Achieving Improved Financial Performance Must Involve Your Providers

In this month's article, we speak to Peter L. Duffy, MD, MMM, FACC, FSCAI, who has spent the last 30 years not only honing his craft as an interventional cardiologist and treating coronary artery disease, but being a staunch advocate for the ways and means of how interventional cardiology can be delivered specific to quality and outcomes. As a board member of the Society for Cardiovascular Angiography and Interventions (SCAI), a leader within his practice and several hospital system cardiovascular service lines, Dr. Duffy also recognizes that the relationship between provider and hospital has taken on greater significance. He shares his observations and concerns with us as healthcare continues to evolve. It is for these reasons that he serves as a medical advisor to Terumo Health Outcomes to better help us chart a course and offer solutions for hospitals and providers. — Gary Clifton, VP Care Pathways

Introduction

By Ryan Graver, Divisional Vice President, Terumo Health Outcomes

It has been said that in any service industry, there are three components that define delivery of that service: good, fast, and cheap — and that you can have only two of those options. U.S. healthcare is good and fast, but we are certainly not cheap. As our healthcare system continues to explore the means whereby we can deliver care more cost effectively, existing examples can show us how to scale a more cost-effective system through increasing attention to quality, outcomes, and risk.

Over the past decade, U.S. hospitals determined that a viable solution to manage cost pressures was by controlling those who were responsible for generating costs, i.e., providers. As a result, we saw a steady and significant effort to purchase physician practices; specifically, cardiology as a subspecialty was targeted in these efforts. However, the reality is that system costs did not go down, profitability largely did not improve, length of stay stayed flat, readmissions continued, and both the total cost of care to payers and out-of-pocket expenses for patients continued to rise. Why didn't we see sweeping cost improvement driven by the major roll-up of provider practices by hospitals? It can largely be attributed to the simple fact that the employment of providers by hospitals does not address the perversely aligned incentives that inherently exist in our system.

It is important that every cardiologist understand just where his or her compensation is coming from.

In our last article[1], we discussed the multiple references from the Center for Medicare & Medicaid Innovation (CMMI) and Centers for Medicare & Medicaid (CMS) referring to mandatory bundled payment programs, and the impact that quality, outcomes, and operational efficiency have on the bottom line of any program. We are excited to share Dr. Duffy's insights and perspective on what all this really means to a cardiologist, and why those in the healthcare field should be preparing for and taking action to position themselves successfully for what's next.

Dr. Duffy, in our last article[1], we discussed changing payment models. Can you help articulate why cardiologists , now more than ever, should pay attention to these types of proposed changes?

It is often said that the practice of medicine is an art, but the delivery of healthcare is a business. While we as cardiologists focus on patient care and derive great satisfaction from applying our clinical training and expertise, enjoy interacting with our colleagues and support staff, and find great reward in bringing hope and improvement in the quality of life to our patients, we must recognize that our compensation is dependent upon our business model and not on just the incredible work that we do.

To that end, it is important that every cardiologist understand just where his or her compensation is coming from. For employed physicians, it is driven by profits generated from the services provided in the care of cardiovascular patients. The vast majority of payment to the hospital is in the form of reimbursement for the technical fees and ancillary services associated with the services we provide. The remainder of that amount, usually less than 20%, goes to the hospital system for physician compensation. At the present time, cardiovascular services are in the enviable position of contributing a significant portion of the hospital's profit. That is because cardiovascular services are highly reimbursed, not because of the complexity of the procedures we perform. Medicare utilizes a cost-based system to assign reimbursement and this has led to cardiovascular care representing the single largest subspecialty spend to Medicare. As a result, Medicare and other third-party payers have these payments under a microscope. They have been working overtime for years to decrease the volume of the services we provide and are constantly working to chip away at reimbursement for our services, regardless of how complex or high-risk those procedures are.

Hospitals and cardiologists need to understand that physician compensation is not tied to the fact that cardiologists are associated with a highly recognized disease state, dealing with life and death decisions daily. The issue is that the cardiology service line is the highest revenue-generating service line in the majority of hospitals. The lost opportunity is not aligning physician and hospital goals, and incentivizing hospitals and physicians to work together to enhance the contribution margin from the cardiovascular service line. Reducing complications, reducing length of stay, and managing risks are the means to increasing contribution margins, and cardiologists need to be part of the solution. The bubble chart in Figure 1 shows how hospitals typically prioritize service lines. These data, from the Advisory Board's State of Our Service Lines analysis[2], show that in 2011 to 2012, cardiovascular service lines were the largest contributor to hospital profit and the second-fastest growing service line. As providers, we must understand this is the main driver of why we have been compensated much higher than other subspecialties for more than the last decade and we must ask ourselves, is this simply going to continue, or do we need to take action?

If a cardiologist's compensation has been driven by both the high impact of cardiovascular service line profitability and growth over the last ten years, what do you forecast for the next ten years?

We have seen a flattening and gradual decline in cath lab volume over the past several years. The number of elective percutaneous coronary interventions (PCIs) is decreasing and we will continue to see a decline in the number of patients going to the cath lab for acute coronary syndromes, given the increased effectiveness of medical therapy and even, to some extent, lifestyle modification. Return to the cath lab to treat in-stent restenosis appears to be at a lower level than ever. Growth will be in the area of structural heart disease, but once these procedures also become commoditized, they will be even greater targets than they are now for reimbursement reduction. Profitability for the system relies on two factors: the income to the system and the cost of the system to obtain that income. While income to the system may flatten or decline, and is driven mainly by set Medicare fees, contract negotiation, and volume; much of profitability is driven by cost. Systems that continue to have high cost will have less profit from their service lines and this is clearly an area where involved and integrated cardiologists can play a major role.

Going forward, it is important for cardiologists who want to protect their standard of living — and I think that would include all of us, employed and independent — to be familiar with how our hospital system is being compensated for our services and develop ways to work in alignment with our hospital systems to maximize their profit. Essentially, if the profits derived from the cardiovascular service line decline, there is every reason to believe that hospital administrators will offset those declining profits by lower compensation to the physicians providing cardiovascular services. Aligning with hospital goals does not mean increasing the volume of unnecessary procedures. Many studies have shown this actually increases the cost to the system and ultimately, can decrease profitability. Rather, cardiologists must look at the overall structure of how cardiovascular care is delivered in their institution, and work with system administrators and managers to ensure that the care that they are providing is not only appropriate, but that it is efficient, effective, equitable, patient-centered, safe, and timely.

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Cardiologists are in the best position to lead their healthcare systems in reaching the goal of achieving the Quadruple Aim: better outcomes, lower costs, improved clinician experience, and improved patient experience. Cardiologists who go beyond being employed by healthcare systems, who are aligned and focused on helping their system reach defined strategic goals, will be in the best position to realize the benefit that achieving these goals will bring to the hospital's profit margin. Doing so will maintain cardiovascular services as a high-percentage contributor to that margin, thus enabling cardiologists to continue to maintain and enjoy the high compensation levels currently earned. Cardiologists who simply remain employees will be at the mercy of their system and easy targets for compensation reduction when profits fall due to poor quality, inefficient processes, and continued waste of valuable resources.

Can you provide an example of where cardiologists could contribute to reducing costs and improving efficiencies, and impact patient outcomes/experience?

Perfecting the same-day discharge process for PCI is a prime opportunity for optimizing resource utilization that virtually no organization has mastered. An ideal process in this regard includes identifying patients eligible for same-day discharge before they are scheduled, coordinating with the scheduler to ensure that those patients are placed in early day slots, and that those eligible patients are then screened for same-day discharge after the procedure as well. The percent of patients who meet both pre and post criteria for same-day discharge and are actually discharged should be tracked (ideally 100%), and reasons for failure to meet the target identified and addressed in a timely manner. Less efficient organizations may meet the target, but only by extending staff hours in the post PCI or holding area beyond the regular closing time. This is costly and wasteful, and can decrease staff satisfaction. Other organizations have same-day discharge processes, but are not utilizing them effectively. These organizations have the most potential for process improvement and will benefit the most from partnering with their cardiologists. The least efficient organizations have no process at all. This is clearly an area where cardiologists can be instrumental in improving efficiency, optimizing resource utilization, and maximizing the contribution margin from the cardiovascular service line, while also enhancing the patient experience and maintaining excellent outcomes.

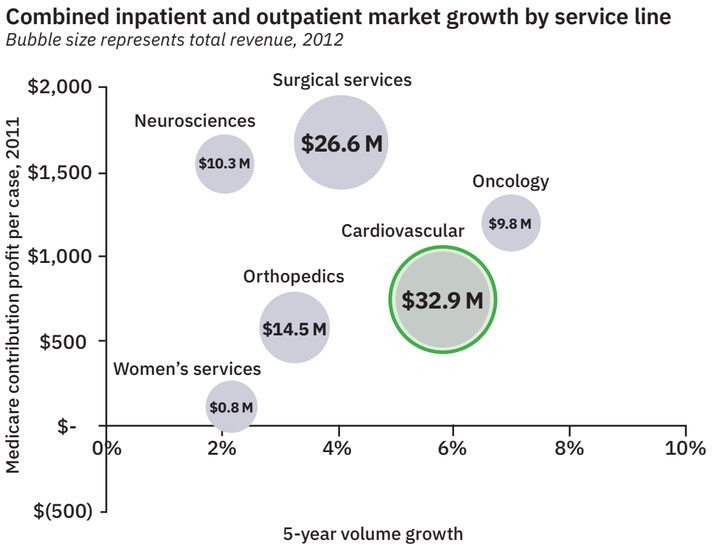

Figure 1. These data, from the Advisory Board's State of Our Service Lines analysis, show that in 2011-2012, cardiovascular service lines were the largest contributor to hospital profit and the second-fastest growing service line. ***Reprinted with permission from the Advisory Board.***[2]

Given the fact that cardiologists have such direct impact on quality, outcomes, and efficiencies, I am wondering if in all your years of practice, has a hospital ever shared your financial contribution to the service line with you and discussed how it could be improved upon?

One of the biggest obstacles all cardiologists (and even service line leaders) have is getting a clear understanding of the finances of the service line. To be fair, part of this is because the costs related to each unique patient's services are often aggregated and thus make these costs somewhat difficult to assign. Additionally, individual systems have unique ways of allocating cost and income, making it difficult to do cross comparisons between systems. However, the fact is that even when such information is available, systems are often reluctant to share it with their cardiologists. For hospital systems to achieve the maximum potential of an ethical and highly profitable service line, administrators will have to rethink this approach and trust their cardiologists by transparently sharing all financial data in this regard. Administrators must also be willing to change their financial assumptions and projections when valid concerns are raised.

Quality needs to be built into our delivery systems. We should receive continuous and constant feedback, and the results should be funneled into our daily routine to optimize future procedures. Platforms like ePRISM that are integrated into our clinical workflow and that link to the American College of Cardiology's National Cardiovascular Data Registry (NCDR) risk algorithms represent a significant step for providers to take control of the quality of the care they provide.

What would you recommend to your colleagues to position them for success and to protect their incomes moving forward?

Unfortunately, COVID has exposed many issues in the U.S. healthcare system. An analysis conducted by Kaufman, Hall & Associates, LLC for the American Hospital Association[3] showed significantly higher expenses for labor, drugs, and supplies, and continued delay of care, all of which is negatively impacting the financial performance of hospitals and health systems through 2021. The report projected that hospitals nationwide would lose an estimated $54 billion in net income over the course of the year, even after taking into account federal Coronavirus Aid, Relief, and Economic Security (CARES) Act funding from 2020. The analysis projects median hospital margins to be 11% below pre-pandemic levels and more than a third of hospitals are expected to end 2021 with negative margins.

Couple the impact COVID is having with the outmigration of cardiovascular cases and the threat of mandatory downside risk programs; the financial outlook in healthcare is frightening. As we move through 2022 and beyond, cardiologists can certainly expect their income levels to be challenged. So, I would call on all of my colleagues to get engaged in driving the strategy and own the results. Whether employed by a health system or as independent providers, we can partner with our hospitals through co-management agreements and other mechanisms, but we need to take ownership. We also must shift our focus away from the old strategy of "just grow volumes." Unfortunately, increasing volume is not a good strategy for increasing profits and simply focusing on cost cutting is equally poor. Cost cutting in most systems usually means pressing suppliers for lower prices for their products and cutting staff hours, pay, or benefits. None of these are good long-term solutions to increasing the profitability of the hospital. The critical component, and why as providers we are key to driving change, is not cost-cutting, but the optimization of resource utilization. Optimization of resource utilization targets includes efforts to enhance efficiency and reduced waste. Examples include on-time starts, case turnover, driving same-day discharges, and improving quality to optimize length of stay, and in all of these, providers are critical to achieving and sustaining high-level performance.

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All physicians believe that they deliver the absolute best care to achieve the best outcomes, but how do we explain medical errors, complications, and delays in care?

All of these are an inevitable part of the practice of medicine. Every cardiologist wants to avoid all three. Minimizing the chance of any of these occurring requires clinical acumen, extensive training, expert technique, and attention to detail in a system that is designed for success. Appropriate patient selection, understanding and reducing patient risk, and tracking patient outcomes and complications and learning from them, is critical in this regard. As a cardiovascular community, we have led the way in medicine by submitting data to registries where we can track and benchmark our performance. Unfortunately, there are many situations where these data are not shared with the cardiologists or if they are shared, the data are discounted and dismissed by the provider. All too often, we minimize things like acute kidney injury (AKI) or readmission, and say, "those numbers just aren't reported correctly", "it really doesn't matter", or "I don't see that in my patients." As physicians, we pride ourselves on being data driven and outcome focused. Are we really?

Conclusion

By Ryan Graver, Divisional Vice President, Terumo Health Outcomes

Dr. Duffy, we thank you for agreeing to participate in this interview and for the incredibly important insights you shared from your experience. Entering 2022, our industry is clearly at a significant point. As you pointed out, with COVID impacting procedure volumes and staffing shortages driving up costs, the focus on achieving financial sustainability is likely to reach a fever pitch. It is hard to stress strongly enough just how imperative it will be for cardiologists and hospitals to find solutions that not only deliver the best quality-driven outcomes for the patient, but that are also cost effective for the hospital. Achieving these goals will require administrators and physicians to have the necessary data and metrics to substantiate performance improvements that in turn will ensure hospital and providers are achieving financial success.

Terumo Health Outcomes has accessed multiple benchmarking tools and analyzed every hospital's Medicare claims data in the United States in order to amass a reference on cost, quality, and cardiovascular service line financial performance.

If cardiologists are interested in comparing how their hospital performance stacks up against others and would like to learn about the solutions that Terumo can offer to help providers and hospitals achieve optimized performance, please contact us at **info@terumohealthoutcomes.com**. Our team is uniquely qualified to help physicians and hospitals address how and what is necessary to address the changing landscape. Our solutions are data-driven, seek to avoid cost, and are clinically focused. ■

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