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INSIDE

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American Health Consultants® is A Medical Economics Company

Want marketing to play bigger role? A formal plan can bring action

Putting together a plan can bring a commitment to action

Parents like to encourage their children to make and keep budgets when they leave home. As a nation, we have expected our elected officials to stop spending into the red and stay within our country's means. Why, then, do so many physician practices fail to create and stick to a marketing budget?

Vickie Alleman, a senior health care consultant with Horne CPA Group in Houston says that without a budget, practice administrators don't know what is expected of them. "That makes them tend to overspend," she says. Making and keeping a budget not only keeps you within your means, it also brings focus to practice goals. "When you commit a dollar amount, you increase the chance that you, as a group, will focus on something," says Alleman. "Sitting down as a group and discussing what is important, why, and how to get to your goals is something of a teaming exercise. It encourages a follow-through on specific activities. And in an era where money is tight, a budget also keeps you aware that there are limited resources."

Getting the right group together

To create a marketing budget, Alleman recommends that in a small practice, the owners and administrator of the practice sit down together. In a larger organization, you might have a meeting that includes the chief executive, the chief financial officer, members of the board, and any marketing personnel you have. "These are the people who are going to make something happen," she explains. "The physicians commit the money, and the rest of the group is responsible for the financial health of the organization. They have to know where the dollars are going and approve of it."

Some physicians may object — both to the notion of spending money on marketing and to the idea of taking time out to participate in a budgeting exercise. But Alleman says you can overcome those objections by asking doctors to look at a marketing budget in terms of organizational goals, or strategic planning. "Two physicians in a small practice may

Marketing Plan Matrix

Goals and Objectives	Communications Strategy and Tools	Budget
Increase referrals from current referring physicians by 10% in first quarter.	Establish weekly lunch and learns at physician offices for physicians and staff. Office manager to establish contact.	Lunch: $75-$125 per week, depending on size of office staff. Promotional items: $2,500 per quarter.
Establish patient satisfaction at 95% and higher.	Identify current problems through patient survey. Based on findings, train staff in communications on quarterly basis.	Patient survey: $2,500. Staff training: $1,000 per quarter.
Increase awareness of new procedure in community.	Public Relations: Send out press release. Set up speaking engagements with local community groups.	Press release: letterhead and postage costs. Engagement set up: staff time. Outsource PR: $1,000-$2,000 per month, depending on market.
Increase awareness of new procedure in community.	Advertising.	Print ads: $5,000, depending on market size. Advertise a minimum of three months; have a call to action in ad. Outside resources needed: copywriter, graphic artist, media buyer, or ad agency with health care expertise.

GOALS AND OBJECTIVES: Specific, measurable, time-oriented focus.
COMMUNICATIONS STRATEGY/TOOLS: Strategy is how you will reach your goals/objectives. Tools are items such as brochures, advertising, health fairs, media interviews, publicity, direct selling. You often need more than one strategy and tool to reach your goal.
BUDGET: The money needed to achieve the goals using specific communications tools.

Source: Horne CPA Group, Houston.

have three goals," she says. "And if you don't quantify how you will achieve them, how will you get there?"

Practices that either don't have the will to create a marketing budget or that can't convince the physician owners and other decision makers it's a good idea often end up doing hit-and-miss marketing.

"You'll get a doctor saying someone called and asked him to sponsor an ad in a high school yearbook," Alleman explains. "But doing it won't give you something whose success you can measure. It isn't effective because it is not likely to be doing anything to get you toward a certain goal. The money you spend has to be attached to a concrete aim."

Creating a matrix to outline your goals, how you will get there, and what it will cost is a good way to start **(see sample matrix, above)**. Once you have set your goals — for instance, improving physician referrals to your practice — you can come up with ideas on how to get there. Perhaps you need a new brochure, says Alleman. Someone has to be assigned the task of getting bids for the brochure. "Ask your peers who they use," she advises. "If a practice has a brochure you like, ask them who did it and how much it cost."

COMING IN FUTURE MONTHS

- Revamping your patient education library
- What telephone medicine can do for your practice
- The secrets of a good radio campaign
- Bringing efficiency to the hospital-owned practice
- Electronic claims filing comes of age

Other resources to help you find information on the products or services you need to buy are area public relations firms and professional organizations and the local hospitals with which your practice is affiliated.

Alleman says you should resist the urge to take on tasks such as creating brochures or doing patient surveys yourself.

"Often, that's a waste of money," she explains. But sometimes, after getting some initial assistance from professionals, a good practice administrator or marketing executive can take over the responsibility. "If you have the survey done the first time, you can often repeat it yourself later."

Don't guess on the numbers

Whatever you do, be sure to get hard numbers for your budget, she warns. "Don't guess. You'll inevitably be wrong."

Alleman says practices should try to commit about 5% of revenue to a marketing budget. "That's actually rare these days, even if that's what they should do." More common, she continues, is to see practices spending about 2% on marketing. "It's much harder to accomplish a lot with the smaller figure, though."

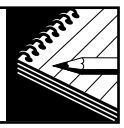
In your budget, you also should allow for some contingencies, such as late requests to sponsor health fairs, which might fit in with your overall strategic goals for growth. A five-physician practice probably should set aside about $3,500 per year for such contingencies. "That allows you to do things you didn't plan for, but which are opportunities you don't want to miss," she says.

If you have never had a marketing plan and budget, Alleman says you should start small. "Do something you are comfortable with. If you need more referrals, do lunches for other physicians and their staff. That costs more in time than money. Don't just jump in with a slick new brochure and change things too fast." ■

SOURCES

- **Vickie Alleman**, Senior Health Care Consultant, Horne CPA Groups, Houston. Phone: (713) 975-1000.

GUEST COLUMN



Creating a big plan on a small budget

By **Kimball G. Herrod**, MBA
Senior Consultant
The Camden Group, El Segundo, CA

Health care providers have had to tighten their belts as they have faced declining reimbursements from managed care organizations and other payers. Medical group and physician practice marketing budgets also have felt the pinch. With the rise of point-of-service and other open-access plans, consumers are regaining the freedom of choice in selecting their health care providers.

In addition, the Internet and other information dissemination media are allowing consumers to become more educated about their health than ever before. Although marketing budgets are being squeezed, consumer-focused marketing plans still play a vital role in attracting patients with choice and increasing practice volume. A proven process for developing effective consumer-focused marketing plans is identified below:

1. **Identify goals, objectives, and time frames.**

The first step in developing a successful marketing plan is first identifying the goals and objectives of the plan. "Begin with the end in mind," as stated in Stephen R. Covey's book *Seven Habits of Highly Effective People*, is very applicable in developing a marketing plan. You must determine what you want to accomplish before you begin developing the plan. For example, if the goal of your marketing plan and campaign is to increase the overall image of the group or practice, you would develop entirely different strategies than you would if the goal of the plan is to get patients through the front door. Different goals and objectives in developing a marketing plan may include the following:

- increasing consumer awareness;
- building the image or brand of the medical group / practice;
- increasing patient volume;
- increasing patient / physician referrals;
- improving patient satisfaction.

Meeting as a management team and with physician leaders to determine the overall goals and objectives is an important initial step that will lay the foundation for the rest of the planning process. In addition to determining the goals of the plan, time frames and a schedule must be developed. A schedule that allows adequate time for analysis should be allowed; however, beware of the "deadly delay," which hinders momentum and support for the planning process.

2. **Interview key stakeholders.**

Interviewing key stakeholders not only will help gain support for the marketing plan, it also will assist in gathering marketing ideas and tactics. As you conduct interviews early in the planning process, you will be able to gain support among key individuals and help them take ownership in the strategies and tactics. Interviews should be conducted with the following:

- physician leadership;
- medical group management;
- referring and nonreferring physicians;
- existing patients;
- former patients.

Others may be interviewed as deemed relevant. During these interviews, you will find out how your physicians and group are perceived by consumers and physicians in the marketplace. Finding out why existing patients choose your services and why physicians refer to your group will help you determine what qualities, benefits, and attributes you should communicate in your marketing efforts. Interviews with nonreferring physicians or with former patients will help you learn what your group must do to improve and what barriers it must overcome.

3. **Assess the situation.**

The next step in the process of developing a marketing plan consists of performing an internal and external situation assessment. The internal assessment reviews current operations, performance, and internal practices of the medical group. The external assessment evaluates key environmental or marketplace factors that will influence the development of the plan.

❑ **Internal assessment.**

Conducting an internal assessment will help identify the overall strengths and weaknesses of the medical group. Reviewing current operations can be accomplished using a variety of research methodologies, such as patient satisfaction surveys, one-on-one interviews, or review of internal data. The internal assessment should help you identify attributes or benefits you provide that differentiate your organization from the competition. Information to be reviewed and analyzed could include the following:

- physician qualifications, experience, and bedside manners;
- office hours, waiting times, and other operational issues;
- quality measures and outcomes;
- existing patient origin (where patients reside);
- accessibility and convenience of physician practices;
- patient volumes by physician, specialty, or service;
- managed care contracts;
- patient satisfaction levels.

Reviewing this information should help identify your organization's strengths to be leveraged in marketing activities and should be a focus of the marketing plan. In addition, this analysis should identify weaknesses that management must be aware of and deal with appropriately.

❑ **External assessment.**

Conducting an external assessment will help identify the opportunities and threats facing your organization. Evaluating the medical group's position in the marketplace will help determine where the group is now and where it needs to go in the future. Information to be reviewed and analyzed could include the following:

- demographic profile of the service area;
- competition and competitor activity;
- area use rates;
- health plan and payer initiatives;
- managed care penetration;
- market share;
- market segments / potential target audiences.

By understanding your competitive environment, you will be able to develop a marketing plan that will help your organization successfully compete in the marketplace.

4. **Identify strengths, weaknesses, opportunities, and threats (SWOT).**

Pulling together data and information gathered from the interviews with key stakeholders, internal assessment, and external assessment, you are now prepared to conduct a SWOT analysis. Although there are many other strategic analysis tools for processing and assimilating information, the SWOT analysis is probably the easiest and most concise tool for summarizing

the organization's overall situation. After completing this analysis, you should meet with the management team and physician leaders to review the findings and evaluate the direction and strategic alternatives for the marketing plan. In this meeting, you should identify key market segments (i.e., demographic, payer, geographic, etc.) you want to target and attract, discuss critical success factors, and revisit the goals and objectives and modify them if appropriate.

5. **Developing marketing strategies and tactics.**

Now that the strengths, weaknesses, opportunities, and threats have been reviewed and evaluated, as well as market segmentation, you are finally prepared to develop specific marketing strategies and tactics to reach targeted audiences. Strategies should focus on communicating your organization's strengths, rather than trying to use promotions to overcome any negative perceptions your consumers already may have established.

For example, if your medical group has been known for having long waiting times, do not develop promotions that communicate "we don't have long waits" or "we have quick physician access." Instead, focus on what you already do well and the reasons you are loved by your loyal patients, such as "our physicians utilize the latest technology" or "our physicians listen carefully and are understanding." Try to differentiate your organization from the competition in areas that really matter to patients.

Specific physician marketing strategies and tactics may include the following:

- developing advertisements in local newspapers and magazines;
- improving satisfaction and increasing communication with existing patients;
- improving communication with physicians in the community by developing a newsletter or providing educational presentations;
- sponsoring youth teams (e.g., little league) or volunteering as a high school team physician;
- developing a Web site;
- targeting specific geographic areas;
- using direct mail;
- presenting health education seminars to community groups.

The primary focus of these activities should be on communicating quality and the strengths of your physicians and organization. As you increase positive communication with patients and physicians, you will begin to build trust and develop long-lasting relationships.

SOURCE

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6. **Achieving agreement on the plan.**

The last step in the process of developing a marketing plan is to have the management team and physician leaders review and approve it. Including these stakeholders throughout the planning process will garner good insights and help them take ownership so the plan can be implemented successfully.

Following this six-step planning process will help you develop a marketing plan that will reach targeted audiences and maximize your marketing budget. Developing a marketing plan without going through the appropriate planning process may lead to a plan that is not consumer-focused and does not achieve your organization's goals. Staying focused throughout the process will increase the effectiveness of your marketing efforts while efficiently using your marketing dollar. ■

Survey shows docs busier and making more money

Direct compensation up in most cases

If physicians have the feeling they are doing more than ever, their gut instincts are right. According to the annual Medical Group Compensation and Productivity Survey by the American Medical Group Association (AMGA), median gross production increased in most specialties between 1997 and 1998, and from 1995 to 1998, it increased in all but one category: emergency care.

All that extra work is being rewarded, although not with the same increases as are evident in productivity. Direct compensation increased in most specialties between 1995 and 1998 and in more than half of the measured specialties during the 1997-1998 year **(for more information on production and compensation, see tables, p. 114)**.

The survey, conducted by the national accounting firm McGladrey & Pullen of Minneapolis,

(Continued on page 115)

Physician Median Productivity
1997-1998

Medical Specialities	1998	1997	Percent Change
Family Medicine	$338,652	$339,011	-0.11
Gastroenterology	947,199	847,000	11.83
Internal Medicine	340,232	342,869	-0.77
Pediatric & Adolescent	352,000	341,726	3.01
Urgent Care	351,547	352,017	-0.13
Cardiac/Thoracic Surgery	1,557,205	1,598,837	-2.60
Emergency Care	423,138	420,678	0.58
General Surgery	877,535	810,036	8.33
Gynecology & Obstetrics	700,798	679,738	3.10
Orthopedic Surgery	1,051,626	1,091,712	-3.67
Urology	895,228	869,799	2.92

Physician Median Compensation
1997-1998

Medical Specialities	1998	1997	Percent Change
Family Medicine	$136,741	$137,100	-0.26
Gastroenterology	217,350	207,000	5.00
Internal Medicine	140,000	136,948	2.23
Pediatric & Adolescent	132,003	133,000	-0.75
Urgent Care	138,086	142,601	-3.17
Cardiac/Thoracic Surgery	385,000	400,000	-3.75
Emergency Care	175,064	178,166	-1.74
General Surgery	242,309	233,874	3.61
Gynecology & Obstetrics	225,000	218,484	2.98
Orthopedic Surgery	296,630	292,071	1.56
Urology	245,145	234,995	4.32

Source: American Medical Group Association, Alexandria, VA.

questioned 2,600 medical groups around the country. Valid responses came from 115 groups.

Among the other findings were these:

• Most experienced physicians have productivity-based pay arrangements.

• Fifty-nine percent of primary care doctors and 57% of specialty physicians have productivity-based pay.

• A quarter of revenues from responding groups is capitated.

The survey also contains a small section on administrative salaries — much smaller than last year's survey — and with less information, making comparison of compensation difficult at best. For 1998, total compensation of select administrative positions was:

• $77,220 for chief financial officers;

• $150,000 for medical directors;

• $150,000 for nonphysician administrators, presidents, or chief operating officers;

• $168,600 for physician administrators or chief executive officers;

• $41,405 for public affairs or marketing directors;

• $46,583 for business office managers.

The survey is available for purchase by calling the AMGA at (703) 838-0033. ■

New compliance guides bring new worries

Developing compliance plan ever more important

In mid-August, a Seattle physician appeared in court to answer charges that he tried to defraud the government of Medicare funds. His was the latest in a string of practices targeted by the Department of Health and Human Services' Office of the Inspector General (OIG). The charges were brought shortly after the department issued its latest batch of voluntary compliance guidelines for Medicare managed care plans.

The guidelines include information on policies, procedures, and standards of conduct; on designating a compliance officer and committee; on developing training and education programs; on creating complaint hotlines; and on performing internal audits to monitor compliance. The guidelines are available in their entirety at the *Federal Register*'s Web site at www.nara.gov, pp. 33869-33887, June 24, 1999. It also is available at the OIG's Web site, www.dhs.gov/progorg.oig under the "What's new" section.

Although this latest group of guidelines initially will have more impact on managed care organizations that run the Medicare managed care programs, they eventually will filter down to physician practices. Practices may be required by their managed care organizations to implement compliance plans the MCOs create.

Physicians a new target

Physician practices heretofore have not been perceived as targets of the OIG, but there is some feeling that a change is coming. According to **Karen E. Davidson**, Esq., a lawyer at the West Conshohocken, PA, law firm of Mackarey & Davidson, government investigators have indicated they are just learning about Medicare Part B billing. They are beginning to understand both the potential for fraud and abuse and the amount of money that could be recouped from practices found to be violating the law.

"I think you will see more [emphasis on medical practices] in the future," she says. "And I think practices would be well-served to start implementing a compliance plan."

Creating a compliance plan almost always requires hiring outside consultants and lawyers. Davidson says practices that have an administrator who is extremely savvy, up on the guidelines, has gone to seminars, and has the time to put together a plan could develop one internally; legal counsel could review the plan when it is complete. Most practices, however, will have to shell out some serious money to put together a good plan, she says.

"Having a compliance program will probably help you sleep better at night," says Davidson. "Spending $15,000 or $20,000 to do this may seem like a lot. But if you have a substantial amount of Medicare billing per physician, it doesn't seem like so much." And the initial outlay of money could seem like peanuts next to fines and penalties levied on practices found to be in violation of regulations. Even if you do commit an error, says

SOURCES

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Davidson, having an effective plan in place may help keep your fines down. "If you don't have a plan implemented, the presumption that you did this inadvertently is gone. You are looked at as if it was more intentional."

While the guidelines aren't compulsory, Davidson says there are sound reasons to create a compliance plan based on the guidelines anyway. "It's like buying insurance. It's an expense, but you do it just in case."

(Editor's note: In future issues of the newsletter, Practice Marketing & Management *will run a series of articles on the hows and whys of creating a sound compliance plan.)* ■

Heavy patient volume? PAs may be the answer

They can perform MD duties at a lower cost

Do you often feel like you need to be in two places at once to take care of all your patients' needs? Are you facing pressure to see more patients each day while your practice is squeezed by reimbursement cuts?

One prescription for relief may be to hire a physician assistant (PA) to work in partnership with your physicians to take care of patients.

If health plans are paying you less per patient, you're going to have to see more patients in a day in order to stay in the black. To avoid rushing patients through, many practices are hiring physician assistants who can handle a caseload of patients on their own without commanding the salary of an additional MD. What's more, reimbursement for PAs is becoming more widespread.

If you're fully capitated, having a physician assistant care for patients still can have a positive effect on your bottom line.

"The physician / physician assistant team is an effective way for physicians to compete in the managed care environment," says **Ron Nelson**, PA-C, president of the American Academy of Physician Assistants (AAPA) in Alexandria, VA. "By working with a physician assistant, a physician can expand the scope of his practice and take care of more patients."

Physician assistants can provide the same type of services as a physician, but at a lower cost. The average salary for a physician assistant is $65,000 a year, according to the academy. New graduates start at about $55,000 a year.

PAs practice in every medical and surgical specialty. By law, physician assistants may take medical histories, perform physical examination, order and interpret laboratory tests, diagnose and treat illnesses, suture wounds, and assist in surgery. They are authorized to write prescriptions in most states.

"We like to tout ourselves as being the right-hand person of the doctor," says **Diana McGill**, PA-C. McGill, who has been a physician assistant for nine years, recently started Pro-Search Medical Placement, a Houston firm that specializes in placing physician assistants with Texas physicians. She works two days a week as a PA for a family practice, where she treats about 30 to 35 patients a day.

"We couldn't imagine running our practice without physician assistants. They add tremendous clinical depth and bring terrific skills and orientation to the practice," says **Peter Dreyfus**, spokesman for Harvard Vanguard Medical Associates, where 500 physicians and 90 physician assistants treat 290,000 patients at 14 sites.

Physician assistants and other allied health professionals often are called "physician extenders" because they act as an extension of the physician.

"It's almost like the surgeons can be two or three places at once," says **Barbara Kahwaty**, PA-C, of her role as a physician assistant in surgical specialties at Harvard Vanguard Medical Associates, a multispecialty group practice in the greater Boston area. For instance, if a patient is having a problem after surgery and the surgeon is not available, Kahwaty can see the patient, prescribe pain medication, and decide whether the patient needs to be seen by the physician. "If I can't solve the problem, I page the surgeons," she says.

If a patient comes in with an acute injury, Kahwaty can deal with it in many cases. If the PA determines that the patient will need surgery, the PA calls the orthopedist, arranges for surgery, and meets the surgeon in the operating room.

Kahwaty, who has been a PA for 19 years, practices in three specialties: orthopedics, general surgery, and urology. She has her own caseload and often is the only practitioner who sees a particular patient. She acts as first assistant in surgery and can perform minor surgery under local anesthesia.

As a PA specializing in surgery, Kahwaty is the exception rather than the rule. More commonly,

Reimbursement expands for work performed by PAs

Most third-party payers cover their services

The services of physician assistants (PAs) are covered by Medicare, Medicaid, TRICARE (formerly CHAMPUS), and most third-party insurance companies, according to the American Academy of Physician Assistants (AAPA) in Alexandria, VA.

Reimbursement rates vary from state to state and insurer to insurer, says **Diana McGill**, PA-C, president of Pro-Search Medical Placement, a Houston firm specializing in placing physician assistants. In Texas, most insurance companies reimburse for PA care at 85% of what a physician is paid for the same services, she says. In the case of surgery, the reimbursement is 85% of the cost of an assisting surgeon. Medicare reimburses at 100% if the physician is on site, she adds.

Fort Collins (CO) Youth Clinic bills the same for a visit to a PA as for a visit to a physician, says **Jeannette Perich**, CPA, administrator. As managed care has increased, the practice has increased the number of physician extenders, she adds.

Harvard Vanguard Medical Associates, a fully capitated multispecialty group practice in Boston, uses more than 90 PAs who work with its 500 physicians, says **Peter Dreyfus**, practice spokesman. "Physician assistants provide care at a lower cost and often enhance the care patients receive," he adds.

There are a number of ways to structure PA compensation. Some receive a straight annual salary; others receive a salary and a bonus based on productivity; still others are partners in the practice and are compensated based on revenues. At Harvard Vanguard, the PAs, nurse practitioners, and other advance practice clinicians are all voting members of the practice. **Barbara Kahwaty**, PA-C, a physician assistant, also serves on the board of the practice. "We had to put our salary at risk, but it aligns all of us on the same team," she says.

Some states allow PAs to work as independent contractors and receive an hourly wage for whatever time they spend in the office, McGill says. However, in all cases, the practice, and not the individual PA, is reimbursed by the third-party payer.

[Editor's note: The AAPA sponsors a course on reimbursement for PAs and similar providers. The daylong course covers coding and documentation, credentialing, avoiding fraud and abuse pitfalls, and working with private insurance and the Health Care Financing Administration. Courses are scheduled for Aug. 9 in Boston and Oct. 29 in Chicago. More locations will be announced later. Information is available from the AAPA meetings department at (703) 836-2272, ext. 3405.] ■

PAs specialize in internal medicine, family practice, and pediatrics.

For instance, at Fort Collins (CO) Youth Clinic, three physician assistants and a nurse practitioner routinely see young patients for common childhood illnesses, says **Jeannette Perich**, CPA, administrator. The nine-physician practice hired its first physician assistant 15 years ago, added two more two years ago, and is hiring a fourth this year.

"There are so many childhood illnesses that aren't life-threatening but need to be treated. Having extenders leaves the physicians available for more critical care," Perich says.

Parents are always given the option to have the child see a physician, and the PA will pull a physician in immediately if needed, she adds. In some cases, physicians utilize PAs as they would a resident or a fellow, McGill says. The PA works up a difficult case, then presents it to the physician.

As an example of a complicated case, McGill cites seeing a patient with abdominal pain.

"I work up the patient, get a good history, and do a thorough physical. Then I present that patient to the physician, who comes into the examining room with me," she says.

Developing a partnership

The success of a physician / physician assistant partnership depends on how well the two can work as a team and how well the patients accept the physician assistant.

"I've seen all sorts of successes with physician assistants, and some failures," says **Marc Benoff**, MBA, director of Dan Grauman Associates in Bala Cynwyd, PA, a management and data consulting

firm specializing in the health care industry.

When an MD/PA relationship doesn't work out, it may be because the physician doesn't feel comfortable giving the assistant a lot of responsibility. That's the reason the AAPA recommends that when a physician and a PA begin practicing together, they should discuss how they should work as a team. The physician with whom the PA will work must be involved in hiring the PA so their personalities will be a good match.

"Arranged marriages" often don't work, points out Kahwaty. If you are an employee of a health plan that is hiring PAs, insist on being involved in the hiring process and carrying out the performance evaluation.

Suggestions to consider

If you're considering hiring a PA for your practice, here are five more suggestions for making it a success:

1. Check on how your payers reimburse for physician extenders, suggests Benoff. You want to make sure you can recoup the cost of the PA salary. **(For details on reimbursement issues, see story, p. 117.)**

2. Have the PA candidate shadow the doctors they are going to work with for a day to get an idea of how they would function in your office, says McGill.

3. Consider hiring a PA on a temporary basis, McGill suggests. This allows the physician and the PA to get an idea of whether they can work together without a binding contract.

4. Have the physician introduce patients to his or her new PA partner and tell patients that the two of them will work as a team, says Dreyfus of Harvard Vanguard Medical Associates.

5. Give your patients a choice about which practitioner they prefer to see.

Never force patients to see a PA if they don't want to. It's a decision the patient has to make. Some patients want to see a doctor, not a PA. Some practices report that patients would rather see a PA sooner than wait for an appointment with their physician. Some patients see a PA because they can't see their doctor and wind up asking for their next appointment to be with the PA. ■

Is your practice ready for a JCAHO survey?

Network accreditation can put you in the spotlight

If your practice is part of a health care network seeking accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), your office may be selected for a site review as part of the accreditation survey process.

JCAHO, based in Oakbrook Terrace, IL, includes a sample of practitioner sites in its survey activities to determine if the network is meeting the standards for communicating with and providing oversight to its components.

JCAHO's Network Accreditation Program, begun in 1994, offers accreditation to health care networks, including integrated delivery networks, health plans, and preferred provider organizations. JCAHO standards state that networks must have a process for selecting and continuously evaluating the performance of its contractors. The networks must evaluate the clinical records and office practices of practitioners being appointed and reappointed to the network.

All sites with which the network contracts are held to the same performance and quality standards applied to the network.

"We're not looking at the actual decisions being made about clinical care or what the practice is doing with a particular patient," says **Gina Val Zimmerman**, executive director of network accreditation surveys for JCAHO. "We are looking for issues around the communication and linkage of the practice site and the network or health plan."

Joint Commission surveyors pick up to eight physician office sites during a network survey, says Zimmerman. Networks are notified of which physician office sites will be surveyed at least six weeks before the survey. It is up to the network to notify the practice sites involved in the survey.

Performance issues that will be addressed by the surveyors include:

- level of integration of health care treatments and services throughout the network;
- availability and accessibility of care and services;
- communication between the network and practitioner sites;

• involvement of the practitioner site in network performance improvement activities.

At most physician offices, the surveyors will be looking at four months' worth of records. This is because most of the networks seeking accreditation are doing so for the first time since the network accreditation program was established in 1994. When the JCAHO does its second survey, three years down the road, surveyors will look at a year's worth of data, Zimmerman says.

The survey process includes interviews with staff, observation of how the physician practice operates, and an examination of medical records.

"Surveyors generally spend most of their time with the office staff. At some point during their visit, they want to have an opportunity to talk with the practitioners, even if it's just for a few minutes," she says.

Surveyors are likely to ask the physicians about their experiences with the health plan or network, she adds. "We're not looking at clinical care but at issues relating to communication, documentation, and what the patient experience is."

Likely candidates

When the Joint Commission chooses physician offices to review during a network accreditation survey, your office is more likely to be selected if:

• you had a lot of patient volume related to the health plan or integrated delivery network in the 12 months before the survey;

• your office is among the sites that have been reviewed by the network during the previous 12 months.

"We won't go to a site with no activity for that particular network, nor would we select a site that hasn't been reviewed by the network," says Zimmerman.

The number and type of physician office sites chosen for review as part of the accreditation survey process is based on the number of sites in the network or health plan and the types of practitioners in the network.

For instance, if the network includes between one and 200 physician office sites, the surveyors would visit up to four practice sites. If the network has more than 500 physician office sites, the surveyors would visit eight.

"We based our selection on a representative sample of the types of practitioners in the network. For instance, if the network has primary care and specialty care sites, we look at both types of sites," Zimmerman says. ■

Here's what JCAHO will be looking at

Network linkage is a key issue

When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visits a physician office site, the surveyors are checking on compliance with eight network accreditation standards. Most of the standards deal with whether the network communicates with and oversees the practice sites with which it contracts, says **Gina Val Zimmerman**, executive director for network accreditation standards.

Here are some of the issues the surveyors address:

❑ **Communication and linkage issues.** The surveyors make sure the practice site is familiar with the network's policies and procedures and how they are to be implemented.

❑ **Performance improvement activities.** The surveyors determine whether staff know the network's performance improvement priorities and whether the physician offices participate in performance improvement activities. "We look at the networkwide process for performance improvement, and how it incorporates physician offices and all other sites where patients receive care," Zimmerman says. Among the things the surveyors look for is how physician offices receive data and information from the health plan and how they send information to the health plan.

❑ **Patient rights.** The surveyors will check to see that staff are familiar with the policies and procedures the network has in place regarding patient rights. "A big area in the network practice site office relates to respect of the members of the network," she says.

Among the areas the surveyors will look at are:

• How does the network handle confidentiality of member information?

• How does the practice site protect patient privacy and security? For instance, the surveyors will check to see if the physician office takes steps to ensure that other patients do not know who is visiting the office and for what reason.

"One issue that has come up in recent years is the possibility of someone walking into the reception area and reading the list of patients who have been treated that day," Zimmerman says. Some physician offices have complied with this part of the JCAHO patient privacy issue by

asking patients to sign in on an index card, as opposed to logging in on a list.

• How are the medical records maintained? For instance, the surveyors will check to see if the records are secured in a back office that is locked at the end of the day.

❑ **Grievance procedures.** Surveyors look at how the physician officers are linked with the health plan or network. Does the practice site know how to handle complaints and grievances? Is there a toll-free number to call? Does everybody in the office from the receptionist to the physicians know what it is?

❑ **Continuum of care in the practice site.** Surveyors examine how well services are integrated. Do the physicians know how to make a referral to another provider? Do the physicians understand what other sites are included in the network? Do they know how to access the referral process? Do they have forms or instructions for referrals? If they need to communicate with the network, do they know whom to call?

❑ **The referral process.** Surveyors will examine how the various settings in the health plan or network are linked. They want to know how the patients' records or other information is transmitted, what information is forwarded with the patient, and how the sites share information.

Are you documenting your education efforts?

❑ **Education and communication.** Surveyors want to determine if staff know what types of education they should provide and if they do so. Surveyors also look for documentation in the clinical records showing education was provided.

❑ **Leadership issues.** Are the physicians involved in decisions made by the health plan? Do practice sites know how to contact the health plan and how to provide input on strategies and procedures the plan may be implementing?

❑ **Management of human resources.** The surveyors want to determine if staff are competent to perform the skills they have been hired to do and if there are sufficient staff to handle the workload. They look at education, training and orientation to the job, competency assessment, and credentialing and licensing of staff.

❑ **Information management.** This section of the survey includes determining if medical records are being maintained for each patient and if the physician office is carrying out policies and procedures on documentation set by the network or health plan. ■

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