When it’s so easy to get caught up in the daily challenges of running a practice, how do you make sure data from patient satisfaction surveys—which often provide details your practice couldn’t get elsewhere—result in action?

One way is to link results with physician compensation, said John W. Phillips, who spoke about the topic during a standing-room-only presentation, “Improving Patient Satisfaction Through Pay for Performance,” during the Medical Group Management Association’s 2005 Annual Conference in October in Nashville, TN. “We’re overdue for physicians having personal risk in patient satisfaction,” he said, noting that other industries (e.g., airlines) are far ahead of healthcare in aligning employee incentives with improving customer satisfaction. “It is simply good business sense to improve [patients’] perceptions.”

If doctors balk at this proposal, he suggested reminding them that it is less expensive to retain the patients you already have than to find new ones. Keeping your patients happy also increases the chances that they’ll recommend your group to family and friends.

Employ a fair, reliable survey method

To overcome physician resistance and ensure that your pay-for-performance program achieves its intended purpose, determine the optimal satisfaction measurement methodology for your practice. In other words, choose a methodology that generates results that are as accurate, unbiased, and statistically valid as possible. “You want to be able to [legally] defend how the outcomes affect physicians’ pay,” Phillips said.

Following are five basic methodologies for surveying your patients:

1. **Written surveys via computer kiosks at the office.** This format is convenient, but respondents decide whether to take it, so the sample is not random. Some doctors may achieve higher response rates than others, resulting in an unbalanced number of surveys per physician, Phillips said. In addition, installing kiosks/computer terminals will generate moderate to high cost compared to other survey methods.

2. **Written surveys mailed to patients.** Less technical (meaning that people will have less trouble taking it), this method may draw responses from only the extremely happy or unhappy patients, skewing results. Substantial variability will likely occur in the number of completed surveys per physician, giving physicians fodder to challenge the statistical reliability of the results. Plus, mail-in/-out surveys are moderately expensive, said Phillips.

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1 Phillips is the president of PivotHealth, LLC, a consulting company in Brentwood, TN. Contact him at 615/373-8745 or via the Web at www.pivothealth.com.
Patient satisfaction

3. E-mail surveys. E-mail surveys tend to achieve high response rates, are easy to take and tabulate, and are inexpensive. However, there is a high potential bias toward computer- and Internet-savvy patients. Although computers may eventually become as commonplace as televisions are now, for the time being, practices that rely on e-mail surveys risk missing valuable data from a significant patient population—particularly the elderly. “Remember, patients age 84 and over have a huge impact on your revenue,” Phillips said.

4. Telephone surveys via automated/voice response. Automated telephone surveys can easily generate an appropriately sized random sample for each physician (e.g., for a four-doctor group, the computer automatically stops calling once it receives 25% of the total responses for each doctor). However, patients may find this survey method impersonal, resulting in low response rates, Phillips said.

5. Telephone surveys in real time. “This is my favorite method,” Phillips said. Although this approach is the most expensive, it’s the most appropriate method to tie to pay plans because it generates the best coverage of all patient segments (i.e., representing different health plans) and provides a random sample, with high statistical reliability and identical sample sizes for each physician, he said.

The interviewers usually are independent contractors, with no bias to influence patients. You can also hire surveyors who speak your patients’ preferred language. With this approach, even on a voluntary basis, you can expect an 85% or better response rate, he said. These personal phone calls can also increase patients’ perceptions that your practice values them.

Provide phone surveyors with a script that lets the patient know that the
• surveyor is calling on behalf of the patient’s doctor—not the practice
• survey is completely anonymous and purely voluntary
• interview will take only a few minutes (e.g., less than five minutes to answer 10 questions)

For quality assurance, record all calls—don’t just track them, he said. Also have a protocol in place for excluding patients with sensitive diagnoses (e.g., patients with mental health disorders).

If you suspect your practice has a problem with patient satisfaction, it is definitely worthwhile to invest in conducting personal phone interviews twice per year, Phillips said.

Select an appropriate scoring system

Next, determine how you’ll score the survey results and how they’ll affect physicians’ pay. As with any compensation plan, “the devil is in the details,” Phillips said. Several factors will influence how much or little financial risk your physicians will have in connection with patient-satisfaction scores.

When developing your survey instrument or questionnaire, keep the following points in mind:
• Make survey questions answerable on a five-point scale (1 = poor, 5 = excellent) so you can calculate average grades for each question
• Establish a committee, including physicians, to help finalize the wording of questions (i.e., wording should be understandable to patients based on specialty and local vernacular)
• Assign a physician influence value, ranging from zero to five or zero to 10—decided by a committee that includes appropriate physician specialists—to each survey question, based on physicians’ ability to affect the outcome of that question
• Multiply these values by the grade on each question to find the score

The influence value represents how much responsibility your group assigns to physicians for their grade on any given question. For example, the question, “How would you rate the comfort of the waiting area?” would probably deserve a physician influence value of 0 because physicians have little or no control over this aspect of the practice. In contrast, the question, “How would you rate the physician’s style?” is completely physician-driven, earning an influence value of 10.

If you use a 0–10 scale, assign most questions an influence value of 5–6, Phillips said. Because influence values are subjective, he also warned not to underestimate how much control physicians have over other aspects of patients’ experience, such as staff behavior. “Physicians generally have substantial influence over staff, probably more so than administrators do,” he said.
Appropriately apply scores to pay

Finally, decide how you’ll incorporate patient satisfaction scores into physicians’ pay. Phillips offered two frameworks for doing so:

1. **Composite score.** With this method, calculate each physician’s score (i.e., average patient grade x influence value) for each question and add all scores together (125 in the example below). Also determine the maximum possible score (140 below). Then divide the physician’s total score by the constant, which is the sum of the influence values (28), to arrive at the physician’s blended average. Next, divide the maximum possible score by the constant to determine the maximum average score. In the example below, the physician earned a blended average score of 4.46 out of a maximum score of 5, indicating a high-level of performance. The funds with which to reward patient satisfaction come from a pool of money the group sets aside for this purpose (e.g., 5% of the group’s compensation pool). That pool is then divided in accordance with how many points each physician earns based on his or her performance. Doctors may earn zero, one, two, or three points, depending on where their blended average score falls on the continuum of 0–5. The group determines how scores will correlate with points awarded. For example, an average score of 4.6 or higher may earn the doctor three points; 4.2 or lower could yield zero points. If the pool of a practice with 50 physicians holds $6 million and the total points earned by all of the 50 physicians is 120, then one point would have a value of $5,000; two points would earn a physician $10,000; and a physician scoring in the highest satisfaction bracket would earn three points, with a compensation value to the physician of $15,000.

2. **Points earned on high physician influence questions only.** This approach is a watered-down version of the composite score approach, Phillips said, and takes into account only the questions that apply to physicians and eliminates questions with an influence value of 0–5. The other distinction is that unearned bonus dollars are returned to the pool. For example, if one doctor in a three-doctor group scored zero points, the third of the pool earmarked for that physician would stay in the general fund and not go to the other two doctors based on their higher satisfaction scores. Instead, the pool would have that much more money available for all three doctors to earn via their normal compensation plan.

**Composite score example: Top performing physician**

<table>
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<th>Question #</th>
<th>Physician Influence Value</th>
<th>Multiplied</th>
<th>Average patient grade</th>
<th>Score</th>
<th>Maximum possible score</th>
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<td>3</td>
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**Constant = 28**

Total actual score = 125
Total possible score = 140
Divided by 28 = 4.46 blended average
Divided by 28 = 5 perfect average

Source: John W. Phillips, PivotHealth, LLC, in Brentwood, TN. Adapted with permission.
The Centers for Medicare & Medicaid Services (CMS) released a final rule November 3 that updates payment rates and revises payment policies under the Medicare Physician Fee Schedule for 2006. Most notably, unless Congress takes action, physicians will see a 4.4% reduction in payment for services.

Disappointment pervades medical community

These cuts were finalized in spite of fierce opposition from the American Medical Association (AMA), the Medical Group Management Association, the American Medical Group Association (AMGA), and other specialty groups urging CMS to do away with its current formula to determine physician payment, which is based on the sustainable growth rate.

“I’m very disappointed that CMS did not accept the input that was submitted by several specialty societies,” says Joel V. Brill, MD, an internist and gastroenterologist in Scottsdale, AZ. “It’s just not right.”

Access for Medicare beneficiaries a major concern

As of press time, the 2006 cuts stand, but a revision is still possible if Congress intervenes. (To support legislation that would overturn the cuts, post your comments on the AMA’s Action Alert Web page at http://capwiz.com/ama/mail/oneclick_compose?alertid=8104801.) “I am optimistic that Congress, through the budget reconciliation process, will do something about this,” Brill says. “But if this conversion factor is allowed to go through, we’re going to have an access problem for Medicare beneficiaries.”

Others in the medical community share these concerns. In fact, after initial payment projections in June—two months before release of the proposed rule—the AMGA surveyed its members about how they would respond to a cut.

“They said they would continue to provide care to their current Medicare patients, but if there were payment cuts, 56% would limit their acceptance of new Medicare beneficiaries and only accept those who came to them through another department or via referral,” says Chet Speed, AMGA’s vice president of public policy. “Further, if there was another 5% cut as expected in 2007, 25% of the respondents said they wouldn’t accept any new Medicare beneficiaries.”

The cuts are particularly insulting to physicians concerned with helping patients enroll in Medicare’s new Part D drug benefit. “Patients are coming into the office and asking questions,” Brill says. “Where are we going to find the time to sit down with patients and go over all of their medicines, go through the formulary choices, and help them make appropriate choices?”

Businesses already feel strain of cut burdens

This change will significantly affect the businesses of physicians who continue to see Medicare patients, says Jon-David Deeson, CHE, MSHA, MBA, a senior manager at Tennessee-based consulting firm Pershing Yoakley and Associates. “We have clients who have Medicare patients representing 35%–45% of their payer mix. To have more than a 4% decline in reimbursement of that large a percentage of their payer mix is going to directly impact physician income.”

This cut is especially burdensome to practices in light of inflation and other costs. “Eventually, you’re going to have a serious problem—like running a lot of practices out of business,” Speed says. “[Although] all physicians will be affected by this cut, primary care will probably be the hardest hit . . . because they have the lowest [salary] baseline to work from,” he adds. To cope with these challenges, Deeson says groups will have to take two steps: 1. Assess the effect the cuts will have on your practice. In other words, determine what percentage of your patient base is covered by Medicare and calculate how much revenue the 4.4% payment reduction will represent. Also check your commercial insurance contracts to determine whether reimbursement for the calendar year is based on the Medicare Fee Schedule for that year, Brill says. 2. Plan how to make up the loss. For example, focus on ways to improve the payment you receive from commercial payers. Many practices don’t have the capacity to increase volume, Deeson explains, so the only solution is to try to bridge the gap on the commercial end.

1 Contact Brill at 602/418-8744 or via e-mail at joel.brill@verizon.net.
2 Contact Speed via e-mail at cspeed@amga.org.
3 Contact Deeson at 865/673-0844 or via e-mail at JDeeson@pyapc.com.
Physician executives give pay for performance mixed reviews; new recruits on the way

Physician executives are unsure of what to make of pay-for-performance (P4P) programs, according to the results of a new poll by the American College of Physician Executives. Almost 40% of poll respondents participate in a P4P program, but approximately 60% say it’s too early to tell whether these programs are a fair way to reward physicians for quality improvement.

“The concept of P4P is correct, but we have a long way to go before all of the unintended consequences are addressed and before the true value of P4P is achieved,” one physician wrote in the comment section of the survey. “To achieve the desired aims, P4P programs must remain rooted in quality measurements and, only later, after achieving a critical mass of credibility, should cost-efficiency measures be added.”

The poll surveyed more than 900 physician executives. Other poll results include the following:

- 57.5% say they are considering participating in a P4P program
- 75.2% say P4P rewards physicians who meet performance goals
- 37.8% say P4P reduces medical errors and improves quality
- 59.8% say P4P will become a permanent part of healthcare
- 18.1% say P4P is a fad

This year’s freshman class largest ever

The entering 2005–2006 class was the largest ever for medical colleges, according to data released on October 25 by the Association of American Medical Colleges (AAMC). More than 17,000 students entered the 125 U.S. medical colleges during 2005, a 2.1% increase over 2004.

“With a physician work force shortage looming, it’s encouraging that more young people are attracted to a career in medicine and that the efforts to increase student enrollment at U.S. medical schools are succeeding,” said AAMC President Jordan J. Cohen, MD, in a press release. “This is a good beginning on the increase in the nation’s supply of doctors that the AAMC believes is necessary to ensure that the healthcare needs of all Americans are met in the next decade.”

Other statistics regarding this year’s freshman class:

- The total number of applicants to medical schools rose by 4.6% to 37,364
- Men contributed 18,744 applicants or 50.2%
- Women contributed 18,620 applicants

CMS launches voluntary reporting program for doc quality data

Marking the shift toward pay-for-performance programs, CMS is launching the Physician Voluntary Reporting Program for physicians to submit data on 36 evidence-based quality measures, according to CMS. Physicians who choose to participate in the program, which will begin January 1, 2006, will submit data about measures such as administering aspirin at arrival for acute myocardial infarction and screening elderly female patients for osteoporosis.

The measures were developed by physicians’ groups and other experts, according to CMS. Although the program is voluntary, CMS Administrator Mark McClellan said in a press release that there could be a link between reporting data and higher Medicare reimbursements, depending on action from Congress.

CMS said the list of 36 quality measures could expand next year. The agency also noted that although they aren’t widely adopted, electronic health records would “greatly facilitate clinical data reporting.”

Dear reader,

After careful consideration, we have decided to stop publishing GPS. This will be your last issue. Beginning next month, you will automatically receive not one, but two other HCPro, Inc., physician practice newsletters—The Doctor’s Office and Private Practice Success—for the remainder of your subscription.

Although I’ll miss writing GPS, I hope you’ll find these publications valuable. If you have any questions or comments regarding previous GPS issues, please feel free to contact me. Also find your complete 2005 index included with this issue. Thank you for your support.

Sincerely,
Debra Beaulieu
Managing Editor
Promote group culture by creating a physician compact

When physicians join a group practice, they sign many documents (e.g., shareholders’ agreements, employment agreements, etc.), most of them legally binding. These documents are intended to protect the group should relationships among its business partners go awry, a topic we’ve addressed frequently in GPS.

Now we propose you compose a document with a more positive spin: a physician compact. Although not legally binding, this is a formal agreement signed by all group members, in which they promise to abide by the group’s mission, vision, and values.

Three years ago, after a restructuring, Southern Orthopaedic Specialists, LLC, (SOS) in Atlanta did just that, to rave results, according to Patricia Brewster,1 MHA, FACMPE, and Todd Schmidt,2 MD, who spoke about the role of the SOS physician compact during their presentation, “Organizational Change and Culture Development,” at the Medical Group Management Association’s 2005 Conference in Nashville, TN, in October.

Commitment to culture change
In 2002, the Atlanta-based physicians of Hughston Clinic, PC, a large, single-specialty group, restructured and formed SOS. The former group was physician-driven with a top-down management philosophy, according to Brewster and Schmidt. When forming SOS, the organization wanted to make a “conscientious change in the culture,” with an emphasis on teamwork, service, and bottom-up management, Schmidt said.

In addition to creating a new strategic plan, business plan, and leadership team, SOS developed a physician compact (which appears on p. 7).3 Drafting the compact required discussions among the physicians that went beyond the usual clinical or business dealings of group meetings. Writing a compact between the group members and their organization required honest, open discussion and alignment of the “give and get” expectations of everyone, said Brewster and Schmidt. “The goal is to use an effective governance and leadership, beyond advocacy, using a strong clinical leader-administrative partnership to verbalize a clear shared vision and strategy,” Brewster said. “We strive then for our culture to be aligned with the strategy and the compact to be aligned with reality,” Schmidt added.

Promise of professionalism
A physician compact is not only instrumental in change management, but it can also serve as a valuable tool in preventing disruptive physician behavior, says applied anthropologist and consultant John-Henry Pfifferling,4 PhD.

Defining appropriate professional conduct is closely related to the process of giving and receiving constructive feedback, a skill that isn’t taught during residency, he says. Pfifferling developed a list of more than 50 constructive-feedback criteria5 to help groups incorporate a code of behavior or professionalism into their compacts. Examples include the following:

• Use well-reasoned arguments to support proposals
• Offer suggestions that build on others’ ideas
• Express appreciation when someone does something well
• Admit to and apologize for mistakes
• Accept feedback gracefully

1 Brewster is CEO of Southern Orthopaedic Specialists and the Southern Orthopaedic Foundation. Contact her at 770/953-6929 or via e-mail at pbrewster@sos-atlanta.com.
2 Schmidt is board chair-elect for Southern Orthopaedic Specialists and board chair for the Southern Orthopaedic Foundation. Contact him at 770/953-6929 or via e-mail at tschmidt@sos-atlanta.com.
3 Jack Silversin, DMD, DrPH, a consultant with Cambridge, MA–based firm Amicus (www.consultamicus.com), introduced SOS to the concept of the physician compact and helped the organization incorporate the agreement into its culture.
4 Pfifferling is the director of the Center for Professional Well-Being in Durham, NC. Contact him at 919/489-9167 or via the Web at www.cpwb.org.
Sample physician compact

Shared vision: A vision that adds value and benefits the practice’s evolutionary years is a vision of the organization’s future. This vision should
• distinguish the organization
• build on organizational strengths
• reflect market trends
• represent a vision of the organization beyond its current status
• be inspirational

A shared organizational vision creates value by
• driving the prioritization of tasks and creating a rational process for resource acquisition and deployment
• giving leaders, physicians, and staff a filter for their decisions
• setting a context for change and linking various change efforts
• inspiring all creative minds
• providing the ability to vent difficult issues and divergent perspectives

Organization’s responsibilities:
• Focus on customers:
  - Be a part of physician-directed group
• Listen and communicate:
  - Receive feedback from management to include quarterly patient satisfaction survey outcomes, monthly financial reporting, and annual goal setting
  - Be listened to and valued
• Be actively involved:
  - Have responsive management
  - Lead and manage organization with integrity and accountability
• Offer rewards:
  - Provide fair compensation based on market and group performance
  - Create a team environment
  - Allow all individuals influence on decisions

Physician’s responsibilities:
• Focus on patients:
  - Make a commitment to a customer focus, which includes
• a timely adherence to clinical schedules
• accessibility
• a commitment to communication/education
- Provide measurable quality care:
  - Use methodology developed by the peer review committee and management
• Listen and communicate:
  - Conduct respectful communication
  - Collaborate with leaders, management, and peers to achieve group goals to include
  • commitment to corporate goals
  • collaboration with local management
  • support of peers
  • commitment of energy and finances to group goals
• Embrace change:
  - Embrace innovation in group practice to include
  • operational process improvement
  • adoption of electronic medical record system
  • openness to adding alternative medicine providers
• Remain actively involved:
  - Stay informed:
    • Read e-mails once every 24 hours and send them with priority notice
    • Participate with physician recruitment committee
    • Participate with marketing involvement committee
• Educate
  - Research foundation development committee
  - Reaffirm commitment to community involvement, including organizations such as
  • hospitals
  • sports teams
  • service organizations

The organization must empower its management and physician-executive teams to work on its behalf. Physician leaders must make decisions based on what is best for the organization. The physician leadership and management team must have authority as well as accountability. △

Source: Southern Orthopaedic Specialists, LLC, in Atlanta. Adapted with permission.
Consultants’ perspective

Insist on restrictive covenants at all physician levels

By Leif C. Beck, JD, CHBC

It’s common for groups to include restrictive covenants in physicians’ employment contracts. These require an associate to refrain from engaging in practice competitively with the employer-group both during employment and for a period after employment ends.

Insist on a restrictive covenant to protect your group’s investment in a new doctor and to prevent him or her from later undercutting the practice’s competitive advantages.

Restrictive covenants are enforceable in most states as long as they are “reasonable” in time and distance.

For example, the prohibition cannot extend longer than what is needed to protect the group—usually one or two years—or farther than the least necessary restricted geographic area. I routinely urge clients to draft their restrictions conservatively to avoid the risk of a court denying enforcement.

One other requirement occasionally arises as well: that the restriction be in the public interest.

For example, if the departure of an OB/GYN results in a community lacking sufficient OB/GYNs to serve its population, a court may refuse to enforce a restrictive covenant. Having been involved as an expert witness on such matters, I’ve seen how this issue can lead to more enforcement problems than one might expect.

Extend it longer

Most groups’ restrictive provisions apply to the term of the new doctor’s employment contract. Therefore, if he or she becomes a partner at the end of that time period, the question of further restriction may arise.

To avoid an unpleasant confrontation, I urge groups to write into the initial employment contract that the covenant will remain in effect if an associate’s status should change.

This provision is important because a young physician may become an even stronger competitor upon leaving the group after two, three, or more years than earlier in the relationship. That doctor will be more firmly entrenched in the group’s patient relations, referral patterns, on-call listings, and operating-room schedules.

The new physician may rightfully not feel obliged to accept or understand the reasons for an ongoing restrictive covenant if such restrictions don’t exist among the senior members.

Although I urge groups to have noncompete provisions at the coowner level, many do not—often because one or two seniors reject the idea. Therefore, providing up-front (i.e., in the initial employment contract) for an ongoing restriction helps start a group toward uniform noncompete promises.

Partner-level restriction

One way to break down veteran physicians’ recalcitrance is to start imposing the restrictions on newer partners and then work up the chain. Allegiance to the group should be a hallmark of success, but physicians are by nature too independent to accept that concept easily.

These days, a competitive group needs some sort of organizational glue to keep its members together. Otherwise, it’s too easy for one or more of them to vote with their feet if partners’ decisions don’t go their way. As one of my consultant-friends puts it, “If anyone can freely leave at any time for any reason, it isn’t really a group.”

Partner-level restrictive covenants thus become important to group success. Asking all members to sign such a provision is ideal, but as mentioned, not always possible.

If one or more partners refuses to sign, the next best approach may be for the willing members to sign and put maximum pressure on those who will not. That could include imposing a “sign it or leave” ultimatum—accepting the risk of losing the partner as the price for strengthening the group—or taking a lesser tack of grandfathering the noncompliers and applying the provision to all others going forward.

At any rate, the restrictive covenant may be critically important to your group. Unless your state is among the few that will not enforce it, it’s wise to put a well-conceived set of provisions into effect at all physician levels.

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1 Beck advises on top-level group practice matters. Contact him at Leif C. Beck Consulting at 610/355-0797 or via e-mail at leifcbeck@comcast.net.