Positioning Your Specialty Practice For The Future

Ronald N. Riner, MD

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The individuals present here today are from varied practice environments. Some of you are in solo practice. Some of you are in small group practices and some are in rather large departments at universities or multispecialty clinics. My comments, therefore, must be somewhat generic but I hope there will be something of substance for all concerned.

My vantage point is from my position as a practitioner and vice president of medical affairs for the largest not-for-profit health care system in the United States — The Daughters of Charity National Health System. We sponsor 44 acute care hospitals spanning the country from California to New York with over 16,000 acute care beds and 60,000 employees. Twenty-three of those hospitals are teaching hospitals with approximately 1300 residents in training in any one academic year. Approximately 20,000 physicians use Daughters of Charity facilities. With entities such as the San Francisco Heart Institute, the Indiana Heart Institute and other large focused cardiology specialty practices we are involved in providing a significant amount of the cardiac care rendered in this country.

The Setting

Let us take assessment for a moment as to what has occurred in the past several years to bring about the milieu in which we find ourselves. The public is currently clamoring for three things as I would see it: 1) universal access to care; 2) access to the latest technology and the finest quality of care; and 3) the lowest possible cost — perhaps, unrealistically low cost. Debate rages as to what is driving our sense of urgency for health care reform. We spend a considerable amount of time discussing quality and costs, but in all my travels and discussions there is almost unanimous feeling that cost issues are the driving force. While the profession readily acknowledges variations in our therapies and our inability to...
measure outcomes successfully, far and away the medical profession and public is overwhelmingly concerned by its inability to harness rising costs. There are numerous reasons for the increase in cost — some controllable and some not controllable. This is really a topic for a different discussion and I merely mention it for background information.

As a profession we have relatively recently turned out a large number of physicians from our universities and educational facilities, the majority of whom are specialists. Cardiology has done its share — in some ways turning out some of the most specialized proceduralists of all the subspecialties. Rest assured, however, the number of administrative personnel has also increased over the past five to ten years and surpasses the gains in the numbers of physicians by a margin of almost 4 to 1. Indeed, 11 million people now find employment in some way through their involvement in health care. One might certainly feel comfortable looking upon health care in this country as an “economic good”.

Enter managed care and those institutions and groups who focus on managing care — really managing costs. In some sections of our country managed care has greater significance than in other areas. However, I believe it is safe to say we will all be looking at more managed care as part of our future. Even Medicare and Medicaid can realistically be viewed as managed health care. What has happened as a consequence? Physicians find themselves moving from the role of patient-advocate to being concerned with allocation of resources. Dr. William Mayo’s statement “The interest of the patient is the only interest” may not be applicable today as we wrestle with all of the varied special interest groups interposed in the doctor-patient relationship. Is this good? Are we a profession or a business? Perhaps this is a rhetorical question. Across the country there is concern and debate over the legitimacy of the professions. There is immense anxiety and self-questioning and at times feelings of being overwhelmed by superior forces. Yes, pessimism — sometimes despair is voiced. But, let us look upon the opportunities that arise from the immense changes that are occurring.

The Trends

I cannot tell you for certain that everything I will put before you will definitely come about. Nonetheless, it behooves us to acknowledge some perceived trends in health care that may have impact on your practice and in specific the specialty practice of cardiology. We are moving from a situation of competition between small groups and solo practices to competition between alliances and networks (Please see Tables 1A and 1B). This in part comes about because of overcapacity. There simply are too many hospitals and a plethora of certain types of physicians. We are also moving from solo to group practice as physicians necessarily band together to bring about economies of scale and allow enhanced access to managed care contracts via group negotiation. There is a broadening of our therapies from treatment of illnesses to a greater emphasis on continuum of care and the movement from acute care to

<table>
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<th>Table 1A. Trends</th>
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<tr>
<td>Competition among individual hospitals and practitioners → Competition among alliances and networks</td>
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<tr>
<td>Isolated services → Continuum of care</td>
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<tr>
<td>Curing and treating illness → Curing and managing health</td>
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<td>Inpatient/hospital care → Outpatient and home care</td>
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<table>
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<th>Table 1B. Trends</th>
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<tr>
<td>Specialty care → Preventative &amp; Primary Care</td>
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<tr>
<td>Perception of Quality → Measurement of Quality</td>
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<td>Ambulatory hospital based care → Office and telemedicine</td>
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There are calls for a change from a specialty oriented medical profession (currently about 70% of MDs) to more primary care focus (currently about 30% of MDs). The theorists would suggest that within the next five years the ratio of specialty care to primary care should be about 50%. This latter phenomena provides some interesting challenges to a specialist, especially to someone caring for patients with cardiovascular disease. Approximately 20% of patients with chest pain will seek out a specialist as their first contact for analysis of chest pain. Additionally, some studies would suggest that approximately 40% of individuals with previously diagnosed ischemic heart disease use their cardiologist as a primary care giver. Indeed, I believe the theorists underestimate the amount of primary care provided by some subspecialists. We live in a society which has come to prize specialization. Every profession has undergone some transformation to increased specialization. Witness the fact that in areas where consumers feel educated they readily seek the attention of experts pertinent to their particular problem (e.g. someone accused of committing murder might directly seek out a trial lawyer in preference to general counsel). It is not my purpose to debate the nuances of the primary care versus specialty care issue. Rather, I merely wish to point out that as a society we have come to appreciate and expect access to certain types of specialized care. Additionally, just as all lawyers are not equal, all accountants are not equal, all physicians are not equal — a fact which businessmen and businesswomen, who strictly view the delivery of professional services as a commodity, do not fully appreciate until they are ill or require the professional services personally.

Other trends are also evolving. It is certainly obvious that hospital acute care admissions are decreasing. More and more work is moving to an outpatient environment (See Table 2). We are also seeing a trend away from traditional office and hospital campus environments to home care and the use of telecommunications (video telemedicine). Finally, underpinning these trends is a strong movement from traditional quality assurance and utilization management to quality measurement. This latter phenomena is not well developed by our profession but it is one which all professional organizations will need to address forthrightly in order to provide appropriate data supporting their activities. There is no doubt that we speak about issues of quality measurement more easily and glibly than we should. Whole departments at university settings are being developed to explore the vagaries and complexities of quality measurement in health care.

The Posture

In light of these trends how would I suggest that you position your specialty cardiac practice? In general, I would make the following recommendations:

A. Strategic planning should be an integral part of your practice management activities. You will need to look critically at your particular practice to see if you wish to function as an isolated subspecialty practice or wish to provide a continuum of cardiac care or integrate with or within a large multispecialty group. If you opt to maintain your image as a specialty practice I would strongly suggest that you consider offering a continuum of cardiac care. This will place greater emphasis on obtaining individuals with clinical cardiological and noninvasive skills rather than purely providing proceduralists. Alternatively, if your practice is procedurally-oriented you will need to form very strong working alliances with large primary care providers capable of extending an adequate number of patients to you and your colleagues to maintain your skills and the volume to sustain your practice. Remember, the gatekeeper for patient activity may come through family physicians and general internists. Many patients may not be able to seek your services directly.

B. Develop leadership within your group to address the sundry issues which are confronting the business aspects of your practice today. In general, physicians do not provide enough time or support for professional colleagues undertaking the management aspects of the practice. I would suggest that all groups prepare to develop and support medical leadership. This leadership will need to be appropriately compensated and rewarded for the time and energy expended to address management issues pertinent to the practice. Emphasizing more formal organizational structures will necessitate some relinquishment of autonomy within a group so that appropriate decisions can be made by the leadership.

C. Communicate. Communication will be crucial to the successful functioning of your practice. Communication needs to come from leader-
ship to other members of your group and from your group to your particular customers and alliances. Information management systems and highly tuned people skills will be absolutely critical to this process.

D. Know Your Customers. These customers are both internal and external. Your internal customers are your employees (often the first line of contact with your patients and outside customers) and your colleagues within the group. Your external customers are numerous, including your patients and payors. Get close to your payors and learn as much as possible concerning their methodologies of doing business. Finally, never forget the importance of your patient as a "customer". Despite the fact that many of your patients may not be in control of the finances concerning your services, their favorable interaction with you and your staff goes a long way in providing an impetus for maintaining them as future patients. I would strongly urge you to take time to talk to your patients about the changes in health care and the manner in which your practice is being altered to accommodate proposed reform activities and payment activities. A few minutes invested with your patients may, in the long run, pay significant dividends.

In conclusion, therefore, how would I suggest that you posture your practice for the future?

A. First, I would suggest that you look forthrightly at what is occurring presently. Ask yourself whether these are trends or fads. As I had mentioned above, I think there are some significant trends which will have impact on the practice of medicine and probably impact significantly the way we practice specialty medicine irrespective of any formal passage of legislation. Keep an open mind about issues that come before you. Don't be reticent about embracing change. Don't make hurried decisions. Build appropriate leadership to address the issues confronting your practice. Carefully analyze potential partners and strategic alliances.

B. Cost-effectiveness and quality measurement will become cornerstones of your practice activ-

Table 2.

COMMUNITY HOSPITALS' BUSINESS SHRINKS


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<tr>
<th>Indicator</th>
<th>Change</th>
<th>1991 Value</th>
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<tr>
<td>Admissions (31.1 million)</td>
<td>-15%</td>
<td></td>
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<tr>
<td>Occupancy (66%)</td>
<td>-13%</td>
<td></td>
</tr>
<tr>
<td>Beds (924,000)</td>
<td>-8%</td>
<td></td>
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<tr>
<td>Hospitals (5,342*)</td>
<td>-6%</td>
<td></td>
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<tr>
<td>Length of Stay (7.2 Days)</td>
<td>-5%</td>
<td></td>
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<tr>
<td>Outpatient visits (322.1 million)</td>
<td>+7%</td>
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*558 hospitals closed, 404 involved in mergers.

Source: Am. Hosp. Assoc., NY Times 6/20/93
ities. Invest in information technologies and staff to address these issues. Finally, look carefully upon the constituencies of your practice. As I have mentioned above, I believe you need to be prepared to offer a continuum of care. Build, if you will, a lifetime of products and services. All practices have their own culture. There is no one appropriate format that is applicable to all practices. One needs to analyze carefully the types of services you feel comfortable providing in the setting in which you practice and position yourself appropriately.

Finally, I would make a strong plea for a large dose of professionalism in your deliberations and discussions. Many of the healthcare reform measures and payment methodologies have been developed by individuals with a business background who look upon patients as cost-conscious consumers and reduce the physician–patient relationship to that of a market encounter. In that setting, economic issues may override concerns about quality, choice and continuity of care. These latter issues must be viewed as items which the profession upholds. They are not trade association issues. Rather, they should be viewed as “social goods”. We bring different perspectives to the table. We have different educational backgrounds and many times different objectives. Our strengths and successes will be noted where all appropriate interests are represented fairly. The direction you should pursue may not be clear. However, you must be open to considering new options. As Robert Frost said so eloquently:

“Two roads diverged in a wood.  
And I took the one less  
traveled by, and that has  
Made all the difference.”

With all the turmoil and ambiguity I know the wisdom of the old sage Yogi Berra, may seem more applicable:

“When you come to a fork in the road, take it.”

At a time when there is a critical need for answers and direction, I would urge you to take a leadership role. Manage rather than be managed. Take time to assess your current status and position yourself to take advantage of the changes which are occurring mindful of your professional obligations and responsibilities.