

VANTAGE POINT

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To remain competitive in the world of managed care, independent practices must prove they offer something special

Pittsburgh center blazes women's imaging trail

Unlike Kevin Costner's *Field of Dreams*, a women's imaging center established in the economic climate of the 1990s can become a field of nightmares. Sure, it can be built, but will they come?

Before starting this kind of facility, the management team needs to assemble a referral base and a population base, and gain the support of managed-care companies. It should identify practice goals and strive to achieve them. It must also be prepared to modify the practice to be compatible with the changes in the healthcare system as they unfold.

Our practice began modestly in 1980 when Dr. Stewart Fogel opened an 800-square-foot office for ultrasound only. His office contained one examining room and one spare room, and was outfitted with a new ultrasound unit for which a six-month deferment was made. The initial investment was less than \$100,000 and Dr. Fogel took no salary for the first year, during which there was only one other employee.

In 1988, a second office was opened in a nearby suburb, and two years later we moved to our current office, which is about 5000 square feet. The combined offices now house 14 examining rooms, four physicians and a staff of 32.

There are two prerequisites for establishing a women's imaging center: a captive audience and a practice mission. It is helpful to be well known to the ob/gyns in the area. Because of competitive pressures, a

center needs to be reasonably certain that it will fill a need for the referring physicians and their patients before attempting such a venture.

If the need exists, the next step is to establish a practice mission. Our goal was to provide top-quality ultrasound and mammography along with excellent service. We pledged to utilize the best available equipment and personnel and deliver service in a timely and efficient manner, and to offer this service in a private, pleasant surrounding.

The next step is to choose a location. It is desirable to be close to major referral sources. Many doctors have offices on hospital grounds, so to maximize patient convenience, the office should be as easily accessible to the referring physicians' offices as to the hospital facility.

Office space is an important concern as well. Consider whether leasing or purchasing would be better; if leasing, the length of the lease should be carefully considered. The toughest decision is likely to be choosing the appropriate amount of office space. Unlike a hospital practice, where expanding square footage is at least a possibility, leasing private office space may limit or prohibit future expansion. Because it is costly to relocate, leasing more square footage than is needed initially may be more cost-effective in the long run.

DOLLARS AND SENSE

A good accountant and a good attorney are necessary allies. We meet with our accountant semiannually and part of our meeting is devoted to analyzing overhead, the reduction of which is imperative in the face of declining reimbursements under managed care.

As a result of our efforts, we have been able to renegotiate better service contracts and purchase new equipment at reduced prices. We



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A central interpretation area that is connected to both the front office and the examining area can optimize patient flow and communication, says Weinstein (pictured with Dr. Stewart Fogel).



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periodically shop around for the best supply prices, and let our vendors know when we can get their products cheaper elsewhere. In most cases, the vendors have matched prices, though in some cases we have switched vendors. In general, supplies purchased from a consumer source are less expensive than those obtained from a medical source.

We also decided to bill in-house rather than use a billing service. In-house billing provides greater control and fewer complaints from patients, and is less expensive. Outside services will generally charge 6% to 9% of total payments received, while the cost of in-house billing can be held to 3% to 4%.

We use no billboard, newspaper, TV or radio ads. Our advertising has always been directly to referring physicians and patients. When the practice was first established, Dr. Fogel visited referring physicians' offices to explain his objectives and solicit their input. We periodically have our office manager visit their office managers to maintain the one-on-one marketing.

Patients are also a great advertising source. If they have a good experience, they are likely to relate this to their doctor and their friends.

UPGRADES AND INNOVATION

Because we are not hampered by administrative red tape and budgetary constraints, we are able to introduce new techniques more easily in our facility than in a hospital setting. Computerized mammography reporting, for example, has become valuable because of Mammography Quality Standards Act requirements. We have been using computerized reporting for both mammography and ultrasound since 1988—long before anyone had heard of MQSA.

Ironically, it was the ultrasound component of our business that originally sparked our entry into the computer age. With all of the calculations required for obstetric ultrasound reports, we decided to invest in a system that would streamline the process and make us more efficient.

The efficiency that we've gained throughout our practice allows for more consistency in reporting among the four doctors.

Our systems can be easily modified and are updated periodically. In a recent upgrade, we shopped around for a commercial mammography reporting and tracking system, but were disappointed to find that most of the products were not flexible

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enough for our needs. We felt that a cookie-cutter reporting approach was not appropriate for complicated cases of suspected malignancy, and wanted the option of dictating an entire report if necessary.

The solution, we found, was to custom-design our own database program for mammography reporting that can track abnormal results, generate patient letters and schedule interval follow-ups. The program is linked to our quality assurance program, from which useful statistics can be generated to provide a "report card" that we can use when bidding for managed-care contracts. Our computerized system also helped us determine that one of our payors was reimbursing us below cost for mammography exams. We were able to correct the situation before too much damage was done.

Before the advent of managed care, practice development was not a major concern as we experienced an average growth of 15% per year. All that has changed. With managed-care companies awarding contracts to large hospitals and networks, free-standing women's imaging centers may become vulnerable. Rather than throwing in the towel, we have cho-

sen to go head-to-head with the larger institutions in competing for managed-care contracts.

A positive relationship with our referring physicians has unquestionably been the biggest plus for us in dealing with managed-care organizations. We were originally excluded from providing services for U.S. Healthcare, one of the major HMOs in our area, but our referring ob/gyns went to bat for us. Dissatisfied with the quality of obstetrical ultrasound they'd been receiving, the referring physicians and their patients pressured the organization until U.S. Healthcare agreed to carve out obstetric ultrasound from their exclusive imaging contract.

In another instance, our referring physicians clued us in to an opportunity we otherwise would not have known about until it was too late. Thanks to their support, we are negotiating with Blue Cross to provide women's imaging services for three new primary-care centers in the Pittsburgh area.

The practice development buzzword for the '90s is "join." In addition to joining every HMO possible (before the doors are closed), joining local networks and multispecialty groups may also be advantageous. We have been successful in diversifying our practice using this approach.

The idea of competing against hospital-based imaging departments for these contracts is daunting, but we've found that by providing both ultrasound and mammography, we can offer managed-care organizations a unique package of services. Managed-care companies are also impressed with the outcomes data that we can generate using our computerized system. We can demonstrate, for example, that an HMO will save money by contracting with us because of our high true-positive biopsy rate. Armed with statistics and the knowledge that outpatient facilities can do procedures less expensively than hospitals, we have been able to convince managed-care companies to consider us as a resource for patient care. ■