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Federal officials coming down hard on messenger-model violators

Taking the right precautions can save you trouble

In late February, the Federal Trade Commission (FTC) in Washington, DC, announced the settlement of charges against a Mesa County, CO-based independent practice association (IPA). Although terms of the settlement were not disclosed, it marked the latest in a string of such settlements against groups of physicians the FTC alleges were fixing prices and preventing competition.

The original complaint, filed in May 1998 against the Mesa County Physicians Independent Practice Association, alleged that its 180 physicians — constituting at least 85% of physicians in the area — fixed terms on which they would deal with health plans and collectively refused to deal with others. That led to higher prices and hindered the development of alternative health care financing and delivery systems in Mesa County, the FTC alleges.

According to **Reed Tinsley**, CPA, an accountant with Horne CPA Group in Houston, physicians who are in messenger-model IPAs need to be extremely careful about how they communicate with each other. "The federal government doesn't like doctors grouping together in a shell in order to jack up health care costs," he says. "If a group of physicians gets angry and tries to deal with managed care as a group, the government will preclude you from collectively discussing contract issues. That means you have to disseminate information to each physician individually."

There are many such cases — settled and pending — in which the "messenger" of the model tells payers that failure to adhere to his physicians' terms will result in all physicians terminating their agreement with the payer. "That means they could damage the payer significantly," says Tinsley. "Through market power and size, the IPA can get what it wants."

While that may seem to be the purpose of banding together in an IPA, the government doesn't like it, Tinsley continues. The upshot is that physicians in messenger-model IPAs can't discuss pricing jointly. They can't collude to terminate or damage a provider network. They can't have a meeting and vote to terminate a contract, and they can't correspond

together or post messages that all members can read on an electronic bulletin board that espouse ideas like, "We won't accept this contract unless we get X amount." **(See related story, p. 44.)**

Each person has to make a decision individually, he adds. "The reality is, if you have a messenger you trust, you know that if he or she brings you a contract, you can assume it's good without colluding with the other providers."

What's legal, and what's not?

The government itself has an abundance of information available to practices that can help them determine if they are acting within the law. On the FTC Web site, www.ftc.gov/bc/health.htm, one section — Statements of Antitrust Enforcement Policy in Health Care — includes information on how messenger-model IPAs can be organized and operated.

Those acting within the law, the FTC says, are arranged simply to facilitate contracting and minimize costs associated with it. The messenger in the model is used only to convey information to payers obtained individually from providers. The key, says the FTC, is "whether the arrangement creates or facilitates an agreement among competitors on prices or price-related terms."

In looking at messenger-model IPAs — and Tinsley says the FTC will look at virtually all such agreements — the commission will determine whether the messenger facilitates collective decision making by network providers, rather than independent unilateral decisions. Specifically, it will look at whether the agent:

- coordinates the providers' responses to a particular proposal;
- disseminates to network providers the views or intentions of other network providers as to the proposal;
- expresses an opinion on the terms offered;
- collectively negotiates for the providers;
- decides whether to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms.

If the agent engages in such activities, the arrangement may amount to an illegal price-fixing agreement.

Tinsley, who is working on a booklet for the American Medical Association that includes information on messenger-model IPAs, says all the antitrust activity and scrutiny by the FTC shouldn't discourage physicians from forming such groups. Along with the cost benefits that can accrue to members, he says, payers prefer working with groups rather than individuals. And there shouldn't be any reason to fear the FTC looking at your IPA as long as there are firewalls created to separate each participating practice, and each participating practice makes contracting decisions on its own.

Tinsley offers the following advice:

- engage a messenger independent of the IPA and its members;
- require the messenger to meet with each IPA physician individually to discuss concerns about current contracting relationships and to determine what each doctor desires from its current and future contracting relationships;
- require that all discussions concerning prices occur individually with each practice and the messenger.

Once the messenger has concluded discussions with the payer, he or she presents the contract to each participating practice individually. Each then accepts or rejects the contract. If the practice rejects the contract, it is free to contact and work with the payer on its own to develop or maintain a contractual relationship. The messenger also usually informs the payer who rejected the agreement and lets the payer know it, too, can contact each of the practices individually to develop an individual contractual association. ■

SOURCE

Reed Tinsley, CPA, Horne CPA Group, Houston. Telephone: (713) 975-1000.

COMING IN FUTURE MONTHS

- Tips to reduce your rate of claims denials
- Want to work with happier physicians? Help them deal with job-related stress
- Marketing health care to men may be an idea whose time has come
- How a practice case manager can increase efficiency, improve patient care
- How effective are your outcomes and patient satisfaction measurements?

10 reasons your practice needs a Web site

Can millions of Web-surfers be wrong?

While those who travel on the information superhighway are quick to tell you it isn't paved with gold, there are still some great reasons for your practice to consider launching a Web site. We talked to two practices with sites to ask them why your practice should follow their lead. Here's what they said:

1. **Web access is growing exponentially.** The number of people with access to the Internet continues to grow, says **Neil Baum**, MD, a urologist in practice in New Orleans who launched his site last year. "This is a way to let your patients and prospective patients know that you are current, up-to-date, and on the cutting edge."

2. **It doesn't have to cost a lot.** Baum started his site (www.neilbaum.com) for about $3,000. **Eric Swift**, program supervisor at the four-physician Spine Center in San Francisco (www.spinenet.com), paid about the same amount when his site launched in 1994. He currently spends about $10,000 per year to maintain the site and is planning a major revamp that will cost more. But Swift says you don't have to spend a fortune to get the benefits.

3. **It really does bring traffic to your door.** Swift says that in the first year, about 5% of the patient base at the Spine Center could be traced to the Web site. The next few years, it reached 10%, and in 1998, half the surgical business at the center came through the Web. "I can trace about $20 million per year through Internet clients."

4. **It helps you communicate with patients and prospective patients.** Baum uses his site as a way of helping patients and prospective patients gain access to information about issues they want to discuss with him or procedures they may be considering. For instance, if a patient calls with questions about infertility, the receptionist can make an appointment and then point the patient to the Web site for information on the subject.

5. **Plenty of information exists on how to create a Web site.** Baum used the American Medical Association and specialty organizations in doing his research for a Web site. Those organizations keep track of practices and physicians with Web sites. "I looked at those sites, found out who did the ones I liked, and went from there," Baum says.

6. **There are some great tangent marketing opportunities once you are on the Internet.** Swift's initial plan was to partner with America Online to take care of spine-related questions for the Internet service provider. "They didn't think we were big enough to handle what would happen." But now that the spine center is established, other such opportunities have presented themselves.

For instance, for an additional $1,250 per month, the center advertises with sidewalk.com, an entertainment-oriented Web site, as the only health care banner ad on its home page. Since that banner ad appeared, traffic on the site has increased by more than 50% in four months.

7. **Specialists can reach a national market.** When the Spine Center started, it focused on rehabilitation, says Swift. "But as the practice grew, we saw our specialty as dealing with failed surgeries, and we knew we had to reach out to a national market. The Web gives us that market potential."

8. **It can be a timesaver for physicians.** By directing patients to Web information or articles he has written, Baum is able to spend more time talking to patients about their care, rather than explaining the basics of a particular problem. The Spine Center, too, sees the Web site as a timesaver. With 5,000 hits per month, Swift spends part of each day keeping on top of the e-mail that comes in.

"I download it twice a day, go through the questions, sort them, and decide who needs a physician answer, who needs a therapist answer, and what is garbage," he says. Most of the questions end up being forwarded to the medical director, who spends his own time in the evening answering the questions. "That helps to differentiate us from other sites," Swift explains. "You go right to the man with us. And that means that in two hours, he might be 'seeing' 25 new patients that he otherwise might not have time for."

9. **Web sites are cheaper than advertising.** Swift says the cost of creating a simple Web site and maintaining it is much lower than the cost of other advertising. If you already advertise but don't have a Web site, you may want to investigate switching.

10. **It's great PR.** Even if you end up not seeing a patient because he or she was screened out, the effort your practice has made will be appreciated. For instance, Swift says one patient who wrote for information from the center ended up sending the doctors his films for review. The physicians pointed out something other doctors had missed. The patient was able to get more tests; his case was reopened by his insurance company, and he was retrained for another job. "He wrote a letter thanking us. You just can't get enough good PR like that. People like that sing our praises."

Keeping up

Swift says most practices could benefit from a Web site. "It tells people what you do, and it gives patients more information about their conditions." But if you do embark on this path, Swift says you should be prepared for the work that having a Web site entails. You don't have to have an e-mail form that lets people send you messages, but if you do include one, keep up with those messages and pay attention to what they say.

If a large number of questions are about particular issues, you may want to include links to other sites that provide more information or add a page about that topic to your own site, says Swift. You also can include answers in a frequently asked questions page.

(Editor's note: ***For two additional examples of how a World Wide Web site can be used, see stories at right and on p. 51.)*** ■

SOURCES

Neil Baum, MD, Private Practice of Urology, New Orleans. Telephone: (504) 891-8454.
Eric Swift, Program Supervisor, Spine Center, San Francisco. Telephone: (415) 353-6464.

Contract cancellation posted on Web site

Listing reasons on the Internet draws fire

When Sarasota (FL) Memorial Hospital's physician hospital organization (PHO) decided to end its contract with United Healthcare of Florida, it informed its 440 physician members of the decision through its Web site.

The PHO set up the Web site about a year ago as a way of communicating with its members. The site includes a directory of members, fee schedule information, a list of benefits for self-insured groups, links to other sites, and announcements that are of interest to PHO members.

"We put the information on the Web to inform our 440 physicians who are members of our PHO. We wanted to make sure our PHO members knew we had terminated United, and we wanted them to know why. We weren't trying to reach anyone outside the PHO and were surprised when we found that we had created a stir," explains **Gary Hickerson**, director of operations for the PHO.

That stir included a letter from the insurance carrier's corporate legal department asking the PHO to remove the reasons for termination from its Web site. The site now includes only an announcement that the contract has been terminated.

Among the reasons the PHO cited for ending its contract were what is considered a United practice of downcoding, denying claims for services rendered, losing claims and then denying resubmitted claims for failure to file in a timely manner, and improper payment of claims.

"The hospital had a contract for HMO patients, but they were also sending us PPO patients and paying us at HMO rates," Hickerson says.

Other complaints from PHO members included allegations of United's failure to pay pediatricians properly for immunizations and carving podiatry out of the network in violation of the PHO agreement. ■

Bringing mental health care into your PCP

It's not such a crazy idea!

Although much has been made in the news of the lack of mental health care in many managed care insurance plans, the trend toward integrating and providing a continuum of care is leading many primary care practices to bring behavioral health inside their walls.

One such example is Methodist Medical Group (MMG), a 100-physician practice in Indianapolis. **Nicola Scott**, RN, MHA, director of behavioral health network services at MMG, says the idea to put behavioral health specialists into primary practice locations came from one of her providers. "We already had our own separate behavioral health practice in our own location," she explains. "This was just a way to bring the services to the primary care practice."

Initially, one of the three psychologists met with the primary care practices in six locations and told them he and his colleagues could offer the service a half day per week in their practices. "It was a way to reach patients who otherwise either wouldn't seek the care or who were in crisis and really needed the care."

Growing popularity

A year later, the program has expanded to include all of the psychologists, some of whom work a full day per week in practices. The program is so popular that one of the pediatric groups encouraged MMG to hire a child psychologist who spends a half-day a week in the practice. "There is a real interest in this program," says Scott.

Along with providing 30-minute consultations for patients, the program has an added benefit: Psychologists and the clinical social worker are available to physicians for consultation on problems their patients may have. And even though the time they spend at each practice is limited, Scott says the psychologists always are available for emergencies, and they will work outside their normal time frame in such cases. "We really can't meet all the demand right now," she says. "That means the program will have to grow."

The behavioral specialists still carry their own caseloads, and the consultations are billed through the behavioral health department office, not through the primary care provider. "That makes us financially accountable, which is another thing the physicians like," says Scott.

Aside from letting the practice physicians know their schedule, there is little marketing done for the program. "We put signs in the lobbies saying that doctor so-and-so will be here Thursday afternoon and that they can see the receptionist to schedule an appointment," says Scott.

Not having aggressive marketing makes sense, she says, especially because most patients are reluctant to let others know they are seeing someone for a mental or behavioral health problem. By having this low-key approach, the stigma of seeking care is reduced.

"This is a great chance to do something good for your patients and also provide consultation opportunities for your physicians."

That won't work for every practice, Scott admits. "You have to have the demand there for it to work. And you have to look at your payer mix and make sure that this is financially a good idea. We often see patients without insurance or whose insurance won't cover this and end up seeing them for free. But it is good for your patients."

You also need space to house a counselor or psychologist a half day or full day every week, she adds.

If you think there is some demand but not a lot, Scott says you can start out slowly. One of her psychologists began with a monthly stint for a half day and now has a full day once a week at the practice.

The situation also may be more complex for practices that don't have affiliated behavioral health specialists, she says. But most practices do have a psychologist or counselor to whom they refer patients, and those doctors are the place to start. "Approach them and see if there is an interest."

"This is a great chance to do something good for your patients and also provide consultation opportunities for your physicians," Scott says. "If you have a patient, and something is not right, you can bounce things off of the psychologist. There is an opportunity for coordination of care."

Scott also points to the increasing number of studies that show that the cost of medical care

SOURCE

Nicola Scott, RN, MHA, Director, Behavioral Health Network Services, Methodist Medical Group, Indianapolis. Telephone: (317) 865-6922.

goes down if behavioral health care needs are met. That means such a program can be a selling point to your payers. "This can keep people like substance abusers or potential suicides out of the emergency room and out of the hospital," she says.

Pediatric practices in particular might benefit from such a program, Scott adds. "The parents are either quick to want an attention deficit diagnosis or quick to discount such a diagnosis from a physician. This is a great help for physicians in those cases." ■

Management

Houston physicians form own insurance company

No gatekeeper, no preauthorization for care

Frustrated with the loss of control over patient care caused by managed care, Houston-area physicians formed Physicians Inc., a physician-owned integrated health care delivery system with its own insurance company.

"Our primary purpose was to provide the community with a solid alternative to the cookie-cutter approach to medical care and insurance plans," says **Paul Handel**, MD, outgoing president of the Harris County Medical Association and a founder and stockholder in Physicians Inc., the umbrella company for the health insurance firm and its network of physicians, hospitals, and ancillary service providers.

When insured patients need health care, all the decisions for their care are made by the physician and the patient. There is no gatekeeper, no requirement for referral authorization or preauthorization of care, and no retroactive denial of coverage.

The physician-owned insurance company doesn't have a medical director. Instead, more than 150 volunteer physicians serve on the medical management team, reviewing admissions, diagnostic studies, and treatment plans to make sure each patient gets the best possible treatment.

Components of the company, which is owned by more than 1,400 physician investors, are Medical Community Insurance Company (MCIC), which offers Physicians Health Plan, a fully insured group health plan to businesses; and Gulf Coast Independent Practice Association, a network of more than 4,500 physicians, most of whom are in independent practice or small groups. MCIC started marketing and insuring people on Jan. 1, 1998.

With a year of experience under its belt, the company is growing steadily, with more 3,000 insured lives and a network of 4,500 physicians, 70 or more hospitals, and more than 375 pharmacy locations, as well as other ancillary services. The company's long-term goal is to cover 15% to 20% of the Houston market.

"With a new company, it takes time to establish credibility. We spent a good deal of time in the first year getting ourselves known," says **Michael Manley**, president and chief executive officer.

Houston physicians have been eager to sign up with MCIC because of the company's philosophy of putting decisions for care back into the hands of the doctor, Manley says.

"MCIC is set up so that we do not second-guess the doctor. We feel the patient and the doctor together can make appropriate decisions as far as care is concerned," Handel adds. The staff and shareholders of the company say it is in the best interest of the patients, the physicians, and the company's bottom line to pay for the care the physicians feel the patients need, he says.

"Medical literature is replete with studies that show the appropriate intervention at an appropriate time is the least expensive method of treatment. You can't make money by withholding treatment," Handel says.

Physicians' reimbursement is based on the Medicare Resource-Based Relative Value Scale. The reimbursement schedule puts Houston physicians toward the low end of reimbursement for PPOs, but HMOs in the area typically reimburse physicians at lower rates, Manley says.

"We believe our reimbursement schedule is equitable. I don't think that physicians are going to get wealthy, but they will be able to maintain their practices, and that is critical," Handel says.

He points out that physicians may suffer heavy losses if they accept some managed care

(Continued on page 52)

Practice
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Targeted tests screen for 'job happiness'

A new preventive anti-stress technique?

If we could accurately predict whether a prospective employee will be happy in a specific job, we might avoid untold emotional and financial pain. According to one expert, we already have the tools to do just that.

"The more employees are matched up with the requirements of the job and vice-versa, the more healthy they will be," says **Robert Edenborough,** PhD. Edenborough is a managing consultant with ASE-Consulting Group, part of the occupational division of London-based test publisher NFER-NELSON.

He also is the author of *Using Psychometrics: A Practical Guide to Testing and Assessment*. Psychometrics means, quite simply, mental measurement. "Psychometrics seeks to understand aspects of mental functioning that have an impact on behavior and performance," he explains. "For example, attention to details might show up as accuracy in your work."

A good mental fit is critical to job satisfaction, Edenborough notes. "Employees tend to feel stressed if you ask them to do things they can't do," he says. "I personally have poor spatial ability. If I have work that requires me to find my way about or to assemble things, I find it very hard, which also makes me very impatient."

Exactly how does psychometrics measure mental job suitability? "In effect, by replicating part of the job, like solving a particular problem," says Edenborough. "In other cases, you look at people's fundamental aptitudes, approaches — their ways of looking at other people. If they are inclined to be sociable, they will tend to describe themselves to you as such, and that would be relevant for teamwork or working with the public."

A sample set of questions might begin with a basic statement such as, "I like handling figures." It might be posed as a true/false choice, or it might ask the respondent to agree or disagree on a scale of one to five. "This simple response would tell you pretty directly how comfortable the employee would be with anything from keeping petty cash to managing corporate accounts," he says. "It may seem naive on its own, but people do tend to tell the truth."

After that initial response, the testing can become more complex. "You can then ask, 'Which is most true of you?' and add any number of variables — visiting with people in the office, whether you like your workplace be neat and tidy, and so on," says Edenborough. "As you pair and re-pair the responses, you get a much better idea of the individual's mental aptitudes."

Investment can be modest

Instituting psychometric testing at your company does not have to be expensive, he says. "If you're talking about high-volume recruitment using one or two simple ability measures, it may only cost a few dollars per head. If you were conducting an assessment for the CEO of a Fortune 500 company, a consultant could charge up to $4,000."

Before choosing an individual or a company to conduct the testing, you should consult an industrial psychologist. "There are a number of companies that publish tests, and they also tend to give advice, training, or consulting services," Edenborough adds. "Be sure to also check references and formal affiliations."

SOURCE

- **Robert Edenborough**, ASE, Hanover House, 2-4 Sheet St., Windsor, Berkshire SL4 1BG, England. Telephone: 011 44 175 3850 333.

You also should consult with your legal department. "There have been some legal challenges in the U.S., mostly centered on the relevance of the content of the tests," he points out. "So be sure to check with legal in terms of the design of the test and the relevant norms groups. The acid test has always been, is the content defensible?"

The bottom line, he says, is that this type of testing can be well worth the time and expense. "With unhappy and inefficient employees — and these go hand in hand — you definitely have increased absence and increased staff turnover. After all, some people may take a job they know they won't enjoy just because they really need it. And traditional interviewing doesn't tend to catch that." (CIGNA Corporation has developed an interviewing method that falls somewhere between traditional interviewing and formal mental aptitude testing.) ■

In drug testing, you get what you pay for

Are you missing 70% of possible 'positives'?

There are several common errors employers make when implementing a "drug-free workplace program," not the least of which is looking to save money on their testing procedures.

That can be a big mistake, warns **Wes Caldwell,** vice president of CHG subsidiary Health Management Group Ltd. (HMGL), and Vanguard Consulting, a wholly owned HMGL subsidiary located in Signal Mountain, TN. (CHG provides substance abuse policy, education, testing, and liability insurance services; HMGL manages workplace drug abuse programs.) "Most employers go out and buy a drug test as cheaply as they can get it; they're more worried about convenience than anything else," he says. "But many of those tests miss up to 70% of the true positives."

In others words, Caldwell says, not all drug tests are created equal. So how does an employer know which tests to select? The finest testing available is a "0 tolerance" test. The term "0 tolerance" was trademarked by Nashville-based Aegis Laboratories.

"Aegis is the only laboratory certified 'forensic' by the Substance Abuse and Mental Health Services [SAMHSA]," Caldwell explains. SAMHSA is a unit of the federal Department of Health. "The same batch of urine that produces a 2% positive rate under standard testing will produce a 10% rate under 0 tolerance."

These kinds of tests are the most rigorous, and most expensive, available. The next level of sensitivity is represented by those tests approved by the College of American Pathologists Forensic Urine and Drug Testing. "There are only a few hundred of these," he says.

Employers should not use a drug test unless it is certified by one of these bodies, he insists. Costs vary. "Aegis testing is in the $50 to $70 range [per person]," he says. "Standard tests under SAMHSA may be in the $25 to $30 range." (For more details and studies on drug abuse in the workplace, visit the SAMHSA site on the World Wide Web at: www.samhsa.gov.)

Caldwell says it is well worth the investment. In fact, he asserts, "Wellness people need to look at substance abuse policies as the No. 1 health issue in the workplace."

That's not just because of the threat substance abuse poses to employee health, he says; an effective policy can mean huge dollar savings, depending on what state you're in. "In Georgia, for example, you get a 7.5% premium credit on workers' comp [if you have a drug-free workplace program], and in Ohio it's anywhere from 6% to 20%," he notes.

In all, 12 states have such incentive statutes, he says. "But this is just the 'chump change.' If your drug testing doesn't reduce your workers' comp claims by 50%, you're missing the boat. If you don't reduce your group health costs by 25%, you're missing the boat."

You also should see a quantum leap in productivity. Caldwell recalls the story of a Nashville company called PIZ, which began testing a couple of years ago. "At that time, they had roughly 100 employees," he says. "About a year ago, the director of marketing at Aegis notice the testing volume had dropped off, so he called PIZ to see what was going on."

Testing had dropped because the company now employed only 50 people, despite the fact that business was up by 10% to 20% a year. The

SOURCE

- **Wes Caldwell**, Vanguard Consulting, 2510 Dowler Circle, Signal Mountain, TN 37377. Telephone: (423) 842-8341.E-mail: VanguardatCDC.net.

reason for the work force reduction? Drug testing. "They can handle the same amount of business with half the people; they never realized what a drain on productivity the users were," Caldwell explains.

There are four keys to an effective workplace drug abuse program, he says:

- You must do drug testing.
- You must have a written policy statement.
- Employee education and training must be addressed.
- You need a strategy for dealing with employees who test positive.

That final point is critical. "Dismissal is not a strategy," he says. "Not when you're perhaps talking about 15% to 20% of the work force."

Caldwell isn't talking about a 30-day "miracle cure," either. "The employee has to undergo evaluation by a trained substance abuse counselor. Then, he must be monitored on a random basis for at least two years." In other words, he concludes, "There is no short-term answer."

Program helps workers harness brain power

Exercises can reduce frustration, job stress

There are any number of wellness programs that address fitness of body, mind, and spirit, but how many address the fitness of the brain itself?

That's exactly what **Paula Oleska,** MA, head of Natural Intelligence Systems Inc. in New York City, purports to do with her seminar on "Brain-Friendly Work Practices." Her program involves "a series of systems and techniques that help improve brain function by using different movement and touch techniques," she explains.

The seminar program takes about 16 hours, which can be scheduled as either two days, or one day and two subsequent half days a week apart. The latter structure is ideal, she points out. "The sessions aim to create certain habits that employees will develop with their brain function. Spacing them out will help solidify their learning and allow them to apply it to actual [work] situations," she explains.

The lectures help employees understand not only how their own brains function, but also how the brains of their co-workers function. This understanding, along with the exercises, can help employees perform better by boosting their memory and concentration and can lead to improved communication and morale among employees.

How it works

The first part of the seminar is a lecture and discussion that introduces a working model of brain — the right and left brain hemisphere functions, or the emotional brain and the behavioral brain. Each employee also determines his or her individual brain-dominance profile — dealing with hemisphere, eyes, ears, and hands — and how that profile manifests in daily life.

"This gives employees a much better understanding of how they process information; how they respond to given situations," Oleska explains. "For instance, individuals who have a preference for left-brain processing like structure, time, and focus. Right-brained employees prefer the big picture; they're good at coming up with creative solutions." These insights will not only help employees understand why they may be having difficult communicating with a colleague, but they also will give them a starting point for change in their own brain function.

In the next part of the program, the participants are taught exercises that create greater brain integration, so each employee can attain more access to his or her whole brain. **(Some of these exercises are described on p. 50.)**

In addition, employees are taught more generic stress-busting techniques. For example, there are "stress-release points" located on the bony protuberances above the eyes. Holding them lightly for two to 10 minutes, slightly tugging on the skin, "can reduce your stress reaction to particular a issue," says Oleska. "If you think about that stressful thing, you will experience a change of reaction."

Once the series has been completed, employees are encouraged to see Oleska for a follow-up, at which point they can address any specific challenges that remain.

These techniques "clearly help improve productivity," Oleska asserts. "They help boost morale and self-esteem. Most participants report

that they now have an easier time responding to stressful situations, and they have a much higher stress threshold. They're not thrown off balance as easily."

One employee who has reaped significant benefits from the seminar is **Eva Ochmanska,** MS, a programmer for human resources development at American Express in New York City. "There were some things about my job I found more difficult to do, like filling out expense vouchers," she recalls. "I had to do it as part of my job, but I'd wait as long as I could. I would charge the business expenses on my personal charge card, pay the bill myself, and then wait several months."

Naturally, this affected her emotionally as well as financially. "I felt bad about myself because there were things I had to do that I couldn't do, and I was stressed out because I had to pay the bills with my own money," she says.

She took Oleska's class and started doing some exercises on a daily basis. One in particular, which she started doing several times a day, involved a "cross/crawling" — using opposite hands and knees — which Oleska says will integrate both sides of the brain.

"They helped me in a lot of areas to do things I didn't want to do or like to do," she explains. About two weeks after she began the exercises, Ochmanska, an admitted "pack rat," cleaned her apartment thoroughly. "I felt I was outside of my body watching myself," she says. She also began sorting through her files at work, throwing out things she didn't need. "I began doing my vouchers about a month after I started the exercises, which was a year ago. The changes have been permanent; and I still do the exercises practically every day."

Her mental state, she says, is "much better." She can do things when she needs to do them. "And if I work a 10-hour day and I'm tired, I can take a break and do an exercise, and then I'm OK again." ■

SOURCES

- **Paula Oleska**, MA, Natural Intelligence Systems Inc., 275 Madison Ave., Suite 2218, New York, NY 10016. Telephone: (888) 200-9048. E-mail: paula.oleska@erols.com.
- **Eva Ochmanska**, American Express, 40 Wall St., 22nd Floor, New York, NY 10005. Telephone: (718) 728-1427.

Wellness program offers brain exercises

Simple movements said to boost performance

Most of us are either "right-brained" or "left-brained," which predisposes us to prefer (and excel at) different types of work-related tasks. Through specifically designed exercises, however, we can achieve better integration of the hemispheres in our brains, allowing us to perform more effectively. That, in turn, can boost self-esteem and morale on the job, according to Natural Intelligence Systems Inc. in New York City.

Natural Intelligence Systems offers staff a number of exercises designed to achieve that integration. For example, one basic exercise it encourages employees to perform at least once a day is called a "crossover movement." This exercise can be done sitting or standing: Simply touch one hand to the opposite knee. While it sounds quite simple, Natural Intelligence Systems says the exercise stimulates both hemispheres of the brain to work together and is designed to boost memory and concentration.

Doing the 'Lazy 8's'

Another exercise is designed to help eye coordination, which is important because many staff do a lot of computer work. Eyestrain can manifest not only as a headache or stiff neck, but as a lack of concentration.

The "Lazy 8's" exercise is done this way: Circle the eyes in the air with one hand at a time. Start with the thumb of one hand in front of the nose, and "draw" circles upward around the left eye, and then the right, all the time slowly following the thumb with the eyes. Next, change to the other hand. Finally, repeat using both hands simultaneously to engage the whole brain. This exercise should be repeated about five to 10 times, which will take a total of about one minute.

Natural Intelligence Systems reports that this exercise can counteract eyestrain and help improve reading speed and comprehension. ■

Physician-owned insurer uses high-tech approach

Internet, 'virtual business' are keys to success

To compete in a competitive market, Medical Community Insurance Company (MCIC) in Houston has developed key business strategies that distinguish it from most other managed care companies and give it the potential to grow rapidly without a large expenditure of capital.

Strategies include heavy use of the Internet, creating a virtual business model, creating alliances with experts in the field, allowing the company's staff to focus on customer relationships, and working with network physicians on health management.

The company is in the process of building one of the nation's first Internet-based health care companies. Its World Wide Web site, www.physiciansinc.com, includes a public section with general information about the company and its insurance product, and separate sections, some of which are password-protected, for physicians, members, employer customers, and insurance agents.

Unlimited quotes

For instance, general insurance agents can use an Internet application to get quotes on groups of two to 50 employees and to enroll them through the Internet. That allows the company to deal with an unlimited number of quotes, says **Christine Hollinder**, marketing director.

The physicians' area of the Web site has copies of physician service agreements and fee schedules, protocols for various diagnoses, applications to certify patient eligibility and advise of admission to the hospital, links to Physicians Inc. committees, and a bulletin board for physicians.Physicians Inc. is the physician-owned health care system in Houston that owns MCIC **(see story, p. 46)**.

MCIC has created strategic partnerships with other organizations that allow it to have access to skills and experience without the expense of hiring full-time staff. For instance, the company has a strategic partnership with The Texas Medical Association Insurance Trust, which is a licensed third-party administrator that offers customer service, claims administration, and billing.

Other services provided by strategic partners include physician education, risk management, marketing, actuarial, credentialing, legal, Internet, and utilization review.

"These strategic partnerships enable a new company to have years of experience from day one without the expense of developing its own procedures or making big upfront investments in systems," Hollinder says.

Are you big enough?

If the physicians in your area are interested in starting a similar organization, here are some suggestions from Physicians Inc.:

1. **Make sure your market is big enough to support your company.** For instance, the Houston market has a population of 5 million. Capturing just 10% of that market is big business, points out **Michael Manley**, president and chief executive officer. "You have to be in a market that gives you the possibility of growth. If your market is too small, you can't make it work," he says.

2. **Make sure you have the support of the physicians in your community.** This will help you develop a broad selection of physicians and hospitals, which is the key to making a managed care organization work, Manley says. "You need a delivery system that gives enough choice, but you also have to have physician leaders who will be involved." The plan has more than 150 physicians who volunteer their time on hospital review teams, governance, and committees to develop protocols.

3. **Develop a comprehensive marketing strategy to make sure all stakeholders in your market know about your company.** Marketing strategies include radio advertising, advertisements in a weekly business journal, direct mail, and special events for insurance agents. In addition, physician members of the network are encouraged to tell their friends and contacts with small businesses about the company. ■

(Continued from page 46)

contracts that put them in a position of treating patients at a rate lower than their costs. "We are trying to tell our doctors that they have to examine their contracts all the time and study the reimbursement rates. If they aren't adequate, they should reject the contract. You can't make up for low reimbursement with a high volume of patients. You're just losing more money on more patients."

As of the first of the year, the plan has had about 30 admissions with an average length of stay of 2.5 days. A volunteer medical management team made up of physicians who practice at each hospital reviews all admissions. If the panel finds a physician hasn't delivered appropriate treatment, the doctor and hospital still are paid, but the physician is counseled on how to render more appropriate treatment, Handel says.

The second time it happens, the doctor is warned in writing. If it happens a third time, the records of the three incidents are sent to an independent review organization. If it finds the treatment was inappropriate, the physician is out of the network, Handel says.

The physicians on the medical management team have developed best-practice treatments for some common chronic conditions such as hypertension, asthma, and diabetes. The guidelines, which are distributed to network members and available on the firm's Web site, offer a summary of the latest in medical breakthroughs. ■

Practice Management

Capacity analysis can offer managed care insights

How many MDs do you really need?

In the increasingly data-driven environment of managed care, one consultant's message fits right in: Success in managed care boils down to capacity. This analysis comes from **Theresa Raczak**, MBA, president of Lincolnshire, IL-based MedComp. Raczak says capacity analysis lets a practice see if it is employing the right number of physicians doing the right things at the right time, with the appropriate number of support staff.

Put another way, is your practice employing too many physicians — or too few — given your managed care patient base?

Raczak recommends practices measure physician productivity in several ways and compare the data with national benchmarks. Areas of measurement might include number of patient visits per physician or gross production, defined as gross charges for professional work done by each physician, calculated on the basis of relative value units (RVUs) submitted by each physician.

If a group's patient base is at least 50% capitated, it can perform a utilization analysis per 100,000 members based on physician work components of the Resource-Based Relative Value Scale (RBRVS) measure used by Medicare.

Raczak recommends gathering one year's worth of data for an initial measurement. Then, generate reports on a monthly or quarterly basis to update this information.

Figure 1 **(see p. 53)** shows how a practice can track the number of patient visits for each physician and compare this against an average for the practice as a whole and against industry averages. Raczak says two good starting points for such benchmarks are cost and productivity surveys compiled by the Medical Group Management Association (MGMA) in Englewood, CO, and the American Medical Group Association in Alexandria, VA.

You also can compare physician productivity based on gross charges. Again, numbers can be reported for each physician and measured against the average for a practice and against industry averages.

Raczak emphasizes that it is important to look for trends across several forms of measurement rather than using data from one category. That prevents a practice manager from making assumptions based on data from only one area. In addition to gross charges and patient encounters, other good measurement categories are RVUs, patient satisfaction, and collections (for practices that are not heavily capitated).

Among the trends practice managers need to look for are whether a practice's reimbursement of a physician is in line with the physician's productivity. "If you're paying physicians at the 75th percentile, but you're getting only the 50th percentile in gross charges, you may be overpaying

Figure 1

XYZ Clinic — 1997 Visits — Capacity Analysis
Gastroenterology

Physician	1997 Visits	XYZ Average	Survey Mean	Average Mean	MD Capacity	Survey 75th	Average 75th	MD Capacity
A	2,136			115.4%			91.7%	
B	1,653			89.3%			70.9%	
C	1,229			66.4%			52.7%	
TOTAL								
3	5,018	1,673	1,851	90.4%	2.7	2,330	71.8%	2.2

Source: Charts on pp. 53-54 are from the Medical Group Management Association, Englewood, CO.

the physicians. Or if you have 14 physicians, this data may tell you the practice only needs 11 or 12," she says.

As in the example MGMA provides in Figure 1, a practice can measure physician productivity in terms of patient visits compared to the 75th percentile based on a survey compiled by a national organization such as MGMA. The 75th percentile was chosen as a point of comparison because the practice has determined, again by comparing its data against MGMA's, that its physician salaries fall in the 75th percentile nationally for its category of specialists.

Figure 1 shows that when measured in terms of patient visits, physician productivity for a specific practice only falls at 71.8% when looking at a national average of all practices in the 75th percentile.

Unless a practice is growing its business, it wants to look for productivity in the 95% to 100% range, Raczak says. If a practice *is* attempting to grow its business, productivity should be in the 85% range. But the information presented in Figure 1 may not tell the whole story. In this case, a practice manager may decide to look at productivity based on gross charges in case the procedures performed by its physicians are more complex and thus take more of a physician's time.

Remember that while numbers don't lie, they need to be taken in perspective and discussed with a physician leader, Raczak emphasizes. A physician's productivity numbers may be out of whack for several reasons:

- The physician could be undercoding.
- The physician's patient base may represent an older or sicker population.
- The physician could be referring to specialists too much.
- The physician's patients could represent what Raczak calls "the worried well" — patients who visit the doctor for every little ache or pain.

Regardless of the reason, a physician perspective on this information is vital, Raczak says. A fellow physician is in the best position to determine whether outliers exist because of the nature of the patient base. In addition, if there needs to be a discussion with the physician whose numbers are outside the norm, the information has more credibility coming from a fellow physician.

Physician buy-in also is important when setting up a measurement system, she says. If physicians have a say in what data are being used to measure productivity, they are more likely to assign credibility to the data. For this reason, Raczak recommends forming a committee of physicians in your practice to put the measurement system in place.

But will physicians even see the need to measure productivity? Raczak admits it can be a hard sell. "Yes, physicians may resist this kind of measurement," she says. "But the reality is, these groups are losing money. The average primary care physician practice loses $50,000 per doctor. And at the end of the day, the money has to come from somewhere."

Figure 2

Primary Care

Benchmark Productivity, Work RBRVS, All Payers

Family Practice	100%
Internal Medicine:	95%

Managed Care Utilization Analysis per FTE

Average (for XYZ Clinic) of total RBRVS	4,985
Managed Care Target RBRVS	5,600
Actual to Target	89%

Managed Care Utilization Analysis per 100,000 Members

Average (XYZ Clinic) of total RBRVS	314,858
Managed Care Target RBRVS	378,867
Actual to Target	83%

Figure 3

Gastroenterology

Benchmark Productivity, Work RBRVS, All Payers	
Gastroenterology	109%
Managed Care Utilization Analysis per FTE	
Average (for XYZ Clinic) of total RBRVS	10,499
Managed Care Target RBRVS	8,600
Actual to Target	122%
Managed Care Utilization Analysis per 100,000 Members	
Average (for XYZ Clinic) of total RBRVS	28,124
Managed Care Target RBRVS	23,193
Actual to Target	121%

The good utilizers may even embrace the concept of productivity measurement coupled with incentive pay — another must if productivity measurement is going to be effective, Raczak says.

There are as many models of incentive pay as there are physician groups, she says. It could be measured on straight productivity by RVUs, or a combination of productivity based on RVUs and patient encounters. "It really depends on the group's payer mix, the degree of risk they're willing to take, and if they're willing to pay just based on productivity or want to incorporate patient satisfaction as part of the mix."

Figure 2 **(see p. 53)** shows that initial examination of productivity among a practice's primary care physician base looks pretty strong — family practice physicians have 100% productivity, while internal medicine physicians have 95% productivity.

However, when the total RBRVS values are compared against managed care targets, a practice may be operating at 89% capacity. On the other hand, based on the number of referrals to gastroenterologists, utilization as measured per full-time physician comes out to 122%. This information shows that the primary care physicians in a practice may be over-referring cases to gastroenterologists. A physician leader in the primary care practice may want to meet with the key gastroenterologists to whom the practice refers in order to identify referral guidelines. There may be procedures — such as a flexible sigmoidoscopy — that primary care physicians can handle themselves.

Practices that are more heavily capitated will obviously need to measure productivity a different way. Figure 3 **(see above)** represents data that can be used by practices that are majority capitated. The examples shown compare productivity among a group's primary care physicians with national benchmarks based on RBRVS. Benchmarking data like these are available from actuarial firms such as Milliman & Robertson in Seattle.

If the process sounds like it can be a lot of work, you're right. Raczak admits it does take time to put a system in place — how much depends on a practice's current information management capabilities, the number of physicians in the practice, and how much information already is available.

But many managed care companies already are measuring productivity for the practices they contract with and in some cases are using this information to reward or penalize physicians. Doesn't it make sense, Raczak asks, for your practice to measure these data internally to make sure you are being portrayed accurately? On the flip side, your practice could use this kind of data to show a payer that your physicians are effective utilizers capable of managing a capitation contract, she suggests. ■

Are your PPOs merely capitation in disguise?

Discounted fee-for-service cloaks budget limits

Whether you're aware of it or not, most physician groups participating in preferred provider organization (PPO) contracts with insurers are capitated — even though the contracts are presented as discounted fee for service (FFS).

That's the view of orthopedist **Thomas P. Schmalzried**, MD, president of California Orthopedic and Sports Medicine Associates in Los Angeles. The difference in how payment works out between a PPO and an HMO really amounts to a mere delay, he argues.

A physician group's PPO contract in a given year will reflect discounted fees on a per-fee basis, but in actuality, there is a limit on a PPO budget allowed by the insurer for each PPO plan it offers, just as there is for an HMO plan. If that PPO budget limit is exceeded by providers in a given budget year, the budget for the next year is reduced to make up for that loss.

Doctors see the reduction in the form of further discounted fees, and that is exactly what

physicians have seen in recent years. The subtle form of capitation is simply retrospective rather than prospective, Schmalzried says. It's also a big reason for the heavy administrative costs in managed care.

"Those who are paying for health care are no longer in the 'insurance' business," he explains. "Insurance implies risk. Today there is no risk because there is a budget for spending. Whether this occurs 'upfront,' as with capitation, or 'retrospectively,' as in discount [fee-for-service] PPO's, they are both a manifestation of budgets. This feature is here to stay — regardless of what it is called."

Discounted FFS, with its tight but hidden overall budget target, requires tighter budget controls such as utilization analysis, case management, concurrent review, and claims adjudication, all of which require more staff and technical support.

Those administrative costs consume resources that could be better spent on preventive care or on keeping a lid on patient costs. The better option for everyone, he says, is for physicians to take charge of capitated contracts, assume the risks, and be personally accountable for how resources are used.

What surveys show

Schmalzried's assertion that discounted FFS contracts are cutting physician revenue each year is supported by two recent surveys conducted by the Englewood, CO-based Medical Group Management Association (MGMA).[1] One survey, the MGMA salary review, shows most physician and administrative salaries are not growing, according to **Lisa E. Pieper**, MBA, MGMA project manager. "They [physicians] are keeping costs down and working hard, yet physician salaries — and [administrators'] — are static. This is the squeeze that our members are in."

According to data in the survey, released in late 1998, group practices' FFS gross collection percentage, which is the percentage of gross charges collected by group practices, continued its downward movement throughout 1997 to 69.2%, marking the first time it has dipped below the 70% mark. In addition, FFS adjusted collection percentages — the amount of billed charges collected by medical groups — stayed level at 95.5% for multispecialty practices in 1997, continuing an 11-year trend of either flat or slightly declining.

A third key indicator comes from the cost factor, as reflected in MGMA's 1998 cost survey of 1,334 medical practices. Once costs are factored into the equation, actual revenues declined by 5.5%, according to the survey.

Reference

1. Schmalzried TP, Luck JV. Capitated reimbursement for medical services returns control of the patient to the surgeon. *Orthopedics* 1998; 21:620-631. ■

In Brief

MGMA offers new recruitment service

Looking for the perfect physician for your practice? The Medical Group Management Association (MGMA) in Englewood, CO, is introducing a new service to help practices find the right doctor. Interactive Career Opportunity Network features an on-line database in which group practices and other organizations can list the qualifications they seek in physician applicants. More than 1,100 job opportunities have been listed with the service since it went live at the end of last year.

The network also allows physicians seeking new positions to browse through an employment opportunities database by state, region, and specialty, and then reply to openings on line or by touch-tone telephone 24-hours a day.

Physicians can access the database free through MGMA's Web site, www.mgma.com or by phone toll-free at (877) 700-0203. An additional feature allows physicians to register in a confidential positions-wanted section and post their resumes on line.

Employers using the network receive instant on-line access to candidate responses to position openings. They also may look in the positions wanted section for potential candidates.

Fees for employers to use the program are based on the length of time a position is featured and the number of opportunities listed. For additional information about the Interactive Career Opportunity Network, call (877) 877-6462. ▼

Y2K solutions offered

To help health care providers deal with the year 2000 problem, American Health Consultants, publisher of *Practice Marketing and Management*, offers the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers. This 150-page reference provides answers to questions such as these:

- Will your computers and software work?
- What does Y2K mean for patient care?
- What will happen to your medical devices?
- How can you make sure your vendors are Y2K compliant?
- Are you at legal risk due to Y2K?
- Are you prepared if Y2K delays HCFA payments?

The manual is available for $149. For details, contact American Health Consultants' customer service at (800) 688-2421 or www.ahcpub.com. ▼

Part B spending drops as HMO presence grows

Here's one more item to factor into your practice's budgetary and strategic planning: As commercial managed care's percentage of a given market increases, researchers have uncovered a related "spill-over" phenomenon that results in less traditional Medicare fee-for-service (FFS) spending, along with a subsequent change in physician practice patterns.

In fact, Part B Medicare FFS spending falls an average 1.5% per beneficiary with each 10% change in local HMO enrollment levels, says the study, "Association of Managed Care Market Share and Health Expenditures for Fee-for-Service Medicare Patients," published in the Feb. 3 *Journal of the American Medical Association*. The study found Medicare FFS spending fell by 2.5% when HMO penetration rose from 20% to 30% and dropped 3% when penetration rose from 30% to 40%. Similarly, Medicare Part A spending also fell 2% to 3% with each 10% increase in local area managed care penetration.

FFS spending tends to increase as Medicare HMOs expand their presence in a market, the study found. In fact, a 9.4% jump in Medicare FFS spending occurs when HMO Medicare enrollment rises from 10% to 20%, according to the study. ■

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Editor: **Lisa Hubbell,** (thehubbells@earthlink.net).
Vice President/Group Publisher: **Donald R. Johnston,** (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com)
Production Editor: **Terri McIntosh**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.