approve the copy."

Once the university president said yes, Eliscu had him sign a media release and booked the shoot.

The existing relationships with the Magic and the university enabled Eliscu to secure members of the Magic team, U.S. National Team soccer player Michelle Akers, and the president, athletic director, and football coach from the university to participate free of charge in the ads.

The final photographs look just like those from the national campaigns but with the Jewett logo at the bottom. Each month, a different celebrity appears in the ads.

And even though this year's basketball season is in jeopardy due to the player lockout, Eliscu is still high on the potential exposure the ads bring. "The 17,000 Magic season ticket holders will still get the magazine," she says. "And the Magic organization will have to work harder to keep their fans in touch with the organization. I don't see it as bad luck or timing."

Eliscu says the cost to shoot and produce the ads was about $1,500 each, and there are 24 ads scheduled. Those costs include makeup, photography, the art director, film, separations, and publication. The costs were already budgeted for Jewett, which has a contractual responsibility for sponsorship with both organizations. This campaign added an additional cost of about $250 to that budget, she says.

Got another opportunity?

Shortly after the whole "Got Milk?" campaign came together in the summer, Eliscu, while traveling, saw that the Cleveland Clinic was sponsoring an osteoporosis screening where people who participated could have their photograph taken with the milk mustache. There are 100 such events throughout the country until the end of the year, and the best photograph will appear in an issue of *People* magazine next year. Eliscu called and signed Jewett up for the Orlando promotion (1-800-WHY MILK).

Sponsors provide a nurse and a dietitian, help to scout a location, and in return have permission to do whatever they want for visibility. Eliscu says Jewett chose a local farmers market for the location. "The great thing is that we look like a

Getting in on the sporting action

Not every community has a professional sports team or a well-known college level team. And teams usually have long-standing relationships with physician practices that act as team doctors. But **Andrea Eliscu**, RN, president of Medical Marketing in Winter Park, FL, says that shouldn't stop you from trying to develop relationships with those teams.

"Certainly the easiest way to get in is through an expansion situation," she says, noting that when the Orlando Magic came in 1987, she was able to foster a relationship between them and Jewett Orthopedic Clinic. **(For more on that relationship, see related story, p. 138.)** "If they already exist and have a relationship with a practice, you have to work very hard to take that contract away."

You should start by getting to know the coach and general manager and let them know what you have to offer. But beware: You shouldn't get into this kind of relationship expecting money. Indeed, usually a contract will require you to spend more money than you make from the relationship. "You are a sponsor; you will be asked to advertise, to do things with the team," explains Eliscu.

But you do get visibility. For instance, Jewett's name appears on the Magic scoreboard. "The gain comes from the increased name recognition." And there are other perks. Every Jewett office has signed Magic jerseys and photographs of the stars. When a star is injured, your physicians are talking to the press. "But you have to understand that you are paying out dollars for this kind of relationship. You have to decide whether that expense is worth the air time you'll get." ■

champion for hosting this whole campaign, it will tie in with the milk ads, and we maximize exposure for a long time."

The costs for the road show, known as the Better Bones Tour, were nothing but any advertising which Jewett wanted to do for the event. The National Dairy Council and the National Osteoporosis Foundation of Washington, DC, did their own promotions, too.

Although the link between milk and osteoporosis makes orthopedics practices a natural choice for such a campaign, Eliscu thinks that other practices could take advantage of the "Got Milk?" and Better Bones opportunities. Family practice, internal medicine, endocrinology, radiology, pediatrics, obstetrics, and nuclear medicine practices could all have an interest in osteoporosis prevention, diagnosis, and treatment. "If you deal with aging, if you deal with osteoporosis, its impact or treatment, you might be interested," she says.

And even if the Better Bones Tour passes you by, there are probably other opportunities available throughout the year — either through the National Osteoporosis Foundation or through another organization. The Arthritis Foundation is one which often sponsors community events that could use practice sponsorship, notes Eliscu.

As for the "Got Milk?" ads, anyone can do that and finding the local celebrities doesn't mean you have to live in a city with a professional sports team, she says. In a smaller community, the scout master, your local parish priest, or your mayor could be called upon to wear the milk mustache. "Use the people you know, who you have a relationship with. Don't call up the Seattle Supersonics if you don't know them."

Eliscu admits that this campaign was more time-consuming than most marketing projects she handles for Jewett. "You have to make sure that all the people you photograph are happy — that they get copies of the pictures and copies of the publication. But then they see themselves and everyone else in it who participated, and it keeps us in their mind month after month. It creates added value."

It also provides a morale boost for the practice as a whole, she adds. "There is so much physician-bashing that the marketing we do has to be creative and tell its own story. This makes us look good." ■

Learn the fine art of win/win negotiation

Everybody's negotiating something

By **Kriss Barlow**, RN, MBA
Barbara Burke, EdD

"Negotiation is not natural to most physicians. We were trained to gather the data and come up with the right answer. In negotiation there is no right answer." — Michael Hostetter, MD

Perhaps you have thought of negotiations as "hard-nosed," aggressive, and confrontational.

Such characteristics may work well when negotiating the purchase of a car or house. In many negotiations, however, you are dealing with people with whom you wish to maintain long-term relationships, people with whom you will wish to do other business deals. If so, you need to resolve conflicts or reach resolution in a manner that you and the other party can both support for the long term. In these situations you need a negotiator who presses not for win/lose but rather for win/win solutions. People who sit side by side and mutually seek a joint solution to a problem are focused on win/win.

The need for negotiation occurs frequently in a physician's practice. While some negotiation is in place on the clinical side, much of the challenge arises in the business world of medicine. The issues are complex and the number of people involved is significant. In the past week, it is likely that someone has asked your opinion because they were in the midst of a dilemma and needed some options for moving forward. While general advice is offered, there is no perfect solution; the negotiation process is at work.

Physician negotiations may include:

- dealing with a difficult partner in your practice;
- integration/consolidation discussions with another physician practice;
- talking with a hospital about a joint venture, affiliation, or practice development opportunities;
- managing everyday operational and staffing issues within the practice;
- renewing a contract with a payer.

The context may differ in each of those situations, but what you need to bring to these discussions is the same.

Planning your strategy

As an active participant, what does win/win-negotiating mean for you, the physician negotiator? First of all, it means you plan.

There may be a few people who are genetically wired to negotiate. If you are not one of them, you need to be a bit more methodical. You need to articulate: "What are our interests? What are our options? What will we do if we cannot satisfactorily come to a joint solution?" More importantly, you need to be able to answer those questions for the people with whom you are negotiating. Formulate the answers to the same questions from their perspective. Do you understand their needs, their vulnerabilities, and their options? Thinking through this process helps you plan options that may meet the needs of both parties.

In order to accomplish this dual planning, some people develop planning sheets in two columns: on one side, is their party's list of desired outcomes, major concerns, and possible options. In the second column, complete this same list for the other party. Flesh out this sheet as much as you can before you begin talking. If you are representing a number of physicians, gather their input. Think through the following in detail:

1. **Desired outcomes.** What does each party want from the negotiation? Why are you talking? What is the dream you each have that brings you to the table?

2. **Concerns.** What would make the deal hard to sell to your constituency? Are there needs for security (vs. risk), control, or dollars that need to be met through the deal? Many physicians are risk-adverse and will take a smaller upside return if the downside risk is smaller. Similar concerns can make or break a deal. These concerns may be apparent or you may need to discern these from your conversations.

3. **Options.** What are the best options for the deal that you can imagine? What issues could you put on the table that do not mean much to you, but might be very meaningful or useful to the other party? Providing first-rate billing services, malpractice insurance, or managing physician calls, might be a few items that could enhance a negotiated deal.

4. **Bottom line.** No plan is complete without a well thought out walk-away position. If you cannot come to agreement, what will you do? When you know this position very clearly, you can more easily evaluate positions that may be offered. Of course, you will know what you believe to be the other party's best walk-away position, so you can offer strategies to improve on these. And, at the appropriate time in negotiations, you may decide to use your walk-away position to press for resolution.

Having your outcomes, concerns, options, and walk-away position well articulated will give you power. You need to know what outcomes and options are ideal and which ones you can live with. Keep this information

updated as you proceed with the negotiations. This knowledge provides the building blocks for a deal that both parties can support.

A process needs to be established that clearly defines the rules of the road and ensures the environment is geared to a win / win outcome. Keep these key factors in mind when you are actually in the process of negotiation:

• **Insulate your hot buttons.** Not everyone has a personality you will enjoy. Not everyone will be tactful. Some people may seem to be intentionally trying to antagonize you. Your job is to stay focused on the deal and not on emotions that will not help. Take a break. Keep your head clear. Stay focused. Go forward.

• **Draw out the other side.** Actively seek to understand their position. Confirm from them what outcomes they desire, what are their concerns about the deal, what options do they see as being feasible. Seek their solution to the issues that you are facing. You can ask "What would you do if you were me, taking this deal back to my partners? How would you sell it?" Confirm any tentative solutions that you reach: "Will this meet your need to (fill in the blank)?"

• **Create the future together.** Use ideas and solutions from both sides. Attribute ideas and solutions to the other party so the groundwork is laid that the emerging solution is truly the product of both parties.

If the push to reach resolution is losing steam, ask, "What will you do if we walk away from this?" You may wish to volunteer what you will do if you leave the negotiations. Knowing your walk-away position helps you evaluate whether you can come up with a better joint solution or if walking away is, in fact, what needs to be done. Sharing this option can also bring both parties back to the table with renewed energy for finding an option that is better than their respective walk-away positions.

Reinforce where your discussions have taken you so that it is evident that you have truly designed the deal together. This is a powerful tool in having a solution that is not only mutually supported, but about which both parties feel good.

There may be an assumption that the physician will lead the process. After all, physicians generally lead definitive processes with decisions driven by fact. If you choose not to be at the center of the negotiation process, this must be clearly stated. Recognize that someone else will negotiate on your behalf, and you will be included when they request input.

The health care field today is filled with opportunities that need to be negotiated. As consolidation, alliances, and joint ventures increase, this need to negotiate will only grow. Every aspect of health care benefits from the active involvement of physicians. The skill of negotiation must be developed and nurtured with the physician who is a great negotiator mentoring others.

Negotiating may be new to many physicians. There is no single right answer in negotiations, which is the opposite of how most physicians are trained. Still, there is an overlap in skills between negotiations and physician training. In win / win negotiation setting, physicians will find that their skills at listening and problem solving from divergent data will help them to reach solutions that are embraced by both parties in the negotiation process. Consequently, physicians with these skills can serve as very effective negotiators.

***Kriss Barlow**, RN, MBA, is a Senior Consultant with Corporate Health Group-Twin Cities. Telephone: (888) 334-2500. Her area of expertise is physician relations and strategy.*

***Barbara Burke**, EdD, is Director of Business Development at St. Vincent Hospitals and Health Services, Indianapolis.* ■

The Good Negotiator

Who can be the quarterback to such a process? Obviously not every one makes a good negotiator. When looking at the planning and process requirements for win / win negotiation, the characteristics for a good negotiator may not be what you would assume.

Good negotiators:

• listen well and hear what people are really saying (perhaps behind their words);

• think well on their feet;

• can formulate creative solutions and draw on options not previously on the table;

• want to not only do a business deal for today, but build a lasting partnership;

• know when to be generous and when to confront;

• behave respectfully;

• stay on task with the issue at hand;

• have their own emotions well in control e.g. no hot buttons that will ignite and potentially disrupt the process. ■

By seizing opportunities, MDs emerge winners

Physician-owned HMO thrives in rural market

Just like the old stock market adage "Buy low, sell high," taking a proactive stance in managed care can work best when conditions in the managed care marketplace are less than ideal. The experience of a physician-led and owned managed care organization, Virginia-Carolina Managed Care Inc. (VICARE), is a prime example.

The Franklin, VA-based company seized the opportunity created by employer dissatisfaction with rising premiums by starting its own HMO in this rural area of approximately 12,000 in 1995. Three years later, the gamble has parlayed into a company with 27,000 covered lives, 1,700 physicians under contract, and 20 affiliated hospitals. The company's coverage area runs down the eastern shore of Virginia, including Williamsburg, across the peninsula area of the state and into the northeast corner of North Carolina.

Bed days per thousand average 160, compared to the average of 200 for the other major system in town.

VICARE's story illustrates the opportunities for physician-run organizations that are willing to take initiative, says **Bob Coburn**, a consultant with William M. Mercer consulting firm in Chicago. There will be an employer backlash against the ever-increasing premiums of large insurer-owned HMOs, he says. "The best-functioning plans on an ongoing basis are going to be integrated systems owned and run by physicians. They will be the better plans based on patient satisfaction, clinical excellence, and low costs. The only plans I'm aware of now that meet these four criteria are run by physicians."

VICARE's beginnings were spurred by a local employer looking to lower its health care costs, says **Karl Beier**, MD, a physician with an OB/GYN practice who also serves as chairman of VICARE. In 1995, Union Camp Corp., a paper manufacturer that employs about 3,500, put the word out that it was dissatisfied with rising health care costs and was entertaining proposals from other insurers.

"That really sort of galvanized the doctors in this community to respond. In reality, they [Union Camp] represent 10% of anybody's patients in this town," Beier says.

Union Camp's announcement came at a good time. Three months earlier, a group of physicians (including Beier) and representatives from a local hospital had began working with a consultant to prepare for what they saw as the inevitable infiltration of managed care into their market. "At the time, we were sort of a cutoff for managed care. We started looking at what was happening in managed care in the peninsula area [about 30 miles from Franklin] and saw a lot of people who live in our community but work in the city being pulled into health plans." Beier's practice and the other practices in town were not included in these networks, meaning some patients had less of a financial incentive to use their practices.

The Union Camp announcement set the group's plans in motion, enabling it to respond to Union Camp's proposal and create its own managed care organization. It was a bit of a gamble to try to convince the town's largest employer that it should put its faith in a start-up organization.

Physician Relations Update (ISSN 1068-5278) 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. POSTMASTER: Send address changes to **Physician Relations Update**, 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), $455. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $227 per year; 10 or more additional copies, $136 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 $44 each. (GST registration number R128870672.)

Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Managing Editor: **Francine Wilson**, (404) 262-5416, (francine.wilson@medec.com).
Production Editor: **Nancy McCreary**.

Hours of operation: 8:30 a.m -4:30 p.m.

Editorial Questions

For questions or comments, call **Francine Wilson** at (404) 262-5416.

VICARE eventually won the contract after six months of negotiations, beating out the more experienced Centera Health System, an integrated delivery system of several large hospitals in a neighboring community.

Because Union Camp is self-insured, VICARE did not need to get an HMO license from the state. It assembled a network of 200 physicians and six hospitals, formed an organization financed by a $5,000 contribution from each of the 24 founding physician partners and matching funds contributed by a local hospital, and contracted with a third-party administrator to handle administrative processes. The result was something that resembles a point-of-service product, although it is reimbursed on a discounted fee-for-service basis. It utilizes a primary care physician gatekeeper system, with utilization management run by VICARE through a part-time medical director, two RNs, and three LPNs.

The Union Camp contract served as a model for the approach VICARE uses with other employers, using what Beier calls a "gain share" approach.

"With Union Camp, we had to promise them that we would drop the cost of health care 20% the first year," he says. "They [Union Camp] started from a traditional indemnity plan with no discounts. I used an actuary and came up with a fee schedule for the network, not even allowing for any utilization management savings or PCP savings. We ended up dropping costs 35% the first year. So I made an arrangement with them [for the next year]. I said, 'we'll give you the first 20%, and we'll take anything above that."

As a result, the participating physicians are motivated to practice good utilization management, Beier explains. "Physicians are owners, and they will work hard to make the company work. Because physicians are owners, they don't churn the product," he says.

Word of the Union Camp success gave VICARE credibility with other employers. In addition, VICARE's 15-member board includes three employer representatives, which serves as a marketing tool to other employers. (The three employer representatives are appointed by the hospital, which has seven board slots on the board; the physician group also has seven slots, and Beier, as chairman, occupies the 15th position, serving as a tiebreaker when needed).

Another element of the Union Camp relationship that VICARE uses with all employer clients is to generate monthly reports that illustrate health care costs and money saved through utilization management.

VICARE's success has spurred developments beyond the extra employer business. VICARE eventually purchased the third-party administrator it was under contract with, increased its number of shareholders, and brought in two additional hospitals as equity partners.

In addition, the company is in the process of expanding from a self-insured client base into a partnership with a national company to develop a fully insured plan.

"Because we don't have an HMO license, we need someone to take the risk," Beier says. "We've worked out an arrangement with a national insurer that will allow us to be their delivery system exclusively in Virginia and North Carolina. We hope to have that out by Jan. 1."

The company also is developing an electronic credentialing system, which will provide administrative support to physicians who must submit credentialing information to other payers with whom they contract. "When physicians get the credentialing packages from the insurer, they'll send it to us. We'll call the insurer and offer to sell our services to them," he says.

Beier also is spending more of his time traveling to other communities to work with physicians who hope to emulate VICARE's success in their own market. The opportunities are there, Beier insists, if physicians are willing to seize it and can work together. ■