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INSIDE

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American Health Consultants® is A Medical Economics Company

Being part of one-stop shopping can give you a convenience edge

How a radiology group gives 'storefront' a whole new meaning

Vicki Brown knows a good idea when she hears it. As marketing manager for Radia Medical Imaging, an Everett, WA-based radiology practice with five offices in the Puget Sound area, she attended a conference in late 1996 where she was privy to a discussion between Nordstrom officials and representatives of an Illinois hospital. They were talking about a mammography clinic that had opened in a retail setting. "What a novel idea!" Brown recalls thinking.

That good idea led Brown down a path that culminated in Radia opening a sixth imaging office housed in the downtown Seattle department store Bon Marche in January. It is one of only a handful of radiology centers housed in retail establishments, but one that she believes will be profitable and a boon to patients who crave convenience.

When Brown first heard the discussion at the Minneapolis conference, she was so taken with it that upon returning to the Seattle area, she called the manager of Nordstrom in Seattle for an appointment and put together a proposal. Internal issues kept Nordstrom from pursuing the idea, although management was intrigued, she says. Not wanting anyone else to catch wind of the idea, Brown then approached Bon Marche, a local department store owned by Federated Stores.

KEY POINTS

People are busy and convenience is their watchword. When one radiology practice looked at how to better serve its clientele, it decided to bring its services to where they were: at the local department store.

Opening in an up-market facility has been tried successfully elsewhere, so Radia Medical Imaging had a template to follow. The new office generated a great deal of media attention when it opened in January and hopes to be seeing 40 patients per day within five years.

Making a practice easily accessible to patients by locating where they shop could be adapted to other practices. Among those that might benefit from storefront or in-store operations: podiatry practices near shoe stores, sports medicine practices near health clubs, or dermatology practices near day spas.

"The Bon had a space that was used for storage close to the hair salon, next to Intimate Apparel. It would be ideal," says Brown. She presented her idea to Federated management, but again, external issues caused delay.

Others might have been discouraged. But at the same time, mammography centers opened in two other Federated stores — one in The Fountain Court in Cincinnati at a Lazarus Store and one at a Rich's Store in Perimeter Center Mall in Atlanta — and an article in a local paper about mammography was published. In it, Nordstrom management said there would be no mammography center in their Seattle store.

The heavy competition between Federated stores and the article led the Bon to reconsider its delay. "They said they would like to move ahead at our earliest convenience," says Brown.

'Interesting' obstacles

The next step, explains Brown, was creating a contract that was essentially a department license agreement written for vendors. "Concern over patient confidentially and the operation of a clinic demanded that we work with both attorneys to change the agreement to fit the need," she says. "This became quite a laborious task. Federated attorneys were well-versed in 'retailese' but needed an education in the subtleties of health care law. Radia, on the other hand, needed an education in retail so we could begin to speak the same language for the common good." The two could not appear as partners, Brown says, and disclaimers had to be written on any advertising Bon Marche and Radia pursued together. "Systems had to be developed so we could come to agreement on events and the special handling of signage. Communication has been quite an interesting process."

During the process, another element was added to the mammography center: Radia decided to add bone density testing services to the mix.

Once the contract was finished, Brown got started on marketing. "While the clinics and referring doctors in the area are key to the success of Radia Women's Imaging in the Bon, I am also appealing to the Bon Marche customer," she says. "Customers can be prompted to schedule an appointment because they have seen advertising or listened to a news spot. We actually have had one patient drive down from Vancouver, BC [about 200 miles from Seattle], because she caught a local news story on the day we opened. She drove down because it would have taken her three months to get a bone density appointment there."

The Bon helped with marketing, placing brochure holders in all the women's dressing rooms for Radia flyers. The brochures were also inserted into all Bon shopping bags, and the store installed elevator signs. There was an effort to get media attention, and the two daily papers, as well as local television stations, covered Radia's entrance into the retail world.

So far, about 15 people per week take advantage of Radia's new location. Within five years, Brown hopes that number will climb to 40 patients per day. A marketing campaign is planned for prior to Mother's Day, and Brown is also focusing on employee education as a way to increase business. "Often, customers ask fitters from Intimate Apparel as they fit a bra about lumps that could be causing physical discomfort," says Brown. "They question what should they say or do for these customers. Radia held a speaking event in February to begin to educate Bon fitters. Providing the type of information to share with their customers in a script format will also be an important step at this event."

Convenience, with a touch of style

Another element that Brown thinks will help bring patients in — and ensure they come back — is how the patients are treated. Convenience is key. Not only can patients phone in to make appointments, but they can make one while they shop. Once at their appointment, they wait in a tastefully decorated suite. After registration and answering demographic and insurance billing

questions, the patients can either stay in the waiting room or shop. If she chooses to shop, she is given a pager that will tell her when to return for her exam.

The technologist ushers the patient to dressing booths where she can change into "a salon-quality, color-coordinated" cloth smock — no paper gowns here. A VCR plays breast self-examination tapes while she waits.

Other amenities provided include a Bon Marche gift and free cosmetic and perfume samples. Again emphasizing speed and convenience, the breast films are delivered by courier to Providence Hospital the same day, where two radiologists review them. The reports are sent to the patient's physician after they are screened. The patient is notified by mail or telephone of the results.

While Radia will bill all insurance carriers, Brown says the practice is looking at ways women who don't have insurance coverage can charge the $103 cost of the exam to their Bon Marche charge account.

Brown says persistence has brought this dream to fruition. "We have a relatively new brand," she says of the 35-physician practice, the product of a 1997 merger between Puget Sound Radiology and Radiology Associates. "This little clinic has taken our brand much further than it would have otherwise been because of the wonderful press coverage we have had. Even if the clinic doesn't go anywhere, it will have taken us to places we wouldn't have otherwise gone without it. People know what Radia Medical Imaging is now because of the coverage."

Is this something other practices can mimic? Absolutely, says Brown. Among the types of practices that could consider retail partners are dermatologists, who might like to link up with salons or day spas. Orthopedic practices could partner with health clubs. And podiatrists might consider locating near a shoe store.

"People are so busy these days they need to begin bundling tasks. The thought is: 'If I can get everything at virtually one place I will have more free time.' We felt women needed and wanted to combine their health care needs where they shop." ■

SOURCE

Vicki Brown, Marketing Manager, Radia Medical Imaging, Everett, WA. Telephone: (425) 297-6247.

Marketing

What do dentists know that you don't?

Pleasing patients, community grows business

If you found a way to double your practice in less than five years, you'd jump on that bandwagon. If you could make sure that the new patients you brought in were profitable, even better. What's the secret? Most physician practices don't know the answer, but if you talk to the most successful dentist in your market, you might get some ideas.

When *Practice Marketing & Management* asked marketing and management gurus for advice practices should take in 1999 **(see *PMM*, January 1999, p. 1)**, one of the most common responses we got was to improve customer service. **Peter Boland**, PhD, a consultant with Boland Healthcare in Berkeley, CA, told *PMM* that one place to look for guidance on how to do that is dentists. We took him up on the challenge.

Don DiGiulian, DDS, is a partner in Branford (CT) Dental Care, a three-dentist practice in a town of about 30,000. In the last five years, by actively marketing his practice and ensuring that patients get the best in customer service, he has grown from seeing patients 36 hours a week himself, to filling 72 hours a week with the three dentists. "We are open every Saturday now, and Friday afternoons," says DiGiulian. "And we do

KEY POINTS

Fewer than half of most dental patients have insurance coverage. That means dentists have to be very proactive in providing exemplary customer service, and they can t be afraid to market. These practices can provide object lessons to physician groups.

Most good dental practices make going to the dentist as convenient as possible. They try to see a patient within 24 hours of a request for an appointment; they open extended hours; they offer payment options.

By taking good care of your patients and your wider community you can increase good will, increase patient-based referrals, and bypass the dictums of insurance companies by making patients your advocate with their employers.

that — and can do that — because we are aware of the market and what people want in this day and age."

DiGiulian has long been interested in marketing and believes he has been "ahead of the curve" in that area. The New England dental market is tough, he says. In his area, the population has been stagnant. The small number of patients moving into the area are offset by the number moving out. "That means you have to be competitive." The best way to do that is to make sure people know your name, he says. "Even if they don't come to you, when someone asks if you know of a good dentist, your name should be first on their lips."

DiGiulian makes sure he and his partners are active in the community. Along with membership in the local Chamber of Commerce and service clubs, he encourages his partners to take on other volunteer roles, like coaching Little League or soccer teams or working with community groups to clean up local lakes and streams.

He has also made his practice available to day care and elementary schools as a field trip destination, and he conducts programs on dental health in these schools. The practice is available to the schools, day or night, for any emergency.

DiGiulian puts out a patient newsletter four times a year, which he also sends to other dentists in town. "It's a way to show them what they should be doing," he says. "And it's a bit like casting bread upon the waters." There is no harm, he adds, in making sure other dentists know his name as a referral source. He also does mass mailings to the whole town about his practice.

By making himself and his partners visible in the community, DiGiulian says the community will know and trust him enough to come into his practice, or at least recommend it to others.

Once in the practice, good customer service and quality care keeps them there. Along with improving access to the practice, Branford Dental Care has increased convenience by offering a wide choice of payment options. Patients can use credit cards, or a "lay-away" plan that lets them pay ahead. They are given discounts for paying cash up front.

DiGiulian also makes it a practice to give patients what they want. Previously, patients who requested a cleaning were required to have an exam first. Now, they are given just what they ask for, but are counseled during the appointment on what, if any, other care is needed for good dental health. The practice believes strongly in patient education — not just because it's the right thing to do, but because DiGiulian believes that it is a smart marketing move. "The more informed and educated they are the more and better dentistry they will want."

Certainly, DiGiulian's efforts have been fruitful. He gets 50 to 70 new patients a month, a much higher than average rate for the area, he says.

Profiting from growth

Growth for its own sake isn't enough. Certainly in medicine, declining reimbursement has meant that seeing more patients doesn't necessarily mean making more money. **Steve Rempas**, DDS, has a five-dentist practice, Webster Dental Care, in Chicago. When he started building a new office last year, he wanted to make sure that his business included people who would spend money.

When he made the move last year, about a quarter of the patient base was capitated. The goal after the move was to eliminate all capitated patients. Currently, just 15% of the patient base is capitated. "Insurance companies increase fees for patients, promising that good practices will get a share. But we haven't seen a cost-of-living increase or any bonuses. And we are an exemplary practice," says Rempas.

Rempas has focused his efforts on creating a state-of-the-art practice. "If you have heard about or read about a new piece of dental equipment, practice, or procedure in the last 10 years, we have it," he says. "We are 100% computerized, our X-rays are digitalized, the charts are in the computer. We are at the forefront of modern dentistry."

He promotes that to his 7,000 patients and the community at large, and over the last five months, business has doubled every month.

Both Rempas and DiGiulian got many of their ideas from **John Christensen**, president of Chrisad, a Larkspur, CA, consultancy that is regarded as one of the best customer service, market research, and marketing agencies for dental practices in the country.

Christensen, who is just starting to branch out into medical practices, says practices seem to be accepting whatever the insurance companies foist on them because they can't see another way to grow their practices.

"You need to take a different approach," he

Here's a Top 10 list that can boost your profits

Painless lessons from dentists

While some would argue that the lack of managed care in the dental profession makes their situation different, the best dental practices still have plenty of marketing and customer service ideas that any good physician practice can emulate**.** Here are 10.

• **Have a party for your patients.**

Don DiGiulian, DDS, of Branford (CT) Dental Care, hosts a night at the local minor league baseball team. Patients sign up for tickets and he purchases them. For the $200 or $300 cost, DiGiulian says he buys a lot of good will. "They see you with your kids and your family in your Bermuda shorts. Suddenly, you are more of a real person to them."

• **Be on time.**

Physician practices probably hear this mantra all the time, but DiGiulian says if you are continually late, all you are telling your patient is that you don't value their time. **Steve Rempas**, DDS, of Webster Dental Care in Chicago, makes it a point never to keep patients waiting more than 20 minutes — and then only if it's an emergency. "You have to watch where you double-book," Rempas says.

• **Don't leave patients alone.**

Patients going to the dentist or doctor are often nervous. If at all possible, don't leave them sitting for long periods of time alone.

• **Know your patients.**

Rempas makes sure every file contains a picture of the patient. That way, when someone comes in for an appointment, the reception staff can greet him or her by name. **John Christensen**, president of the dental consultancy Chrisad in Larkspur, CA, recommends that you keep information on your patients — such as their children's names and ages, and anything you know about their hobbies or interests — in their file so that your support staff can ask them a question that demonstrates you know who they are.

• **Make your waiting area inviting.**

Make sure you have a good collection of magazines and coffee-table books, says Rempas. Invest in a television and VCR and put patient education videos on TV. Even if you don't generally treat children, your patients may have kids, so have a well-stocked children's area, too.

• **Offer consistent information.**

Rempas says all the major questions patients and prospective patients have should be answered the same way. He has written a book of scripts, from which any receptionist or support staff member can read. "That way, all the same information is given for all common discussions."

• **Teach your staff about your practice.**

Rempas also uses his support staff as marketers. They are all taught about one or two procedures so they can discuss them intelligently. "We do a sell job that is subtle, but effective," Rempas says. "It reinforces our practice and our modern equipment."

• **Check up on patients.**

DiGiulian makes it a point to call patients the evening after they have had a difficult procedure. Doctors should do the same.

• **Give free treatment where appropriate.**

This can be formal, such as donating services to a battered women's shelter, says DiGiulian, or something more informal. For instance, recently a man came in with a toothache. He needed a root canal. "I did the procedure, but then built up the tooth for him and gave him a tooth-colored filling for no charge. That will bring in more patients. And when he's ready for a cap, you can bet he'll come back to us."

• **Take time with patients.**

Christensen says many physicians believe that if they spend more time with patients, they will make less money. But the opposite is true. "If you take the time to treat patients as individuals, you will make more money. They will refer you to others. They will come to you for treatment that is not covered by their insurance. If you make the time, you will make more money." ■

says. "You need to go out to the market and find out what they want. That's what we do with dentists. That way, you can make patients and their employers see the difference in the quality of care and circumvent that whole insurance dictatorship process."

If you are perceived as being superior in your market, adds Christensen, then patients will

SOURCES

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bypass the insurance and pay out of their pocket, or ask employers for insurance coverage that pays for their chosen practice.

Key to Christensen's philosophy, however, is knowing what the market wants. "You have to do the research and configure your practice to deliver that. Then you market to gain the largest numbers of the highest-income and best-insured patients. As soon as medical practices understand this, they will take control of their destiny."

Rempas says he truly believes that what he has learned — from 23 years of experience and from Christensen — can apply to physician practices. "We have a lot of doctors as patients. They all send their friends because they never have to wait. We just aren't late. I tell them all the time that I wish it was the same when I went to the doctor. And it can be." ■

Practice management

Concocting a recipe for practice success

New MGMA survey looks at the best of the best

There always have been hints in the Medical Group Management Association (MGMA) surveys of how the best practices operate. But now MGMA has taken the information from its annual *Cost Survey*, asked some of the better performers more specific questions, and come up with a survey that closely analyzes the strategies of superior practices.

The new *Performances and Practices of Successful Medical Groups* survey includes in-depth information on profitability and operating costs; production, capacity, and staffing; and accounts receivable and collections. It also includes profiles of 19 practices to paint a clearer picture for readers of just what it takes to become a better performer.

Among the findings of the survey:

The best groups use formal strategic planning, rigorous financial management, and customer-focused innovations.

Superior practices have open communication, a high level of physician job satisfaction, and trust between administrators and physicians.

Physicians at better practices have a good grasp of their finances, competitive positions, and performance goals.

Better-performing practices work harder, doing about a quarter more procedures than all multispecialty groups in general.

Compensation for physicians is based at least partly on productivity **(for more on productivity-based pay, see related story, p. 37)**.

The best practices are willing to invest heavily in information systems and quality management programs.

Most of the better performers have at least basic clinical laboratory and radiology services. Others have more extensive ancillary services, including pharmacy, outpatient surgery centers, physical therapy, and cardiac stress testing.

Physicians at better practices have a good grasp of their finances, competitive positions, and performance goals — without having to dig them out of files.

Customers — patients, insurers, employers, and group physicians — are all paramount to the superior practices.

7 key steps

The survey points out seven steps to better performance that all practices can adopt. They are:

1. **Detailed cost accounting.**

This helps the practice figure out how much a particular procedure or treatment costs them. Practices that do this can prepare reports outlining revenue and costs according to treatment categories. Cost accounting also helps managers determine what expenses actually relate to activities that generate revenue.

2. **Transaction costing.**
Also called activity-based costing, this allows practices to allocate expenses to each function. Most frequently, these systems are based on relative value units. The information generated by transaction costing can help a practice in contracting by showing to payers in black and white what a particular treatment costs.

3. **Zero-based budgeting.**
In zero-based budgeting, each manager justifies his or her proposed activities and expense budget as if they were being performed for the first time, without reference to any previous year. It is an attempt to minimize slack that may result through incremental budgeting that simply adds a uniform inflation factor to last year's numbers.

4. **Physician incentives.**
Physicians are rewarded for efficiency and cost control while still maintaining high-quality care.

5. **Effective managed care contracting.**
Key to this step is understanding all aspects of managed care — from discounted fee for service to capitation. Better performers often have contract review committees that look at contracts. They also understand their cost structures enough to negotiate favorable reimbursement rates and make shrewd contracting decisions.

6. **Effective coding.**
Superior groups will emphasize coding procedure training and explicit coding processes. Improper coding can result in lost revenue. The better performers regularly review their systems, and many opt to have that review conducted by an outside firm.

7. **Improved service delivery.**
By optimizing each provider's particular style — for example, varying schedules according to need and practice patterns — better performers provide more efficient care. The better performers also believe in quality management and improvement, and are willing to invest in support staff as a way to make their practices run smoothly.

[Editor's note: The Performance and Practices of Successful Medical Groups *survey is available from the MGMA for $225 for members, $275 for affiliates, and $350 for non-members. For more information, contact the MGMA at (888) 608-5602.]* ■

Numbers help a practice measure up to its potential

Clinical, operational benchmarking prove worth

As part of the billion-dollar integrated health delivery system Clarian Health Partners, Methodist Medical Group (MMG) of Indianapolis has to make a case for every dollar the 100-physician practice spends. "We are a deficit for our system," explains **Kyle Allen**, RPh, MBA, chief operating officer at the practice. "Primary care groups usually are. That means that we have to prove to them that our costs are reasonable." A benchmarking program seemed the natural way to make the case for continued financial support.

What Allen didn't anticipate was the kind of impact the program — which includes both clinical and operational benchmarking — would have on the practice. The group saved $3 million from the operational side of the program, and was able to improve preventive care through its clinical benchmarking.

Operational goals are largely based on data from the Medical Group Management Association (MGMA) of Englewood, CO. Allen says targets and variances from targets are reviewed monthly and a report is sent to the board. **(See story on what a report contains, p. 36.)** Annually, a more in-depth look helps Allen with budgeting. "We see where we are, where the MGMA says we should be, and the variance. We look at what is controllable and what is not."

Control what you can

Being pragmatic about what can be controlled has been key to the operational benchmarking program's success, Allen adds. "Our chief financial officer has a lot of experience, and with the management team discussed what measures were appropriate for us to focus on." For example, rent may show a big variance, but it isn't controllable. "But we can control physician compensation."

The program has been extremely successful. From its start in 1996, it has saved more than $3 million in operational expenses. Those savings came from several areas, including reducing benefits expenses, cutting transcription costs by half, and consolidating or closing 12 clinic sites. For example, one practice had four internists

working full-time in an office. But they were only seeing about 30 patients a day among them. "We asked ourselves: Why are they there? We closed the practice. And savings like that occur because we were looking. Every single practice is judged against data. So is every staff member we replace. We always ask: Do we have to replace that person?"

What should be included in management reports?

When **Kyle Allen,** RPh, MBA, wants to know how her practice compares to goals every month all she has to do is look at her monthly report. What does it include?

Allen, chief operating officer of integrated practices at Methodist Medical Group in Indianapolis, includes four main sections in her report.

• **Practice operations:** This includes targets and actuals for the following areas:

— **Capacity:** The percent of practices with non-traditional hours and percent with open panels, and gross and net revenue per physician.

— **Staffing salary:** Ratio: Figure as a percent of both gross and net revenue.

— **Physician salary ratio:** As above

— **Administrative expense ratio:** Includes figures for the month, the yearly budgeted total, and the year to date actual.

• **Overall financials:** Includes the actual, the budget, and the variance for net income for the month and the year to date.

• **Risk/covered lives:** Includes the monthly totals and year-to-date budgets and actuals for commercial and senior patients. Also includes sections on net premium yield, medical expenses for commercial patients, and variables, such as the number of inpatient days and cost per prescription.

• **Billing:** Includes the monthly and year-to-date totals for:

— gross days in accounts receivable;
— gross collection percentage;
— adjusted collection percentage;
— capitation payment percentage;
— collection goal;
— actual collections. ■

Allen says the best way to get your physicians and staff on board for the operational benchmarking — which she admits is a harder sell to those who aren't familiar with or interested in the business side of medicine — is to show them local examples where benchmarking has worked. "Find some place down the street," advises Allen. "That was our advantage. We told them, 'Call this doctor and ask them how it works.' And you should always focus on the long term. Tell them that you can't sustain this level of loss, and if you want a job in three years, this is how you have to get there."

Administrators and support staff, who have more and more work foisted on them, also may need convincing. It helps, says Allen, if you are large enough that a finance department does the reports for you. But even if you aren't, you can ease the burden by meeting and talking about your benchmarking needs regularly. "We don't just say, 'See you in a year when your budget is due.'"

There is help for practices, too, adds Allen. Along with the MGMA, the Group Practice Improvement Network based at Henry Ford Health System in Detroit has material that can show your practice what others are doing in a particular area. The network can be reached at (313) 874-4746.

Clinical program

The clinical benchmarking started when a staff-model HMO was absorbed into MMG in 1994, Allen says. "We wanted NCQA [the National Committee for Quality Assurance in Washington, DC] accreditation, and so we started the clinical benchmarking on the whole organization."

First, MMG did peer audits of patient charts, says Allen. What the practice found was that although some physicians used a preventive service sheet that noted what preventive care was given and when, some did not. Those who did use the sheet were more likely to ensure that women got timely mammograms and that children were appropriately immunized. "It is an intermediate outcomes measure," says Allen. "You improve preventive care, and it's just intuitive that that improves overall outcomes."

When Allen looked at HEDIS data as a clinical benchmark, she says she was surprised at how well MMG was doing. "On preventive care measures of the networks that participate with our HMO, we are best in 10 of the 15 measures.

That's significant."

The target was to reach 90% to 95% compliance in preventive care, she says. After three years, MMG continually meets or exceeds those targets. And because clinical benchmarking related to the health and well-being of patients, Allen says convincing the physicians to use the benchmarking program was easy. "They were actually excited about it."

The latest part of the clinical side of the program included the 1996 launch of seven different clinical guidelines — for adult asthma, depression, diabetes, COPD, early identification of pregnancy, hypertension, and tobacco use. The MMG team that developed the pathways used national standards as a template. The goals, Allen says, were to minimize variance in patient care, improve quality of care, and find places where performance could be improved.

Interim results have shown that the guidelines have made care more consistent. More physicians are using the pathways — for instance, they are more likely to document tobacco status of patients, and if they are users, to advise them on the health consequences and help them to quit.

The results are reviewed monthly, Allen says, although not every target is looked at every month. So far, the physician enthusiasm has continued.

There is always resistance to adding work, says Allen. "But if you have a vision to sell them on how this will make their practice better over the long run, that some work will be eliminated, then you can do it. For instance, if they use the preventive care sheet, then they don't have to thumb through every page of a chart to see what's needed." ■

SOURCE

Kyle Allen, RPh, MBA, chief operating officer, integrated practices, Methodist Medical Group, Indianapolis. Telephone: (317) 929-2411.

Is productivity-based pay a sore point?

How one practice took the pain out of change

Frederick (MD) Medical & Pulmonary Associates faced a typical situation. The practice of two physicians and two nurse practitioners was expanding, says administrator **Christy Carton**. The two owners were taking on a new partner, as well as an associate. It presented the ideal opportunity for changing the compensation system to something that rewarded the physicians fairly for their efforts.

But finding a way to do that might be tricky — after all, some have said that the best a practice can hope for is to be equally unfair in divvying up pay and profits. "We were hoping to find a way to allow the physicians to both share in the benefits of the practice as it was, but also to grow and move forward," says Carton.

What they ended up with was a blueprint for the future growth of the practice that rewarded physicians for doing the work that they felt met the goals of the practice as a whole. Different kinds of encounters were weighted according to how they moved the practice forward. Carton says the process was virtually pain-free, since the blueprint came from the physicians themselves.

As an added bonus, the physicians are paying more attention to the business side of the practice, Carton says. "They measure themselves, not against each other, but against their own goals. And that is a good thing."

Prior to the change, Carton says the physicians simply divided up any leftover money at the end of the year. But with new physicians coming in, there was a concern over how fair that would be. And when they talked about how to divide the money, there were some disagreements — whether nursing home work, which involved more travel, should be compensated more than hospital visits, and whether the criteria should be patient encounters or revenue generation.

Objectivity needed

After talking with other physician groups and a few consultants to get their ideas, Carton brought in Virginia Health Care Consultants (VHCC) to facilitate the discussions. She says most administrators are too close to the physicians and the practice to be objective.

John Hayford, vice president of the Fairfax-based consultancy, started by getting the physicians to talk about their goals — both personal

IDT System Distribution

	Receipts	Office Hours	Hospital Encounters	Nursing Home Encounters	This Quarter Total Distribution
VALUE	25%	30%	15%	30%	100%
AMOUNT TO DISTRIBUTE	$10,000	$12,000	$6,000	$12,000	$40,000
Dr. A	3,314	2,512	1,863	2,779	10,468
Dr. B	2,230	2,332	1,701	7,074	13,337
Dr. C	2,512	3,349	1,458	1,516	8,835
Dr. D	1,944	3,807	978	632	7,361

Productivity Data Entry — Quarter 1

	Receipts	Office Hours	Hospital Encounters	Nursing Home Encounters
JANUARY				
Dr. A	42,316	42	266	14
Dr. B	28,333	38	240	36
Dr. C	30,376	57	201	7
Dr. D	25,289	63	142	3
Total	126,314	200	849	60
FEBRUARY				
Dr. A	40,555	43	255	16
Dr. B	29,212	40	236	42
Dr. C	33,787	55	208	9
Dr. D	24,3000	61	135	5
Total	127,754	199	834	72
MARCH				
Dr. A	43,808	41	260	14
Dr. B	27,620	39	237	34
Dr. C	31,799	56	202	8
Dr. D	24,652	67	133	2
Total	127,879	203	832	58

Source: Frederick (MD) Medical and Pulmonary Associates.

and practice. “The pressures of managed care have made practices realize they have to be fair and efficient,” he says. “They have to grow the practice, and be rewarded for productivity that achieves that goal. They are dependent on each other for survival, yet they compete against each other.”

For a total of six hours, Hayford worked with the physicians to determine how they saw the practice progressing. Did they want more hospital work, or less? Is there a physician who wants to slow down as he or she approaches retirement? What areas of the practice will attract new business? “Just getting them involved means they are more likely to buy into the final product,” says Hayford.

Once they come up with an idea of what they want to reward, Hayford and his team take real historical data and plug in the numbers so that the physicians can see what the reality would be.

Then, a computer program is created and the administrator or office manager simply has to plug in numbers.

Different practices will come up with different equations, says Hayford. For example, a four-physician practice budgets for a quarterly profit of $40,000. Physicians A, B, C, and D decide what aspects of their practice are important, and weight each one accordingly **(see tables, p. 38)**. They have decided that office hours are important to their future, so they weight that aspect at 30%, meaning at the end of each quarter, 30% of the money will be based on their share of office hours. Thus whoever has the most office hours in that quarter will be rewarded with the greatest share of that 30%.

The administrator or business manager need only enter the data in monthly for the physicians. All calculations are made automatically by the program, Hayford says.

Give it time

Hayford recommends that practices try any new compensation system for a year — or six months at the very least. "You have to have time to adjust your patterns of practice," he explains. "And there are seasonal fluctuations that will alter one quarter adversely, but not another." If after that time they want to make a change in weightings, it is a simple matter.

The cost for VHCC's program, which includes the facilitation, depends on the size of your practice. The base price is $2,000.

Carton says the program was well worth the money. "Sometimes, administrators are so close that we talk around things. Consultants are removed from the situation."

Whatever new compensation program you go with, she advises that you get all the stakeholders involved from the beginning. "Find out what is important for the personal and practice growth of you doctors," she says. "Listen, let them talk, and determine the goals of your practice." ■

SOURCES

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Physician perspective

Defining quality care means providing the 'right' care

By **Jean Edwards Holt**, MD, FACS
San Antonio

One of the goals in health care should be to change our patients' perception of "My doctor is good, he did everything for me" to "My doctor is good, he did the RIGHT thing for me." Inherent in this transition is defining what is right, in the present framework of cost containment. Hence come the words "value" and "quality."

I appreciate the Institute of Medicine's 1990 definition that quality consists of the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." To me, as a physician, the No. 1 concern with this definition is the concept of "desired" outcomes. According to many health care leaders, "desired outcomes" refers to outcomes desired by the patient. I sincerely question that an intelligent and informed patient, much less many we see without such a fund of knowledge, can judge appropriate health outcomes.

We should nevertheless strive for patient satisfaction, informed consent, and discussion of alternative treatment modalities. These are at the heart of "patient-centered care," an integral part of the doctor-patient relationship. However, patients, particularly older ones such as in my practice, often desire to be placed in the hospital unnecessarily; busy working adults desire "quick fixes," such as steroid injections instead of long-term physical therapy; parents desire antibiotics for a sick child even with no evidence of a bacterial infection. Are these desired outcomes quality medicine? What people want from health care may be an appropriate goal when considering customer-based business, but I still contend that a customer deciding on the shoes they want and the operation they want are not the same.

I propose instead that as the pendulum swings from pure cost containment as a stimulus for change to discussion of quality and value that this is the prime purview for the concerned, informed, and knowledgeable physician to step

up to the plate and lead the charge in the discussion of what quality is and how it should be managed. This is not only desirable but essential.

For physicians, a difficult concept in this definition is the dichotomy of quality for the individual and the population concurrently. We have been trained with the individual patient as our focus. Payment by capitation is one way to urge us to better adapt to this dual concept. Six or seven years ago, when I first learned of this payment modality, it appeared inherently evil; withholding care seemed to be the only outcome. If we truly accept that improving the health of our society is our goal — not cost containment or utilization management — then payment to keep a population healthy is not inappropriate. The whole concept of capitation has been negatively affected by its association with the perceived evils of managed care. The capitation rate must, however, be distributed fairly and not just be what is left over after administrative and shareholder profits are sucked out of the health care dollar.

When we continue a discussion of quality for any length of time, we arrive at the need for complex and sophisticated information systems to gather data to transform that into information, which can help us gain knowledge about our practices and move toward righting what is wrong. Presently, when nonclinicians are entering clinical data, it often is flawed — the foundation of the process is incorrect, therefore the conclusions meaningless. However, we should continue to support advances in quality monitoring, even in light of inadequacies.

This convoluted web of achieving the right care at the right time by the right person in the right place with the data of what is right imposed onto a less-than-adequate infrastructure is quite frustrating to all of us. Just as I take pause that the present "administrative checkoff lists" imply real quality — patient satisfaction, nice receptionist, short waiting time, close to home, etc. — I also realize that our professional credentialing, board certification, hospital privileges likewise do not adequately address quality. Most physicians know colleagues meeting all our professional requirements that we would not consult for ourselves or our families. And yet, odds are they have a full waiting room. To redefine quality, therefore, we must be willing to focus on evidence-based medicine, foster outcomes measurement, and renew cooperative efforts with our colleagues, hospital administrators, managed care company executives, and our patients. ■

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