

CARDIOLOGY PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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California Groups Take Businesslike Approach

After prodding from state officials, medical groups in California are adopting more businesslike strategies, such as retaining earnings, building up reserves, conducting yearly financial audits, and identifying and reviewing poor-performing contracts.

At the beginning of last year, after years of financial hard times for groups, the California Department of Managed Health Care introduced a financial reporting system for more than 200 large groups and IPAs that accept managed care risk. The new system has radically changed the methods that practices use to manage their finances, says Don Crane, president of the California Association of Physician Organizations. The association, in Los Angeles, represents 75 IPAs and large groups. The lessons the California groups have learned after instituting the new practices are instructive for medical groups nationwide.

Reporting Requirements

California groups now must report their ability to track future debts, their record of payments, and their cash on hand to meet current liabilities. About 90% of the groups have performed well on the first two indicators, but only 60% had enough cash on hand, state records show.

The state does not penalize groups that fail to meet the standards, but low-scorers are feeling the consequences, Crane says. Some health plans are not assigning new patients to them, he adds. To conform to the

standards, groups are keeping cash on hand, say Crane and others. Many medical practices are ending the tradition of distributing cash to members at year-end, a tax-avoidance strategy that left nothing in reserve. Also, modest reimbursement increases this year are making it easier to build reserves; however, some experts say that some practices may have to cut physician pay if they want to keep more cash on hand.

Cash Is King

Retaining an adequate amount of cash is crucial because cash is king in California's heavily penetrated managed care market, says Chris Ohman, president of CapMetrics, managed care researchers in Emeryville, Calif. Ohman is also the coauthor of a new study on group solvency for the California Health Care Foundation in Oakland.

Unlike fee-for-service reimbursement, capitated contracts leave physicians open to huge financial risks, such as an unexpected rise in utilization or reduced payments at year-end from risk pools, which can amount to millions of dollars, Ohman says. "Without sufficient cash on hand, if a capitation check from a health plan comes in late or is short, or if there is a surge in claims, a group could be in a lot of trouble," Ohman explains.

Many medical groups in California have been forced to close due to unexpected liquidity crises, say Ohman and others. The California Medical Association (CMA), in San

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Denver Cardiologists to Open Comprehensive Outpatient Center

South Denver Cardiology Associates, a practice that includes 12 cardiologists, plans to open a \$15 million, 60,000 square foot cardiac care outpatient center in an effort to provide better patient care and to accommodate growth of the practice. The cardiologists' main goal in building the center is to offer integrated care in preventive, diagnostic, and therapeutic services to individuals in the community. "South Denver Cardiology Associates wants to be the regional leader in prevention, early

to send a patient to a hospital dietitian for cholesterol teaching, to a weight-loss clinic for weight management, to a community-based program for smoking cessation, to a local health club for exercise, to the hospital for diagnostic testing, to a psychologist's office for counseling, and to the library for education," says Karyl VanBenthuisen, MD, president of the group. "There has to be a better alternative for our patients. We believe that this 'heart-center' model might make taking care of patients

more health care resources, and they need hospitalization and rehospitalization," she says. "Our goal is to create a facility that is quickly accessible for preventive and diagnostic care. Our center is not based on the philosophy of 'Build it and they will come,' but rather, 'Build it so they *can* come.'"

In addition, the center will allow for significant practice growth. "We simply do not have the space to provide and promote the array of services that represent adequate preventive care," Lambert says. "The opening of the center will quadruple the space we have now, and allow us to expand the services we can provide to the community."

In the past, hospitals set strategy for cardiac services in Denver. But now one practice wants to control its own destiny and determine how to serve its patients most effectively.

Meeting Patient Needs

"Denver is somewhat unusual in that we have a number of large cardiology practices, but we each serve a certain section of town," says Lambert. "For years, all of the large cardiology groups met to plan the creation of a cardiac hospital. We even created a limited-liability corporation. However, it became clear that the cardiologists would admit to such a hospital only if it was located near their own practice." Interestingly, patients also seem to follow boundary lines, adds Lambert. "When we did the demographic analysis of our patients, we found that they all came from the south Denver area," she says.

The group admits primarily to three hospitals: Swedish Medical Center, Porter Adventist Hospital, and Littleton Adventist Hospital. "For years, the hospitals have set a strategy for their cardiac services, and we have simply hitched our plans to their plans," says Lambert. "But over the years, with the changes brought about by managed care, it has become evi-

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diagnosis, and treatment of cardiovascular disease," says Brenda Lambert, administrator of South Denver Cardiology Associates.

The Spectrum of Care

"We want to create a health care facility that will expand our ability to diagnose and treat heart disease," Lambert continues. "The outpatient center will encompass care across the spectrum of cardiovascular disease, from the prediction of cardiovascular risk in healthy individuals to the diagnosis and management of patients with established cardiac disease. Our center will offer expert medical providers, state-of-the-art equipment, and specialty services focusing on modifying the progression of heart disease, all with a strong emphasis on prevention and wellness."

"It's common for a busy cardiologist

easier and more patient friendly."

Better preventive care and more timely access to such care are sorely needed in Denver, Lambert explains. "The problem providers are facing in the Denver area, as in other communities around the country, is that patients cannot access the system quickly and easily," she notes. "They simply cannot receive timely preventive cardiac care. For example, our patients with urgent or emergent problems are seen right away; but patients who call for check-ups or follow-up care cannot be seen for four or five weeks, and that is quick compared to the other cardiology groups in town."

The inability of patients to be seen by a cardiologist quickly means that patients tend to be somewhat less healthy by the time they finally receive care, Lambert explains. "By then, they need more care, they use

“It’s common for a busy cardiologist to send a patient to a hospital dietitian for cholesterol teaching, a weight-loss clinic for weight management, and a community-based program for smoking cessation. There has to be a better alternative for our patients.”

—Karyl VanBenthuisen, MD, South Denver Cardiology Associates

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dent that we need to decide what strategies will best serve us and our patients. We want to control our own destiny as well as determine how we can best serve our patient base.”

The group has a strong managed care influence, with a patient mix of 16% Medicare, 3% Medicaid, 7% nonmanaged care, and 74% managed care. Since illness prevention is considered a strong focus of managed care, the group wanted to enhance its services in this area.

The group began discussing potential strategies in 1999. “Out of our discussions was born ‘SDCA 2000,’ our business plan for the new outpatient center,” Lambert says. The center will be completed in early 2003.

Continuum of Services

The services offered by the center will cover the continuum of care, from prevention through treatment and rehabilitation following an event.

The center will include a computed tomography (CT) center, which will provide calcium scoring to determine at a very early stage whether an individual is building up plaque in the coronary arteries. In addition, the cardiologists hope to use the CT center to provide noninvasive coronary angiography, thus avoiding the need for more expensive and invasive procedures, such as cardiac catheterization.

The center also will include a 4,000 square foot wellness and rehabilitation facility. “This portion of the center will primarily house a typical primary cardiac rehabilitation program,” explains Lambert. “But it will also provide wellness support to individu-

als with comorbidities and conditions that put them at higher risk for coronary disease, such as diabetes, hypertension, high levels of stress, and a family history of cardiac problems. Our 12-week wellness program will address nutrition, exercise, and mind-body issues. We will also have a specific exercise program designed by exercise physiologists, and an exercise area.”

An education area of approximately 3,500 square feet will seat 150 people for education programs; the area can be separated into three sections, one of which is a full kitchen where cooking demonstrations and classes will be provided.

Approximately 10,000 square feet will include physician offices and a diagnostic center, which will provide echocardiography, nuclear imaging, treadmill tests, stress echocardiograms, and Holter monitoring. A cardiac catheterization suite will permit outpatient diagnostic coronary angiograms—typically performed in hospitals—and diagnostic cardiac catheterization.

Complementary Medicine

One of the most unusual aspects of the center is the addition of complementary medicine to the cardiology practice. The center will include a 1,000 square foot studio, in which classes in yoga, Pilates, imagery, and stress management will be offered. Also, massage therapy, acupuncture, lipid management, and weight management will be available.

Lambert acknowledges that many cardiologists and other physicians

around the country are skeptical of the value of complementary medicine. “But this year, for the first time, the American College of Cardiology held a meeting focused on how cardiologists can add complementary medicine to their practices,” she notes. “So complementary care has been embraced by the college as an appropriate mechanism for care. In addition, scientific research has indicated that several complementary therapies—such as biofeedback, transcendental meditation, imagery, and other stress management therapies—can lower blood pressure. Studies on vitamin and massage therapy have also suggested that these therapies improve risk factors for coronary disease.”

Lambert acknowledges that the group was criticized when it first announced the inclusion of complementary therapies in the outpatient therapies. “Some of our own physicians are even having a little trouble embracing these therapies,” she says. “Eventually, we will be able to see, through our own experiences with patients, the benefits that can result.”

The group’s physicians will learn about these therapies and will even experience some of them prior to the outpatient center’s opening, Lambert adds. As a result, they will be well versed about the treatments so they will be able to answer patients’ questions accurately. Physician comfort with complementary care also will be increased because the physicians will have control over the services offered in the center.

“Because we will offer those complementary services in-house, our

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physicians will have control over them and the practitioners we employ," Lambert says. "We will verify practitioner credentials and ensure that their services are of high quality. Patients who may be reluctant to try a new type of therapy because they do not know if a practitioner is reputable will also feel more comfortable because of our stamp of approval."

Benefits for Physicians

For the group's physicians, the center will offer important benefits. "Of course, we hope to have some financial payoff," Lambert says. "Potentially, we can enhance practice revenue by offering new services. For exam-

working hours to issues of patient care," she says. "They reference scientific background and published studies to support their decisions. SDCA 2000 is possible because of that cohesiveness. Not many groups could create such a finite vision and be able to put that vision into operation."

In addition, patients themselves may pay for many of these services, thereby adding to the practice's income. "The pro formas for the wellness and education components, however, show that we will likely just break even in those areas," Lambert points out. "But the physicians believe that these are critical components of their vision for care."

The center will allow cardiologists to expand into diagnostic areas in which they have not previously earned technical fees.

ple, adding the CT scan technology and the cardiac catheterization lab will improve our revenue flow. Medicare recently cut cardiologist reimbursement by 8% for 2002, and reimbursement by managed care payers is tightening as well. Our goal is to maintain our physicians' current level of income."

VanBenthuisen believes that building the center is a business decision for the group. "It gives us opportunities to expand into diagnostic areas in which we have not previously earned technical fees," VanBenthuisen says. "The building itself is an excellent long-term investment. Finally, the addition of new services, including the educational programs for the community, will hopefully increase our visibility and increase referrals."

Such benefits can be realized only because the group is characterized by two important qualities: vision and cohesiveness, Lambert adds. "The group collaborates easily on all decisions, involving everything from

Most important, the center will offer the cardiologists the opportunity to become managers of the spectrum of cardiovascular disease, rather than simply being interventionists after disease is clearly established, says Lambert. "The doctors are tired of just fixing problems at the back end of care," she comments. "They would prefer to influence the care offered early on, which might prevent people from needing higher level interventions."

The growth of the population and the demographics of Denver's residents can make such a center a viable business opportunity. "The services offered by the outpatient center will be in demand because south Denver is experiencing strong growth of a white-collar population," Lambert explains. "Many of these services are not covered by insurers and therefore will be paid for by patients out of pocket. An area with mostly blue-collar residents might not be able to support such a center."

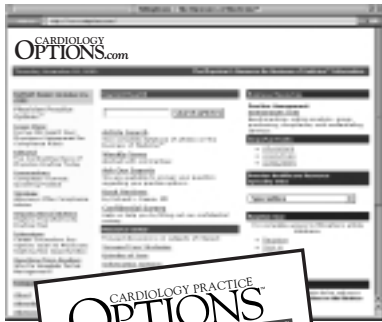
Not surprisingly, the responses to the plans for the center from area hospitals and physician competitors has been mixed. "One hospital has decided to build a catheterization lab in response to our plans," Lambert says. "However, most hospitals believe that our center will enhance services to the patients in the community and that hospitals will benefit due to increased community awareness and earlier detection of heart disease. It is less costly for hospitals and insurers to care for a patient who is diagnosed in the earlier stages of that disease. Furthermore, our outpatient center is not a heart hospital. Our physicians will maintain their admitting privileges and their relationships with the hospitals and will continue to perform all routine consultative and diagnostic-therapeutic procedures there."

"The initial response of physicians to the center has been generally favorable," says VanBenthuisen. "Isolated physicians have interpreted this as a grab for patients from the primary caregiver. When we have had the opportunity to explain that we intend to continue to serve primarily as consultant cardiologists and that this center is simply a mechanism for integrating diagnostic and therapeutics into one building, there have been fewer objections."

Only one primary care physician in the area has criticized the group's plans, Lambert adds. "The physician expressed a concern that we would try to assume primary care responsibility for all these patients, and thereby take business away from him," Lambert says. "It reminded us that we need to keep our relationships with the primary care physicians in mind, and that we will need to educate our referring physicians about the potential benefits of this type of integrated care model."

—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).

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