

CARDIOLOGY PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

July 15, 2001

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With Stents, Volume Yields Better Outcomes

Numerous studies of cardiac procedures have shown a positive relationship between the volume of procedures performed by a physician or at an institution and the outcomes of those procedures. Such a relationship is supported by most large-scale studies of angioplasty, which prompted the American College of Cardiology in Bethesda, Md., and the American Heart Association in Dallas to issue minimum volume guidelines in 1998 for percutaneous coronary interventions (PCIs), such as angioplasty, coronary stent procedures, direct coronary atherectomy, and laser therapy.

Cardiologists, however, debate the validity of these volume guidelines, which recommend a minimum of 400 annual procedures for hospitals and 75 annual procedures for physicians. Some cardiologists argue that volume standards should be lowered because recent technological advancements, such as coronary stents, have reduced complications following PCIs, thereby bringing the performance of low-volume physicians and hospitals up to that of high-volume physicians or hospitals.

Debating the Numbers

A recent study supports the volume thresholds in current guidelines, even given the quality-of-care improvements that result from using stents. Paul D. McGrath, MD, and colleagues report in the Dec. 20 issue of JAMA that higher volume providers (both physicians and hospi-

tals) generate better PCI outcomes, even after factoring in the advent of the coronary stent. The researchers found that patients undergoing procedures handled by relatively low-volume physicians had a 45% increased risk of coronary artery bypass graft (CABG) surgery compared with patients treated by high-volume physicians. They also found that patients having procedures at relatively low-volume hospitals had a 36% increased risk of death within 30 days compared with patients being treated at high-volume institutions.

"For years, cardiologists have debated the number of angioplasties a physician or hospital must perform annually to achieve high-quality outcomes for their patients," says McGrath, a practicing cardiologist at Maine Medical Center in Portland, and a research associate at its Center for Outcomes Research and Evaluation. "Some physicians believe that stents are the 'great equalizer' because they enable all providers, regardless of PCI procedure volume, to improve PCI outcomes. Our study looked at whether stents had improved the level of outcomes for low-volume providers to that of high-volume providers. The study's findings show that even with the benefits conferred by stent technology, patients still face a greater likelihood of a positive outcome following a PCI if they receive care from high-volume providers."

The study is unusual because its scope involved the entire Medicare

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Technology Wreaks Havoc, Solves Problems

Today, many physicians are working much harder than they did in the past to build and maintain successful practices. They are struggling partly because managed care has brought many changes to health care, and these changes have disrupted how they practice medicine.

In response, physicians have been operating more efficiently and more effectively by using new technology and new processes to speed the flow of information among colleagues and patients and to smooth the flow of patients between offices. But innovative ways of practicing and new information systems tools can be disruptive as well, as we report in our article on page six.

While many innovations tend to be cheaper, simpler, and more convenient than other ways of practicing, they can be extremely difficult to master initially. Innovations create opportunities for some, but are unappealing for others.

Consider just a few of the new “disruptive” technologies that are being marketed to physicians. One is a handheld device with software that allows physicians to use the Internet to capture encounter data, to make sure that coding is done correctly, to check patient insurance eligibility, to issue “clean claims,” and to do billing and collecting functions. Some handheld ultrasound devices can diagnose heart disease, cost less than \$20,000, and are an alternative to the diagnostic function of \$200,000 stand-alone machines.

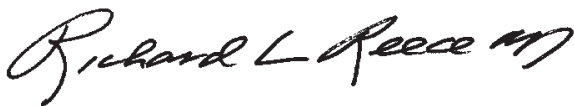
Another common disruptive innovation is software that can automate certain business functions and enable physicians to take a medical history and issue a complete patient record and bill while the patient is in the office.

Speech recognition software is yet another innovation. Such programs allow physicians to dictate medical records and “trigger” referral letters, prescriptions, and patient education modules. They also can be used to build a rudimentary electronic medical record.

Experts in disruptive innovation agree that many physicians are seeking technologies that work simply, cheaply, and conveniently, such as the automated telephone systems, called patient response networks, which patients can call to hear the results of tests reported in their physician’s own voice.

Overall, however, new and existing technologies tend to over-complicate the typical physician’s work and address the needs of a relatively small group of high-end specialists who are treating very sick patients. Most physicians would agree that what they need are simple solutions, not comprehensive complex systems.

At *Practice Options*, we write extensively about disruptive innovations and will continue to do so in an effort to help physicians find the best and simplest solutions to become more successful.



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Psychiatrist Offers Productivity Ideas

By Richard L. Reece, MD, editor-in-chief

Many physicians today are finding they are working longer simply to maintain their income. Cuts are being made in Medicare and in reimbursement from others sources while administrative needs are rising, forcing physicians to spend more on overhead.

Marshall O. Zaslove, MD, a practicing psychiatrist in Napa, Calif., believes that current pressures on physicians do not necessarily mean they must automatically work more hours or take home less pay. For the past 28 years, Zaslove has practiced in solo, group, office, hospital, administrative, academic, and military settings. In addition to full-time practice, Zaslove serves as director of the Zaslove Group, in Napa, a consulting firm that provides seminars on physician productivity.

Enhancing Productivity

The author of *The Successful Physician: A Productivity Handbook for Practitioners* (Aspen Publishers Inc.: Gaithersburg, Md., 1998), Zaslove describes in his book more than 140 strategies physicians can use to increase their professional effectiveness and career satisfaction.

While physicians may not need to work more, there is no doubt that they need to do more with less. "Today, more so than in the past, physicians need to get more done in less time with fewer resources," Zaslove says.

David Selden, president of Enterprise Health Solutions, health care consultants in Salem, Mass., agrees. "All physicians are finding that they need to provide the same level of service in less time, or more service in the same amount of time," he says. Specialty physicians may feel the pressure of time spent with patients even more acutely than their

primary care colleagues because diagnosis for specialty physicians is often much less straightforward than it is for many of the conditions that PCPs face and may therefore take longer, Selden says.

Psychiatrists are one example of specialty physicians who are finding they need to do more with less. Psychiatrists and other specialists have been hard hit by lower reimbursements resulting from managed care discounts and Medicare cuts,

who have had less contact with their peers than other physicians may not be as aware of strategies being adopted by the larger medical community to adjust to the new realities of medical practice, he says.

Time Management

The first strategy Zaslove promotes is to become an efficient manager of time. "Time management is an unfamiliar concept to most physicians," he says. "In medical school and dur-

"Once practitioners recognize their individual practice patterns, they can make major changes in how they utilize their time."

—Marshall O. Zaslove, MD

Zaslove explains. Many specialists face tremendous competition, not just from other specialists but from nonphysician caregivers who claim to work more efficiently—and for lower fees—than specialty physicians, he says.

Selden agrees, saying, "In many instances, managed care organizations have been weighing which providers to use in order to keep the costs of care down."

What's more, many specialty physicians who are in solo practice may find it difficult to realize the practice efficiency benefits—such as shared overhead, group purchasing, or collective negotiation with payers—that specialists in group practices might enjoy.

"Many physicians who have tended to be more devoted to the older models of practice have had difficulty adopting the types of practice management changes prompted by managed care," Zaslove explains. Specialty and primary care physicians

ing residency, physicians are never taught time management skills. As a result, there is tremendous variability in the efficiency of physicians. Almost all physicians can benefit from gaining better time management skills."

Zaslove's book compiles the best time management ideas set forth by successful practitioners, and the reader can choose optimum strategies for individual improvement. "I polled only physicians, because they are the ones who understand the inefficiency pitfalls of medical practice and can provide concrete strategies for improvement," Zaslove explains. "My research has revealed that all physicians have individualized patterns of inefficient and efficient use of time. Once practitioners recognize their own patterns, they can make major changes in how they utilize their time."

Indeed, there are dozens of inefficient patterns of behavior that most physicians exhibit. "Common time

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wasters include paperwork, interruptions, time spent on the telephone, meetings, friction with staff or with patients, and downtime,” Zaslove says. “Every physician immediately recognizes these nonproductive activities, because all physicians encounter them in their practices.

data during the office visit.”

Finally, Zaslove emphasizes the frustration physicians feel when they need to complete paperwork. “Every physician needs to examine and rationalize paperwork required not just for reimbursement, but for record-keeping and communication

card system. “Physicians can analyze their practice throughout the day, and jot down on a card all the unusual problems that come up in their practice,” Zaslove explains. “For example, physicians might note medication side effects that they don’t understand, or questions asked by patients that they cannot answer. Then, they can search for the specific knowledge they actually need. They will know exactly what their individual pattern of knowledge deficit is, so that they can use their knowledge-seeking time efficiently.”

While almost all physicians browse through journals, this activity is inefficient. “What are the chances that the information a physician encounters by randomly reading a medical journal article will apply to a current patient?” he asks. “A better strategy is to pinpoint topics that are relevant to the cases the physician is currently treating. Then the physician can focus on culling specific information that meets his or her needs from the journals. All of the relevant articles can be combined into a personalized desktop reference. This way, the information is not only tailored to the individual physician’s needs, but is available immediately, when it’s needed. Surveys of physicians indicate that using desktop references is the second most widely used form of knowledge acquisition.”

Relationship Management

The first most widely used method is peer contact. “When physicians have a question, they telephone a peer and get the answer,” Zaslove says. “They get the knowledge they need at the time they need it, phrased the way they need it, and they can interact with a real person. This knowledge acquisition system can be systematized. I encourage specialists to set up their own knowledge network so that they can acquire and trade knowledge through a source that is always available to them.”

One physician in a new market built his practice by getting referrals from nurses. Within a year, he was turning away patients.

Once physicians determine which are the biggest time wasters for them and start developing strategies to eliminate them, they are on their way to converting inefficient time into efficient time.”

Reducing or eliminating attendance at meetings can increase a physician’s productivity, for example. “We attend many meetings out of habit,” Zaslove explains. “These are the meetings that should be eliminated immediately. Attendance at other meetings should be considered carefully. Maybe we don’t need to be present, but we can simply get on the minutes distribution list. Maybe a colleague can go, represent our viewpoint, and bring back the materials. Physicians can probably cut their meeting attendance by 60% to 70% and not miss a thing.”

Physicians can adopt strategies to make time spent on the telephone more efficient as well. “Up to 30% of our patient contacts are actually not face-to-face, but over the phone,” Zaslove says. “Yet physicians never receive any training in how to use the phone efficiently. What helps: Determine quickly if a phone conversation will be a waste of time because you need to see the patient anyway. If the call is just to reassure the patient, use a strong, positive approach, and skip details. To avoid callbacks for information, make sure the patient understands and records important

with referring physicians,” he says. “Physicians should eliminate paperwork inefficiencies wherever they can. For example, they should just record the information that will be relevant to their intended audience, and remind themselves that they are not engaged in a literary exercise.”

Knowledge Management

Just as important as time management is knowledge management: a set of strategies to help physicians obtain needed information as quickly as possible. “Knowledge management for physicians is crucial,” Zaslove says. “As all physicians know, the practice of medicine has changed dramatically in the past five to 10 years, and many of the techniques that modern practitioners use have changed radically.

Because information is now being generated and disseminated so rapidly, not only to physicians but to patients as well, physicians can no longer use the traditional methods of knowledge acquisition and management. “Typically, physicians would go to lectures and browse medical journals to obtain knowledge,” Zaslove says. “This is what we were taught in medical school—that these random activities would somehow generate information we can use. In fact, there couldn’t possibly be any more inefficient way of getting knowledge.”

Instead, physicians might use a

“Managing relationships may be the single most important change a physicians can make to increase productivity.”

—Marshall O. Zaslove, MD

Developing a personal knowledge network is one result of a third group of efficiency strategies Zaslove labels relationship management. “Managing relationships is probably the single most important change any physician can make to increase his or her productivity,” he says. “But it is also the most unrecognized, ignored aspect of our professional lives. I have found that the most productive professionals are experts at managing relationships with patients, co-workers, and colleagues.”

Zaslove offers the example of a friend who recently entered psychiatric practice in a county with an overabundance of psychiatrists. “After only a year, he was turning patients away. I was quite surprised that he had built his practice so quickly, and asked him how he did it. He said, ‘I get all my referrals from nurses.’ I asked, ‘Why do they refer to you instead of to the other psychiatrists?’ He said, ‘Because I talk to them, and the other doctors don’t.’ This kind of relationship building is a strategy we often overlook because we don’t think it’s a productive way to spend our time.”

Optimal Strategies

While Zaslove asserts that there is no single ideal way to practice, he nevertheless believes that well-run practices exhibit several common behaviors.

“The most successful practices are those in which the physicians are introspective, assess their practice patterns, are open to new ideas, and are willing to make changes in their practice behaviors,” Zaslove says. “They maintain good relationships with numerous colleagues so that they can spot trends early.”

Physicians can grow their businesses and enhance their income through adoption of some very simple productivity strategies. “I’ve observed how a focus on productivity has enhanced patient volume in my own work as well as in other practices,” he reports. “But the quality of the care we’re providing and the satisfaction we get from medical practice turn out to be more important than reimbursement. The better our practice fits what we really want to do, then the more productive—and happier—we will be.”

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16). Readers may contact Zaslove at 707/226-7703 and order his book (\$29) from Aspen Publishers at 800/638-8437.

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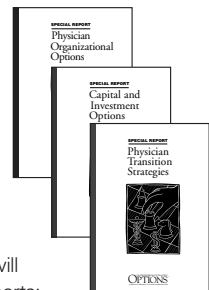
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New Technologies Disrupt, Improve Care

By Richard L. Reece, MD, editor-in-chief

Now, along with all the new technology and e-health solutions to improve health care delivery and make practicing medicine easier comes the terminology to define them: “disruptive innovation.” The implications of that term are certainly not lost on physicians, as they struggle to decide how to incorporate new technologies into their practices. What’s more, that struggle hasn’t been made easier by the recent gyrations of the Internet-based companies and the services and products they provide, which have caused uncertainty about what new technological tools and which innovations—if any—will guarantee success.

A Disruptive Oxymoron?

As a term, “disruptive innovation” seems like an oxymoron. “Disruption” connotes uncertainty and turmoil, while “innovation” connotes better times ahead. And physicians, who have been struggling for the last 20 years with the uncertainty of a changing health care environment, are right to parse its meaning for what the term means to them and how they practice medicine, today and in the years ahead.

“The history of disruptive innovations tells us that incumbent institutions will be replaced with ones whose business models are appropriate to the new technologies and markets. Instead of working to preserve the existing systems, regulators, physicians, and pharmaceutical companies need to ask how they can enable more disruptive innovations to emerge. If the natural process of disruption is allowed to proceed, the result will be higher quality, lower cost, and more convenient health care for everyone.” This is the thrust of the argument put forth in an article, “Will Disruptive Innovation

Cure Health Care?” in the September/October issue of *Harvard Business Review*, in which Clayton M. Christensen, Richard Bohmer, and John Kenagy predict how disruptive innovations could affect health care.

“Disruptive innovations are cheaper, simpler, more convenient products or services that start by meeting the needs of less-demanding consumers,” they say in the article. What that means for health care, the authors say, is likely to be an opportunity for some, but an unappealing disruption for others. The three authors argue that our health care institutions have exceeded the level of care needed by patients and physicians, who are asking only for technologies that work simply, cheaply, and conveniently. “Most existing technologies,” they state, “over-complicate the typical physician’s work [and] ... address the

regulatory, and paperwork burdens; help to ensure their compliance; and increase their productivity and profitability. In fact, physicians are likely to look favorably on innovations leading to the “higher quality, lower cost, more convenient health care” that the three HBR authors say comes from disruptive innovation.

But some health care providers will find these new technologies to be decidedly disruptive—not because of the efficiencies and cost-savings they provide, but rather because of the way they challenge the status quo. For example, some of the estimated 2.5 million office staff employed by physicians may find that any new technology that increases productivity by off-loading current internal business functions will result in a smaller office staff. And with Allen Wenner, MD, who founded a Web-

In health care, disruptive innovations are likely to offer cheaper, simpler, more convenient products or services that may present an opportunity for some but will be unappealing for others.

needs of a relatively small population of high-end specialists treating very sick patients. Simple, targeted solutions, not comprehensive complex systems, are the order of the day in most offices, clinics, stand-alone centers; outpatient surgery centers, and in-patients’ homes.”

Who Feels Disrupted?

In what way, then, are disruptive technologies in health care disruptive and to whom? Certainly most physicians won’t hesitate to embrace technologies that ease their bureaucratic,

based company that automates the medical history (at www.medhistory.com), saying that automating the medical history can reduce staff requirements by 30% in one year, medical office staff are likely to be dubious about embracing such disruptive innovations.

Some computer companies are likely to find certain emerging technology trends to be not only disruptive but also bad for business. Take the legacy computer companies that have systems installed in more than 150,000 offices and hope to install

more. For them, some of the emerging technologies could destroy those long-term strategic plans. After all, why would a physician group install a legacy system at the cost of \$40,000 to \$50,000 per physician when it could perform most of its functions—claims processing, billing, and collecting—on the Internet on a per-transaction basis with systems that require little up-front capital and no updating or maintenance?

HMOs that consider themselves indispensable for claims processing and utilization review are also unlikely to fully embrace disruptive technologies. This is especially true for the HMOs that view their role as the health care industry's exclusive administrative intermediary—the essential middleman—between the patient and the provider. New technologies may “disintermediate” them by rendering them totally obsolete.

Resisting Disruption

Likewise hospitals that view themselves as the organizing centers of health care will not be quick to adopt innovations that could disrupt that sense of control.

Some physicians also may find new technologies difficult to accept. Traditional specialists may resist marketing their clinical functions to less well-trained physicians, physician assistants, nurse practitioners, and even patients. They may reject out-of-hand, for example, the practice of letting patients record their own patient history using a computer-directed system. Also, physicians who see no medical role for the Internet almost certainly will shun these new technologies. There is a sizable, but dwindling group, of physicians who are reluctant to use technology in their offices, fearing it may represent an end to their practice.

On the other hand, there are those in health care who see opportunity in this so-called disruption. Among the companies that are seeking to devel-

op simpler alternatives to expensive care—and thereby helping physicians to participate in what the HBR authors see as health-care-related dis-

scription basis” in administrative areas such as billing and collections, payables management, payroll management, cash management, finan-

Payers that consider themselves indispensable for claims review and processing are unlikely to embrace disruptive technologies.

ruptive innovation—are two start-up Web-based companies in Waltham, Mass. The first is Catalyst Medical Solutions Inc. (at www.cmedsolutions.com), which was founded in 1999 by three physicians trained at Harvard Medical School and Massachusetts General Hospital. Their company seeks to provide doctors with technology to enable them to perform procedures inside or outside the hospital by using templates that automate the descriptions of the procedures the physicians perform.

The templates also can be used to generate progress notes on, and bill for, those procedures. The company's mission is “to improve the delivery of health care services by replacing outdated, cumbersome, wasteful business processes with quick, efficient, and user-friendly tools that take full advantage of the potential offered by Web-based technologies.” In other words, the company plans “to bring the Internet to the bedside to improve the way doctors care for patients,” it says.

Another company that embodies the characteristics of a disruptive innovator is Athenahealth.com Inc. (at www.athenahealth.com), co-founded in 1997 by two Harvard graduates who had previously served as consultants with Booz, Allen & Hamilton and its managed care consulting group. Athenahealth.com also seeks to use new technology to make health care delivery more efficient. It claims to provide “a full range of integrated business services over the Internet on a flexible sub-

scribing reporting, credentialing, and call center services.

What the founders of these types of companies are talking about might also be called “disruptive simplification technologies”—meaning technologies that give practicing doctors the ability to perform tasks personally that have been done only in centralized institutions, such as hospitals and insurance offices.

Disruptive innovation, like other trends emerging in health care and in information technology, can be viewed as an opportunity or as a threat, as physicians are being forced to make choices that could determine whether and how they will practice medicine. C. Everett Koop, MD, the former U.S. Surgeon General, has been quoted as saying that current and future doctors have three basic choices when it comes to practicing in today's changing health care environment:

- Work harder and earn less
- Retire
- Embrace information technology.

Dubbed the 3 Rs of modern medical practice—recede, retire, or retool—these choices are reminders that to survive and thrive in the medical field today, astute physicians will consider or focus on automated disruptive simplification technologies to rid themselves of the complexity-driven overhead now required or imposed upon them by large centralized organizations.

—*Edited by Paula Grant, in Lincoln, Va.*

articles on information technology are available on our Web site (see page 16).

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database and analyzed data from more than 167,000 patients who had PCIs performed by more than 6,500 physicians at 1,000 institutions in 1997.

The researchers used Medicare national claims history data, including Part A (hospital) and Part B (physician) claims. All Medicare enrollees ages 65 to 99 who underwent at least one PCI in 1997 and who filed both Part A and Part B claims were included in the analysis. The outcomes measures analyzed included CABG procedures following the PCI during the same episode of hospital care (an indication of a failed PCI) and the mortality rate within 30 days.

Claims for angioplasty, stent, and atherectomy were used to calculate individual physician PCI volume. Considering both the ACC minimum volume thresholds and data indicating that PCIs performed on Medicare enrollees account for 35% to 45% of total PCI volume, the researchers allocated the providers into Medicare PCI annual volume categories as follows:

- Low-volume physicians performed fewer than 30 PCIs
- Intermediate-volume physicians performed 30 to 60 procedures
- High-volume physicians performed more than 60
- Low-volume institutions performed fewer than 80
- Intermediate volume institutions performed between 80 and 160
- High-volume institutions performed more than 160

Higher Volume, Better Outcomes

The analysis clearly revealed better outcomes for the high-volume physicians. When the data were adjusted for morbidity, for example, the rate of

CABG for patients treated by high-volume physicians was 1.55%, compared with 2.25% for patients treated by low-volume physicians, indicating a 45% increase in risk for patients treated by the low-volume physicians. Furthermore, 5.26% of patients who experienced either subsequent CABG or 30-day mortality were treated by low-volume physicians, compared with 4.75% of patients treated by physicians in the high-volume category.

High-volume institutions also had better outcomes. The 30-day mortality rate for patients treated at low-volume institutions was 4.29%, compared with 3.15% for patients treated at high-volume centers, a 36% increase in risk of mortality for patients at the low-volume centers. In addition, 5.87% of patients treated at low-volume centers experienced either subsequent CABG or 30-day mortality, compared with 4.78% of those at high-volume institutions, representing a 22% higher risk of a poor outcome at the low-volume centers.

“These findings indicate that the volume of PCIs a physician or a hospital performs is a good proxy of how their patients will fare following those procedures,” McGrath says. “Patients should be asking questions about the hospital’s and the physician’s experience in performing PCIs.”

Interestingly, patients with a greater degree of comorbidity were more likely to be treated by higher volume physicians and institutions. High-volume physicians, for example, were more likely to treat patients needing a multivessel procedure, researchers say. Yet even when unadjusted for morbidity, the data show that high-

volume physicians had better outcomes than low-volume doctors.

The study shows that higher volume physicians and hospitals are a patient’s best bet, even given new PCI technologies. “The biggest quality-of-care impact of the introduction of the coronary stent is that, for both low- and high-volume providers, the rates of bypass surgery following angioplasty with stent implant have dropped significantly,” McGrath notes. “But even so, the rates exhibited by high-volume providers are still lower.” McGrath adds that the use of stents has not changed the risk of mortality of PCIs.

In fact, the researchers found that high-volume physicians are more likely to use stents. “Perhaps the clinicians at high-volume institutions are more likely to become experienced with new technologies more quickly, since large academic medical centers become involved in new innovations early through participation in clinical trials,” McGrath says. “These physicians may therefore be more comfortable with, and more willing to use, the stents than their colleagues at low-volume institutions.”

Implications for Cardiologists

The main factors driving the volume-outcome relationship in angioplasty are not defined by the study, but are likely to reflect the fact that providers simply improve with experience.

“On the cardiologist side, the positive correlation between volume and outcomes is a representation of physician judgment, which is reflected in how physicians care for individual patients based on the sum of their experience,” McGrath says. “Regard-

(Continued on page 9)

“These findings indicate that the volume of PCIs is a good proxy of how their patients will fare following those procedures.”

—Paul D. McGrath, MD, Maine Medical Center

Practices might improve quality by designating those clinicians who have the best outcomes as high-volume providers, the researchers say.

(Continued from page 8)

ing institutional volume, the volume-outcome relationship is probably a marker of how effective the systems and processes in the hospital are. In institutions with greater angioplasty volume, the hospital technicians and nurses know how to work most effectively and can implement evidence-based clinical protocols. Together, all of these factors feed into better quality of patient care and better survival rates.”

In fact, the volume-outcome relationship in angioplasty, as in other cardiac procedures, has been found in numerous clinical studies. “Experience breeds proficiency,” confirms John W. Hirshfeld, MD, a practicing interventional cardiologist, director of the cardiac catheterization laboratory at the University of Pennsylvania Medical Center, and professor of medicine at the University of Pennsylvania School of Medicine in Philadelphia. He also chairs the ACC’s Cardiac Catheterization and Intervention Committee and authored the 1998 guidelines on recommended angioplasty volumes.

Concentrating Procedures

Given the complexity of the procedure, the volume-outcome relationship in angioplasty is no surprise, Hirshfeld says. “Coronary angioplasty is a complex cognitive and technical procedure that a physician must perform frequently to be able to handle difficult cases and the complex situations that can arise unexpectedly in a seemingly straightforward procedure,” he says.

For cardiologists, therefore, the findings from the study by McGrath and colleagues have important implications. “Given the large number of studies showing a volume-outcome relationship in angioplasty, it is

unconscionable to allow multiple physicians in a group practice to each perform a small number of procedures,” Hirshfeld asserts. “Cardiology groups should concentrate interventional procedures in the hands of a small number of physicians so that those physicians can achieve the requisite experience level to achieve optimal outcomes. This strategy will provide a better quality of care to the group’s patients.”

Subspecialty Practice

Some practices have subspecialized by triaging angioplasty procedures to a core set of cardiologists, McGrath explains. “Other practices may have a large number of cardiologists in a single group, each performing angioplasty procedures at a relatively lower volume,” he adds. “These practices may be able to improve their quality of care by tracking outcomes for each physician, determining who has the best outcomes, and then designating those clinicians to be the high-volume providers of angioplasty.”

Cardiologists seeking to enhance outcomes by consolidating activity in a small number of physicians, however, may face political challenges. “For example, competing groups are unlikely to refer their interventional work to a practitioner in a competing practice group,” he says.

Overall, study data supporting the volume-outcome relationship in angioplasty have had a limited effect on actual practice. “Low-volume practitioners have a hard time accepting the fact that their outcomes may not as good as those of high-volume physicians,” Hirshfeld says. “They simply do not believe that they are not offering high-quality care to their patients.”

To enhance quality, low-volume physicians might seek to practice at

high-volume hospitals because the data suggest that the volume-outcome relationship incorporates a strong institutional effect.

Contracting for Volume

Unfortunately, roughly half of the institutions that perform angioplasty do not meet the ACC’s recommended guidelines for minimum activity levels. What’s more, hospitals that might seek to combine their angioplasty programs could face significant resistance from physicians, patients, or other interested parties.

As researchers continue to collect data on the volume-outcome relationship in angioplasty, referral patterns might begin to shift, McGrath says. “Cardiologists who practice at institutions that see a low volume of angioplasty patients can determine how close to a major tertiary center they are, and refer to the high-volume center if they can,” he says. “A good number of angioplasty procedures are done electively, rather than on an emergency basis. This time factor would allow patients to be transferred to higher volume centers.”

Currently, managed care organizations are beginning to contract with high-volume providers. “Contracting based on volume is occurring around the country as MCOs and employer groups have begun to channel patients to preferred providers and hospitals,” McGrath explains. “Such channeling is receiving a groundswell of support from providers and payers. Given the strong evidence supporting the positive relationship between volume and outcomes, I believe we will see more contracting based on volume as the years unfold.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Doctors, Plan Collaborate on Pay

Frustrated over delays in payment in many states, physicians have filed lawsuits seeking redress through the courts when other methods have failed. In the suits, physicians are working through their state medical associations to attract attention to the tactics of health plans. The physicians say the health plans have systematically adopted a strategy to delay or deny payment. Health plan associations say physicians are seeking to damage managed care.

In February, the Connecticut State Medical Society (CSMS), in New Haven, filed two lawsuits in a Connecticut State court against six managed care organizations, including Aetna, Cigna, and Anthem, seeking to force managed care plans to pay physicians more quickly. In March, medical societies in California, Georgia, and Texas and 40 physicians filed federal class action lawsuit under the Racketeer Influenced and Corrupt Organizations (RICO) Act. It alleges a conspiracy among managed care plans to “deny, delay, and diminish payments” to physicians.

Forum for Discussion

But physicians in Washington State have taken a different tack. “Historically, although we have had public policy differences, we have also enjoyed a collaborative culture between the health plans and the hospital and medical associations,” says Tom Curry, executive director of the Washington State Medical Association, in Seattle.

Over the past two years, the CEOs of the Washington State health plans Premera Blue Cross, Regents Blue Shield, First Choice, and the Group Health Cooperative have participated in a discussion group with Curry and the CEO of the Washington Hospital Association. Known as the forum, the group addresses frustrations and concerns among members.

As a result of these meetings, the group has recently added the CEO of the Association of Washington Business to its membership and financed the development of a new corporation that will focus on reducing the transactional difficulties that frustrate payers and providers.

“We certainly respect the fact that other state medical associations have reached such a point of frustration that they feel their best course of action is to file a lawsuit,” Curry says. “We are not at that point yet. Our physicians appreciate the fact that we are trying to find an administratively focused resolution to the problem of delayed payments. We want to try a

collaborative resolution before we pursue other tactics.”

In general, the health plans named in the lawsuits have declined comment, except to deny the accusations. Aetna issued a statement expressing disappointment that the CSMS had not brought its grievances to Aetna’s attention first. Gordon Grundy, MD, medical director of Aetna Connecticut and a member of the CSMS, has said he was surprised and disappointed by the lawsuit because Aetna had heard nothing but strong support for the progress made since Bill Donaldson, CEO of Aetna, addressed the society last year and promised changes in Aetna’s attitudes and actions toward physicians.

Cigna issued a statement saying the lawsuits were unwarranted because “the company’s decisions are made by medical professionals.” Anthem said, “the courts are not a productive forum for debate.”

Defending Managed Care

Organizations representing health plans have defended the plans. “Over the last few years, health plans in California have been actively trying to improve the system,” says Robert Pena, a spokesperson for the California Association of Health Plans, in Sacramento. “For example, last year health plans, hospitals, and physicians reached an agreement on a bill passed in the California State legislature that deals with fair billing and payment practices. That bill went into effect this year.

“The allegations of collusive and anticompetitive practices are ridiculous,” Pena continues. “California

A group is working to reduce the transactional difficulties that frustrate physicians and payers.

has a very competitive health plan market. I’ve never seen any evidence that health plans are working together to negatively impact physicians or hospitals in the state.”

Kirkland McGhee, acting director of the Georgia Association of Health Plans, says, “It is our position that organized medicine and individual physicians want to do anything they can to damage managed care. Physicians, hospitals, and health plans are going to have to align their interests before the entire health care system is destroyed,” McGhee adds. “Physicians may not like managed care, but if they destroy the current system, we may end up with something worse: a federally financed system. And that is not good for anyone.”

—Reported by Deborah J. Neveleff, in *North Potomac, Md.*, and Editor-in-Chief Richard L. Reece, MD, in *Old Saybrook, Conn.* More information on physician strategies is available on our Web site (see page 16).

Practice Building Requires New Ideas

Neil Baum, MD

Some physicians believe that after they have joined all of the managed care plans in their community, their days of practice promotion are over. Nothing could be further from the truth.

Today, marketing and practice promotion are even more important than in the old days of fee for service. Many physicians confuse marketing and practice promotion with slick newspaper advertisements and radio and television commercials. Most physicians can promote their practices with marketing strategies that are easy and inexpensive to implement. These strategies should address patient satisfaction, exceeding expectations, fulfilling unmet needs, communication, staff, access to care, wait times, and wellness.

Patient satisfaction. Satisfied patients are the best word-of-mouth marketing tool a physician can have. They tell others about the positive experiences they have had with physicians and their practices. On the other hand, and also by word of mouth, dissatisfied or unhappy patients can affect a practice, but this time negatively.

If a group of physicians was asked, "How many of you have a quality practice?" one hand for each physician in the audience would go up. But when asked, "How do you know?" few of those doctors would reply. Physicians need to measure

patient satisfaction. At least once a year, they should conduct a satisfaction survey that asks their patients what they liked best and least about

should try to ascertain what needs are going unmet in the community and develop an expertise in one of these areas. If, for example, there is no

Practice promotion today is even more important than it was under fee for service and can be done simply and inexpensively with these marketing strategies.

their practice. Then, physicians need to act on what they learn from the surveys. There is no better way to attract new patients than to keep current ones satisfied and happy.

Exceed expectations. Physicians should make every effort to exceed patients' expectations regarding their health care. Physicians can do so by having their offices open early in the morning and in the early evening. Opening the office on Saturday mornings also helps to accommodate patients who work on weekdays.

Another way physicians can exceed patients' expectations is by giving them appropriate educational materials about their medical conditions. This can be done even before patients arrive at the office by asking the receptionist to inquire about the nature of the visit when they call to schedule an appointment and then sending patients educational material before they arrive.

If, for example, a patient has an elevated cholesterol level, the physician can send information about the interpretation of the cholesterol test results or the importance of the ratio of total cholesterol to high-density lipoprotein. In this way, physicians will see educated patients, who are informed about cholesterol, when they arrive for their appointments.

Fulfill unmet needs. Physicians

physician working with patients who are attempting to lose weight, an opportunity might exist to become the local expert in this area by becoming knowledgeable about nutrition, exercise, and dietary regimens. Giving talks to potential referring physicians and writing articles for the local newspaper and magazines can help to publicize expertise in niche markets. Although this form of marketing may take several years to produce results, the rewards can be beneficial.

Specialists who develop expertise in a specific condition may be able to obtain referrals from other specialists in their community. For example, a specialist may be doing procedures or diagnostic tests that other physicians in the community are not doing, or they may have equipment or training that others do not have, which may also lead to referrals. A crucial factor in these referrals is that the patients return to the colleagues who referred them and that they not be treated for conditions the referring doctors can handle.

Improve communication. The next most important aspect of good physician referral relations after ensuring that referred patients are returned to their original doctor's care is promptly reporting the consultation results to the referring physi-

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Neil Baum, MD, is a urologist in New Orleans and the author of Marketing Your Medical Practice—Ethically, Effectively, and Economically. (Gaithersburg, Md.: Aspen Publishers, Inc., 1991). Readers may contact Baum at 504/891-8454 or at neilb89@aol.com. More information on marketing is available on our Web site (see page 16).

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cian. Referring physicians fully appreciate hearing promptly from other physicians and many are likely to discontinue sending patients to physicians if they do not hear back about consults.

Don't forget staff. The greatest surgical skills and the best marketing program will be wasted if a physician's staff doesn't place a priority on satisfying the needs and the wants of patients. All of a physician's marketing efforts can be ruined if the receptionist puts a patient on hold for several minutes or a staff member is rude to a patient or family member. Using nonmonetary methods to motivate staff may be a way to ensure that every patient has a good word-of-mouth experience with a physician and his or her practice and may help to retain staff as well.

Provide easy access to care. Physicians should make every effort to see that patients can contact them by telephone or e-mail, and that patients do not have to wait too long to make an appointment. This strategy is particularly true for new patients, especially those with an urgent problem who will not want to wait four to six weeks for an appointment. Leaving a few openings in the appointment schedule to accommodate emergencies, urgencies, and new patients may be a good, simple practice development tool.

Avoid excessive wait times for patients in the waiting room. The number one complaint most patients have about the health care profession is excessive waiting to see the doctor. Most patients start getting anxious and upset after waiting more than 15 minutes for their appointment.

Physicians can easily evaluate the efficiency of their practices by conducting a time-and-motion study, which involves placing a sheet on the front of every patient's chart for about 10 days. Record the time of each patient's appointment, the time each one is directed to the exam

Non-Monetary Staff Motivators

When seeking to motivate staff members, physicians can use the following strategies:

- Encourage continuing education
- Have regular staff meetings
- Recognize the achievements of staff
- Use distinctive uniforms
- Demonstrate care for staff and their families
- Reward staff for saving money or reducing overhead
- Include staff in practice decisionmaking processes

—NB

room, the time the patient leaves the office, and the time the patient spends with the doctor.

Physicians who do this study may be surprised to find that some of their patients may be spending 60 to 120 minutes in the office but only about five to 10 minutes with each patient.

This simple technique allows physicians to identify problems and find solutions to them. In one practice, a time-and-motion study revealed that it started experiencing delays around 2:30 to 3:00 each afternoon. Typically, at this time, the practice was seeing one or two patients with urgent care issues or emergencies that needed to be addressed. These patients did not have appointments at the beginning of the day but were told to come to the office and that staff would work them into the schedule. As a result, the patients who were scheduled at the end of the day were delayed by approximately 30 to 45 minutes.

After identifying this scheduling problem through the time-and-motion study, the practice created a 20-minute segment each day from 2:50 to 3:10 p.m. that is now left open to accommodate add-ons and emergencies. This 20-minute slot is not filled until the office opens in the morning.

Physicians need not worry about this time going unused. The time will

be spent either seeing patients or catching up on dictation and patient callbacks. All physicians can make an effort to be more sensitive to and more respectful of patients' concerns about excessive waiting times.

Recognize the importance of wellness and illness. In medical school, physicians studied diagnosis and treatment of diseases but spent little time studying preventive medicine. The environment today is different and patients are just as interested in staying healthy as they are in being treated for illness and sickness. Therefore, physicians should make sure that patients know that they are making an effort to keep their patients healthy and well. Examples of this strategy include participating in cancer screenings or giving patients cards to hang in their showers or closets that offer instructions on how to do self-examinations of the breasts and testicles.

Most women have heard about the importance of doing breast self-exams but few men know about the importance of regular self-examinations of the testicles. By offering patients such self-examination instruction cards that contain the practice's name and address, physicians can promote wellness and keep their name in front of the patient and family on a daily basis.

—Edited by Paula Grant, in Lincoln, Va.

In Lawsuit, Connecticut Physicians Cite Unfair Practices of HMOs



Timothy B. Norbeck has been the executive director of the Connecticut State Medical Society, in New Haven, since 1977. Norbeck has worked with physicians since 1967, spending six years at the American Medical Association in Chicago until 1973, and serving as executive director of the Rhode Island Medical Society from 1973 to 1977. Editor-in-Chief Richard L. Reece, MD, conducted this interview. Practice Options published another interview with Norbeck, "Aim for Profit Detracts From Patient Care, Says Connecticut Medical Society Director," on March 30, 1999.

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Q: In February, you held a press conference to announce two lawsuits against six large HMOs that operate in Connecticut. One lawsuit was submitted on behalf of the Connecticut State Medical Society; the other was on behalf of five physicians who practice in the state. What is the nature of these lawsuits?

A: The Connecticut State Medical Society (CSMS) took an unprecedented step in filing separate actions on behalf of its 7,000 physician members against our state's six largest managed care organizations. Both suits claim that Aetna, CIGNA, ConnectiCare, Anthem, Oxford, and Physician Health Services (now part of Health Net)

have systematically harmed physicians and patients by their illegal policies and practices, which include arbitrarily denying "medically necessary" care; denying care without proper explanation; arbitrarily downcoding claims; failing to staff utilization and clinical departments properly; and engaging in improper claims review by employing computerized programs to reduce or deny claims automatically.

We also claim that these health plans systematically breached the terms of their contracts with physicians. These lawsuits take direct aim at health plan policies and practices that leave initial medical care decisions to insurance company bureaucrats instead of relying on the professional judgment and expertise of physicians.

In the first of the two actions, CSMS seeks injunctive relief to change the egregious behavior of these insurers. The second, a class action lawsuit by five of our member physicians, seeks damages rather than injunctive relief. Physicians and their patients have been damaged by the arbitrary and, we believe, illegal actions of the insurers, and it appears that only something that threatens the insurers' bottom lines seems to get their attention.

Q: What led you to file these lawsuits?

A: There is a limit at which forbearance ceases to be a virtue, and the CSMS and its physician

members have reached that limit. It was the only other viable alternative available to us. There is a time to communicate and negotiate, a time to legislate and regulate. We have tried them all. There is also a time to draw a line in the sand and fight, and we felt that time had come for us.

Our state legislature was very responsive to our pleas for managed care reform, as was our attorney general, but the abuses continued despite their positive actions.

We asked ourselves some important questions. Why do HMOs delay, deny, downcode, and bundle claims? Because they can. Why do they ignore managed care reform measures enacted by a concerned legislature? Because they can. Why do they offer physicians one-sided, coercive, and unfair contracts? Because they can. We are not going to take it anymore. The time has come to take a stand. We must alter the face of medicine, and we believe our actions give us the best chance to do that.

After ignoring our concerns, as they seem to have done in other states, the insurers respond to our suits by saying, "Why don't we talk further?" Further talk appears to be fruitless. The harsh reality is that the insurers have all the leverage. And you know the old saying about compromise: The lion and the lamb can lie down together, but the lamb won't get much sleep.

Q: Last May, William Donaldson, the president of Aetna,

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"There is a time to communicate and negotiate, a time to legislate and regulate. We have tried them all. There is also a time to draw a line in the sand and fight, and we felt that time had come for us."

“We felt we could no longer continue the status quo, hoping that legislation or regulation would solve our problems, that something would come along and save the patient-physician relationship.”

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addressed the society and promised a change in Aetna's behavior. What were his promises, and what has ensued?

A: In May 2000, then Aetna CEO William Donaldson acknowledged that the pendulum had swung too far in favor of the insurers, and he promised a change in his company's corporate attitude toward physicians. In all fairness to Donaldson and Aetna, they deserve some credit for making that appearance before our House of Delegates, and we believe his effort to reach out was sincere. For whatever reasons, however, it became apparent that he was wrong about the changes to come. For example, Aetna included in physician contract negotiations an all-products clause, requiring that physicians participate in all of Aetna's product offerings if they wanted to participate in any of its products. The promise of eliminating the all-products clause, however well intentioned, did not meet our physicians' expectations. The clause was amended in only a limited way. There were and remain variations of that clause that are troublesome.

Although concessions were made on some issues, our other publicized major concerns of medical necessity determinations, financial disincentives to limit referrals, and unilateral contractual changes were not addressed. These were significant disappointments for CSMS.

Q: *Do you believe that the main reason for delayed payments is the desire of insurers to make money on the interest earned by delaying payment?*

A: Yes. There are huge amounts of money that can be added to insurers' bottom line by gaming the system in that way. One economist

has suggested that a very large HMO can earn up to \$400,000 in one day on the float. With the downturn of the stock market, there is even a greater incentive now to delay payments. Remember, the first obligation of a for-profit insurer is to its shareholders, not to the policyholders or patients. And that is a big part of the problem.

Q: *The AMA and Richard Blumenthal, Connecticut's attorney general, have both backed your actions. What are their roles, and how important is their support?*

A: We are delighted for the support of the AMA and Blumenthal, however, neither is directly involved in, or signatory to, our actions. Blumenthal has long been a proponent of managed care reform, as has our Connecticut General Assembly, and the AMA has done a remarkably good job of advancing the cause in Congress.

In taking our actions, we felt that we could no longer continue the status quo, hoping that legislation or regulation would solve our problems, that something would come along and save the profession and the patient-physician relationship.

Q: *Can you offer examples of how patient care has been negatively affected by HMO practices?*

A: We have heard many stories of how insurer abuses have negatively affected patient care. One that goes to the heart of why we are suing involves an elderly gentleman from North Haven, who is nearly blind. He had a double knee replacement, and his surgeon's recommended course of treatment was four days in the hospital and eight days in an in-house rehabilitation facility. The insurer insisted, over the surgeon's

vigorous objections, that the patient did not need any rehabilitation. The patient returned home and promptly fell down the stairs and then fell again. Fortunately he did not break his hip or legs, but his knees swelled alarmingly. In great pain, he returned to his surgeon, who then drained two quarts of fluid from each knee.

Here was a surgeon with considerable skill and training, who had known his patient for years, and yet his judgment was overruled by someone who had never seen the patient and who was following generic guidelines in denying needed therapy. Every day, many physicians find that, although they have spent one third of their lives in professional training, their determinations of medical necessity are being overturned by someone with little or no real knowledge of the case.

Many physicians wait interminably to get needed procedures approved, while others have their claims arbitrarily delayed, denied, downcoded, or bundled with other claims in an effort to reduce payment. Physicians are tired of the ceaseless burdens on their already overworked administrative staffs, who are forced to endure endless insurer hassles just to stand up for their patients. All of these unfortunate situations affect patient care negatively.

We must remember that when an insurer reserves for itself the right to determine what is and what is not medically necessary, it also reserves for itself the ability to control what it will pay for. The North Haven patient is just one painful example of why this egregious practice must be changed. His pain and suffering were considerable, and there is no telling how much that lack of in-house reha-

“We feel that we are on the right side here, the patients’ side, and we are in this for the long run, however long and whatever it takes. There is no other struggle in medicine as important as this.”

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recovery and ambulatory ability.

How the quality of patient care is negatively affected by insurer abuses is also evident in the following example. A group of pediatric oncologists in our state told us that it has had its fees arbitrarily slashed by 50%. The physicians are complying with the insurer’s unfair and coercive contract because they can’t bear to look parents in the eye and say, “Your child is terribly sick and needs this care, but the insurance company is not paying us enough so you need to find another doctor.” Insurers know that physicians are too committed to their patients to abandon them, so they take advantage of physicians’ strong sense of responsibility.

Q: *Why did you file your lawsuits in state court, rather than joining the medical associations in California, Georgia, and Texas in their federal lawsuit against HMOs?*

A: First, we applaud the actions of those state medical associations. They deserve much credit for stepping up to the plate like that, and I know that they have wonderful legal representation as well.

We chose to go to state court because we believe it was our best bet for relief considering our circumstances. Our actions were brought on behalf of Connecticut physicians claiming insurer violations of Connecticut’s Unfair Trade Practices Act. Filing in state court also enabled us to avoid implications of the federal Employee Retirement Income Security Act of 1973, which covers self-insured employers. Our actions were brought by physicians for breach of their contracts by managed care companies.

Q: *Are you concerned that managed care insurers will be formidable opponents?*

A: Surely, managed care insurers are formidable opponents with significant funds at their disposal and have many public relations personnel to present their position to the media. However, we feel that we are on the right side here, the patients’ side. What’s more, we are in this for the long run, however long and whatever it takes. There is no other struggle in medicine as important as this.

We are not in this to destroy health insurance. But health insurers should facilitate, not undermine, quality of care. Insurers must be balanced and not heavy handed, they must be fair, and they must respect patients and physicians as partners, and not treat them as adversaries.

Some may compare our battle with insurers to the David vs. Goliath struggle—and it is a most difficult task for us—but remember who won that battle.

Q: *Do you think that your lawsuit may prompt medical associations in other states to follow you?*

A: Yes. Several of them have contacted us about that possibility. We hope that they will join us in their own state courts, and our legal counsel will help them to do so, if they wish. Certainly the grievances that patients and physicians have in Connecticut are no different from those in other states where managed care has significant penetration. Like many other state medical associations, CSMS has had considerable success in attaining meaningful managed care reform—thanks to our legislature—but our insurers ignore many of the reforms,

just as their counterparts do in the other states.

Q: *Given that you represent physicians in a state that is home to many insurers, do you feel that you are in the center of the debate regarding managed care practices?*

A: An editorial last spring said Connecticut is the insurance capital of the nation and as such is a fitting setting for this litigation.

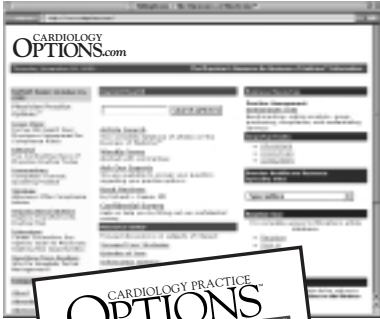
We believe that it is incumbent on CSMS to stand up in this way. We believe it is the right action, at the right time, by the right people, for the right reasons. Real doctors with face-to-face knowledge of their patients should be making medical decisions.

Insurers have tried unsuccessfully to invoke the old financial smoke screen and claim that our suits are about money and being paid. But physicians are like small business owners: They, too, have bills to pay and payrolls to meet. Imagine how angry you would be if payment for your services or products were delayed for no legitimate reason. Slow pay or no pay is unacceptable.

Are physicians expected to apologize for wanting to be paid on a timely basis? Insurers certainly don’t apologize or tolerate delays in the collection of their premiums. The policyholders either pay on time or there is hell to pay. We are not going to play that game, and they are not going to intimidate us with their flurry of smoke screens. They are not going to be able to run away from these lawsuits.

—*Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

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