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Is 5 Minutes per Patient a Sign of the Times?

A family physician in Connecticut has a sign posted in his reception area that says, "I have time for only one question." While this sign may be an exaggeration, it is indeed a sign of the times when all physicians are struggling to see enough patients to cover their costs. Some physicians are spending as little as five minutes with each patient.

Among the many problems with such a frenetic pace is that physicians can be perceived as brusque, uncaring, or worse still, may miss a significant diagnosis. Also, of course, they may not be able to deliver adequate patient care. For these reasons, physicians are seeking ways to move patients through the office quickly while also improving the quality of care they deliver.

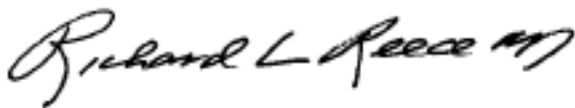
One method being considered was developed by Kaiser Permanente to train physicians to get to the heart of each patient's medical problems quickly. Known as the "Four Habits" model, the Kaiser program offers a set of interview techniques doctors can use during each patient visit. The four habits are:

1. Invest in the beginning—create rapport quickly; elicit patient's concerns, and let the patient know what to expect
2. Elicit the patient's perspective—determine the patient's goals; explore the effect of the condition on the patient's life
3. Demonstrate empathy—be open to the patient's emotions, and
4. Invest in the end—deliver the diagnosis as it relates to the original concern, explain the rationale for any tests you are doing, summarize the visit, and review the next steps.

Another approach involves having a patient fill out an index card that lists three questions for the physician to answer. In this way, the physicians will know the chief complaint and the next two as well. Also, physicians can use Soapware, an electronic medical record system that fosters a subjective, objective, assessment, and plan for each patient. The software (at www.soapware.com) helps physicians document patient concerns and findings.

Still another approach involves software called Instant Medical History from Primetime Medical Software (at www.medicalhistory.com), which allows a patient to use a computer to answer questions in a simple yes or no algorithm based on the patient's age, sex, and chief complaint.

Regardless of the system physicians choose, the reality of the situation is that all providers are being asked to do more today than they ever have in the past. Therefore, they need to find solutions to increase productivity while also working to improve quality. Those who do it well will be rewarded with increased pay and possibly with even more patients.



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Comorbidities Complicate HF Care

Cardiologists will undoubtedly treat a growing number of elderly patients with heart failure as the U.S. population ages. As a result, cardiologists must be aware of how the most common comorbidities in this population affect heart failure treatment, experts say.

"It is important for cardiologists to consider the comorbid conditions of their heart failure patients who are 75 years of age and older," says Michael W. Rich, MD, a cardiologist and associate professor of medicine in the cardiovascular division of the Washington University School of Medicine in St. Louis. "Comorbidities have a significant impact on the clinical presentation and, in some cases, treatment of cardiovascular diseases in elderly people." Rich enumerated these conditions and their effect on elderly heart failure patients in a recent article in the *American Journal of Geriatric Cardiology* (Am J Geriatr Cardiol. 2005; 14 (3): 134-141).

A Disorder of Aging

Heart failure is the quintessential disorder of cardiovascular aging, Rich says. "Heart failure is a common disorder among the elderly because it reflects the effects of aging on the heart and other organ systems," he adds. "It is also linked to the high prevalence of other cardiovascular diseases such as hypertension and coronary artery disease."

But heart failure in the elderly differs in many respects from heart failure that occurs in middle-aged

patients, Rich continues. "Most importantly, the elderly are more prone to having a host of other chronic conditions, many of which are non-cardiac in nature, like kidney problems, depression, and incontinence," he says. "These conditions are often directly relevant to the management of heart failure."

Unfortunately, recent advancements in heart failure treatment—including the development of beta blockers and ACE inhibitors—may be less applicable in the elderly compared with how they work in younger adults. "This limited benefit is due in part to the fact that most major clinical trials have not focused on elderly patients," Rich explains. "Furthermore, the presence of multiple comorbidities in the elderly population has limited the impact of advancements in medical therapy."

A number of features distinguish heart failure in the elderly. One feature widely recognized among cardiologists relates to left ventricular ejection fraction. "Most middle-aged heart failure patients—probably about 90%—have reduced ejection fraction," Rich explains. "Heart failure with preserved left ventricular function is not rare in this population, but is certainly less common. In contrast, in patients over age 75, particularly in women, most heart failure occurs in the context of normal left ventricular ejection fraction."

Ultimately the treatment of these two conditions may be relatively similar, but almost all major heart failure

trials have focused on heart failure with reduced left ventricular ejection fraction. "Therefore, the applicability of clinical trial findings to the elderly is limited," he says. "Most clinical trials did not enroll very many elderly individuals, and those who were enrolled were not really representative of most elderly heart failure patients because they had reduced left ventricular ejection fraction."

Other, less recognized, characteristics distinguish the elderly from middle-aged heart failure patients. One is prevalence: Fewer than 1% of middle-aged individuals have heart failure, while approximately 10% of elderly individuals have the condition. Another is gender: In middle age, more males than females experience heart failure, while females carry the greater burden among the elderly. Coronary artery disease is the common precursor of heart failure in middle-aged patients, while hypertension is the likely cause of heart failure in the elderly. Furthermore, because randomized controlled trials have focused on middle-aged rather than elderly patients, treatment tends to be empiric—rather than evidence-based—among the elderly.

Conditions to Consider

Finally, one of the most important distinguishing features of heart failure in the elderly is that these patients have many conditions that complicate heart failure treatment.

"Since renal dysfunction has the most direct implications for heart fail-

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The elderly are prone to having kidney problems, depression, and incontinence, conditions that are directly relevant to the management of heart failure, says cardiologist Michael Rich, MD, of Washington University.

ure, it may be considered the most important comorbid condition,” Rich notes. “Accordingly, renal dysfunction is the comorbidity that cardiologists appreciate most widely.” Rich notes that creatinine clearance in the elderly is low even when intrinsic renal disease does not exist. Aging impairs an individual’s ability to excrete excess sodium and water, so that volume overload may occur in people prone to developing heart failure. Furthermore, standard heart failure therapies, such as diuretics, ACE inhibitors, and angiotensin receptor blockers, may contribute to progression of renal failure. As a result, many studies have demonstrated that renal function status is an important predictor of outcomes in heart failure patients of all ages, Rich says. “Clearly, as renal function worsens, heart failure symptoms also tend to worsen and prognosis declines,” he adds.

Effects of Depression

A comorbid condition that tends to be less well-recognized but has important implications for heart failure is depression, which occurs in 15% to 20% of elderly heart failure patients. “Cardiologists often do not recognize depression in their heart failure patients,” Rich says. “They may attribute a down mood to the circum-

stances of the heart failure itself rather than considering whether this mood is an associated psychological condition. But depression does influence quality of life and affect prognosis, because it increases the individual’s risk of arrhythmias and sudden death. It also influences heart failure management

to the extent that depressed patients are less likely to comply with recommended medical treatment.”

Another condition, arthritis, has a high prevalence among the elderly. Non-steroidal anti-inflammatory drugs (NSAIDs) are currently the most common treatment for arthritis, Rich notes. “But these drugs tend to worsen heart failure and antagonize the effects of conventional heart failure medications, including ACE inhibitors and diuretics,” he says. “This creates a difficult challenge. Arthritis may bother these patients more than their heart failure, so it is not appropriate to withhold that treatment. But cardiologists should recognize the interaction between arthritis medications and heart failure medications and make some allowances.” The cardiologist might increase the diuretic dosage for patients taking NSAIDs to overcome the salt and water retention that occurs with NSAID use, he suggests.

Incontinence is another condition that affects heart failure treatment. “Incontinence is less common than arthritis, and cardiologists may not consider asking their patients about it,” Rich says. “But diuretics used in heart failure treatment will exacerbate incontinence, contributing to non-compliance. In fact, because incontinence can be an embarrassing prob-

lem, patients might not take their diuretics on days when they are going to be away from home. Cardiologists should be attuned to the fact that incontinence is possibly a contributing factor to a patient’s reluctance to take diuretics as prescribed and should address that issue with patients.”

Chronic lung disease, by causing diminished pulmonary function, leads to increased dyspnea and exercise intolerance in older heart failure patients, says Rich. Furthermore, the presence of chronic lung disease can make it more difficult to determine the cause of breathing difficulties.

Cognitive impairment is common in elderly adults and can have a significant effect on heart failure care. Cognitive dysfunction interferes with a patient’s ability to participate in the self-care behaviors required for managing heart failure, Rich says.

Also, standard heart failure therapies, including diuretics, vasodilators, and beta blockers, can exacerbate postural hypotension and falls, Rich continues.

Other Challenges

Another concern is malnutrition. Rich lists a number of factors contributing to malnutrition in the elderly, including lower intake of nutritional foods, diminished appetite, loss of enjoyment from eating, neuromuscular conditions (such as stroke and Parkinson’s disease) that affect the ability to eat, poor dentition, and difficulty swallowing. Comorbidities in heart failure patients can worsen these factors because dietary limits—such as protein restrictions in patients with renal disease—may be required. Furthermore, he adds that advanced heart failure can lead to a decline in lean body mass.

What’s more, comorbid chronic illnesses, inadequate dietary intake of nutrients (such as iron, folate, and vitamin B12), and the use of medications (such as NSAIDs) associated with gastrointestinal blood loss can contribute to anemia in elderly heart failure patients. This anemia, in turn, can exacerbate the symptoms of heart failure and worsen prognosis.

Polypharmacy—the use of five or more regular medications—is another serious concern. Heart failure often requires at least three medications, and the comorbidities mean elderly

“Because randomized controlled trials have focused on middle-aged rather than elderly patients, treatment tends to be empiric—rather than evidence-based—among the elderly,” Rich explains.

patients need even more drugs, Rich says. "Polypharmacy interferes with medication compliance since the more medications the patients are taking, the less likely it becomes that they are using their medications correctly," he says. "In addition, there is an exponential relationship between the number of medications and the risk of drug interactions."

Cardiologist Involvement

Given these possibilities, cardiologists should be aware of the full scope of comorbid conditions that elderly heart failure patients suffer, Rich advises. "A heightened awareness of the high prevalence of these conditions and the direct effect they have on the clinical presentation and management of elderly heart failure patients is crucial to addressing patient needs and ensuring that the right medications are prescribed," Rich says. "It is easy for the cardiologist to say that the patient should stop taking NSAIDs because of their effect on heart failure, but that advice would completely ignore the fact that the patient's main limitation in terms of activities may actually be due to arthritis rather than to heart failure. As cardiologists, we need to focus on a larger goal in the care of elderly patients: that of helping them feel better and achieve maximum independence and functionality."

Most internists and geriatricians would say that a coordinated multidisciplinary approach, including cardiologist participation, would be most useful in caring for elderly patients, Rich says. "A cardiologist can make recommendations while the primary physician would play an important role in advising the patient about what treatments would

be desirable given the patient's comorbidities," he says.

Coordination among specialists is a particular concern given the potential for drug interactions. "By working together, cardiologists and their colleagues in other specialties can ensure that medications are balanced and that the entirety of the patient's health is being addressed," Rich says. "For example, there may not be many good alternatives to NSAIDs, but other options for arthritis pain can be considered. Working with the patient's primary care doctor or rheumatologist to design a better regimen for managing the arthritis would be desirable. Similarly, if a cardiologist identified incontinence as a problem, then he or she might refer the patient to a geriatrician or a urologist to address that specific issue. Often, it does take several physicians with varying expertise to address common comorbid conditions."

Interestingly, many elderly heart failure patients are not referred to a cardiologist for consultation. "Middle age people are much more likely to be referred to a cardiologist or to have had a cardiology consultation at some point in their management, particularly as they approach the more advanced stages of heart failure," Rich says. "In contrast, the elderly, particularly nursing home patients, are unlikely to have undergone cardiology consultation."

Since cardiologists may be less attuned to the comorbidities of their elderly patients, they may be overly aggressive in treatment recommendations, Rich says. "In the absence of evidence from clinical studies that treatments will definitely improve outcomes for the elderly, aggressive treatment may not benefit the

patient, particularly considering that the very elderly might have a different view of what they consider a desirable outcome," he adds. "They might be more interested in symptom control and quality of life than in mortality, which has been the primary endpoint of many of the clinical studies involving treatments that are directed by a cardiologist."

Quality of Life

Therefore, the patient's personal goals—including both quality and length of life—should be discussed in the context of treatment objectives. "Goals of therapy will vary considerably from individual to individual," Rich emphasizes. "In designing therapy, the physician has to consider the goal of treatment from the patient's point of view. If a patient's goal is to live as long as possible regardless of how well he feels, then it is reasonable to be more aggressive in pushing life-saving treatments like beta blockers, ACE inhibitors, spironolactone, and even certain devices. The cardiologist might also work to get the patient off of NSAIDs, which have an adverse effect on the patient's cardiac condition. But if the patient's primary goal is to feel reasonably well and remain active and independent, the cardiologist might take a somewhat different approach to managing the patient. NSAIDs might be acceptable, for example, along with lower dosages of beta-blockers to minimize side effects. Recommending treatments that satisfy the elderly patient's desires will ultimately lead to the best outcome from the patient's perspective."

—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 8).

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Are Individual or Group Incentives Best?

By Omid B. Toloui and Mikele M. Bunce

Pay for performance (P4P) systems have introduced a fundamental change in the way physicians are rewarded and reimbursed. The advancement of P4P programs and increased interest and investment by the federal Centers for Medicare & Medicaid Services (CMS) in P4P, shows that P4P is not merely a trend, but an evolving system that has the potential to improve health care quality. As greater investment is made in these systems, it is increasingly important to examine the advantages and disadvantages of the way in which incentive payments are distributed to providers and the methods for effectively distributing the payments.

Incentives Recommended

The impetus for current P4P systems was the Institute of Medicine's landmark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which recommended monetary incentives as a means of placing more emphasis on care quality. The report said health systems need to foster higher quality care, increase accountability, and reduce errors and practice variation. Subsequently organizations such as the Leapfrog Group, Bridges to Excellence, and the Integrated Healthcare Association (IHA) developed programs to reward providers for

improved quality. Moreover, employers and health plans started to view P4P systems as a potential mechanism for ensuring a return on their investment in health care, or as a way to "get more quality for their buck."

Current P4P programs measure quality of care and patient satisfaction in outpatient and inpatient settings. These programs base provider financial incentives on a variety of metrics. Most programs incorporate common performance measures, public reporting of quality data (such as provider scorecards), mechanisms to reduce

Incentive Demonstration project.

Currently, payment incentives for participation in P4P programs are distributed in lump sums to provider groups or individual providers based on aggregate and individual provider data, respectively. The IHA P4P program provides monetary incentives to medical groups based on each group's total performance against a set of criteria. This year, however, IHA will award an additional 10% bonus to physician groups that use a physician-level incentive program that incorporates frequent measurement and feed-

Some P4P programs that have provided incentives to groups are starting to see benefits in giving bonuses to individuals.

medical errors and practice variation, and rewards for adopting clinical information systems.

Two Forms of Reward

Among all P4P systems, two main types of incentive payments prevail: bonuses and withholdments. The former is the most pervasive as its determination and distribution is the least complicated. Bonuses are typically paid annually based on a set of criteria with relative weights. For example, IHA uses clinical performance, patient experience, and IT investment in its P4P program. The other, less common incentive or "disincentive" is a withholdment in payment, which is characterized by a monetary reduction of a certain amount from a standard payment. One example is the DRG payment reduction for hospitals that do not meet a predetermined quality threshold at the end of three years in the CMS and Premier Hospital Quality

back on clinical metrics and patient experience. In essence, this 10% bonus encourages medical groups to formulate a system of providing incentives at the individual physician level.

Some P4P programs that have traditionally provided incentives to medical groups as a whole are starting to realize the benefits of giving bonuses to individual providers. There are unique advantages and disadvantages to the provision of provider incentives at the group and individual level. It is wise for organizations to determine which reward methodology is best for the organization's structure and goals.

Individual Rewards

The benefit of a group reward is that providing a physician performance bonus on a group level demonstrates that all physicians in the group are valued equally. The potential financial effect of the bonus may be reduced as the risk/reward is spread evenly among all participants. If there are no quality

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measures for a specific specialty, as is the case for the majority of metrics related to primary care, specialists can still benefit from the reward program.

Moreover, provider groups may need to base their incentives on group performance in order to achieve adequate sample size and valid data for certain quality metrics. The more aggregated data are used to measure performance across procedures or among individuals, the greater the probability that the performance results will fall around the mean, thus mitigating the potential financial impact. Furthermore, a report by the Leapfrog Group shows that whenever variation at the provider or procedure level is hidden, the interpretation of the results becomes increasingly difficult, making it harder to act on the results.

On the other hand, individuals may believe that physicians who do not actively participate in increasing quality scores should not reap the benefits. Proponents for rewarding individual physicians rather than the medical group as a whole attest that those physicians who provide better care should be acknowledged accordingly. The goal of P4P programs is to provide a direct incentive to increase quality of care. It can be argued that it is easier to affect individual rather than group per-

formance, so therefore, incentives should be provided on an individual level. Research suggests that individual physician incentives can increase physician productivity at a greater rate than incentives at the group level.

programs will eventually reach 20% to 30% of total physician compensation. Currently, P4P programs typically account for less than 5% of physician compensation. Since the potential P4P payment is relatively minor at this point, non-monetary bonuses can be just as successful as cash bonuses in letting physicians know that they have done their job well and that their efforts are appreciated. In an article published in *BMC Health Services Research* by Paul Krueger and colleagues, two of the best predictors of job satisfaction were overall satisfaction with pay level and knowledge that the organization recognizes employee contributions. Hence, the feeling of being appreciated at one's job is often just as important as compensation as it relates to job satisfaction.

Contrarily, physicians may feel that non-cash bonuses are not as tangible as monetary bonuses. One of the complaints expressed at the IHA Stakeholder's Meeting last year was that individual physicians did not know what their medical group did with the group's recent P4P bonus. These physicians said that they did not feel an incentive to continue putting effort into a program when the benefits are not realized individually.

Some medical groups have put

bonus to individual physicians. Medical groups also can create a reward system that separates the bonus payment into one portion for the medical group and one portion for individual physician rewards.

If cash rewards are granted, it is essential to communicate when those rewards will be received, the expected dollar value of the rewards, and the entity that will provide the awards. Jeff Kamil, CMO of Blue Cross of California said recently that 600 of 1,300 physicians who received bonuses of between \$500 and \$5,000 threw away the registered letters and bonus checks without ever opening the envelopes. It is important, therefore, that when monetary and other bonuses are paid, those making the payments should be clear to recipients the reason for the bonus and the method used to send the payment.

Recommendations

Researchers at RAND and UC Berkeley have conducted physician group leadership surveys related to the IHA program and found that the lack of transparency on P4P payment methodology is confusing to medical groups and that it creates distrust. It is important that whichever incentive methodology medical groups use, it should be clearly communicated to all physicians and stakeholders involved.

Incentives at the provider level are worth considering as an addition to any P4P program. Furthermore, some research shows that quality bonuses based on and distributed to the individual physician are more effective and increase physician productivity. What's more, provider groups should carefully consider the level (meaning individual, group, or a combination) and the form in which they distribute bonus payments and ensure that the methodology is consistent with their group's culture, characteristics, and goals.

—More information on physician practice strategies is available on our Web site (see page 8).

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Some medical groups have put

bonus payments toward facility improvements, such as an updated physician lounge. While facility and other improvements may be appreciated, it is often easier to associate individual non-monetary bonuses to one's performance than it is to appreciate workplace improvements. For instance, providing physicians with PDAs may improve medical operations while also providing a tangible

Group Rewards

The Medicare Payment Advisory Commission anticipates that physician reimbursement through P4P

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