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## Current trends in U.S. cardiology practice



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### ABSTRACT

Over the last six years, the practice of cardiology in the U.S. has experienced a substantial transition from independent practice to practices integrated within hospital systems. This change has been driven by major economic factors that have largely been determined by the federal government. Meanwhile, cardiologists' salaries and the demand for new cardiologists have remained stable. Best practices have embraced this new partnership with hospital systems to improve quality, cost, and access to cardiovascular care.

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### Introduction

In 2007, the president of the American College of Cardiology, Steve Nissen, commissioned a task force to focus on cardiology workforce solutions. At that time, it was felt that there was a workforce crisis. The task force concluded there were approximately 4000 open positions for cardiologists, and each of the 750 cardiologists graduating that year would have at least 6 good cardiology job offers [1]. The task force predicted the problem would likely worsen over the next decade given the epidemic of obesity (and concomitant heart disease) and the baby boomer bulge in our population with 3.3% of our population achieving Medicare age per year [1]. For a variety of economic reasons, the workforce crisis never materialized. This article will describe practice as it existed in 2007 and as it is currently practiced. It will explore the underlying economic drivers of the major shift to integration with hospital systems and re-evaluate the demand for new cardiologists. Finally, this article will comment on several positive trends that have emerged which are transforming the delivery of cardiovascular care.

### 2007

In 2007, 90% of cardiologists were in an independent private practice [1]. There were small and large groups, but the typical size was between 5 and 10 cardiologists within a single specialty practice. Governance was generally by the partner/owners of the practice. Smaller to midsize groups typically compensated themselves with an equal split of income, and there was little sub-specialization. Often times, general cardiologists also practiced intervention and vice versa. Larger groups tended to be more subspecialized and had more sophisticated professional management. These larger groups often compensated themselves according to a productivity-driven plan or a blend between productivity and sharing. Large and small groups made use of extenders about a third of the time, and it was recognized that non-physician providers were able to generate revenues 2–3 times their salary. In some larger groups, team-based care became very highly developed, especially in heart failure/transplant programs and device clinics. The workforce consisted of a large portion of older cardiologists (44% were over the age of 55 years) (Fig. 1), and many of

Conflicts of interest: Suzette Jaskie receives consulting fees regarding practice of cardiology and structure of the industry from Boston Scientific and St. Jude Medical.

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<http://dx.doi.org/10.1016/j.tcm.2014.08.005>

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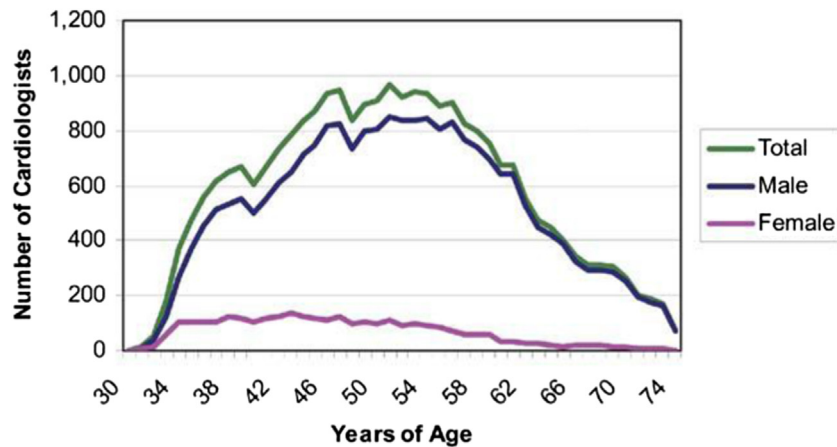


Fig. 1 – Cardiologist age distribution (2008). (Adapted with permission from Rodgers et al. [1].)

these cardiologist had done well financially up until then. Early retirement was at a higher rate than it is today.

Large and small groups had basically the same economic engine in 2007. Approximately 28% of revenues came from the technical aspect of testing [2]. Thus, large and small groups tended to perform echocardiography and nuclear imaging within their offices. The fees for technical work whether performed in the office or the hospital were identical. Overall testing represented 50% of a typical group's revenue, 29% of revenues were derived from evaluation and management codes, and 15% of revenues from procedures. Dr. Jere Hines, Cardiologist and Former Governor of the Illinois Chapter of the ACC, stated it this way: in a typical practice, 1 cardiologist was paid for by testing, 3 from evaluation and management codes, and 2 from procedures [2].

Although cardiologists were involved in quality initiatives such as National Registry of Heart Catheterization & Intervention (ACC NCDR-PCI, managed by the ACC) and Door-to-Balloon Time (D2B; National program for emergency PCI for patients presenting with acute myocardial infarction), these programs were largely managed by hospital administrators. The ACC Pinnacle (outpatient) registry had just been delivered and was almost stillborn due to the workflow problems created with electronic medical records. The American College of Cardiology made great efforts to educate its members about the appropriate use of expensive testing such as nuclear. It was also recognized that healthcare was becoming an increasingly larger portion of the gross domestic product in our country, reaching over 16.2% by 2007 [3]. However these efforts were largely unsuccessful presumably because these tests generated such a large revenue margin for private practice groups.

## Variation of care

In the mid-2000s, the Dartmouth Atlas of Health Care issued a report indicating that there was a huge variation in cost and in the number of procedures done regionally. For example, in the treatment of chronic stable coronary artery disease, there was up to a several fold difference in cost in comparing cardiology care in Miami, Florida versus Salem, Oregon [4–7]. However, there was no difference in outcomes or patient

satisfaction. This information and evidence-based guidelines led to the development of appropriate-use criteria by the American College of Cardiology [8]. This initiative produced modest impact, however, at the sacrifice of a decrease in revenues (Fig. 2).

## 2008–2010

Economic and other industry factors substantially changed practice economics. The first major economic change driver came in 2008 with a financial meltdown in the United States. Overnight, the demand for new cardiologists started to decline as the older cardiologists—who were retiring early—were now staying on the job. The second major driver impacting practice economics was declining reimbursement for physician services and the increasing reimbursement delta between services provided by physician entities and those provided by hospitals. The third economic driver impacting practice economics is characterized by understanding circumstances impacting utilization. The rising number and increasing prevalence of Radiology Benefit Managers and the publication of the COURAGE Trial added up to fewer services for cardiologists to provide. These factors combined put tremendous financial pressure on cardiologist practices with physician compensation as the only “balancing account.”

## 2010: The carrot and the stick

### 2010 Medicare physician fee schedule

Even though American physicians take pride in the fact that the federal government does not control *all* of healthcare, it controls a substantial portion. It controlled enough that 61% of all practicing cardiologists in the U.S. dissolved their private practices and integrated with hospital systems (Fig. 3). It remains uncertain whether this was a deliberate strategy of the Medicare Payment Advisory Commission (MedPAC) to push independent cardiologists into larger entities or an accidental consequence of a sequence of poorly timed rule changes based on bad data. MedPAC had apparently observed a significant growth in Medicare part B

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