Practice Management Polonaise: A Work in Progress

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This is the first in a series of articles for this new section in The Journal of Invasive Cardiology. The focus of the section will be on issues social, ethical and economic impacting the practice of medicine and, in specific, the practice of medicine as it pertains to the treatment of patients with cardiovascular pathology or the prevention of cardiovascular disease, mortality and morbidity.

As your editor for this section I hope to be able to bring you concise and pragmatic information that will find helpful in positioning your respective practices to successfully flourish in our new and evolving environment. Guest contributors will be asked to participate in sharing their expertise and any who have general questions or specific questions concerning items appearing in this section are encouraged to contact me through the editorial offices.

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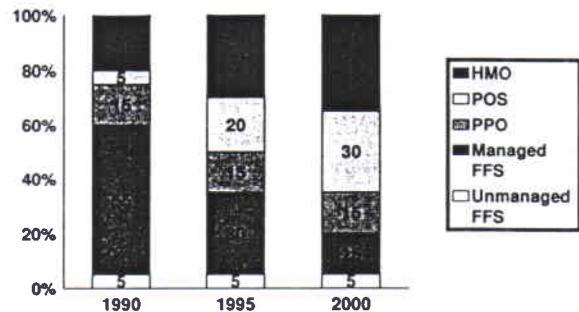
Our comments and articles will emphasize the rapid triple time theme of a polonaise as well as the concept of *evolution*. Indeed, evolution is the way I would like to frame the context of the issues we will discuss. While it is impossible to completely isolate one's emotions and personal feelings concerning issues as important as patient care and medical practice, I would like to assure my audience up front that I will make every attempt to maintain my objectivity — an objectivity gleaned from a vantage point as being a former program director of internal medicine/ cardiovascular division director/practitioner of invasive and noninvasive cardiology and one who now focuses most of my time assisting physicians and physician groups with issues that will be discussed in subsequent publications in this section.

So much for preliminaries. Let me begin by setting our current scene. As we start 1996 we look back on 1995 as the first time that annual growth in corporate America's health cost declined 2% from 6% the previous year, although overall spending on health care hit 14% of gross domestic product. In 1994, the health care industry saw 1,100 mergers and acquisitions worth $60 billion. Through an aggressive acquisition strategy, Columbia/IICA Health Care turned itself into a $15 billion operation with margins close to 20%

in less than eight years. Considerable consolidation has also occurred in the pharmaceutical industry and we have seen increased HMO activity. A Foster Higgins survey noted that HMO premiums increased 9.7% in 1994 for large employers and 6.2% for small employers.[1] HMO premiums in certain sections of the country are now at 0% as considerable consolidation occurs within the HMO industry. In short, private sector reform, in response to significant market forces, has made the issue of government driven health care reform almost a moot point.

Figure 1. Network–based forms of managed care will dominate by 2000



Source: Sixth Report of COGME, 1995

Demographics

Pertinent to the practitioners of cardiology it should be recognized that cardiovascular diseases remain the leading cause of death in this country and that the demographics of our population favor continued need and growth of cardiovascular services. In 1986 there were 72 million people over the age of 45. By the year 2000 there will be 122 million people older than 45 and despite our best attempts at preventive medicine, as the population ages, there will be continued need for expertise in the therapeutic care of patients with cardiovascular disease.

Managed Care

Managed care is a generic term that applies to a potpourri of structures by which payors obtain coverage for their enrollees. These arrangements vary form section to section of the country and range from discounted fee–for–service to creative capitation arrangements. Issues surrounding these payment mechanisms are topics unto themselves, but irrespective of which section of the country one practices in, it is very probable that network–based forms of managed care will dominate by the year 2000 (Figure 1). More importantly, Medicare and Medicaid are likely to move into managed care formats.

Practice Variation, New Technology, Accountability

There will be continued growth of new technology pertinent to the treatment of patients with cardiovascular disease. Witness the recent rapid rise in the use of stents for the treatment of coronary artery disease. This rapid endorsement of new technologies has put significant resource constraints on facilities and is being monitored carefully by payors. Variation in the use of new technologies and the endorsement of new technology will come with a concomitant responsibility and challenge to discuss outcomes and clinical efficiencies that may impact other forms of therapy and technology. There will be a need to develop clinical pathways and guidelines applicable to the use of these new technologies. These undoubtedly should be pathways and guidelines developed by the professional societies and individuals cognizant of the processes of clinical care. Additionally, new technologies will enhance and continue the trend away from inpatient care to other locales of treatment. This "transformation of place" will also serve as a topic for future articles.

Table 1. Cardiovascular Practice Future Trends

Solo/Small Group	→	Large Single Specialty or Multispecialty/Networks
Generalists	→	Very Specialized Areas of Expertise (Disease Management)
Inpatient	→	Outpatient/Office
Isolated Imaging, Recording and Report Generation	→	Centralized Data Management/Electronic Medical Record
Isolated Event Care	→	Longitudinal Care

Table 2. Trends

Fragmented Delivery	→	Integration of Services
Acute Care	→	Prevention & Wellness
Fee–for–Service	→	Managed Care/Capitation
Ad Hoc Services	→	Outcomes/Database Information

Practice Motif

More physicians are practicing in groups (single specialty or multispecialty). Just as there is a consolidation occurring in the hospital industry, so too, among and between physician groups. The new types of structures present a veritable vegetable soup of acronyms or arrangements ranging from loose networks to salaried employees. These structures are being met with variable success and acceptance. Many lessons have been learned and many new organizational structures are yet to be appreciated. This area alone will be furtive ground for additional discussion. The successful positioning of your clinical practice in relation to primary care and tertiary care providers in other networks/payors and integrated delivery systems will be key to the obtainment of access to contracts and "covered lives".

The Future

In the future, those practices which can distinguish themselves on the basis of cost, quality, services offered, name recognition and availability will flourish. More attention to overhead and management issues will become of paramount importance. No absolutes are projected, but the trends as outlined in Table 1, 2, and 3 will need to be appreciated and put in the context of the environment in which you practice.

Table 3. Trends

Fee–For–Service		Managed Care
Referral Based	→	Winning & Keeping Contracts
Acquisition of Latest Technology	→	Cost–Effective Care by Guidelines and Care Pathways
Patient Centered	→	Contract Negotiation (Payors)
Hospital Centered	→	Managed Care Organizations

Medicine–The Profession

"The best interest of the patient is the only interest to be considered"

– Wm J. Mayo, MD

This statement becomes progressively more profound in an environment emphasizing cost and finances. It is a fact that for a growing number of physicians income is attached to conduct that furthers corporate profitability. There are significant ethical issues involved in denial and withholding of care just as there are professional ethical issues involved in the inappropriate and over–utilization of resources. The nature of the contractual arrangements that are being festered on the clinical community need to be looked at carefully. The traditional role of the physician as a patient advocate is being questioned and challenged in many quarters and an exploration of these matters is also germane to the area of practice management.

In short, it is my hope that we will be able to use this section in The Journal as a forum to address critical issues that will have bearing on the successful management of your practice. Again, I welcome your comments and suggestions, and I look forward to future dialogues.