
ISSUES IN CLINICAL PRACTICE

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Lessons in Managed Care

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DESPITE MANY PHYSICIANS' perceptions or hopes of immunity, managed care continues to grow and evolve, influencing the daily realities of practicing medicine. Change is inevitable and needed. We should meet the challenge by being proactive and creative rather than resisting. In helping to organize the Managed Care in Infectious Diseases conference in Chicago in June 1995 and sharing experiences since then, we note the emergence of a number of important lessons. Although everyone's situation and needs vary, the following 10 rules or lessons may be useful to consider as medicine evolves, especially in the specialty of infectious diseases.

Lesson 1: Your Slice of the Health Care Pie Is Shrinking

It is interesting to note that, despite managed care, the amount of money being spent on health care in the United States has not declined, either in actual dollars or as a percentage of the gross national product. Even the experts in cost control through managed care speak of a leveling off of spending as opposed to any true savings. In other words, the health care pie itself is not getting any smaller; however, the physician's portion or slice is shrinking while other sections, such as legal, marketing, and

administration are growing [1]. Although some physicians have not yet felt the impact of managed care, many have, and predictions of future income for specialists, and particularly subspecialists, are increasingly dire [2]. It is essential that we accept the future as quite different from the past. The slice of the pie that contains traditional hospital infectious diseases consultation services will continue to shrink. To compensate for the decline in hospital patients, we must be able to provide patient care services for people at home. There are opportunities in many other areas, as well [1]. We must also be prepared to demonstrate and prove our value or accept a reduction in income.

Lesson 2: Ask To Be Paid for What You Do

As a cognitive subspecialty with no exclusive procedures, infectious diseases physicians have traditionally provided expert advice in many areas without compensation [3-8]. Asking to be paid for this advice in an era of managed care is entirely reasonable, especially when physicians are asked to accept lower fee-for-service contracts. Even in a capitated or salaried environment, recognition of the value of these services is important to patient care and the survival of our specialty [1].

Examples of underpayment include direction of hospital infection control programs, microbiology laboratory services, quality assurance programs, and antibiotic formulary review. Other services, which may be more difficult to separate out and identify, include telephone or "curbside" consultations, travel advice, and guidance that we provide so that an institution can meet OSHA regulations. Expert time invested in these areas benefits patients and ultimately saves health care dollars, so compensation is clearly justified. There still are, however, administrators who do not accept the value of saving money as much as bringing in new revenues. Considerable planning and marketing skills are required to establish an infectious diseases position in every hospital with over 500 beds.

Lesson 3: Pursue Opportunities To Expand Your Services

Infectious diseases specialists' traditional consultative services account for an average of \$.04-\$0.15 per member per month (PMPM) in a capitated environment [1]. That amount can increase dramatically as new services are added. Contributions in additional areas also offer increased opportunity to risk-share with payors and to be rewarded for cost-efficient management. In a more integrated managed care environment, the ability to effect cost-savings increases the physician's value to an organization.

Some of the service areas to consider are outpatient intravenous antibiotic therapy, travel clinics, clinical research trials, human immunodeficiency virus (HIV) care, infection control and epidemiology, the microbiology laboratory,

employee health, and occupational health—specifically with regard to OSHA bloodborne pathogen regulations. The infectious diseases physician's skills and training can be a valuable addition to any area where data gathering, analysis, and reporting support effective decision making; for example, outcomes monitoring, information systems, resource management, and quality improvement programs [1,9–12].

Lesson 4: Begin To Gather Outcome Data—Now

Payors gather massive amounts of data regarding utilization of services, practice patterns, and cost, in addition to the demographic characteristics of their members. Most of this information is ignored, even though it may be useful. Physicians should begin to gather their own data, designing the indicators and collection methods to assure that measurements are both accurate and meaningful. At some point, the data may be used to demonstrate the physician's value, as well as to support a reasonable level of comfort with risk-sharing contracts. Beginning the process early allows for a learning curve, more control, the opportunity for internal improvement, and the option to be proactive and approach payors *before* the moment when actual survival may be at stake.

Data to consider collecting might include clinical outcomes for the diseases or infections representing a high percentage of the practice, especially those translating into high-dollar utilization of the health care system (e.g., cure and relapse rates, duration of hospitalization, length of parenteral therapy). Others should include patient satisfaction and practice costs. In choosing data points, physicians should con-

sider those reflecting costs and outcomes that they can realistically control or affect in the provision of care.

Lesson 5: Prepare and Use a Business Plan

It is essential that physicians devote appropriate time and resources to assessment, planning, and evaluation with regard to the business of practicing medicine. To remain in control of patient care, as well as survive financially, physicians must also develop business skills. They need to be able to analyze the past, set goals, and determine the feasibility of projects for their own practice or institution as would any successful business. They need to be accountable in managed care.

Lesson 6: Devote Time and Attention to Marketing

It is increasingly important for physicians to understand the market dynamics in their particular environment and to know whom to approach to get things done. Be prepared to articulate and demonstrate the measurable, value-added, and cost-saving services of the infectious diseases specialist. Other professionals, such as accountants, lawyers, marketing specialists, and even pharmaceutical representatives, may support and assist in these efforts. Their resources and expertise may facilitate the translation from a medical framework to business concepts in the language administrators and payors understand. However, do not underestimate the power of direct involvement of the physician in approaching and working with decision-makers. The idea that a doctor will actually sit down and discuss business plans, still a surprise

to many managers, carries considerable weight and respect.

Lesson 7: Be Prepared To Risk-Share

Physicians who practice in a region where capitation has not yet become the primary method for risk-sharing have a window of opportunity to prepare for its emergence. Prior to any commitment to this kind of full risk-sharing, it may be possible to plan a gradual integration of services billed through "bundled" charges, which are attractive to payors. An example might be to offer to provide outpatient parenteral antibiotic therapy to identified patients in return for a per diem charge that includes the supplies and nursing time. If that works, the cost of the laboratory tests required for monitoring can be included. Eventually, the cost of the antibiotic and even physician services can be incorporated [13]. Another example would be to accept a capitated PMPM or *per case* per month reimbursement that only covers physician services for a particular diagnosis, such as osteomyelitis or HIV, rather than all services and/or all patients [1,14,15].

It is advisable, however, to be cautious and careful prior to any commitment to risk-sharing. The physicians should have an accurate understanding of the costs involved, their own historical practice patterns, and the population of patients for whom they will be responsible under the contract. It may be of value to approach payors with an offer of assistance or partnership on a pilot project for a predetermined period. During this time, the cost-savings possible when an infectious diseases specialist is in control from the beginning can be demonstrated. Care of the HIV patient population is prob-

ably the safest example of risk-sharing potential for the infectious diseases specialist [1,14].

Lesson 8: Do Not Risk What You Do Not Control

Although it is feasible to provide services in many areas, it is not always possible to control the cost of providing them. To take a financial risk that depends on things or people that cannot be directly managed or controlled is a gamble.

An example of a high-risk situation of this kind might be when a physician contracts to provide outpatient services for a specified population of patients on a PMPM basis, without any control over hospital utilization. If the hospitals are capitated under the same plan and increase the number of early-discharge patients, the physician may be overwhelmed with the number and acuity of patients who require outpatient services.

Physicians should manage their risk as much as possible by gathering data about patient demographics and cost of care prior to negotiating capitated fees. Certain situations may be covered by a catastrophic reinsurance policy, such as new developments in drug therapy for HIV that increase costs well beyond what could have reasonably been expected during the contract period [1].

Lesson 9: Be Active Politically

Physicians must align with other physicians to provide effective input and lobby for change that does not compromise their ability to provide excellent patient care. Local, state, and national associations can be utilized, as well as smaller groups with similar interests. As managed care evolves, physicians'

input is required to assure decisions that are in the best interests of patients. These efforts will require a commitment of time and patience, as well as tenacity. Results will not usually be achieved overnight.

Lesson 10: Identify Opportunities for Improvement

Both cost efficiency and quality are key requirements for success in the managed care environment. Patients are, indeed, the customers of third-party payors, and their satisfaction and well-being are finally becoming as important as cutting costs. Physicians must be willing to systematically measure and evaluate their own practice parameters and behaviors. They must also provide leadership within their practice or institution in ongoing efforts to improve internal processes and quality of care.

Retrospective and concurrent outcome data should be gathered to profile clinical practice. Clinical pathways or guidelines may be used to standardize care as much as possible, project costs, and identify outlier situations [16–22]. Feedback and education for physicians and staff will be an effective mechanism to gain support and participation [23,24].

When potentially effective interventions are designed and implemented, it is important to measure the results after a reasonable period and to continue efforts to improve both clinical and business practice patterns.

In this time of transition of health care to a managed care system, the patient needs the involvement and leadership of physicians even more than before. There are many opportunities to improve patient care in this time of change—and to

demonstrate the value of the physician, as well as specialty services.

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Quotes, Images & Anecdotes

Each year the Annals of Improbable Research bestows the less-than-coveted Ig Nobel prizes for actual achievements "that cannot or should not be reproduced." Awards are presented at a formal ceremony in Cambridge, Massachusetts, followed by apres-Ig festivities, though recipients often do not appear to claim their prizes. Some past Ig Nobel prize winners:

CHEMISTRY. Jacques Benveniste, for his discovery that water, H₂O, is an intelligent liquid, and for demonstrating to his satisfaction that water is able to remember events long after all traces of those events have disappeared.

PHYSICS. Drs. Georget, Parker, and Smith of Norwich, England, for their rigorous analysis of soggy breakfast cereal, "A Study of the Effects of Water on the Compaction Behavior of Breakfast Cereal Flakes." (This award prompted a critical article in *Nature* by Sir Robert May, science advisor to the British government, who thinks that the Ig Nobel committee really ought to stop awarding these silly prizes because they ridicule serious science. Of course, the Ig Nobel Awards Committee supplied a crushing rebuttal, and Georget and colleagues accepted their award.)

PSYCHOLOGY. John Mack of Harvard Medical School and David Jacobs of Temple University, mental visionaries, for their conclusion that people who believed they were kidnapped by aliens from outer space probably were. Mack and Jacobs did not appear to collect their award. Those present were very concerned.

MEDICINE. Drs. Nolan, Stillwell, and Sands, for their painstaking research report, "Acute Management of the Zipper-Entrapped Penis."

ECONOMICS. Dr. Robert J. Genco of the University of Buffalo for his discovery that "financial strain is a risk indicator for destructive periodontal disease."

BIODIVERSITY. Chonosuke Okamura of the Okamura Fossil Laboratory in Nagoya, Japan, for discovering the fossils of dinosaurs, horses, dragons, princesses, and more than 1000 other extinct "mini-species," each of which is less than 1/100th of an inch in length.