Prescription for a Healthy Practice: A Business Plan

BY SHARON WORCESTER
Southeast Bureau

DESTIN, FLA. — Success in a rheumatology practice requires that the medical practice also be viewed as a business, and a cornerstone of a good business is its business plan, according to Dr. Max I. Hamburger.

Almost all other entities in medicine have business plans, including insurance and pharmaceutical companies and government agencies, he said. These groups study the marketplace; they know the leadership, have a plan for achieving their goals, and have tools for measuring their success.

Physicians can level the playing field by being equally prepared with a working business plan in place, Dr. Hamburger said.

Rheumatologists tend to resist defining their practices as businesses, but thinking of them as such can improve both quality of care and the bottom line, said Dr. Hamburger, assistant professor of clinical medicine at the State University of New York, Stony Brook.

It helps to recognize that the skill sets required for good patient management and good practice management are similar in many ways.

For example, both require evaluation and management through the collection of subjective and objective data, assessment, and planning.

It also helps to view a business plan as a tool that simply defines what you are going to do, where you are going, and how to get there, he said, challenging his audience to "resolve to draft a practice and business plan upon returning home."

"You have to write it down," he said, explaining that the act of putting the plan on paper serves as a "cognitive commitment" to follow the plan.

The goals, however, must be achievable, which requires a solid knowledge of the environment in which you are practicing.

Not only does a business plan document your vision of all the details of your practice, it also can help you identify gaps in preparedness, force an objective examination of all the details of the practice, identify necessary resources, project financial needs, and serve as an "owner's manual" for daily operations and activities.

A number of metrics tools are needed to evaluate the practice's progress and success. Year-to-year budget comparisons, cost accounting, and claims analysis are particularly important, Dr. Hamburger explained at a rheumatology meeting sponsored by Virginia Commonwealth University. He added that other useful tools include 3- to 5-year projection spreadsheets, relative value unit-based provider and payer analyses, and productivity formulations.

Practices are more likely to fail when they don't have a good business plan in place and when they fail to employ proper metrics; there are ways of improving the odds of success: Agree on a practice vision, write (and follow) a business plan, employ proper metrics to measure performance and refine goals, and review and modify the plan annually, he advised.

Dr. Hamburger's presentation was made during a symposium supported by an unrestricted educational grant from Centocor, Genentech, and Smith and Nephew, all of which he has served as a member of the speakers bureau, and from which he has received educational grants, and/or conducted clinical trials. ■

AMA Should Follow Apology With Action

BY MARY ELLEN SCHNEIDER
New York Bureau

African American physicians are looking for action to back up the words of apology recently tendered by the American Medical Association for more than a century of racial inequity and bias.

In accepting the AMA's apology, the National Medical Association (NMA), which represents minority physicians, urged the AMA leadership to work with them on three initiatives: recruiting more African American physicians, reducing health disparities among minorities, and requiring medical schools and licensing boards to make cultural competency mandatory for medical students, residents, and practicing physicians.

"We really want to use this apology as a springboard," said Dr. Nedra H. Joyner, chair of the NMA board of trustees and an otolaryngologist in Chicago.

These changes will be critical to reversing racial health disparities that have led to poorer health outcomes in African Americans, she said.

"Talk is cheap," said Dr. Carl Bell, professor of public health and psychiatry at the University of Illinois at Chicago.

Dr. Bell said that while he is hopeful that the AMA will take some meaningful action to reduce health disparities, he is unimpressed by the apology alone. Instead, he would like the AMA take a stand on issues that would advance minority health in the United States. For example, he said that he wants to see the AMA push for single-payer national health insurance, be stronger in challenging the pharmaceutical industry, do a better job of promoting public health, and support research into minority health and mental health issues.

Dr. Warren A. Jones, the first African American president of the American Academy of Family Physicians, agreed further action is needed but called the AMA's apology "appropriate" and "timely." This is not an apology of convenience, he said, but a signal of a change.

The AMA now has an opportunity to ensure that cultural competency becomes a tool in the medical armamentarium in the same way as the stethoscope or the scalpel, he said. "Now is the time for the AMA to put its resources where its mouth is," said Dr. Jones, executive director of the Mississippi Institute for Improvement of Geographic Minority Health.

The AMA offered the apology in July to coincide with the release of a historic paper in its flagship journal that examined race relations in organized medicine (JAMA 2008;300:306-313). The paper, which chronicles the origins of the racial divide in AMA history, was prepared by an independent panel of experts convened by the AMA in 2005. The panel reviewed archives of the AMA, the NMA, and newspapers from the time to provide a history from the founding of the AMA through the civil rights movement.

'Talk is cheap,' and the AMA should back it up by supporting research into minority health issues.

DR. BELL

The paper notes a number of instances where the AMA leadership fostered racial segregation and bias. For example, in 1874 the AMA began restricting delegations to the organization's national convention to state and local medical societies. This move effectively excluded most African American physicians because many medical societies, especially those in the South, openly refused membership to them. Later, in the 1960s, the AMA rejected the idea of excluding medical societies with discriminatory practices.

During the civil rights era, the AMA was seen as obstructing the civil rights agenda, the paper noted. In 1961, the AMA refused to defend eight African American physicians who were arrested after asking to be served at a medical society luncheon in Atlanta.

In its review, the independent panel applauded AMA for its willingness to explore its history. But the researchers also noted that the legacy of inequality continues to negatively affect African American physicians and patients. For example, in 2006 African Americans made up 2.2% of physicians and medical students, less than in 1910 when 2.5% were African American.

In a commentary to accompany the history, Dr. Ronald M. Davis, immediate past president of the AMA, acknowledged the "stain left by a legacy of discrimination" and outlined what AMA is doing to eliminate prejudice within the organization and improve the health of minority patients (JAMA 2008;300:323-325).

Dr. Davis said that the AMA leadership felt it was important to offer the apology because it demonstrates the "current moral orientation of the organization" and lays down a marker to compare current and future actions.

Within the organization, AMA has in place a number of policies that explicitly prohibit discrimination in membership and support funding for "pipeline" programs to engage minority individuals to enter medical school. In addition, in 2004, the AMA joined the NMA and the National Hispanic Medical Association to form the Commission to End Health Care Disparities. That group has been working to expand the "Doctors Back to School" program, which brings minority physicians into schools to encourage students to consider careers in medicine.

The ultimate goal is to have as much diversity among physicians as in the general population, where African Americans make up about 12% of the U.S. population, Dr. Davis said. "Obviously, we have a long way to go," he said. ■

Senators Inquire About Pharma Opt-Out Program

Without the American Medical Association program that lets physicians opt out of having their prescribing data sold to pharmaceutical companies, physicians would have no influence on how their data are used by sales people, the association told two senators who inquired about the program.

The Physician Data Restriction Program (PDRP) allows individual physicians to restrict pharmaceutical companies from disclosing their prescribing data to pharmaceutical sales representatives.

Sen. Herb Kohl (D-Wis.), chairman of the Special Committee on Aging, and Sen. Dick Durbin (D-Ill.), assistant majority leader, wrote to the AMA asking about the type of outreach and physician education the association does on the program, the number of physicians who participate, and how the AMA ensures pharmaceutical companies adhere to the program.

AMA Executive Vice President and CEO Michael Maves told the senators that the PDRP has been promoted in more than 70 periodicals, through e-mail "blasts," and in the annual AMA physician census. "The AMA has done significant outreach and marketing to the physician community at large," Dr. Maves said in the letter, adding that, as of April, some 13,000 physicians had chosen the program.

Physicians who believe their data have been used inappropriately can complain through the AMA; to date, only one such complaint has been received, Dr. Maves said.

"Upon AMA investigation, the pharmaceutical company found an error had been made during processing," he told the senators. "The process error was immediately corrected and additional safeguards were put in place."

The senators said they are considering legislation to create a federal academic detailing program, which could be an objective source of information on all prescription drugs.

—Jane Anderson