

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

June 2004

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Speaking Up for Malpractice Reform

Over the past several years, we have all heard experts talk about various ways to solve the medical liability crisis. Officials from the AMA and from state medical societies have been vocal and persuasive. In addition, thousands of physicians have marched on state capitols in many of the crisis states: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming.

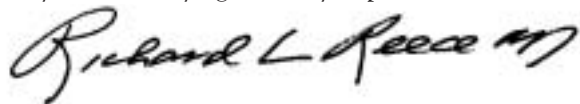
Patients tell some of the most compelling stories about the crisis, especially those who have been denied access to obstetrical care and to the care of specialists who have been forced out of business or have had to move to other states due to the crisis. The Fox television network recently ran "Why Doctors Are Quitting," a news program in which the victim of an automobile accident in Mississippi suffered brain damage because no neurosurgeons were available when he was brought in for care. Many neurosurgeons have left Mississippi because of high liability insurance costs.

Another story in the same program told how neurosurgeons in Florida are declining to see children because malpractice attorneys will say in court that the standard of care requires a pediatric neurosurgeon when a child has a head injury. Another story involved a three-physician group of obstetricians in New York who lost a malpractice suit and now may have to stop providing obstetrical care because they can no longer afford the insurance premiums.

Henry Kopel, an assistant U.S. attorney in Connecticut, wrote in *The Hartford Courant* recently that his wife, an obstetrician-gynecologist, is paying more than \$80,000 annually for medical malpractice insurance coverage, and the premium is expected to increase by several thousand dollars every year. Even if she changed jobs or retired, she would need to maintain coverage because patients retain the right to sue for at least 20 years, he said.

Stewart Dunsker, MD, a retired neurosurgeon in Cincinnati, is developing a workable reform proposal. Last year, he co-founded Doctors for Medical Liability Reform (at www.protectpatientsnow.org), and brought together 10 specialty organizations and raised \$7 million, he says. The organization seeks to inform the public and the media about the issue and has placed advertisements in *The Wall Street Journal* and *USA Today* and in newspapers in Washington state and North Carolina, Dunsker says.

All physicians should add their voice to the malpractice reform movement by writing letters to local newspapers and addressing community groups. We can point out that lawyers who claim to protect patients against the few bad doctors may also be denying critically ill patients access to the many good ones.



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New Tool Helps Predict Mortality Risk in Heart Failure Patients

Researchers at the Institute for Clinical Evaluative Sciences in Toronto and Toronto General Hospital have developed a simple tool to help cardiologists predict the mortality risk of heart failure patients. The EFFECT heart failure risk scoring system, which relies on factors that are easily identifiable within hours of hospital presentation, can predict mortality risk at both 30 days and one year.

The research identifying the predictive variables in the scoring system, along with the tool itself, was presented in the Nov. 19 issue of JAMA.

Identifying Variables

“Mortality rates and rehospitalization rates vary significantly among cardiovascular patients, including heart failure patients, in different hospitals and different regions across the United States and Canada,” says Douglas Lee, MD, the lead author of the study. “One factor likely to be responsible for some of that variation is the degree of patient acuity. We wanted to identify variables that contribute to a higher risk of death so that clinicians could intervene and potentially improve outcomes for their high-risk patients.” A cardiologist, Lee is also a doctoral research fellow in the Department of Health Policy at the University of Toronto and a research fellow at the

Institute for Clinical Evaluative Sciences.

Such intervention could occur in both inpatient and outpatient care. In a hospital, higher risk heart failure patients might be put under close observation in a monitored setting, Lee posits. At discharge, they could be referred to a cardiologist rather than to a generalist for management and might benefit from closer follow-up care. At the same time, medications commonly known to be beneficial for heart failure patients might be prescribed more diligently for higher risk patients.

The researchers identified the strongest predictors of heart failure mortality and used these predictors to create a clinical tool that could be used at the bedside to stratify risk in patients. “Heart failure has a high mortality rate; one-year mortality rates in population-based studies have been reported to be as high as 40%,” Lee says. “However, very few clinical tools are available for physicians to use to stratify that risk of mortality.”

Understanding Differences

Understanding the differences in mortality risk among heart failure patients can enable cardiologists to have more informed, individualized discussions with their patients about care options. “In my clinical practice, I have noticed that heart failure

patients who were fairly young and healthy with few comorbidities were being told that they had a one-in-three chance of dying over the following year,” Lee observes.

“At the same time, elderly patients with heart failure and several comorbidities were also told that they had a one-in-three chance of dying,” Lee continues. “On average, heart failure patients may have a one-in-three chance of death, but this is not a meaningful or helpful statistic when we are trying to discuss a particular patient’s condition.”

In fact, predictive factors and mortality rates identified in clinical trials may not accurately reflect the patient populations encountered in clinical practice. The research by Lee and his colleagues is unusual in that until now a specific tool to predict heart failure mortality had never been developed for patients in the community setting.

“For acute myocardial infarction, a number of predictive instruments, such as the thrombolysis in myocardial infarction risk score, have been widely disseminated and can be used to guide therapy,” Lee explains. “Yet there are very few mortality risk models for heart failure patients. Those that do exist have been developed in the Medicare setting and are used for risk adjustment. These methods cannot be easily used at the patient’s bedside because they

(Continued on page 4)

“On average, heart failure patients may have a one-in-three chance of death, but this is not a meaningful or helpful statistic when we are trying to discuss a particular patient’s condition.”

—Douglas Lee, MD, Institute for Clinical Evaluative Sciences

(Continued from page 3)

require large administrative databases or extensive chart reviews and rely on detailed data and complex equations to predict risk. Prior to pursuing our research effort, we could not find any rules or instruments to predict heart failure risk in the community setting.”

Better predictive models can lead to changes in physician practice patterns and care decisions, Lee says. “We hope that by better understanding which patients are at higher risk, we might eventually be able to modify the way we treat them so that their outcomes improve over time,” he notes.

Predicting Mortality

Using a national database that tracks all hospitalizations in Canada, the researchers identified all patients admitted to an acute care hospital in Ontario between 1999 and 2001 with a diagnosis of heart failure. They abstracted a random sample of 2,624 heart failure patients and performed a detailed chart review, tracking a number of factors that could potentially predict mortality.

“There is a long list of potential variables that have been associated with mortality in heart failure patients,” Lee explains. “We asked an expert panel of Canadian heart failure specialists to help us identify which factors we should be considering as potential variables that might predict mortality. We then restricted the variables to include only those that could be identified at admission (such as vital signs, initial laboratory test values, patient demographics, and comorbidities), which are easily obtainable from the patient history. Using these variables, we conducted a multivariable regression analysis to identify the factors that are the most significant predictors of mortality at 30 days and one year.”

The analysis revealed that the major predictors of mortality included

- Age. Advanced age was associated with higher mortality.
- Vital signs, including systolic blood pressure and respiratory rate. Low systolic blood pressure and a high respiratory rate were associated with higher mortality.
- Laboratory test values for sodium and urea nitrogen concentrations. Low sodium concentration, anemia, and declining renal function were associated with higher mortality.
- Comorbid conditions, including cerebrovascular disease, dementia, chronic obstructive pulmonary disorder, cirrhosis, and cancer.

“With the exception of anemia, these variables were not only predictors of mortality at 30 days, they were also predictors of mortality at one year,” Lee observes. “So this same set of variables can predict two different outcomes.”

Evaluating Function

The analysis was designed to be independent of left ventricular systolic dysfunction. “Left ventricular function has been found to be one of the strongest predictors of heart failure mortality in clinical trials,” Lee says. “Not surprisingly, we found that left ventricular function data

do add to the predictive power of the scoring system. However, we wanted to develop a list of variables that could be used to predict mortality early in the hospitalization. Even if echocardiography has been performed, the findings on left ventricular function often are not available to clinicians at the time a heart failure patient presents to the hospital.”

Furthermore, in population-based studies in the United States and

Canada, as many as one third of hospitalized heart failure patients may not have undergone echocardiography, so many patients may not have an assessment of left ventricular function. “We wanted to create a very general tool that could be used by all institutions,” Lee notes. “Since many patients have not undergone echocardiography, and some hospitals do not have access to echocardiography, including left ventricular function as a predictive variable would severely limit the application of the risk model.”

The model was validated in two ways, giving weight to the strength of the findings. “We validated internally by resampling from within the data set hundreds of times to determine how the model performed in different combinations of patients,” Lee explains. “We also validated externally by testing the model on a data set composed of heart failure patients who were admitted during a different time frame in a different set of hospitals.”

Managing Risk

Using the strongest predictors of mortality as a framework, Lee and his colleagues developed a heart failure risk scoring system that

“We wanted to create a very general tool that could be used by all institutions,” says Lee.

clinicians can use at the patient’s bedside to predict both 30-day and one-year mortality. This tool creates a risk index by adding patient age to respiratory rate, and then adding or subtracting various levels assigned to comorbidities and other predictors of mortality. The resulting score falls within one of five risk categories, indicating that risk of mortality is very low (less than or equal to 60), low (61 to 90), intermediate (91-120), high (121-150),

or very high (greater than 150).

The tool is available in the JAMA article, and clinicians can calculate the score electronically by accessing the tool on the Web (at www.ccort.ca/CHFriskmodel.asp). "We are working on adapting the tool into a PDA format as well," Lee says.

The Charlson Index

The risk index that the heart failure risk scoring system yields is specific to heart failure mortality, unlike the Charlson comorbidity index, which is another way of estimating mortality risk after adjusting for comorbidities and is commonly used in many specialties, including cardiology.

"The Charlson comorbidity index has been widely used," Lee explains. "It is relatively simple and can be used in the clinical setting as well as in studies that are based on large administrative datasets, including Medicare databases. Like our index, the Charlson index assigns a score in the presence of certain comorbidities. But our analysis indicates that the relative impact of different comorbidities on mortality in heart failure patients differs from what the Charlson tool proposes." This result is not surprising, given that the Charlson index was developed in a generic population of patients, and the relative influence of comorbidities in a generic population of patients could be very different than that of a heart failure population, he adds.

In particular, Lee's team found that certain comorbidities have more of an effect on mortality in heart failure patients than would be

expected using the Charlson index. "For example, according to the Charlson index, renal disease is one of the less significant predictors of mortality," Lee says. "It is assigned two points out of a possible six. But we found that renal disease is a very strong predictor of mortality in heart failure patients. Similarly, chronic obstructive pulmonary disorder and dementia are each assigned one point in the Charlson index, while we found that the presence of these conditions is significant in heart failure patients."

Another difference is that not all of the scores in the Charlson index are in the heart failure risk scoring system. "For example, the presence of peptic ulcer disease is assigned one point in the Charlson index, but we did not find it to be a significant predictor of mortality in heart failure patients," Lee says. "So this condition was not included in our index."

Practice Implications

The EFFECT heart failure risk scoring system could have important implications for the care decisions made for both high-risk and low-risk heart failure patients. "For example, patients designated as low risk could potentially be discharged early," Lee points out. "In contrast, if the index indicates that particular patients are at a high risk of mortality, they could potentially benefit from being admitted to an observation or step-down unit, where they could be monitored more closely than they would be on a standard nursing ward. Closer observation of these patients might improve their outcomes."

Also, patients who have very high predicted mortality rates may want to think carefully about the aggressiveness of treatment options. "The index could provide a basis for physician-patient discussions on a patient's wishes for the aggressiveness of care as well as end-of-life care," Lee suggests.

Finally, high-risk patients may be referred to cardiologists for ongoing follow-up care as opposed to being referred to generalists. "Research indicates that cardiologist care is associated with improved outcomes in heart failure patients compared to care provided by internists or family physicians," Lee notes. "High-risk patients may benefit substantially from specialist care following their hospitalization."

Lee acknowledges that the applications of the heart failure risk scoring system have to date been hypothetical and not yet proven to be effective by randomized trials or prospective studies. "We need further testing of the tool before we can confirm how effective it is in a particular care setting," he says. "Our analysis allows us to propose a method that could be used to stratify heart failure risk and contributes to current knowledge because, until now, a method that could be used to stratify risk in heart failure patients did not exist. In future research, we will consider how to assess the practical ways in which this tool can be used, and how it might change cardiologist practice patterns."

—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).

The heart failure risk scoring system could have important implications for the care decisions involving patients who are at high risk, as well as those who are at low risk, for heart failure.

In-Office Procedures Can Help PCPs Offer More Services, Expert Says



John Pfenninger, MD, is president and director of the National Procedures Institute, in Midland, Mich. Founded in 1989, the institute teaches primary care physicians how to perform inpatient and outpatient diagnostic and therapeutic procedures, thereby allowing them to enhance their patient care and practice revenue. Pfenninger is the author of *Procedures for Primary Care Physicians* (Mosby, 1994), and a second edition, Pfenninger and Fowler's *Procedures for Primary Care* (Mosby, 2003). Editor in chief Richard L. Reece, MD, discussed with Pfenninger how PCPs can do more in-office procedures.

Q: Why did you decide to teach primary care physicians to do more procedures?

A: I am trained as a family physician, and I taught procedures at the Mid-Michigan Medical Center's family practice residency program for 12 years. During that time, I received many requests to speak to community physicians about these procedures, because most family practice residency programs do not adequately train family physicians to perform them.

Eventually, I decided to leave the residency program and change my clinical practice from family medicine to a practice that offers only office surgery and procedures. When I found that I was still continually

approached to teach procedures, I created the National Procedures Institute. The mission of the institute is to teach procedural skills to primary care practitioners to enable them to enhance their medical practices.

Q: Why is the ability to do procedures important for primary care physicians?

A: Primary care and family physicians have discovered that while they can offer excellent care and treat many chronic conditions, their reimbursement is astonishingly low. For example, a primary care physician can spend 20 minutes with a patient managing his or her hypertension, diabetes, and other concerns, but will be reimbursed only \$50 or \$80 by Medicare.

In contrast, procedural reimbursement is much more reasonable. For example, a primary care physician who sees a lesion on a patient's face and cannot identify it will refer the patient to a dermatologist, who might spend 10 minutes removing the skin lesion and be reimbursed \$150 to \$200. The bottom line is that primary care physicians are providing a tremendous amount of care, but they will continue to get very low reimbursement compared to that of specialists unless they can begin to perform some of these procedures in their own offices.

Filling out all the forms required by managed care takes an incredible amount of time, but does not

improve quality of care one bit. Writing prescription refills also takes time and is not reimbursed. Providing care for medical problems is reimbursed at a very low rate. But if I perform a vasectomy, it takes me 30 minutes and I get paid \$500.

Primary care clinicians can try to incorporate more procedural work into their practices. By doing more procedures, they can enhance their income such that they can maintain viable practices and continue to provide primary care to patients in their communities.

There are so many straightforward procedures that primary care physicians can do—such as drain abscesses, remove cysts, perform skin biopsies, inject joints, and perform sclerotherapy—but they are afraid to do them. They need to learn which procedures they can perform in their offices and which procedures they should refer to a specialist.

Q: Is there a value to patients as well?

A: Yes. Unquestionably the ability of primary care physicians to perform certain procedures has a great value to patients. The unfortunate delay in discussion and treatment associated with being referred to a specialist is eliminated. The convenience to the patient is enhanced. Patients can receive care from their own physician, rather than from a specialist who is likely to be a stranger.

Primary care physicians need to learn which procedures they can perform and which procedures they should refer to a specialist, says John Pfenninger, MD, of the National Procedures Institute.

Finally, because primary care physicians can do procedures that can be safely performed in the medical office environment, the costs of care are reduced. This benefits insurers and other payers as well as patients, who often have to cover a portion of their own health care costs. In our office, for example, the average cost for a colonoscopy was \$840, compared with \$3,000 in our hospital GI lab. Imagine a couple without insurance: They have to pay \$6,000 for a screening procedure. Many won't have it done at that price.

Q: *In what area is the greatest growth right now in terms of procedural care?*

A: Cosmetic procedures—such as botox injections, collagen injections, hair removal, microdermabrasion, and sclerotherapy—are the biggest growth area in procedural care. These procedures do help patients, but frankly, they are not really reflective of the reason that most of us chose to enter the medical profession.

These cosmetic procedures are lucrative for physicians, however, because they are often not covered by insurance, so patients pay out of pocket and physicians are therefore paid what they charge. And patients are willing to pay: They pay up-front on the day of service, and there is no administrative or billing hassle associated with obtaining payment.

Cosmetic procedures constitute virtually the only area of medicine where that is true. For the most part, physicians accept insurance payments from insurance companies and the insurers pay what they want to pay. When I started in private practice in 1991, I was reimbursed for

89% of what I charged that year. Last year it was down to 63%. Physicians can raise fees, but it doesn't matter what they charge, because only a certain amount will be paid. In Michigan, we have had only one increase in Medicaid fees in 10 years.

The only way out of this box is to offer a service that will pay physicians for their time. If physicians do a cosmetic procedure that takes 15 minutes and they charge \$300, they get paid \$300.

Q: *What are some of the procedures that primary care physicians can learn easily and perform safely in their offices?*

A: Two procedures are the treatment of abnormal pap smears and the removal of genital warts. Genital warts are serious, and the human papilloma virus can cause cervical cancer. There is an epidemic of these infections, given today's sexual freedom. Family physicians can learn how to recognize them, as well as abnormalities on the cervix, and treat them with a procedure called colposcopy.

Another procedure is the no-scalpel vasectomy. This procedure is performed by making a small opening in the skin of the scrotum with a special instrument used to isolate the vas. No stitches are necessary. I can do three vasectomies in an hour without rushing, including prep time, procedure time, and time to complete the necessary medical forms. The new VasClip procedure is even easier.

Colonoscopies also can be done in the office if the right monitoring equipment is in place. Sclerotherapy for spider veins is also done easily and safely. Radiofrequency surgery has

replaced much of laser surgery and is not difficult to do. Casting, splinting, and other orthopedic procedures are performed by family physicians all the time. Allergy tests, IUD insertions, endometrial biopsies, hemorrhoid treatments, stress ECGs, ultrasounds, joint injections, wound repairs, and excisions are other straightforward procedures that are often not taught well in residency programs but are procedures that a primary care physician can learn easily.

Q: *Can physicians perform these procedures once they have taken a course in how to do them?*

A: Not always, even though most courses are very "hands-on." In some cases, such as a skin biopsy, physicians can leave the course knowing how to do the procedure and begin to do it immediately. For other procedures, certain programs will offer the educational background and physicians must then be precepted by another physician before they can perform the procedure on their own.

Q: *How does a physician ameliorate the risk of doing procedures in the office rather than in a hospital?*

A: One key is to be careful not to perform procedures such as a colonoscopy on high-risk patients. Physicians need to screen potential colonoscopy patients first to ensure that they are healthy. If risk screening is done properly, there is virtually no danger in performing the procedure in the office. In fact, multiple studies about the safety of office-based surgery have shown that physicians are very good about screening out the high-risk patients. Most other procedures have little risk involved.

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The ability of PCPs to perform certain procedures has great value to patients by eliminating delays, improving convenience, and allowing them to receive care from their own physicians, Pfenninger says.

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Q: How do specialists and specialty societies typically respond to primary care physicians when they begin doing procedures in the office?

A: Not surprisingly, they feel threatened at first. They claim that they are worried about patient quality, and there's a genuine concern there. Family physicians should ensure that their quality of care will be excellent. They should not do procedures just to make a fast buck. Actually doing the procedures is the easy part; taking care of the whole patient and the family can be much more difficult.

After the specialists find out that family physicians who perform procedures are offering excellent quality care, they embrace them. When I began my procedure-based practice, a local surgeon called me and said, "This is a bad idea. You are taking a risk with your patients." But he called me after a few years and said, "You know, you're doing a good job. But you're going to make a mistake or have a complication at some point. If you need me, I'm here." We all need to work together.

Family physicians cannot just presume that they can immediately do all the procedures that specialists do. They have to learn how to do them, to do them cautiously, and to do them well. If they can't do them well, then I'm really against them doing the procedures.

Denton Cooley, MD, chief of surgery at the Texas Heart Institute, wrote the foreword to the second edition of our book. He said, in essence, "Do it, be careful, do it well." The fact that he was willing to put his name in our book has sent a message to specialists who might have initially been concerned about family

physicians doing procedures.

Q: Are there any malpractice concerns?

A: It depends on the procedure. And malpractice is variable because each insurance company has different rules. In Michigan, there are basically three levels of primary care insurance: family practice, family practice with minor procedures, and family practice with more procedures. Offering hospital care and

change their practices in order to survive. Internists are especially hard hit because the majority of their reimbursement is from Medicare, and they have been poorly trained for office-based practice. Therefore, they have the most to gain by doing more procedures.

It is not surprising that the idea of performing procedures in the office has appealed to primary care physicians, who earn one half to one third

"Family physicians cannot just presume that they can immediately do all the procedures that specialists do. They have to learn how to do them."

obstetrics is part of the equation. My practice is considered to be a family practice with minor procedures.

Once family physicians start doing procedures, their premiums will increase a little but they will pay for that increase very quickly.

Q: Have primary care physicians embraced your message?

A: Yes. When we first began, we did just two or three seminars a year. This year, we will be doing more than 120. The number of attendees has grown by about 25% to 30% every year. Furthermore, the first edition of *Procedures for Primary Care Physicians* was expected to sell 5,000 copies, but sold 55,000. When the second edition came out in August, the print run was 12,000, with an expectation that 6,000 copies would be sold by January. Three months after the book came out, the publisher was into a second printing.

This demonstrates that primary care physicians realize that they must

of what specialists earn. They feel that they are in an economic box created by flat reimbursements, rising costs, time constraints, increasing paperwork, and the malpractice problem. They are told that one way out of the box is to become more efficient by using information technology, but this is only a small solution. Another way out of the box is to provide ancillary services (such as laboratory services) and diagnostic services (such as x-rays and bone density testing), but that solution is also not enough.

The simplest and most direct solution is to return to the way a physician used to practice: doing a variety of procedures at the point of care. It improves patient care. Patients like it. The financial bottom line is better while overall health care costs are reduced. Everyone wins.

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

"After the specialists find out that family physicians who perform procedures are offering excellent quality care, they embrace them. We all need to work together."

Study Calls for More Research on Declining Elderly Disability Rates

Many Americans were caught off guard by the multibillion dollar difference in the estimated cost of the new Medicare law. Before the Medicare Prescription Drug Improvement and Modernization Act of 2003 was enacted, the Congressional Budget Office estimated the cost would be \$400 billion over 10 years; after the law's enactment, the Office of Management and Budget estimated the price tag would be \$534 billion. While some pundits prefer to blame the \$134 billion difference on partisan politics, others argue that the reason for the difference is rather simple: CBO and OMB used different actuarial assumptions to determine the Medicare costs.

But it isn't only actuaries and politicians who are struggling to get a handle on how a rapidly aging population could affect the nation's health care system; researchers are also grappling with the issue. Although their findings seem to indicate that chronic disability among older Americans is declining, across studies the findings are not entirely consistent.

That inconsistency was the impetus for the study by Brenda C. Spillman, a senior research associate at the Urban Institute, in Washington, D.C. She reported on her research in "Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost," which appeared in the March

issue of *The Milbank Quarterly*.

Understanding Trends

In summarizing the findings of other researchers, Spillman points out that "studies examining the age-adjusted prevalence of disability among the elderly have found declines in recent years." That good news, she goes on to say, "is tempered by other findings that some aspects of disability show reductions but not a consistent downward trend."

Spillman's purpose in her study was to examine closely the various factors driving the trends in chronic disability among the elderly and to suggest how those trends could affect health care utilization and costs. "Clearly," she asserts, "we need a better understanding of the underlying structure of changes in the prevalence of disability in order to estimate the likely short- and long-term cost implications of a reduction in disability and to predict how disability rates are likely to change through midcentury as the population continues to age."

For her study, Spillman used data for 1984, 1989, 1994, and 1999 from the National Long-Term Care Survey, which seeks to identify people aged 65 and older who are chronically disabled as defined by their ability to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs). The NLTCs collects detailed data on disability,

service use, family support, and health and demographic characteristics.

Describing the NLTCs as a complex survey, Spillman found "its complexity represents a strength for the detailed examination of disability patterns." And although her research addresses five specific questions related to these patterns, her study—as she points out—raises many questions that need answering before policymakers begin to make changes in the Social Security and Medicare programs.

Moving Downward

Overall, Spillman's study found a clear downward trend in the percentage of chronically disabled elderly: 22.1% of the elderly reported having a chronic disability in 1984 and 19.7% reported so in 1999. Until 1994, 73% of the elderly reported being free of chronic difficulty or disability in any ADL or IADL, and the proportion rose to 74.7% by 1999.

"Underlying the downward trend in aggregate disability is a pattern of steadily increasing equipment use and declining human help with disabilities," Spillman says. "Conversely, the prevalence of receiving human help with any disability fell from 19.8% in 1984 to 15.9% in 1999."

This downward trend in the number of chronically disabled elderly did not lead to fewer elderly entering long-term care facilities, however.

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"Underlying the downward trend in aggregate disability is a pattern of steadily increasing equipment use and declining human help with disabilities," says Brenda C. Spillman in her report on the decline in elderly disability rates.

Study's Disability Measures

To be considered chronically disabled for the study by Urban Institute senior research associate Brenda C. Spillman, *Changes in Elderly Disability Rates and the Implications for Health Care Utilization and Cost*, a person, for at least three months, had to have needed help or to have used equipment to be able to perform at least one activity of daily living. In the study, ADLs were defined as

- Eating
- Getting into and out of bed
- Getting around indoors
- Toileting
- Bathing
- Dressing

Also considered chronically disabled were the elderly who were unable to perform independently for at least three months at least one instrumental ADL. For the study, IADLs were defined as

- Doing light housework
- Doing laundry
- Preparing meals
- Shopping for groceries
- Getting around outside
- Taking medications
- Managing money
- Using the telephone

The study stated that “ADLs are basic activities necessary for personal care and generally are an indicator of a greater level of disability or frailty than IADLs, which are activities more closely related to the ability to live independently.”

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“The reduction in the disability rate does not appear to have resulted in a lower prevalence of institutional residence, contrary to what might be expected if the reduction resulted solely from improved health among the elderly,” Spillman says. “Besides the implication that some aspects of disability may not be improving, the persistence of institutional residence—the most expensive type of long-term care—suggests that the decline in disability may not translate into a similar decline in costs.”

Furthermore, Spillman notes that “the essentially constant prevalence of residence in institutions, where about 95% of residents receive assistance with ADLs, bolsters the apparent concentration of declines at lower levels of disability, as indicated by the dominant reduction in the IADL disability rate.”

As for the noninstitutionalized elderly, Spillman found that the per-

centage of those who were both disabled and living in the community fell annually by an average of 0.2 percentage points from 1984 to 1994, and she attributed this finding to the large decrease in IADL-only disability. “The decrease in the rate of IADL disability accounts for more than 80% of the overall 3.8% decline in human assistance over the 15-year period,” she says.

Declines in Age Groups

Spillman’s research also looks at disability declines within age groups (65-to-74, 75-to-84, and 85-and-older), finding a downward trend in overall disability for every age group. The largest absolute declines occurred in the 75-to-84 and 85-and-older age groups, which Spillman says is not surprising because the prevalence of disability is far lower among the young elderly and so the declines in their disability

rates would be the least.

“As for the elderly as a whole, significant declines in the prevalence of persons receiving ADL help in the community or living in institutions came only after 1989 for all age groups,” Spillman continues. “In fact, through 1994, the increase of 0.7 percentage points in the proportion of the elderly aged 85 or older and receiving human help with ADLs or institutionalized was sufficient to overcome a similar decline for the youngest age group.”

An Unanswered Question

The study also seeks to identify whether trends can be found in individual ADL and IADL activities. “A central unanswered question is whether declines indicate improvements in health or environmental changes that promote greater independence for any given level of frailty,” Spillman says.

In comparing her findings with those of other researchers, Spillman points out possible reasons for differences in research findings and suggests potential trends. For example, in discussing the downward trend in the IADL money management component, Spillman suggests that one reason for the steep decline (a 3.7 percentage point drop in help with money management between 1984 and 1989) might be attributed to the fact that beginning in 1987, the Social Security Administration began to make payments to beneficiaries by a direct deposit method. This fact, she argues, could have affected how this IADL component was perceived by the elderly and not necessarily indicate an improvement in their cognitive or physical health.

Citing the findings of an earlier study by other researchers who suggest that difficulty in managing money is usually associated with cognitive difficulties, Spillman notes that the SSA’s direct deposit payment method may have been a factor

Parsing the Trends

In addressing the trends affecting disability among the elderly, analyzing which aspects of disability have declined, and suggesting possible implications for health care utilization and costs, the study of changes in elderly disability rates by Brenda C. Spillman, senior research associate at the Urban Institute, tackles the following questions:

- How has the prevalence of chronic disability among the elderly changed since the mid-1980s?
- Does the trend in the prevalence of disability differ for specific components, such as disability only in basic activities necessary for independent living or disability managed solely by the use of equipment?
- Are trends different for younger ages and older cohorts?
- Are there particular activities for which disability declines are larger or which appear to be more amenable to independence with the use of special equipment or to changes in environmental or social factors?
- What are the implications for future costs?

in the decline in the reporting of this IADL component among the elderly, since it may have “encouraged the greater use of banks and bank-based money management services, including the automatic payment of bills.

“It may be more generally true that advances in technology and the greater availability of services in the economy reduce the reliability of a link between declines in IADL disability and improvements in health,” Spillman observes. “The respondents’ perceptions of disability also may have changed for activities that are facilitated by environmental changes.”

Even though the mean number of IADLs among the disabled living in the community declined over the 15-year study period, the mean number of ADLs for which assistance was received increased for the disabled living both in the community and in institutional settings.

In fact, Spillman found that no single ADL declined in prevalence over the study period. These findings,

Spillman suggests, may indicate that improvements in their environment, rather than in their health, made it easier for the disabled elderly to manage their IADL activities.

Perhaps the most significant finding in Spillman’s study is how much more research is needed to understand the causes for the declines in chronic disability among the elderly. In discussing other studies, Spillman points out variations in the findings on disability trends and argues that “much remains to be understood before the drop in disability can be associated convincingly with savings in either Medicare or long-term care spending and before we can conclude that the rate of improvement seen in recent years will continue.”

Her study, Spillman notes, may indicate that the overall downward trend in elderly disability rates is not necessarily due to better health. “Rather, at least some of the observed declines are likely to reflect improvements in the environment that affect

both the ability of the elderly to cope with activities associated with independent living and whether they perceive themselves to be disabled.”

What’s more, Spillman says her findings show that the trends underlying the decline in disability rates need to be studied in more depth, particularly in the following areas:

- Changes since 1994 in the use of home health and other paid home care and who has paid for such care
- The relationships among three factors: disability, chronic conditions, and Medicare spending
- Trends in equipment use and the relationship between specific types of equipment and the amount of long-term care
- The role of underlying health, physical limitations, and cognitive status in the decline of IADL disability.

Addressing these issues is not simply an academic exercise, Spillman argues, pointing out that the percentage of elderly will increase to 20% of the population by 2030. Because the implications of that growth remain unclear, before policymakers make significant revisions to Medicare and other programs that affect the elderly they need to take an even closer look at the factors that are driving these trends, Spillman contends.

Yet, despite her exhortation calling for such research, Spillman ends her report with a cautionary prediction: “Even if the observed improvements in physical functioning continue and research is able to demonstrate improved health and lower costs, the impacts on future health care and long-term care costs will be profound.”

—Reported and written by Paula Grant, in Lincoln, Va. More information on practice strategies is on our Web site (see page 16).

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Building Growth Signals Opportunity

By Glen Perkins

A relatively new development trend started in the United States last year: Construction on a number of medical office buildings. This new growth is expected to continue this year for these buildings, which are designed to meet the specialized needs of physicians and others in the medical community.

The reasons for this trend are apparent when one considers that health care is a major part of the U.S. economy, and in many cities, it is one of the few sectors fostering job growth. At the same time, physicians want to deliver superior patient care while keeping costs down.

Many physicians have found that moving from a traditional hospital medical campus to a new medical office facility can produce meaningful savings. The benefits of such a move, however, are not merely financial. The convergence of the health care and real estate sectors creates benefits for physicians, their patients, and their practices.

Convenience and Savings

Many patients find that hospital settings can be inconvenient and even intimidating. New medical office facilities typically feature easier access and more convenient parking, and many aim to offer a more patient-friendly environment.

What's more, medical office buildings can be strategically located in or

near the communities they serve rather than being confined to an area immediately surrounding hospitals. Some medical treatments require patients to visit practitioners' offices often and for relatively short visits, which makes convenience important to patients. Another benefit is that the new facilities may be technologically advanced, enabling physicians and staff to be more efficient than they would be in an older facility.

Many doctors who struggle to reconcile the rising cost of leasing office

become a center for physicians to give patients cross-referrals to other practitioners whom they know and trust to offer quality health care services. This synergy benefits both patients and physicians, and thus enhances the patient-physician relationship.

Building Design

The state-of-the-art design of new medical office buildings can help meet physicians' specific needs. In fact, some real estate professionals work with physicians to ensure that

The state-of-the-art design of new medical office buildings can help to meet the specific needs of physicians.

space in hospital complexes may find that moving off hospital grounds to a medical office building can result in a savings per square foot while improving patient and physician convenience, especially if an ambulatory surgery center is available in the same building.

Some physicians may prefer a medical office building in which they can become an equity partner. Physicians who have an ownership interest in a large facility can enjoy additional cash flow and some appreciation of the equity generated by a quality institutional building. The cash flow acts as a cushion against what otherwise might be rising rents, and the appreciation creates a secure method for physicians to build a retirement fund.

When physicians have an ownership position, they not only occupy a portion of the building, they also have the opportunity to populate the building with complementary practices. The medical office building can

the buildings are designed by physicians for physicians. Once the real estate and design professionals understand the specific needs of the specialties involved, the building can be designed to meet the appropriate power requirements and vibration isolation needs, to isolate heating and air conditioning supply and return, and to comply with other specific requirements.

Unlike other property development, medical office buildings present unusual challenges for physicians who must meet regulatory requirements during site selection, financing, and construction, as well as when operating the property. When such specialized development is done correctly, the reward is a functional and attractive state-of-the-art facility that benefits physicians, patients, and the developer.

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

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To Fix Health Care, Let's Separate What We Want From What We Need

By Patrick N. Renaud

All parties in the health care system subscribe to the axiom that adequate health care should be both accessible and affordable to all Americans. The parties disagree, however, over three fundamental questions: What is adequate? What is accessible? And what is affordable?

Our wants and needs involving tangible goods, such as automobiles and houses, are much easier to deal with than are those involving intangibles such as faith and love. For example, we may want a foreign sports car but we know an American minivan will satisfy our need for adequate transportation. Or, we may want a million-dollar mansion but we will settle for a more modest home to meet our need for housing.

An intangible want is not easily distinguishable from an intangible need, and health care could be considered to be replete with both. Granted, we receive health care in a system that delivers tangible services, but how that system is organized and financed, and who is responsible for it, seem to be intangible. To add clarity to these intangibles, we will first address the wants in health care, which will help us begin to understand the needs in health care.

To understand what is wanted in health care requires us to gain the

perspective of the primary special interest groups involved: consumers, physicians, purchasers, and regulators. Once we understand what each group wants, we can answer the three questions involving what is adequate, accessible, and affordable. Then, we can develop a list of actual needs and ideas about how to satisfy them.

What Consumers Want

Regardless of whether we are providers, purchasers, or regulators, we are first of all consumers. And when we view health care from our consumer point of view, we all want unfettered access to an adequate and affordable health care system. Most consumers want to be able to go to any physician or other provider of their choice without interference. What's more, they would prefer either to pay nothing out-of-pocket for that privilege or to pay only a modest sum. Consumers also want quality health care for themselves and for their family members.

Since the 1950s, health care in the United States has been viewed as a benefit of employment in an industrialized society. The American consumer's expenditures for transportation, shelter, food, and clothing have always been viewed as the primary responsibility of the purchaser. Not so with health care, which is often viewed as an entitlement to be paid by an employer or an insurer. In fact, this system has led some consumers to believe that they should not have to pay anything for their health insurance, even though they are willing to pay for all of the insurance premiums for their cars and homes.

Among consumers, therefore,

“adequate” means the best health care available, “accessible” means any provider at any time, and “affordable” means little or no extra cost.

Evaluating the Wants

Anyone in the health care delivery system that renders health care services is a provider. And although physician providers may not have precisely the same agendas as nurses, lab technicians, or pharmacists, all providers share common concerns regarding the need to offer adequate, accessible health care.

To meet this need, these providers would define the following wants: “adequate” means having the right resources of time, place, and numbers of providers to perform their respective jobs; “accessible” means their patients can use their services with little or no interference from managing organizations; and “affordable” means they will receive the fair remuneration they need to operate successfully. All of these wants appear to be reasonable; the issue is to what degree they are attainable.

For this discussion, purchasers are those who buy health care, such as employers that sponsor health care plans. The number of such purchasers is decreasing, according to researchers, primarily because the cost of health care has risen precipitously. While this group is not homogenous, we might assume that many purchasers view adequate health care in a barebones sense; that is, what is needed to cover employees' basic health care needs. By definition, accessible health care for this group would be far more restrictive and center on the most

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efficient providers. Affordable health care would be a budgetary issue that varies widely from one employer to another and may involve considerable cost-shifting to the consumer.

Again, from the context of being reasonable, purchasers have a strong argument that they should not be expected to continue paying for health care after costs have risen at double-digit rates for most of the last two decades. Still, employers may have a difficult time backing away from their position as health care purchaser because employees view employer-sponsored care as an entitlement.

Government officials who deal with health care issues do not always agree about how the wants are defined, about the methods needed to solve the health care system's problems, or about the role government should play in the system. To these officials, adequate health care usually means that every citizen should be able to get the right health care; accessible health care means that all citizens, including the 43.5 million who are uninsured, should be given equal treatment, and affordable health care means that citizens should not have to mortgage their future to pay current health care bills.

These are reasonable wants, but the proponents of methods to fulfill them range from those who call for conservative, incremental reforms and changes in state laws to those who seek a more liberal, national universal or single-payer health care system. Given these divergent points of view, how can an accommodation acceptable to all parties be reached, and how can government regulators assist in the process?

To precipitate a change from "wants" to "needs," all participants in the debate need to agree on at least

four important perceived conditions.

Needs Assessment

First, they need to set priorities. The best place to start is to identify and prioritize the wants that should be considered needs. Consumers want adequate, accessible, and affordable health care. Providers want protection from a malpractice system gone beyond its original

single-payer system say the requisite tax burden of such a system would be unreasonable.

Fourth, they must have a bipartisan solution. In fact, perhaps the most important ingredient in changing a want to a need is to generate bipartisan support. Both liberals and conservatives agree that the health system as it is now structured needs repair, but they disagree on how to fix it.

Once we understand what health care consumers, physicians, purchasers, and regulators want, we can begin to answer the questions of what is adequate, accessible, and affordable.

intent. Purchasers want to protect the bottom line and to keep costs within a budget. Regulators want to ensure that the uninsured will be covered.

Second, the participants must agree on what is essential. A want becomes a need when it is perceived to be essential. For example, if the majority of Americans perceive that it is in their best interests to pursue a single-payer health system, then the candidates who espouse their support of such an idea may be elected. On the other hand, if the majority considers incremental health reform the more prudent approach, then the health care system will continue to pursue that approach.

Third, they must decide what is reasonable. A want cannot become a need unless it is perceived to be reasonable. Using the example cited above, if the public perceives that it is more reasonable to cover all Americans under a single-payer system at whatever cost, it will happen. Conversely, those who oppose the

Localized Care

Once there is agreement on ways to meet these four conditions, we can begin to solve the problem. In 1992, I wrote to the newly elected President Clinton and presented a broad plan to solve the health care crisis. I suggested that since some argue that "all politics is local," it could also be postulated that "all health care is local" too. The plan would be for the federal government to facilitate regional committees throughout the country. These committees would be made up of representatives from all walks of life with at least an abiding interest and some credible knowledge about the problems in health care. They would be asked to prepare, within a specified time, bipartisan solutions to solve the problems identified as being essential and reasonable.

The results would either be implemented by acclamation or by law as necessary. I believe that such an approach could have worked then and can still work now. The most difficult

"One of our nation's biggest disgraces is that 43.5 million citizens lack health insurance."

issues these regional committees could address with plans for action and pilot projects include the following:

Coverage for the uninsured. One of our nation's biggest disgraces is that 43.5 million citizens lack health insurance. The regional committees could develop pilot projects to implement diverse solutions ranging from greater tax incentives for small businesses to broadening the scope of Medicare and Medicaid to include the currently nonqualified, uninsured population.

Malpractice reform. Almost everyone knows a doctor who has left the practice of medicine because he or she could no longer afford to pay the premiums for liability insurance. As a result, many communities are medically underserved. Perhaps a project to limit malpractice awards plus putting the cases into a compulsory arbitration system could help keep liability costs down.

Efficient utilization of resources. On the other side of the equation, many communities have too many critical care beds for the populations they serve. The regional committees could review the needs for acute care beds and reassign facilities as needed to accommodate those that are no longer needed for acute care to serve nonacute care needs.

Reasonable pricing. One of the most difficult topics in this debate involves the cost of care. Much work needs to be done to make health care more available to all Americans.

Electronic physician referrals. The ease with which pharmacy and mail-order companies process claims demonstrates that it is time to develop a similar system regionally and nationally to ease the workload on

physicians. The Health Insurance Portability and Accountability Act (HIPAA) has already paved the way for eventual implementation. The system developed should include electronic storage of personal patient data and a simplified method of referring patients to specialists and hospitals and for lab testing.

Relief for purchasers. Employers, especially those with fewer than 1,000 employees, have been seeking economic relief from the rising cost of health care benefits. In fact, many employers no longer offer benefits to employees, a significant factor in the rising number of uninsured Americans. Policymakers should consider offering additional tax credits for the employers that offer benefits, and these credits should be graduated according to the percentage of contribution each employer makes toward those benefit costs.

Insurance reforms. There is a distinct lack of uniformity in the laws governing the best practices of health insurers. There should be a comprehensive study conducted examining the various idiosyncrasies of the state and federal laws, including mandated benefits, to determine the most effective legislative initiatives.

Consumer-driven health care. One recent strategy in health care delivery involves empowering consumers to be smarter purchasers of care. Programs based on this strategy deserve a chance to work, and we should endeavor to combine the best features of these programs to allow them to survive and thrive.

Wellness initiatives. Health care experts, particularly those with a lot of experience in the system, have seen that many of the most

intractable health care quality and cost problems could be alleviated by behavior modification aimed at minimizing or eliminating certain lifestyle habits that threaten health. Steps should be taken to support programs that work.

Long-term care for the elderly. One of the most overlooked and therefore undeveloped health care coverage issues involves long-term care. The largest insurers have so far failed to develop comprehensive, cost-effective long-term care plans. Insurers should redouble their efforts to develop products that have a pay-off to the insured whether or not those insured use it for care or whether they die before it ever pays them a dime.

Measuring health care quality. There is much debate about what is quality health care and how to measure it. Organizations such as the Leapfrog Group in Washington, D.C., are producing reports that are close to the mark. The regional committees would need to commit to some consensus about what constitutes good measurement and then notify the public.

Even after these issues are fully addressed, other problems will remain. However, we will be well on our way to providing a workable health care system that keeps costs under control. But first we need to distinguish our wants from our needs. Or, as the politician, diplomat, and former presidential candidate Adlai Stevenson once said, "Understanding human needs is half the job of meeting them."

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

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