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*June 2007*

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## Three New Books Offer Insight into Medicine

Physicians have a lot of lessons to learn from the retail industry. That's one of the points Regina Herzlinger, PhD, makes in her new book, *Who Killed Health Care: American's \$2 Trillion Medical Problem—and the Consumer Driven Cure*, (McGraw-Hill, 2007). Sometimes called the “Godmother of consumer-driven care,” Herzlinger asserts that there is a full-blown attack on the structures and architects of our present health care system. “Four armies are battling to gain control: the health insurers, hospitals, government, and doctors. And the doctors, the group whose interests are most closely aligned to consumers' welfare, are losing.” Only patients working with their doctors can prevent further damage, says Herzlinger, a senior fellow at the Manhattan Institute for Policy Research and the first woman to be tenured at the Harvard Business School as the Nancy R. McPherson Professor of Business Administration.

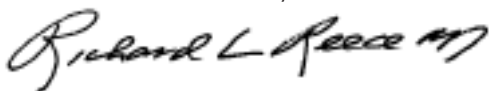
Herzlinger suggests that the health system needs smaller, disease-focused medical facilities, a national system of medical records, mandatory performance evaluations of all medical organizations, and mandatory health insurance.

In addition to Herzlinger's publication, two other books offer insight into current medical practice. One is *Better: A Surgeon's Notes on Performance*, (Henry Holt and Company, 2007) by Atul Gawande, MD. A surgeon and writer, Gawande is a staff member of Brigham and Women's Hospital, the Dana Farber Cancer Institute, and *The New Yorker* magazine. He is also an assistant professor of surgery at Harvard Medical School.

In his book, Gawande says doctors can do better by always washing their hands between patients, being diligent, possessing moral clarity, and always striving to improve. The book consists of a series of inspirational case studies. His suggestions for becoming a positive deviant (someone at the top of the bell curve) are: ask unscripted questions, don't complain, write something, and change.

The second book that offers insight into current medical practice is *How Doctors Think*, by Jerome Groopman, MD (Houghton Mifflin Company, 2007). Groopman is a member of the Harvard Medical School faculty and a writer for *The New Yorker*. He explores why doctors miss diagnoses, gives a series of cogent examples, and examines the flaws in cognitive thinking and impulsive biases that lead to diagnostic mistakes. Although Groopman is a graceful essayist, the book is disappointing for two reasons. First, Groopman seems to have a negative attitude toward using information technology as a diagnostic support tool, and second he fails to offer practical solutions for how busy practitioners can avoid misdiagnoses.

Taken together, these three books offer excellent insight into the operations of the current health care system.



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# Hospitalists Are Improving Patient Care

**H**ospitalist care has gained wide recognition from primary care physicians and specialists such as cardiologists, gastroenterologists, nephrologists, oncologists, orthopedists, pulmonologists, and rheumatologists, among others. These physicians are working with hospitalists to co-manage their inpatients, and are touting hospitalist care as a useful strategy for improving care quality and enhancing their own practice efficiency.

A survey last year by the Clinical Advisory Board in Washington, D.C., showed that 40% of all 5,000 U.S. hospitals currently employ hospitalists. Larger hospitals use hospitalists more frequently than smaller facilities. The survey showed that 71% of hospitals with 500 or more beds employ hospitalists, 55% of hospitals with 200 to 499 beds use them, and 45% of hospitals with 100 to 199 beds employ them.

## Market Trends

The use of hospitalists has increased as a result of several factors, including rising financial pressures on both community physicians and hospitals, the increasing cost of malpractice insurance, and concerns about patient safety, according to a study published in the *Journal of General Internal Medicine*, "Health Care Market Trends and the Evolution of Hospitalist Use and Roles" (*J Gen*

*Intern Med.* 2005 February; 20(2): 101–107).

"Certain specialties very quickly welcomed hospitalist involvement in patient care," says Ronald Greeno, MD, adding that the strategy holds some untapped potential for certain specialists, particularly those who are used to taking care of their patients' general medical problems. Hospitalist care is particularly helpful for specialists whose patients tend to have multiple medical problems.

Greeno, a pulmonologist, is a founder and chief medical officer of Cogent Healthcare Inc., a company in Irvine, Calif., that provides comprehensive hospitalist programs to hospitals nationwide. Since 1993, he has practiced as a hospitalist at Good Samaritan Hospital in Los Angeles, where he also serves as co-medical director of the ICU and respiratory medicine department.

Edward T. Casey, DO, a hospitalist and an instructor of medicine in the Department of Hospital Medicine at the Mayo Clinic in Rochester, Minn., says, "Hospitalists have a unique perspective on the care of hospitalized patients. Because they focus on inpatient care, they are very knowledgeable about hospital processes and know how to get things accomplished quickly and efficiently. They also ensure that a patient's needs are met at discharge."

Kim Le, MD, a nephrologist with

Premier Nephrology in Los Angeles, finds hospitalists manage patients' overall medical problems while addressing all issues that may arise. The three nephrologists in Premier Nephrology have worked with the hospitalists at Good Samaritan Hospital for seven years.

"Hospitalists help ensure the continuity, coordination, and timeliness of care," Le comments. "The hospitalist is already there in the hospital and is always available and responsive, whatever the patient needs."

Greeno agrees. "For example, most ESRD patients have multiple comorbidities, possibly including diabetes, peripheral vascular disease, coronary disease, hypertension, or lupus," he says. "The opportunity to delegate the management of these complex medical problems to a hospitalist during a patient's hospital stay makes the hospitalist model attractive to nephrologists."

## Changing Medical Priorities

One reason hospitalists are needed is that managed care has focused on keeping patients out of the hospital and shortening lengths of stay. As a result, hospitalized patients in general are sicker today than they were years ago, requiring closer observation and more intense care.

Mary Jo Gorman, MD, MBA, chief executive officer of Advanced ICU Care in St. Louis, says, "Years ago,

(Continued on page 4)

**"Hospitalists have a unique perspective on the care of hospitalized patients. Because they focus on inpatient care, they are very knowledgeable about hospital processes and know how to get things accomplished quickly and efficiently. They also ensure that a patient's needs are met at discharge," says Edward T. Casey, DO, a hospitalist and instructor of medicine at the Mayo Clinic.**

(Continued from page 3)

most physicians would typically have a lot of patients in the hospital at any given time. They would spend three or four hours each day at the hospital seeing five to ten inpatients, and then return to the office to treat their other patients. However, due to reimbursement changes that reduced length of stay and prompted a movement toward outpatient surgery, a physician may have only one or two patients in the hospital. From both an efficiency and a financial standpoint, the physician is better off referring those patients to a physician who is in the hospital all day taking care of inpatients." Advanced ICU Care provides intensivists via telemedicine to ICUs nationwide.

Studies show that care by hospitalists reduces lengths of stay, Gorman adds. "That may not seem like a quality of care issue, but in light of data on hospital error rates and rates of nosocomial infections, shorter inpatient stays lessen patient exposure to risks," she says.

### Benefits for Physicians

Gorman is the president of the Society of Hospital Medicine in Philadelphia, which says about 75% of hospitalists have trained as internal medicine physicians and 11% have trained as general pediatricians. "This training enables hospitalists to provide care to a wide variety of patients, beyond those with internal medicine diagnoses," Greeno explains. Such training allows hospitalists to co-manage patients with surgeons and other specialists, providing general medical care and helping to prevent complications.

"In the presence of a hospitalist program that can deliver high quality care and a high level of service to patients, there are significant advantages for specialists and subspecialists to having a hospitalist oversee their cases in the hospital," Greeno says.

One such advantage is that a hospitalist program allows physicians to maintain a specialty-specific focus.

## Practices Benefit from Hospitalist Care

Specialists can enhance their income by having hospitalists provide primary care to the specialists' hospitalized patients while the specialists provide only the care pertaining to their specialty.

"Specialists do not receive higher reimbursement for the care of a hospitalized patient when handling the totality of care than they would if they were just seeing the patient in the role of consultant, and in most cases, they will be paid less," says Ronald Greeno, MD, a pulmonologist and founder and chief medical officer of Cogent Healthcare Inc., in Irvine, Calif.

"A consulting physician is reimbursed more for a specialist consult than for a history and physical (H&P) and other services provided as a primary care physician," Greeno says. "On the day of admission, if the hospitalist performs the H&P and the specialist dictates a note that indicates the specialist is a consultant, the specialist will be paid more and spend less time than if the specialist functions as the primary care physician and codes the initial dictation as an H&P," Greeno explains. "Financially, the specialist is better off continuing to function and bill as a consultant while the hospitalist co-manages the patient during the course of the hospitalization."

Hospitalists also help community physicians improve practice efficiency and, therefore, outpatient revenue. "Hospitalist care allows community physicians to spend less time at the hospital, freeing more time in their schedules to treat patients in the office," Greeno notes. As a hospitalist, Greeno performs H&Ps, follows patients every day, and writes post-operative orders and discharge summaries. "This is all work that the specialists do not have to perform," he adds.

Edward T. Casey, a hospitalist and an instructor of medicine in the Department of Hospital Medicine at the Mayo Clinic in Rochester, Minn., agrees that physicians can increase their outpatient volume if hospitalists are helping to provide care for their inpatients.

"Hospitalist care frees physicians to treat more patients in the outpatient arena, because they do not need to spend as much time at the hospital," Casey explains. "Additionally, hospitalist care considerably reduces interruptions due to patient-related calls from the hospital. In my experience, most of those calls are not specialty-specific, but rather involve general medical questions that can be easily handled by a hospitalist."

—DJN

"Physicians train in a specialty in order to practice specialty medicine," Greeno asserts. "Hospitalist care frees specialists to practice their specialty, because they have a primary care physician taking care of the general medical problems of their patients while the patients are hospitalized. The specialist does not have to be accountable for all the small, general medical decisions that are made during a hospitalization."

Consider the case of a diabetic patient with renal failure who needs dialysis, and is admitted to the hospital for placement of access. "If there is a hospitalist on staff, the nephrologist will see the patient on the day of admission and continue to supervise daily care from a renal standpoint, while the hospitalist will manage all of the other care needs of the patient," Greeno explains. "In the absence of a hospitalist, the

# Number of Hospitalists Is Rising Steadily

The Society of Hospital Medicine (SHM), in Philadelphia, defines hospitalists as physicians whose primary professional focus is the general medical care of hospitalized patients.

A growing number of physicians serve as hospitalists across the country. According to SHM data, approximately 15,000 hospitalists are practicing in the United States. The SHM estimates that 30,000 hospitalists will be practicing by 2010.

The term “hospitalist” was coined in an article, “The Emerging Role of ‘Hospitalists’ in the American Health Care System,” published in 1996 (*N Engl J Med.* 1996 Aug 15;335(7):514-7). Hospital-based specialists have long existed in Europe and Canada. Founded in 1997 to promote high quality in the practice of hospital medicine, SHM says hospital medicine is the fastest growing field in the history of medicine in the United States.

—DJN

nephrologist manages all care of the patient, including relatively minor and more complex issues related to the patient’s diabetes and other comorbidities. For example, if there is no hospitalist on duty, the nephrologist will get the call at night when the patient needs a sleeping pill or a pain reliever, and will have to write the sliding scale prescription for insulin.”

Gorman of Advanced ICU Care agrees, saying, “Most of the phone calls made to physicians after hours come from the hospital. By eliminating hospital responsibilities, the physician can reduce nighttime phone calls and improve his or her quality of life.”

What’s more, because hospitalists are on-site, they can respond to each patient’s needs quickly, enhancing quality of care and patient satisfaction. “Patients who receive hospitalist care tend to have shorter lengths of stay, and generally are more satisfied with the care they receive,” observes Casey of the Mayo Clinic. “This is because hospitalists are on site every day, all day. So, they are available to quickly respond to problems and questions.”

In addition, the hospitalist under-

stands the patient’s circumstances and health condition, Gorman comments. “Therefore, the hospitalist is a good advocate and can help the patient get the care he or she needs in a more timely way,” she says.

Studies show that hospitalists enhance quality and efficiency of care. In a study of 5,300 patients, researchers found that over two years, patients of hospitalists exhibited lower in-hospital mortality rates and lower mortality rates at 30 and 60 days following discharge. The study was published in an article, “Implementation of a Voluntary Hospitalist Service at a Community Teaching Hospital: Improved Clinical Efficiency and Patient Outcomes,” (*Ann Intern Med.* 2002 Dec 3;137(11):I16). A second study “Effects of Physician Experience on Costs and Outcomes on an Academic General Medicine Service: Results of a Trial of Hospitalists” (*Ann Intern Med.* 2002 Dec 3;137(11):I25) in the same issue of 6,500 patients reported that hospitalist care was associated with lower short-term mortality, and that disease-specific hospitalist experience may reduce resource use and improve patient outcomes.

Another study published in an article, “Associations With Reduced Length of Stay and Costs on an Academic Hospitalist Service,” (*Am J Manag Care.* 2004;10:561-568) said, “Patients managed by hospitalists had shorter lengths of stay and lower costs than patients managed by nonhospitalists, but had higher costs per day. These results suggest that hospitalists increase the intensity of care and may have their greatest impact on specific types of patients and classes of hospital costs.”

## Gaining Acceptance

While some physicians will welcome the opportunity to work with hospitalists, some physicians may prefer not to change their practice patterns and so may resist the idea of working with hospitalists, at least at first. “Physicians take a while to get used to any new idea,” Gorman comments. “But after one or two interactions, most community physicians find that they can rely on hospitalists to provide excellent care, and they embrace the idea.

“When sending a patient to the hospital, the community physician should contact the hospitalist and provide information about the patient’s diagnoses, medications, and other pertinent information,” Gorman suggests. “Unfortunately, it is not uncommon for a hospitalist to call a doctor’s office and find that no one is available to discuss the patient. Adequate information transfer is needed to optimize care quality.

“Community physicians also should communicate to their patients that they are being referred to a hospital specialist who will care for them while they are hospitalized,” Gorman says. “That way, the patients are not taken by surprise when a hospitalist begins providing care.”

—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).

# Strategies for Leveraging Resources

By John W. McDaniel

The art of leverage involves using one's available assets such as financial or intellectual assets to a positional advantage. The word leverage leads most of us to envision a lever in action, and that's exactly what physicians can do with the various components of a medical practice. They can leverage practice assets to improve operational performance and maximize resources.

One of the most effective levers is our mind! Robert T. Kiyosaki, co-author with Donald Trump, of *Why We Want You to be Rich: Two Men—One Message*, (Rich Publishing LLC, Scottsdale, Ariz., 2006) said, "We have been given the most powerful lever on earth, our minds. So use your mind for leverage."

## Five Practice Areas

When leveraging practice assets, processes, and procedures, the real advantage in a medical practice with respect to leverage includes standardization of processes. There is a best way to answer the telephone, a best way to submit a medical claim, a best way to motivate employees, and a best way to notify referring physicians, among others. Highly successful companies, such as Exxon and Home Depot, do not invent new processes each time they open a new location. Similarly, medical practices must strive toward standardization to achieve more with less. Furthermore, standardization simplifies the internal processes necessary for enhanced

practice results through the five key areas in every medical practice. The five key processes in practices are:

1. Reimbursement systems
2. Billing and collection systems
3. Accounts receivable management
4. Operations improvement
5. Practice growth.

Since there is one best approach for the management of both insurance accounts receivable and patient balance accounts receivable, for example, why do most medical practices fail to use the most common approaches in a disciplined fashion? Accounts receivable management is the number one concern among medical practices.

Even though many successful physicians are at maximum capacity with respect to their patient volumes, these physicians have shown they can improve results, even in an era of increasing governmental regulations and declining reimbursement.

## Improving Reimbursement

To ensure long-term success, physicians must compare themselves to and learn from organizations that are effective and achieve excellent results. For example, like other businesses, medical practices must adopt business solutions from other industries such as workflow production models and customer service tactics, to differentiate themselves as high performance practices.

Benchmarking criteria are available through the Medical Group Management Association (MGMA) in Boulder, Colo. MGMA has data on medical practices by specialty and separate information on the performance of individual medical groups. While most medical groups find it beneficial to compare their historical performance, it is also necessary to

compare themselves against their most successful peer group in order to determine their overall level of performance and identify opportunities for improvement.

One of the most important areas of excellence to examine involves reimbursement systems. This area should focus primarily on evaluating coding patterns, practice fee schedules and managed care contracts, fixed-fee arrangements, and coding compliance programs.

While most medical group managers believe the single most important priority is managing overhead, expenses are one of the five levers for improving medical practice results. The other four areas focus on billing and collections and practice growth. While expense management is important, the best one can hope for is to reduce expenses to zero. On the other hand, appropriate revenue cycle management could lead to sustained financial improvement for years to come.

Coding compliance is a significant area of concern for all physicians since most physicians tend to undercode claims. Indeed, physicians tend to overbill for what they document and tend to underbill for what they provide. High performance physicians conduct ongoing analyses of levels of service utilization for major evaluation and management codes against the Centers for Medicare & Medicaid Services (CMS) audit standards to determine potential undercoding or overcoding. These practices also conduct chart audits or have contractors do audits for them.

Audits ensure that the documentation and medical necessity support the various levels of service behind each code. This information can be presented for each individual physi-

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cian for educational purposes to improve the coding accuracy for each physician and to serve as evidence for coding compliance in the event of a government audit.

### **Evaluating Performance**

Here are two other examples of revenue cycle management techniques that high performance physicians use. One is consistent review of managed care contract terms and reimbursement rates. Another is comparisons of the charge/collection ratios for all major payers to determine the effectiveness of various managed care contracts and whether these contracts should be renegotiated or renewed.

Interestingly, few practices conduct managed care contract compliance audits whereby patient accounts are reviewed randomly to ensure that the managed care companies are reimbursing per the contracted fee schedule. Yet, these audits frequently uncover an amazing number of inaccurate payments. The managed care companies have highly trained professionals reviewing claims and paying bills but as in all such operations, these people make mistakes. Also, various practice management programs include modules designed to ensure that the various managed care companies send the appropriate payments.

### **The 80/20 Rule**

As physicians consider benchmarks to evaluate their performance, the initial task may seem overwhelming. Therefore, experts recommend using the 80/20 principle: 80% of a practice's income will come from using 20% of their CPT-4 (procedural) codes and 20% of their ICD-9-CM (diagnosis) codes. Therefore, it becomes imperative that high performance physicians know everything about the 20% of their business that represents 80% of their income.

While these initiatives are not all inclusive, they will help improve reimbursement systems and show the areas

## Efficient Practices Follow Established Procedures

Highly efficient practices have policies and procedures for all important business operations. These practices benefit by having better cash flow as a result of collecting funds faster than practices that do not have such policies and procedures.

Here is a list of the areas of business operations for which highly efficient practices have developed, implemented, and regularly revise written policies and procedures in two areas (front office and business office).

### **Front office operations**

- Patient scheduling and registration
- Insurance verification and eligibility
- Over the counter collections of co-payments, deductibles, and outstanding balances and non-covered services
- Coding validation
- Charge entry
- Referral management.

### **Business office operations**

- Initial billing, which includes pre-billing edits, electronic claim submission and validation, and review procedures for claims
- Rebilling, which includes account follow-up, secondary insurance, rejections, and denials
- Payment posting, which involves tracking claims filed with each insurer
- Claims denial and rejection monitoring and management
- Payer contract compliance
- Transfer of patient balances to self pay accounts, which involves managing self pay accounts and patient payment plans
- Accounts receivable management, which includes monitoring of collection agency performance and write-offs for charity, physician requests, and for administration requests. AR management also includes managing the timely and proper filing of insurance claims and writing off amounts for aged AR reconciliation.

—JWM

that need consistent attention if a group is to perform at a peak level. The next issue to address among the five levers of results for medical practice improvement involves billing and collection processes. The most common thread among under-performing medical practices involves patient billing, collections, and accounts receivable management.

Again, highly efficient physician groups use the 80/20 principle when improving their billing and collection processes. In most medical practices, about 80% of patient revenue comes from 20% of the major payers. In addition, these practices are constantly

reviewing a variety of key financial and operating indicators such as the ratio of gross and adjusted charges to collections ratios to determine both the efficiency of the office staff and the payment turnaround rate from insurers and patients. The goal is to get paid faster so that the practice has lower amounts outstanding.

It is also important to validate reimbursements received from managed care companies since often practices are not reimbursed at the contracted amounts. Practices should consider an editing module to ensure that managed care rates are paid accurately. Also, practices can periodically

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double check reimbursement rates by doing audits.

Another important aspect of this area involves credit balances. The Office of the Inspector General (OIG) of the federal Department of Health and Human Services encourages the prompt refund of patient balances within 60 days of discovery, particularly for Medicare patients.

Many practices make it a priority to collect copayments at the time of service. In its publication, *Performances and Practices of Successful Medical Groups*, the MGMA says better performing practices collected copays and deductibles at time of service 93.55% of the time while other practices collected at a rate of 71%. Indeed, collecting copays before or after a visit has become increasingly important for all practices as Medicare and insurance reimbursement has declined. The average primary care practice gets 15% to 20% of the its total income from over the counter collections.

### Collection Procedures

The reason peak performing physicians are successful in billing and collections is because they have specific programs dedicated to these areas of concern. These practices have formal policies for instituting patient payment plans and to monitor the payments from patients who have agreed to pay regularly. Usually, these patient payment plans include a promissory note that the patient signs when executing the plan.

The most efficient practices take advantage of their respective state prompt payment laws by following up on claims filed 30 to 60 days earlier. If such claims remain unpaid, these practices make telephone inquiries to the appropriate insurers and use their state's reporting procedures to inform the state insurance commissioner about delinquent insurance company payments.

When consultants review the

## Sample Recommendations for Efficient Operations

Some group practices fail to establish standard operating procedures for routine business office activities. A recent assessment of a typical practice showed the practice needed to take the following steps to improve its business operations in five areas: business office operations, patient registration, billing and collections, accounts receivable, and internal controls.

### Business office operations

- Review, revise, and implement written financial policies and procedures
- Use the practice's information system to schedule appointments
- Gather benchmark data for performance monitoring
- Develop claim denial and rejection follow up reporting procedures
- Do a charge validation study to ensure accurate reimbursement
- Conduct an in-service training program each quarter for all physicians and appropriate clinic staff
- Review the professional fee schedule annually.

### Patient registration

- Monitor and report on the reasons for rejections and denials
- Develop monthly targets for over the counter collections
- Establish an effective patient recall system
- Monitor and report on all cancellations and no shows.

### Billing and collection processes

- Monitor collection agency performance quarterly
- Track patient payment plan compliance
- Monitor credit balances to ensure prompt refunding of overpayments
- Train staff to decrease claim rejection and denial errors
- Ensure consistent insurance verification and pre-authorization.

### Accounts receivable management

- Develop segregated aged trial balances by major payers to facilitate follow up with outstanding account balances over 30 days
- Audit accounts receivable and claim denials each month
- Consider using a credit bureau for excessive account delinquencies
- Use state prompt payment laws
- Increase surveillance of charge/collection/adjustment ratios by payer to detect areas of low reimbursement or delayed payments.

### Internal controls

- Have a chart audit committee ensure that the practice captures all appropriate charges each month
- Develop a coding compliance program, focusing particularly on coding and documentation of medical necessity.

—JWM

processes involved in patient visits, collections at the point of care, billing and rebilling, claims denial and rejection follow up, they find that the most efficient practices collect on outstanding claims faster than other groups simply because they have developed and follow procedures for each step in the collection process. It is no surprise

that the common thread of poor performance in medical practices is usually a weak billing and collection process. At the same time, these processes are also one of the strong points among peak performing medical practices.

—More information on practice management is available on our Web site (see page 16).

# NPs, PAs Enhance Care, Access

**M**any physicians looking for ways to see more patients and enhance the quality of care they provide have hired nurse practitioners (NPs) and physician assistants (PAs). Physicians working with these clinicians typically report that these professionals make valued additions to the practice. Both physicians and patients appreciate the need these professionals fill in group settings.

“PAs and NPs can enhance quality of care for the patient, productivity for the practice, and professional satisfaction for the physician,” says Nancy Hughes, vice president of communications and information services at the American Academy of Physician Assistants in Alexandria, Va. “Adding a PA can generate additional revenue, enhance patient volume, reduce costs, and free physicians to treat patients with more complex conditions that require their expertise.”

## Avoiding Complications

Mary Jo Goolsby, director of research and education for the American Academy of Nurse Practitioners in Austin, Texas, says nurse practitioners have been adding value to practices for 40 years. “NPs are very thorough providers,” she comments. “They communicate well, get to know their patients, and ask the right questions. Because they have a special interest in patient education and health promotion, they can help

their patients understand how to maintain their health. They also help patients with chronic illnesses learn how to avoid, recognize early symptoms of, and respond to complications. Research has consistently demonstrated that NPs provide high-quality, safe, and effective care.”

NPs and PAs practice in virtually every specialty. According to the AAPA’s 2006 census, which included more than 23,000 respondents, PAs practice in more than 60 subspecialty fields. About 38% practice in the primary care specialties of family medicine, general internal medicine, general pediatrics, and ob-gyn. Other common specialties include general surgery/surgical subspecialties (25%), emergency medicine (10%), internal medicine subspecialties (11%) and dermatology (3%).

There are more than 115,000 NPs practicing in various settings across the United States, Goolsby says. About two-thirds of NPs practice in primary care settings such as a family practice, internal medicine, pediatrics, or women’s health, and NPs also work in all subspecialty areas.

## Delegating Duties

The background and training of NPs and PAs can vary; NPs are registered nurses who have pursued advanced academic and clinical experience through accredited NP programs. While most NPs have a nursing background, PAs may come from a variety of allied health careers,

including the military and nursing. PAs typically have a baccalaureate degree as well as a degree from an accredited PA program, which focuses on primary care.

While NPs and PAs practice under different state regulations regarding allowable responsibilities, their duties can be similar. Typical responsibilities for both NPs and PAs include taking histories; performing physical exams; ordering and interpreting diagnostic lab work, x-rays, and electrocardiograms; diagnosing and treating common health problems; prescribing or recommending medications or treatment; providing education and counseling; and completing patient-related paperwork. PAs also assist in surgery.

“The type of provider that is best for a medical group depends on the needs of the patients, the needs of the practice, and the needs of the physician,” Hughes explains.

## Meeting a Group’s Needs

The responsibilities of a PA or NP relate to several factors. One factor is simply experience and skill. For example, Michael L. Powe, director of health systems and reimbursement policy at the AAPA, explains that physicians have much latitude in deciding which duties to delegate to PAs. “The physician may decide to delegate the more routine cases or the follow-up of patients with chronic conditions,” he says. “Or the physician may decide that both the

*(Continued on page 10)*

**PAs and NPs can be a successful addition to practices that want or need to enhance patients’ access to care. If a practice is experiencing complaints that physician appointment wait times are too lengthy, then employing a PA or NP can improve patient flow and decrease wait times.**

(Continued from page 9)

physician and the PA will see patients on a first-come, first-served basis. In addition, physicians often expand the range of PA duties over time as they become more comfortable with the PA's demonstrated abilities."

The duties performed also depend on the type of practice involved. "PAs do histories and physicals, perform evaluations, and order tests," Hughes says. "They diagnose conditions, prescribe medications, and, working with a physician, admit patients to the hospital. Typically, PAs handle the more routine cases in a practice, as well as provide ongoing follow-up care and monitoring of patients with chronic conditions. In a surgical practice, for example, PAs perform pre-operative evaluations, assist in surgery, offer post-operative care, perform hospital rounds, and complete discharge orders."

NPs in a community-based practice are licensed independent providers, typically offering the full range of care to their own panel of patients. In a subspecialty practice, the NP may treat certain subsets of patients in a lipid or anemia management clinic, for example, or other disease management setting. Some NPs handle the initial portion of the patient visit for the specialist and then provide follow-up education and ongoing monitoring and care.

### Improving Care Access

PAs treat patients with physician supervision. "The physician does not have to be onsite 100% of the time, but must at least be available by electronic communication," Hughes notes. AAPA knows from its member surveys that 60% of PAs perform minor surgical procedures, 38% manage inpatient care, 24% first-assist at surgery, 19% supervise clinical staff other than PAs, and 40% take call for their primary employers.

PAs and NPs can be a successful addition to practices that want or need to enhance patients' access to

## State Requirements Govern Practitioner Usage

The most important responsibility for physicians using nurse practitioners or physician assistants involves following state requirements governing the duties they can and cannot delegate to NPs and PAs.

"Rather than providing a laundry list of allowable duties, most state laws governing PA care are fairly generic, and simply allow PAs to provide those services that are delegated by the physician and are within the physician's scope of practice," says Michael L. Powe, director of health systems and reimbursement policy at the American Academy of Physician Assistants in Alexandria, Va. "However, there may be some unique limitations based on state law, so physicians should examine their state's law prior to defining PA responsibilities."

The AAPA's Web site offers a summary of state-specific PA regulations and contact information for all state PA licensing boards ([www.aapa.org/gandp/gov-issues.html#laws](http://www.aapa.org/gandp/gov-issues.html#laws)). Physicians must also review state laws to understand allowable NP duties.

care. If a practice is experiencing complaints that physician appointment wait times are too lengthy, then employing a PA or NP can enhance patient flow and decrease wait times.

"When physicians find that they have a heavy patient load but can't or don't want to add a physician to the practice, hiring a PA is often a good strategy," says Powe. "If physicians find that wait times for appointments are 7 to 14 days or more, they may be losing patients to other practices. If physicians are working long hours trying to treat all the patients who need care, their own quality of life may suffer. If physicians are running back and forth between their office and the hospital in order to cover patients, they may need to delegate some responsibilities. All of these situations represent golden opportunities for incorporating a PA into a practice."

Goolsby says, "Anytime physicians are considering adding another provider because of high patient volumes or long appointment wait times, they should consider an NP as a viable resource for the practice."

At Gastroenterology Consultants, Ltd., a nine-physician group in

Milwaukee, PAs take patient histories and perform physicals in advance of the physician consultation. "The PAs see almost every patient before the physicians walk into the room, so that we can treat almost twice as many patients in the same period of time," says Joseph Geenen, MD, a physician in the practice.

### Successful Relationships

To maximize NP or PA productivity, physicians must understand the individual's scope of practice, education, and experience. "If the physician hires a PA and simply uses that individual as a glorified medical assistant or nurse, then the practice will not be maximizing the potential payoff from the PA, nor will the PA be happy," Powe notes.

"Our NPs are not physician substitutes, but collaborative partners," says Michael Oblinger, MD, a gastroenterologist with Charlottesville Gastro-enterology Associates in Virginia. "NPs get referral information, take the patient's history, do the physical, formulate their thought processes about the problem, and present the patient's case to us. The doctors then see the patient in conjunction with the NP. After a procedure, the NP

explains the medications and next steps for follow-up and self-care, and then dictates the examination note.”

Typically, PAs and NPs are highly productive additions to practices. According to the Medical Group Management Association’s *Physician Compensation and Production Survey: 2006 Report Based on 2005 Data*, PA and NP compensation is typically only one-quarter to one-third of their gross charges.

Virtually all public and private payers reimburse for the medical and surgical services that PAs provide. Medicare, Medicaid, and the vast majority of commercial payers in the United States cover services that PAs provide, but the actual rate of reimbursement may differ.

“Most private payers reimburse medical services provided by PAs at 100% of the physician rate, while others may discount the fees by some small percent,” Powe says. “Physicians should survey payers in their own area to get a sense of what PA duties are being covered at what rate of payment.”

NP services are reimbursed, but amounts and circumstances vary, Goolsby says. “Physicians should review their own payer contracts to determine stipulations regarding NP reimbursement,” she advises.

Physicians seeking to get the most value from their use of PAs and NPs should introduce each one formally to patients and to other physicians and demonstrate confidence in their care skills. “Physicians should educate patients and physician colleagues who send referrals to or receive referrals from the practice as to the PA’s competence and range of duties so that they will feel comfortable working with the PA,” Powe counsels.

“When we began using NPs, we provided patients with written infor-

## Practices Find Providers Improve Patient Care

Both physician assistants (PAs) and nurse practitioners (NPs) are helping physician groups to improve the quality of care they deliver.

Michael Oblinger, MD, a gastroenterologist with Charlottesville Gastroenterology Associates in Virginia, says, “The use of NPs has certainly increased our patient satisfaction. A busy gastroenterology practice has a tendency to be procedure-oriented, but the NPs are not. They are information-oriented and patient-oriented. Patients often comment that the NPs seem unhurried, want to listen to them, and are interested in their health.” The NPs see about 50% of the practice’s patients.

“Before we started using NPs, our average wait time was seven days,” Oblinger says. “Now we see patients within three days on average. With the addition of NPs, we have expanded our capacity significantly without having to hire more physicians.”

Some practices have used NPs or PAs to add services. Arthritis Associates in Kingsport, Tenn., developed a dedicated service for fibromyalgia patients by adding a PA to the practice. “These patients require a lot of time,” says Chris Morris, MD, a physician with the group. “Their problems are complex, so care is complex. Having a PA dedicated to fibromyalgia has been a very successful strategy for our practice. The PA devotes more time to each fibromyalgia patient than I can, discussing care and mapping out a therapeutic plan.”

Michael L. Powe, director of health systems and reimbursement policy at the American Academy of Physician Assistants in Alexandria, Va., says, “A long history of research has demonstrated that within the PA’s scope of practice, PAs provide the same quality of care as physicians. In addition, PAs take the time to counsel and educate patients in addition to providing medical services. When patients better understand their medical conditions and the importance of complying with the treatment regimen, they often experience improved outcomes.”

Mary Jo Goolsby, director of research and education for the American Academy of Nurse Practitioners in Austin, Texas, also emphasizes the quality of NP care. “Research has shown that patients who are followed by an NP or a team that includes an NP are more likely to have better outcomes, which may be because the education provided by the NP enhances compliance with prescribed treatment regimens,” she says. —DJN

mation about the NPs,” Oblinger explains. “We instructed our nurses to explain that the NP would be in to see the patient, and the doctor would be in shortly after that, so patients understood they would not see the NP instead of the doctor, but in addition

to the doctor. We wanted them to feel that they were getting added benefit, not a different benefit.”

—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).

**“The use of NPs has certainly increased our patient satisfaction,” says gastroenterologist Michael Oblinger, MD.**

# Managing an Investment Portfolio

By Cameron Short

**M**anaging an investment portfolio never has been easy, but this step in the investment planning process is a key to successful investing. Managing actually encompasses two distinct functions: portfolio management and portfolio monitoring.

Portfolio management refers to the selection of specific investments and the choice of timing to buy or sell, according to your goals and disposition. A higher level of expertise is needed for this activity than most investors possess. These investors should seek the help of a professional advisor or money manager.

Portfolio monitoring is an ongoing activity that provides investors with the information needed to evaluate a portfolio's performance and allows an investor to rebalance the portfolio to keep it on track toward achieving the planned objectives. This function, too, is often left to a professional.

If the physician has the time and expertise to monitor his or her own portfolio well, it is best to use software specifically designed for this purpose. Individuals should not attempt to monitor a portfolio manually.

## The Advisor's Role

The advisor's role can be all encompassing or limited to certain tasks.

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**One of the most important functions of a portfolio manager is to monitor performance. One way to do so is with benchmarking.**

Either way, the duties can be broken down into four major categories:

1. Managing all or part of a portfolio. Typically, an advisor will employ and oversee money managers who evaluate and implement investment options and strategies. The physician also may employ money managers to implement investment decisions.
2. Reviewing the portfolio's performance. This step entails measuring the overall performance of the portfolio and the performance of asset classes and individual investments within the portfolio.
3. Reporting to the physician investor. Reports from the advisor should provide information about the portfolio's performance, compliance with the investment policy, progress toward financial goals, and the effects on cash flow and taxes.
4. Recommending changes to the investment plan. A rebalance plan should be proposed, unless a buy-and-hold strategy is recommended.

Managing a portfolio requires some understanding of environmental factors (such as political and social influences) that may affect the portfolio's performance, so when certain events occur, the physician can respond appropriately. The investor also needs to be aware of the costs involved in managing the portfolio so that he or she can control investment-related expenses. Of course, to monitor performance, the physician will need to get educated on the various measur-

ing techniques. Most important, the investor must have a clear vision of investment goals, a thorough knowledge of the investment and rebalancing strategies, and an understanding of vehicles being used.

One of the most important functions of a portfolio manager is to monitor performance. One way to do so is with benchmarking, which measures the performance of an investment portfolio against certain models. Some investors use the latest 10-year Treasury bond as a benchmark for all bonds. But the term 'benchmarking' usually refers to comparisons with standardized indices. The best known and most reliable indices include the Standard & Poor's 500, the NYSE Composite Index, the NASDAQ Composite Index, Dow Jones 30 Industrials, the Wilshire 5000, the Russell 2000, and NASDAQ 100. Although benchmarking has proved highly effective, the frequent caveat about past results as reflected by the various indices bears repeating. Past performance will not necessarily predict future performance.

## Selecting Investments

When designing an investment portfolio, investors decide what types or categories of investment vehicles to use based on such factors as goals and tolerance for risk. Investors also decide how to allocate assets among these different categories (such as 10% to Treasury securities, 30% to growth funds, 30% to blue chip

stocks, and 30% to aggressive stocks. The next step involves selecting individual securities to buy within each of these groups. This is when working with an advisor is most essential.

When selecting securities, investors should implement a screening system based on certain criteria or minimum standards that he or she expects the investments to meet within each category. If selecting bonds, for example, examine the creditworthiness of various debt issuers. If choosing growth funds, look at the growth companies' total returns over the past year.

Over the past two decades, many investors have favored mutual funds over individual securities. Here's a review of the strengths and weaknesses of each vehicle.

Individual securities can be customized to fit the investor's personality, are especially suitable for large cap stocks, protect against the herd mentality, have potentially higher returns, may lower costs, and may allow the investor to manage his or her tax liability. Conversely, with individual securities, diversification requires a higher minimum investment, there is a lack of professional management unless the investor works with an advisor or money manager, and there is a potentially higher risk.

The strengths of mutual funds include the ability to diversify for a smaller investment and professional management is provided. Mutual funds are especially suitable for small cap, foreign, and emerging-market stocks and have a potentially lower risk. On the other hand, the disadvantages of mutual funds include difficulty in choosing among funds, these funds are "off-the-rack," they have potentially lower returns, higher costs, no ability to manage tax liability, may contain large imbedded capital gains, and are susceptible to the herd mentality.

—More information on physician practice strategies is available on our Web site (see page 16).

## Many Factors Affect Performance

Every investor should know that a wide range of factors can affect the performance of one's investment portfolio. Here's a look at some common factors that affect returns.

**War.** Historically, the stock market declines when the United States is on the brink of war, because foreign and domestic investors become cautious. Conversely, if war breaks out, it could stimulate the economy and lead to more investor activity, which normally has a positive influence on the stock market. Also, foreign wars can affect a portfolio, particularly if the investor holds international stocks or mutual funds.

**The Federal Reserve Board.** The Fed is the national bank of the United States that controls the money supply. All U.S. banks are part of the Federal Reserve System and borrow money from the Federal Reserve to lend to customers. The interest rate that the Federal Reserve charges when it loans money to member banks is called the discount rate. In general, the lower the discount rate, the more money banks will borrow and the more money gets pumped into the economy. If too much money is pumped into the economy, however, prices may escalate and inflation may result. By comparison, if too little is pumped into the economy, a recession may result as economic activity drops.

Watch for signs that the Federal Reserve is about to lower the discount rate, because when it is lowered, interest rates are lowered as well. This action will affect the price and return of stocks and bonds. In addition, consumers and businesses may have more money to purchase goods and services. This factor may lead to higher profits for businesses and thus raise the value of shares of stock in those businesses. Also, investors may have more money to save and invest, leading some to consider putting more money into riskier investments, as returns on safer investments may be low.

**The judicial system.** The return an investor receives on investments depends on the success of the companies he or she invests in. That company's success may be linked to the judicial system. If a company must pay damages from a lawsuit, its earnings and profits may decline, causing the value of stock shares in that company to drop. When stock value drops, investors holding stock may suffer a financial loss. If the setback is temporary, it may mean a financial boon to investors who buy shares when the price is low and then sell the shares when the company and stock price recover.

**Federal government.** The federal government stringently regulates some industries, and some states regulate industries as well. Since industry regulation can directly affect the prices of stocks and bonds related to those industries, it's important to pay attention to the actions of the legislative and executive branches of government. These branches also set and change monetary and fiscal policies that can affect investments.

**Tax laws.** Tax laws (on the federal and state levels) can significantly affect one's overall investment strategy. A physician may invest in a certain vehicle because of the tax advantages it offers, for example, but if tax laws change suddenly and those tax advantages disappear or become less significant, the physician may need to revise his or her investment portfolio.

—CS

# Growing Complexity, Regulations Affect Practice Buy-Ins and Buy-Outs

*Daniel M. Bernick, JD, MBA, is a principal with The Health Care Group and Health Care Law Associates in Plymouth Meeting, Pa. He advises physician groups on the financial and legal aspects of medical practice operations, buy-ins, buy-outs, sales, mergers, and other transactions. He has extensive experience in valuation of medical practices and he has lectured widely to such organizations as the MGMA, American College of Rheumatology, American Society of Ophthalmic Administrators, Medical Society of Delaware, and other organizations. He discussed medical practice valuations with editor-in-chief Richard L. Reece, MD.*

**Q:** What should physicians watch for in practice valuation trends in the early years of the 21st century?

**A:** Since the golden age of medicine in the 1980s, the economics of medical practices have changed quite a bit. There's more downward pressure on the top line in terms of revenue since physicians can't collect full charges and they can't adjust their charges because they're set by insurance companies and Medicare. And on the expense side, the growing complexity of medicine and the regulatory burdens on practices are costly. They also have to have sophisticated billing and computer systems and electronic medical records. So there continues to be a lot of expenses associated with generating the revenue they need.

For these and other reasons, buy-ins, buy-in valuation, and pay-out

valuation continue to be moving targets in terms of providing a value that is both fair to the doctor who's being paid and that supports the practice at the same time.

**Q:** Is the golden age of medicine likely to return?

**A:** No. We're never going back to the days when it was relatively easy to practice medicine, when there was much less regulation than we have now, and when medicine was not subject to the level of legal scrutiny that it is now. The Stark laws and anti-kickback laws are a major focus now. Physicians can no longer post a charge and expect that everyone is going to pay it.

But while we're not going back to the golden age, I believe a lot of the doom and gloom among physicians is misplaced because the demand for physician services continues unabated. The baby boomers are placing significant demands on the health care system as they age and retire, and so I don't see the demand for physician services receding any time soon. Also, several factors will constrain the supply of physicians. So there'll always be a strong demand for physicians in this country.

**Q:** Is there a new breed of physicians who are married to other doctors and who are more concerned about having a balanced lifestyle than physicians did in the past? And is this trend a factor in buying-in?

**A:** It's certainly a factor in recruiting. Groups with more physicians can offer a more balanced call schedule and can enjoy a recruiting advantage. So the desire for a balanced lifestyle with minimum call responsibilities gives an advantage to large groups and to institutions that can afford to maintain large groups. But medicine has always been primarily a cottage industry. Most physicians are still in small groups, either solo practices or two, three, or four doctors together. So, most doctors are in small businesses.

Many young doctors want a certain lifestyle but they also place a value on independence. So by no means is it a given that everybody coming out of medical school will settle for being an employee indefinitely, simply because they want a balanced lifestyle. Many physicians want a balanced lifestyle but subsequently decide to be independent, which would push them toward small groups.

There continues to be a number of physician entrepreneurs interested in buying practices. And, if physicians are willing to go to a less served area, hospitals essentially will set them up for free under an income guarantee arrangement. There are many different options and opportunities for physicians.

**Q:** What problems about buying-in do you see most often?

**“The baby boomers are placing significant demands on the health care system as they age and retire. So I don't see the demand for physician services receding any time soon. Also, several factors will constrain the supply of physicians.”**

**A:** There are three components of value in medical practices. Those are the equipment and build-outs, meaning the so called hard assets; the accounts receivable on the books as of the date of partnership, representing monies that have been earned but not yet paid; and there's the intangible value consisting of the practice's reputation, its phone number, the charts, the location, the existing staff, and patient loyalty.

The first two tend to be relatively non-controversial. In most medical practices, equipment values are not insignificant but certainly affordable. And, there are not many issues regarding accounts receivable. Young doctors recognize that there's a certain amount of money tied up in receivables and either they accept that the senior physician can put those in his or her own pocket or they have to buy into those receivables that they're going to share. Finally, there is the intangible value of good will.

If you have all the systems for a medical practice and a patient base, and all the new doctor needs to do is walk in and start seeing patients, there's a significant value to that.

The last item—goodwill—continues to be a fertile ground for disagreement or discussion. The senior physicians typically feel that they have put a lot of effort into developing the practice and patient loyalties so that the young doctor can be immediately productive. And the young doctor may not fully understand all the things needed to create a medical practice and to build it up. So, he or she may feel the intangibles aren't worth what the senior physicians are asking.

In the early days of buy-ins and payouts, it was presumed almost automatically that the goodwill had a value, meaning a number you could place on it. If you were buying a 50% share in a practice, you would pay 50% of the goodwill as valued. In the past 10 to 15 years, an alternative approach has developed in which the parties agree

**“The senior physicians often feel that they have put a lot of effort into developing the practice and patient loyalties so that the young doctor can be immediately productive. And the young doctor may not fully understand all the factors needed to create a medical practice and to build it up,” Bernick says.**

that they may not be able to reach a consensus on this number.

Instead, you develop a compensation plan, in which the new doctor is phased up from his or her associate level salary to what will ultimately be a full partnership share.

For example, the young doctor or new partner may get 60% or 70% of a full share in the first year of partnership and then get a larger percentage each succeeding year until after four years or so when the young physician gets a full partner share. This alternative approach often reduces the level of tension over agreeing on a fixed number for intangible value. For this reason, it is viewed as a preferred way to approach the problem of valuing goodwill.

We still do some traditional fixed value buy-ins because some physicians are uncomfortable with the newer percentage phase-up approach. But the percentage approach tends to accommodate changing economics. If reimbursements or expenses change over the buy-in period, then the percentage approach will compensate for those changes appropriately. For instance, if receipts and income go down during the buy-in period, the buy-in itself will decrease in value since it's calculated as a percentage. If the numbers are better than expected, then there's a little bit more of a buy-in using the percentage approach. In a way, this approach is fair because

the doctor receives more money even after the buy-in than he or she would have originally expected to receive.

**Q:** Is a four year buy-in typical today?

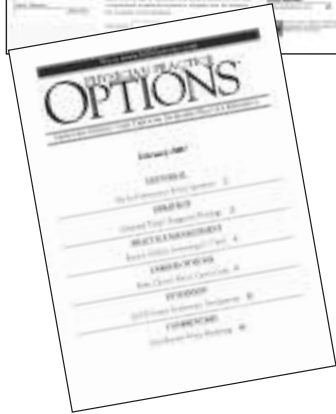
**A:** Yes, four years tends to be relatively standard. You will see variances from that depending on the negotiating position of the parties. In areas where demand for physicians is high, you might see a shorter buy-in period of two or three-years. Alternatively, in a situation in which the senior physician enjoys a higher than average income, you might have a more extended buy-in because otherwise the increase over four years would be too rapid. A two, three, or four year buy-in could provide a windfall to the new doctor.

**Q:** Does the buy-in process differ significantly between primary care physicians and specialists?

**A:** More dollars will be involved in a specialty buy-in because generally there's more income in a specialty practice. The partners in primary care practices often have more modest incomes. And, if the senior partners enjoy a relatively modest income, then it becomes difficult to extract too much of a buy-in because then the new doctor can't pay off his or her medical debts and afford a house too. Specialty practices are generally able to support larger buy-ins than primary care practices can support.

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