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INSIDE

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Looking at the future with alarm? Set your sights on patient satisfaction

Savvy practices monitor patient concerns, make changes

If your practice isn't monitoring patient satisfaction, you may face problems down the road as health care consumers and managed care organizations put more emphasis on patient-centered outcomes as a measure of the effectiveness of health care delivery.

"As the health care market changes, it becomes very important for medical groups to know if they are delivering the kind of care they think they are delivering," says **Nancy Bundek**, PhD, product manager for the survey solutions team for Pfizer Health Solutions (a wholly owned subsidiary of New York City-based Pfizer Inc.), which sells technology-based products and services, including patient satisfaction surveys, to the health care industry. "In this age of consumerism, patients feel their power with their physicians and exercise that power by actively participating in making choices about their health care."

When the Medical Group Management Association in Englewood, CO, listed key indicators for success in its 1998 report *Performance and Practices of Successful Medical Groups,* patient satisfaction was at the top of the list.

"Keeping patient satisfaction at high levels is perhaps the most important element in maintaining and building a medical group's capacity. If patients are dissatisfied with the medical practice, all attempts to grow the group will fail," the report states.

Executive Summary

Subject: Why patient satisfaction is essential to your practice's survival
Essential Points:
• In today's competitive marketplace, unhappy patients are likely to switch to another practice
• Even under managed care, patients have a choice of providers and rely on recommendations from friends and family
• Collection of patient satisfaction data allows your practice to be proactive when managed care plans present their data
• Satisfied patients are more likely to be compliant with care plans, less likely to sue

Patient satisfaction studies can assist you in:

- pinpointing problem areas in your practice;
- determining what patients are looking for in a health care provider and figuring out how to provide it;
- coming up with strategies to retain the patients you already have and get new patients through word of mouth. **(For a list of frequent patient complaints, see p. 107.)**

Experts say the health care market is changing rapidly. With mergers, consolidations, and practice acquisitions, the marketplace is becoming more competitive. Consumers recognize that they have a choice, and they are voting with their feet.

The physician group that wants to be the "provider of choice" — whether it's the choice of individual patients, a managed care plan, or an integrated delivery system — will increasingly find that placing emphasis on patient satisfaction will help it reach its strategic goals, says **Mary P. Malone**, MS, JD, CHE, vice president of Press, Ganey Associates, a South Bend, IN, health care satisfaction measurement firm.

Patients rely on word of mouth

A prime reason to concentrate on patient satisfaction is that patient recommendations are the best way to get additional business, asserts **Tom Aug** of Development Partners, a Cincinnati firm specializing in patient satisfaction improvement for physician group practices.

"People select a physician because other trusted people tell them they are good. Published ratings never mean much unless the patient's cousin or co-worker recommends that physician," Aug says. Recommendations from friends and relatives are the No. 1 reason people choose a physician if they have a choice, he adds.

Even being in a managed care plan doesn't necessarily guarantee that you will get patients, says **Andrea Eliscu**, president of Medical Marketing Inc., an Orlando, FL, firm specializing in public relations, marketing, and strategic planning for physicians.

"You get paid only if the patient comes to you," Eliscu says. "Patients have a choice of physicians on the panel. If they know someone who has had one bad experience, they are likely to go elsewhere. It's a lot harder and more expensive to attract new patients than to keep the patients you have," she adds.

If your managed care plans are already measuring satisfaction, that's all the more reason to do your own satisfaction studies, Bundek points out.

"A medical group that sits back and doesn't collect its own data is totally unable to respond to whatever data comes out of the health plan," she explains. For instance, some MCOs are starting to include member satisfaction as part of the basis for compensating physicians.

Collecting your own satisfaction data on an ongoing basis gives your practice the opportunity to be proactive when the annual member satisfaction report from the MCO comes around.

"A practice can point out that they recognized the problem, took steps to correct it, and that subsequent satisfaction surveys show that patients are more satisfied," Bundek says.

Here are other reasons to monitor patient satisfaction:

- **Healthier patients.**

Researchers have reported that clinical outcomes improve when patients trust their caregivers, Malone says.

"If patients feel they are being communicated with and receiving good services from the caregiver, they are more likely to be compliant with treatment regimes," Malone says. It follows that if patients are compliant, they're going to get better quicker, she adds.

- **Less incentive to sue.**

Research shows that in 70% of cases, people don't sue because of a bad outcome, but because of of a communication problem between the provider and the patient. When a physician ignores a patient complaint, that's what turns rational people into litigants, experts point out.

- **Happier employees.**

Employees who spend the day taking care of glitches in the system and dealing with irate patients are less likely to feel fulfilled in their jobs.

"If you're focused on patient satisfaction, you have a happier organization. Employees are generally happier and have greater satisfaction and rewards if they're not handling complaints all day. It makes the work day more enjoyable for everybody," Aug says. **(For information on how happy employees make happy patients, see p. 101.)**

The results of patient satisfaction studies may surprise you.

"Research suggests that patients and physicians care about very different things," says **Susan MacRae**, RN, research and development associate at The Picker Institute, a Boston-based

Don't let your data collect dust on a shelf

Use it to improve the way your practice runs

Now that you've done patient satisfaction studies, compiled the data, and come up with your patients' likes and dislikes, what do you do next?

It's not enough just to gather the data. You've got to use it to make improvements in the way you do business, or the effort you made to collect it will be in vain.

At the Salem (OR) Clinic, staff members meet in work groups to address the concerns expressed in surveys and come up with strategies for improvement, says **Barbara Gunder**, MA, practice administrator.

"It's imperative to do more than just look at the data. You have to make changes. It should be an ongoing process," says **Tom Aug** of Development Partners, a Cincinnati firm specializing in patient satisfaction improvement for physician practices.

Review satisfaction data on a regular basis, publicize it to your employees, and be driven by the data you get, Aug suggests.

When Aug works with a practice, his goal is to create a group of people in the practice who will obsess over customer service. He encourages the practice to set up a satisfaction steering committee from all departments in the practice, including physicians.

The group meets regularly to assess the data, make changes, measure it again, and keep the entire staff focused on making improvements, Aug says. For instance, if people complain about a surly receptionist, customer service training may be in order. If patients complain about lengthy waits on the telephone, look at replacing your system or hiring more people to answer the phone.

Fallon Community Health Plans, a federally qualified nonprofit HMO contracting with physicians throughout eastern Massachusetts from its headquarters in Worcester, offers customer service training to its physician offices to teach the staff how to be customer-focused, handle angry patients, and keep patients notified of waits. If scheduling is a problem, the health plan provides consultation to help make improvements, says **Christine Micklitsch**, FACMPE, MBA, Fallon's director of physician education and services.

If one department or staff member receives consistently low scores on satisfaction, it's time to act, says **Andrea Eliscu**, president of Medical Marketing Inc., an Orlando, FL, firm that provides public relations, marketing, and strategic planning for physicians.

"It's hard to say, 'You're not doing a good job and nobody likes you.' But if an area is scoring low, you should tell them the customers don't like the way it's being done and talk about how it can be changed," she adds. ■

health care quality assessment and improvement firm. "Technical care is essential, but that isn't all that's necessary for healing and health. Patients place a big emphasis on personal and interpersonal experiences during the treatment process."

Patients want more communication with their doctors, she adds. They want access to information, and they want to be able to talk to their doctors.

"Our research shows that patients aren't very concerned about amenities or touchy-feely issues, like many health care professionals think. What they're looking for is a broad-based coordinated experience when they are respected as human beings," she adds.

Malone tells of attending a patient satisfaction panel discussion during which three of the four speakers stressed that patients put a high value on privacy in a physician's office. The physician who moderated the panel expressed surprise that privacy was a big issue.

Why do you want to know what your patients are thinking and what they seek from a provider? Consider that alternative medicine is growing much faster than the primary care business, even though most of the cost of alternative medicine comes from the patients' own pockets and not their health care plan, Malone points out.

"The same people who complain about $10 co-pays are spending their own money on alternative medicine. If they find value in spending money on alternative medicine, it means that their understanding of quality must be different from physicians' understanding of quality," she says. ■

Communication is key to patient-doctor ties

Take the time to talk to your patients

When a managed care plan did a patient satisfaction study of its members, it found that only one physician in its database of 5,000 had never had a complaint lodged against him, recalls **Tom Aug** of Development Partners in Cincinnati.

"An interview with the physician revealed that his whole philosophy is to make the patient feel that they are the most important thing happening in his life," says Aug. Development Partners is a firm specializing in improving patient satisfaction for physician group practices.

The physician talks on the patient's level and always discusses one or two things that are unrelated to the visit.

"This isn't rocket science. It's making people feel like they are the center of attention," Aug says.

Do your patients actually understand you?

And, here's the other side of the story:

The Picker Institute's comparative database of patient satisfaction questions about physicians reveals that 27% of medical patients feel that they did not get an answer they could understand from their doctor, according to **Susan MacRae**, RN, research and development associate at the Boston-based health care quality assessment and improvement firm.

Among the Picker Institute's other findings:

- When asked if the doctor discussed the patient's fears or anxieties about the treatment, another 27% answered no.
- A whopping 20% reported that they did not have trust and confidence in their doctors.
- Among surgical patients, 18% reported that they didn't get an answer they could understand.

"A lot of this has to do with communication, and it can be solved with common sense and courtesy. There are simple things the doctor can do, like sitting down to be at eye level with the patient and asking open-ended questions," MacRae says.

Patients report that in presurgical meetings with their physicians, the physicians are so preoccupied with providing risk and side effect information that they fail to ask what the patients' concerns are, MacRae says.

"For instance, when women have breast surgery, there are a whole host of topics that are part of the common informed consent process. But when you ask women what their priorities are, they're interested in knowing whether they will be able to wear seat belts or when they will be able to lift their child," she adds. ■

Who are all those people in your waiting room?

Are your patients being ignored?

You may not think your practice's waiting room would be a good place for a homeless person to camp out, but consider the appeal: The surroundings are comfortable. There's usually a water cooler, a pot of coffee, or hot tea available. There are magazines to read. And best of all (from a homeless person's standpoint), sometimes people can sit in a physician's waiting room for hours without anybody even noticing them.

"Where else in American business can you spend an hour and be ignored? Unfortunately, that's the way it is in most group practices," says **Tom Aug** of Development Partners, a Cincinnati firm that specializes in improving patient satisfaction for physician group practices.

Only 10% of patient visit is spent with doctor

Patient satisfaction experts report that a lengthy waiting time is a major source of patient complaints, and it's no wonder. "Only about 10% of the whole patient experience is spent with the physician. Practices need to look at how they manage the other 90% of the time, " Aug points out.

"One of the biggest issues that comes up in our patient satisfaction survey is access. It comes down to delays in waits. Patients are frustrated when they face delays in getting access to the kind of care providers are trained to provide," notes **Cleveland Davis**, physician service specialist for Fallon Community Health Plan in Worcester, MA, a nonprofit, federally qualified HMO contracting with physicians throughout eastern Massachusetts.

As part of the patient satisfaction improvement process, Aug often acts as a "mystery patient": He

Want happy patients? Keep staff happy

Lack of motivation affects service

If your office staff isn't happy, chances are your patients aren't going to be happy either.

"All our research tells us there are direct correlations between employee satisfaction and patient satisfaction. When employees feel committed and cared for, it's easier for them to bring their hearts and souls to work," says **Tom Aug** of Development Partners, a Cincinnati firm that specializes in improving patient satisfaction for physician group practices.

Because only about 10% of a patient's total visit time is spent in face-to-face contact with a physician, the rest of the staff can have a big impact on how the patient feels about the experience, Aug points out.

"If your internal staff isn't empowered or motivated about their jobs, it's going to show up in the kind of services a practice provides," points out **Andrea Eliscu**, president and chief executive officer of Medical Management Inc., an Orlando, FL, firm that specializes in marketing, public relations, and strategic planning for physician practices.

That's why the Salem (OR) Clinic focuses on staff satisfaction and employee appreciation, says **Barbara Gunder**, MA, practice administrator.

"If employees don't feel valued, there's no way they can value the patient," Gunder says.

Each department at the Salem Clinic has an individual employee satisfaction program that recognizes employees for excellence. Employees are encouraged to make suggestions and are rewarded when their suggestions are implemented. Other staff satisfaction projects include staff appreciation lunches and a dress-down day in the summer when employees are allowed to wear casual clothes. ■

schedules an appointment, goes through registration, sits in the waiting room, and goes through the examination process.

"I told one group practice that if I were a homeless person, I'd camp out in their office. You're in comfortable surroundings and can spend hours drinking coffee and nobody ever bothers you, or even talks to you," Aug recalls.

A lot of the waiting time has to do with scheduling problems, Davis points out. Fallon offers scheduling consultations with outliers so they can learn to schedule more efficiently. Improving your scheduling often means changing the way you've always done things, he adds.

Aug and other "mystery patients" observe how the office staff handle the waits that inevitably occur. "We check to see how they communicate with the patients, whether they keep them apprised of the waiting time or act disinterested about it," he says.

It's not enough just to reduce the amount of waiting time; providers also should focus on enhancing the quality of the time spent waiting, says **Mary Malone**, MS, JD, CHE, vice president of Press, Ganey Associates, a South Bend, IN, health care satisfaction measurement firm. "There are simple things practices can do, like giving patients a clipboard to write down any questions they want to ask the doctor," she says. ■

Here's what to ask patients in a survey

Tips for developing a satisfaction survey

A patient satisfaction survey doesn't have to be lengthy, but it should contain questions that will help you discover what patients don't like about your practice and make appropriate changes, the experts say.

Above all, don't just ask questions that you know will generate positive answers. That will defeat your purpose, says **Andrea Eliscu**, president and chief executive officer of Medical Marketing Inc., an Orlando, FL, firm that specializes in public relations, marketing, and strategic planning for physician practices.

Here are some areas you should cover in your patient satisfaction survey:

- **Access to care.** This includes how long it took for the patient to get an appointment, length of time spent in the waiting room and examining room, and how long it takes for phone calls to be returned during office hours and after hours.
- **Communications.** This might cover whether the patient felt the physician listened to them,

how clear the physician's or nurse's explanations were, and whether the patient got all the information he or she needed.

• **Quality of care.** These questions cover how satisfied patients are with the physician's technical skills, the level of interest expressed in the patients' well-being, whether the patients feel they received good care, and whether they would recommend the provider to a friend or relative.

• **Respect and courtesy.** This should be applied to all staff who come in contact with the patient.

• **Practice-specific questions.** This is a good place in which to get an idea of how responsive patients would be to changes in your practice, says **Nancy Bundek**, PhD, product manager for the survey solutions team at Pfizer Health Solutions.

"If you have opened a new clinic or are considering offering vaccinations for senior citizens on Saturday mornings or want to do cancer screenings — such as mammograms or prostate screenings — in the evening, this offers a chance to gauge patient reaction," she adds. "Basically, a physician group can gain some really good insight into a patient perception of the access to care, the quality of care that was delivered, or satisfaction with the patient-physician interaction."

Be sure to add a place for comments, suggests **Mary Malone**, MS, JD, CHE, vice president of Press Ganey Associates in South Bend, IN.

"The comments on the form are really helpful as well. It helps to look at quantitative and qualitative data," Malone says. ■

Methods vary for finding what's on patients' minds

Try several ways for best results

Formal patient satisfaction surveys are not the only way to find out how your patients feel about your practice.

When **Tom Aug** of Development Partners in Cincinnati is hired by a physician group to conduct a satisfaction audit, he looks at data from a variety of sources, including:

• **Member satisfaction surveys from your health plan.** If you're a part of a managed care plan, the MCO is likely to pass on information from its member satisfaction surveys. For example, Fallon Community Health Plan of Worcester, MA, a nonprofit, federally qualified HMO with contracts with physicians throughout eastern Massachusetts, conducts a physician-specific patient satisfaction survey of its clients.

When the surveys are returned, Fallon shares the results with the individual practices and individual physicians and offers to provide interventions for outlier physicians, reports **Christine Micklitsch**, FACMPE, MBA, Fallon's director of physician education and services.

• **Patient complaints.** If you get the same patient complaints over and over, you've got a place to start making improvements, says Aug. If you don't keep a formal log, just ask your staff what people complain about, he adds.

"Many people will complain at the front desk or to the medical assistant but won't say a word to the doctor because they fear it will affect the treatment they get," Aug says.

The Salem (OR) Clinic has one staff member who handles and resolves all patient complaints.

"In the past, patients called in and various managers dealt with the issues. There wasn't a central funnel through which we could identify the issues," says **Barbara Gunder**, MA, practice administrator. Now staff refer unhappy patients to the customer service representative, who helps keep tabs on the complaints.

The patients love getting one-on-one attention from someone who isn't trying to juggle other jobs, and the rest of the staff are relieved of the stress of handling complaints.

"It allows us to keep track of patient concerns by physician. If we see a trend, we can give immediate, direct feedback to the physician," Gunder says.

• **Focus groups.** Some savvy group practices have an advisory panel, made up of patients, that meets once a quarter. The patients are invited to dinner with senior staff. At dinner, patients are asked what they like about the practice, what they don't like, and what can be improved, Aug says.

• **Suggestion boxes.** The Salem Clinic has put a comment box in the waiting room and encourages patients to drop in their feedback, even if they don't get a formal survey.

• **Personal interviews.** Administrative staff from the Salem Clinic occasionally go into the waiting area and ask patients how they've been treated during their visit. The practice also has begun randomly calling patients to find out how their visit went. ■

Physician's Capitation Trends™
• Capitation Data and Trend Analysis •

Pharmacy capitation zooms into the national limelight

Manage drug costs globally, not in isolation

The best political theater in Washington, DC, this summer may have nothing to do with the brewing presidential campaigns. Experts say the issue to watch in health care is how Congress and Medicare officials handle prescription drug coverage.

"As Medicare goes, so goes private-sector insurance," is a common refrain among veterans of health care management. But will that be the case this time? Can the nation afford it? Can private-sector insurers afford it? Will the market demand it regardless?

Capitated providers are well aware that "pharm-cap," the practice of incorporating prescription drugs within the per-member-per-month payment in capitation contracts, is about as risky as the health care business gets. Drug costs are volatile and almost impossible to predict. Drug utilization patterns can lead to either savings or major expenses in the long run, and they are subject to both visible and obscure market influences. Still, pharmacy capitation is virtually standard in markets where capitation is mature, such as Massachusetts, Texas, and California.

Donna Shalala, secretary of the Department of Health and Human Services, recently hailed the prospect of expanding drug coverage to the elderly. "A prescription drug benefit is good health care," Shalala said. "It's prudent policy. It's compassionate government. And the time for action is now," she said in a speech to the National Press Club in Washington, DC.

There is no doubt the expanded benefit is in high demand, shown dramatically by the popularity of Medicare risk contracts that offer free or reduced drugs, notes **Gary Plank**, MD, director of pharmacy services for Security Health Plan, a physician-owned HMO operated by the Marshfield (WI) Clinic. "But how can the nation afford it if Medicare solvency already is an issue?" he asks.

Will the rest of the private sector follow Medicare's lead? "Regarding Medicare risk, I'd say yes," Plank predicts. "The private-sector risk will continue to incorporate pharmacy." Beyond that, however, "I don't know how the nation could afford it."

Given all the attention paid to prescription drug benefits today, chances are these benefits will remain a prominent feature of capitation and other managed care and fee-for-service arrangements for the foreseeable future, Plank and other experts predict. Here are three explosive reasons why:

- **Advertising rules consumers.** The pharmaceutical industry increased its spending on direct-to-consumer advertising by 16% between March 1998 and March 1999, according to a report published in June by the London-based information firm IMS Health. Estimated expenditures came to $1.53 billion. This increase was smaller than the 24% increase reported for the 12 months that ended in December 1998, according to IMS analysts, but they say consumer-oriented drug advertising is here to stay because it is effective at stimulating consumer demand.

At the same time, generic drugs aren't wholeheartedly embraced; after all, they aren't advertised. Most Americans still prefer brand-name drugs over lower-cost generic drugs, according to a June survey by CareData Reports, a White

Plains, NY-based consumer and health research organization. Based on a sample of 20,000 Americans, the survey indicates that only 45% of respondents are satisfied when switching from a brand name to a generic drug.

• **Consumers rule the market.** Even as brand-name drugs go off the patent list and on to the generic domain, pharmaceutical manufacturers will continue to make more than they lose, say IMS officials in a separate report. Overall, the industry generated revenues of $302 billion in 1998. Some $70 billion is expected to be lost in patent expirations in 1998, but consumer demand will continue to drive new development as well as sales of off-patent drugs.

• **Voters rule politicians.** Medicare proposals for prescription drugs are multiplying. As election season picks up, Congress knows that seniors favor financial support for pharmacy costs. A host of ideas and bills are flooding Congress already. The following four proposals would have Medicare provide:

— up to $1,700 per year for drugs with a $200 deductible and a 20% copayment for all beneficiaries;

— a pharmacy benefit strictly for low-income elders;

— comprehensive pharmacy coverage via group purchasing policies, such as rebates, price ceilings, discounts, or competitive bidding for drugs;

— specific outpatient prescription drugs for several chronic disease conditions, such as hypertension, major depression, diabetes, rheumatoid arthritis, and congestive and ischemic heart disease. The thinking is that pharmacy expenditure over the long term would reduce inpatient and outpatient admission cost.

Don't separate drug costs from overall costs

How do physicians handle this chaotic mix of market and economic influences? "What many people are trying to do is to look at the drug benefit independent of total health care cost," says Plank. However, that approach gives a false picture, he warns.

For example, Marshfield's second-highest drug expenditure reduces cholesterol levels, which in turn reduces heart disease and stroke. "Increasingly, we're moving out of treatment of a disease to prevention," Plank says. The costs are high on the drug end, but lower in hospital and outpatient admissions. ■

Risk-adjusted payments offer some protection

Family MDs weigh in on new capitation model

Medicare's proposed risk-adjustment system offers one credible way to protect physicians in capitated contracts, but be sure to use other protections that already exist if you enter capitation.

That's the advice from two researchers at Johns Hopkins University in Baltimore who recently published a study on capitation. Targeted particularly at family physicians, the study focuses on safeguards available to doctors in highly capitated risk environments.

In part, the researchers are responding to proposals already under consideration. Earlier this year, Medicare officials introduced a major restructuring of how Medicare risk rates are set. They proposed a system called ambulatory diagnostic groups (ADGs) that relies on clinical indicators — ICD-9-CM codes, to start with — to predict resource use. **(See details on how this system works in *Physician's Managed Care Report*, April 1999, pp. 55-56.)** In general, the model looks at a patient's prior year's complications (especially if hospital admission was involved) and other medical expenses to statistically predict the coming year's costs.

As it turns out, the range of payments under the ADG method can be significant, and it can make a beneficial difference to physicians dealing with the high-cost risks of capitation, according to the study's two authors, **Gerard F. Anderson**, PhD and **Wendy E. Weller**, MSH.[1] Both are professors of health care finance at Johns Hopkins.

Payment rates could vary significantly, according to their calculations. **(See chart on p. 105.)** For example, one series of calculations shows that the payment range could vary from $1,212 to $15,715 under the new risk-adjusted formula, while the current system would pay a standard $2,625 for all Medicare patients regardless of clinical history.

The researchers ran comparisons for three different scenarios. For instance, a patient with no prior hospitalization would carry a capitation payment amount of $2,625 under the current model and $1,212 under the proposed ACG model.

If a patient's record indicated ambulatory care treatment for depression, ulcers, and coronary atherosclerosis in the prior year, the proposed capitation amount would be adjusted upward to

Comparison of Current and Proposed Medicare Capitation Methods

Patients with health system encounters in the prior year	ADC Model	Current Model
Patient A No prior year encounters	$1,212	$2,625
Patient B Ambulatory Treatment Depression (ADG 23) Gastric Ulcer (ADG 7) Coronary artherosclerosis (ADG11)	$3,480	$2,625
Patient C Depression (ADG 23) Gastric Ulcer (ADG 7) Coronary artherosclerosis (ADG 11) Corneal Edema (ADG 3) Diabetes (ADG 9) Heart Palpitations (ADG 27) 2 hospital admissions for circulatory complications (MDC 5)* 2 hospital admissions for respiratory problems (MDC 3)*	$15,715	$2,625

*Note: MDC indicates major diagnostic cost group, a classification element in the ADG formula.

Source: Anderson GF, Weller WE. Methods of reducing the financial risk of physicians under capitation. *Arch Fam Med* 1999; 8:149-155.

$3,480, compared to the $2,625 payment under the current system, which doesn't make adjustments.

If a patient's record reflected all the conditions above, plus corneal edema, diabetes, heart palpitations, two hospital admissions for circulatory problems, and two hospital admissions for respiratory problems, the new formula would pay $15,715, compared to the current $2,625 payment.

The proposed risk-adjusted formula can offer some measure of predictability at the beginning of a contract year, the authors state. Also, it can limit the losses physicians might incur if they have a sicker-than-average patient load.

Capitation risk adjustment is not a panacea, the authors warn. Physicians should update their reinsurance or stop-loss coverage to guard against liability for high-cost outliers. **(See related story on reinsurance and stop-loss methods, at right.)** Also, they should consider carve-outs and partial capitation contracts, which identify exactly which services the practice will and be responsible for.

Reference

1. Anderson GF, Weller WE. Methods of reducing the financial risk of physicians under capitation. *Arch Fam Med* 1999; 8:149-155. ■

Ready or not, capitation cometh

Physicians become pickier

Capitation isn't winning many popularity contests, but if there's a beauty contest in the health care market, it's clearly gaining status, especially in areas where it's already got a foothold.

That's a key finding of a national survey of capitation trends conducted by a company whose business is to understand the state of capitation — a reinsurance firm.

"We're finding that risk contracting by providers is a way for them to gain more control, and this is being successfully demonstrated across the country," says **Charles Crispin**, vice president and principal of Evergreen Re, a reinsurance company based in Stuart, FL.

In some markets, physician groups and hospitals are becoming quite sophisticated in their dealings with HMOs. "We're seeing a lot more stabilization," Crispin says. In some areas, providers are

becoming pickier than they were before, "dumping the less promising contracts," he says.

Crispin offers one key piece of advice that should be common sense, he says, but often isn't: "If a risk contract is a bad deal at low volume, don't expect higher volume to make up the difference." Basically, a bad deal is a bad deal.

Overall, Crispin's survey finds that providers expect to take on more capitation. On a troubling note, he finds that physicians need to delve more into their reinsurance provisions to make sure they are adequately covered for catastrophic cases. Fine print and elaborate formulas can veil the unreasonable risk being left to the physician, he warns.

To some degree, the survey was capitation-biased. It only focused on markets where capitation already has a 30% foothold. But it reveals some significant trends. The surveyor used a random-dialing methodology. It included 322 interviews — 161 physician organizations and 161 hospitals. Here are highlights of the survey's findings:

• Over half (56%) of provider groups indicate they are involved in capitation to some extent (at least one contract). On average, a practice or hospital reports having five HMO contracts in 1999.

• Physicians are more capitated (65%) than hospitals (47%). But hospitals report a greater likelihood of having global capitation.

• Of providers involved in capitation, about two-thirds (65%) plan on signing new contracts in 1999, seeking an average of 2.6 new contracts.

• About one-quarter (27%) of organizations not currently accepting capitated members intend to sign an average of 1.9 new contracts by year-end 1999.

• Revenues are showing surprisingly strong reliance on capitation. Overall, physician groups report that 40% of their revenues are generated by capitation, while hospitals report 30%.

• Both hospital and physician providers expect their capitation-based revenue to grow notably in the next two to five years. Physician groups predict 44% of their revenue will be capitation-driven within two years, and 51% within five years.

• Multispecialty groups report more capitation-driven revenue than single-specialty practices, although the difference is not as great as might be expected. Among physician groups, group practice administrators estimated an average of 43% capitation-driven revenue, compared with 33% in single specialty practices.

• Both types of practices predict steady growth in their capitation revenues — 47% in two years and 52% in five years for multispecialty practices, and 37% in two years and 47% in five years for single-specialty practices.

• Hospital and physician groups report active participation in both private- and public-sector capitation contracts. Nearly seven in 10 (69%) accept Medicare capitation, and one half (50%) accept Medicaid capitation. Almost all (91%) accept commercial capitation. Populations served by capitation contracts are greater in the commercial capitation contracts — an average of 16,733 members in commercial contracts, compared with an average of 6,338 in Medicare and 6,551 in Medicaid contracts.

Growth expected almost everywhere

Just how much will capitation continue to grow? The best answer is based on regional predictions, the report says: "The trend toward capitation appears likely to continue, but [it] may be reaching a saturation point in California."

For example, 79% of providers in California are involved in capitation, with an average of 60% of their revenue derived from those contracts, and they are managing an average of 9.4 separate cap contracts each. That compares with 50% cap participation in the other western states (excluding California), 52% in the northeast, 47% in the north central United States, and 58% in the southeast.

Capitation-dependent revenue levels are more revealing. They suggest that to some extent, other areas are still dabbling in capitation rather than wholly diving into it. The survey shows 39% capitation-based revenue in western states, 25% in the northeast, 34% in the north central region, and 29% in the southeast. That's why Evergreen Re expects the growth areas to be outside California. Also, practice managers predict they will sign at least one new contract in 1999, whether or not they are now participating in capitation. The data suggest that capitation in these currently 30%+ market penetration areas will generate up to 50% of a practice's revenues in two to four years, Crispin says.

What stop-loss and reinsurance mechanisms are providers using with capitation? The most frequently used mechanism is stop-loss provided through the HMO with whom they are contracting (used by 50% of physicians and 45% of hospitals).

Among the remaining methods, physician groups are split between self-insurance (14%), commercial reinsurance (12%), and "unknown" sources of insurance protection (25%). ■

Time, access key issues in the eyes of patients

Every practice is different, and your patients' main complaints may be unique. In fact, if you have a multispecialty practice, each department may face a different kind of issue.

"You can't generalize in this business, particularly in large multispecialty practices. Waiting time may be a problem in an obstetrics or pediatrics practice, but may not be an issue in a radiology practice," says **Nancy Bundek**, PhD, product manager for survey solutions at Pfizer Health Solutions, a subsidiary of New York City-based Pfizer Inc.

Nevertheless, there are common problem areas that crop up again and again. Here are some of them:

- **Time it takes to get an appointment.** Patients often complain that when they are sick, it takes too long to get an appointment.
- **Lengthy waiting time.** Whether it's how long it takes to get test results back or how long patients spend in the waiting room, they don't like to wait, says **Cleveland Davis**, physician service specialist for Fallon Community Health Plans in Worcester, MA.
- **Telephone access.** Patients don't like to be put on hold or go through a lengthy process to make an appointment or get information, says **Tom Aug** of Development Partners, a Cincinnati firm specializing in patient satisfaction.
- **Inflexible hours.** Working people often ask for the physicians' office to be open on Saturday or for one or two evenings during the week so they can see a doctor without losing time at work.
- **Privacy.** Patients sometimes complain that the billing department mentions their delinquent account in front of everyone else in the area.

"Even if there is a partition, patients feel like everybody in the community will know that they haven't paid their bill," says **Andrea Eliscu**, president and chief executive officer of Medical Marketing Inc. in Orlando, FL.

- **Repetitive record collecting.** Patients complain that they're asked for information over the phone, but then they're also asked to come in 20 minutes early to fill out forms that ask for the same information.

"The staff is trying to make sure there is no error, but the patient feels like no one was listening the first time," Eliscu adds. ■

Multispecialty group finds it pays to advertise

Ads help practice maintain competitive edge

When a Winter Park, FL, radio personality took to the air in ads describing his experience with back surgery at the Jewett Orthopedic Clinic, the clinic switchboard was so overwhelmed with calls that the practice had the radio ad re-recorded to ask callers to contact one of the clinic's six community locations.

"We can't track exactly how many patients we got from the ads, but our spine surgeons have gotten feedback from patients that they did hear the ads. We have had several advertising campaigns, and we feel like it was worked well for us," says **David Cassidy**, internal marketing director at the 24-physician multispecialty orthopedic practice.

Jewett relied on word of mouth for referrals for years, but in today's health care market, the practice has started to advertise to maintain its competitive edge, Cassidy says.

In the not-too-distant past, the only advertising a physician's office did was a discreet ad in the newspaper or a card mailed to patients to announce that a new doctor had joined the practice. That's the way it was at Jewett for most of its 63-year existence — until managed care came into the Winter Park market.

"Because of managed care, hospital consolidations, and some communities having too many physicians in a particular specialty, the health care field is much more competitive today than in the past," says **Andrea Eliscu**, president and chief executive officer of Medical Marketing Inc., an Orlando, FL-based firm that specializes in marketing, public relations, and strategic planning for physicians.

Executive Summary

Subject: Advertising campaigns for physician practices
Provider: Jewett Orthopedic Clinic, Winter Park, FL
Essential Points:
- Ads tout board-certified specialists
- Physicians get feedback from patients who heard ads
- Advertising acts to supplement word-of-mouth referrals

Careful planning needed to develop ad campaign

Don't spend money without thinking it through

Advertising can reap great benefits for your practice, but you need a well-thought-out plan that is directed to the appropriate audience, says **David Cassidy**, internal marketing director at Jewett Orthopedic Clinic in Winter Park, FL.

If you're thinking of advertising your practice, here are some tips to get you started:

• **Don't try to tackle an expert's job by yourself.**

If you don't have a marketing person on your staff, considering asking the public relations department at your hospital for help. Otherwise, hire a consultant for expert advice, or you may spend your money to receive mediocre results.

• **Take advantage of the expertise of sales people at radio and television stations.**

"Radio and television stations want to break into the health care industry, and they are willing to be incredibly helpful," says **Andrea Eliscu**, president and chief executive officer of Medical Marketing Inc., an Orlando, FL-based firm specializing in marketing, public relations, and strategic planning for physicians. Radio and TV station advertising experts can give you a wealth of information on demographics and market research that will help you reach your target audience, she adds.

• **Make sure there is enough money in your marketing budget to cover the cost of advertising.**

A campaign with a minimal budget may be just a waste of money. Eliscu recommends that 1% of gross business be invested in marketing and development, but adds, "in my experience, nobody ever budgets that much."

• **Track the referrals that come from the advertising.**

At the very least, set up a dedicated phone line for people who hear your ad and call for more information. This won't tell you how many calls are converted into patients, but it will give you an idea of the impact of your advertising. ■

If growth is part of your strategic business plan, you may want to consider advertising, she suggests. "These days, when a practice has worked very hard to recruit physicians with special credentials, they want to keep them busy and attract the kind of patients who can take advantage of the doctor's special expertise," Eliscu says.

For instance, last year, Jewett launched a radio and print advertising campaign to increase community awareness of the fact that all six locations now have board-certified doctors specializing in joint replacement.

"When total joint surgery became more acceptable, every orthopedist in the area was doing them. We undertook a campaign to show that our six specialists are truly dedicated to the science of total joint restoration," Cassidy says.

Cassidy says the practice has spent "significant dollars" on its radio, television, and print campaigns. "There are dividends when you have name recognition. When you are in the top of peoples' minds, it makes the time, energy and investment worthwhile," he adds.

The Jewett Clinic's advertising programs are targeted to payers and referring physicians as well as patients. ■

Constant communication helps office run smoothly

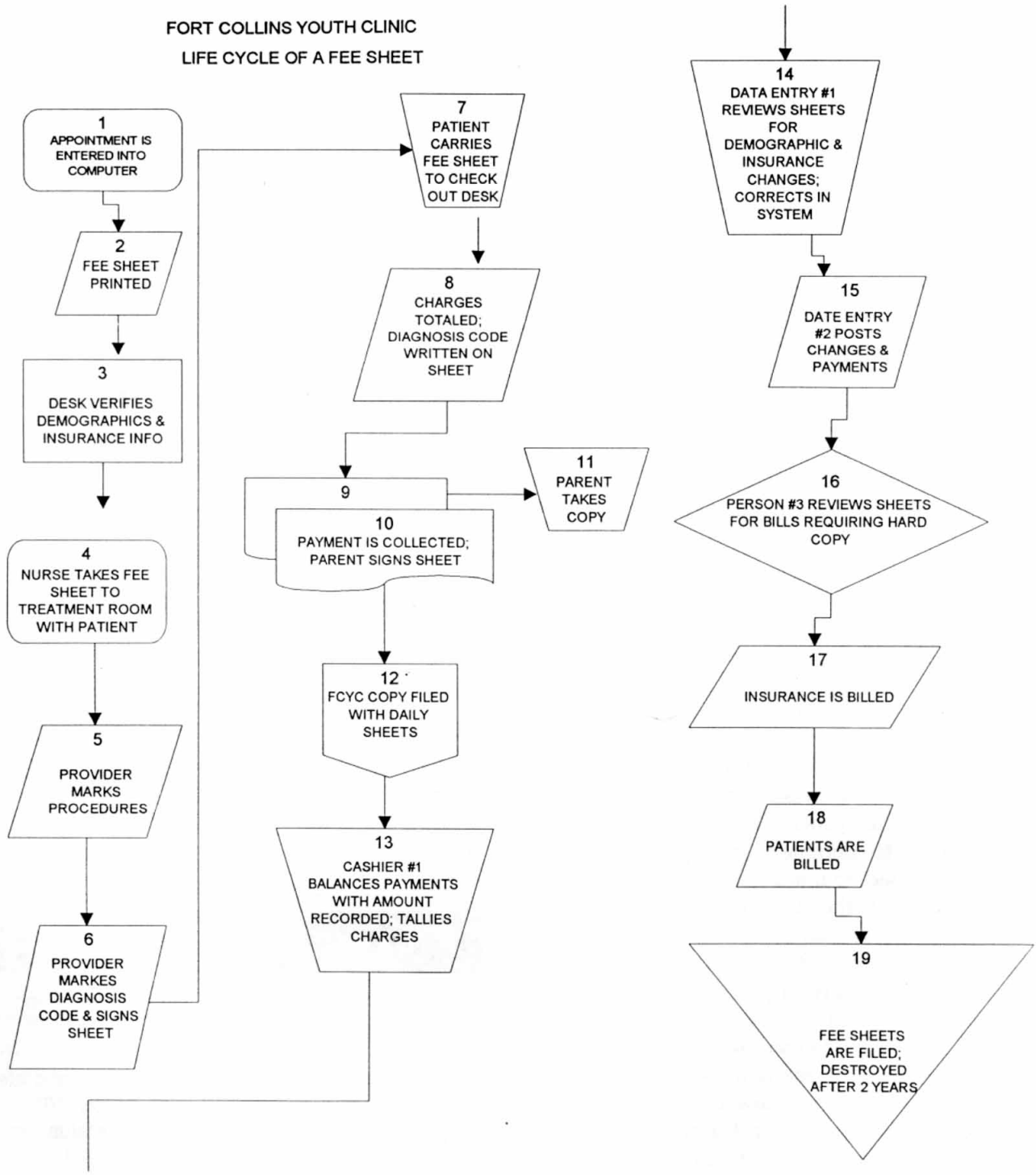
Flowcharts track how the business works

For a physician's office to run smoothly, it's not enough for people to just concentrate on doing their jobs, says **Jeannette Perich**, CPA. Instead, staff must work together and understand how what they do affects the rest of the staff, says Perich, administrator of the Fort Collins (CO) Youth Clinic.

Executive Summary

Subject: Flowcharts facilitate staff communication
Provider: Fort Collins (CO) Youth Clinic
Essential Points:
• Staff working together ensures smooth delivery of services
• Charts show each department where it fits in
• Staff meet regularly to discuss how to better work together

Life Cycle of a Fee Sheet



Source: Fort Collins (CO) Youth Clinic.

Along with customer service for patients, Perich stresses internal customer service among staff to ensure the service delivery system works smoothly. The clinic has implemented strategies to promote better communication among staff. These include regular meetings at which staff members share knowledge and ideas and using flowcharts as a communication tool to allow individuals to see the impact of their actions on the rest of the operation.

"So many times, people get caught in their own little area and don't realize the impact they have on other people," Perich says.

That's why Perich uses flowcharts to give staff an idea of how the business systems work and how their part fits into the entire process.

"We were looking at processes and trying to see where bottlenecks happen in the practice. It's helpful for the staff to see where they fit in," Perich says.

For instance, one flowchart, "Life Cycle of a Fee Sheet," tracks the path of the fee sheet from the time a patient is scheduled for an appointment through the time the account is paid. **(See flowchart, p. 109.)**

"This helped the people at the front desk understand that if we don't have good demographic information and good insurance information, we can't bill out. Our staff has a better understanding of the whole picture and how the entire process works," Perich adds.

For instance, by studying the flowchart, employees can see how benefits are sometimes denied because the patients are no longer covered by a certain plan, Perich says. "Then we have to start all over again and resubmit the claim, and this is bad for the cash flow," she adds.

Another flowchart traces telephone calls, how they are routed, and what decisions need to be made to route the calls. Another tracks the patient visit and details who comes into contact with the patients and how their actions affect the patients.

For the fee sheet project, Perich started the process by asking a staff person to write out the entire process of how a fee sheet moves through the practice. After the process was written out, Perich went back to each member of the staff who handles the fee sheet to make sure it was correct. Then she used an off-the-shelf flowchart software program to create a document that was easily understandable to the staff.

"Putting it in flowchart form makes it much easier to read. People get turned off by long narratives, and they tend not to read them," Perich says.

Perich meets once a week with all the managers in the office. This includes managers in the business office, nursing, lab, and transcription areas. The entire staff of 63 meets for lunch once a month. The staff includes eight physicians, four midlevel providers, and a laboratory staff.

"We talk about what we need from other staff people and what they need from us in order to do their jobs well. This all ties into communications and customer service," Perich says.

Giving the staff an opportunity to communicate regularly has been "a tremendous help" in ensuring that the office runs smoothly, Perich adds. For instance, one staff member recently proposed making a change in his department and didn't think it would make any difference to the rest of the staff.

"As soon as it was mentioned, about four people here spoke up about how it would impact their departments," she adds. ■

HMO project improves infant mortality rate

Project tracks pregnant Medicare patients

Concerned by low birth weights and high infant mortality rates in the Philadelphia area, four competing HMOs have collaborated on a project designed to improve birth outcomes in the Medicaid population.

The Healthier Babies project identifies and tracks behaviors and health status of pregnant Medicare women in a five-county region of Southeastern Pennsylvania. All providers who see pregnant women covered by the four Medicaid HMO plans use a universal prenatal encounter form to identify

Executive Summary

Subject: Project to improve birth outcomes for women on Medicaid

Essential Points:

- Four competing Philadelphia HMOs collaborate
- Providers all use a standard intake form
- Insurers track behaviors and health status, and intervene when needed
- Aim is to reduce infant mortality rate

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and track the health behaviors of their patients, says **Richard J. Baron**, MD, president and chief executive officer of Healthier Babies, Inc.

The project was developed by Health Partners, a leading Medicaid HMO in Philadelphia. Other participating health plans include Keystone/Mercy, Health Management Alternatives, and Health Resources Management.

The data collected during the prenatal visits is put into the Healthier Babies database, giving insurance company case managers the information they need to determine which pregnant women need interventions to improve their health and that of the babies.

For instance, the case managers are using the information to enroll the women in smoking cessation and diabetes management programs, to institute nutritional programs, to find shelter and food for homeless pregnant women, and to schedule cesarean sections for HIV-positive patients or drug users.

Before the project was implemented in May 1998, the four HMOs participating had four different methods of collecting clinical data on its Medicaid patients, Baron says. These included reports by telephone, fax, and paper documents. Many times, data collection and reporting fell between the cracks because the various types of paperwork and ways of reporting made it impossible for physicians to comply, he adds.

"There was no way that the doctors could comply with four different procedures for these patients," Baron says. Now, there is a standard form for collecting data for all HMOs, which operate across five counties. Healthier Babies finished collecting a year of data on May 1.

"It's not our expectation that we will be able to demonstrate a specific impact now. The major thing it has done is make information about the patients available to their HMO so that the HMO case managers are doing more outreach and women who have certain needs are being offered certain services," Baron says.

For instance, one HMO reports that it now is identifying 40% more pregnancies with the Healthier Babies database. In the past, the only way it identified a pregnancy was when it got a claim from an obstetrician.

The average physician's office does not have the ability, knowledge, or resources to solve the problems that cause low-birth-weight babies, Baron points out.

"The managed care providers have the ability to follow women longitudinally across sites. No individual physician can do that," he says.

When the project began, 11.5% of the mothers in the five-county area gave birth to low-birth-weight babies, almost 2.5 times the national health goal, Baron says. The Philadelphia area has a 60% Medicaid population.

In suburban counties, where there is a smaller Medicaid population, the low-birth-weight rate is 6% to 8%, Baron says.

"It's a public health problem of major proportions. Every obstetrician taking care of Medicare patients cares about it, and every one would do what they could to make it better," Baron says.

The goal is to reduce greater Philadelphia's infant mortality rate from eight to 12 deaths per thousand to five deaths per thousand.

The program tracks about 15,000 pregnancies each year across five counties. The pregnant women see a doctor an average of seven times, for a total of 105,000 encounters in a year. Nearly

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800 providers see patients at 250 to 300 sites. The sites include city health centers, residency clinics, and private doctors' offices.

"We have a very heterogeneous provider environment. It was a challenge to come up with a new standard of care and get it implemented across such a wide variety of venues," Baron says.

When the project was proposed, some physicians complained about the extra time they would spend filling out the form.

"We suggested that the physicians regard providing the information the same way they would regard sending a diabetic with a complicated pregnancy to an expert. It is a process of providing the information they need to improve their health," he adds.

The providers and managed care organizations expressed concerns about patient confidentiality, Baron says. "We were collecting a lot of sensitive data. They questioned whether we had the authority to do that," he says.

The ultimate answer was that Healthier Babies acts as an agent of the insurance company, has access to the same information as the insurance company, and faces the same confidentiality issues as an insurance company, Baron adds.

The database was designed so it cannot be widely accessed. For instance, if a patient is a member of HMO "A" for the first half of her pregnancy and HMO "B" for the remainder, HMO "B" cannot get access to the records from the first half of the pregnancy.

In the future, the HMOs and county health departments will team up to coordinate a smoking cessation program for pregnant smokers identified by the database. A grant from the Robert Wood Johnson Center for Health Care Strategies, Princeton, NJ, provided money to capitalize the project. User fees from the Medicaid HMOs are used to support the day-to-day operations. ■

SourceKit

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