INFECTION CONTROL
CONTRACTING FOR SUCCESS

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Disclosure: Nothing to Disclose
MIDC FOUNDING PARTNERS
PREPARING TO NEGOTIATE
MIDC

Founded in July 1994

8 ID ---------now 34 ID Physicians

52 Hospitals

>20 contracts ~750K revenue
Very few hospitals without at least 2 groups providing ID services:

- minimal leverage available

- pay minimal $ for contracts - if at all!
Hospitals – pay for performance is here!

ECF’s – need to keep pts. in facility

LTACH’s – most MDRO on earth
Preparation for Negotiation

**Internal**
- Define *your* needs
- Establish *your* wants
- Delineate *your* costs
- Structure *your* BATNA

**External**
- Define *their* needs
- Delineate *their* BATNA
- Review past obstructions to success
- Define Fair Market Value (FMV)
**INTERNAL PREPARATION**
*(IT’S ALL ABOUT YOU)*

<table>
<thead>
<tr>
<th><strong>Define your needs</strong> –</th>
<th>a requirement, necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Define your wants</strong> –</td>
<td>a desire, wish</td>
</tr>
<tr>
<td><strong>Delineate your costs</strong> –</td>
<td>personnel - ?physician</td>
</tr>
<tr>
<td></td>
<td>“lost” profee revenue</td>
</tr>
<tr>
<td><strong>Know your BATNA</strong> -</td>
<td>Best Alternative to Negotiating an Agreement</td>
</tr>
<tr>
<td>Need/Necessity</td>
<td>Want/Desire</td>
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<tr>
<td>--------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Increase Revenue</td>
<td>IC contract</td>
</tr>
<tr>
<td>Decrease antibiotic $$</td>
<td>Pharm D hired</td>
</tr>
<tr>
<td>Decrease BSI</td>
<td>Chlorhexidine towels</td>
</tr>
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COSTS

3 Types

1. **Present Costs** – costs at the present time with no program in place

2. **Cost of Inaction** – costs incurred by doing nothing – usually not the same as present costs
   - if problems are present- inaction breeds escalation
   - if problems don’t exist – you’re probably not looking hard enough
3. Cost of Definitive Action – costs incurred by achieving the goal

- hospital/facility

- your costs

  a. personnel

  b. lost clinical revenue

    - lack of time

    - loss of relationship
# COST EXAMPLE

## EMPIRIC ANTIMICROBIAL THERAPY FOR NOSOCOMIAL PNEUMONIA

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Present cost</strong></td>
<td>($40,000/mo) and escalating</td>
</tr>
<tr>
<td><strong>Cost of Inaction</strong></td>
<td>($60,000/mo)</td>
</tr>
<tr>
<td><strong>Cost of Definitive action</strong></td>
<td></td>
</tr>
<tr>
<td>Pharm D</td>
<td>(7,000/mo)</td>
</tr>
<tr>
<td>Ab savings</td>
<td>10,000/mo</td>
</tr>
<tr>
<td><strong>Net savings</strong></td>
<td>3,000/mo</td>
</tr>
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## BATNA
(BEST ALTERNATIVE TO NEGOTIATING AN AGREEMENT)

<table>
<thead>
<tr>
<th>Strong</th>
<th>Weak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive leverage</td>
<td>Minimal or no leverage</td>
</tr>
<tr>
<td>Group favorable terms</td>
<td>Hospital favorable terms</td>
</tr>
<tr>
<td>No need to offer accommodations</td>
<td>Must offer accommodations</td>
</tr>
</tbody>
</table>
BATNA EXAMPLES
BEST ALTERNATIVE TO NEGOTIATING AN AGREEMENT

Strong -  NO INCREASED COSTS
          NO DECREASED REVENUE
          A "WANT" BUT NOT A "NEED"

Weak -   SUICIDE
          DIVORCE
          SELF MUTILATION
          USE "DEPENDS"
          BECOME A HOSPITALIST IN ELKART, IN
MY BATNA SUCKS!! NOW WHAT?
Strengthen your BATNA:

A. Turn Needs into Wants

B. Develop Options
   - Investigate alternative revenue streams
   - Consider alternative staffing for Ab stewardship program
   - Review “Bundle” for BSI

C. Discuss “walkaway” scenario – Define impact of saying NO
   - IT FEELS GOOD, BUT .....................
D. Gain Local Support

Pharmacy Director

IC Chair

Chrmn of Medicine

E. Gain Sharing Approach??

LEGAL, BUT WHO’S GOING FIRST?
PREPARING TO NEGOTIATE
EXAMPLE

Need – Increased revenue for an ID doc

Want – IC/PT contract for at least 30K/yr.

Costs – LOW – physician already employed

BATNA – WEAK - If we don’t get contract, group will lose money or we’ll have to let physician go!!
Most people don’t care what **YOU NEED**, so

Define **THEIR NEEDS** –

- Decreased nosocom. Infx.
- Decreased FTEs
- Improved public/family perception of hospital safety
- Their boss’ attention!!

**FOCUS OF YOUR PRESENTATION**
DELINATE THEIR BATNA

OPTIONS:
- FIRE PHARM D TO SAVE MONEY
- HIRE ANOTHER ID DOCTOR/GROUP
- DO NOTHING – NO PERCEIVED NEED
EXTERNAL PREPARATION

Review past obstructions to success

Money – everybody has a budget

Personality conflicts – underappreciated problem
- relationships make/break deals

Perception of increased work for no benefit

What’s in it for them?

Beware the middle management sand bag!
MIDC  
P = PRETTY  

U = UGLY  

C = CONTRACTING  

A = APHARISMS  

ie. Not good enough to be “pearls”
YOUR ABILITY TO SATISFY YOUR NEGOTIATING PARTNER’S INTEREST IS DIRECTLY RELATED TO THE LIKELIHOOD OF NEGOTIATING A SUCCESSFUL DEAL
Define Fair Market Value (FMV)

**actual definition**: a price at which buyers and sellers with a reasonable knowledge of pertinent facts and not acting under any compulsion are willing to do business

**functional definition**: what people/groups in the same region are paying for the same services.

- directly related to the perceived need and value of the service in question
THE PRESENTATION - SHOWTIME

DEMONSTRATE NEED – watch your verbiage

“You must have known….”

“I’m sure we’re both concerned about….”

ARTICULATE VALUE

DELINEATE REIMBURSEMENT

Understand your costs

Understand FMV

Understand BATNA – yours/their

- defines leverage available
REAL MEN DON'T NEED LEVERAGE
Defining Leverage

Contracting partner has no alternative – no one wins in a hostage situation

You bring unique skill – how long can you hold your breath?

You’re willing to do something nobody else does – ex. Service hosp with poor payer mix, ECF, LTACH

You’re willing to go someplace nobody else goes – the “Hinter lands”
WHAT VALUE ARE WE SELLING?

Knowledge? – infx.control, antibiotic stewardship, (assumed unfortunately)

Skills? – most can be purchased elsewhere

Availability? – cash will make most people available
WE **ALWAYS** HAVE AN ELEMENT OF LEVERAGE BECAUSE WE POSSESS A UNIQUE ABILITY:

LEADERSHIP

(Combines above with willingness to communicate and passion to make a difference)
LEADERSHIP EXAMPLES

CHANGE PHYSICIAN BEHAVIOR

ANTIBIOTIC UTILIZATION

DIRECT PATIENT CARE

IV TO PO

DECREASED LOS

UTILIZATION OF RESOURCES
Demonstrate **Need** – if they already knew this, they would’ve *called you*

Objectively **Articulate Value** - see “Value” article in CID from IDSA CAC; “SELL” LEADERSHIP

Agree to **Reasonable Reimbursement** – self defined and largely a function of past experience, your costs, your BATNA, and FMV

Alternatively, ..................................................
Assume the “WE’RE NOT WORTHY” position and plead for mercy!!
HOURLY CONTRACT EVALUATION

Ex. – Most IC/PT contracts; Avg. $100-110/hr.

Incremental Costs – Usually none – you usually have the physician capacity to service contract

Incremental Time – You need to be physically present to service the contract

Relative cost – 4 inpatients seen/hr coded @ 32 level or 2 pts. @ 33 generates $180-200
Contracts are not only revenue generators, they’re revenue protectors.

Some of our best contracts actually “cost” us money when viewed unilaterally.

Contract evaluation must occur in light of overall benefit to group from both contract net revenue and “other” opportunities brought to the group through the contract.
PREPARING TO NEGOTIATE
FOR LTACH IC CONTRACT

NEED – to maintain clinical revenue base; don’t need contract

WANT – IC/PT/Wound care contract

COSTS – None – we’re already fully staffed in the institution

BATNA – PITIFUL!!
LTACH – Only ID group invited on a closed staff but needed to provide contracted administrative services.

Contract stipend - $40K/year

ID services – IC/PT, QI teams, Peer Review, and any other random perceived administrator need: Rate <<$100/hr.

Clinical ID Census ~ 50 patients/day
SOME CONTRACTS WHEN VIEWED UNILATERALLY ARE FINANCIAL LOSERS....BUT PROTECT A LARGE CLINICAL REVENUE BASE
Demonstrate Need – They may or may not know

Objectively Articulate Value

Agree to Preferential Reimbursement

Alternative – Walk away – if you’ve got leverage, by definition, you must have a strong BATNA
“LEVERAGED” CONTRACT

Underserved areas: No or few ID’s

Agree to provide high level of service – both clinical and contractual, with the following contingency:

A. Multi-year contract

B. Preferential (~$150-200/hour)
SO, IF IT’S SO EASY, WHY DOESN’T IT ALWAYS WORK?

1. NO/INSUFFICIENT PREP or GREAT PREP ……….. with HAPLESS PRESENTATION!

2. UNDEFINED BATNA – how do you know when to say “Yes” or walk away?

3. IDIOT SAVANTISM – know literature but can’t define goals or make presentation

4. RIGIDITY – No role unless afflicted with PD/MS; be flexible and practice answers to difficult questions
FLOOD INSURANCE – ANSWERS TO DIFFICULT QUESTIONS

1. “Our Pharm D does antibiotic control and Pathology runs Infection Control! What do YOU offer??

2. “What should we do about C. Difficile?

3. “We’ve tracked your antibiotic utilization, and it’s higher when compared to others.”

4. “What experience do you have in ________________?”
HE/SHE WHO PRACTICES ANSWERS TO DIFFICULT (AND SOMETIMES UNFAIR) QUESTIONS WILL DIFFERENTIATE THEMSELVES FROM OTHER CANDIDATES
Contracting entity – group or individual?

Payment – hourly or flat fee

Term – usually 1 yr; ? Automatic rollover

Responsibilities
- hours, committees, etc.
- beware the open ended clause - ?QA
1. Satisfying your negotiating partner’s interests will increase the likelihood of a successful negotiation

2. Leadership breeds leverage

3. Not all contracts are profitable when evaluated unilaterally

4. Practicing diplomatic answers to difficult questions will differentiate you from others.
REFERENCES


The Value of ID Specialists: Non-Patient Care Activities. McQuillen, et al CID 2008:47 (15 October)

THANK YOU

LARRY MARTINELLI M.D.

MIKE BUCKLEY M.D.

IDSA

CLINICAL AFFAIRS COMMITTEE

MY MIDC PARTNERS