The Quest for Independence

Stake your claim to medical practice freedom

by JEFFREY BENDIX, MA Senior Editor

The fight against the pressures facing independent primary care practices can take many forms. For some, it has meant joining forces with other practices to attain the benefits that come with size without sacrificing their day-to-day autonomy. Others are taking a different route—minimizing the bureaucratic obstacles to practicing medicine by adopting direct pay practice models. »
INDEPENDENCE THROUGH DIRECT PAY

The lure of a direct pay model became apparent to Brian Forrest, MD, after working as an employed physician with two large integrated systems in his native North Carolina.

“As an employee I had absolutely no control of my own schedule. They just wanted to run as many people through there as they could,” he says. “It was all based on how many people you could roll through the door and how good a coder you were.”

He recalls the aftermath of one day where he saw 63 patients. “I couldn’t sleep that night, wondering ‘what did I forget? How many tests did I miss, how many prescriptions didn’t I give?’

Forrest’s solution was to found Access Healthcare, which he describes as “a direct primary care micro practice model,” in Apex, North Carolina. Apex accepts no third-party reimbursements, either public or commercial. Instead, patients pay a monthly membership fee ranging from $45 to $85, plus a $20 “scheduling charge” to cover the variable overhead of the visit, primarily lab work.

The different fees are designed to cover additional services, Forrest explains. While the overwhelming majority of patients opt for the basic $45 monthly charge, for an additional $20 per month Access will provide a patient with up to four generic prescription medications. “If the patient can pay just one monthly fee and not have to bother with going to the pharmacy to get their prescription filled, it’s something they really like,” he says.

Other services beyond the basic level Access can provide include monthly massages and visits from a dietician, who will go grocery shopping with the patient and teach him or her how to read nutrition labels.

“These are all services people told us they needed over the years,” Forrest says. “Imagine for $20 a month having someone come to your house 12 times a year and be willing to shop with you or review food diaries. We’ve had three patients in the last year who’ve lost over 100 pounds doing this.”

Forrest estimates Access’s net profit per-patient is two to three times that of the typical fee-for-service primary care practice, despite charging patients about 80% less than the typical practice. He’s able to accomplish that by keeping overhead low. The practice has three providers including Forrest, and two staff members who function as medical assistants, receptionists, and referral coordinators. (Forrest calls them “the ultimate cross-trained patient care coordinators.”)

“They are able to handle all that since we don’t file insurance there’s no reasons for billing and coders, and all that bureaucracy goes out the window,” he explains. “It’s a complete contrast to the idea of traditional insurance, where three-fourths of your job is making sure you get paid for the visit.”

Forrest says he schedules one patient per hour, even though most visits take less time than that, so as to create availabilities for walk-ins. During a typical eight-hour day he will see between 12 and 15 patients.

Access also looks to technology—specifically, its electronic health record system—to help improve efficiency and keep costs down. Without having to worry about meaningful use and Medicare quality initiatives, Forrest says, providers can focus on using the system for charting.

“We use an EHR that’s really intuitive and that allows me to get all my notes done in about 30 seconds per patient and in a much more complete way than when I was writing them down or dictating them,” he says. “Now when a patient walks out our door their note’s completely done.”

The system’s e-prescribing feature is also a significant improvement over writing out prescriptions manually, he says, particularly when refilling multiple medications for a patient. Instead of having to write the patient’s name and medical-
tion directions on each script, “now you can do each of those refills in less than five seconds. And when the bulk of people’s prescriptions don’t necessarily change every visit, it really speeds that workflow up.”

Access recommends a mail-order pharmacy to its patients that, in addition to being cheaper than most retail pharmacies, will generate a weekly report of which patients didn’t take delivery of their prescriptions. “We love that, because it allows us to call the patient and say ‘we sent this prescription but apparently you told the pharmacy not to fill it, and what happened there?’ It really helps with compliance,” Forrest says.

Forrest says he is contacted frequently by other doctors wanting to know about his model.

Typically, “they either sold their practice to a hospital system or they went to work for a system right out of residency, and now they’ve had enough, because they’re seeing the same things I did. It’s all based just on seeing as many patients as they can and coding as high as they can. We’re seeing a huge number of those folks saying they want to change over to a direct care model where they don’t have to deal with that baloney.”

**RETURNING TO INDEPENDENCE**

Lisa Klein, MD, FACC, a pediatric cardiologist in Louisville, Kentucky, is one who has tired of “the baloney” that frequently accompanies health system employment and has decided to strike out on her own. When she spoke with Medical Economics she had recently given notice at UK Healthcare and was in the process of setting up her own practice.

“I decided to leave corporate/academic medicine because I felt tired of being told how many patients I needed to see and when I needed to be there, and having every aspect of my professional life micromanaged,” she explains. “After 23 years of being in practice I just got fed up with it.” Before UK HealthCare she had worked with a practice owned by the University of Louisville Hospital, and the Sanger Heart and Vascular Institute in North Carolina, part of Carolinas HealthCare System.

Klein will be starting small in her new practice to reduce the financial risk. At the outset, she says, her staff will consist of a receptionist, an electrocardiogram technician, and two others who she says will be “clinical-service type employees.” She is leasing office space and equipment from an adult cardiologist practice. (“I’m basically leasing the whole operation,” she says.) In addition, she will be using an outside vendor for billing and many other administrative tasks.

Financing for her start-up is coming from proceeds of the house her family sold when they left North Carolina to return to Louisville, along with a loan from her husband. “I don’t want to take a public loan if I don’t have to,” she explains.

To begin building up a patient base, Klein is contacting pediatricians in the Louisville region, many of whom she knows from her previous practice. “I tell them, ‘this is what I’m doing and I’d really appreciate if you’d refer me patients,’” she says. “They’ve all been very supportive and say just let us know when you go live.”

She also plans on visiting many of them personally with gifts of organic fruit and vegetables, rather than more traditional fare like donuts and pizza. “I feel like I should practice what I preach,” she explains. “Also, my focus is going to be on a more personalized type of preventive approach, so I feel like getting off on that sort of foot would be beneficial.” A marketing communications firm is developing a logo and website for the practice.

Klein acknowledges that self-employment will bring its own challenges, including a reduction in income. But she’s willing to accept those in return for the ability to practice medicine how she sees fit.

“As an employee I had absolutely no control of my own schedule. They just wanted to run as many people through there as they could.”

—BRIAN FORREST, MD, APEX, NORTH CAROLINA
CONSIDERING DIRECT PAY

I have been operating my direct-pay practice (I accept no insurance; patients pay me a low monthly fee for care) now for more than two years. I am out of the “start-up phase” of the business. I am successfully making a living using an entirely different business model than most doctors in this country. Here are the tools I have found most useful in building a successful direct-pay practice.

Essential #1: A good office space

I am not in a typical medical office area, but instead intentionally found a homely-looking space in a commercial office complex. I designed it to feel different from most doctors’ offices: comfortable and welcoming. From the outside it looks like a house, not a medical office, and I’ve filled it with comfortable furniture, pleasing decorations, and coffee for patients on request. Patients will make a point to come in just to chat; and we can because our schedule allows us the extra time to connect with our patients.

This was my biggest start-up expense, but I believe it was absolutely essential in building a new mindset in my patients.

Essential #2: A staff that believes

I now have two nurses (to handle 600 patients), both of whom came from my previous practice. Both of my nurses are zealous in their belief in the direct-care model. Part of their zeal comes from the fact that their lives are so much better in this new office setting, but also, much of it is because they truly like to help patients. My practice model is all about customer service and exceeding expectations. I am really fortunate to have staff to whom that focus comes naturally.

Essential #3: The right communication tools

The one thing my patients value the most in my practice is access to me and my staff. If they have questions, they can call the office or reach me via secure messaging. While it’s technically OK to use e-mail for communications (as long as patients sign a HIPAA waiver), I found that most of my patients value security in communication over ease of use. Here are three ways I communicate with my patients:

A good phone system. I use Ring Central which is a VOIP Internet phone system, which allows me to cheaply have a complex phone system. Voicemails are e-mailed to me; faxes are also received and turned into e-mails. I can text with patients as well as hold a conference call. It has its flaws, but overall we get a lot for a low price.

Messaging system. I use Twistle, which is a HIPAA-compliant “chat” system. This might be the tool my patients value the most. It works like a secure chat, with apps available for Apple and Android phones. It also notifies me via e-mail when patients have tried to contact me, and my nurses can be copied on the messages as well. I can securely send lab reports (as PDF files) or handouts regarding conditions as attachments, and patients can send images (rashes, wounds, etc.) to me from their mobile app.

E-mail system. While I don’t encourage e-mail communication, some patients prefer it. We use our own domain hosted on Google’s Gmail website. It’s very easy to use and extremely affordable.

Essential #4: Billing systems

I experimented with several billing systems. I initially used Intuit Quickbooks and their integrated billing features. For a while I used ADP’s automatic billing system, which worked fairly well, but didn’t integrate well. Most recently, a new start-up, Hint Health has built a very elegant and easy-to-use billing system specifically designed for direct-care practices. They are very easy to work with, and solve issues quickly and easily. They also integrate with several EHR systems, and are always open to further integrations.

Essential #5: Facebook

Hands-down, the best marketing tool I have is my Facebook page. Not only does it provide an easy communication tool for patients and those interested in my practice, but I can promote posts to the exact demographic I am interested in. I promote any specials I am running for new patients, but I also promote posts or articles that highlight how my practice is different. The money I’ve invested here has paid itself over manyfold.
Fighting back, part 2

I feel is best for the patient is not to care too much about how much income I'm generating,” she says. “Now I’ll be at the mercy of the insurance companies, but I’ll still have more control over my day-to-day life. I’ll be available to my patients but I won’t have to be available to an entire medical center.”

CARVING OUT YOUR NICHE

Even as an employee of a hospital or health system, there are ways of carving out some independence, provided you know what you want and are savvy about getting it.

Mary Ann Bauman, MD, an Oklahoma City internist and Medical Economics editorial adviser, discovered a few years ago when she decided to look for ways to reduce her practice hours.

A 26-year employee of Integris Baptist Health Center, Bauman wanted to devote more time to traveling on behalf of the American Heart Association (where she is a national board member), and visiting her parents and other family members around the country. She found the solution from a patient who described how he shared his job, spending two months on and two months off.

“I started thinking, ‘You could do that reasonably well in primary care medicine, because you see most of your patients at one month, three months, six months or one year intervals,’ she says. ‘So you could do it if you had someone who practiced the same way you did and could see patients when you weren’t there.’

Bauman sounded out a younger colleague—Erin Glasgow, MD—who wanted to devote more time with her pre-teen children. Together they approached Integris administrators and sold them on the idea. Now, Bauman says, she sees patients the equivalent of five half-days per week, 24 weeks per year. Glasgow sees patients the other two-and-a-half days.

Bauman emphasizes that the arrangement took a great deal of preparation, especially when it came to minimizing the impact on other providers.

“We always call in once or twice a day and the staff has permission to call us anytime with questions,” she says. “So even though we’re part-time, it’s never a burden on our partners. That’s really important in making this model work.”

PRIVATE PRACTICE SURVIVAL TIPS

Join forces

Consider joining an independent physician association (IPA) to align with other physicians. Some have found that membership helps them negotiate tricky situations with payers where they might not otherwise get reimbursed.

Look for high-impact savings

The major expense items that practices need to get right are occupancy and personnel costs. Find ways to save on property costs and how to get the most from your employees.

Focus on billing practices

Make sure that someone in the practice has clear accountability for checking that all services get billed. Physicians can eliminate work that isn’t reimbursed through better claims management.

Ensure collections

Check on referrals and insurance authorizations before providing services and ask patients for copays at the time of check-in.

Review the fee schedule

You may discover you’re losing money in ways you may not be aware of. Regular review and calibration of your fee schedule could help.
The only way I can do what I feel is best for the patient is not to care too much about how much income I’m generating.”

—LISA KLEIN, MD, FACC, A PEDIATRIC CARDIOLOGIST IN LOUISVILLE, KENTUCKY

because they would like to try something like this,” she adds. “So I think we’re pioneering something that looks very attractive to others.”

A bigger challenge than not imposing on other providers has been the impact on staff members. As part of the job-sharing arrangement, the physicians agreed to merge their nursing staffs. But that has required overcoming what Bauman calls “pod-it is.” “It’s the attitude of, ’I work for this doctor and I’ll help you out, but I don’t feel any responsibility to the other doctor,” Bauman says.

The problem surfaced when one of the physicians would send in orders for a patient on a day when she didn’t have office hours. “The work wasn’t always getting done,” she says. “So then we set up a system where the nurse whose doctor is in takes care of their doctor, and the other one does referrals and correspondence of both doctors.

“We knew going in that the staff situation would be our biggest challenge, and it is,” she says.

On a personal level, she adds, the decrease in practice time has required both financial and psychological adjustments. She was prepared for the former, but the latter came as a surprise. “I knew my income was going down, because I wouldn’t be seeing as many patients. But the emotional response I had to the change was very challenging, because it felt like I was not being productive. That might not be true for everyone, but it certainly was for me.”

Bauman offers two pieces of advice to other employed physicians seeking a job-sharing arrangement. First and foremost is to have a partner that practices the same way you do. And I would sit down with the person and hammer out questions like ‘are you going to be upset if I ask you to see a patient for me? What about taking calls when I’m not there? What are you comfortable with in terms of things like staff members doing prescription refills?’ Things like that are critical, because you could end up hating each other.”

Second is to find a champion among the system’s administration. “If you have an existing relationship with someone, that’s where I would start, because they can really grease the skids for you,” she says. In her case it was the boss of her immediate manager. “He kind of smoothed it over with everyone else.”

In presenting your case to administrators, she adds, detailed preparation is vital. That means presenting information such as how much time you actually spent seeing patients in the previous year, how much time you expect to do so while job-sharing, and what the financial impact is likely to be. “Do your homework ahead of time so you really know your practice, and hammer out as many details as possible before you start.”

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