# PROFESSIONAL PRACTICE PLAN

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## Background

A medical service practice plan is defined, in simple terms, as a formal document which regulates patient care and billing of members of the medical school faculty. Since 1967 when Dr. Clyde T. Hardy, Jr., Associate Dean for Administration at the Bowman-Gray School of Medicine began his study on faculty practice plans, more and more medical schools have been adopting practice plans. Dr. Hardy discovered that, out of the 77 schools reporting in answer to his questionnaire, 22 (28%) had active faculty service practice plans and 16 different schools were in the process of analyzing plans for their use. By 1970, a similar survey revealed that of the 86 schools responding, 75 (87%) had working practice plans or practice plans in the process of being established.

A Practice Plan Task Force was appointed by the Dean of LSU School of Medicine in Shreveport in March, 1974, and we have requested from every school in the country information concerning their practice activities. To date, we have received 80 responses, and 76 (95%) of these schools stated that they had working practice plans or were in the process of initiating practice plans; 4 reported that they currently had no practice plan and had no intention of establishing one in the near future. From these few statistics, it is obvious that a large majority of the medical schools are concerned with medical service practice plans and are delving into the problems involved with them.

There are numerous reasons why medical schools have turned to developing practice plans. At a Council of Deans Meeting of the Association of the American Medical Colleges in March, 1973, Dr. Robert G. Petersdorf, Professor and

Chairman of the Department of Medicine of the University of Washington pointed out that the recent activities in Washington, D.C., will make medical schools more dependent on practice funds than has been the case previously. To quote Dr. Petersdorf, "This has been reinforced by the attempts of many faculties and clinical departments who have been examining their practice plans and who have been looking at the patient care dollar not only to increase their personal incomes but the incomes of their departments and institutions.... We need to operate under the assumption that all schools depend to a greater or lesser extent on practice income." We are all painfully aware of the drastic cutbacks in federal spending towards research. It is obvious that additional sources of income must be found. With the implementation of Medicare and Medicaid programs, a new interest in faculty group practice plans has been stimulated in a number of medical schools. New methods of billing and collecting for services rendered must be developed. A precise system of documentation, which can undergo federal scrutiny, must be developed. These methods and systems can best be formulated on a University-wide basis.

There are other reasons for establishing medical service practice plans. As early as 1966 in the Clinical Session of the House of Delegates of the American Medical Association, a joint report concerning medical school finances was submitted by the Council of Medical Education and the Council on Medical Service. To quote from their report, "It has become necessary, therefore, to develop methods for supplementing the salary of many clinical faculty personnel who have chosen to follow academic careers. In addition, economic factors such as the extension of voluntary health insurance and expansion of welfare benefits have markedly decreased the volume of indigent patients that have traditionally served as a major resource of clinical teaching.

"Under appropriate circumstances, these two problems, the need for

supplementing salaries for clinical teachers and the diminishing number of indigent patients available for clinical teaching, may be resolved through extending the privilege of caring for paying patients to career clinical teachers in the medical school hospital where the patient will contribute to a teaching program." It is a widely shared view that in order to retain the artistic skill acquired while in medical school, physicians must practice medicine. Doctors must be active in the application of their knowledge and of their skill. In addition to this, members of faculties of medical schools feel that it is their duty to the local community to offer the medical services, for which they have been trained, to aid those who require these services.

In January 1970, Dr. George A. Wolfe, Jr., Dean and Provost, University of Kansas School of Medicine, presented to the AAMC his views in a more economically oriented manner concerning medical service plans. To quote Wolfe, "The days of barter of services in medical education are ended. No longer can we trade free care of patients for teaching material nor can we expect volunteer teachers to give teaching services for the privilege of admitting patients to a University hospital or for the title of Professor. No longer can the laboratory support the rest of the hospital nor the hospital support the teaching program, nor the teaching program support the hospital." It should be recognized by all that in terms of the full-time faculty needed, the resources available to most medical schools, either in the form of state funds or grant monies, are not sufficient to provide complete compensation.

In the studies previously mentioned concerning the number of medical schools which have faculty practice plans, it was also apparent that there is a variety of different types of plans used by different schools. There is no one correct way to organize a faculty fee-for-service activity. There are

some schools which have limited involvement of the administration and find their systems very satisfactory. Others require complete dominance by the Dean and his council.

Should We Have A Plan?

It was the assignment of this Task Force to determine, first of all, if the School of Medicine in Shreveport actually needed a practice plan and, second, to determine the type of practice plan we should have. An extensive literature search was undertaken to determine the pros and cons of a medical service plan, and each member was asked to submit the advantages and possible disadvantages of having a plan. Each member was asked to solicit the views of other members of his department, fellow specialists, friends and associates. Input was obtained from practicing physicians, as well as from full-time faculty members.

The advantages were numerous when compared with the disadvantages. The members basically agreed that patients need to be seen on a regular basis in order to perfect and sharpen professional skills; not only will the professional retain his status, but the patient also will greatly benefit. Many of our faculty have certain specialized skills and could provide specialized services to the community. As a result of the offering of these specialized skills, Shreveport could become a medical center enlarging its area of contact for the benefit of all, including the local practicing physicians. As local physicians refer patients to our specialists now, our physicians would be in a position to reciprocate. Laboratory facilities and faculty members with knowledge of basic science research would be available to all, greatly enhancing the community physician's care of his patients. With the collection of Medicare and Medicaid funds for services rendered currently at Confederate Memorial

Medical Center (CMMC), "new money" will be brought into the Shreveport area, which has not previously been collected.

There are certain benefits to be obtained which would apply mainly to the University. As stated at many national meetings, new sources of funds and incomes must be found by medical schools, not only for salaries for the physicians, but also for continued school growth. LSU Shreveport is certainly at its growing stage. In order for our faculty to continue to grow, our salaries must be competitive with those of other medical schools. Currently, our school depends a great deal on research funds and state funds to support the faculty and operations. The state of Louisiana provides support for this medical school in the 70-75% range. As our needs increase, we cannot expect the state and the legislature to continue to support our activities to this degree.

Our student enrollment is expected to reach approximately 246 by 1976, 305 by 1977, 364 by 1978, and 400 by 1979. Many students are already complaining that they do not have enough patient involvement in their education now. There are too many students for the number of patients available. Where will we get these additional patients for study purposes? With the advent of the National Health Insurance, it is likely that there will not be any more "charity" patient . Every patient will be considered private. The University faculty must develop a rapport with the local community now to prepare for the future.

In August of 1973 a memorandum was issued by M. D. Woodin, Ph.D., President of LSU, concerning the outside employment of University paid employees. Item #3 of this memorandum under the heading of Statement of Policy of Outside Employment states, "No full time member of the faculty or staff shall engage in such outside employment (or continue such employment if already so engaged) without the written approval of the department head and the Dean..." A formal

practice plan joined by all the faculty members of the University in Shreveport greatly facilitates the implementation of PM-11.

The disadvantage most often proposed to the Task Force relates to the competitive nature of the practice of faculty physicians with community physicians. It is feared that if the University provides the facilities for practice, a faculty member might conceiveably be able to charge less than the local physicians for the same services. Once the faculty member has established a practice, what will limit him or prevent him from using his University facilities for almost the sole purpose of seeing patients? It has been generally agreed upon that any practice plan written would have to include built-in safeguards against unfair competition with local physicians. It was also agreed that there must be a method of establishing a ceiling, either in the amount of time a physician can spend seeing patients or on the amount of income he can generate, established to prevent any faculty member from spending too much time in the private practice of medicine. Indeed, University surveillance of the practice of medicine by its full time faculty members may curtail current practice activities.

It should be mentioned that various agreements between the medical school and the community physicians, entered into prior to the arrival of our present Dean, are not adaptable to the development of a practice plan. It must be acknowledged that the School has undergone a number of developmental changes since these agreements were made, and the members of the Task Force feel that they are no longer acceptable or valid. Dr. Grulee made it abundantly clear to the faculty and community medical leaders, before he was selected and before he accepted the office of Dean, that initiation of a practice plan would be one of his highest priority items. In addition, he outlined the basic elements of a plan to the faculty, the Board of Directors of the

Shreveport Medical Society, and to the Visiting Staffs of several local private hospitals.

Based upon the experiences of other schools, both state-supported and private, and after considering the pros and cons discussed above, it was decided that we should proceed with the development of a practice plan at this time. The purpose of this plan is to allow members of the faculty of the School of Medicine in Shreveport to engage in professional practice in order to fulfill their teaching and research assignments, maintain their competence and use their knowledge for the benefit of patients in this area.

To recruit and retain a strong, competent faculty, it is essential that a school of medicine offer a satisfactory and clearly defined program for the competitive compensation of its faculty. It is further recognized that in terms of the number of full-time faculty needed, the resources of the University are not sufficient to provide complete compensation. Funds are generated as a result of professional services and the purpose of the "Medical Service Plan" is to define:

A. The philosophy under which professional activities of the faculty should be rendered.

B. The setting or environment in which the professional activities are to be rendered.

C. The manner in which the faculty should be compensated for these professional services.

D. The manner of distribution of income generated by the service.

What Type Plan Suits Us Best?

Having determined what we wished the practice plan to do, it became necessary to determine the type of plan which would best accomplish our goals. A medical service plan involves so many people, so many administrative and

financial details, that the formulation of a new plan should be undertaken by systematic methods. Our approach began, as indicated above, with a canvas of all medical schools in the United States concerning their medical practice plans. We have received 59 complete medical service plans, and a review of these reveals that there are three common forms of medical service plans: A geographic full-time system, a strict full-time system, or a departmentally organized system. In a strict full-time system, all income is turned over to the institution or to the Dean. The faculty receives a straight salary which is unaffected by the amount of clinical work or collections. In the geographic full-time system, the faculty member receives a base salary from the University and is permitted to supplement this from seeing patients. A practice plan developed under departmental organization places the burden of collection and distribution under the department's jurisdiction. The Task Force concluded that a plan basically designed as the geographic full-time plan in which a salary is guaranteed to every faculty member is advisable.

Several of the Task Force members have made trips to various schools across the country to view other practice plans in operation. The LSU School of Medicine in New Orleans was the first school visited. Their operation is in the process of being reorganized from the departmental basis to a university-wide program. Funds used at the New Orleans school for departmental and school growth are derived to a large extent from Medicare and Medicaid funds. We viewed with considerable interest their methods of collecting and billing for Medicare and Medicaid. As a result of this trip, we became certain that there are funds available for the services that our physicians are rendering at CMMC, and that documentation procedures must be updated to facilitate the collection of these funds. We must also devise appropriate methods for billing and collecting from third party intermediaries such as Medicare and the Louisiana

Welfare Department. These same sentiments were expressed after similar visits to the University of Texas in San Antonio and to the University of Texas, Southwestern Medical School in Dallas. These schools have developed adequate billing systems and are in the process of collecting for services rendered to Medicare and Medicaid patients. It was pointed out at the University of Texas in San Antonio and at Southwestern in Dallas that with new legislation on the horizon, specifically public law 92-603, section 227, medical schools may have to change their approach for billing Medicare and Medicaid intermediaries. Further information was gathered at the clinic managers meeting held in April this year concerning Section 227. The results of the enactment of public law 92-603, Section 227, would be to alter the present billing format based on a private fee-for-service schedule to a reasonable-cost schedule, thereby reducing the amount received for a service rendered.

Several general points of agreement have been reached. It was agreed that all full-time members of the faculty should be members of the professional practice plan and that all members of the part-time faculty should be members if they so desire. It was further agreed that all income derived from professional services should be included and distributed by the plan. The Dean and the University should receive a certain percentage of the income from the plan, but the faculty member contributing a large amount to the plan should receive some incentive for his efforts in the delivery of health care. It was recognized that a ceiling on the amount of income allowed to be made through the practice of medicine would have to be established in the plan. Finally, it was agreed that all faculty members should receive a guaranteed base salary paid from "hard" University funds.

There are, however, many areas on which we have not reached agreement. These include detailed guidelines for distribution of income, management control,

management services, and other organizational problems. It was suggested that perhaps we could use outside assistance in the formulation of our plan. There are areas in which we have no basis for action, specifically our dealings with Medicare and Medicaid intermediaries. In as much as these sources will provide large sums to the school, it is important that our dealings with them be handled in a professional manner. There are many technicalities involved in the actual writing of the plan and certain legal aspects with which we are not familiar.

The Task Force decided to seek the names of outside consulting firms which could be of assistance to us in our tasks. Several were suggested but one firm in particular was often mentioned. This firm is Kasonic, Chappelle, & Associates, Inc., John Kasonic, President. The firm was recommended from numerous outside sources including the University of Texas at San Antonio; the University of Texas, Southwestern Medical School in Dallas; the University of Washington, in Seattle; the Medical Group Management Association; and members of the AAMC. On the basis of these recommendations we decided to invite Mr. Kasonic to Shreveport to view our situation and see what he could offer us. Upon completion of a two day visit he submitted a proposal to the Task Force. This proposal contained two phases of development:

Phase I involves the development of the professional practice plan itself. The development of the plan would involve seven tasks which are as follows:

Task 1: Conduct discussions with various key members, representative of the faculty, hospital and school administration and community physicians.

Task 2: Working with the members of the task force, prepare a first draft of the professional practice plan and the individual professional employment agreement.

Task 3: Review and discuss the various elements of the professional practice plan and the individual professional employment agreement with key personnel and members of the Task Force.

Task 4: Modify the draft documents for presentation to the general faculty.

Task 5: Prepare, present, and discuss the final draft document with the Dean of the School of Medicine.

Task 6: Assist the School of Medicine, the hospital executive staff, the faculty, and the task force with the resolution of any final issues.

Task 7: Develop an implementation plan for efficiently and effectively accomplishing the principals and concepts of the approved documents. The deliverable products of this phase would include 1) an approved and acceptable professional practice plan which outlines policies and principals under which professional faculty practice will operate at LSU Medical Center School of Medicine in Shreveport. 2) an approved and acceptable employment agreement which will provide for consistant and professional service contracts between the school of Medicine and full-time faculty members.

Phase II would deal with the determination of the appropriate process for billing and collecting professional fees. The steps involved in implementing phase two are as follows:

Task 1: Project initiation

A. Orientation of School of Medicine and hospital staff.

B. Finalization project organization including School of Medicine Staff.

C. Prepare a detailed work plan and task assignment.

Task 2: Review of existing reimbursement systems

A. Develop flow of funds by department

B. Initiate discussions with fiscal intermediary, regional HEW, state and parish Medicaid and others.

C. Prepare documentation of problem areas.

Task 3: Detailed analysis of alternative systems.

A. Examine progress on professional practice plan.

B. Review professional services contracts written and implied.

C. Determine cost of operation of faculty fee-for-service income system.

D. Determine the cost of operation for faculty cost reimbursed income system.

Task 4: Determine impact cost and benefits of each alternative.

A. Develop cost and benefits of each strategy.

B. Impact on faculty plans and organization.

C. Impact on hospital and professional funding for Medicare and Medicaid.

Task 5: Management Review and Selection

A. Presentation of alternatives to the Dean and others.

B. Selection of cost or fee-for-service approach.

C. Phase two report.

The firm submitted the following list of professional references:

1) Children's Orthopedic Hospital and Medical Center, Seattle, Washington.
2) Case Western Reserve University
3) Association of American Medical Colleges
4) University of Tennessee
5) University of Washington

At the July 11, 1974 meeting of the Practice Plan Task Force it was decided by the members of the Task Force that Kasonic, Chappelle, & Associates should be accepted as the consulting firm for the School of Medicine in Shreveport with the following privosos:

1) Favorable letters of recommendation must be received from each of the references supplied in the firm's proposal.

2) Mr. John S. Kasonic will be our primary contact with this firm.

What Major Problems Remain?

The conclusion of this paper brings into view some problems we face now, which are obviously controversial. By presenting them here, we by no means are indicating that we have reached any solutions or recommendations concerning these issues. Some of the issues have been topics of extended conversations while others have simply been mentioned.

An obvious point which must ultimately be resolved is where the faculty physicians will practice medicine. Possible inpatient facilities could include CMMC under its current management, or managed jointly by LSU and the hospital board. Another possibility would be a university-owned hospital. A third possibility would include the admittance of our faculty to the staff of local hospitals. Outpatient facilities will also be needed. It is feasible that a medical school clinic building could be constructed for such a practice. It has also been mentioned that the Comprehensive Care Clinic, built in the front of the LSU Medical School adjoining CMMC could be used for paying patients, in addition to its use as a comprehensive care center.

Certain agreements and contracts currently exist which must ultimately be changed if the faculty is to practice medicine. Existing contracts between LSU and the present faculty would have to be altered. Restrictions

on practice and assignment of fees would have to be written into a new agreement. The CMMC bylaws as currently published include references to assignment of LSU faculty Medicare and Medicaid funds to Medical Center Clinics, Inc. These bylaws are in need of revision. New contracts must be entered into between LSU School of Medicine in Shreveport and certain third party intermediaries for services rendered to the medically indigent, the over 65 and those covered by certain commercial insurance companies. And, finally, the relationship of the LSU School of Medicine in Shreveport with the rest of the LSU System must be defined.

Some of the problems may be faced by this Task Force; others must be solved by the Dean, other members of the LSU Administration, the Executive Committee, and the general faculty. It is hoped that our consulting firm will give us help and advice in some of these areas based on their experience with other institutions. The task is not easy, but it is important to know that other schools have faced, and are facing, their own problems of similar magnitude. We have learned from dealing with these other schools, that all have their problems in the present era of rapid changes in federal funding of patient care, research and education.