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Reimbursement System Needs an Overhaul

Eight years ago, the disease management industry barely existed. Last year, it generated \$715 million in revenue, an increase of 24% over the revenue it generated in 2002. DM grew quickly because it filled a void. Delivering care to patients with chronic conditions in episodic office visits is both inefficient and ineffective. These patients need continuous support and monitoring, the kind that is given in home care settings and outside of settings that deliver care to patients with acute conditions. Managed care organizations saw this need, developed the infrastructure to fill it, and did so without including physicians, except as medical directors or in other necessary and limited capacities.

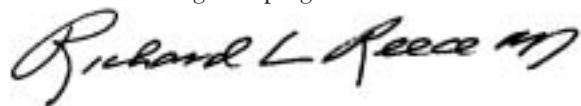
DM grew quickly also because it replaced utilization review, which had displeased patients and physicians and was considered one of the most onerous aspects of the early versions of managed care. By replacing utilization review with DM, managed care organizations found they could increase the quality of care they delivered to patients and cut their costs.

So, the gap between episodic office visits and patients living with diseases at home was seen as a vast uncovered niche. Patients with chronic, progressive diseases had been virtually ignored and were often getting sicker, sometimes experiencing problems requiring more timely interventions. Most of these problems occurred between doctor visits. These patients were beyond the reach of doctors, who were trapped inside their offices by a system tying reimbursement to face-to-face office visits.

When it became apparent that nurses could communicate with patients and track them through home visits, telephone follow-ups, Internet instructions, and home-monitoring devices, the role of nurses grew. They were asked to educate patients, foster self-care, monitor compliance with treatment modalities, and identify the need for intervention in time to avert ER visits and hospital stays.

DM has successfully improved care and cut costs, but it has done so largely without physicians. While delivering care in their offices, physicians do not have the time, data, information systems, or communication technology to deliver DM effectively. They are also limited by a reimbursement system that does not pay them to coordinate care across specialties. Some doctors support DM programs because they see that such programs produce better outcomes and improve patients' knowledge about their conditions.

What's needed is a radical overhaul of the financial reimbursement system. While the current system worked in the 1950s, it's time to develop one that meets the needs of the 21st century—one that allows physicians to contract with DM companies and to be paid for achieving better outcomes and for overseeing and administering DM programs.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD
Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
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Vienna, Va.

John W. McDaniel
President and CEO
Peak Performance Physicians, LLC
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Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

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Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD
Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD
Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

EMR Helps Increase Revenue

A growing number of cardiology practices are investing in electronic medical records as cardiologists recognize that EMRs help practices to increase efficiency and improve the quality of care they deliver to patients.

“EMRs enhance practice efficiency by offering quick access to complete patient information,” says Natalie Rowe, a consultant with the Horizon Group, health care consultants in Virginia Beach, Va. “They also improve the security of patient information, lead to more thorough and accurate documentation of services, and offer physicians the ability to report on patient data. EMRs enhance quality of care by ensuring that complete information is available to physicians at the moment when patient care decisions need to be made. In addition, they improve medication safety by checking drug interactions.”

Information Access

Arthur McDowell, MD, one of eight physicians with Middlesex Cardiology Associates, which has three locations in Connecticut, agrees. “The main benefit of an EMR is quick and easy access to complete information from any location,” he says. “But an EMR is especially beneficial to a cardiology practice, where access to testing information—specifically, information on stress test outcomes, echocardiogram outcomes, and cardiac catheterization results—can dramatically influence treatment decisions.”

In some instances, tests may be duplicated if paper charts cannot be

found in a timely fashion, McDowell adds. “An EMR offers great value from a practical perspective, a quality of care perspective, and an economic perspective,” he says.

Cardiologists are like many other specialists in that they treat patients with chronic illnesses who need ongoing care, Rowe explains. “Patients with chronic illnesses generate so much information for medical groups to maintain and track,” she notes. “By managing this information, an EMR can help cardiologists understand their patients’ current health. Furthermore, since EMRs keep discrete data that can be graphed and trended, patients’ medical progress can be tracked and analyzed over time.”

For Middlesex Cardiology, the high cost of managing paper charts was a primary reason it implemented an EMR in January 2001. “Our transcription costs exceeded \$250,000 annually,” McDowell says. “We also faced a space crunch. Our practice had grown to the point where we needed to enlarge our medical record room and hire more staff to manage the charts. The anticipated cost of this expansion, in conjunction with the growing costs of transcription, made investing in an EMR a wise business decision.”

Middlesex Cardiology implemented the Amicore Clinical Management EMR, which operates on a tablet PC. “This was the best option for our practice because we wanted mobile access to information,” McDowell explains.

The cardiologists carry the tablet PC into the examination room and use it the way they would have used a

paper chart to record the specifics of a visit, the patient’s health status, and treatment steps, McDowell continues. Following a series of prompts, cardiologists can enter most of their notes regarding a visit. Other notes can be entered via dictation or written using a pen attached to the tablet PC.

“In addition, the tablet PC allows us to access, via the Internet, our hospital medical system results information repository, which includes all laboratory and radiology test results and emergency room visit and inpatient stay information,” McDowell states.” In this way, the system allows us to seamlessly gather complete medical information about the patient at the point of care.”

Enhancing Efficiency

The time needed to create an EMR for a new patient is comparable to the time required in a paper record system, McDowell says. “I can create a full note on a new patient, using drop-down lists to build a note, in less than five minutes for most patients,” he observes.

Notes on patient follow-up visits take slightly longer to create using the EMR than they did via dictation. “A follow-up visit note required about one minute to dictate, and it takes about two minutes to create an electronic note,” McDowell acknowledges. “However, the fact that the information is in the system and can be accessed quickly from any location whenever we need it more than compensates for this slightly longer note creation time. And it vastly enhances

(Continued on page 4)

“An EMR is especially beneficial to a cardiology practice, where access to testing information can dramatically influence treatment decisions,” says Arthur McDowell, MD, of Middlesex Cardiology.

(Continued from page 3)

our daily efficiency, as we no longer have to call a secretary to pull paper charts or run out of the examination room to access patient information sent by the hospital.”

Various system functions contribute to enhanced practice efficiency. Staff use the system to schedule patient appointments, for example, by finding the next available opening that is convenient for the patient. The system also automatically generates reminder phone calls to patients before the scheduled appointment.

In addition, the practice manages all prescriptions and prescription renewals through the EMR, which can fax prescriptions electronically to a pharmacy. “Given that our practice treats about 100 patients a day, this efficiency creates a tremendous savings in staff time, allowing the cardiologists and the practice’s six physician extenders to treat additional patients,” McDowell asserts.

Electronic Links

The EMR also improves staff efficiency by contemporaneously generating patient test reports, including the cardiologist’s interpretation of these reports, and can fax them electronically to the patient’s referring physician. “Not only does this function increase the efficiency of our staff, it also enhances the turnaround time for the testing reports, making our referring physicians happy and thereby helping us build the financial success of the practice,” McDowell says.

Before adopting the system, Middlesex Cardiology sought to maximize efficiency by linking the EMR to the information systems in its hospital and laboratory providers. As a result, these organizations can electronically send patient information directly to

the practice’s EMR, obviating the need for the practice’s staff to scan in test results and hospital reports.

The EMR also helps to ensure appropriate coding, reducing a practice’s risk of claims of fraud and abuse, while simultaneously optimizing revenue. “Most doctors undercode because they are afraid of the repercussions of overcoding,” McDowell says. “The EMR checks that the documentation matches the assigned code. Furthermore, physicians are often in a hurry and, in the rush to create a handwritten or dictated note, may not record all of the services they actually performed. The EMR ensures appropriate reimbursement by prompting physicians to document all the services provided to the patient.”

Improved Results

Given these many sources of efficiency, it is no surprise that the EMR has enhanced Middlesex Cardiology’s finances. The practice’s transcription costs have decreased by \$128,000 annually. In addition, since the implementation of the EMR, the practice has been able to absorb an additional 8,000 patient visits each year, contributing to an increase in revenue of more than \$480,000 annually. Since implementation of the EMR, the practice has experienced a 50% increase in the volume of office-based procedures and has added four physicians with no associated increase in support staff.

“It takes an inordinate amount of staff time to handle paper charts—pulling charts, refiling and inserting new information into them, finding missing charts, finding information within charts, and documenting patient information,” says Rowe. “An EMR automates these processes

and streamlines them considerably, freeing staff to perform other tasks or reducing a practice’s staffing needs.”

Like Middlesex Cardiology, practices typically find that other savings accrue from reductions in transcription costs, chart materials and supplies costs, and space costs. “Instead of storing paper records, cardiologists can use that office space for revenue-generating purposes,” Rowe explains. “For example, they can create another patient examination room to help improve patient flow.”

Rowe encourages practices to consider nonfinancial benefits as well. “These benefits may not be as easily measurable, but they can be just as meaningful as financial benefits,” she notes. “Improved quality of care for patients is one such benefit, and improved quality of life for physicians and staff is another. An EMR can make the process of providing care much less frustrating and burdensome.”

While the EMR at Middlesex Cardiology has helped to reduce practice expenses and improve practice revenue through greater patient flow, McDowell notes that the most significant benefit is easier access to information. “Easier access to information yields better quality of care because complete patient information is available in real time and enhances professional satisfaction,” he says. “I could not imagine functioning in my practice without this EMR.”

The adoption of EMRs by physician practices has been somewhat slow, partly because physicians are intelligent people accustomed to having “all the answers” but they are not necessarily technologically savvy, McDowell believes. “Sometimes, physicians are reluctant to embrace

The EMR allowed the practice to cut its transcription costs by \$128,000 annually and to add 8,000 patient visits each year, contributing to an increase in revenue of over \$480,000 annually.

Functionality, Pricing Drive EMR Selection

When selecting an EMR, physicians should carefully consider four factors—functionality, pricing, support, and maintenance—says Natalie Rowe, a consultant with the Horizon Group, health care consultants in Virginia Beach, Va.

The first consideration is functionality. “Physicians must determine what features are important to them and what they can live without,” Rowe says. Cardiologists should decide, for example, how they want to enter data. “Many cardiologists appreciate the efficiency of point-and-click systems in which they can quickly select elements for documentation and follow-up care from pick lists presented by the system,” Rowe says. “But many want the ability to enter free text, particularly in the assessment portion of the note. Some systems offer a combination of data input, including point and click, voice recognition, handwriting recognition, and/or dictation, allowing them the flexibility to create a note that fits their needs.”

Many other functions are available and may vary in importance to different cardiology practices. “For example, some systems allow cardiologists to brand their chart notes and letters that go back to referring physicians,” says Rowe. “Similarly, if the ability to send interoffice messages is important to cardiologists, they can look for systems with this function.”

Prescription writing is another function that cardiologists typically want. “EMRs with a prescription-writing function allow the practice to fax prescriptions directly to the pharmacy, enhancing practice efficiency and ensuring prescription accuracy,” Rowe says. “These systems also check for drug interactions and can check formularies to determine which medications are covered by a patient’s insurance.”

Other functions further improve quality of care. “Cardiologists may want to select a system that includes embedded clinical guidelines,” Rowe offers. “Many EMRs integrate clinical guidelines into their systems, allowing decision support. Systems may also prompt clinicians to provide particular health maintenance services.”

A second consideration is price. “Cardiologists must consider whether a system will fit into their budget,” Rowe says. “By performing a return-on-investment analysis, the physicians can define an amount they are willing to spend.” Physicians should find out how the licenses are sold—meaning per provider, per concurrent user, or per visit volume—so that they can consider the true cost of using the system, she adds.

Third, vendor support should be evaluated. “The important aspects to inquire about include the amount of support, the type of support, the amount of training provided under the contract, and the speed with which the vendor will respond to requests for support,” Rowe says.

Finally, maintenance must be evaluated. “Cardiologists should ask how much the vendor is charging for maintenance, and whether this price includes updates as well as upgrades,” offers Rowe. —DJN

technological change because they do not understand it well and they do not want to look foolish or incompetent,” he says. “Therefore, the implementation of an EMR must be executed

such that all of a practice’s physicians are learning the system together, sharing information about the various functions in a nonthreatening way.”

Rowe agrees, saying that physician

support for new technology is important. “Physicians must be involved in system adoption from the start and be given time to get used to the idea,” she says.

One key is to have a physician champion, a person who has the respect of the members of the practice. “If one or two physician champions encourage the others and explain the value of an EMR in a nonthreatening way, then all the physicians will acclimate to the idea,” McDowell says.

Educational seminars and other training opportunities that address cardiologists’ concerns directly and help them get acclimated to the new system also can smooth the process. “By providing hands-on training and keeping the physicians informed about the implementation process, medical groups can help even the most resistant physicians come around,” says Rowe. She also recommends calling references provided by EMR vendors and making site visits to practices using systems that are under consideration.

Physicians tend to focus on the choice of the EMR, but Rowe emphasizes that many systems can work for a given practice. “Instead, cardiologists should focus on planning the system implementation,” she says. “If the system roll-out is not planned in an effective way, any system can fail.”

A second stumbling block to adoption of an EMR cited by many physicians is the cost of the system. Rather than focusing on the cost, McDowell contends that physicians should focus on the return on investment. “Practices that carefully choose and adopt a system will find that by the end of the first year, the system will have paid for itself,” he says. “At worst, it is a break-even proposition. In this light, cost should not be considered an insurmountable obstacle.”

—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).

Report: DM Programs Don't Cut Costs

After conducting a literature review to determine whether disease management programs reduce the cost of health care and how Medicare might use such programs, the Congressional Budget Office recently concluded there is not much evidence that disease management reduces health care spending. CBO is a nonpartisan government agency that prepares policy analysis reports at the request of members of Congress. Last month, it published its findings on DM in a report, *An Analysis of Literature on Disease Management Programs* (available online at <http://www.cbo.gov>).

The CBO conclusions are contrary to the findings of employers, health plans, and DM companies, which have shown that these programs help reduce costs and improve quality. What's more, the studies the CBO examined are out of date, says Al Lewis, executive director of the Disease Management Purchasing Consortium, in Wellesley, Mass. Since the studies the CBO analyzed were published, other research has demonstrated the value of disease management, he adds.

Old Data

"The studies the CBO used are, on average, two and a half years old, and based on study designs a year and a half older than that," says Lewis. "So these are data that are four years old in an industry that's only eight years old. In a new industry like this one, each year is like a dog year of experience, so the gap of four years between the data reviewed and today is a very long time. The CBO report is the equivalent of trashing the automobile

industry after trying to use a crank to get a car going on a cold morning."

Instead of reviewing the literature on disease management, CBO researchers could have done a more accurate analysis of the cost-effectiveness of disease management by meeting with and interviewing disease management experts, Lewis adds.

"If the CBO wants to know whether or not disease management programs save money, it should talk to people who use these programs," says Lewis, "and not rely on old data that fails to provide accurate, current information. This industry keeps growing, and an industry that fails to save money won't survive."

Even though the report concludes that such programs may not reduce costs, DM may still be worthwhile, said CBO Director Douglas Holtz-Eakin. The CBO examined studies of disease management programs for congestive heart failure, coronary artery disease, and diabetes, selected because they are highly prevalent among Medicare beneficiaries. The CBO also reviewed articles on cost-effectiveness in such medical journals as *JAMA*, the *British Medical Journal*, and *Diabetes Care*.

"We focused on the question of whether those programs could pay for themselves," Holtz-Eakin said in a letter to Sen. Don Nickles (R-Okla.), the chairman of the Senate Budget Committee who requested the report. "The proposition that decreased use of acute care services might offset the costs of the screening, monitoring, and educational services in disease management programs is clearly appealing, but, unfortunately, much of the literature on those programs does not directly address health care costs."

The federal Centers for Disease Control and Prevention in Atlanta estimates that the treatment of chronic diseases accounts for more than 75% of the nation's \$1.4 trillion annual cost of medical care. The goal of DM programs is to educate patients about their disease and help them manage its symptoms by, for example, taking steps to control blood sugar in patients with diabetes in order to stave off blindness, kidney failure, and other circulatory problems.

High-Cost Care

A survey of employers by Mercer Human Resource Consulting in New York shows that DM programs are growing quickly among purchasers. In a report on the survey, *Mercer's National Survey of Employer-Sponsored Health Plans 2003*, Mercer says the percentage of employer-sponsored health plans offering DM programs grew to 58% last year from 41% the year before.

A number of health plans outsource such work to more than 100 companies that have crowded into the market. Typically, chronically ill patients are monitored over the phone via nurse call centers, which work with information provided by labs, doctors, and pharmacies. DM programs are now expanding to include depression, cancer, kidney disease, obesity, and low-back pain.

Nickles requested the CBO review last year after lawmakers included a provision in the Medicare Prescription Drug Improvement and Modernization Act that created a demonstration program for beneficiaries to evaluate whether preventive efforts can improve clinical results

The CBO conclusions are contrary to the findings of employers, health plans, and disease management companies.

and decrease costs. If the demonstration is successful, DM programs could become a permanent part of Medicare, according to officials at the federal Centers for Medicare & Medicaid Services. The lead demonstration project will include about a dozen sites across the country, each covering 20,000 or more patients. The CBO says in its report that it will monitor that demonstration project and use its data to revisit the issue of whether DM programs can save Medicare any money.

Savings Unproven

But, at least as of now, the CBO has found that there is scant evidence the programs are cost-effective. Its report concludes that the focus of DM programs is often on the processes of care or on intermediate measures of health. As a result, the CBO report says, it is difficult to determine from such data whether overall savings have occurred. In the report, CBO researchers also note that the few studies reporting that DM programs reduce costs do so for controlled settings and generally fail to account for all health care costs, including the cost of the intervention itself.

Therefore, the CBO concludes, if DM programs are applied to broader populations, any reported savings might not be attainable and the programs could raise costs. CBO's final conclusion is that although some studies indicate that DM programs reduce health costs for select groups of patients in the short term, "little research directly addresses the issues that would arise in applying DM to the older and sicker Medicare population."

In its report, CBO notes that since the most common health consequences of diabetes are chronic rather than acute, diabetes disease management programs (DDMPs)

should be evaluated for savings over the long term. "There is strong evidence that disease management interventions for diabetes reduce patients' HbA_{1c} levels and increase their compliance in getting recommended examinations and screening (such as foot and eye examinations)," the report says. "However, there is not comparable evidence to conclude that disease management programs achieve other medical management targets (such as lowering weight, blood pressure, and cholesterol levels) or improve health outcomes (such as reducing rates of blindness or kidney failure)."

The CBO reports that a few studies found that programs for diabetes can save money in the short run. It quotes an April 2002 article in *Diabetes Care* ("Does Diabetes Disease Management Save Money and Improve Outcomes?") that reports lower costs and utilization for patients enrolled in an HMO's DM program. The savings described in that study were \$395 per member per month in average paid claims for patients in the program, compared with \$502 for other patients, but then notes that "the results from this study have limitations, including possible selection bias from optional enrollment and the limited applicability of the HMO setting. Also, the reported savings did not include the cost of the DM program."

The CBO also cites a study published in the January 10, 2001, issue of *JAMA* ("Effect of Improved Glycemic Control on Health Care Costs and Utilization"), in which savings of \$685 to \$950 per patient per year were reported for patients with improved HbA_{1c} levels. That study compared patients who had their HbA_{1c} levels decrease at least 1% during the first year of the study and remain at that point for an addi-

tional year (about 15% of the study sample) with patients who did not. "But patients who saw improvements in their HbA_{1c} levels probably differed from patients who did not in many other ways that would affect their health costs, so the reported results may have little to do with the effects of DM," the study says.

Officials with the Disease Management Association of America said the CBO report fails to include recent studies that demonstrate cost benefits. In a conference last month in Orlando, several studies were presented that showed cost savings from 10 different diabetes management programs and 11 asthma management programs, according to Christobel Selecky, DMAA president.

In an article in the July/August issue of *Health Affairs*, researchers reached conclusions that appear to contradict the findings of the CBO review. In an article, "Effectiveness of a Disease Management Program for Patients With Diabetes," researchers analyzed the first-year results of a multistate DDMP sponsored by Cigna Corp., a national managed care organization in Philadelphia. They concluded that the overall costs of care were significantly lower in DDMP sites, and Cigna saved more than it spent on the program. Pharmacy costs showed mixed results. Quality of care scores, such as the number of diabetes patients who regularly checked their blood sugar levels, were significantly better at the DDMP sites than at sites without the program. "These programs have a profound impact on the quality of care and costs on a short- to intermediate-term basis," Allen Woolf, Cigna's national medical director told *The Wall Street Journal* in a Oct. 20 article about DM. —Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is on our Web site (see page 16).

One report concluded that the overall costs of care were significantly lower at diabetes disease management sites.

Variation in Quality Exists Nationwide

By Richard L. Reece, MD, editor in chief

Wide variation in the quality of hospital care and outcomes for Medicare recipients with the same chronic conditions exists throughout the country, according to researchers at Dartmouth Medical School in Hanover, N.H. Their research is featured in "Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients With Severe Chronic Illness," an article in the Oct. 7 edition of *Health Affairs*.

In an analysis of Medicare claims at 77 hospitals, the researchers found that the frequency of physician visits, the number of diagnostic tests, and the rate of hospital and intensive care unit stays varied widely. In what the authors say is the most significant finding of their study, "a higher intensity of care and larger amounts of spending don't mean better quality or longer survival times," says John E. Wennberg, MD, an epidemiologist who directs the Center for the Evaluative Clinical Sciences at Dartmouth.

Data Analysis

Wennberg led the study and is the principal investigator and series editor of the *Dartmouth Atlas*, published by CECS and funded by the Robert Wood Johnson Foundation, a philanthropy in Princeton, N.J. The *Atlas* has documented significant geographic variations in medical practice since the early 1970s. The researchers use large health care claims databases (including those from Medicare and Blue Cross and Blue Shield plans) to analyze national, regional, and small area variations in medical practice in 306 hospital referral regions (HRRs). The researchers compare utilization rates for several diseases and acute medical conditions, such as coronary artery bypass graft surgery and hip

fractures. They also examine the regional practice rates for such standards of care as blood tests and eye exams for patients with diabetes.

The *Atlas* was last published in 1999 and a new edition is planned for late this year or early next. "We demonstrate that in American health care, geography is destiny," says Wennberg. "Both the amounts and kinds of care provided to residents of the United States are highly dependent on two factors: the capacity of the local health care system (which influences how much care is provided) and the practice style of local physicians (which determines what kind of care is provided)."

In the current series of studies published in *Health Affairs* (the results of which will be featured in the next *Atlas* edition), Wennberg and colleagues evaluated the efficiency of the 77 hospitals for geriatric care and heart and pulmonary disease in man-

both in quality of care and cost," says Wennberg.

For example, despite evidence that the survival rate is the same for patients with lumpectomies as it is for patients with mastectomies, the rates of mastectomy for breast cancer per 1,000 Medicare enrollees in Pennsylvania in 1999 varied in the state's 13 HRRs from 0.8 to 2.4 per 1,000 female Medicare enrollees. Surgery for benign prostatic hyperplasia (transurethral prostatectomy) varied from 4.4 to 11.1 per 1,000 male Medicare enrollees.

Because both procedures have alternatives of apparently equal medical value (lumpectomies instead of mastectomies and no surgery instead of TURP), the data suggest that the medical opinions of local physicians concerning the value of these treatments vary, Wennberg says. "The wide variations in surgical rates suggest that physician, rather than

One study found that more care and money don't mean better quality or longer survival.

aging chronically ill Medicare patients during the last six months of life. The authors looked at variations in care for more than 90,616 patients, age 65 and older, who suffered from solid tumor cancers, congestive heart failure, and chronic obstructive pulmonary disease. Then, they compared the illness-adjusted frequency of physician visits, hospitalizations, and ICU stays.

Comparing Numbers

What they found reinforces the conclusions Wennberg reached in previous research on practice variation, he says. "Variation remains one of the greatest problems facing health care,

patient, preferences are the deciding factor in most cases," he explains.

Patient Choice

The inference to be taken from such data is that health plans and provider organizations might reduce variation by informing patients about their options, using evidence-based medicine as a guide. "Unwarranted variation cannot be explained on the basis of illness or the preferences of patients," says Wennberg. "Such variations result from influences that the supply side exercises on the patterns of practice."

A second article in the Oct. 7 edi-

tion of *Health Affairs* addresses treatment decisionmaking. In "Policy Support for Patient-Centered Care: The Need for Measurable Improvements in Decision Quality," the authors, led by researchers at the Health Decision Research Unit of Massachusetts General Hospital in Boston, conclude that "the phenomenon of practice variation draws attention to the need for better management of clinical decision making as a means of ensuring quality. Different policies to address variations, including guidelines and measures of appropriateness, have had little demonstrable impact on variation itself or on the underlying quality problems. Variations in rates of interventions raise questions about the patient-centeredness of decisions that determine what care is provided to whom."

Certain agencies—such as the Centers for Medicare & Medicaid Services in Baltimore; the Agency for Healthcare Research and Quality in Rockville, Md.; and the National Committee for Quality Assurance (NCQA) in Washington, D.C.—should develop policies that encourage patient involvement in treatment decisionmaking, the authors say.

"The persistent widespread variation in rates of procedures will continue until there is a concerted effort to attend to the quality of individual decisions," the authors point out. "We recommend that improvement in the quality of patient decision making be given highest priority on the pay-for-performance agenda of private and public payers."

Wennberg encourages health plans and providers to use the measures in NCQA's Health Plan Employer Data and Information Set to improve physician and patient decisionmaking. Such basic measures as ensuring

that patients with diabetes get blood tests and eye exams and that victims of heart attack get aspirin and other medications will cut mortality and morbidity rates, he says.

Exceeding Demand

Caution is required, however, when two possible treatment options appear to be of equal value, such as lumpectomies versus mastectomies. "Variation cannot be interpreted from the point of view of the patients' welfare, since it is not clear whether patients actually had much of a say in determining which treatment they received," explains Wennberg. Data suggest that the number of surgeries now provided in many regions exceeds what patients informed of the comparative efficacy of both procedures would demand, he says.

His conclusion is reflected in the study of Medicare claims data at the 77 hospitals. "This marks the first time Medicare claims data are being used to measure the performance of individual hospitals and identify hospitals that appear to be doing a better job managing chronic illness and patient care," Wennberg says. "We found that no matter how preeminent the hospital, care varies widely. What was particularly interesting is that we found quality is inversely correlated with the intensity of care and that the better hospitals are using fewer resources and providing fewer hospitalizations and physician visits."

The Dartmouth researchers identified hospitals where Medicare enrollees are receiving much more intensive care for common medical conditions, raising questions about usual methods of identifying so-called best hospitals, such as those named in an annual report by *U.S. News and World Report*, for example. The

authors used the 2001 *U.S. News* report to study the seven hospitals that ranked highest in geriatric care.

"Our performance measures provide a very different perspective than that provided by *U.S. News and World Report's* measures," the authors say. (The magazine bases its rankings in part on institution-specific measures, such as number of nurses per bed). "In addition to documenting marked variation across hospitals, our performance measures make transparent the relationship between management decisions that determine the size of the professional workforce and the numbers of hospital beds and other resources, on the one hand, and the costs and use of care, on the other," the researchers note.

Physician Visits

Among other findings, the researchers say that patients receiving care from New York's Mount Sinai Medical Center spent almost twice as many days in the hospital as patients treated at the Mayo Clinic's St. Mary's Hospital in Rochester, Minn. They also found that patients in the Mount Sinai Medical Center and the UCLA Medical Center had twice as many visits from physicians as patients treated at Duke University Hospital in North Carolina. Days spent in intensive care units for patients at the UCLA Medical Center were three times as many as for ICU patients at MGH, the researchers found.

In addition to utilization variations, the quality of care for geriatric patients suffering terminal illnesses varied widely. The number of patients who died as hospital inpatients, rather than at home or in hospice, varied from 32% of all deaths to more than 52%. For example, patients at St. Louis University Hospital were nearly 70%

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One study recommends that improving the quality of patient decision-making be given the highest priority.

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more likely to spend time in intensive care than were people who died as inpatients at Mayo Clinic hospitals.

Practice variation also was significant among the nation's leading academic medical centers, including those ranked at the top of the *U.S. News and World Report's* lists of best hospitals for geriatric care, particularly in the numbers of different physicians who cared for patients during their last six months of life. The numbers of physicians responsible for managing chronic illness ranged from 12 per 1,000 decedents at Duke University and the Mayo Clinic, to 20 and 22 per 1,000 decedents at UCLA and Mount Sinai, the researchers said.

In addition, patients at UCLA and Duke were less likely to see a primary care physician than were patients at St. Louis University or Mount Sinai Medical Center, and patients at UCLA had 2.8 times more visits with specialist physicians than with primary care physicians.

Patterns of Practice

In a third study, discussed in "Variations in the Longitudinal Efficiency of Academic Medical Centers," in the *Health Affairs* Oct. 7 edition, researchers reviewed the care patients received during their initial hospitalization for one of three reasons—heart attack, colorectal cancer, and hip fracture—in one of 299 hospitals that belong to the Council of Teaching Hospitals. The council is a policy development organization affiliated with the Association of American Medical Colleges in Washington, D.C., and has members from about 400 major teaching hospitals and health systems, including 64 Veterans Affairs Medical Centers.

Led by Wennberg's colleague Elliott Fisher, MD, a Dartmouth professor of community and family medicine, this study examined patterns of practice, quality of care, and health outcomes. Researchers found that the overall intensity of medical services delivered

to patients with serious chronic illnesses varied by as much as 60%. In determining intensity of care, they examined lengths of stay, procedures performed, and physician visits. They found that patients in the highest intensity hospitals spent more time in the hospital and the ICU, had more frequent physician visits in the inpatient setting, had more specialists involved in their care, and received more imaging services, diagnostic testing, and minor procedures.

Compared with the low-intensity group, those in the high-intensity group had

- Use of evaluation and management services that was 56% to 82% higher
- Diagnostic imaging that was 20% to 26% higher
- Diagnostic testing that was 73% to 94% higher, and
- Rates of hospital visits and new specialist consultations that were about twice as high.

Not surprisingly, costs were significantly higher in the high-intensity teaching hospitals for an acute care episode, the researchers say. Medicare reimbursement for hospital and physician services was 47% to 58% higher in the high-intensity teaching hospitals (such as New York University

example, among hip fracture patients, there were no significant differences in death rates across groups. In fact, among heart attack and colorectal cancer patients, there was a "small but statistically significant increase in the risk of death as intensity increased."

The most disturbing element of the Dartmouth research was evidence that a very high intensity of care for people with certain terminal medical conditions might hasten death, says Wennberg.

Some of the solutions Wennberg and his colleagues propose to help physicians and health plans reduce variation have long been considered effective, such as the use of evidence-based medicine to set standards of care. Others are more innovative and just recently considered good medicine, such as an emphasis on patient involvement in health care decision-making. And some are difficult to achieve, such as controlling capacity.

Medical practice variation is "remarkably resistant to change," Wennberg explains, adding that there are steps physicians and others can take to begin to reduce disparities, such as rewarding providers for efficient, high-quality performance. A provision in the Medicare Prescription Drug Improvement and

The MMA takes steps to address unwarranted variation in health care.

Medical Center, Cedars-Sinai Medical Center in Los Angeles, and Jackson Memorial Hospital in Miami) in comparison with the lowest intensity hospitals (including Mayo Clinic affiliate St. Mary's, Strong Memorial Hospital in Rochester, N.Y., and Richland Memorial Hospital in Columbia, S.C.).

The most significant finding was that there was no association between higher intensity of care and long-term mortality rates, the authors note. For

Modernization Act of 2003 (MMA) that creates a demonstration to test this idea is a significant step in the direction of addressing unwarranted variation in health care, he says.

—Edited by Martin Sipkoff, in Gettysburg, Pa. The Oct. 7 Web edition of *Health Affairs* is available at www.healthaffairs.org, and more information about the Dartmouth Atlas is available at www.dartmouthatlas.org. More information on practice strategies is available on our Web site (see page 16).

Six Year-End Tax-Saving Ideas

By David B. Mandell, JD, MBA, and Steve P. Dunbar, CFP

Physicians work too hard and have trained too long not to make tax planning a priority. The alternative is to spend 40% to 50% of their time working to pay taxes to federal and state governments. Still, most physicians do not dedicate even one day a month to developing and maintaining a strategy to reduce their tax liability. Since there are at least six strategies physicians should adopt now to save taxes on 2004 income, it is important that they devote at least some time to tax planning before the end of the fiscal year.

Physicians are like all citizens in that they need not overpay their taxes. Federal and state tax laws require physicians, individuals, and all businesses to pay their fair share of taxes. Developing legal ways to minimize one's tax liability is not a crime; it is simply smart business management. Or, as Judge Learned Hand once said, "There is no reason to pay more taxes than the law would provide; there isn't even a patriotic duty to do so."

David B. Mandell, JD, MBA, is a principal with Jarvis & Mandell LLC, in New York. He is the author of The Doctor's Wealth Protection Guide (Wiley & Sons, 1999), and of Wealth Protection, M.D. (Wiley & Sons, 2004). Steve Dunbar, CFP, is a charter member of the Wealth Protection Alliance with Jarvis & Mandell. Mandell and Dunbar may be reached by telephone at 800/554-7233 or by e-mail at info@wealthprotectionalliance.com.

Taking Deductions

The first step physicians should take when developing a tax-saving strategy is to ensure that they take a deduction for risk management and asset protection planning. Medical practices can use closely held insurance companies (CICs) when looking to make annual tax-deductible contributions of \$80,000 to \$175,000 for asset protection and risk management programs. These CICs typically are very small insurance companies that primarily insure the practice. CICs enjoy extremely beneficial tax treatment (made even better by an April 2004 law signed by President Bush) by allowing physician owners an opportunity to build tax-favored wealth, as opposed to giving profits to insurance companies or building wealth subject to income and capital gains taxes.

Physicians can use a CIC to insure all, or portions of, their practice's significant risks, such as medical malpractice liability protection, medical malpractice "defense only" policies, sexual harassment and wrongful termination claims, and audits by federal authorities (such as the Centers for Medicare & Medicaid Services).

Asset Protection

The second step involves developing an asset protection plan for the practice's most valuable asset: the accounts receivable. Physicians are keenly aware of the malpractice liability crisis, but many may not realize that a large judgment against them or

against any of their partners could likely threaten all of the practice's accounts receivable.

Typically, accounts receivable are a medical practice's most valuable asset. For this reason, many physicians have implemented an asset-protecting strategy for their receivables. While the details of such a strategy can be quite extensive, for the purposes of this article, it should be mentioned that at least two of these strategies (financing and enhanced factoring) may allow a practice to protect this asset and reduce the practice's income tax burden as well.

A reduction in income taxes is possible because of the deductions this strategy generates. Thus, if asset protection—in addition to tax reduction—is a concern, most tax and financial professionals will recommend that physicians investigate their options in this area.

Using NonQPs

Many tax advisers suggest that physicians use traditional tax-qualified investment plans, such as pension, profit-sharing, Keogh, and 401(k) plans. In fact, tens of millions of Americans participate in such plans each year. Since these plans are tax-qualified, most deposits into these plans are 100% deductible. Of course, the Internal Revenue Service has strict rules about how much one can put into such plans, which employees must be able to participate, and when one can get one's

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Typically, accounts receivable will be a medical practice's most valuable asset. For this reason, many physicians have implemented an asset-protecting strategy for their receivables.

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money out of these plans. Typically, there are tax penalties for early withdrawals.

On the other hand, nonqualified plans (sometimes called nonQPs) have few restrictions on how much can be contributed and who can participate, and have no penalties for early or late withdrawal. Unlike qualified plans, nonQPs are not well known, therefore few Americans participate in them because many employees are unaware that their employer offers them or because their employers have not created one.

Not developing a nonQP is a wasted opportunity, since nonQPs can provide tremendous tax and retirement benefits, while allowing maxi-

created by the FLLC or FLP to the limited partners or to members who are in lower tax brackets.

Most physicians are in a 40% tax bracket (for state and federal taxes) and many of them have children who are over age 14 and who are in a 10% or 15% tax bracket. For these physicians, an FLLC or FLP can save significant amounts on taxes for income earned by FLLC or FLP assets, such as mutual funds, real estate rentals, stocks, and bonds.

Tax Deferrals

Another step in reducing taxes involves the use of annuities. There are two types of annuities: fixed annuities (which pay a fixed return over a

states that do exempt them, annuities are an ideal tool to safeguard wealth.

Charitable Giving

Many Americans cherish the right to give to the charitable institutions of their choice. The problem, many times, is that they do not know how to give or they assume that their family will suffer as a result of their giving. There are many ways physicians can make charitable gifts while benefiting their families as well. The most common tool for giving in this way is to use a charitable remainder trust. A CRT is an irrevocable trust that makes annual or more frequent payments to the holder of the trust (meaning the physician, a family member, or both). The payments can be made until the holder dies. What remains in the trust then passes to a qualified charity of the holder's choice.

A number of advantages may flow from the CRT. First, the physician will obtain a current income tax deduction for the value of the charity's interest in the trust. The deduction is permitted when the trust is created, even though the charity may have to wait until death to receive anything.

Second, the CRT is a vehicle that can enhance the physician's investment return. Because the CRT pays no income taxes, the CRT can generally sell an appreciated asset without recognizing any gain, enabling the trustee to reinvest the full amount of the proceeds from a sale and generate larger payments.

Finally, the trust will be eligible for an estate tax deduction if it passes to one or more qualified charities upon the holder's death.

—More information on practice strategies is available on our Web site (see page 16).

An annuity will let a physician invest funds that would otherwise go to the government and defer taxes on the earnings until the physician retires, when the physician may be in a lower tax bracket.

mum flexibility as well. Physicians can find out more about how nonQPs can help them invest wisely and get a tax advantage by asking their tax professionals about them.

Shared Income

Often physicians use family limited liability companies (FLLCs) and family limited partnerships (FLPs) for asset protection. In addition to being useful as asset protection vehicles, FLLCs and FLPs can allow physicians to save thousands of dollars each year in income taxes. These plans help physicians cut their taxes through a strategy called income sharing, which means spreading the income

period of time) and variable annuities (which have an underlying value linked to an investment in the stock market). If physicians have assets that they do not intend to use until retirement, there is no reason not to use an annuity to defer income taxes.

Under realistic assumptions, a \$500,000 stock portfolio may generate an annual tax liability of \$10,000 to \$25,000. An annuity will let a physician invest funds that would otherwise go to the government and defer taxes on the earnings until the physician retires, when the physician may be in a lower tax bracket. Additionally, some states protect annuities from creditor claims. In the

“There is no reason to pay more taxes than the law would provide; there isn't even a patriotic duty to do so.”

—Judge Learned Hand

DM Is Changing the Delivery of Chronic Care, Expert Says



Victor Villagra, MD, FACP, is president of Health & Technology Vector Inc., an independent health care consulting firm in Farmington, Conn.

Villagra has extensive experience in managed care, disease management, and technology assessment. Previously, he was national medical director and vice president, quality and medical strategy at Cigna Health Care, and a past president of the Disease Management Association of America. Board certified in internal medicine and a fellow of the American College of Physicians, Villagra holds a faculty appointment at the University of Connecticut Health Center. In this interview, he speaks with Editor in chief Richard L. Reece, MD, about the role of physicians in disease management programs.

Q: Recently, you said, “Now is the time to do medical management right.” What does that mean?

A: That statement referred to managing disease in the context of a managed care organization. It implies that managed care organizations may not have done medical management right, by concentrating on utilization management. “Doing medical management right” refers to applying clinical criteria and clinical reasoning to medical decisionmaking. Managing resources automatically follows good clinical practices. If the guidance used to manage disease is evidence-based, then you’re not likely to make mistakes.

Q: You have also said that disease management companies have

evolved. Can you explain how they have transformed the outpatient delivery system?

A: From the physician’s point of view, the outpatient delivery system has not changed at all. For example, when I was in practice 20 years ago, my practice overhead was 55%. The design of that clinic—the architecture, the workflow, the staff responsibilities, the receptionist, the physician assistant, the nurse practitioner, the physician, the technology supporting the practice—all of that has changed very little in the intervening years. Yet patients’ needs and expectations have changed. More of them present with chronic illnesses. Consumer-patients want to participate in their medical decisions more and more. They are more mobile and busier than ever, so going to the doctor must yield real value. The office environment has not adapted to these patients’ demands.

Few industries over the last 20 plus years have not changed. The “architecture of care,” particularly in primary care, has not evolved to lower production costs or overhead to increase efficiency and to meet patients’ needs. Physician practices will need to assimilate information and communication technology, redefine staff roles, and transform the physical architecture of the office space if the doctor’s office to meet the new kinds of patients’ needs and remain a viable entity. We must break away from the old model and be open to design a new one.

Not everything has been stagnant, however. Suddenly, out of left field, comes disease management. Its movers concede that people with chronic disease can’t be taken care of in 10-minute doctor visits three or four times a year. Instead, these patients need constant repetitive interaction using a variety of approaches to reach them, such as the telephone, faxes, mail, the Internet, and even remote monitoring devices installed in their homes. These communications tend to be highly structured, their contents are evidence-based, and nurses are the main overseers of care but always are respectful of the physician’s treatment plan.

Q: If you were a practicing physician in a clinic today would you use disease management techniques?

A: If I were a practicing physician in a clinic today, I would have modern disease management organizations as my back office. I would see patients, and I would continue to make decisions about their treatment course. But nearly all of the education, the reinforcement, the motivation, and the support for behavior change would come from my disease management back office. I would also need a computerized, expert decision support tool to help me manage the staggering amount of scientific information constantly being produced. My typical patient would likely be a Medicare patient with chronic obstructive lung disease, congestive heart failure, probably depressed, and would be seeing various specialists.

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“From the physician’s point of view, the outpatient delivery system has not changed at all [over the past 20 years].”

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So, my disease management back office would gather all the information from the various specialists seeing my patient, such as the cardiologist, pulmonologist, and endocrinologist, and organize it and present it to me efficiently. My role would be what we have always envisioned the primary care physician to be and that is the manager and coordinator of complex cases like this. But now I would have all the support I need to do it well.

To provide this type of care requires a radical redesign of the office space, the workflows, and the technology. So that is what I mean when I say that the outpatient delivery system has to be completely transformed, and the disease management community has provided a radically new template proven to be operationally and financially viable.

Q: *Disease management has grown rather quickly in the recent past, in part because it has been done without the knowledge or input of physicians. Is that correct?*

A: That is partially true. Physicians have been involved, but the kinds of physicians involved have been those who have stepped outside of the proverbial box. These physicians have teamed up with business people, information technology experts, data managers, and financial experts to create disease management organizations. So physicians have been involved, but they have completely broken outside the mold of the typical clinic-based system. Besides, their target went beyond a single patient and they focused on large populations of patients with like problems, such as diabetes or heart disease, for whom the burden of self-care can be overwhelming. These physicians realized that the battle against chronic disease is won or lost, not necessarily in the office, but in

the real world where people live and work.

Q: *Why are managed care organizations involved in disease management?*

A: Because managed care and any other payer has much to gain from better care. In addition, to run a disease management operation successfully, one needs access to large amounts of data and lots of patients with similar conditions. Managed care organizations have the data, and they are natural aggregators of insured individuals. So they can more easily than anyone else identify a critical mass of patients who need assistance with chronic care.

From the managed care organization's point of view, it makes good sense to hire a disease management company to meet its disease management needs. The investment to put together the infrastructure to offer disease management is so substantial that many companies buy the service from independent disease management organizations rather than building it. Individual physicians might never be in a position to match that. That's why it makes more sense for physicians to align themselves with disease management companies rather than to reproduce DM services in their offices.

Managed care should encourage DM companies to work more closely with treating physicians for several reasons. I'm concerned that if disease management companies fail to align themselves with physician practices, their legitimacy will remain in question. Furthermore, there is the general perception that managed care organizations are charged with a dual role of managing the financial risk (insurance) and medical decisions and this dual role poses an irreconcil-

able conflict of interest. Patients could extrapolate that perception to disease management. That's why one of my missions is to find a way to operationally realign disease management with practicing physicians more than with managed care.

One might wonder why I would ask managed care organizations to pay for disease management and abdicate the credit for dispensing medical-related advice to patients. The reason is that the public has never held the insurance industry as the most trusted source of medical information. Every survey I have ever seen exploring the issue of trust with medical matters places doctors and nurses at the top of the pyramid and managed care at the bottom. So why should managed care fight this strongly held secular belief? Why attempt to build "brand equity" dispensing medical advice when the real locus of trust resides elsewhere?

Managed care can certainly benefit from the lower cost of better care and those lower costs can in turn be passed on to consumers as lower premiums and richer benefits. Now, that is the role the public has entrusted to the insurance sector and therefore represents a more logical role for managed care to play.

Q: *Will the movement toward consumer-driven health plans affect disease management?*

A: Yes, and physicians need to be involved in the consumer movement. They can do so by aligning themselves with disease management organizations that can satisfy consumer-patients' information hunger anytime, anywhere. It's the only mechanism where you can have evidence-based-grade information disseminated to consumer-patients in a repetitive, structured, organized, multimodal fashion. No other system

"If physicians are paid for how well their patients do, then physicians will begin to seek cost-effective ways to deliver good outcomes."

does that today. You can't do it through advertising because advertising is not objective. The individual physician simply does not have the reach or the time in the office to do it. Seven minutes of time in front of a patient doesn't work. There is no other mechanism for reaching that many people.

Q: *You have used the term "evidence-based" often in this discussion. Do you mean that disease management uses evidence-based medicine more than the traditional system?*

A: Disease management evolved when evidence-based medicine was emerging as a way of delivering the right care. The disease management companies are among the most avid consumers of clinical guidelines anywhere, which just started to surface about 15 years ago. Now we have hundreds of guidelines. So, the disease management movement grew up at the same time that evidence-based medicine was the recommended best-practice norm.

But disease management also came along when consumerism in health care was emerging as an important trend. So, in addition to being evidence-based, and having sophisticated information technology embedded with guidelines, many disease management companies knew they had to be friendly toward consumers. They have what I call the Ritz-Carlton approach to interaction with patients. This consumer orientation, in tandem with scientific rigor, is a hugely important attribute of disease management companies and accounts for much of their popularity.

Q: *Doesn't remote monitoring break with the tradition of having the patient see the doctor in the office?*

A: Yes, it does, and for some things, it's absolutely impera-

tive that patients see their doctor. But for the majority of things that pertain to chronic care, the physician doesn't need to see the patient in person. Frankly, it's often the patient's inactions that drive most of the poor outcomes. The physician has to make the treatment decisions and that often requires seeing the patient. But from then on what matters most is the patients' compliance, how well they understand their disease, how motivated they are to adhere to lifestyle changes, and how they avoid complications by just taking their pills as told.

Q: *But since most doctors are reimbursed for seeing patients in their offices, how do they get paid when participating in disease management?*

A: You're asking a very good question. And the answer will have to come from payers. The payers, starting with the government all the way down to private insurers, need to recognize the value of interpersonal interaction regardless of whether that visit is in an office, over the phone, or some other type of remote interaction. There are several organizations that recognize this and already reimburse for online visits. That type of reimbursement needs to continue and grow.

Second, the attitude that physicians can get paid only if they see the patient needs to change. Instead, physicians should be paid for outcomes rather than for production. If we are paid for how well our patients do, then we will begin to seek more cost-effective ways to deliver good outcomes. This approach to physician payment would require dramatic changes in our medical reimbursement system and the change must begin immediately even if it takes years to refine.

Q: *How are the disease management companies reimbursed?*

A: DM programs are paid for outcomes. For example, if they agree to achieve a 15% improvement in a clinical outcomes, and if more than 90% of patients are satisfied with their service and they save 5% of costs by preventing avoidable admissions or ER use, they're rewarded. Right now, none of that income is shared with physicians. That's because doctors have not been involved in what disease management companies accomplish. But if doctors become directly involved and seek a more active role, then disease management companies ought to share their revenue. There is a vast repository of waste trapped in poor quality care that disease management companies and physicians, working together, can extract from the system and in the process, serve patients better and generate new revenue. Those revenues could be reinvested in modernizing the office infrastructure and expanding the practice.

But until we have a financial engine that makes the physician an active participant, we're not going to see a change. One method for fueling this change may be the pay-for-performance movement in effect across the country. That means the physician has a base pay and a portion of his or her compensation is variable based on attaining certain quality benchmarks or outcomes. High-performing physicians can add to their income, in some cases substantially.

Disease management companies could easily help physicians achieve those quality targets and then both entities could benefit financially from delivering good outcomes. Physicians and disease management companies should be natural allies in improving both care and compensation.

—More information on physician practice strategies is available on our Web site (see page 16).

“There is a vast repository of waste trapped in poor quality care that DM companies and physicians, working together, can extract.”

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