ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ACADEMIC

clinical practice

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1999 Summer Symposium Proceedings

BY WILLIAM SCHU, JR.

When AAMC president Jordan J. Cohen, M.D., closed his keynote remarks at the GFP Summer Symposium by quoting Visa chairman Dee Hock, there was the feeling among the listeners that a revolutionary vision had been presented. While outlining his proposal for a new system of health care delivery—which Dr. Cohen dubbed "collaborative care"—he borrowed these words from Hock:

> Substance is enduring; form is ephemeral. Failure to distinguish clearly between the two is ruinous. Success follows those who are adept at preserving the substance of the past by clothing it with the forms of the future. Preserve substance, modify form, and know the difference.

What follows is an excerpted version of Dr. Cohen's remarks. The full text, and the thoughtful responses prepared by fellow panelists Paul B. Ginsburg, Ph.D., William MacBain, and Judith Feder, Ph.D., are available using the order form on page 2 of the symposium issue.

"Robert Dickler, Senior Vice President for Health Care Affairs at the AAMC, and I have been engaged in active discussion over the past several months, aimed at conjuring up a vision of what the next iteration of the health care system ought to look like. My comments today reflect those discussions.

"The substance of what any improved system ought to do is to provide everyone with access to affordable health care of high quality. The form in which we're doing it at the present time clearly needs to change. We need to concentrate on how to alter the current form so that we can preserve the substance and achieve the vision to which we have all dedicated our lives. I want you to suspend disbelief, and think about where we are with the health care system in this country and what we can do to envision a better system.

"We've learned many lessons—both positive and negative—as a result of health care's experiment with market-oriented managed care. We've learned that there are significant limitations to allowing the market to refashion the system for health care delivery in this country. For example, the market has proven

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Group on Faculty Practice 1999 Summer Symposium was held on July 16-18 at the Loews Miami Beach Hotel in Miami, Florida.

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Friday, July 16

Pre-Conference Program

Process-Centered Management: Improving Service and Operational Efficiency

8:15–9:30am, July 16

OVERVIEW

Harry Bloom
Director, Performance Improvement Practice
CSC Healthcare Group

Lessons from the Field

- Overview
- Case Studies: University of Maryland, Henry Ford Health System, University of Florida

Goals/Objectives

- To share experiences with using process-centered management (PCM) as a tool for "leaping tall departments in a single bound."
- To understand the problems associated with centralizing billing activities and how new organizational models will improve front-end and back-end "revenue cycle" functions.
- To define a more staged approach that practice plans might consider adopting to improve billing and collections functions. This new approach should address the problems of fragmentation of the billing process, lack of specialty and customer orientation, and lack of physician involvement.

Key Points

- The "revenue cycle" is typically described as consisting of front-end and back-end processes. Front-end activities occur prior to a patient service; back-end activities occur after a patient service.
- A "process" is a group of activities that collectively deliver value to a customer.
- Billing at many practice plans involves fragmented front-end functions—such as scheduling, registration, etc.—and perhaps centralized back-end functions, with functional heads in each area of activity, perhaps independent of each other. A process-centered focus requires a team approach that cuts across departments and may include the entire process (i.e., end-to-end revenue cycle activities), a process champion or owners, process outputs, and enterprise-wide process outcomes. The process-centered team is responsible for all steps in the revenue cycle process, for example, for a group of similar specialties.
- Customer service is best managed around end-to-end processes, not in fragmented departmental encounters.
- PCM is characterized by: a) department and faculty are the key process performers, although they are inside a larger process team comprised of the school and the medical center as "customers;" b) standardized, shared, best practice "end-to-end" processes that enable key process outcomes to be achieved; c) single-point accountability; d) leading and lagging indicators to measure performance across the entire process; and e) incentives and rewards tied to achievement of team-oriented process outcomes.

Paradigm Shifts that Characterize PCM

FROM	*TO*
• Department and Faculty as customers	• Department, faculty as key process performers…inside larger process team comprised of school and AMC as customer
• Duplicative, self-contained functions enable control	• Standardized, shared, best practice end-to-end processes that enable key process outcomes to be achieved
• Unclear lines of accountability	• Single-point accountability
• Lagging indicators as measures of performance	• Leading and lagging indicators measure performance across the entire process
• Incentives and rewards tied to longevity	• Incentives and rewards tied to achievement of team-oriented process outcomes
• Continuous, incremental improvement (left-to-right thinking)	• Discontinuous, breakthrough improvement (right-to-left thinking)

Case Study Presentations

Evaluation & Management of Vital Processes at Maryland

9:30–11:45am, July 16

Robert Barish, M.D.
Associate Dean of Clinical Affairs
Bernard A. Carpenter, Jr.
Executive Director of University Physicians Inc.

Goals/Objectives

- Demonstrate the effect of payer rules and disorganized business processes on the financial performance of the FPP
- Provide insight into the conditions affecting performance
- Describe the process and techniques deployed to manage the situation

Key Points

- HMO penetration and FPP collection ratios are related
- Collection rates are declining because of payer "rules" and immature, inconsistent FPP business processes
- Process improvement techniques can be helpful in remediating the situation
- A "hybrid" level management structure can be effective
- Peer review is an effective management tool for administrative processes
- Investments are required in administrative systems and can provide favorable returns

Lessons Learned

- Act now – it's later than you think
- Peer pressure is a powerful change agent
- Physician involvement and leadership are crucial
- Creditability, timely data are a must
- Organization is not the point – function is

Critical Success Factors

- Dean's leadership
- Active physician involvement
- Ability to measure progress and outcomes

Current Status of the Project/Strategy

- Project underway and gaining momentum

Case Studies of Process-Centered Management

University of Maryland University Practice Plan
- Redesign of the "Front-end" sub-processes of the Revenue Cycle
- Pre-registration, insurance verification, pre-certification

University of Florida Faculty Group Practice
- Redesign of the "Back-end" sub-processes of the Revenue Cycle
- Activity Capture through final Bill Resolution (coding, submission, reconciliation, collection, write-off, etc)

Henry Ford Health System
- Redesign of the entire Revenue Cycle

University of Florida: A Model for Process Redesign

9:30–11:45am, July 16

Nancy S. Hardt, M.D.
Assistant Dean for Clinical Affairs and Managed Care, University of Florida College of Medicine

Goals/Objectives

- Reverse this trend: reduced revenue growth with unchecked expense growth
- Align compensation (biggest expense) with productivity (source of revenue)

Key Points

- Departmental budgets are uniform in format
- Information systems permit roll-up of departmental budgets

- Budgets divide revenue and expenses by mission
- With existing subsidies intact, departments "stand on own bottom" or risk losing autonomy
- Steps 1-5 above create the atmosphere for "buy-in" to redesign billings/collections processes
- Place accountability for parts of billing process where it belongs, be it department, clinic, or back-end functions

Lessons Learned

- Buy-in starts at top and bottom
- Struggles between academic mission and financial realities are inevitable
- Education/communication are very, very important
- Messengers need support
- Change takes time, so be proactive
- Implementation is the hardest part; invest adequate resources
- Faculty go through a grieving process: denial, anger, bargaining, depression, acceptance

Critical Success Factors

- Obtain support at highest level (University President; Hospital CEO, Dean)
- Communicate important messages 3 times
- Ask for input from employees at all levels. Use it.

Current Status of the Project/Strategy

- Our project has never been "finished" even though the financial situation has stabilized
- As parts of the project show results, we "remodel" processes to maximize success and isolate failure, for example:
  - We now have data on the criteria for differentiating tertiary care from community care
  - We have determined our clinical costs as a tool to negotiating managed care contracts. As a side benefit, cost analysis can be used to stimulate cost containment behavior.

Henry Ford Health System Revenue Cycle Redesign

9:30–11:45am, July 16

David Hefner
Partner, CSC Healthcare

Goals/Objectives

- To develop a systematic, seamless process to improve customer service and satisfaction.
- To develop a single-point accountability for the revenue cycle process, with aligned performance standards, measures, and incentives.
- To increase collections by at least 4 to 6 percent.

Key Points

- Address systemic issues that cross multiple sites and multiple areas of accountability.
- Focus on information flow breakdowns that require cross-functional integration.
- Establish revenue cycle accountability characterized by:
  1) overall single-point accountability for the end-to-end process and outcomes;
  2) local points of direct authority/accountability for core functions, including centralized registration and verification, inpatient abstraction, transaction capture, billing, collections, customer service.
  3) strong matrix management for shared functions, including point of service patient registration and screening, coding

Poster Session

Susanne Larkins, Staff Associate, AAMC

Composition of Practice Plan Governing Boards

Board Member	Percent of FPPs reporting as Board Member(s) %
Elected Faculty	84
SoM Dean	70
All Dept. Chairs	65
Some Dept. Chairs	27
Practice Plan CEO	27
Other Univ. Rep(s)	27
Departmental Appointees	19
Medical Director	16
Hospital CEO	16
Community Rep(s)	16
Univ. President	14
Other FPP Exec(s).	14
VP-Clinical Affairs	11
Basic Science Rep(s)	8
Univ. Bd. Member(s)	8
Med. Center Pres.	8
Hospital Bd. Member(s)	3

and documentation, medical records management, and information management.

4) a performance monitoring and measurement system with clear targets and expectations.
5) strong oversight mechanism that demands that performance meet or exceed targets while maintaining collegiality and collaboration.

Pre-Conference Program

Medicare's Outpatient Prospective Payment System (PPS): Implications for Faculty Practice Plans

2:00–3:30pm, July 16

Robert D'Antuono
Assistant V.P., Division of Health Care Affairs
Donald Tower
Senior V.P., Vogt Management Consulting
William Vogt
President, Vogt Management Consulting
Charles Smith, M.D.
Executive Director, Medical College Physicians, University of Arkansas College of Medicine

Key Points

- PPS will reduce payments to major teaching hospitals by about 10.6 percent.
- Revenue reductions may result in hospital constraints on outpatient facility operations and access.
- Efforts to improve the efficiency of outpatient business processes will be important.
- PPS may prompt a re-negotiation of contractual service arrangements between hospital and practice plan physicians relative to the outpatient clinic area expenses.
- PPS may result in shifting certain high-cost procedures performed in the outpatient clinic to the physician office setting.

The allocation of resources within teaching hospitals and medical schools is one of the key processes by which these institutions achieve their objectives.

Saturday, July 17

General Session

Integrated Delivery Systems: Strategies for Collaboration Among Physicians and Hospitals

8:00–10:00am, July 17

Aligning Governance, Funds Flow, and Financial Incentives

Ralph W. Muller
President and CEO of the University of Chicago Hospitals and Health Systems

Goals/Objectives

The allocation of resources within teaching hospitals and medical schools is one of the key processes (along with appointments and promotions) by which these institutions achieve their objectives. One important role of governance is to evaluate and modify the resource allocation process in these institutions. This presentation will evaluate how this process varies in integrated delivery systems (IDS) as compared to more conventional academic medical centers.

Key Points

- Access to resources is critical to achievement of academic objectives—the advancement of patient care, teaching, and research.

- Essential that the process for allocating intra-institutional resources is tied to securing resources from external sources.
- Encourage all parts of the IDS to strive for self-sufficiency; avoid encouraging requests for more subsidies.
- Critical missions should be recognized by outside sources (e.g., payors, students, and donors).
- Stability of funds flow can no longer be assumed; all flows should be up for reconsideration every several years.
- Focus on doing things well, because markets will penalize inefficiency and unresponsiveness.

Duke's Clinical Business Units and Integration Efforts

Paul Newman

Executive Director, Private Diagnostic Clinic, Duke University Medical Center

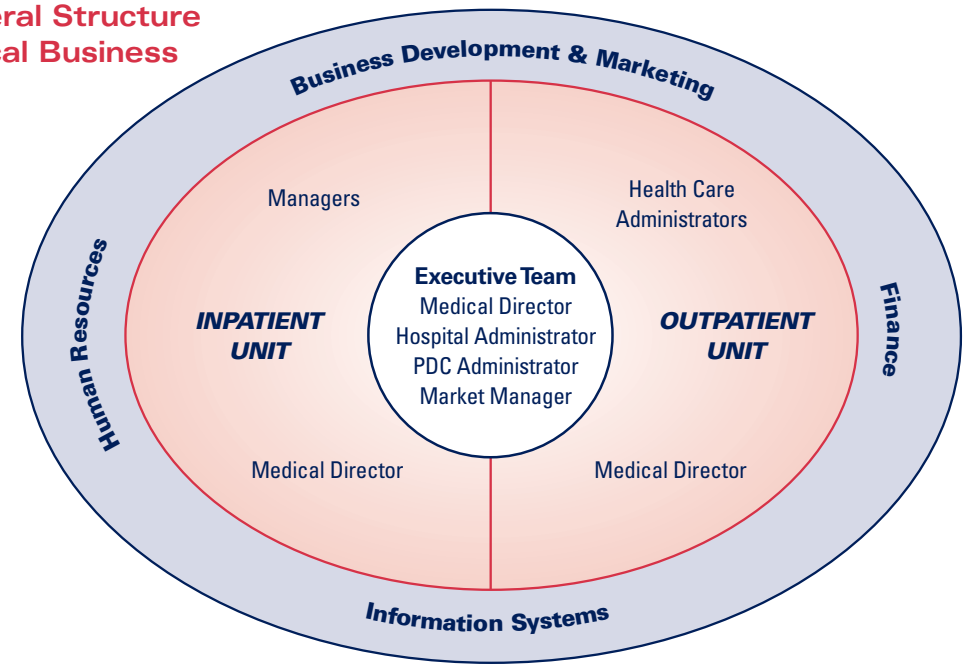
Goals/Objectives

- To describe the potential benefits of integration, and in particular, clinical business units (CBU).

Key Points

- Integrated delivery systems can create a more rational approach to health care delivery; streamline products and services into lines of business; create opportunities to lower costs while improving standards of care and performance; allocate business costs over a large and diversified revenue base; allow for economic leveraging for contracting; and benefit marketing and product differentiation through enhanced geographic distribution.
- A CBU at Duke is defined as a management model that brings together physician, administrative, and business support staff for purposes related to the successful operation of a distinct, or a number of related clinical services.
- Clinical business units can enhance quality of patient care; increase accountability; improve communications; focus on patient and family needs; minimize duplication of services; promote service consistency; align incentives for all team members; enhance financial management performance; optimize marketing efforts.
- CBUs at Duke have succeeded in improving communication, accountability and quality of care—all of which are crucial for the success

General Structure Clinical Business Unit:



of an integrated delivery system. CBUs have not yet met all financial expectations, but must now focus on tougher internal issues, such as prioritization of resources, reducing expenses, and the development of improved models of care.
- It is less clear at Duke if CBUs can successfully be implemented across other entities in the health system.

Physician Networks Contracting and Affiliation Strategies

Sheldon Retchin, M.D.
President, Virginia Commonwealth University

Goals/Objectives

- To understand the marketplace influences that have led to the strategic experiments by academic health centers (AHCs) over the past 10-15 years.
- To appreciate the rationale for the expansion of the primary care capacity of AHCs in the early 90's.
- To scrutinize and assess the alternative strategies used by AHCs for expanding their primary care capacity.
- To review the "affiliation strategy" approach used by MCV Physicians and MCV Hospitals for contracting with managed care plans.

Key Points

- Because most AHCs have historically emphasized specialty practices, they have found themselves poorly prepared to meet the demands of comprehensive care for a defined population. Thus, virtually all AHCs sought new approaches to reinforce their primary care capacity. The tactical diversity among AHCs offers an opportunity to gain insight into what may be effective in the future.
- There are four essential reasons for expanding the primary care capacity of AHCs: access to "downstream referrals," negotiating contracts with third party payors, assumption of risk for covered populations, and creating a distributive network as an insurance vehicle.
- There are three alternative strategies used by AHCs to expand their primary care capacity: the "assembly strategy," the "acquisition strategy" and the "affiliation strategy."
- The assembly strategy involves the building of new primary care practices as start-ups, often by recruiting recently finished postgraduates and constructing practices from mostly new patients.
- The acquisition strategy involves the protection of AHC referral networks by purchasing established primary care practices in the community.
- The affiliation strategy involves the collegial association of AHC primary care physicians with community primary care physicians through the formation of physician networks.
- Size of capital investments, long-term operational costs, access to downstream referrals, ability to assume global risk, likelihood of adverse selection and ability to negotiate with third parties are the discriminating features of the three primary care strategies.
- Annual fees from physicians, direct and indirect revenues from patient care, "profit" margins from risk contracts, and management services are the four principal sources for financing AHC primary care strategies.

Information Technology Is Changing Our World: The Rise of Clinical Systems

10:30am–11:30am, July 17

Christine Malcom
V.P., Provider Services, CSC Healthcare Group

Goals/Objectives

- Describe the coming growth in clinical information systems and the Internet explosion.
- Outline the elements of the clinical suite for solutions, focusing on the electronic medical record (EMR).

- Show how faculty practice plans have benefited from clinical systems development.
- Demonstrate how faculty practice plans are uniquely positioned to lead this change.

Key Points

- Consumer level of expectation is high, due to Internet use outside the health care industry putting pressure on health care providers to improve technology and information resources for patients.
- Practice plans have the capacity to succeed in clinical systems development, based on a common practice infrastructure and a history of sophisticated computer talent at most medical schools. The team practice of specialty care is a perfect environment for network clinical systems development; AMC reputation and capabilities create an opportunity for health care Internet portal development. In addition, practice plans enjoy leverage with their hospitals to create funding and joint clinical systems development opportunities.
- The benefits of clinical system development are great, including a seamless patient experience; better coordinated care; rich and complete physician/patient data for diagnosis and research; strong connections to patients and referring physicians; and real time productivity management and monitoring.

Round Table Discussion #1

Three Initiatives to Integrate Physicians at the University of Pennsylvania Health System

12:00 noon–1:15pm, July 17

Leslie C. Davis
Associate Vice President for Subspecialty Networks and Clinical Service Groups
I. William Ferniany, PhD
Senior Vice President for Professional Services
University of Pennsylvania Health System

Goals/Objectives

- To describe key strategic initiatives used by the University of Pennsylvania Health System to link with independent physicians.

Evolving Health Care Environment and UPHS Response

ERA Years	A *Early '90s*	B *Mid '90s*	C *Late '90s*
Environment	• Need to maintain • Education and Research Mission	• A Plus Managed Care Intensifies • Revenue per Units of Service Falls	• A Plus B Plus Quality Will Win
Response	• Ensure Flow of Patients • Secure Teaching Sites • Become Attractive to Emerging HMOs (Full Risk Contracts) • Cut Costs	• Enhance Competitive Position with HMOs • Accept Carve Outs Where Necessary • Increase Flow of Fee for Service Patients • Cut Costs	• Best Practice's • Best Value • Best Outcomes • Cut Costs
Components	• Fully Integrated Academic Health System - Primary Care Physicians - Multispecialty Satellites - Teaching Hospital - Home Care and Hospice - Managed Care Infrastructure	• Subspecialty Networks • Clinical Service Groups • Network Hospitals	• Health and disease Management • Report Cards and Balanced Scorecard • Incentive Pay for Performance

- To share UPHS' strategy to develop clinical service groups which will grow market share and increase consumer image throughout the region.

Key Points

- These strategies will enhance existing relationships with primary care physicians and affiliate hospitals
- Enhance and support health and disease management efforts
- Strengthen system integration
- Provide a readiness strategy for carve-out capitation for specialists, which has penetrated other parts of the country
- Provide a defensive strategy against "pure play" companies
- Support health system growth and expansion
- Protect and secure tertiary and quaternary referrals

Lessons Learned

- Who really controls physician networks and affiliations? Physicians or hospitals?
- Issues encountered related to branding of physician networks
- Misunderstanding of the concepts related to clinical service groups
- Marketing and/or promoting entities (hospitals) vs. horizontal clinical service lines
- Issues with affiliate (non-owned) hospitals

Critical Success Factors

UPHS' critical success factors are:

- Admissions
- Outpatient encounters
- Consumer image
- Marketshare

Current Status of the Project/Strategy

- 11 networks have been established, with a goal of 15 in FY2000
- 12 clinical service groups have been developed, each in varying phases of development
- PENNReferral program staffed, funded and rolled out in 2 large primary care offices

"Too little attention is being paid to the complex issues of 'organizational culture' in efforts to restructure the clinical enterprise. The task of culture building is enormous and requires a long period of planned intervention and realignment of reward systems."

Roger Bulger, Marian Osterweis and Elaine Rubin , Mission Management: A New Synthesis (Association of Academic Health Centers, 1999)

Round Table Discussion #2

Aligning the Faculty Practice Plan with Its Institutional Culture

12:00 noon–1:15pm, July 17

Johns Hopkins University Experience

Kenneth P. Wilczek
Assistant Dean, Johns Hopkins University

Goals/Objectives

- To sensitize faculty practice plan leaders to the importance of institutional culture in developing, leading, and managing faculty practice plans.

Key Points

- We should embrace our culture, not fight it or try to change it.

- Integration is difficult in faculty practice plans, because of:
  - natural flow of authority
  - vested interest of faculty
  - cultural conflicts between academic and practice
- A culturally "compliant" faculty practice plan model has a much better chance of success than a "forced fit" textbook model of practice.

Lessons Learned

- Go with the flow
- Integration isn't all it's cracked up to be
- Culture is a powerful thing; it can't be ignored, and it can make or break a practice plan
- Faculty buy-in is essential

Critical Success Factors

- Understand the personality of your institutions: what makes it tick, what is important
- Include faculty and staff in all major initiatives, and pay attention
- Provide flexible, honest, knowledgeable leadership

Current Status of the Project/Strategy

- Project is complete and goals achieved—a very successful reorganization of billing functions
- Project is consistent with the Johns Hopkins culture

UCSD Experience

Lawrence S. Friedman, M.D.
Medical Director, Primary and Ambulatory Care, UCSD Medical Group

Goals and Objectives

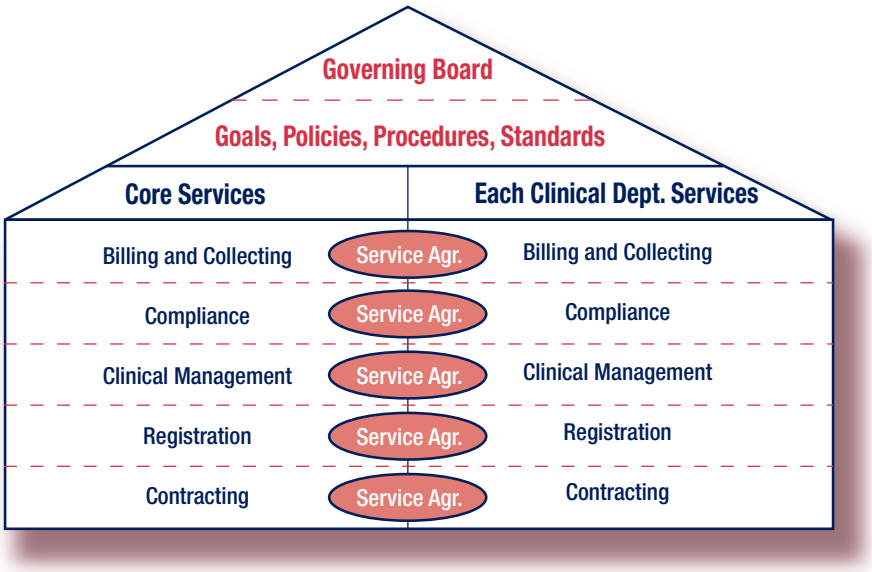
- Describe UCSD institutional culture and faculty practice by evolutionary history, demographics, visions and governance.
- Describe faculty practice successes, challenges and critical success factors.

Key Points

- Founded in 1966, UCSD School of Medicine was created, without a pre-existing clinical core or heritage, as a teaching and research institution. Its greatest success has been in its research.
- There is ongoing debate about the range, priority and structure of clinical activities and their oversight.
- With departmental input, the Clinical Board of Governors was created to bring structure, standards and documented accountability to clinical commitment.
- Primary care is restructured and funded by the enterprise, with productivity and compensation linked to incentives for access, utilization and service.

Critical success factors

- Convert data into useful information/clinical reports
- Faculty must embrace evidence-based practices as an important "teaching" message
- Trainees must be prepared for a world of evidence-based practices
- Create academic rewards for clinical excellence
- Move decision-making from committees to faculty responsive administration
- Evolve equilibrium between Departments and Clinical Board of Governor



Round Table Discussion #3

MSO Services: New Directions, New Possibilities

12:00 noon–1:15pm, July 17

UTSW Business Planning Service

Stephen E. Selby
President/COO of UT Southwestern Health Systems

Goal/Objectives

The goal of this presentation is to explain how the MSO at UTSW established a new service, called "Business Planning and Management," in reaction to the demand from the faculty group practice to assist in the development and implementation of their business plans.

Key Points

- A full-service MSO should have a unit that helps the group practice develop business plans for its clinical program initiatives.
- This unit needs to be staffed as if it were an internal consulting department.
- Most of the business plans will come from clinical department program initiatives.
- A typical departmental business plan should include a narrative report (e.g., scope of the project, market analysis, contracting and legal issues) and a financial section (e.g., pro-forma income statement with volume and revenue projections, expense details, capital requests).
- Most business plans fail because they don't get the correct political approvals, they don't get needed funding, or they are poorly implemented.
- Good business planning results in good programs that are well funded and implemented.

SUNY-Stony Brook MSO Redirection

Ellen Dank Cohen
Executive Director, Clinical Practice Management Plan at SUNY-Stony Brook

Goals/Objectives

- To share how and why SUNY at Stony Brook modified its MSO structure to respond to changes in the external environment and the wishes and needs of its current and perspective clients.

Key Points

- External factors are changing the business of medicine.
- Faculty practice plans were, and continue to be, a form of an MSO.
- Faculty practice plans effectively render MSO services.
- In this cost-conscious market, it's a good business decision to add to services or value whenever or wherever feasible, rather than buy or build it from scratch.
- The MSO of the new millennium will render those services, which its perspective or current clients want to buy, rather than try to tell their clients what they need to buy.
- The millennium MSO will be a flexible service organization. It will provide those services that were historically recognized as MSO functions, in addition to new and different services that respond to the environmental changes and/or its client base.

"There is at least one point in the history of every company when you have to change dramatically to rise to the next performance level. Miss the moment, and you start to decline."

Andrew Grove, Chairman & CEO, Intel Corporation

Lessons Learned

- Form does follow function
- Provide services people or organizations want, not what you think they need or you want to sell, i.e., a la carte vs. package
- Learn from your own mistakes and the errors of others
- Economies of scale/align incentives
- When you've seen one MSO, you've seen one MSO

Critical Success Factors

- Superior management is required
- Measure your core competencies, and offer those services
- Change as your environment changes
- Standardize the service model:
  a) appointment scheduling
  b) referral management
  c) clinical protocols
- Distinguish capabilities and demonstrate enhanced levels of service

Current Status of the Project/Strategy

The transition of the MSO is still in process. Small successes have been realized. The external environment is changing so quickly that the MSO must be an evolutionary process rather than a fixed set of services.

Contact Capitation at Washington University

Ronald J. Chod, M.D.
Assistant Vice Chancellor for Clinical Affairs, Washington University, St. Louis

Goals/Objectives

- Successfully manage global risk contracts within an academic and community-based multi-specialty IPA
- Enhance patient choice, access and satisfaction under managed care
- Enhance physician autonomy in patient care decision making
- Lessen burden of managed care on physician's practices
- Reward physicians for improvements in medical resource utilization

Key Points

- Provider-sponsored managed care offers the potential to judiciously control spiraling health care costs and to improve the quality and efficiency of care.
- Alignment of financial incentives among primary care physicians, specialist physicians (academic and community) and hospitals provides a platform for maximizing medical resource utilization, efficiency and quality of care.
- Capitation of primary care physicians and specialists maximizes alignment of financial incentives for providers, de-emphasizes gatekeeping and enhances coordination of care.

- Pilot experience with contact capitation provides early evidence of the impact capitation has on discretionary resource utilization by specialist physicians.
- Risk contract management provides a unique opportunity to financially support the development of innovative clinical effectiveness, disease management and case management programs.

- Development of the requisite infrastructure to manage global risk contracts enhances the opportunity for physician-sponsored organizations to contract directly with employers.

Lessons Learned

- Alignment of financial incentives among primary care physicians, specialists and hospital providers requires shared vision, innovative model development and physician leadership.
- Development of acceptable, innovative models of specialist reimbursement requires significant time, energy and leadership, particularly in the academic environment.
- Effective monitoring and accurate judgement of success under managed care remains a significant challenge for academic physicians, as well as community specialists.
- Strengthening relationships between academic and community physicians, primary care physicians and specialists, and physicians and hospitals through joint contracting has the potential to benefit patients through judicious and thoughtful management of medical resources.

Critical Success Factors

- Unwavering leadership and intense efforts to gain stakeholder buy-in are required to develop and implement alternative physician reimbursement and utilization management strategies.
- Continuous monitoring and honest communication of success and failures are required to maintain support as management systems and physician partnerships evolve.
- Development of adequate personnel, expertise and infrastructure to successfully manage risk requires significant investment of time and resources.

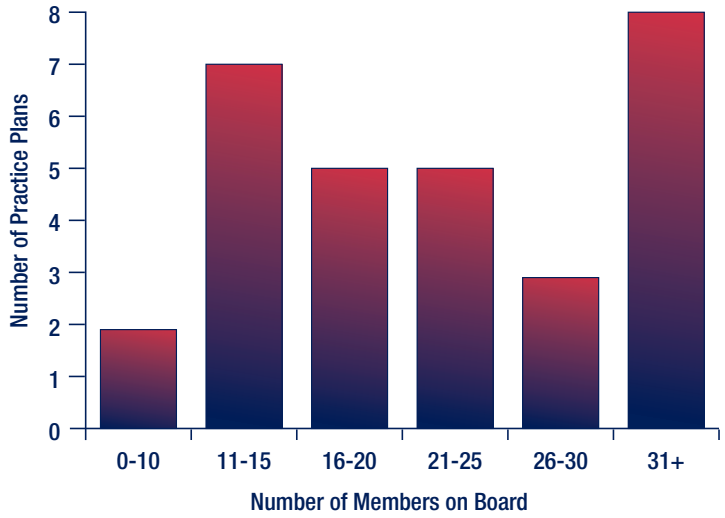
Current Status of the Project

- Contact capitation payment methodologies developed and implemented in all subspecialties.
- A minimum of eight months' experience has been generated in each subspecialty.
- Early data suggests improved overall physician reimbursement on a RVU basis, but with moderate variation in the success of individual specialty pools.
- A minimum of one year of complete data will be required to alter individual specialty payment methodologies and to fully assess utilization trends and effectiveness of disease management programs.

Poster Session

Susanne Larkins, Staff Associate, AAMC

Practice Plan Governing Board Size



Special Round Table Session

Stark Self-Referral Laws Update

5:00–6:30pm, July 17

Robert Saner
Partner, Powers, Pyles, Sutter & Verville, PPC

Goals and Objectives

- Provide greater understanding of the implications of Stark-2 for operational issues in academic medical centers
- Clarify the current status and enforceability of Stark-2
- Update attendees on possible legislative changes to Stark law

Key Points

- The Stark-2 statute is currently enforceable, even though regulations have not been finalized
- The compensation provisions in Stark-2 affect almost every faculty practice plan
- Physician compensation is the most obvious area for concern
- Other likely concerns include network development, community outreach, recruitment, practice acquisition, hospital contracts and intra-system transfer
- The existing compliance status of many transactions within academic medical centers remains ambiguous
- An advisory opinion process is available, but largely untested
- Compliance programs are just beginning to focus on Stark
- Federal enforcement is minimal, but private party litigation is increasing
- HCFA Stark-2 regulations are unlikely to clarify and simplify Stark-2
- Legislative amendments are necessary, but politically difficult

Sunday, July 18

Round Table Discussion #4

The Clinical Enterprise and the Internet: Strategy Matters

10:15–11:30am, July 18

Robert Noel
Principal of Greystone.NET, Inc.

Goals/Objectives

The Internet economy requires all organizations to rethink their current strategies and develop new business models. This workshop will explore the need for the clinical enterprise to develop focused strategies for marketing services, communicating and conducting transactions with patients, physicians and consumers.

Transaction Oriented Web: Physicians

- Consultation and referral directly through the web
- Continuing Medical Education
- Clinical research and trials…information and patient referral through the web
- On-line patient transactions
  1. Medical record access
  2. Results reporting
  3. E-mail link with specialists and patients

Note to Members:
The General Session, Sunday, July 18 from 9:00am - 10:15am is not covered in this issue.

Key Points

- Web sites were easy to launch technically; therefore they were launched without strategy.
- Web sites are progressing in complexity from information to interactions to transactions.
- The clinical enterprise needs to identify target markets for a Web strategy, and develop goals for each target market.
- The clinical enterprise needs to develop a Web culture within the organization.
- The clinical enterprise needs to develop a return on investment model for Web development.

The "State of the Art" Consumer Healthcare Web Sites

- ***Clinical content integrated with service line information***
- ***Some interactive technologies (Physician databases, risk assessments, appointment request forms, etc.)***
- ***Beginnings of relationship management (E-mail push subscriptions)***

Round Table Discussion #5

Clinical Process Improvement and Cost Savings through Gainsharing

10:15–11:30am, July 18

Charles A. Peck, M.D.
Director, Physician and Managed Care Services
Robert E. Wilson
Partner, Arthur Andersen, LLP, Washington, D.C.

Goals/Objectives

To acquaint the audience with the elements of a clinical process improvement program that appropriately aligns physician and hospital incentives by focusing on measuring quality (both clinical and service) as the primary yardstick for rewarding physicians.

Key Points

- There is no common, broadly accepted definition of gainsharing today.
- The working definition is "a collaborative contractual arrangement between a hospital and independent physicians to motivate their additional effort, attention and responsibility with regard to improving the quality and cost effectiveness of hospital care."
- The best way to lower cost is to improve quality.
- Gainsharing can be an effective strategy to align incentives in targeted clinical areas (high cost, high volume, procedure oriented).
- A clinical process improvement and gainsharing program requires significant commitment from hospital senior management and dedicated physician involvement.

Round Table Discussion #6

Front End/Back End: Building Better Registration, Billing and Collections Systems

10:15–11:30am, July 18

Wake Forest University

Denise Fetters, CCAM
Director of Business Operations, Wake Forest University School of Medicine

Goal/Objectives

- Improve up-front registration through decentralization
- Increase day-of-service cash collections
- Reduce days in accounts receivable
- Improve overall collection rate
  - ✔ Reduce deduction rate
- Improve charge entry lag time reduction through decentralization
- Reduce TES (transaction editing system)
- Improve customer (internal/external) satisfaction
- Formulate Point of Service Tracking Reports
- Implement Registration and Business Operations Credentialing Program
- Establish a system-wide foundation of business principles to guide transactions across all business processes, regardless of where they occur

Key Points

- Reduced registration errors
- Increased day-of-service cash collections
- Reduced days in accounts receivable
- Improved overall collection rate
- Reduced TES edits
- Implemented Point of Service Reports
- Implemented Registration and Business Operations Proficiency Program
- Improved internal/external customer/patient satisfaction

University of Nevada

David V. Schapira, M.D.
Dean, University of Nevada School of Medicine, Las Vegas Campus

Goals/Objectives

- To understand the obstacles that lead to inefficient billing and collection practices.
- To learn how to simplify the billing and collection process in order to minimize human error and maximize efficiency.
- To understand the importance of organizational communication.

Key Points

- In view of the complicated nature of billing, careful attention is required for registration and pre-authorization.
- Sophisticated computer programs can further complicate this process.
- Physicians must be willing to accurately code and document all patients in a timely fashion.
- Errors in registration and coding lead to the need for a significant staff of account managers.
- Geographic isolation and absence of dialogue between the registration clerks, nursing staff, physicians and account managers further increases error rate and cost.

Lessons Learned

- Maximizing geographic proximity and dialogue decreases the error rate and increases timeliness of billing.
- Increased accuracy of billing allowed for the downsizing from 22 individuals to 3 with a savings of $1.3 million.

Current Status of the Project/Strategy

- The collection rate has increased from 28 percent to 44 percent and the insurance denial rate has decreased from 55 percent to 35 percent.
- The practice plan has operated at a $2.3 million profit over the last year, as opposed to a $2 million loss the prior year.

Cover Story

▶ CONTINUED FROM PAGE 1

incapable of ensuring that we have adequate investments in education and research, and it has contributed to the erosion of public trust in physicians and in the system as a whole.

"But we've also learned that it is possible to control the escalating costs of health care by reducing unneeded services, and improving the processes of care, among other things. The future of health care delivery will be determined by a combination of evaluation and proactive restructuring. I believe we should opt, and work for, a balance that favors deliberate change.

"To do this, we first have to decide what we want. Certainly we need a system that is fiscally responsible. We simply can't go back to the days of open-ended escalation of health care costs. We need a system that is more patient- and family-centered than the one we have today—which is often too provider- and payer-centered. The system needs to be evidence-based and quality-driven.

Our core mission is education. And that's what is required here—educating ourselves, the public, and other providers about the possibilities of a new mode of health care delivery.

"The way to begin engineering a revolution is to leverage the strengths of academic health systems to promote a new brand of health care. That's my fundamental premise. Within the academic community, we have the seeds for this revolution and the ability to conduct it—if we can figure out how to coalesce our knowledge and commitments. We must leverage the strengths of the systems to avoid the serious adverse consequences of unfettered and undirected market evolution.

"Academic medicine has strengths to build on, including a tradition of leadership, a legacy of accountability, a commitment to innovation, and a well-deserved reputation for quality. Our core mission is education. And that's what is required here—educating ourselves, the public, and other providers about the possibilities of a new mode of health care delivery. We must use our expertise in this area as a catalyst for creating a better delivery system.

"What could a 'national league' of academic health systems—with a common set of goals and standards—do if we began to pool and utilize, for example, our knowledge of evidence-based medicine in a much more systematic way than we now do? We could promulgate a common set of standards for service delivery. We could potentially rationalize the distribution of highly specialized services and find ways to eliminate duplication, minimizing costs.

"If we arrive at some consensus on what the principles of 'collaborative care' might be, we could accelerate the transfer of new scientific advances to clinical practice, and begin to more effectively negotiate with payers in a way that would level the playing field. We could help make

significant improvements in the coordination of care across various provider groups. We could be the catalysts for movement toward a more acceptable, more appropriate system.

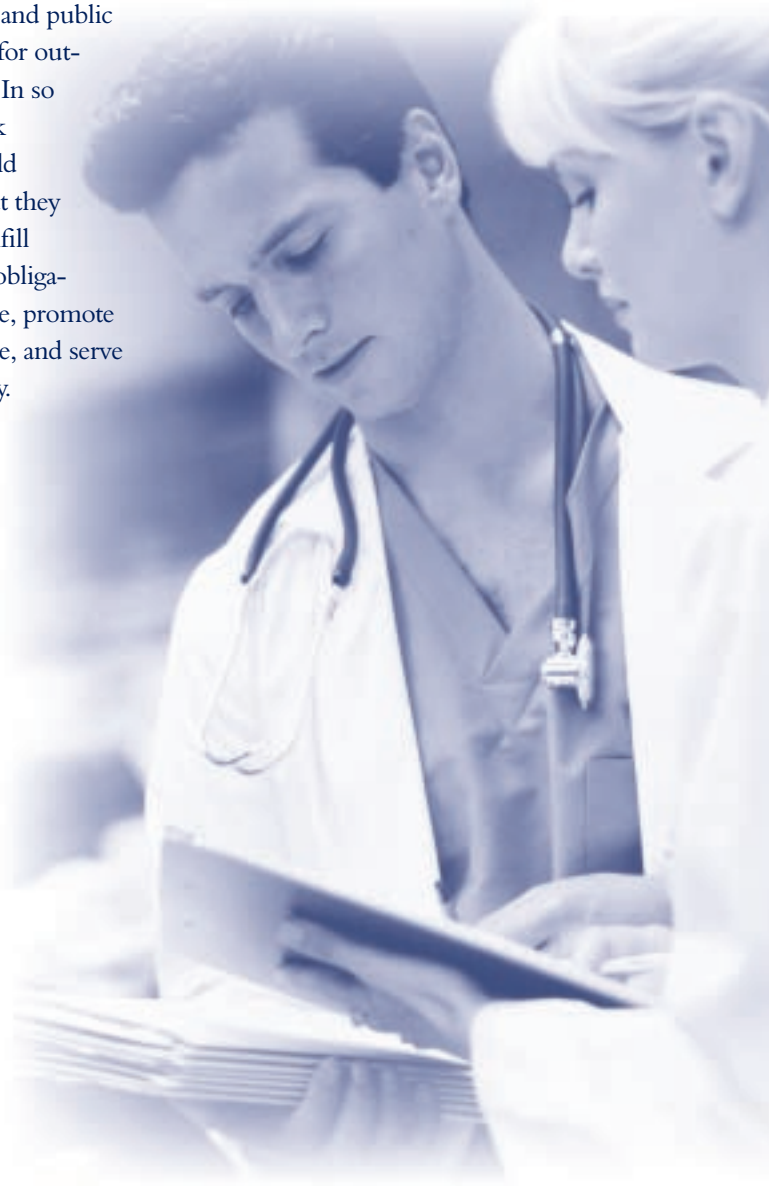
"Why collaborative care? Above all else, we need collaboration between doctor and patient; between generalists and specialists; between physicians and hospitals; and between hospitals, faculty members, and community-based providers. We need better collaboration between and among health care systems. We must be more accountable for the health outcomes and the health status of our patients. We must fully capitalize on the promise of information technology, finding ways to rapidly optimize both clinical and administrative procedures. If we could find ways to learn from another and to leverage those changes that are already being made, we would have a significant opportunity to make a difference.

"Is it affordable? Does a system with all these attributes fulfill the very first requirement that we laid out? There's reason to be optimistic that it would be. Minimizing variations through the real application of evidence-based case management approaches offers enormous opportunity for reducing cost. Exploiting information technology to enhance the storage and communication of data, and lessening the demand for unneeded services also hold cost-saving possibilities.

"The next steps are to convene leadership from across all components who are interested in, and are willing to endorse and pursue, the key features of collaborative care. We need get a demonstration project moving to test the effectiveness of this approach to health care. We can negotiate a payment scheme to reward and develop performance standards, and maybe create an *Institute for Collaborative Care*, in which we would assemble health care economists, ethicists, practitioners, public health professionals and others who have important contributions to make.

"Above all else, we need to develop compatible and useful clinical information systems—the Holy Grail that health care has been after for some time. Our best chance to find it is to combine our efforts in some collaborative fashion to establish a common set of communication standards. Finally, we could launch a public information campaign to broadly communicate what 'collaborative care' could accomplish. I think this set of ideas would be enormously appealing to the public if it could be properly communicated.

"In summary, the revolution I would like to foment envisions a national network of academically-oriented health care systems that are linked to other elements of the delivery system committed to implementing the elements of 'collaborative care.' Network members would monitor outcomes systematically, share information freely, benchmark against system-wide standards, and disseminate quality improvement information immediately. They would pursue common strategic principles, learn from one another, and project to the public—and to themselves—a coherent image of documented quality, continuous improvement, and public accountability for outcomes of care. In so doing, network members would help assure that they continue to fulfill their ongoing obligations to educate, promote new knowledge, and serve the community.



Chair's Message

Charles W. Smith, M.D.
Chair, GFP Steering Committee

Dear Colleagues:

As the incoming chair of the GFP Steering Committee, my first order of business is to thank Steven Burkett, our immediate past-chair, for providing the GFP with strong and effective leadership over the past year. Many thanks to Venkat Rao, M.D., who has completed his 3-year term on the Steering Committee, for his effort and contributions to the Group. I am also pleased to welcome our new Steering Committee members elected at the GFP National Business Meeting on Sunday, July 18, during the 1999 Summer Symposium in South Miami Beach. The new members are:

- Lilly Marks, Chair- elect (University of Colorado);
- Albert Bothe, Jr., M.D., Member-at-large, term ending 2001 (University of Chicago);
- Kenneth Wilczek, Member-at-large, term ending 2001 (The Johns Hopkins University).

The balance of our Steering Committee membership includes: Steven Burkett, immediate past chair (University of Tennessee); Raymond Mayewski, M.D., Member-at-large (University of Rochester); Charles Mittman, M.D., Member-at-large (University of California, San Diego); and Marion Woodbury, Member-at-large (Medical College of South Carolina).

In addition, we are very fortunate to have Richard Krugman, M.D., the dean of the University of Colorado School of Medicine, as the GFP's official liaison to the AAMC Council of Deans. Dick has served well in this position for two years.

This special Summer Symposium Proceedings issue of the newsletter provides those unable to attend the meeting with highlights of general sessions and round-table discussions. We hope you find this issue a useful resource, and we encourage you to send for the detailed hand-outs on presentations for topics that you find most interesting. The Steering Committee will meet next on October 23 to begin planning the 2000 Symposium. We encourage you to contact staff or any member of the Steering Committee with your suggestions for topics and speakers.

I look forward to a more detailed report of GFP activities and plans in our Fall issue.

Warmest regards,
Charles Smith, M.D.

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