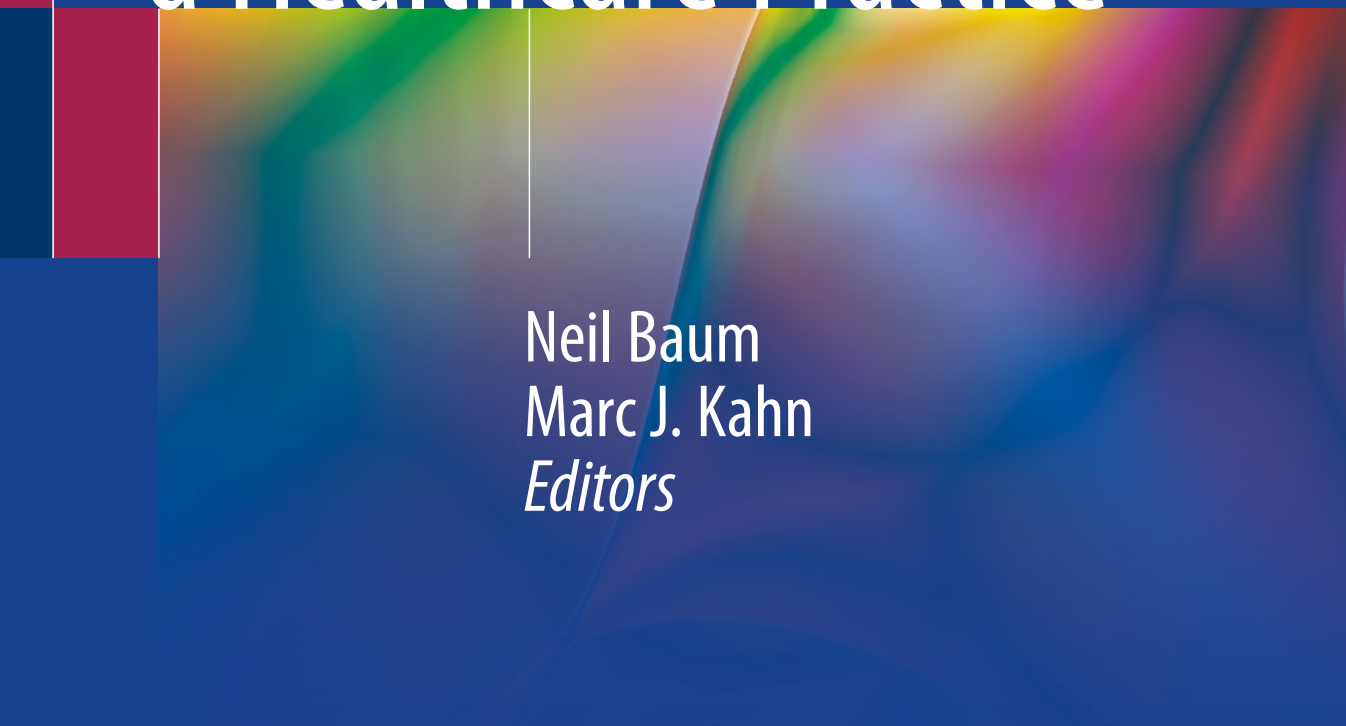
The Business Basics of Building and Managing a Healthcare Practice



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Editors

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To my loving wife, Linda
To my children, Alisa, Lauren,
and Craig
To my three grandchildren,
Ryan, Shelby, and Bennett
You all make my world go round.

But most
Of all
To my patients
Who have
Been a source of
Inspiration and joy
I thank you
For allowing me
To serve you.

Neil Baum

To Chris, my loving wife
and partner of 40 years
And our children Abby and Ben

And to all of my teachers
and students over many years
You have taught me more than
I could have ever asked for.

Dr. Marc Kahn

Foreword

It is a privilege to be a physician. Every day, you will meet total strangers, who will share with you their deepest thoughts. Some of your patients you will cure. For others, you will alleviate their suffering so that they can live their lives and their potential. However, there will be some patients who will need you to hold their hand and comfort them as they let go. It is a privilege to live a life of such meaning.

We are drawn to the practice of medicine through a desire to help others. To achieve our passion to heal, we have had to make sacrifices of time, effort, and money. For new graduates, who have made these sacrifices, it is hard to now be required to navigate the turmoil in the US healthcare system. However, it is important to remember that in every generation, the medical profession has been challenged by external forces. Today, we are learning to deal with the "industrialization of medicine" and the related influences that are impacting on our professional lives. This book focuses on how to build and manage a medical practice. This is essential knowledge if we are to retake control of our professional lives and participate in a meaningful way in the national discourse on the future of the US healthcare system.

In 1970, the USA spent $100B ($380B constant dollars) on healthcare, which represented 7% of the gross domestic product (GDP). The cost per capita was $400 ($1800 constant dollars). By 1990, the USA spent 12% of the GDP, and the cost per capita was $1200 ($4800 constant dollars). Fast-forward to 2018, the USA spent 17.9% of the GDP. The total cost was in the trillions ($3.5T) and the cost per capita $10,700. In 2018, physicians and hospitals represented 50% of the cost [1].

In the USA, we spend more on healthcare than any other developed nation [1, 2] (Organisation for Economic Co-operation and Development (OECD)). Despite the trillions spent on healthcare, too many people have poor access to care. Prior to the full implementation of the Affordable Care Act (2013), 44 million Americans were uninsured. Today, approximately 27 million Americans are uninsured. However, in 2017 the number of people uninsured rose by 700,000 [3]. Sadly, the uninsured are just the tip of the iceberg. According to the Commonwealth Fund, in 2016, of the people *with* insurance, 28% (41 million) of working-age adults in the USA were underinsured. 52% of the underinsured reported problems paying their medical bills and 45% went without needed care because of the cost [4]. High-deductible insurance plans with lower premiums were a large part of the problem. For a

family of four earning $50,000 per annum, a $10,000 deductible plan is almost like having no insurance.

It would perhaps be appropriate if, as a result of spending 17.9% of the GDP on healthcare, the USA had the best healthcare system in the world. However, in nearly all measures of health, the USA ranks poorly. For example, in 1980, life expectancy at birth in the USA vs. the OECD average was 73.5 and 74.5, respectively. Yet, in 2017, it was 78.8 vs. 82.2, respectively. Another example is the risk of a pregnancy-related maternal death (maternal mortality ratio per 100,000 live births – MMR). In 1990, the MMR in the USA was 14 vs. 11 for the OECD average. By 2017, the maternal mortality ratio (MMR) in the USA dramatically rose to 30 vs. a decline to 7 in the OECD [2].

The US healthcare industry has responded to the rising costs and poor outcomes by merging hospitals, providers, insurers, etc. In 2017, a record was set of 115 mergers [4]. Eleven of these mergers involved institutions with net revenues of at least $1B [4]. Clearly, institutions merge to protect themselves. In my opinion, there is little or no evidence that the creation of these large healthcare systems has resulted in lower costs and/or improved health outcomes, but they have certainly "industrialized medicine" to the detriment of the individual physician.

Physicians challenged by the cost and time spent managing their practices have sought employment. In 2016, physician-owned practices were no longer the majority. In 2018, *The Survey of America's Physicians* reported that just 31.4% of physicians were identified as independent practice owners [5].

The authors of this book have appropriately pointed out that US medical schools and graduate education programs produce well-trained physicians in all aspects except business and finance. Too few medical schools offer courses or advice on the business of medicine. The good news is that in 2017, there were over 70 medical schools that offered a combined MD/MBA program [5].

This book is written by two very experienced practicing physicians and covers the basics of business and finance. It is essential reading for every doctor, whether setting out to establish a private practice or wishing to negotiate an employment agreement. This book is, undoubtedly, as its title suggests, *The Best Book on Business Basics of Building and Managing a Medical Practice*. This book is divided into three sections. Section I deals with the basics of business, Section II covers starting a new practice and/or successful contract negotiations, and Section III discusses strategies for building and growing a successful practice.

The authors: Neil Baum, MD, is an Associate Clinical Professor of Urology at Tulane University School of Medicine and Louisiana State University School of Medicine, in New Orleans, LA. Dr. Baum is a Board-Certified Urologist with a successful practice for 30 years. Marc Kahn, MD, MBA, is the Peterman-Prosser Professor and Sr. Associate Dean at Tulane University School of Medicine. He is a Professor in the Department of Medicine with adjunct appointments in the Department of Pharmacology and the AB Freeman School of Business.

Despite the current challenges facing the medical profession, I believe it is a privilege to be a doctor. The guidance and knowledge, provided by the authors, will help ensure that young physicians have meaningful and successful careers.

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Introduction and Why Doctors Need to Read This Book

Why Doctors Need to Consider Medicine a Business

> May you always have work for your hands to do. May your pockets hold always a coin or two. Irish Blessing

> Physicians who aren't good at business won't survive. Russel J, *Washington Post*, May 10, 2010

The authors of this book have a combined 90+ years (NHB 50 and MK 40) as practicing medical doctors. We have seen tremendous changes not only in the clinical aspect of medical care but also tsunami-like changes on the business aspects of practicing medicine. A few examples include managed care (perhaps mis-managed care), capitation, the Congress passing of the Affordable (?) Care Act, the introduction of coding and relative value units to determine compensation, the concept of the employed physician, the implementation of the electronic medical record, and more recently the use of telemedicine to provide care for patients without being eyeball-to-eyeball with the patient.

Today nearly every doctor leaves medical school and their postgraduate training with excellent skills for diagnosing and treating medical illnesses. However, almost all physicians leave their training programs with no skills, or at most a few skills, to become successful businessmen and businesswomen. In fact, most physicians have earned a stigma and a reputation of being deficient in the business of medicine. Historically, doctors have a reputation for being good at caring for their patients but poor at managing the business aspect of their practices. There are numerous complaints in medical education from graduating students, residents, and fellows that the curriculum hasn't changed very much since 1910, when educator Abraham Flexner analyzed medical school curriculums across the country and proposed standardization of pre-clinical and clinical years in his groundbreaking Flexner Report [1].

Currently, few medical schools are offering courses or advice on the business of medicine. That's the bad news. The good news is that in 2017 there are 148 medical schools that offer a combined MD/MBA program [2]. However, you don't have to have an MBA to be able to grasp the basic con-

cepts of business that will affect your practice. Moreover, incorporating the principles of business into your knowledge base will serve both physicians and their patients as well.

Yes, we have heard that barriers and obstacles to educating students, residents, and fellows about the business of medicine are the time constraints in most educational and training programs. But let's be honest: do you need to know how many ATPs are created within the Krebs cycle to be a good clinician? There are things you learn in medical school that are not as relevant to the practice of medicine as basic accounting, creating a business plan, practice management, and leadership. These are the skills that you can be certain to use on a regular basis and far more than the names of the 12 cranial nerves and what they innervate….unless you are a neurologist or neurosurgeon!

We advocate that learning the basics of business with its application to healthcare is also important in the creation of a doctor who will have a profitable and ultimately an enjoyable and possibly longer and more productive career.

Why is understanding the basics of business important for the practice of medicine? If you don't understand the business component of your practice, you may not be able to survive in today's marketplace where profit margins are going to be razor-thin. The reality is if you don't understand business practices, you can't survive in today's market. You will no longer be practicing medicine and providing the care to the patient that you went to medical school to treat. American healthcare is different than every other profession or business. Healthcare is the largest and most regulated industry in the US economy, and because of excessive regulation, it doesn't follow the basic laws of supply and demand.

This book is intended to be a roadmap or GPS for doctors, regardless of whether they are employed, join a small group, or, for those rare doctors, who decide to start their own practice, to follow in order to not only be good clinical physicians but also good businessmen and businesswomen. We deem that this book will help doctors make a difference in the lives of their patients but also help them make good financial decisions.

What's the bottom line? If the contemporary physician doesn't understand the business of medicine, you won't be able to survive in today's market. And it would be very sad if you couldn't provide care to the patient(s) you went to medical school to treat! Having a basic understanding of business will enable you to be a good doctor and also a good businessman or businesswoman. It is our hope that this book will provide you with the basics of business that were omitted in your medical school training.

New Orleans, LA, USA

Marc J. Kahn
Niel Baum

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Part I

Basic Business Concepts and Principles

Why Doctors Need to Consider Medicine a Business

1

Marc J. Kahn and Neil Baum

Case: Sally

Sally is a PG-3 and spent a rotation with an internist in private practice. She often accompanied him to the doctor's dining room and heard many of the doctors complain about decreasing reimbursements, rising overhead, additional government regulations, increasing paperwork, learning to use another electronic medical record program, the issue of burnout, and a host of other complaints. She seldom heard any of the older doctors talk about the joys and benefits of becoming a doctor. Furthermore, she started second guessing her decision to become a physician. Was she mislead or misguided?

This chapter is not meant to discourage you but to reassure you that you have made a good decision to join one of the greatest and most enjoyable professions on this planet. However, in order to have that enjoyment, it will be necessary to have a modicum of business skills that you probably did not receive as a medical student.

Let us begin with the topic of becoming a doctor to achieve wealth. This is probably the worst reason to select medicine as an occupation. A comparison was made between the incomes of a UPS truck drivers and physicians. This very revealing graph (Fig. 1.1) shows that a UPS truck driver enters the workforce and begins to earn money at age 18. However, a physician usually is incurring debt for 8–10 years and only enters the workforce around age 30. Therefore, it takes a physician nearly 17 years to equal the accumulated wealth of a UPS truck driver.

Now consider if the UPS truck driver worked the same hours as a physician, 60–70 hours a week, and received overtime pay, then it would take nearly 24 years for the physician to equal the income of a UPS truck driver.

Downsides to Becoming a Physician

It is unlikely that the UPS driver gets complimented about the great delivery he just completed! Whereas the physician is likely to receive multiple warm fuzzies or compliments nearly every day in practice. Most physicians state that it is the gratitude and relationships with patients as being the most rewarding factor in being a physician.

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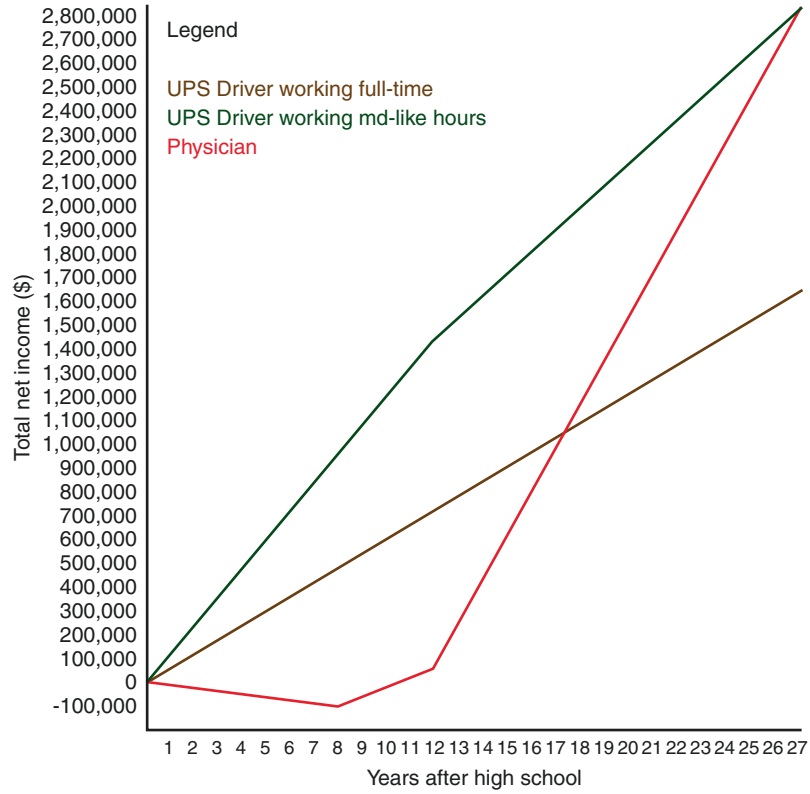

Fig. 1.1 Salaries of UPS driver versus physician

The UPS driver who drives and delivers packages 6–8 hours a day is probably bored after a few hours in the truck. However, a physician has such a variety of activities, and no day or patient is ever the same. Boredom is never an option or a complaint in healthcare.

The UPS driver is lifting heavy boxes all day long and is probably at risk for early onset chronic back pain. Back pain is usually not considered an occupational hazard for physicians. (Exceptions are cardiologists, radiologists, and cardiovascular surgeons who wear heavy lead vests and are bending over patients for many hours a day.)

Anyone who even alludes to the notion that men and women decide to become doctors is primarily motivated by avarice and money needs to refer to Fig. 1.1. The reality is that if doctors want to achieve wealth quickly, they just might consider becoming a UPS truck driver!

Nearly every physician who decides to become a doctor knows fully well that they will probably have on average $250,000 of debt that will have to be repaid with interest, that they will have to get up in the middle of the night to go to work to care for the sick and ill patients, that they risk litigation and lawsuits during their career, and that will defer gratification and accumulation of wealth for many years.

Yet, thousands of bright, talented young men and women will enter the healthcare profession and that applications to medical schools are at an all-time high. We become doctors because we truly have a calling. We want to help people not only get well but now we are interested in helping patients and the public stay well and avoid getting sick and needing to see the doctor. We become physicians because we enjoy the gratification from patients who thank us every day for all that we do to make them better or keep them well. We do not believe there is another profession that offers the kind of daily feedback from their customers or clients that physicians so often receive and enjoy.

For the most part, physicians love what they do, and money is not the primary driver for joining the exclusive club of health-care providers.

However, this choice of profession does not negate the fact that we are small business men and women and have to be concerned with the business aspect of our practices in addition to being good clinical doctors.

You will seldom ever find a doctor who went into medicine to practice "business." But nearly all doctors say that they need practical, real-world guidance to run the business side of their practice. This book is written for medical students, residents, fellows, and newly minted doctors to fill the void from most medical training programs that void of providing business skills necessary to become complete doctors.

Why Do We Become Physicians?

Doctors are in a field where there is growing demand, a declining supply of physicians, and formidable barriers to entry with more applicants to medical school every year. In 2017 there were more than 20,000 new enrollees which is 1.5% greater than the previous year [1]. Every other industry or profession would kill for this type of economic advantage. If you believe that the healthcare industry is tough, imagine working in an industry such as digital cameras or print newspapers. Can you imagine working in an industry or profession for which demand is declining, or where there is an oversupply of competitors who can provide the same services that you do at a much cheaper price or send it to India and China to produce at a fraction of the cost, or if almost anyone can quickly gain access to the field with minimal or no barriers to entry? The dynamics in our profession assure us that there will always be work and future employment.

Doctors have instant status as soon as the initials M.D. appear after their name. With these two initials after your name, you have credibility that is immediately accepted by your patients. For example, if a patient comes to a doctor he or she has never met before, he or she will willingly divulge the deepest secrets of their past medical history, including menstrual history, bowel habits, and even their sexual history. No other professional guarantees its young members such instant credibility. Doctors should appreciate their prominence in the community. Doctors must always uphold a high standard of confidentiality and ethical behavior and should never take for granted our lofty status with our patients.

Medical doctors are in the top 5% of wage earners in the United States; yet, many of our colleagues are complaining about their incomes. If we compare the average physician's salary with those for all other jobs, our salaries are at the top of the income chart. Also, most of the others in that rare top 5% do not have the same upside potential that physicians do. Many successful physicians earn two to three times more than the average physician [2].

Physicians are fortunate not to be compelled to retire at a certain age. Because the practice of medicine is not physically demanding, many physicians can work into their 80s if they so desire as most hospitals and groups do not have mandatory retirement. Only recently have older doctors, especially aging surgeons, been asked to submit voluntary evaluation and consider accepting an assistant for certain surgical procedures [3].

Doctors, compared with many other professionals, have a wonderful lifestyle. The practice of medicine affords most men and women with the ability to spend time with their families, being able to take 2–4 weeks of vacation each year and having an option of working 8–10-hour days. This book will provide numerous examples of becoming more efficient and more productive so that the doctor can be home for dinner with his\her family. Except for the hours when physicians are on call, they have reasonable lifestyle choices. Younger physicians today are opting to work fewer hours per week, even if it means a lower income. Doctors also have the ability to select a geographic location and the kind of practice they wish to have; a choice that is not as readily available to other professionals. Many career choices have geographic limitations as to where employees can live or are at risk for the possibility that they could suddenly be transferred anywhere at the whim of a superior, but physicians can work almost anywhere they choose. They can determine where they would most like to live before embarking upon their careers.

There are more opportunities for physicians than for those in other professions, especially for those entering practice within 7 years of graduation from training programs. Doctors can elect to work for themselves, join a large group practice, or be employed by hospital or academic healthcare centers. Although an employed physician must answer to a boss, starting salaries for employed physicians have increased, and these doctors function relatively independently when compared with other types of professionals who are employed by a large group, company, or organization [4].

By using examples that we provide in this book, the young doctor can actually sculpt the kind of practice they wish to have. Doctors can carve out the exact kind of practice that makes them most comfortable. If a doctor is interested in seeing only patients with certain diagnoses or in providing only a limited number of treatment options, he or she can easily do so. If a doctor wants to see certain kinds of patients (e.g., older, geriatric patients or pediatric patients), this can easily be done. If the doctor wishes to see patients who speak only another language beside English, then this, too, can easily be achieved. If you want only patients who pay cash or want to have a concierge practice, where a limited number of patients pay an annual fee to have 24/7 access to your practice, then this is also within the realm of possibility.

For the most part, physicians are told almost on a daily basis how terrific they are, which is unlike the UPS driver. There is not a day that goes by that most physicians do not receive a compliment or accolade about the care they provide. If ego satisfaction and gratification are your drivers, then you have selected the right profession.

The practice of medicine provides job security and a future of guaranteed employment. It is a sad commentary that so many graduating lawyers are unable to find a job practicing law and also have thousands of dollars of debt that must be repaid [5].

This is not the case with American medical doctors. Everyone who graduates from medical school and a training program can find a job. It may not be a perfect job, but, nonetheless, it is a profession that is in demand and will certainly provide a future of job security.

Even though we face the challenge of declining reimbursements and higher overhead costs, a different career track would not have eliminated these detractors. These same challenges exist in almost every industry and in almost every profession. These challenges in other industries have resulted in extinction, because competition has created ways to do the same things either better or less expensively. Companies, organizations, and practices have done so because they have found ways to be more efficient and more productive. Ultimately, they have done things better. Healthcare is one of the industries that have focused on creating greater efficiencies and lowering operating costs, becoming more efficient and more productive, preserving patient satisfaction, and improving clinical outcomes. This scenario presents an opportunity for improving quality, preserving patient satisfaction, and, yes, improving the bottom line (i.e., increasing productivity).

In spite of all the hardships and detractors associated with modern healthcare, doctors have much to be thankful for. Those working in other industries have their lists of complaints, but they are often powerless to make changes, because they are neither owners nor partners in the business. If they are members of a large organization, many layers of bureaucracy must be penetrated in order to make changes. Doctors enjoy the opportunity to have significant control and the tools to implement change and to tweak our practices to improve the services that we provide our patients. We have local, state, national, and specialty organizations that are eager for young doctors to join and help make the practice of medicine better for patients and for doctors. (See Chap. 9 on organized medicine.) If we put our problems and complaints with modern medicine on a scale and then weigh those issues and concerns against the benefits of being a doctor, then we will find that the scale weighs heavily on the pluses and we should be thankful to be member of this wonderful club.

Why Do Doctors Need to Understand the Basic Principles of Business?

Most physicians will earn $10–12 million over their practice lifetime. However, it is physicians who will control multiple times that amount of money by directing healthcare for the patients that they provide care. With the mere signature of a physician, they control almost 100% of all healthcare expenditures yet physicians receive only 18% of the total $3.5 trillion in healthcare expenses [6]. Using basic business skills and outstanding clinical management, individual physicians or groups need to understand that in order to be successful, the physicians will have to prove that they can deliver a better product at a lower cost than their competitors. This is the direction of the future of American healthcare. Perhaps that is why 20% of the enrollment in US business schools are physicians [7]. The authors do not believe that an MBA is going to be a necessity for surviving in the future for new physicians. However, we do believe that a minimum knowledge about business will be required, and we believe that is what is the purpose of this book: to help young doctors cross the bridge between practicing medicine and running a business. Young doctors need to understand that the business of medicine will determine their future success.

Our training teaches us how to diagnose and treat medical conditions. Few of us have any training in the business of healthcare. It is imperative that we understand and accept that healthcare is a business. It really is no different than Coca-Cola, Microsoft, or Apple but just on a much smaller scale. Those companies need to be concerned about profit and loss and expenses including overhead just as a medical practice must monitor on a regular basis. One big difference is that healthcare is a very regulated industry. We have laws established by both the federal and the state government that we must adhere to closely or face huge fines and penalties.

The patient in this millennium has high deductible insurance coverage, expensive premiums, and often co-pays that makes the patient have skin in the game. The nature of medical practice has placed a price tag on nearly everything a doctor does or orders. The days of transparency have arrived, and when a patient asks how much is CT scan or what is the cost of BRCA gene test, the doctor needs to know the answer or be able to provide it quickly for the patient.

Sally's Experience

Sally was despondent about her experience after her rotation with the internist in private practice. She discussed her experience with the dean of the medical school and recommended that other students not be assigned to a physician harboring such negative attitudes about the medical profession. The dean placed Sally in touch with a more encouraging and constructive physician. The dean pointed out that despite all of the challenges, medicine is still a desirable profession and the majority of doctors would choose the healthcare profession again. Sally also decided to make an effort to understand the role of business in medicine. Out of her negative experience, she left with the understanding that becoming a complete physician means to be a good clinician and to become knowledgeable and competent in the dollars and cents of the practice of medicine.

Bottom Line

When a physician takes the Hippocratic Oath, the focus is most primarily on the clinical aspects of the care he\she provides to the patients with a medical problem. However, the young physician has not only answered a calling but also needs to understand a business. The importance of business in healthcare can be succinctly stated by the title, A Doctor by Choice, a Businessman by Necessity, of an article in the New York Times by Dr. Sandeep Jauhar [8]. It will be a necessity for all physicians to have a basic understanding of the basics of business in order to have a successful practice. This book will provide those basic business principles and metrics that will put you on the road to a practice that you will enjoy and will ensure your productivity.

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2 Time Value of Money, or What Is the Real Financial Value of an Opportunity?

Marc J. Kahn and Neil Baum

Case: Martika

Martika graduated college 5 years ago and took a job with Bond Enterprises, a holding company, as her first job. As an economics major, Martika always envisioned a career in business. After her mother's death from breast cancer 2 years ago, Martika began to have doubts about her career choice and volunteered at the hospice that cared for her mother prior to her mother's death. After speaking with friends and doing some research, she began to explore medicine as a potential career. She took premedical science classes at a local college, did well, studied for the MCAT, applied, and got accepted to her state medical school.

Because of her business background, Martika wondered if medical school would be a good move financially. Her current job at Bond paid well. Going to medical school would involve borrowing money for tuition and living expenses, and she would not be able to work while being a student. Although she would be paid for residency, her salary would be significantly less than that of a practicing physician. Over her lifetime, would her eventual salary as a physician compensate for her medical school debt and lost income? Would she be able to practice the specialty of her choice or would she be limited to higher paying specialties? Is medical school worth it?

One of the most basic principles of finance is the time value of money. Conceptually, money is worth more now than at some time in the future. Stated another way, given the choice, you want your money sooner rather than later. This is because invested money earns interest and because you can use the money you have now for things that may not be available later. As an example, the time value of money means that if you are lucky enough to win the million-dollar lottery, you want the million dollars now, not $250, 000 a year for the next 4 years.

Why is this so? Money has an opportunity cost. For example, suppose you want to buy an antique clock. If you have the money now, you can successfully negotiate the price and buy the clock. But, if you do not have the money now, you would have to wait until later to purchase the clock, and the clock may have been sold to

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someone else and may no longer be available. Similarly, if presented with an investment opportunity, having money on hand allows you to make an investment that may disappear at a future date. Obviously, having money on hand provides a financial advantage for the holder to use the money for purchases, to lend, or to invest.

In addition to opportunity costs, money has more value in the present because most of us do not hold our money in a basket under our beds or buried in metal box in the backyard. Rather, we either put the money in the bank for safe keeping or invest the money. Either way, our money can earn interest. Interest is the money paid for the use of your cash. When you borrow money from a bank, or through your credit card, the bank charges interest, a fee for the use of their money. Similarly, if you put money in a bank, or lend money by purchasing bonds, you are compensated with interest payments for the use of your money.

Interest can be simple or compounded. As an example of simple interest, if you invest $100 at 6% annual interest, at the end of the year, you will have $106. Compounded interest allows for you to effectively earn "interest on your interest." When Benjamin Franklin died, he left approximately $5000 to each of the two cities Philadelphia and Boston. He required that the money be invested and that there would be two times that the money could be withdrawn: a partial withdraw 100 years after his death and a final withdraw at 200 years. Because of compounded interest, at 100 years each city received a payment of $500,000, and at 200 years, each city received approximately $20 million. Franklin described compounded interest as, "Money makes money. And the money that makes money makes money [1]."

Going back to the example of a $100 investment at 6% interest, if the interest was compounded monthly, at the end of the year, you would not have $106 but $106.17. If interest was compounded daily, at the end of the year, you would have $106.18. The extra 17 or 18 cents arises by earning interest on interest. Although a mere 17 cents may seem trivial, suppose your initial investment were $100 million. Now your compounded interest alone would be over $6,170,000 in 1 year—a substantial sum indeed!

Compounding can also be illustrated by the following fable:

A peasant shepherd comes upon a young girl who has become ensnared in a bear trap. He hears her cry out and frees her. The young girl is so thankful that she promises the peasant a large reward as her father is king of the empire. Upon meeting the king, the peasant is offered 100 lbs. of wheat. Noticing that the king has a chessboard displayed on a table, the peasant offers an alternative reward. The peasant suggests that the king put two grains of wheat on the top left square of the chessboard and then doubles the number of grains successively throughout the 64 squares of the chessboard. The King quickly agrees to this alternative assuming that the uneducated peasant has made a silly concession. Understanding the concept of compounding, the wise peasant has actually struck a great deal. If the number of grains of wheat doubles on each successive square, then the sum of grains is $2+4+8+16+\ldots,+2^{64}$ for a total of over 18×10^{18} grains of wheat which would weigh more than 1645 times the global production of wheat in modern times! The amount of wheat placed on an individual square is "compounded" by the amount on the previous square. Certainly, compounding is important if you are borrowing or lending money. For the borrower, compounding costs money, and for the lender, compounding allows money to grow.

In addition to the interest rate, the number of times compounding occurs in a given period can also affect the total interest. The more compounding periods there are, the greater the total interest. For example, $1000 borrowed at 6% annual interest would cost $60 of interest if the interest were simple or not compounded. If the interest were compounded monthly, the total interest payment would be $61.68, daily compounding yields a total payment of $61.83, and we can even calculate continuous compounding which would yield a total annual payment of $61.84.

Many commercial loans including credit cards display interest as APR (annual percentage rate). For example, if you were considering taking out a

business loan of $300,000 to start a medical practice with an interest of 6%, your annual interest payment would be $18,000 or $1500 per month. However, the actual payments on such a commercial loan are typically higher as they include not only the cost of interest but also the additional fees attached to the loan. The APR includes these extra costs. In the above example, if the loan also includes closing costs, insurance, and origination fees totaling an additional $5000, then your original loan amount would be $305,000. At 6% interest, the new annual payment would be $18,300 for an APR of 6.1%. The APR gives a better estimate of the actual cost you pay to borrow money because the APR includes the cost of interest plus the cost of additional fees. When shopping for loans, the APR gives a good sense of the monthly costs of borrowing money and can be used to compare loans. However, borrowers need to be cautioned that it is not only the APR that is important in choosing a loan but also the duration of the loan. A 10-year loan spreads out the additional fees associated with the loan over a much longer time period than a 24-month loan lowering the APR substantially. However, a borrower would pay more total interest on a longer loan. Therefore, when borrowing money, it is important to consider not only the APR but also the total number of payments to determine the better loan for a given situation.

In addition to interest (also called the cost of capital or discount rate), understanding a business opportunity requires understanding of present and future value of money which is intertwined with the time value of money. As is now obvious, the future value of money is greater than the present value because of opportunity costs and the cost of capital. Put mathematically, future value (FV) = present value (PV) × $(1 + r)^t$, where r is the interest rate or cost of capital and t is the number of pay periods between the present and the future. As a simple example, suppose a recent college graduate borrows $200,000 prior to starting medical school to cover her 4 years of schooling. Assuming an interest rate of 3% and assuming she plans to pay the loan off in a single payment 10 years from borrowing the money, the future value equation tells us that her final amount due will be $268,783.28. Alternatively, if an entrepreneurial business student lent her the money on the same terms, the business student would earn over $68,000 in the transaction!

Net present value is a business tool used to determine the financial benefit or detriment of business opportunities, and it relies heavily on the concept of the time value of money. Essentially, if costs or payments occur in the same time period, they can be simply added to or subtracted from each other. However, because of the time value of money, payments or costs accrued at different time periods cannot be simply added or subtracted because their true value depends on when these transactions occur. To calculate net present value, all costs or payments are brought to the present value, using the present value equation, and can then be summed. In general, from a business perspective, any opportunity presenting positive net present value is beneficial, whereas any opportunity with negative net present value is not advisable.

Going back to our introductory case with Martika, the financial value of an MD degree can be summarized as:

Value of MD = total change in salary with an MD less the cost of medical school attendance less the wages lost during training. These costs and payments must all be corrected for the cost of capital and calculated at the present value.

Using several assumptions in our model including an annual interest rate of 3%, a cost of medical school attendance of $70,000, a salary increase of $130,000 after residency with 3% growth per year, and a 4-year residency duration, the net present value of Martika's MD is over $1.7 million [2]. Certainly, this is a hugely positive net present value, making the decision to go to medical school financially advantageous and something that Martika should consider from a financial perspective. Obviously, the above analysis does not begin to take into account career satisfaction, self-actualization, social status, and other nonfinancial benefits that Martika might derive from a long career as a physician. In fact, there is probably no more valuable degree in the world than a US MD degree.

Bottom Line on What We Have Learned About Time Value of Money

1. You want your money sooner, rather than later.
2. Early investing can compound earnings leading to a greater net value.
3. Getting an MD is a terrific financial investment.

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3 Basic Accounting and Interpretation of Financial Statements

Marc J. Kahn and Neil Baum

Case: Bryce

Bryce is in his second year of faculty at an academic medical center. He was invited to serve on the Board of Directors of his school's faculty practice plan, a role he desired because of his interest in practice management and because he wanted to become involved in academic leadership. When it came time to present the financial statements, Bryce felt at a loss. What is EBITDA? What is AR? Why are there multiple statements distributed to the group, rather than a simple table? Why does it appear as if there are different ways to account for the same transaction? Bryce wonders if anyone, other than the business folks in the room, really understand what these statements and metrics mean. Bryce wished that he took an accounting class in college or at least paid more attention to his roommates who were business majors. Bryce quickly recognized that there was a void in his education and that he was going to have to play catch up if he wanted to keep up!

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Basic Accounting

Basic accounting is predicated on the simple equation that *assets* = *liabilities* ± *equity*. In simple terms, looking at personal wealth, this means that your total wealth, your equity, is equivalent to what you own less what you owe. When balancing our own bank accounts, we automatically perform this arithmetic calculation. Each month we have an account balance (equity) which we add our monthly paycheck (asset) and subtract our payments (liabilities). Examples of liabilities might be mortgage payments on our home or our car expenses. Such a system of bookkeeping may be fine for an individual with a few transactions per month, but makes error detection difficult. Suppose you entered the wrong payment or the wrong salary amount. Would your account be overdrawn?

Double-entry accounting, which dates back to the eleventh century, is a system of bookkeeping where every entry to one account requires an opposite, yet equal, entry into another account. These two entries, termed debits and credits, allow for error detection as the sum of all debits must equal the sum of all credits for all accounts. The terms "debit" and "credit" are not foreign as we are used to having debit and credit cards in our wallets. A *credit* card allows us to make purchases that are payed at a later date, whereas a *debit* card represents a bank account from which funds are withdrawn. For the bank issuing the

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cards, the credit card payments are recorded as credits as they increase the fund balance of the bank once paid, and the debit card payments are recorded as debits, as they create a negative fund balance in the bank when paid. The system of double-entry accounting gives the two cards their respective names. This is considered a check and balance of both personal and business finances. With every transaction recorded as both a debit and a credit, the totals of each should always balance. When there is a value difference between debits and credits, it indicates a recording error and usually allows identifying of the error and making corrections very easily. Double-entry accounting provides a complete record of financial transactions for a business and avoids costly errors.

A simple example of double-entry accounting might be when an ophthalmologist's office sells a pair of glasses for $250. This could be recorded both as a debit of $250 to an account named "assets" and a credit of $250 to an account named "revenue." This is because the glasses represent an asset to the ophthalmology office that is lost during the sale, whereas the payment for the glasses represents a gain in revenue for the office. Generally, from a bookkeeping perspective, there are five types of accounts: assets, liabilities, income (revenue), expenses, or capital accounts. Each of these have subaccounts that are recorded as a series of debits and credits. This type of bookkeeping is often referred to as "T-accounts" as these are recorded as a large T with the account name on the top of the T and on the lower part of the T debits are recorded on the right and credits on the left. An example of T-accounting is shown in Fig. 3.1.

Bookkeeping using the principles of double-entry accounting results in financial statements that are used daily in all businesses. The three basic financial statements used by businesses are as follows: (1) The income statement, also called the profit and loss statement or P&L which demonstrates the "bottom line" of net gains or losses; (2) the balance sheet which uses the basic accounting equation and lists assets, liabilities, and retained earnings (equity); and (3) the cash flow statement that shows the outflow and inflow of cash related to operations, investments, and financing. Sometimes a fourth statement called the equity statement is produced, which represents changes in the retained earnings (savings) of the company. Analysis of financial statements can provide an estimate of the financial health of an organization or practice and can be used in planning future business strategies.

The financial statement of greatest interest to most physicians, and the one distributed on a monthly basis, is the income statement. The income statement typically covers a range of time such as the previous month, the fiscal year to date, or the previous quarter. The "bot-

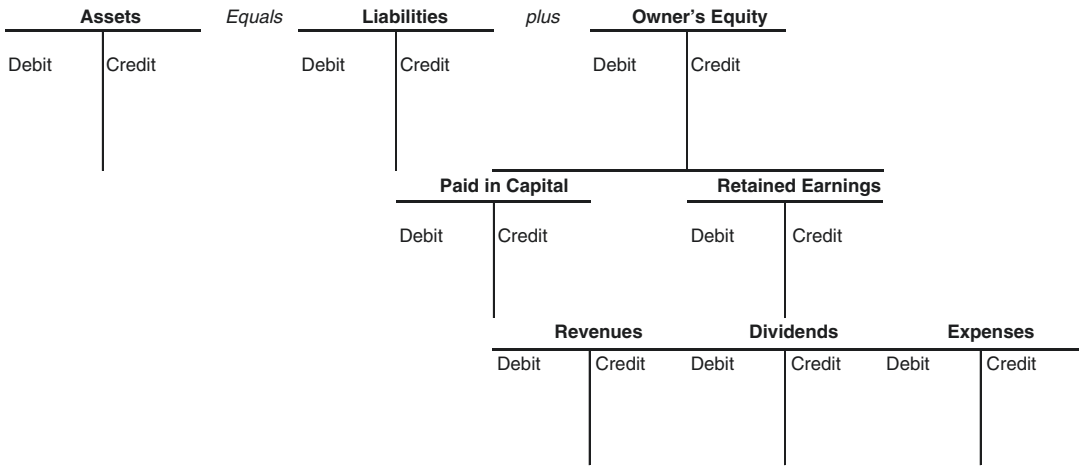

Fig. 3.1 Basic T-Accounting

tom line" of an income statement is the net profit or loss for the given time period. Typically, income statements include information for the preceding period and the previous year for comparison. Income statements usually include entries for both budgeted and actual revenues and expenses. Figure 3.2 shows the income statement for Bryce's academic group practice.

From the income statement, looking directly at the bottom line, we can see that for August 2019, the group practice is "in the black" by $14,706, meaning they have income that exceeds expenses by that amount. In spite of a relatively small positive bottom line, the practice is behind budget by $184,850. This may be of concern if such a trend continues. Looking at both expenses and revenue, the income statement tells us that the practice is behind budget due to both low revenue and increased expenses. Certainly, were this to continue, this would be a problem as the practice may not be able to pay its bills. Persistence of this trend would require finding the cause and then providing a solution to remedy the declining revenue or rising overhead expenses. From a historic perspective, the practice is doing better financially than the previous month where the net earnings were only $379, but the practice is not doing as well as the previous year where net earnings were $114,706. From a year to date perspective, the practice is $129,412 in the black, but is still below budget, but much better than this time last year, where the practice was "in the red" for $212,478.

Bryce practices at Site E. Looking at the top of the income statement, Bryce can see that his site is doing the most financially productive of all of the sites and is above budget. This may mean a bonus for Bryce in the future! Certainly, looking at just a few areas of the income statement, we can learn a lot about Bryce's practice.

The balance sheet, unlike the income statement, represents a snapshot in time. The balance sheet provides information on how assets are funded: through debt, equity, or other capital. Assets are generally listed in order of how easily they can be converted to cash, also known as liquidity. Liabilities are listed in the order that they need to be paid from first to last. Accounts receivable refers to money owed, the practice by patients and insurers that has yet to be paid. It is an asset as it provides positive value to the practice. Accounts payable represents money that the practice has to pay. This may be due to patients that were overcharged or for patients who were charged for a service that was later paid by an insurance company and a refund is due to the patient. Accounts payable is a liability because it is money that needs to be paid. Again, for the balance sheet, from the basic accounting equation, *assets* = *liabilities* + *equity*. Equity is that money left over which adds retained value to a company or practice.

Bryce's balance sheet is shown in Fig. 3.3. First, the balance sheet must balance according to the accounting equation, or assets must equal liabilities plus equity. For Bryce's practice the assests and liabilities are equal as he has both assets and debt plus equity of $770,000. Sometimes, the financial health of an organization can be determined by the debt-to-equity ratio. This D to E ratio is a measurement of risk. The ratio tells how well debt is managed. For Bryce's practice, this ratio is calculated as total liabilities divided by equity, which gives a ratio of 1.66. Generally, higher debt ratios are concerning. An optimal ratio is 1.0. Debt ratios above 2.0 are typically not acceptable to most businesses. Next, look at how the equity has changed over time. Looking at balance sheets for the past several years can demonstrate if the business/practice is growing or contracting. Finally, return on equity (ROE) is defined as net income divided by equity which provides a measure of how well the equity is being used to derive income. For example, if the practice purchased colonoscopes with their equity, the ROE could be an indicator of the success of that strategy. ROE of 15%–20% is generally considered good.

The cash flow statement shows where cash enters and leaves a business in three areas: operations, investments, and financing. Ford Motors provides us with an example of a cash flow statement. Simply stated, Ford Motors is in the business of making cars. However, looking at the cash flow statement for Ford Motors on yahoo finance for 12/31/15 [1], we see that the total cash flow for Ford from operations was $16.2 million, the total cash flow from investments was a $26.1 million loss, and the total cash flow from financing was

1-MONTH (MTD)						2-MONTHS (YTD)			
BUDGET	ACTUAL	FAV (UNFAV)	Jul-18	Aug-18	DESCRIPTION	BUDGET	ACTUAL	FAV (UNFAV)	Aug-18
4,647,325	3,966,168	-681,157	4,109,613	3,898,084	SITE A INCOME	8,890,534	7,864,252	-1,026,283	7,736,099
258,703	152,674	-106,029	118,978	115,425	SITE B INCOME	517,405	268,099	-249,307	209,341
3,009,639	1,905,153	-1,104,486	1,924,358	3,101,420	SITE C INCOME	6,019,278	5,006,572	-1,012,705	4,444,469
808,428	620,808	-187,620	100,230	95,308	SITE D INCOME	1,616,857	716,116	-900,741	281,561
445,608	657,427	211,819	546,321	632,577	SITE E INCOME	891,217	1,290,004	398,788	1,033,651
29,917	32,108	2,191	1,036	21,875	OTHER INCOME	59,833	53,983	-5,850	3,650
9,199,620	**7,334,338**	**-1,865,282**	**6,800,537**	**7,864,688**	TOTAL INCOME	**17,995,124**	**15,199,026**	**-2,796,098**	**13,708,770**
-7,834,158	-6,058,899	1,775,259	-5,520,796	-6,679,667	LESS: Practice -REALTED COSTS	-15,525,502	-12,738,566	2,786,936	-11,674,289
1,365,461	**1,275,439**	**-90,022**	**1,279,740**	**1,185,022**	NET COST OF PRACTICE ASSESSMENTS	**2,469,622**	**2,460,460**	**-9,162**	**2,034,481**
					COST OF PRACTICE:				
538,291	601,893	-63,602	539,745	515,602	NET SALARIES & WAGES	1,076,582	1,117,494	-40,913	954,284
143,535	162,839	-19,304	166,758	133,518	FRINGE BENEFITS	287,070	296,357	-9,287	295,592
7,519	7,515	4	6,544	4,455	OPERATING SUPPLIES	15,038	11,970	3,068	9,041
246,905	244,385	2,521	281,058	220,831	PURCHASED SERVICES	493,811	465,215	28,595	500,977
12,873	15,223	-2,350	72,045	13,704	UTILITIES & POSTAGE	25,747	28,927	-3,180	74,257
44,652	33,740	10,912	31,368	39,009	OTHER EXPENSE	89,304	72,749	16,555	55,607
85,417	74,070	11,347	85,400	82,470	FACILITY FEES	170,833	156,540	14,293	164,730
1,079,192	1,139,665	-60,473	1,182,918	1,009,588	TOTAL OPERATING EXPENSES	2,158,384	2,149,253	9,132	2,054,489
					NON-OPERATING EXPENSES				
125,858	133,316	-7,458	124,691	128,771	MALPRACTICE EXPENSE	251,717	262,087	-10,370	249,317
-39,145	-12,248	-26,897	-28,248	-68,042	LESS: RECOVERIES	-78,290	-80,291	2,001	-56,848
86,713	121,068	-34,354	96,443	60,728	NET MALPRACTICE EXPENSE	173,427	181,796	-8,369	192,470
1,165,905	**1,260,733**	**-94,827**	**1,279,361**	**1,070,316**	TOTAL COST OF PRACTICE EXPENSES	**2,331,811**	**2,331,049**	**762**	**2,246,958**
199,556	**14,706**	**-184,850**	**379**	**114,706**	NET EARNINGS	**137,811**	**129,412**	**-8,400**	**-212,478**

Fig. 3.2 Income Statement

BALANCE SHEET
31-Dec-19

ASSETS		**LIABILITIES**	
Current Assets		Current Liabilities	
Cash	$ 2,100.00	Notes payable	$ 5,000.00
Petty Cash	$ 100.00	Accounts payable	$ 35,900.00
Temporary investments	$ 10,000.00	Wages payable	$ 8,500.00
Accounts receivable	$ 40,500.00	interest payable	$ 2,900.00
Supplies	$ 34,800.00	taxes payable	$ 6,100.00
Prepaid insurance	$ 1,500.00	unearned revenues	$ 2,600.00
		total current liabilites	$ 61,000.00
Total Current assets	$ 89,000.00		
		Long-term liabilites	
Investments	$ 36,000.00	notes payable	$ 20,000.00
		bonds payable	$ 400,000.00
Property, Plant & Equiptment		Total long-term liabilites	$ 420,000.00
Land	$ 12,000.00		
Buildings	$ 180,000.00	**Total Liabilities**	$ 481,000.00
Equiptment	$ 201,000.00		
Less: depreciation	$ (56,000.00)	**OWNER'S EQUITY**	
P,P,E net	$ 337,000.00	Retained earnings	$ 280,000.00
		accumulated other income	$ 9,000.00
Other Assets	$ 308,000.00	total equity	$ 289,000.00
Total Assets	$ 770,000.00	**Total liabilites & Equity**	$ 770,000.00

Fig. 3.3 Balance Sheet

$14.3 million. Based on an analysis of cash flows, Ford Motors is almost as much a lending company as they are a car manufacturing company!

In addition to the basics of the three financial statements, there are other terms and additional information that can be derived through analysis of financial statements. One commonly used line item in an income statement is EBITDA or earnings before interest, taxes, depreciation, and amortization. EBITDA is sometimes used as an alternative to net income. EBITDA is used in income statements as it eliminates the effects of financing (interest) and capitalization (depreciation and amortization). EBITDA and net income are very closely related.

Additionally, analysis of financial statements can help to evaluate how well the practice is performing at collecting money owed to the practice. This refers to "days in AR" or days in accounts receivables. This metric can be calculated from the charges for the past year divided by the days in a year. Because most health expenses are discounted by insurance companies and other third-party payors, charges are very different from revenue in healthcare. In addition to the income statement, you would need to know total charges to make this calculation. Additionally, many third-party payors will not pay bills that are older than 180 days. Days in AR is an important number to know! The greater the days in accounts receivables is a barometer of inefficiency in the practice. Examples of rising days in accounts receivables may be a result of the doctor not submitting charges in a timely fashion, or could result from a payor that is delayed in making payments, or an office staff member that is making errors in submitting claims to the insurance company and have an increase in denials requiring

resubmitting the claim which delays payment to the practice. Unfortunately, one of the quickest ways to reduce days in AR is to write off debt. When reviewing financial statements, it is important to know how and when debt is written off and not collected.

Finally, the health of a practice can be assumed by the liquidity of the practice which gives an impression of the amount of money the practice has on hand in case of emergency. This can be presented as "working capital" which is the difference between current assets and current liabilities. For Bryce's practice, his working capital, from the balance sheet, is $89,000 minus $61,000 or $27,000. A company with negative working capital could not pay off short-term debts if required to do so and would be considered illiquid. Another commonly used indicator of liquidity, or ability to pay debt, is the current ratio, the ratio of current assets to current liabilities. For Bryce's practice, this ratio is 1.46. A current ratio between 1.5 and 2.0 is generally considered good.

Although there are many other calculations based on financial statements used by businesses, these are the major ones used, and understanding these will go a long way toward being able to analyze financial statements.

Return to the Case

Bryce went to the business manager of his practice to learn more about the data presented at the board meeting. His office manager was quick to point out that she worked for Bryce, and not the other way around. She explained the accounting used in his practice and gave him a much better understanding of the financial well-being of his practice. Bryce was satisfied that he was working in the right place and also felt more confident the next month when the group's financial statements were presented because he would be able to understand the financial statements and could actively participate in the discussion. He even knew enough to ask about days in AR and was pleased that it was only 28 days and improved from last year. Bryce considered enrolling in the school's MBA program which would be valuable in the future.

Bottom Line

(no pun intended) What are the three principles we have learned about accounting and financial statements?

1. Assets = liabilities + equity.
2. There are three basic financial statements: the income statement, balance sheet, and cash flow statement.
3. Understanding basic principles of accounting allows physicians to understand the financial health of their practice and allows for strategic planning.

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Revenue Cycle Management

4

Brandt Jewell

Debra's Case

Debra is a new employee with little experience in working at the front desk of a medical practice. She is replacing June who left for maternity leave and not expected to return to her position. Unfortunately, Debra had only a few days to work alongside June before she left for her leave of absence.

June is available by phone, but Debra is hesitant to disturb her now that she has expressed her intentions to resign. The back-office staff are extremely busy and do not seem to know the details of dealing directly with the patient. The practice administrator assumes that Debra learned all she needed to know from June, and she has not been available when June had questions for her.

How can Debra get up to speed on her responsibilities so check-ins flow smoothly? Further, what should Debra do to understand the entire revenue cycle process? What part does the front office play in coordination with the back office where billing and collections occur? What, if any, responsibilities will she have in collecting from patients?

Debra has a keen interest in the workings of a medical practice and sees herself as becoming an integral part of the management team. But first, she has a lot to learn and is watching all the moving parts. Even in her short tenure, she has identified some areas that need improvement. Especially communication!

Introduction

Medicine is both a calling to provide high-quality medical services to patients, and it is a business that must generate sufficient revenue to cover expenses to remain viable. Your education and training as a physician focused almost entirely on your clinical knowledge. While you may be ready to enter medical practice and apply your clinical expertise, you are likely less comfortable managing the necessary financial and operational components. You will need help in the business performance aspects of medical practice management whether you are opening a new practice or joining an existing organization. You will be more effective in all practice settings if you know about operations, provider productivity, cost control, and process consistency.

This chapter reviews components of the revenue cycle and briefly discusses these factors in the context of how they affect revenue. It will

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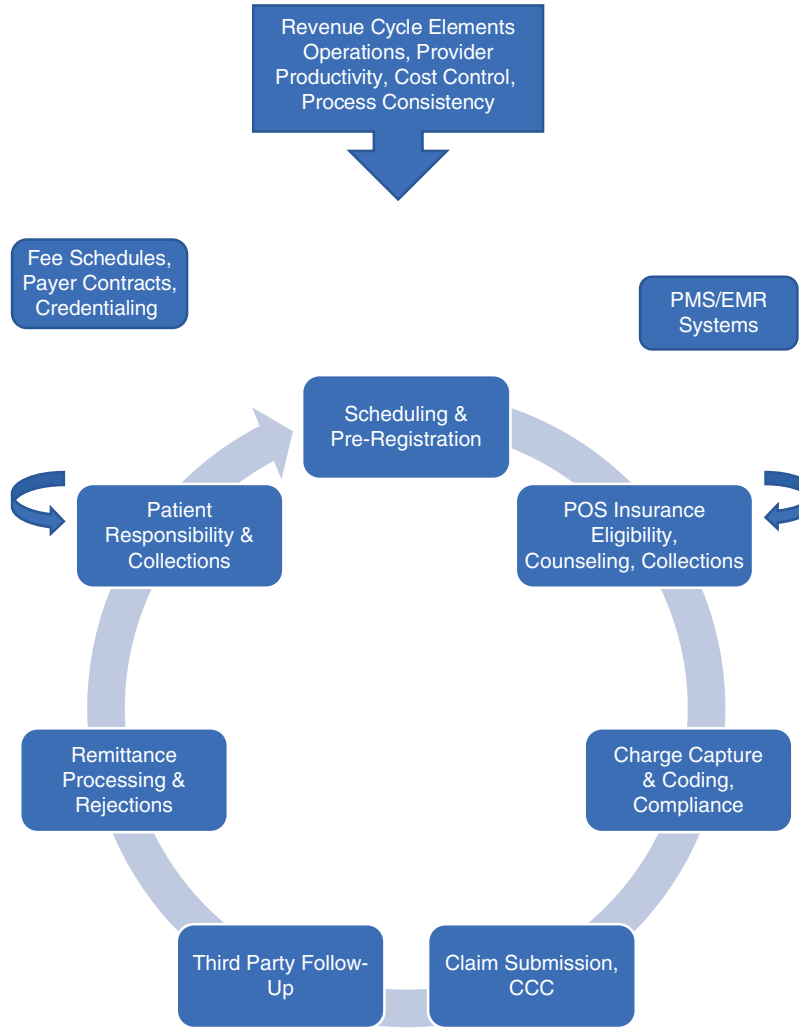

Fig. 4.1 Revenue cycle elements

address appointment scheduling, registration, coding, charge capture, patient and insurance billing, account follow-up, and collections. Figure 4.1 provides a visual of the elements and the workflow of revenue cycle management.

Following are the steps involved in managing revenue cycle processes. We do not address operations, provider productivity, cost control, or process consistency in this chapter.

The revenue cycle is a complex process that requires collaboration across multiple areas of the practice. Consistently efficient procedures are vital for the practice to achieve ongoing fiscal stability.

Scheduling, Preregistration, and Appointment Reminders

A patient encounter begins with the prospective patient's first call to your practice, which is usually handled by the receptionist at the front desk

or a central call center. Practices of all sizes rely on the contribution of many staff members to provide the necessary coverage during times when the volume is high. Cross training and knowledge sharing are paramount to ensuring that all responsibilities are handled deftly. Though the use of technology is expanding, such as online appointment scheduling and registration and using phone trees to route the patient's call, nothing compares to the impact of the person-to-person contact.

The greeting the new or existing patient receives has far-reaching implications ranging from patient satisfaction to payment for services to building your practice panel to risk management. A happy patient is likely to be compliant and to pay for medical services. A disgruntled patient is more apt to have an adverse outcome and to sue you for malpractice.

The story begins with who answers your telephone and how the person regards the patient's feel. Perception is reality in the eyes of the patient.

Providing consistent training ensures that staff members who answer telephones and receive patients have excellent communication and listening skills. Moreover, coach them on how to ask the right questions and how to be sensitive to patient requests, even when they may disagree with the urgency or "needs" a patient expresses. Ask your employees to view their jobs as problem solvers and information gatherers—not appointment bookers or gatekeepers. Practices are most successful when employees have pride and ownership in the processes and patient experience. Align incentives with objective metrics and accountability wherever possible.

Scheduling

A healthy revenue cycle relies on proficient appointment scheduling as the first step in generating a patient encounter. The primary objective of appointment scheduling is to fill provider schedules within a given workday or workweek to maximize practice revenue and provider utilization. Not every practice is incentivized on volume alone; some reimbursement systems are based on quality or cost outcomes associated with value-based contracts. It is important to establish a scheduling policy that reflects the business model of your practice and your specialty and preferences as a provider. In addition to patient, provider, and staff satisfaction, revenue suffers when breakdowns in scheduling occur. Staff members must understand the financial implications of filling a provider schedule and work to avoid gaps or vacant appointment slots. There are many techniques for maximizing schedule utilization, depending on the focus of your practice and specialty. Practice management consultants can be helpful resources for reviewing scheduling options if your staff or leadership lacks expertise.

Preregistration

When a new or established patient calls to schedule an appointment and the date and time are set, the dialogue between the caller and your telephone receptionist must include capturing complete and accurate demographic data (name, address, telephone numbers, workplace, and insurance coverage), reviewing the billing policies and collection procedures, and giving directions to the office or facility if necessary. Be sure to document the patient's email address and preferred method of contact by the practice. Repeat any information the caller may not understand and ask if there are any more questions or concerns before politely ending the call.

Appointment Reminders

When a patient misses an appointment, you lose time and income. Appointment reminders help you increase revenue by reducing the number of patients that do not show up for their scheduled appointments. Automated email, text, or telephone appointment reminders can save valuable staff time and help maximize provider productivity. Many practices choose to make manual reminder calls, which is resource intensive but

yields more accurate indicators of patient intention. Develop consistent criteria for practice staff to double-book or manage appointments based on feedback from appointment reminder efforts.

Registration/Eligibility

Establishing a registration procedure to obtain accurate patient information is an essential function of the revenue cycle, especially in the case of payments by third-party payers where accurate information is a prerequisite for reimbursement. After scheduling the appointment and collecting the information, the next step is to verify insurance coverage details with the plan provider(s) by phone or online before the patient arrives for the appointment. You can mail or email new patients a copy of the practice registration forms and payment policy with a confirmation of the appointment time.

Some practices post patient registration forms on their website for those who prefer to provide information online before arriving for their appointment. Preregistration efforts speed up the registration process by reducing the time needed to fill out or update demographic information or medical history at the time of visit. This process will also help providers stay on time throughout the day by reducing check-in processing time.

Check-In

The practice's front-office employees are a gateway to the financial health of the medical practice. Their knowledge of billing and their ability to educate patients on the practice's financial policies, define patient expectations, and collect payments at the point of care are critical to a well-run billing and collection process. The ability of the front-office employees to obtain and transcribe/input patient information accurately and efficiently is vital to ensuring that the billing is accurate the first time.

Upon the patient's arrival, front-office staff should present or request all relevant paperwork, including updates to the patient's demographic and insurance information and any new medical practice information. The patient's demographic information must be updated every time the patient presents for an appointment to ensure its accuracy. The practice's financial policy and the HIPAA Privacy Policy are a part of the information package. The front-office staff should obtain the necessary signatures in writing and copy the insurance and identification card and request the patient's co-payment, deductible, or any open balance payments.

Whether your patient is new or established, it is critical to verify whether the insurance information you have on file is correct or needs updating. Front-office staff will also "arrive" the patient in the practice management system so the clinical staff knows the patient is ready to be roomed.

Coding

Documentation and coding processes form the basis for a compliant and optimized revenue cycle. Failure to keep abreast of current coding changes and initiatives not only impacts cash flow but can also result in significant fines and sanctions as mandated by state and federal statutes. It is crucial to understand the implications of noncompliance with standard coding initiatives and consistently monitor adherence to practice policies.

As services are rendered (professional and facility), complete documentation of the history of the condition, physical examination, and medical decision-making process should be documented by the person providing the service (e.g., the physician or other healthcare professional) or by an employee directly observing the services being rendered such as a scribe. Regardless of who creates the documentation, the record must accurately reflect the encounter and all services ordered and provided.

Based on the documentation, procedural and diagnosis codes are chosen to describe the services rendered to the patient, which is typically done by the physician/provider who provided the care. Additionally, many organizations employ certified coders who code services through chart

abstraction to ensure that all charges are supported by appropriate documentation.

Charge Capture

After accurate coding and documentation, the revenue cycle progresses from the clinical stage to the capturing of the charges. Charge capture encompasses the appropriate transfer of documentation and coding to the actual billing instrument (encounter form or superbill). Obviously, the practice wants to capture all revenue for services that are performed, but it is not uncommon for practices to leave potential revenue on the table during this process. Missing charges can occur at a high rate if the charge capture process is inexact. Mechanisms must be in place to ensure a closed-looped charge capture process that verifies charges with appropriate source documents, either electronically or manually, to ensure that each service delivered is billed appropriately.

- *Office and outpatient services.* Daily, a designated employee should reconcile all patient encounters (scheduled and unscheduled) to patient charges entered. Most practice management systems offer a standard reconciliation report. Alternatively, the employee may need to reconcile the schedule/patient arrivals with the charge tickets to ensure all charges are entered. Automating this process is recommended to reduce manual error and resource requirements.
- *Hospital and facility services.* All services should be entered in the practice management system, including emergency services (entered retrospectively). As services are performed, each physician/provider records and reports his or her activities on a designated charge application platform (desktop, mobile device, etc.). Alternatively, the physician completes a card, log, or other designated manual form with a record for each service provided. Weekly, a designee generates a charge reconciliation report to identify any missing charges [1].

Charge entry should be immediate, as revenue cannot be realized in cash until the charge is entered and the billing process starts. Delays in charge entry known as "charge lag" reduce practice revenues and cause significant stress for providers, who often struggle to catch up after getting behind on timely charge entry. Establish consistent expectations for your practice or group with objective accountability measures for all providers and staff.

Point-of-Service Collections

The practice must collect all co-payments and deductibles when services are rendered, called point of service (POS) collections both as a requirement of the plan payer, including Medicare and Medicaid, and as a good business practice. Cash collection goals should be in place based on total expected payments and collections at the time of service. Traditionally, copayments have been collected at check-in, but health plans have been increasing patient financial responsibility (including coinsurance and deductibles), which requires patients to be responsible for a greater portion of their healthcare costs. Policies/protocols for payment plans and patient accountability are developed so practice staff has clear guidelines to manage collections and patient expectations.

Because coinsurance and deductibles cannot be calculated accurately until the services are known, best practice is to shift these time-of-service collections to the time of checkout. This action ensures that all rendered services are charged correctly so that patient responsibility can be appropriately assigned and collected.

Checkout

The patient checkout process is where the follow-up activities after the visit occur. Checking out includes the following processes:

- Reschedule patient for their next appointment.
- Schedule surgeries and other tests.
- Secure external referral and authorizations.

- Collect residual point-of-service payments and issue receipts to patients.
- Offer any relevant discounts or payment plan options to patients consistent with the medical practice payment policy, post payments, and issue receipts to patients.

It is important to set up patient workflows that ensure a formal checkout process for each patient. When checkout is missed, patient care and revenue are both negatively impacted. Determine clear protocols for staff and patients so that this critical process is never skipped, even if the physical layout is not conducive to a checkout desk/window.

Patient and Insurance Billing

After proper coding and documentation of services, business office staff must ensure that the charge captures are accurate. Then, they can assume responsibility for accurate billing to patients and third-party insurers. This action entails using an appropriate practice management system, processing bills electronically, maintaining acceptable relations with the payers, devising internal information system process, and creating other organizational steps.

For maximum productivity, an effective billing office requires adequate organization, supervision, and oversight and should offer incentives for collection performance. You can work hard to optimize patient encounters through proper coding and other functions, but your efforts are fruitless without an efficient billing office.

Claim Submission Process

Most medical practices batch their claims daily, combining the most recent date-of-service bills, secondary claims, and rebills for submission. When the practice submits less frequently, for example, once a week, it will delay the practice payments by one to 4 days. Over time, this delay may significantly affect the practice's cash flow.

Timely claim submission is a requirement to ensure smooth cash flow in the practice. All payers have a claim filing deadline based on the date of service. Most commercial payers maintain 30–90-day filing deadlines. Medicare claims must be filed within one calendar year from the date of service. Claims received after these deadlines will be rejected. It is crucial to identify all payer claim filing deadlines and implement policies to ensure the practice adheres to those time limits to avoid unnecessary write-offs.

Regardless of how the practice submits claims, and whether the claims are initial submissions, rebills, or secondary, the billing staff should review the claim to ensure its accuracy. If there are errors on the claim, then it should be suspended until it is corrected [2]. An excellent model to follow is the 3Cs: clean, current, and correct claims. Submitting clean, current, and correct claims improves the effectiveness of the revenue cycle, thus improving the cash flow and the financial bottom line.

Account Follow-Up and Collections

Insurance follow-up involves investigating the status of the claim with the payer and pursuing a well-defined process to ensure that the claim is adjudicated and paid.

The practice should separate the claims into two types:

1. Accounts without a response from the payer
2. Accounts with a response that requires more work

The staff should prioritize the accounts receivable requiring more work by (1) the time frames associated with filing and appeal deadlines as instituted by the payer and (2) dollars outstanding. Staff can improve results by focusing on high-dollar accounts and those accounts with short deadlines. From a resource allocation perspective, it is negligent to construct an appeal only to realize it is past the payer's deadline for the appeal and the rework was a wasted effort. Employees should work insurance and patient

correspondence as it arrives. The correspondence may supply the new information needed regarding the account and thus eliminate the need to initiate communication with the patient or the payer.

Patient Collection Process

A patient has many ways to pay an outstanding account balance. Practice staff should make it easy for the patient to pay by offering multiple payment options, as follows:

- *Check-in, checkout.* Have a well-defined payment collection process at each point to ensure timely reimbursement and reduce the cost of billing. Collect payments, coinsurance, unmet deductibles, and patient balances when the patient is physically present in the office.
- *In the examination room.* Consider permitting medical assistants, nurses, and/or schedulers to accept payment via a portable device in the examination room, thereby bringing the work to the patient rather than sending the patient to the checkout desk to make a payment.
- *Scheduling*: Develop a collection process for schedulers to obtain outstanding patient balances. When the patient calls to schedule an appointment, the scheduler can see the patient responsibility balance and accept payment over the telephone via credit or debit card. Another option is to transfer the patient to the billing office to collect the payment before the patient presents for further care.
- *Appointment reminder.* Utilize an appointment reminder system that includes a review of the scheduling templates 1 or 2 days before the visit to determine outstanding patient payment obligations. The employee should contact the patient by telephone or a patient portal to attempt to collect the outstanding payment via credit or debit card prior to the patient presenting for care.
- *Billing inquiries.* When patients call the business office with billing questions, ensure that employees have a well-defined process and telephone script that prompts the patient for payment during the billing call.
- *Online bill payment.* Direct patients to the practice's patient portal or payment system to encourage patients to pay online.
- *Credit card on file (CCOF).* Many practices use a CCOF system to offset the out-of-pocket costs due to higher patient financial engagement in their healthcare plans (3) [3].

Patient Statement

A patient statement is an invoice to notify patients of their financial responsibility for outstanding balances on their account. In addition to the balance, the statement usually provides a chronological record of any transaction activity that has occurred on the account. Statements are typically sent to patients by US Mail but now are available via patient portal or other secure electronic means.

Because of changing health plan designs with more significant deductibles, coinsurance, and copayments, a larger portion of the amount owed to the medical practice is now the patient's responsibility. It is critical that the front desk staff are trained and given the necessary tools to determine the expected patient portion at the time of service. It is also important that the patient is aware of the practice's financial and that those policies are enforced consistently.

It is essential for the medical practice to analyze the effectiveness of their patient statement process and determine opportunities to optimize cash flow. The obvious "best practice" is to collect as much as possible while the patient is in the office. The overall goal is to reduce the time to receive payments, which ultimately reduces the cost of collections [3, 4]. A clear and concise patient statement that does not generate patient confusion or questions will help with all collection processes.

Payment and Denial Posting

Once a medical practice receives payment for services, the payment is either posted to the patient account electronically or manually. For

professional services, it is essential that payments be posted to individual charges, often referred to as "line-item posting." This process is in contrast to posting the entire sum of payments for all services rendered to the patient's account. Failure to line item post significantly reduces the opportunity to identify and improve revenue cycle performance.

Payment posters need direct access to the payers so that they can ask questions about electronic remittance advice (ERA) or explanation of benefits (EOB). They also need advanced education regarding insurance and the codes reported on the ERA or EOB so they can interpret the account. Payment posting must be accurate which requires the poster to be diligent and well-trained. If the payment poster makes mistakes in posting payments or interpreting the accompanying information provided on the ERA or EOB, your practice may fail to appeal denials or under-profile payments. Further, an ill-timed or inaccurate payment posting process may result in the failure to bill patients for balances due after their insurance has paid [3, 5].

Denial Posting

When the claim or line item on the claim has been denied by the payer, the notice of denial is posted to the practice management system accompanied by reason codes that describe the adjustment by the payer. The claim adjustment reason codes (CARC) and the remittance advice remark codes (RARC) reflected on the EOB/ERA show the action taken on the account. The adjustment may be an adjustment of payment denial on the account, which is typically categorized as soft or hard denials. A soft denial is a denial of payment; however, the payer is passing along the responsibility for payment to another party. This process involves changing the financial classification on the account and submitting it to another payer or the patient for payment. A hard denial, conversely, involves considerable investigation, follow-up, and potentially, the need to submit an appeal to the payer for payment.

It is important to track these account adjustments, investigate their root cause, and be proactive in preventing and/or reducing these adjustments. Many of these denials relate to errors conducted at the practice site, such as denials caused by the absence of pre-visit financial clearance to include lack of authorization or missing referral for services performed. Others are caused by excessive lag time for initial charge submission and account follow-up, which results in denials for untimely filing. At the time the denial is posted, the noncontractual adjustments should be reported in the practice management system like other transactions.

Bad Debt

Based on the practice's financial policies, when an account is deemed uncollectible by the practice, the balance is moved to a different financial status for collection consideration and adjusted off the accounts receivable. At this point, the practice may also consider initiating the process of discharging the patient from the practice. Most practice management systems allow the debt to be moved to a bad debt status but remain visible on the patient accounts. With this alert or tickler status, the staff can easily recognize the bad debt status. If the patient tries to make another appointment, he or she should be informed of the outstanding balance. The staff member can request payment for the collection's balance at the time of scheduling or at the time the patient presents for their appointment. The patient may be asked to pay this balance before any future appointments are scheduled, depending on the policies of the practice.

Credit Balances and Patient Refunds

Credit balances usually result from miscalculations or posting errors, and issuing refunds is a time-consuming task. Credit balances should be researched regularly and worked daily/weekly and refunded within 60 days of the posting. Payment posting employees can work the credits daily after

they post payments, but generally, the business office employees work credits from a credit balance report each week to correct payment posting errors and ensure the appropriate funds are sent to the patient/and or payer. The Centers for Medicare and Medicaid Services (CMS) and many commercial payers require medical practices to repay overpayments within a specified period. These credits offset your total accounts receivable, and if they are high, then it may understate the dollar value of the accounts receivable and misrepresent the performance of the revenue cycle.

Fee Schedule and Pricing for Medical Services

As a business, the pricing of medical services is important. You should systematically review your fee schedule at least annually to ensure it is appropriate based on reimbursement levels, the local market, and other factors. A clear indicator of fees that are too low is to watch the EOBs and ERAs where payers reimburse at 100% of the charge. If your fees are too low, you will likely lose out on potential revenue from one or more payers.

Staff Education of Policies and Procedures

Education of physicians and staff on each area of the revenue cycle is essential to ensure a healthy process and efficient operation of the medical practice. Learning should occur through a combination of in-house training and outside workshops and seminars. Many quality web-based education tools are available to help minimize the cost of outside education. New employee and provider onboarding should include dedicated training on revenue cycle management, including policies and protocols.

Key Revenue Indices

There are several key revenue indices to consider as part of your practice's revenue cycle that create the framework for achieving financial success. Collections, as with most businesses, drive revenue. The two largest subcategories under collections are charges and reimbursements. Charges include volumes generated by providers, charge entry, fees, coding practices, and contract negotiations. Reimbursements encompass the payer mix, adjustments, denials, follow-up, front-end processes, payment posting, claims process, and contract management.

Recommended Steps to Maximize Revenue

Follow these six steps to manage the revenue cycle better and improve financial health:

1. *Analyze the practice's revenue cycle.* Understand the complete revenue cycle process outlined herein and verify that all the necessary steps are managed appropriately.
2. *Document financial policies and procedures.* Recording the financial policies and procedures will help your practice on a daily basis and serve as a safeguard against unexpected events. In addition to documenting these protocols, you must also reinforce with training and accountability to be successful.
3. *Review financial tools.* The proper use of a superbill or encounter form will reduce claims processing time and provide for appropriate and fair payment. The form must be easy to use for the provider to code and for the billing staff to understand. Take the time to review and revise the form if necessary.
4. *Review managed care contracts.* Every managed care contract should have a contractual obligation that requires payment within specific, preestablished time frames, which is also mandated by state prompt pay laws. Fee schedules and other requirements should be in the contract or ancillary materials. Contract policies should be outlined, and documentation should be available for staff to follow. Providers should also understand the contract requirements, which typically include preauthorization and precertification. Patients should sign an advance beneficiary

notice or similar document prior to receiving services to assume financial accountability for services that may not be covered by the benefit plan. Managed care contracts should be mutually negotiated, either directly or indirectly, through an affiliation such as an independent practice association or a physician-hospital organization to achieve negotiating leverage.

5. *Review the practice's current fee schedule.* Compare the fee schedule to certain standards, including benchmarks or history of reimbursement in the practice, at least annually, to ensure that all the codes are up-to-date and fees are set at reasonable levels.
6. *Make sure the practice is compliant.* The five most important federal fraud and abuse laws that apply to physicians are the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Law (Stark law), the Exclusion Authorities, and the Civil Monetary Penalties Law (CMPL). Other statutes that apply and affect medical practices are the Health Insurance Portability and Accountability Act (HIPAA), the Occupational Safety and Health Administration (OSHA), Medicare/Medicaid, state medical board guidelines, the Food and Drug Administration (FDA), Clinical Laboratory Improvement Amendments (CLIA), Incentive Act, and the Fair Credit Reporting Act. Your practice must have a compliance plan to address all these areas, and your staff must be knowledgeable of how these laws affect your practice.

Conclusion

Revenue cycle management is an enormous responsibility for any practice and calls for day-to-day awareness to attain maximum revenue and compliance. This chapter provided an overview of each step in the process, but there is much to learn about each functional area. The essential points in this chapter are to identify the stages, from beginning to end, and to apply the following principles:

- Cross training, knowledge sharing, and ongoing education/training are paramount to ensuring that all responsibilities are handled deftly.
- Whether your patient is new or established, it is important to verify at check-in whether the insurance information on file is correct or needs updating.
- Understand your revenue cycle tools and how to use them. If you find weaknesses, fix them. You should conduct a review of your superbill or encounter form, practice management system, and other documentation tools at least annually to safeguard against lost revenue.
- It is imperative that you and your staff understand the implications of noncompliance with standard coding and documentation initiatives.
- Documenting financial policies and procedures are fundamental in ensuring your practice's revenue cycle runs smoothly.

Debra's Case

Debra's keen interest in her new position and her desire to learn all that she can to be an asset to the practice has inspired her to list ways that she can grow professionally. She believes her best contributions to the team will come through education and communication. Her list of objectives includes the following:

- Study and apply the policies and processes of the practice.
- Join a professional organization that connects her with other medical practice staff members.
- Attend educational programs with an emphasis on revenue cycle.
- Seek training and education from revenue cycle and practice management experts.
- Cross-train for other positions in the organization.
- Be a good teammate and communicate effectively.

As she gradually gets to know her coworkers, she eagerly seeks guidance and input from those who are knowledgeable of "best practices" in medical practice operations. She desires to be a team player and a positive contributor to the success of her organization. Debra understands that she plays a key role in the financial health of the practice, patient satisfaction, and provider efficiency. The practice will benefit from her taking ownership of the front-office responsibilities and being invested in its operational and financial success.

Bottom Line

The revenue cycle is a complex process that requires collaboration across multiple areas of the practice. Consistently efficient processes are vital for the practice to achieve ongoing fiscal stability.

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Contracts and Negotiation

5

Marc J. Kahn and Neil Baum

Case: Sherri

Sherri is in her final year of her Maternal Fetal Medicine Fellowship and has received her first job offer in a large inner-city obstetrics and gynecology practice. Sherri first learned of this position through a recruiting firm that sent her an email 3 months ago. Sherri spoke on the phone with the recruiter who connected her with the medical director of the practice. Following her interview, Sherri felt that this practice was a good fit for her; it was large enough that call would not be onerous; the patient population included medically underserved patients who she like to care for; she liked the other physicians and office staff and had a good vibe about the work environment. Another plus for Sherri was that the practice was in a city where she had friends and family. In reviewing her job offer, she was a bit overwhelmed. Although the salary was more money than she thought she would ever earn, was it fair? Sherri had over $300,000 in educational debt, and there was no provision to help her pay for some of her loans, a benefit that she knew others in her fellowship program had been offered with other practices. There was no provision for CME and license expenses. Sherri wondered what was negotiable? Sherri never had previous experience with an employment contract. She felt like a fish out of water. She was not comfortable asking for more money. Should she hire an employment lawyer? Although she only weighed 110 pounds, Sherri wished she were in the NFL where at least she would have an agent to help her negotiate.

Before initiating contract negotiations, new physicians should research the practice they wish to join. You will want to conduct a due diligence. Questions to find the answers include the rate of physician turnover, percentages of physicians engaged by the employer who make partner and the average length of time to achieve partnership, the employer's profit or loss history, past payouts of bonus and incentive agreements, malpractice claims against the physicians in the practice, pending litigation against the physicians in the practice, and the reputation of the partners and of the employer in the community. What the

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employer has actually done in the past may be more important than what the hiring physicians promises to do in the future. The best advice before getting to the meat of the contract is for the prospective physician to take reasonable steps to do a background check on the practice they plan to join. It is also a good idea to look at the financial statements of the group, especially the income statement for the past 2–3 years.

A contract is a legal agreement, typically between two parties. Although contracts can be verbal, healthcare contracts are almost always written such that all parties in the contract are protected legally and so that there are no misunderstandings between the parties of the contract. The parties of the contract are the entities involved in the agreement. The terms and conditions of the contract spell out the rights and responsibilities of each party in the contract. Terms and conditions often include legal remedies that parties can use if there is a suspected breach or violation of the terms in the contract.

Basically, a contract has three parts: offer, acceptance, and consideration. An offer is a promise to provide something, acceptance is an agreement by the promisee to abide by the contract, and consideration is a legal concept that involves the bargaining for a quid pro quo that provides a benefit to the promisee, in this case the physician joining the practice, and a detriment to the promisor, in this case the salary and benefits provided to the physician., For example, if I tell you that I am going to give you $100 and then renege, this offer is not a contract as there is no consideration. No exchange of promise occurred. On the other hand, if I tell you that I will give you $100 for cleaning my gutters and you accept my offer, then this is a contract. There is the offer to clean gutters, acceptance of my proposed fee, and consideration, the exchange of fee for services.

Today, very few physicians enter solo practice. Because most physicians are employed by a group medical practice, hospital, or educational institution, most physicians receive and will need to negotiate an employment contract. Physician employment contracts are both similar and different from other employment contracts. Because most physicians have limited experience with contract law, it is always prudent to have employment contracts reviewed by a legal expert who is representing your best interests. We suggest that you seek legal representation from an attorney who has previous experience with healthcare law and contracts. In many academic practices, an offer letter is substituted for a formal contract. From a legal perspective, assuming verbiage in the offer letter spells out that the letter is binding, this is really a type of contract. Academic practices sometimes use offer letters because of the assumption that they are less formal and less subject to close legal scrutiny. Be careful, however, with offer letters and make sure that as with an employment contract, you do not agree to something that you will later regret. Alternatively, some offer letters may not be binding and are sometimes more like letters of intent that merely propose initial terms for the eventual formal contract. In this case, physicians should use caution in accepting the offer prior to seeing the formal contract.

Employment contracts should stipulate a start and end date and should specify the renewal process. The process for terminating the contract should be clearly articulated.

Most contracts allow an employer to terminate an agreement with or without cause, commonly after the first 90 days.

Where there is termination without cause, many employers (especially physician groups) include a provision that allows you or the employer to terminate your employment without cause. A notice provision will often require written notice of 30–90 days prior to termination.

A termination for cause should require the employer to stipulate the reason for the termination in writing. This agreement should also include an opportunity for you to fix any breaches or deficiencies within a reasonable period (typically, 5–30 days).

An employed physician should recognize that a five-year contract that allows termination without cause after a shorter amount of time effectively reduces the contract length to that shorter time period. So, if you agree to 90 days termination without case, make sure that will be enough

time for you to find a new position should the hospital enact that termination due to factors outside your control, such as budget restrictions. Also, be fully aware whether the termination of an employment agreement also terminates your privileges at the hospital where you are employed. Unfortunately, an employment contract may result in losing medical staff privileges should the contract go away. This could mean not only a loss of employment but a loss of privilege to work at the hospital where you were employed.

Provisions for malpractice insurance after the physician has left the practice should be provided. This is called gap or tail insurance and is discussed in greater detail in Chap. 15. In most instances, malpractice insurance is provided by the employer; however, sometimes the new physician will need to pay out-of-pocket for such coverage.

For employed physicians, it is preferable to have occurrence-based malpractice insurance coverage. This insurance covers incidents that happen during the coverage year when you were employed, regardless of when a claim is filed. For example, if your occurrence-based policy covers you during your time of employment, but you are named in a law suit after you leave the employed practice, you will still be covered by the employer or the practice.

If you have claims-made coverage (for claims filed during the coverage year), you will need a tail coverage when your employment ends. This covers incidents that happen during employment but are not litigated until after employment ends. If the employer offers a claims-made policy, your employment agreement should specify whether the employer will pay for part or all of your tail coverage upon termination of employment.

The major focus of a physician employment contract is the stipulated compensation. Compensation takes the form of salary, benefits, and incentive pay. Physician salaries depend on specialty, location, experience, demand, and a host of other factors. This makes comparison between offers difficult and may limit the ability to negotiate a salary. Typically, after the first year of employment, physician salaries include some portion that is at risk in the sense that it is related to productivity. This at-risk portion is typically dependent on work relative value units (wRVUs), charges, or collections. Because collections depend on a number of variables including payor mix, ability of the practice to bill and collect for services, and contracts signed with third-party payors, incentive pay based solely on collections may not accurately reward hard work. Benefits typically include health insurance, vision and dental insurance, malpractice insurance, money for CME and licenses, vacation, sick leave, and disability insurance. Additionally, maternity and paternity leave may be offered as a benefit. More recently, because of the student debt that young physicians have acquired, loan repayment can be of benefit. Many practices also offer a signing bonus and money for relocation. Because this money may be considered salary, there may be tax implications that should be understood prior to signing the contract.

In general, hospitals and health system employers offer a better range of benefits and more retirement options than private practices. Employers typically provide the following: health insurance for the employed physician (and possibly for family members); annual license fees; annual medical staff dues; a stipend for continuing medical education (CME) which includes travel, hotel, and meeting registration fees; malpractice insurance (occurrence-based or claims-made coverage); and 3–4 weeks of paid time off (a benefit that typically combines vacation, CME time, and sick time). You may also find some employers offering retirement plans, moving expense allowance (if you are taking a position in a different area of the country), educational loan forgiveness, and, less commonly, paid sick leave. All of these benefits can be negotiable, and it is unlikely that you will receive all of these benefits. Therefore, it is prudent to select the ones that are most important and make an effort to have them included in your contract. Also, if your compensation is based in part on productivity, analyze how your income may be affected when you take paid time off.

It is a reasonable request by the potential employed physician to request a copy of the top 10 Current Procedural Terminology (CPT)

billing codes used in the practice or in the hospital prior to signing the contract. In addition, physicians should consider how you will be compensated based on a percentage that does not include ancillary services or diagnostic testing. For a specialty that is primarily diagnostic testing or laboratories, the actual compensation might be considerably lower than presented.

If an employer offers a base salary plus incentive compensation, look closely at how you would qualify for incentive payments and how they are calculated. Many incentive models are still based on collections or work relative value units (wRVUs). You may want to estimate wRVUs to estimate what your bonus or incentive might be.

A comprehensive employment contract clearly lays out your obligations regarding the schedule you will follow as well as the call schedule. Employers often leave scheduling provisions loose so that employed physicians have flexibility to deal with the needs of their patients and the practice. However, the following should be stipulated in your employment agreement:

You need to be aware of the promises the employer has made regarding your schedule. For example, if the employer promises that you will not work more than one Saturday per month or agrees to a flexible schedule, get the specifics in writing. The call schedule will vary from practice to practice and also will depend on the geographic location of the practice. You can expect a contract to practice in a rural area may be able to provide complete educational loan forgiveness and a high salary, but they may not be able to offer extensive call coverage because of the shortage of physicians.

It is important to be sure your call responsibilities are not more burdensome than those of other physicians employed under similar terms. Also, find out whether the employer offers compensation for taking additional call.

Specific part-time schedule (if applicable) – This process is especially important if you are paid on a salary basis. It prevents the employer from taking advantage of you by requiring you to work more hours than agreed upon. Also, you want to avoid restrictions preventing you from taking extra employment or obligations. For example, if you wish to moonlight in an ER, make sure that you are not prevented from doing so by stipulations in your contract.

A peculiarity of physician employment contracts is the issue of restrictive covenants. These are also called noncompete clauses and are used to prohibit a physician from practicing in a certain geographic area for a set period of time in the case of termination or separation from the practice. The radius is usually determined by your practice's location and could range from 5 miles in a densely populated suburban area to 50 miles or more in a rural area. Many physicians believe these covenants will not be enforced; however, the courts in most states will uphold them if they are reasonable. For this reason, you should review the covenant as though it is entirely enforceable. Litigating a covenant, either from the employer or employee's perspective, is costly.

Restrictive covenants are important to a group practice by preventing one of their employees to leave and take patients away from the practice and thus to then compete with the original group who hired them. Restrictive covenants can be difficult to enforce in some jurisdictions as they represent restriction of trade. It is important to have restrictive covenants closely reviewed by an employment lawyer, and if part of the final contract, the geographic limitation should be limited in radius and the time restriction should be as short as possible which is typically one to 2 years.

Another issue specific to a physician employment contract is the issue of partnership. Partnership is a commitment to partial ownership of the practice. Unlike having equity in a commercially traded company, partnership is illiquid in that it is difficult to value, nearly impossible to sell, and may carry the obligation on part of the physician partner, to cover any shortfalls in practice income with personal income. Typically, partnership is a benefit offered after several years of employment, and typically becoming a partner involves a series of payments or salary offsets over several additional years until partnership is achieved. Another complication of partnership is the distribution of ownership. Is it equal across the group, or is the majority of the ownership

held by those who entered the partnership first, the senior partners? The compensation differences between junior and senior partners should be clearly articulated prior to signing the contract.

Finally, the employment contract should specify what happens if the group is acquired by another party or in the event of a merger or consolidation. This type of clause is called assignability. If the employment contract remains in place after merger or acquisition, then it is assignable. If the contract is null and void in case of such an event, then it is nonassignable. The contract should offer a remedy to the physician in the case of nonassignability. This could include release from the noncompete clause or a financial payout to the physician whose contract was voided by change in ownership.

Most physicians have had little training or previous experience in the art of negotiation. Some physicians assume that nothing is negotiable and accept an initial contract as is; some feel that everything is negotiable. Basic negotiation skills are obviously important, especially when negotiating your starting salary as this is the amount that all future increases will be based upon. Simple math tells us that a 3% increase on $300,000 is more money than a 3% increase on $200,000.

More than anything else, a successful negotiation depends on having information. If you know what others are getting paid for the same job, you know your negotiation point. Luckily, especially in academic medicine, salary information is available. The Association of American Medical Colleges (AAMC) publishes annually salary information divided by specialty, geographic region of the country, public/private medical school, and faculty rank. This data is not self-reported but is gathered from business offices of medical school ensuring its accuracy. Additionally, many states, such as Florida, have sunshine laws, making all salaries of public employees available to the public. As such, the salary of any faculty member at a state school may be available online. For nonacademic jobs, Medscape publishes salary information that is gathered from survey responses. Other survey-derived data comes from the American Medical Group Association (AMGA), the Medical Group Management Association (MGMA), Merritt Hawkins, and the US Bureau of Labor and Statistics Occupational Employment Statistics. Care should be used when interpreting self-reported data as physicians who report salaries are more likely to be those on the higher end of the spectrum. Evidently, this type of salary information is absolutely critical at the beginning of any salary negotiation. It is also important to gather other information about the practice prior to negotiation including the degree of competition for patients from other groups, the patient payor mix, and expected work schedules including call.

A successful negotiation involves compromise on both sides and results in an outcome that is usually not perfect for either side, but is mutually beneficial to all parties. As such, be prepared to make concessions and when asking the other side to do so, treat people with respect, be patient, and have logical reasons for your requests. Again, use the information you have gathered before the negotiation to make your points. When you are negotiating, set priorities. Identify your limits and identify those things that you could concede if necessary. Develop a strategy. What could you give up and in exchange for what else? Start off with an easy issue, such as office space. Then build up to harder negotiating points such as salary or partnership. Finally, return to issues that are likely not to be contentious such as vacation time so that both you and your employer can feel good about the negotiation. After most of the bargaining is done, return to those last unresolved issues like restrictive covenants. These trickier issues will be easier to negotiate once both sides have a feeling for each other and both sides have a vested interest in a successful resolution.

There are law firms that specialize in healthcare law that will review your contract at a reasonable fee. These firms often will offer you unlimited email consultation with your attorney. These online law firms will help you understand the terms of your contract and help you create a negotiation strategy. These firms often have access to survey reports on physician compensa-

tion to determine how much physicians in your specialty and in area you are considering earn. You can anticipate that the firm will ask employed colleagues in similar practice situations about their compensation.

Lastly, in the interest of all parties, get your final negotiated contract in writing including all concessions on both sides. Although both sides may negotiate in good faith, anything not written is difficult to prove, especially if there is a change in personnel in the group.

Back to the Case

Sherri gathered information including the salaries offered to the three other fellows completing her program. She was able to find cost of living conversions for different cities in the USA and was able to derive a fair range of salary for a starting Maternal Fetal Medicine Specialist in her new city. She also was able to get information from her specialty society about benefit packages offered to new graduates. Sherri was not able to negotiate her starting salary, but was able to negotiate a signing bonus. The practice had never offered a loan repayment program and was uncomfortable about the tax ramifications of such a benefit. Sherri conceded this issue but was able to negotiate a more generous family leave arrangement, which is important to her as she thought about starting a family. When Sherri reviewed the contract, she realized that little things such as money for CME and licenses were included. She got her contract in writing and hired an attorney friend of a colleague to review it. Sherri really wanted the job offered as it met so many of her personal and professional needs, so she was less in charge of the negotiation, but at the end she felt satisfied and comfortable that her first job would be a good fit.

Bottom Line

Make sure you understand and are comfortable with what you are signing, but do not try to demand an unreasonable number of changes.

Physician contracts today are not "take it or leave it" propositions. There is room to negotiate on things like salary, educational loan forgiveness, and call. Again, physicians in demand are more likely to get favorable terms, which is one of the advantages of locating in a region where they may need doctors, such as a medium-sized or rural community. Remember, there is give and take.

1. A contract is a legal document. Get everything in writing and have a legal professional review prior to signing.
2. Do not be afraid to negotiate. Gather information, stay calm, and have a rationale for your asks.
3. Negotiations involve compromise. Identify your limits from the onset. Use your ability to compromise to get the things you really need.

Entrepreneurship and Formulating Business Plans

6

Marc J. Kahn and Neil Baum

Case: Anji

Anji has been an academic hospitalist in a large teaching hospital for the past 7 years. She is generally satisfied with her job as she gets to work with students and residents, and she enjoys the pace of hospital medicine. While making rounds, she notices the increasing number of patients who are hospitalized at the end of their lives with terminal conditions. Although Anji derives career satisfaction from dealing with patients in the end of their lives, and in spite of the fact that she finds these patients to provide valuable teaching points for her trainees, Anji wonders if a palliative care service would be a better way to care for such patients. Moreover, Anji believes that such a service would not only improve patient care and trainee education but may also be cost effective. She does a quick calculation of hospital costs and the costs of implementing a new service, but is unclear if her math is correct. Anji has been at various meetings with hospital administrators who talk about *business plans* for new endeavors, but she has no idea where to start. She knows that she will need to make a strong business case for any new service as the hospital has been operating on a very narrow margin. How should she proceed?

Nearly every MBA program in the country includes a course on entrepreneurship, yet physicians, who are typically innovative problem solvers, do not recognize their work as entrepreneurial. In fact, many physicians' innovations are entrepreneurial, and the ability to make a strong business case for a new idea is a very valuable skill which will make the physician unique and special within the practice or the organization. Although some physicians are uncomfortable talking about medicine as a business, medicine is very much a business, and every young doctor should be aware of the basic knowledge of business that is discussed in this book. There is nothing unethical about the business of medicine; in fact, creating a sustainable model for patient care typifies ethical behavior, especially when we consider distributive justice. As resources are always limited, an innovation that is financially sustainable is much more likely to provide

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services for a large number of patients than one that is costly and inefficient.

Although many physicians naively consider a business plan to be nothing more than a financial analysis including projected income statements, sources of funds, and maybe a breakeven analysis, a complete business plan is much more than merely the financials. The very process of creating a carefully constructed business plan necessitates market research, careful thought, and strategic planning, all important aspects in making a case for your idea. Furthermore, a well-developed business plan is more likely to get a project approved than one that is poorly constructed and incomplete. There are many suggested formats for business plans, but in this chapter, business plans will be divided into the following sections: (1) the executive summary, (2) description of the project, (3) trends analysis, (4) target market, (5) competition, (6) risk assessment, (7) marketing plan, (8) operations, (9) technology plan, (10) management and organization, (11) milestones, and (12) financials.

The executive summary is probably the most important component of a business plan, and often it is the only section that will be read by people who have the authority to either accept or reject your idea. If the executive summary is compelling, then the rest of your plan will be evaluated; if it is not compelling, your idea will likely not be considered further. Because the executive summary is so critical, it is recommended that you write this section after creating the other components of the business plan. An executive summary can be an itemized synopsis highlighting the other chapters in the plan, or it can be a narrative that tells the story of your idea. The narrative format has the advantage of providing information that gets the reader excited about your idea. In a narrative format, you can identify the problem that you are trying to solve and generate an emotional response from your readers, especially if the problem is compelling, like Anji's suggestion of "trying to improve the care of dying patients and to provide support for their families." The executive summary needs to be brief, no more than one page, but effective, akin to an elevator pitch where you have only 2 or 3 minutes to make a case for your idea. Because the executive summary is so critical, it is important to obtain input on the executive summary and provide constructive suggestions so that you motivate the decision makers on this most important section.

The project description briefly provides the mission and objectives of your idea. This is where you define what you plan to do and why. This section may also include your progress to date in implementing your idea. For example, this part of the business plan outlines the resources necessary for a palliative care service. Resources would include space and personnel including physicians, nurses, and trainees. The project description might also include the fact that space has already been identified for the potential unit. The project description also includes a statement confirming the need for your idea: to reduce the inpatient census and to provide specialized palliative care services for terminal patients. Finally, this section could include the fact that you already have residents assigned to cover such patients included in the residents' educational program, a fact that makes your idea more likely to be approved.

Trends analysis allows you to compare the landscape for your idea to other hospitals, cities, or locales. This section allows you to articulate a strategy on how your innovation might maintain a strategic advantage for your hospital or practice. Moreover, this section should also include any assessment of potential growth in the area of your innovation. Any strategic decisions that may be dependent on seasonality, such as flu season, or variations in practice patterns due to vacations, should be included in this section. For example, this section could include an analysis of trends in palliative care services in the USA. It could also include whether your competitors have such services and if not, why implementing a palliative care service would provide your institution a strategic advantage over competitors.

The timing of when you first implement your plan may be important. For example, because fellows with specific training in hospice and palliative medicine finish training in June, if you were going to recruit new physicians, you would need

ample lead time prior to June if your plan were to attract new graduates.

The target market section describes who will be served by your idea. Is this a particular group of patients, physicians, or referring doctors? What is the expected volume of patients who might receive the services you are planning to provide? Is your idea scalable so that you could expect an increased market share in the future? Identifying a target market also allows you to advertise to particular groups. In the case of a new palliative care service, your target market would not only include patients but also physicians and nurses who would be a source of referrals for your palliative care. Especially in the case of hospice services, physicians typically write the order for these services but it is the nurses and social workers who decide which hospice to use. Do not omit this important target market.

The size of your target market allows you to better estimate expenses and revenue. In your business plan, it will be important to make sure that your target market is large enough to support the initial investment in space and personnel, but not so large that planning becomes untenable. It is your job to formulate your target market such that decision makers can be convinced that your plan is viable.

Identifying the competition in your market space allows you to assess the likelihood of the success for your plan. Competitors are important because if your idea truly had no competition, a savvy decision maker might wonder if your idea has merit. The competitive analysis of your business plan should identify who your competitors are, on what basis you compete, how you compare with your competitors, how you anticipate the arrival of new competitors, and how you have identified barriers to entry for new competitors. The business sage, David Porter, described strategy as the interaction of five elements that he termed "forces": (1) supplier's power, (2) buyer's power, (3) threat of substitution, (4) threat of new entry, and (5) competitive rivalry [1]. These elements are critical in assessing your competition. In medicine, the suppliers are typically the referral sources whose power derives from their ability to direct patient flow. The buyers are the patients themselves or the insurers who pay for medical services. Substitution may include alternative diagnostic or therapeutic procedures to those that you are proposing in your business plan. New entrants into a market space are frequent in the modern healthcare arena with hospital and insurer mergers that create larger entities providing services in a given geographical region. Rivalry is also obvious in the competitive healthcare space. These competitors are the entities doing the same or very similar functions as you are proposing. Your business plan should address each of these issues as you make the case for your new idea.

Assessing risk is important in any business decision. What are the strengths of your plan compared to other ideas? How can you be sure to attract market share? Is your idea new to the market providing a "first-mover advantage?" This section of your business plan should address the types of risk inherent in implementing your idea. Every new innovation has some element of risk, but how you communicate your ability to deal with this risk dictates the success of your plan. Risk includes market risk where your idea may not catch on. The market may not be ready for your idea. For example, it was a slow start when the hospitalist movement first began, because of deep-seated fears that hospitalists would lead to a breakdown in patient care due to fragmentation of care. Competitive risk is the risk assumed due to changes in the way the competition does business. If you start a palliative care service, will others follow? Will you still be able to attract market share? Execution risk is the risk that you will not be able to manage the initial phase of your plan. If your hospital is not ready to start accepting new palliative care patients due to preexisting insurance contracts, space issues in the hospital, or personnel issues in the hospital, then your plan is likely to fail. Finally, there is a capitalization risk that you may have underestimated costs and overestimated revenue such that your costs exceed revenue making your plan untenable. It is obviously best to be conservative in financial predications, but not so conservative that your innovation looks like a financial failure from the start. It is important to recognize that

implementation of any innovation has risk. Your job in your business plan is to identify those risks and to be able to provide reasonable assurances that despite these risks, your idea will still be successful.

In the marketing plan section of your business plan, you will clearly articulate how you will attract business. How will you let patients and referring doctors become aware of your services? What message will you use in your advertising? Where will you advertise? How will you use social media? Marketing courses in business school typically talk about the "four P's of marketing": product, price, place, and promotion. Product defines the tangible aspects of what you are providing, price defines your cost and provides examples of why you are cost advantageous over your competitors, place describes where you are offering your services, and promotion describes your marketing activities. Remember, people buy services, not features. For example, people buy an electric drill not for the material used to construct the drill housing, but they buy an electric drill because they need a hole. Similarly, people choose a palliative care service because they want care that is compassionate during the dying process. They do not usually choose a palliative care service because of the specific medications used to mollify symptoms of the terminally ill.

Akin to the four P's of marketing that businesses use, customers want the "five F's": (1) function (how the service meets their needs), (2) finances (what will this cost), (3) freedom (how convenient is the service), (4) feelings (are they comfortable with the services), and (5) future (what will happen to services over time). It is important to address each of these points in your marketing plan.

In the operations section of the business plan, you have the opportunity to describe how you will manage your innovation. Who will be in charge? Who will you employ? What is the reporting structure? How will you measure outcomes? How will you grow? It will also be important to discuss how you will manage complaints by patients or referring physicians. What are your processes for resolution? Other aspects of the operation if your innovation needs to be included are information such as to how money is handled and demonstration of HIPAA compliance.

Deciding on a technology platform should be articulated in a separate section in your business plan. Technology includes not only the electronic health record but may also include the systems used for billing and collections and the systems used to measure quality outcomes. An appreciation of cost of technology should be included. Finally, a discussion on new technologies that may be useful in the future may make your business plan more complete and may help to define future strategies.

In the management and organization section, you will list the people who will be part of your plan. Deciding who is on the management team may be critical in the success of your innovation. Many senior administrators understand that getting the right people in the right places is critical to the success of any business.

The milestones section of your business plan is used to establish a road map to keep you on track for success. This includes both short- and long-term goals. It also articulates priorities. Priorities may include patient satisfaction, cost savings, or revenue at different points on the time horizon.

Finally, the last section in a business plan includes the financials Typically presented as a pro forma, where assumptions are made to predict future performance, it is this section that can make or break your plan. In addition to the three basic financial statements (income statement, balance sheet, cash flow projection), this section typically includes a statement of sources and use of funds and a breakeven analysis. It is critical to clearly define the assumptions used in your pro forma statements from the onset, and these are often listed in their own unique part of the financial section. Assumptions typically include projections of future costs, future reve-

nues, and inflation. These statements include more than one time frame so as to be complete in your analysis. For the income statement, for the first year, monthly projections are provided, quarterly for years two and three and annual projections for years four and five. Cash flow is projected monthly for the first year and quarterly for years two and three. The balance sheet is projected quarterly for the first year and then annually for years two through five. A complete description of financial statements is provided in Chap. 3.

You will want to include a list of sources of funds, including those that are recurring and those that are one time. Sources may include the hospital, health system, medical school, or philanthropy.

Finally, you will want to estimate how much income you will need to pay back your expenses and at what point you will break even. In general, to calculate the gross revenue needed to break even, you will need to know your fixed expenses (rent, salaries, utilities, etc.) and your variable expenses. For example, if your fixed expenses were $70,000 a month, you would need to generate more than just $70,000 to break even, because each month you have costs that vary depending on patient volume including costs of disposable equipment (e.g., tongue depressors), costs for medications, and costs for supplies. If you know your variable costs as a percentage of gross income, then you can calculate your breakeven revenue as follows:

Fixed Expenses/Gross Profit Margin

In the above example, if 30% of your gross revenue went to cover variable costs each month, then your breakeven point would be $70,000/0.7 = $100,000 of revenue a month. You could also look at your pro forma to see at what point in time you would break even with an estimated revenue of $100,000 per month. This type of analysis is important in determining the financial feasibility of your endeavor.

Back to the Case

Anji met with the business manager of her department and began to gather information necessary to construct a business plan. She met weekly with her business manager to clearly articulate her idea, strategy, and expectations. Together, they generated reasonable financial assumptions and constructed a pro forma that suggested that her palliative care service would break even in about 2.5 years. Because her plan was financially viable with a reasonable return on investment, and because it was consistent with the mission of the medical center to provide excellence in patient care, the plan was approved. Anji waited patiently to see the fruits of her work including patient satisfaction and to see if her financial assumptions were correct.

Bottom Line

1. A well-written business plan can allow you to get support for your innovations.
2. Physicians are, by nature, entrepreneurs.
3. Setting reasonable assumptions allows for the projection of future financial viability.

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Managing People

7

Marc J. Kahn and Neil Baum

Case: Chris

Chris has been chair of the Department of Radiology at a community hospital for the past 3 years. She became chair after working in the department for 11 years when the former chair retired. Chris was the obvious choice for chair based on her ability to get along with others, her perceived leadership skills, and her seniority in the department. Although Chris has always prided herself on her interpersonal skills, shortly after assuming the role of chair, she began to have problems with two of her junior colleagues who both started in the department 2 months prior to Chris' appointment as chair. The two junior associates graduated from the same residency program and had been friends for several years. Chris' difficulties began with the holiday schedule during her first year as chair. Neither of the associates agreed to take call during Christmas, a role typically reserved for junior members in the group. Chris ended up covering the Christmas holiday herself, but problems have escalated. Chris finds her decisions continually questioned and feels that she is not respected by the two junior associates. She is worried that her role as chair will be undermined and worries that her position may be in jeopardy. Chris has discussed her feelings with the two junior physicians, but there has been no resolution. She prefers not to terminate them, but is having second thoughts about renewing their contracts for the upcoming year. What should she do?

Leadership is often discussed but rarely taught during a physician's educational journey. Although there are people who are naturally skilled at being leaders, many aspects of becoming a successful leader can be taught and reinforced even for people who are naturally good leaders. It is our experience that most physicians have some leadership abilities that they have used to their advantage to get into and succeed in college, and medical school, and successfully complete postgraduate training. However, many physicians are uncomfortable taking charge of personnel issues, especially when they pertain to disciplining and terminating an employee.

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The primary driver of effective personnel management is the strength of the leader. Although there are many leadership styles described in the business literature, we suggest some common leadership principles that are necessary regardless of an individual manager's style. We suggest that effective leaders possess the following four attributes: integrity, accountability, vision, and communication skills.

Integrity implies that a leader acts ethically, fairly, and consistently. An effective leader is aspirational and someone who others want to emulate. Many of us entered the medical field inspired by people like Albert Schweitzer, C. Everett Koop, William Osler, Benjamin Spock, or even Marcus Welby. Part of integrity is the ability to provide the sense that a group is better with the leader in charge than without. Those who lead with integrity allow others to feel important; they do not abuse power. They allow others to receive rewards and do not hoard accolades. They are not capricious; they make calculated consistent decisions that are considered fair by the group.

Accountability assumes that the leader not only takes responsibility for their own decisions but also take responsibility for any consequences that their decisions produce. Effective leaders not only hold themselves personally accountable but are also able to instill a sense of accountability in their reports to the group or the organization. This includes getting others to complete projects on time, maintaining a respect for timelines, and working for the betterment of the team, not for the benefit of just the leader.

Accountability is well demonstrated by the following example: In previous times, while playing poker, a knife with a buckhorn handle was often used to indicate whose turn it was to deal the cards. A player had the option to "pass the buck" if they wished to pass the deal to the next player at the table. Passing the buck subsequently became a metaphor in international politics when countries refused to address a threat or concern with the hope that another country would deal with the problem. "The buck stops here" is a phrase attributed to President Harry S. Truman who kept a sign on his desk with this motto. Truman would refer to this motto often: "You know, it's easy for the Monday morning quarterback to say what the coach should have done, after the game is over. But when the decision is up before you–… the buck stops here."

Vision is the ability to develop and articulate goals and a plan for reaching them. Vision implies a balance between what is possible and what is practical. To quote Eric Hoffer, "The leader has to be practical and a realist, yet must talk the language of the visionary and the idealist." Truly visionary leaders are unusual and not always effective, especially if they are thought to be unrealistic. An example of a visionary leader is Steve Jobs whose vision for Apple computer was at times totally unrealistic and unmanageable, but whose vision led to one of the most successful companies in the history of humankind.

Communication is essential in a leader who hopes to capitalize on the collective wisdom of the team. Seldom are leaders successful in isolation. Rather, in order to be effective, leaders need to develop teams that share information and learn from each other. Effective leaders foster communication, encourage dissent and discourse, and empower others to feel comfortable about contributing ideas for the betterment of the group. Effective leaders know how to listen and are consistent with their message. In the world of social media, there are now multiple avenues for effective communication. The use of social media will be specifically discussed in Chap. 20. Effective leaders use a palate of tools to communicate a consistent message.

Jack Welch served as CEO of General Electric (GE) for many years, and his communication skills are legendary. Welch believed that if his company could not be number one or number two in any product line, then they should get out of that market space. A great example of Welch's ability to communicate this vision is the story of a consumer survey asking who made the best gas ovens. The survey revealed that GE came in second, although they did not even make a gas oven! Welch's communication skills put GE in everyone's mind when thinking about appliances, regardless of whether or not they were even in

that market space. Welch's ability to communicate and articulate what GE was as a company created a halo effect whereby consumers were so impressed with their electrical appliances that they felt that they must also make great gas appliances even though these were not in their product line.

Medicine is practiced in teams, and in addition to having an effective leader, effective teams need to work together. The first part of working together is for the team to trust each other. Trust implies a sense of openness among team members and the lack of any one member feeling vulnerable. If a team has a culture of trust, then the team will embrace conflict. Conflict is not always a bad thing in that discourse leads to better decision-making through the generation of diverse opinions and ideas to better solve problems.

A great example of the value of diverse opinions is the story of Tabasco hot sauce. Allegedly, the executives at Tabasco were trying to increase their market share. Ideas from the group included marketing Tabasco in Asia where spicy foods are appreciated, creating a Tabasco cookbook, and even creating new products such as corn chips that contained Tabasco sauce. Apparently, one executive thought differently and offered the idea that to sell more hot sauce, the company should double the width of the bottle opening. The rest is history. This simple fix of increasing the diameter of the bottle opening was said to increase sales significantly.

Trust and welcoming conflict allow teams to feel a sense of commitment to the organization. Committed groups act to the betterment of the organization. Commitment leads to accountability, whereby all members act to further the mission of the group and call out those individuals who are not acting in the group's best interests. Accountability leads to achieving collective results which do not benefit any one person but work to improve the final product of the organization.

In managing people, the above steps are a necessary progression to get buy-in and to get the best results. But what do you do when people do not behave?

The first step is to listen. Listen to other employees who have complaints. Listen to patients. Listen to the employee in question. Through listening, you will gather information to help you better understand the situation. The fault may be with the employee, or it may be a structural problem. Physicians who do not complete medical records on time seldom do so to be bad people; rather, these cases are typically the outcome of a faulty system or an electronic health record that is cumbersome to use or does not provide feedback that charts need to be signed.

Next, give clear feedback. Feedback is best when it focuses on behaviors rather than results. This prevents subjectivism. For example, rather than complaining that an employee always comes in late for work, focus on the behavior and mention that when the receptionist comes in late, phones are not answered, and patient problems are not addressed in a timely manner. Feedback should also focus on the impact the negative behavior has on the organization. In the above example, that impact would be bad customer service. Finally, effective feedback should focus on the consequences of the bad behavior. "When you don't complete your medical records in a timely fashion, we don't get paid." For effective feedback*, focus on behaviors, focus on the impact these behaviors have, and focus on the consequences of the behavior*. In addition to these three primary features, feedback should be specific, accurate, unbiased, usable, timely, and welcomed by the recipient.

Always document the problems you are having with an employee. A record of bad behaviors is essential if your actions may result in dismissal.

Be consistent. Set policies and hold everyone accountable for these policies.

Set consequences and timelines**.** Make it clear to a poorly performing employee that there are consequences to behaviors. Set limits on when you expect improvements and set milestones for improvement.

Take action. Sometimes, as unpleasant as it might be, an employee may not be right for your organization. It is better for the whole team to replace that individual. Typically, other

employees speak negatively about the errant (would delinquent be a better word?) employee. The leader should avoid at all costs talking adversely about another member of the staff or another physician. This behavior makes the leader look weak and creates distrust among other employees who fear that you may be talking badly of them to other staff members.

Back to the Case

Chris met with her two junior associates. She clearly articulated what the group's expectations were for them. She listened to their opinion on the situation regarding the two junior associates. Additionally, she recognized that she was not communicating well. She explained the history of the department and the fact that junior associates were not only respected but were an important part of the team and that the practice always required that junior associates take call on holidays. Ultimately, the junior associates would eventually benefit from less call on holidays as they matured in the department. Chris agreed to have more regular meetings with the department to articulate strategy and vision and to allow a forum to voice complaints. Unfortunately, over the next 2 years, her two junior associates became less and less willing to work as a team. They eventually decided to start their own practice. Fortunately, the "divorce" was mutual and collegial. Their departure did save Chris from the uncomfortable situation of having to fire them directly.

Bottom Line

1. In managing people, first develop your own leadership skills.
2. Conflict can be used to make better decisions.
3. Sometimes, an employee has to be terminated. This may be best for the employee, the group, and patients. (The concept of firing an employee will be discussed in greater detail in Chap. 15 regarding legal requirements for terminating an employee or a partner.)

8 Basic Personal Finance and Investing

Marc J. Kahn and Neil Baum

Case Study: Jamal

Jamal is 40 years old and about to complete his neurosurgery residency. He was a non-traditional medical student, starting medical school after working for a start-up in the biotech industry for nearly a decade. During medical school, his wife worked as a labor and delivery nurse. He and his wife had a baby daughter when medical school started. Although Jamal has medical school debt of nearly $300,000, he does have $40,000 saved in a 401 K from his previous employer. He already signed a contract for a job with a large multispecialty group practice. His contract includes a signing bonus of $50,000 along with $10,000 to be used toward moving and other related expenses. His initial salary is guaranteed for 1 year at $550,000. After 1 year, and for the next 3 years, his salary includes a $400,000 guarantee and bonus to be paid based on his clinical productivity. Although his employer will not be contributing toward his retirement for the first 2 years, however, after 2 years, his employer will match his contributions up to 10% of his take-home pay to a retirement plan. The benefit package provided by his employer includes life and disability insurance, health insurance for him and the ability to purchase health insurance for his family at a reasonable cost, and an allowance for CME. Jamal is happy to be finally finishing residency and earning real money. He is concerned that he has not really paid attention to things such as life insurance and how to put money away for retirement and wants to make sure that he can retire by age 65. He is anxious and in need of advice.

Physicians are typically in the top 5% of wage earners in the USA, and physicians in specialties, such as neurosurgery, can easily be in the top 1% of wage earners. Despite this fact, many physicians find themselves ill-equipped to manage their money due to lack of expertise and training. It is very prudent, if not essential, for physicians to solicit the help of a financial planner. The earlier a physician establishes a relationship with a financial planner, the better because of compounded interest that was discussed in Chap. 2. In addition to a financial planner, it is also important for a physician to have an accountant.

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Even though doctors can do their own taxes, the time spent doing this is probably worth more than an accountant will cost. Additionally, an accountant's signature on a tax return is reassuring. Even with a financial planner, understanding some basic investment strategies will allow for a more fruitful relationship with a financial planner.

One of the fundamental tenets of investment is the relationship between risk and reward. This means that the *greater risk an investor is willing to take, the higher the potential reward, and the higher the potential loss*. An example of the relationship between risk and reward is the story of the Beardstown Ladies who were featured in both the lay press and television [1]. This group, composed of older women in Illinois, formed an investment club known formally as the Beardstown Business and Professional Women's Investment Club in 1983. This group achieved notoriety for its returns on investment of over 23% per year for their first 10 years of activity, greatly exceeding average market returns. These women even wrote a book titled, "Beardstown Ladies' Common-Sense Investment Guide." Based on the concept of risk and reward, returns this high would suggest that this investment group assumed a high level of risk, or that they were extremely lucky. However, neither explanation appeared to be the case in a review of their portfolio. Rather, when audited, it appeared that the group did not properly account for returns, as they included new contributions to the fund by members in the group in their calculation of total return on investment. When properly audited and accounted for, the group was found to have a rate of return of only 9%, which is nearly 5% less that the return on the S&P for that same time period. This finding is consistent with another investment concept which asserts that the average investor will earn an average rate of return. This means that the only way to consistently beat the market average in an investment portfolio would be to either have unusual luck; to have improperly accounted for earnings, as in the case of the Beardstown Ladies; or to have insider information which will land you in jail. In fact, in a perfect market, factors affecting stock prices are already figured into its cost. When Amazon first started operations, the financial benefit to FedEx who shipped their products was theoretically already accounted for in the FedEx stock price. For those who have trouble believing that over time, they cannot beat the market average, because they have a "better broker" or because they are a "better investor." Consider 100 people standing in a room each holding a penny. They flip their coins in unison and sit down when the flip landed on tails. At some point, someone is left standing. Are they a "better" coin flipper than all of the others? Certainly not!

Another important tenet of investing is the concept of diversification which can help to mitigate risk. For example, consider an investor who owns stock in an airline company. This investor is at risk if oil prices rise, because then his stock will lose value since the major expense of an airline is its fuel costs. To diversify, this investor may want to also purchase stock in an oil company. This move will provide a hedge against rising oil prices, thus decreasing the value of his airline company stock. If he invests in oil companies, he will be financially protected due to the increased value of his oil company stock. Similarly, if oil prices fall, the value of his oil company stock will decrease, but his airline stock will provide a financial hedge against such a rise in oil prices. Diversification can be accomplished by owning stocks in multiple economic sectors, or by owning stocks in different areas of the world.

We have spent time using stocks as examples, but what exactly is stock? Simply stated, stock represents ownership or equity in a company. Suppose your family owns a company that makes chocolates. The shareholders in this family business are you and your relatives. Suppose further that the chocolate business is becoming increasingly successful such that the company wishes to expand to a national market. This is going to require a significant amount of cash for additional equipment, supplies, employees, and marketing. Where can you obtain the additional funds? You could ask the shareholders to contribute personal money toward the expansion. Alternatively, you could sell part ownership in the company to investors. This part ownership is

stock, and when companies do this on a large scale, it is known as going public. Shareholders are able to vote on company policies as they are part owners.

Stock price is dependent on many variables, but because stocks are traded publicly, there is a market that determines the stock price. The return on investment for a stock purchase is related to the riskiness of the stock itself with the rate of return being the same for all stocks of equal risk. Owning stock carries financial risk because if a company goes bankrupt, the stock may be worth nothing. Some stocks pay dividends which are periodic cash payments to shareholders. Some stocks never pay dividends. As with all stock prices, the value of a stock that pays dividends is incorporated into the stock price. This particular type of stock is known as common stock. There is another type of stock called preferred stock, which obtains its name because in case of bankruptcy, preferred stock holders are paid before common stock holders. However, unlike common stock, preferred stockholders do not really have equity (ownership) of the company and do not have voting rights. As such, preferred stock can be thought of as a type of debt. Because preferred stock is less risky, its rate of return is generally less than common stock.

Generally, if a stock is undervalued, we should buy it. On the other hand, if a stock is overvalued, we should sell it. But suppose we believe the stock is overvalued and we do not own it? A short sale refers to selling overvalued stock that you do not have at a later date. This type of investment is legal but risky because if you are wrong, and the stock price increases, you have to provide the stock at the higher price even though it was priced lower at the time of the transaction. The finance pages often include stories about people who made money in the stock market in the face of a steep decline. Typically, these people are said to have shorted the market. What they did was to sell stock that they did not own at an inflated price only to later purchase the stock at a discounted price, then sell the stock to the buyer at the higher price, and pocket the difference as a profit. As an example, in 1992, George Soros was said to have made $1 billion in 1 month by shorting the British Pound or betting that it would decrease in value [2].

Most investors diversify their stock portfolio through the purchase of mutual funds or exchange traded funds (ETFs). Mutual funds are companies that pool money from many investors and purchase many stocks to make up the fund. This allows the investor to have a diversified portfolio without having to personally purchase many individual stocks. There are several indicators (indexes) of the strength of the US economy based on stock prices. The Dow Jones Industrial Average (DJIA) is calculated as the sum of 30 representative stocks divided by a number called the Dow Divisor. The Dow Divisor is formulated such that stock splits or other structural changes do not alter the DJIA. The divisor also corrects for inflation. Another commonly used index is the standard and poor 500 (S&P 500). The S&P 500 is a weighted sum of the prices of 500 large common stocks actively traded in the USA. Index funds are mutual funds that follow a given index. These are also called ETFs. An ETF is like a mutual fund but typically includes all of the stocks contained in an index. Owning ETFs is like owning a piece of the Dow or a piece of the S&P. ETFs are diversified due to the varied industries and economic sectors represented in the index.

Another way that your family chocolate company could raise capital to expand would be to borrow money from the public. This type of business debt is called a *bond*. Bonds are less risky than stocks because in the case of bankruptcy, debt holders are paid first. Based on what you have learned, it should not come as a surprise that bonds generally have a lower rate of return than stocks as they are less risky. Bonds typically pay interest on the borrowed money several times a year. These payments are called coupons. Bonds are also sometimes called fixed income investments because their value is predetermined at the point of sale. Bonds have a maturity date that designates the date when the bond principle is to be paid. Bonds also have a face value dictating the payment due at maturity, and bonds have a coupon rate. An example is a 10-year $10,000 US Treasury Note with a 6%

coupon rate. We know that this bond will mature at 10 years at which point the holder is entitled to full payment of $10,000. The bond holder is also entitled to two $300 coupon payments per year for the life of the bond. Many of us have received US savings bonds as gifts from an aunt or uncle. These are called zero coupon bonds as they do not have biannual interest payments. Rather, they are discounted at the point of sale. For example, currently you can buy (online) a $100 US savings bond for $50. The bond reaches face value at 20 years and will continue to earn interest for up to 30 years. Aunt Sally purchased that bond for you for your first birthday because it only cost her half the face value, and she wanted to provide money for you when you reached 21 years of age. Your aunt also felt good about contributing to the US economy and she knew that savings bonds carry no risk as they are backed by the US government.

Another major type of financial instruments includes derivatives or options. Derivatives are investments whose value depends on the value of an underlying asset. Fire insurance is an example of a derivative. If you purchase fire insurance for the total value of a $400,000 home, the insurance policy is worth nothing unless your house burns to the ground at which point it is worth $400,000. Fire insurance can therefore be considered a derivative investment on your house.

Generally, there are two types of options called "puts" and "calls." A put is the right to sell, and a call is the right to buy. Physicians are familiar with options without realizing it. Take a salary structure that includes a salary guarantee and a salary cap. The salary guarantee is an option provided to you that is a derivative of your salary. A salary cap is a benefit to your employer and is also an option. In the above example, the salary guarantee is a put because it protects against low earnings, whereas the salary cap is a call as it sets an upward limit. The value of options can be calculated where the value of the put is set to be equivalent to the value of the call. In options lingo, this is called a zero premium collar, and such a strategy may be better at setting physician salary caps and guarantees than trial and error [3].

Options are traded on the Chicago Board Options Exchange. For example, on December 14, 2018, an investor could purchase a call option on Apple stock for $5.25 for a strike price of $165 with an expiration date of December 28. At that time, Apple stock was trading at $167. This means that any time prior to December 28, the holder of the call option could purchase a share of Apple stock for $165. Obviously, this option is worthless at the point of purchase because the option costs over $5 so the holder would have to spend $170 for something worth $167. Suppose the price of Apple stock rose to $175 prior to December 28. Then, the option would be profitable as the holder could purchase for $170 something worth $175. Puts work the same way but are a right to sell so are profitable when a stock price falls below a certain value.

Why are options important? Obviously, they are speculative investments as they require some prediction of the future, and they are zero sum as for every seller, their needs to be a buyer so someone always wins and someone always loses in an options transaction. Stock purchase, in contrast, can provide a net gain for both seller and buyer if the stock price goes up after purchase.

Like fire insurance, options can be used as insurance for stock purchases. Say you purchased 100 shares of Apple stock at $165. You would be out of pocket $16,500. If you wanted to reduce your out of pocket expenses, and have an immediate return on investment, then you could sell call options on your stock. Let us say you sold 100 calls for $5 each with a strike price of $170 and an expiration date in 6 months. You would immediately receive $500 for the options sale. Assuming the stock price prior to expiration was $175, you would be forced to sell your shares at the strike price of $170, and would receive $170 × 100 = $17,000. Your net profit on the transaction would be $1000, $500 from the option sale and $500 from the $5 increase in price per share. On the other hand, if the stock price never went above $160, the options you sold would be worthless, but you would still have the $500 from the sale and would effectively recoup the money lost on

the stock price drop. This investment strategy is called selling covered calls. The calls are covered, because you own the underlying stock. There is nothing illegal about selling calls on stock you do not own (uncovered calls), but this is extremely risky because there is theoretically no upward limit to the stock price, and if the stock price increases you would have to provide the stock at the strike price regardless of the cost. For example, if something remarkable happened to Apple and the stock price went to $1165, and you owned no shares, you would have to provide 100 shares for this price even though at the time of the option purchase shares were trading for $165. You would have to pay $116,500 for stock that was only worth $16,500 at the time of the option sale for a net loss of $116,000!

Another way to use options as an insurance policy on a stock is the concept of a protective put. In this instance, you buy a put to protect you against an unexpected drop in stock price. Using the above example, suppose you bought 100 puts on your Apple stock that you bought for $165 a share. Suppose the puts cost $5 and suppose the expiration date is in 6 months and that the strike price is $160. This strategy would mitigate any drop in stock price that is more than $5 because if the price drops to say $150, you still have a right to sell it at $160.

These examples show how options can be used to protect stock investments, but also show how selling uncovered calls can be quite risky indeed.

What gives US currency value? Many physicians are shocked to learn that US currency is not backed by gold or silver since 1933. Currency backed by gold or silver is called commodity currency. A great example of the definition of money and the concept of commodity currency occurred on the tiny island of Yap in the South Pacific (Yap is also known for being the highest per capita consumers of Budweiser beer!). On Yap, instead of gold or silver, several hundred years ago, money came in the form of large limestone disks, often weighing several tons, which were traded in exchange for goods and often transported on small bamboo canoes. Because of the sheer girth of these stones, the concept of money on Yap became abstract, and the coins or large stone disks could often not be moved at all. Interestingly, there is a story about one large stone that ended up on the bottom of the sea due to a huge storm that capsized a canoe. Even though the stone was under hundreds of feet of water, the stone was still considered currency and was traded as any other stone. This abstract notion of money should not be unfamiliar as we never see our money in a bank, but believe that it is there based on pixels that produce account information on our computer monitors. This is another definition of faith.

What gives the US dollar value? The US dollar is fiat currency, meaning its value is backed by the US government. One US dollar is valued at the amount of US goods and services that can be purchased for that dollar. A dollar bill in your wallet has the seal of the US Federal Reserve System. The Federal Reserve System is a bank for banks. The Federal Reserve does not print money; that is the job of the Bureau of Engraving and Printing. Rather, the Federal Reserve can loan money to banks. Why would banks need to borrow money? When you deposit $100 into a bank, they do not store the $100 in a vault. Rather, the bank lends the money to others and collects interest on the debt. This greatly increases the total supply of money in the USA. In fact, for large banks, only 10% of deposits must be held in reserve. When banks fall below this level, they have to borrow money from the Federal Reserve. As such, the Federal Reserve controls the economy. Although it does not print money, it sets interest rates for short-term loans to other banks which in turn affects interest rates on car loans, mortgages, and other bank loans. The Federal Reserve can also buy and sell US government bonds. If the Federal Reserve wants to slow the economy, the Federal Reserve will increase interest rates and will sell bonds to reduce the amount of money available for spending. If the Federal Reserve wants to stimulate the economy, it can decrease interest rates to encourage spending, and the Federal Reserve can buy bonds to put more money into the economy.

Back to the Case

Jamal took the advice of others and found a financial planner who was highly recommended by his brother-in-law. Jamal and his financial planner discussed his short- and long-term financial goals including providing for his family, providing for his daughter's education, and his desire to retire at 65. Jamal bought additional life insurance and invested in mutual funds and worked out a monthly purchase to dollar average. With dollar averaging, if the market dropped, Jamal's mutual funds were cheaper that month, and if the market rose, his current funds were more valuable, but the funds he bought were more expensive. Jamal comfortably invested the most he could each month based on his budget. Jamal also hired an accountant.

Bottom Line

1. Get a financial planner and an accountant.
2. Reward is related to risk. There is no free lunch!
3. The average investor earns an average rate of return.

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Organized Medicine

9

Marc J. Kahn, Neil Baum, and Michael S. Ellis

Case: Amber

Amber is in her second year of residency training in physical medicine and rehabilitation at a major academic medical center. Amber became interested in how to make healthcare changes for populations of patients from a policy perspective. She has received emails from the AMA inviting her to attend an AMA-sponsored meeting in Chicago. However, Amber has never considered herself much of a joiner. What should she do?

Organized medicine allows individual physicians to join an organization in order to advocate for themselves and their patients. This can be done at the local, state, and national level. Organized medicine gives physicians, medical students, residents, and fellows a voice. It is through organized medicine that physicians can advocate for the best-quality care for their patients while also ensuring that doctors are treated fairly. It is through organized medicine that young doctors learn about the economics and politics of American medicine. This chapter will briefly discuss the history of organized medicine in the United States and present a case as to why young doctors should participate in organized medicine and learn about the real world of American medicine.

History of Organized Medicine in the United States

Prior to the establishment of the American Medical Association (AMA) in 1845, *anyone* could publicly place a sign stating they were a doctor as there was no national standard for training a doctor.

In 1845, Dr. Nathan S. Davis called for the first national medical convention, which led to the establishment of the AMA in 1847. Their first charter was focused on scientific advancement, setting standards for medical education, launching a program of medical ethics, and improving public health. These were the initial goals of the AMA more than 150 years ago, and they are still the aspirations of the organization today. The AMA is the first organization of its

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kind in the world to establish uniform standards for medical education, training, and practice as well as the first to develop a national code for ethical medical practice. Ever since its inception, the AMA Code of Ethics dictates professional conduct for all practicing physicians. The AMA sets the standards for medical education and, to this day, sets the standards for the ethical behavior for physicians.

The AMA provides health and scientific information to its members and to the public and carries out a broad range of health education programs via mass media and lectures. It keeps its members informed of significant medical and health legislation, and it represents our profession before Congress and other governmental bodies. The AMA sets standards for medical schools and internship programs, and it alerts the public to fraudulent medical remedies, snake oil salesmen, and other medical charlatans.

Publications of the AMA include the highly rated *Journal of the American Medical Association (JAMA)* and 11 other journals devoted to medical specialties such as internal medicine, psychiatry, and pediatrics. In addition, the AMA publishes the online journal *JAMA Network Open*, which focuses on original medical research.

Just a few decades ago, it was not unusual for physicians to be members of their county medical society, specialty society, state medical association, national specialty society, and the AMA, but those numbers are steadily decreasing. While the practice of medicine seems to be changing almost daily, support for organized medicine as a whole seems to be decreasing during a time at which patients and their physicians need help more than ever. Let us not forget the dictum that there is strength in numbers. It would be very difficult for one doctor to create changes in healthcare policy. Whereas if doctors join together in support or protest of legislation, it becomes a much more powerful display, and much more can be accomplished if we function as a group instead of complaining to one another.

Historically, just as the economy expands and grows during war, physician membership in organized medicine usually increases during difficult times—times in which medicine is facing more intrusion by government regulation and restriction on how physicians can and do practice medicine, often without consideration for the protection of patients' rights. In the 1950s, about 75% of all practicing physicians in the United States were members of the AMA. According to recent statistics in 2017, membership in the AMA is only about one-sixth of the nation's physicians [1].

So, where are all the physicians going? Today, there appears to be apathy among older and younger physicians for participation in organized medicine. Certainly, costs are one constraint especially if a physician joins local, state, or national organizations plus one or more of the specialty societies. Many practices and hospitals that employ physicians will cover the costs of these annual dues to these organizations. However, this provision must be in the physician's contract (see Chap. 5). In addition to cost concerns, doctors today have time constraints that might preclude going to additional meetings and taking time away from their families.

It has not been easy for organized medicine. Some of the consequences may be worth noting. Physicians are no longer the powerful force in society they once were. Their opinions and recommendations no longer go almost unchallenged. Organized medicine as one voice among many physicians can command greater attention. The AMA's use of political action committee (PAC) dollars can also be used to assure that legislators at least listen to physicians' views.

There was a time, more than half a century ago, when organized medicine played a key role in physicians' lives and held enormous sway over US healthcare policy-making. During that time, three quarters of physicians were simultaneously members of their county and state medical societies and the AMA [2]. Physicians spent many hours of their free time in these three groups, dealing with clinical learning, running for elected offices, holding forums, and hammering out positions on all kinds of issues.

For most older physicians, that era is long gone. Now, a much smaller percentage of doctors belong to the AMA or county societies, and they

are more likely to join their medical specialty societies than any other organization.

Specialty societies enjoy very high membership rates and do not seem to have a problem staying relevant to doctors. However, each specialty society has developed its own particular position on healthcare issues, replacing the once unified voice of the House of Medicine with a chorus of sometimes conflicting views.

Meanwhile, doctors seem to be following the growing trend among all Americans of moving away from groups. The 2000 book *Bowling Alone*, by Robert D. Putnam, demonstrated this trend by showing that even as the number of bowlers continued to rise, the number of people in bowling leagues had markedly fallen [3].

What Are the Reasons to Consider Joining Organized Medicine?

Organized medicine consists of groups of physicians categorized into three: (1) practicing physicians, (2) young physicians, and (3) residents and medical students. Each group or section works together to advocate collectively on behalf of the physician–patient relationship, patients' rights, and medicine as a whole. Each individual group also works together to advocate for their section's interests. Giving physicians and medical students a voice in the business of medicine allows physicians to advocate for the best quality of care for their patients and ensures physicians are also treated fairly on the state and national levels.

Organized medicine has been front and center in confronting the problem of physician burnout which is impacting nearly 50% of all healthcare providers (see Chap. 22 on burnout). Burnout is a complicated issue brought about by the physician's feeling of irrelevance in a complex healthcare market. Organized medicine has recognized that medicine is a business and doctors are in dire need of guidelines on suggestions for running an efficient, productive, and, yes, profitable practice that is relevant to the care of patients. These organizations are providing young doctors with the necessary tools and resources to run a cost-effective medical practice and to hopefully feel less burned out.

Compliance with national imperatives is a major problem that impacts nearly every practice. There are compliance regulations that are onerous, time consuming, and difficult to interpret. Recent reports looking at HIPAA and Meaningful Use audit findings have shown that most organizations do not retain the necessary supporting documentation of completion of a core set objectives and measures. This places the practice at increased risk of decreased reimbursement, costly fines, and prevention of certain patient populations, such as Medicare and Medicaid, from accessing the practice. Many organizations offer audit solutions that help practices verify and validate that privacy and security programs meet compliance and business objectives.

Organized medicine has been, and will continue to play, a major role in the education and training of young physicians. You can plan on accessing the latest in technology and education through your national, state, local, and specialty organizations.

Our national medical societies and organizations have taken a leadership role in confronting and managing the American opioid crisis. This has been a crisis which the medical community is culpable, and we have taken responsibility for solving this crisis and reducing the use of opioids and providing services for those who are addicted to these drugs. Organized medicine, as a national voice, had the clout to affect change through education and through their ability to direct local and national resources toward solving this crisis [4].

One of the best examples of the effectiveness of organized medicine was a report in the New England Journal of Medicine in 1991 authored by Dr. Lucien Leape who reviewed 30,000 randomly selected patients' hospital records. The study shocked the medical profession. This report demonstrated that nearly 4% of patients admitted to a hospital suffered an injury that prolonged their hospital stay or resulted in measurable disability and that nearly 14% of those injuries were fatal. Further, the study found that 70% of those injuries were clearly preventable. The study

extrapolated that data of 30,000 patient records to the entire nation and estimated that 120,000 people were dying from preventable medical errors [5]. The study showed medication errors accounted for the largest group of preventable medical errors. Dr. Leape estimated that there were one million preventable medical errors in the United States each year, and the cost of these errors added to the already bloated healthcare budget by $33 million every year. This report in the NEJM generated front page coverage in nearly every major American newspaper. This was an unacceptable blemish on American healthcare that galvanized organized medicine (AMA) as this was such a large problem that one person or group could not possibly solve. The AMA demonstrated that error prevention systems were in place in other industries such as the airline industry. The AMA recommended that the healthcare profession adapt the same systems that were accomplished in other industries and that errors could be reduced and the quality of medicine improve.

Shortly after the publication of the Leape report, the AMA, Joint Commission, and the American Association for the Advancement of Science hosted a conference on errors in medicine where a prevention, education, and research agenda was established [6]. It was through this pioneering work on part of a group of organized physicians that patient safety was recognized as the sine qua non of quality. Thanks to these doctors and organized medicine there were, for the first time, sophisticated and efficient methods of measuring quality that could compare institutions and doctors through the quality lens. The take-home message is that change can occur in medicine, albeit slowly, but when we put the patient first and recognize that we are fallible but that we can correct our errors, we are, indeed, making progress.

Medical associations provide unparalleled networking opportunities, allowing young doctors to connect with their peers, mentors, and other industry leaders. As a member, you are in the unique position to attend conventions, seminars, and other related events with like-minded professionals in the field. Medical associations will provide you with not only clinical collaboration but also socialization with like-minded colleagues.

A medical association's annual meeting represents an incredible opportunity for you to meet and network with the largest gathering of your peers every year. Networking with professionals outside your place of employment or practice can give you a broader perspective on the market and healthcare in general. Listening to the experiences of others may even leave you feeling energized and refreshed with the feeling you are not alone in the fight to change the course of American medicine.

The field of medicine is always in a state of change. Healthcare professionals can keep up with the newest developments and scientific breakthroughs through their associations' seminars, journals, CME courses, and other educational opportunities. Additionally, many associations, especially the specialty societies, offer all of the certification courses you will need throughout your entire career. Your professional organization also provides access to mentors, giving you an opportunity to participate in mentoring others as well. Having a mentor in any field will help your career grow and thrive. As an association member, you are in the unique position to gain a competitive edge by utilizing all of the educational resources and marketing materials available to you.

Associations are always looking for young doctors to help organize their annual meetings, workshops, CME courses, and legislative committees. Helping your organization work to improve your profession as well as to improve the overall state of healthcare can be a very rewarding opportunity. Working on these projects will also be a great introduction to organized medicine and will often serve as a springboard to reach higher levels in the organization.

To fully receive the benefits of membership, you need to be engaged with the association. With any membership, however, you get what

you put into it. Get involved early in your career and as often as possible, and you will reap the benefits offered to you as a member.

Healthcare associations are great places to find the latest jobs in your field! If you are looking for a new position during your training, most organizations collect positions available throughout the nation, and you can submit areas where you would like to work and find available jobs in your specialty and in a location where you would like to work. An excellent resource is www.healthecareers.com. This site allows you submit your name and email, and you can be notified electronically as new jobs become available.

There are several special examples of organized medicine besides the AMA, state organizations, and specialty societies that you may consider joining. These include the following:

The American Medical Women's Association (www.amwa-doc.org) is an organization which functions at the local and national level to advance women in medicine and improve women's health.

The National Medical Association (NMA) (www.nmanet.org) is the voice of African American physicians and the leading voice for parity and justice in medicine and the elimination of disparities in healthcare for all Americans regardless of ethnicity.

The NMA represents the interests of more than 50,000 African American physicians and the patients they serve. NMA is committed to improving the quality of health among all minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research, and partnerships with federal and private agencies.

The American Medical Student Association (AMSA) is the oldest and largest independent association of physicians-in-training in the United States. AMSA members are premedical students, medical students, interns, residents, and practicing physicians. AMSA is focused on future physicians who believe that patients and health professionals are partners in the management of healthcare and that access to high-quality healthcare is a right and not a privilege. The AMSA annual convention is the largest gathering of medical students and regularly draws an attendance of more than 1500 physicians-in-training, medical educators, and health policy innovators. AMSA continues to search for new and innovative ways to improve healthcare, healthcare delivery, and medical education.

AMSA remains a leader in the campaign for resident work hour reform—authoring the Patient and Physician Safety and Protection Act of 2003. The passage of this act by Congress limited the work week of residents and fellows to 80 hours per week [7].

AMSA publishes an excellent magazine, *The New Physician*, available to all students and new physicians which will provide information you need to enrich your medical training and launch your career as a physician.

AMSA local chapters continue to reach out to serve the health needs of their communities. Annually, local chapters contribute over one million hours of community service.

Amber's Case

Amber's trip to Chicago was "mind-blowing," allowing her to serve as an alternate delegate for the first time. Because the AMA trip to Chicago was her first introduction to organized medicine on a national stage, she did not know what to expect, which made for an even better experience.

She experienced collegiality of residents from all different walks of life and all different types of programs, from multiple geographic areas all coming together for one specific cause. She decided to become involved in organized medicine because she knew that there were strengths in numbers and that a group of doctors could advocate better for patients than one doctor alone could possibly accomplish.

Bottom Line

Organization medicine has the objective of promoting the science and art of medicine and also to enhance public health. Let us not forget that there is strength in numbers. It is highly unlikely that one person can produce significant changes in healthcare policy. However, when we work together through the auspices of organized medicine, we can improve American healthcare. By standing together, united in vision and commitment, physicians can shape the healthcare system this country needs.

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Part II

Your First Job

Transition from Training to Practice

10

Marc J. Kahn and Neil Baum

Case: Phil

Phil is a fellowship-trained neurosurgeon. He had 13 years of training and 5 years of military service, including several tours in Afghanistan and Iraq, to pay back for his education and thus did not have any appreciable debt upon entering private practice. Phil has skills for midbrain surgery using stereotaxic localization of brain tumors. He was a highly skilled surgeon, but because of his extensive training and not having any mentors during his military experience, he was at a loss for the process of transitioning from training\military payback to private practice.

Moving from a training program to private practice can be a stressful time for any doctor. For your previous training experience, you are in a cocoon or bubble and are protected by staff and faculty from your training program. There are so many things to take into consideration when making that transition to practice. Balancing your current workload as a resident or fellow and then managing family responsibilities while attempting to start your new practice can often lead to mistakes and missed opportunities. This chapter will help make that transition seamless. The following suggestions are a compilation of advice from several young physicians who entered private practice within the past 3 years. They will share what worked for them, and what they would do if they had a chance to start all over again.

Ideally, you would like to have everything in order and ready to start caring for patients the first day you begin your practice.

The first recommendation is to start early, which is usually 6–9 months prior to the end of your training. This is not easily accomplished and will require a significant commitment of time. Everything takes time to prepare for practice, and often, more time than you anticipate. Obtaining a license in another state can take months of correspondence, copying of transcripts from undergraduate and medical school, proof of citizenship, and copy of your medical degree issued by a medical school approved by the state board. This vetting process by state boards of medical examiners can be very frustrating as you are used to having documents and forms regarding patient care available at the click of a mouse. However, when you have to work with other people, such as bureaucrats in state medical societies, insurance companies, lenders, real estate agents, lawyers, contractors, third-party

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payers, and technology firms can be a source of anxiety and frustration. Because let's face it—no one is as eager to start a practice as you.

Even when everyone is onboard, much of the preparation for a practice takes time, and there is not much you can do can speed up those processes. For example, the credentialing process for most hospitals require at least 6 months.

Most successful transitions use a check list. An excellent check list is provided in Fig. 10.1 provided by Physician Practice Specialists (https://physicianpracticespecialists.com/contact/).

You have finished your residency\fellowship, signed your contract or lease, had business cards and stationery printed, and your name is on the door added to the list of doctors in the practice. What do you do next?

You cannot hope to be ready to practice on the first day of practice if you have not done all the necessary steps required to be a real doctor. These action steps cannot be done on the last day or even the last week of your training program. It actually takes months of preparation to become licensed in the state where you are going to practice, to obtain credentials to practice at the hospital(s) where you are going to work, and to be placed on insurance plans so you can see patients and be compensated for your services.

Credentialing with Insurance Companies

We cannot emphasize how important it is to begin the credentialing process early as it may take 4–6 months in order to obtain permission to see their patients covered by their insurance. We have seen doctors start practice and have a state license to practice but are not on the insurance plans and cannot be paid for the services. This can be a source of great frustration to a young doctor starting his\her practice.

Credentialing is a process used to evaluate the qualifications and practice history of a doctor. This process includes a review of a doctor's completed education, training, residency, and licenses. The process also includes any certifications issued by a board in the doctor's area of specialty. You do not have to necessarily be board certified, but if you are going to practice a specialty, you must demonstrate that you are at a minimum board eligible.

Credentialing with insurance companies otherwise known as provider enrollment or achieving in-network status can be extremely challenging especially if this is your first foray in that process. Even with experience and every tool at your disposal, the credentialing process can still be exhausting. Here is a brief overview of how to complete the provider enrollment or insurance credentialing process to become an in-network provider. This is an overview of the process, but keep in mind that each payer may be slightly different [1].

Start with obtaining your CAQH ID. This is the Universal Credentialing Data Source, which is designed to make the credentialing process easier for providers by gathering data in a single repository that may be accessed by participating health plans and other healthcare organizations. The CAQH ID enables providers to easily update their information. Commercial payers will require this information for your application. Make sure CAQH has a valid W9 and malpractice certificate uploaded. You can easily register for your CAQH ID online at https://proview.caqh.org/PR/Registration.

Next, join a network by requesting join network on the insurance company's website. Sometimes it is not easy to find join network site, so always contact the payer to follow-up with your request or call them if you cannot find the join network request. Many of the insurance companies have credentialing hotlines set up; hence, check out their website for this number.

If the panel is open or if insurance company is in need of doctors in your specialty or additional primary care doctors, then the credentialing process can be started. They will request some information from you on the phone (CAQH ID, NPI, Practice EIN). The practice EIN is an employer identification number (EIN) or the nine-digit number assigned by the IRS. It is used to identify the tax accounts of employers and others even if there are no additional employees. The IRS uses the number to identify taxpayers who are required

HEALTHCARE START-UP ISSUES

The following is an **abbreviated** list of items for consideration when contemplating opening a new practice. This list is not complete, and should be considered to be only a general guide. Actual needs will be dictated by specific markets, programming, and strategic goals of the principal(s) involved.

PLANNING

1. Select a qualified consultant to develop:

    1. Business Description and Goals
    2. Market Assessment
    3. Financial Feasibility Study: Assumptions, Proforma Financial Statements and Capital Requirements
    4. Operational and Marketing Strategies

FACILITIES

1. Select Office Site/Negotiate Lease
2. Design Office Layout/Tenant Improvement Needed/Desired
3. Design Office Signs (Interior/Exterior)
4. Design Employee Workstations
5. Investigate Structural Alterations/Regulatory Issues/Infection Control Issues
6. Address HIPAA (Privacy Regulation) Facility Design Issues
7. Design Patient Flow (Incl. Privacy) Issues
8. Lay Out Exam Rooms/Procedure Room/Public Areas/Staff Areas
9. Select Phone Systems: Design And Layout
10. Plan EHR & EMR system | Billing, Accounts Receivable & Practice Management Information Systems
11. Select Information System Hardware and telecommunications equipment
12. Procure Office And Clinical Equipment
13. Select Supply Vendor And Order Initial Inventory

PRACTICE MANAGEMENT

1. Select Legal Counsel And CPA
2. Develop Legal Structure
3. Create Corporate Documents
4. File Fictitious Business Name
5. Establish Tax ID Number
6. Obtain Business License
7. Obtain Business Liability, Malpractice, And Worker's Compensation Insurance
8. EHR: Selection and Implementation of an Electronic Health Records system (PM and EMR)
9. Prepare for Health Plan(s) Participation Including Medicare/Medicaid to meet all Relevant Requirements Established in Federal/State Guidelines and Demonstrate Compliance *(Physical Plant, Equipment, Supplies, Written Clinical and Administrative Policies/Procedures, Forms, Staff Qualifications, Traceable Systems, Chart Note Review, OSHA, Etc.)*
10. Negotiate Payor Contracts
11. Identify Clinical Services/Develop Special Program/Services
12. Write Clinical and Operations Policies, Procedures And Protocols
    1. Office Systems and Information Flows
    2. Appointment Scheduling
    3. Patient Registration
    4. Check-in/Reception
    5. Medical Records
    6. Nursing/Back Office
    7. Check-out Reception
    8. Referrals/Follow-Up Care
    9. Pharmacy
    10. Supplies (Clinical/Non-Clinical)
13. Conduct a HIPAA Risk Assessment for Privacy, Security and Breach Notification rules
14. Establish Practice Management Benchmarks And Indicators By Which To Judge Success
15. Develop A Medicare Fraud And Abuse Compliance Program And Evidence Of Implementation
16. Conduct Ongoing Operational Reviews And Strategic Planning

Fig. 10.1 Checklist for transition from training to practice. (Used with permission from Provider Services Nationwide (providerservicesnationwide.com))

Financial Planning

1. Establish And Implement An Operating Budget
2. Set Up Billing And Collection Protocols/Policies
3. Open Bank Accounts
4. Establish Working Capital Line of Credit
5. Establish Credit Card Processing Capability
6. Determine Outsourcing Needs/Establish Contracts (e.g. Billing, Payroll)
7. Establish and Implement Proper Purchasing Policies And Procedures
8. Establish Accounting And Reporting Systems For Effective Cash Management
9. Develop Financial Management Policies And Procedures
10. Establish Proper Internal Control Measures

Human Resources

1. Develop Personnel Policies And Initial Staffing Plan
2. Establish Proper Orientation And Training Programs
3. Establish Internal Safety Program
4. Set up Payroll And Quarterly Tax Reporting Systems
5. Post Federal/State Mandated Employee Postings
6. Develop Position Descriptions
7. Develop A Compensation and Benefits Plan
8. Recruit Employees

Marketing and Referral Development

1. Develop Collateral Material
2. Establish And Implement A Marketing/Referral Development Plan
3. Develop A Public Relations Program
4. Plan and Develop an Online presence program

Fig. 10.1 (continued)

to file various business tax returns each year. You need to be certain that the practice EIN you provide is exactly the same one on the W9 that should already be in CAQH.

It is necessary for you to follow up on the material you submitted. It is very common for your request to fall through the cracks at the payer level. Information and documents may be lost or misplaced, and it is unlikely that you will be notified that the file is incomplete. Therefore, we suggest that you call the payer frequently and ensure that everything is proceeding correctly, and if a document or a form is missing, you can promptly submit or resubmit anything that is required or missing.

Once credentialing or primary source verification is complete, you will now move to contracting. The contracting phase is the all-important part of the process that determines how much you will be paid for your services on the payers' members. A contracting representative will be assigned to you and that representative will draft your agreement. Your agreement is drafted by the payer usually after 3 months since you initiated the process of credentialing and will move through the contracting department.

It is at this time when your fee schedule is created. You will want to follow-up every week or two to check status with the payer regarding your fee schedule.

Be certain to review the fee schedule before signing as they may submit a lousy initial agreement. The fee schedule is not always included, so you may need to request a fee schedule and provide the payer with your top 20 codes or the procedures you perform or plan to perform most often.

After signing the contract, plan on an additional 30 days for them to load your name, contact information, and fee schedule in their system. At that time, you will be issued a provider identification number (PIN) and a letter of participation which indicates your effective date of having permission to see their patients.

You are still not done! You must verify payer participation and save the email or letter received from the payer confirming participation. Finally, ensure your billing system is updated with payer information (EDI enrollment) and only then can you start submitting claims.

Do you understand now why this process takes a long time? This is a brief overview of how to become credentialed. It does take time and you cannot be paid unless you have a self-pay practice when credentialing is not required.

Ten Suggestions for Getting Started

There are ten suggestions for the transition process to take place. All these suggestions might not apply to you and your practice, but we can assure that most of the suggestions will be helpful.

Find a Mentor

Your senior partner may not be able to help you—chances are he or she entered private practice more than 10 years ago. We can assure you that his\her clinical skills probably will not translate into transition skills of helping you in your shift from training to practice.

Finding a mentor is a vital step after finishing your residency. A senior physician who knows the ropes or the politics of the medical community can be an invaluable resource. A senior physician will likely be flattered that you have asked him\her for guidance and counsel. You will find it invaluable to reach out to older, mature, seasoned colleagues and pick their brains about practice and the realities of the real world of medicine.

We recommend selecting an older physician who is visible and has status in your medical community. Examples might include an executive in your local medical society, the previous chief of staff at your hospital or even a family friend in the medical profession. It is not necessary to select a mentor in your specialty. If you are a surgeon, select an internist or a medical specialist. If you are in sports medicine, select a cardiologist or rheumatologist. Your purpose in selecting a mentor is not primarily to develop a referral source but to learn the unique aspects of your medical community.

The mentor will introduce you to physicians with whom you have something in common and would be your future professional allies. Your mentor may also include you in social functions at the hospital that you might not be on the invitation list. Ask to join the mentor at the first few hospital staff meetings, requesting him\her to introduce you to his friends and contemporaries. You will find that the advice from a mentor is priceless. The mentor can actually help with the rapid acceleration of your career.

Learn How to Write or Create an Effective Referral Letter

Most residency programs focus on the diagnosis and treatment of disease. They provide little training on the techniques of communicating with other physicians. Therefore, most new physicians unknowingly provide the primacy care doctor with too much information. Like you, today's doctors are too busy to read two to three page letters. Not only will they be unimpressed by a lengthy letter, chances are they will not even read it.

Referring doctors will appreciate letters that are short, to the point, and timely. What information are primary care doctors looking for in a letter from a referring doctor? The working diagnosis, the medications you prescribe for their patient, and treatment plan are most often cited. (For more information on communicating with referring physicians, see Chap. 13.)

Meet the VIPs

As soon as you begin your practice, you must introduce yourself to several key people in your hospital. They are:

- The medical director
- The hospital administrator
- The chief of staff

- The chief of your department
- The emergency room physicians and staff
- The business/admitting office staff
- The physician services representative
- The marketing/PR staff
- The director of MCE
- The head of physician referral services

Court Other Physicians

You need a core group of physicians to send you patients. Probably 10–15 physicians who will refer to you on a regular basis is all that is initially needed. Block out time each week for calling upon doctors you think could send you referrals. Initially, you will find that doctors in practice less than 5 years and older physicians near retirement are the best contact to make.

Look beyond your specialty when courting referring physicians, but on the other hand, do not neglect your own specialty as you may find colleagues in your specialty do not perform the procedures that you do as a result of your recent training.

You might also consider sending a brief letter to a doctor you plan to meet a few days before the scheduled appointment. The letter could mention your training and areas of interest and expertise, as well as why you moved to the community and any personal information that may be of interest to the doctor you are approaching. Sending a brief thank you letter after the meeting is also a nice gesture.

For example, if you are a recently trained plastic surgeon and an older plastic surgeon is not trained in breast reconstruction, then he\she may be happy to send you his patient that needs your services. Invite this colleague to assist you. This way, the older physician is still involved in the care of the patient and assured of getting the patient back.

Remember, you do not always need to meet a potential referral source in the doctor's office. Visit the physicians' lounges, and the physicians' dining rooms and attend social events organized by the hospital, such as sporting events and health fairs.

The Buddy System

Most medical staff offices have programs to orient new physicians to the hospital. Be sure and find out if the hospital has a "buddy system" in which an assigned physician will be your guide and show you around the hospital and the medical community. Request a copy of the medical directory and names of other new physicians on the staff. Find out when staff meetings are being held and which committees you might join. Be sure and contact the chairpersons of committees that are of interest to you or provide opportunities to meet new physicians.

Contact Nonphysicians

In addition to courting physicians, make an effort to introduce yourself to the nurses in your hospital to discuss your area of expertise and interest. Meeting the community's pharmacists is also a good idea; patients often ask them to recommend a physician. Other worthwhile contacts include podiatrists, chiropractors, lawyers, social workers, beauticians, barbers, and manicurists.

Especially for Surgeons

In order to have your first cases go smoothly, introduce yourself to the operating room supervisor and staff. If you will be performing procedures new to the staff, offer to provide an in-service program to the operating room nurses. Before leaving your residency, obtain copies of your instrument cards to present to the operating room staff so they can have the appropriate instruments on hand for your first cases. This measure will ensure that all the instruments needed, sutures that you require, having intraoperative medications on hand, and having any additional equipment that you need for your surgical procedures will be available for your early cases that you schedule in the hospital.

Beforehand your first few cases, meet with the scrub nurse and the circulating nurse and indicate

your plans, wants, and needs—including your glove size. Educating the operating room personnel before surgery begins is the best way to succeed for your first few cases. It is very important that your first few cases are seamless. There will be people looking at your behavior, your skills, and your outcomes so be sure that the early cases are representative of your personality and your talents.

Keeping in Touch

Address/file cards can be used as an effective method of keeping your name in front of not only the physician but also the staff. A good card will contain not only your name, address, and phone number but a FAX number, direct line to your cell phone, and even your home number. Additionally, you can include your office hours; answering service; professional information number (PIN); partners; names of your office manager, secretary, and nurse; and any other information you might feel is helpful such as the insurance plans you are on even if the recent edition does not include your name and contact information.

Pharmaceutical Contacts

Knowing pharmaceutical representatives and medical manufacturing companies can also be helpful. From prescription pads and calling cards to computer software programs and educational videos, they have the materials and resources to assist new physicians set up their practices. Some companies even have divisions for the sole purpose of helping new physicians begin their careers. Physician services departments will have the names and telephone numbers of the contacts who can help you.

Setting Fees

Lastly, you will want to consider how much to charge. Few areas will impact your practice more than the fees on which you decide for your services. Most studies indicate that few patients select doctors on the basis of fees alone. If you join a group or have partners, this task will be easy as their fees are your fees. Occasionally, a colleague will share this information with you. Another technique is to use the relative value unit. These values can be obtained in "Relative Values for Physicians" [2].

And our final advice—do not go to work the day after you complete your training on July1! Why? There will never be a time in your life when you will be able to have a long vacation with very little responsibility. We understand that you may have significant debt and are eager to lower your financial obligations. (See Chap. 11 on debt reduction.) We suggest that you consider, at a minimum, a 4–6-week hiatus between ending your training and starting your practice. If the practice or hospital you are joining managed without you for months or years, a few additional weeks will not make a difference. Yes, they may be eager for you to begin but should take advantage of this hiatus and take a long vacation with your significant other and your family. We can assure you that you will not have 6 weeks off from your practice until 35–40 years later when you retire. We have never seen or heard of a doctor who has regretted this decision.

Case Study

Phil went online and obtained a checklist for the process of licensing and credentialing. He spent nearly 6 months to prepare for the transition to private practice. He joined a single specialty neurosurgery practice and had partners help with the hospital credentialing process. Phil admits that there was nothing easy about the move from training to practice, but starting early was his best advice. He also took a much-needed vacation after being discharged from the service and was delighted that he did.

Bottom Line

It is true that medicine has undergone significant changes since the first day you started medical school or even began your residency. Many young physicians are discouraged at the future prospects in healthcare or find starting a practice daunting and will opt for becoming an employed physician. However, there are still wonderful opportunities available to every physician regardless of the length of practice. The transition from residency to private practice can be less overwhelming by knowing and implementing the right steps for success.

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Managing Student Debt

11

Marc J. Kahn and Marissa Lespinasse

Case: Dimitri

Dimitri is a fourth-year medical student who is about to graduate from a private medical school in the northeast. Dimitri has borrowed money to cover his medical school expenses and has additional loan debt from college. His total educational debt is over $300,000. Dimitri is fortunate to have matched into his first-choice spot for his family practice residency. He is going to a small town in the southeastern USA. He has just met with his financial aid counselor to do his exit interview to review his total debt and is astonished by the amount of money he will be expected to repay. What are his repayment options?

In 2018, the mean and median indebtedness of all medical school graduates was $196,520 and $200,000, respectively, with debt being higher for graduates of private medical schools when compared with public medical schools [1]. A total of 16% of medical school graduates reported debt of over $300,000, and 71% of graduates reported some medical education debt. Certainly, Dimitri is not alone. The cost of attendance at US medical schools has increased at a pace surpassing that of inflation, with a median four-year cost of attendance for private schools for the Class of 2019 at $330,180 [1].

Despite the high cost of attendance, going to medical school is financially advantageous with a net present value of over $1.6 million [2]. This means that someone would have to give you $1.6 million prior to starting medical school for you to be in the same financial position at retirement as if you went to medical school! A medical education is an investment with an excellent return. Even for students planning careers in lower paying primary care specialties do well financially as physicians. A recent study investigated whether or not students could afford a career in primary care using financial planning software [3]. The authors concluded that a primary care field remains financially viable for medical school graduates with median levels of debt. The study further concluded that graduates with high levels of debt needed to consider extended payment plans, loan forgiveness programs, or living in area of the country with a lower cost of living in order to cover their educational debt.

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In spite of the fact that going to medical school is a good financial move, the amount of debt accrued by graduates can be onerous, and because physicians have a high earning potential, they have little choice but to pay back their loans. They cannot default. Generally, monthly loan repayments include both a portion of the amount borrowed (principal) and a portion of the interest accrued over the life of the loan. Remember, you have to pay for someone to lend you money. For new graduates, or in the case of financial hardship, most loans allow for a grace period where payments can be temporarily suspended or delayed with the accrual of additional interest. Again, if a physician delays paying their loans, they will be penalized with additional interest payments. As such, it is generally not advisable to delay the start of educational loan repayment.

Basically, there are three types of traditional loan repayment models for physicians: (1) standard repayment, (2) extended repayment, and (3) graduated repayment. Standard repayment requires the borrower to make fixed monthly payments that include both principal and interest. Typically, the borrower is required to pay off the principal and interest in 10 years. Of course, if a borrower has multiple sources of loans (federal government and private loans), all of the loans can be consolidated into one loan. For federal loans, the loan servicer can consolidate all of the federal loans. If both private and federal loans are going to be consolidated, the borrower must go through a third party who basically "buy" the individual loans and package them as one larger loan. Consolidating federal and private loans together has the disadvantage of being less flexible with repayment options than federal consolidation, but has the advantage of lower interest rates at the cost of higher monthly payments. Typically, consolidated loans are paid off over a longer period of time (20 or 30 years). Generally, this reduces the monthly payment, but increases the total amount of interest paid over the life of the loan, raising the overall total amount paid back by the borrower. Standard repayment is the "default" if no other type of repayment plan is chosen.

Extended repayment, such as consolidation, allows the borrower to spread out the payments over a longer period of time (25 years for federal loans) with an increase in the total interest accrued. As such, the monthly payments are lower, but the total amount of money repaid is increased due to interest charged on the loan during the extended repayment period.

Graduated repayment allows the borrower to make smaller payments initially, with increases in payments after several years. As with extended payment, the borrower pays for this benefit with higher interest payments.

In addition to the three typical repayment models, borrowers can enter into an income-driven repayment plans. In each of these, the amount paid per month in repayment is closely tied to income earned. These repayment plans are generally divided into those that are income contingent and those that are income based. Income contingent plan payments are based on the lesser of either 20% monthly discretionary income or the amount you would pay on a fixed payment plan over 12 years, adjusted according to your income. All income-driven plans allow borrowers to make monthly payments based on family size and adjusted gross income. Typically, payments are capped at 10% to 15% of discretionary income. For a typical resident earning $50,000 per year with a household size of one and $300,000 of debt, under the income-based repayment plan, payment would average about $370 per month. In addition to income contingent and income-based repayment plans, borrowers can enter pay as you earn (PAYE) or revised pay as you earn (REPAYE) plans, both of which require payments that are calculated as a percentage (10%) of discretionary income. In the PAYE plan, repayment is never more than you would have paid in a standard 10-year repayment plan. For PAYE, payments are calculated each year based on income and family size. Under REPAYE, 100% of negative amortization on subsidized loans is forgiven in the first 3 years and 50% after that. About 50% of negative amortization on unsubsidized loans is forgiven during all years under REPAYE. As with all financial decisions, it is best to discuss loan repayment strategies with a financial advisor before making any final decisions. Each repayment plan has its own

tax implications including whether or not the payments of principal and/or interest are tax deductible. Additionally, some repayment plans may allow for loan forgiveness after a certain number of payments.

Are there ways to have someone else pay off your educational debt?

In 2007, the College Cost Reduction and Access Act was created to provide indebted college, graduate, or professional school graduates a way to reduce their federal student debt burden by working in public service. Loans considered eligible for public service loan forgiveness (PSLF) included any loan issued under the federal Direct Loan Program including subsidized and unsubsidized Stafford loans, Grad PLUS loans, and federal Direct Consolidation Loans. Unfortunately, private loans were not deemed eligible for forgiveness. For more information on PSLF, go to the government website, https://studentloans.gov/myDirectLoan/pslfFlow.action#!/pslf/launch.

To qualify for PSLF, the borrower has to fill out an employee certification form at the time of hire and has to make 120 monthly, on-time payments in a qualifying plan and has to work full time for 10 years in a government or not-for-profit (501c) organization. Qualifying repayment plans for PSLF include any one of the previously described income-driven repayment plans (income contingent repayment, income-based repayment, PAYE, or REPAYE). The huge benefit of PSLF is that after making 120 qualifying payments, and submitting the required application for forgiveness, the remainder of the loan balance is forgiven. When originally established, there was no cap or maximum amount of loan debt that could be forgiven. Under the qualifying income-driven repayment plans that qualify for PSLF, your payment is only dependent on your income. Those with higher debt, have a larger amount of debt forgiven at the end of the repayment period. Over the past few years, attempts have been made to cap the amount of PSLF at $57,000. More recent proposals include eliminating PSLF entirely. The future of PSLF remains uncertain, but as of the time of this writing, PSLF remains intact under law.

In addition to PSLF, there are several other federally based loan forgiveness programs. All three branches of the military (Army, Navy, Air Force) offer medical school scholarships through the Health Professions Scholarship Program (HPSP) that cover medical school tuition and fees and provide a stipend for living expenses for medical students in exchange for military service. What is often not recognized is that the military also offers loan repayment opportunities after graduation from medical school. Loan repayment does require active military duty and/or reserve status in a branch of the US military. The amount of repayment can be substantial (up to $275,000) and may also include sign-on bonuses for practicing physicians that range between $220,000 and $400,000 depending on specialty. More information on HPSP is available for all branches of the military at https://www.medicineandthemilitary.com/joining-and-eligibility/medical-school-scholarships. For those who hope to apply to HPSP, selection boards tend to look at all aspects of an applicant's application – leadership, extracurricular activities, fitness, grades, and scores – so they can determine who will succeed in both medical school and the military.

Like the military, the Indian Health Service offers loan repayment, paying up to $40,000 for a 2-year service commitment for service in Indian Health Service facilities providing care of American Indians or Alaska Natives. More information is available on the Indian Health Services website: https://www.ihs.gov/loanrepayment/. This loan repayment program requires a two-year commitment to practice in health facilities serving American Indian and Alaska Native communities.

For physicians involved in research careers, the National Institutes of Health (NIH) offers a competitive loan repayment program where successful applicants who agree to a two-year minimum contract to engage in research funded by a nonprofit organization are provided up to $35,000 per year to repay undergraduate, medical school, or graduate school debt. The NIH also offers loan repayment programs for clinicians from disadvantaged backgrounds or for physicians engaged

in health disparity research. The loan repayment programs recognize the financial pressure on young scientists and will pay up to $35,000 annually of a researcher's qualified educational debt in return for a commitment to engage in NIH mission-relevant research. For more information, go to the NIH site, lrp.nih.gov.

The National Health Service Corps (NHSC) offers loan repayment for those physicians who commit to working at least 2 years full-time at an NHSC-approved site. These are typically in rural communities or in the inner city. Physicians who practice primary care or mental health are eligible for up to $50,000 that is tax free and extendable for an additional 2 years. See nhsc.hrsa.gov to apply for a NHSC repayment loan.

In addition to the above federal programs, many states have programs that repay medical school loans for physicians who agree to practice in medically underserved regions or federally designated health professional shortage areas.

Finally, many practices and hospitals offer a sign-on bonus for new hires, if not a direct stipend for loan repayment. Most of these offers require that the physician spend a minimum of 2 years with the group. For a $25,000 bonus, assuming a 25% tax rate, the signing bonus would net $18,750. That sum could be used to make an extra bonus payment on student loans, saving thousands of dollars in interest over the life of the loan.

In addition to loan repayment, it may also be advisable to refinance debt at a lower interest rate. Depending on the interest rates on loans and interest rates offered by consolidation companies, this may be an attractive way to decrease the total money paid on a loan. However, because monthly payments tend to be high with third-party consolidators, this plan is only advisable for those able to make higher monthly payments to pay down debt quicker. As with other decisions, careful consultation with a financial advisor is important before making any decision regarding loan repayment.

Finally, we would like to conclude with eight rules for paying off debt [4]:

Rule 1: Map out all of your loans for a clear picture. Create a master document such as an Excel spreadsheet that includes the details of, and contact information for, all loans including amounts owed, issuing institutions or programs, and entities that service the loans. Make this a comprehensive list to include all educational debt, credit card debt, car payments, and spouse's debt. Set up a column for the lender, remaining balances, the percent interest you are charged, fees that are incurred, monthly payments, and any special notes. Keep it simple, but commit to updating this monthly. Especially for your educational loans, keep notes on early repayment and deferral. These details determine your options for loan repayment and forgiveness. If you are not sure, ask your lender or visit www.nslds.ed.gov. You can log in and see the loan amounts, lender(s), and repayment status for all of your federal loans. If some of your loans are not listed, they are probably private (nonfederal) loans. For those, find a recent billing statement and/or the original paperwork that you signed.

Rule 2: Pay off your debt within 7–8 years, max. To do this, live within your means and try to avoid the accumulation of bad debt (debt that is not used to purchase an asset that grows in value).

Rule 3: First, pay off those debts that have the highest interest and fees (always count the fees as well).

Rule 4: You might make an exception and pay off any small loans first to give you a sense of pride and accomplishment. This act can be very motivating to encourage you to continue to reduce your debt.

Rule 5: Make sure you and your family remember to simultaneously develop good saving habits and put money aside, even the first year after graduation or after you complete your training. Since you have little money to risk, invest it conservatively. You can afford more risk later. In turn, this money should grow dramatically over the coming decades.

Rule 6: Do not buy a house too quickly. On average, physicians keep their first job for less than 3 years, and it takes much longer than

that to break even on a house, especially when you add in all the costs including taxes, improvements, and repairs.

Rule 7: Get a handle on the relative cost of individual loans (the subsidized and unsubsidized ones) by comparing interest rates, loan terms, and other factors affecting repayment. Ensure a solid grasp of the repayment particulars for each loan, such as grace periods and forbearance and deferment options. Different loans have different grace periods. A grace period is how long you can wait after leaving school before you have to make your first payment. It is 6 months for federal Stafford loans, but 9 months for federal Perkins loans. For federal PLUS loans, it depends on when they were issued. The grace periods for private student loans vary, so consult your paperwork or contact your lender to find out. Do not miss your first payment!

Rule 8: Before choosing a repayment option or consolidating loans, do the math to ensure the plan makes financial sense. Work with a financial advisor experienced in debt management, if necessary. However, make sure that advisor is NOT the same person telling you to not pay off your loans and instead roll the dice in the stock market, or buy a house before you are ready.

Back to the Case

Dimitri met with a financial advisor and decided to enter an income-driven repayment plan during residency. He hoped to be able to use loan repayment during his time spent in residency, in a small not-for-profit hospital, toward qualification for the PSLF program. He planned to remain in the small community and to work for a federally qualified health center. After 10 years, he hoped that the PSLF program would still be in place when he would become eligible for loan forgiveness. Dimitri felt comfortable with the $370 per month repayment schedule. He remained optimistic that as a physician, even one engaged in primary care, he would enjoy his lifestyle and career and that financially, he would be secure.

Bottom Line

1. Most medical students in the USA graduate with educational debt.
2. Physicians will be able to pay back their debt.
3. There are many opportunities for loan forgiveness including federal and state programs.
4. There are a number of flexible repayment plans offered through the federal government.

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MIPS MACRA and Payment Models

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Marc J. Kahn and Neil Baum

Case: Adil

Adil is in his first year of private practice after completing an internal medicine/pediatrics residency program. Adil's initial contract included a two-year salary guarantee with the potential for a generous production-based bonus after his initial probationary period. Adil's practice manager recently informed the group that reimbursement for many of their Medicare and CHIP patients would include pay-for-performance focusing on quality, value, and accountability. Adil is at a loss. He believes that he is providing such care for his patients, but is not sure that he can prove it. When shown some preliminary data on his quality metrics from the bulky and cumbersome EMR, Adil is certain that he has never cared for at least 20% of the patients attributed to him. Adil wants to learn more about payment models including MIPS (Merit-Based Incentive Payment System) and MACRA (Medicare Access and CHIP Reauthorization Act).

The USA lags globally on health outcomes placing in the bottom quarter of developed countries for life expectancy, having the fourth highest infant mortality and having the highest adult obesity rate according to the Organization for Economic Cooperation and Development [1]. The World Health Organization ranks the USA 37th in health behind countries such as Cyprus and the small island of Dominica. The poor performance in US health metrics happens despite the fact that the USA leads the world in per capita health expenses. The reasons that we do not get the value for our healthcare dollar in the USA are complex and multiple. However, one major reason for the relative failure of the US healthcare system is that the USA does not have a single healthcare system to care for all citizens, leading to gaps in care and inefficiency.

There are basically four health systems used throughout the world. All but about 40 countries use an out-of-pocket system where patients pay for health services with personal money or tangible goods without an insurer or third-party intermediary. An example of out-of-pocket care includes Cambodia where 91% of healthcare

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spending is out-of-pocket, as compared with the USA where only 17% of patients pay out-of-pocket. In stark contrast, in the UK, less than 3% of healthcare spending is out-of-pocket [2]. In spite of expansion of Medicaid services for the poor, out-of-pocket healthcare remains the system used by poor adults who do not qualify for Medicaid throughout the USA.

Working adults with employer-based insurance in the USA and many European countries including Germany, Belgium, and Switzerland in addition to Japan participate in the Bismarck system of healthcare. Named for the Prussian Chancellor Otto von Bismarck, this system was created during the unification of Germany in the nineteenth century. In the Bismarck system, insurers and providers are private. Insurance is funded through employee and employer contributions. With the sole exception of the USA, other countries using the Bismarck model mandate health insurance for all citizens, and insurance companies cannot make a profit on health insurance.

The UK uses a model of healthcare named after the social reformer, William Beveridge, called the National Health Service (NHS). The NHS is financed by the government through taxes. Physicians are public employees, and most hospitals and clinics are owned by the government. In the Beveridge model, the government is the sole payer establishing charges for doctors and healthcare organizations. Healthcare is considered a public service in this model. In the USA, this is the model used by veterans through the Veteran's Administration and by Native Americans through the Indian Health Service.

Canada uses a system that has features of both the Bismarck and Beveridge models. Providers are private workers, but payments come from a government-sponsored insurance company that every citizen pays for. The single payer has considerable market power to negotiate drug, hospitalization, and physician fees. In the USA, this is the system we call Medicare, providing care for older citizens.

In the USA, about 17% of GDP goes toward health expenditures. Administrative fees for healthcare are high in the USA, at 20%, compared with 3% in the UK. In the USA, the majority of the healthcare dollar goes to hospital care. Physician and clinical services are next, but the amount going to physicians is decreasing as prescription drugs are becoming more expensive.

How Did We Get Here?

Prior to 1930, healthcare in the USA was largely out-of-pocket. Insurance was expensive and uncommonly held by patients. Employees working in occupations considered dangerous or hazardous, such as mining or railroads, sometimes had access to company-employed physicians and clinics whose services were covered by the company. During the Great Depression, when families were struggling financially, Franklin D. Roosevelt passed the Social Security Act. Although he originally thought to include universal healthcare in his plan, due to strong opposition from the American Medical Association, Roosevelt decided against this course of action. As a result, during the Great Depression, the health of Americans was compromised as families preferred food and shelter over their health.

In 1933, during the construction of the Colorado River Aqueduct Project, the surgeon Sidney Garfield established Contractors Hospital to provide care for workers on the project. The hospital was initially having financial difficulties as they would not turn a patient away and many patients did not have either the insurance or the money to cover services. Harold Hatch, an engineer, came up with the ingenious plan to have insurance companies pay Garfield a fixed amount per employee per day to cover the worker's medical services upfront. This is an early if not the first example of prepaid health insurance in the USA. In Garfield's case, for 5 cents a day, workers were covered for work-related injuries, and for an addition 5 cents, paid by the employee, they were covered for all other medical problems. Garfield was later contacted by another industrialist in 1942, Henry J Kaiser, who was building the Grand Coulee Dam with 6500 workers and their families. Garfield recruited a team of physicians into a prepaid group practice to provide coverage. This was the beginning of Kaiser Permanente that now has over 11.7 million members, over 208 thousand employees, and 720 medical centers.

About the same time, during World War II, the availability of workers became limited due to the war efforts, and there was concern for inflation as had been witnessed in Germany during World War I. To help stabilize the economy, in 1942, the Stabilization Act was passed to stabilize prices, wages, and salaries. This act was passed in part to prevent companies from capturing employees, a limited resource, from other companies solely on the basis of salary. In order to compete for employees, companies began to offer benefits, including health insurance, to attract workers as they could no longer compete on salary. An added benefit for employees was that these benefits were not considered income, hence not taxable. This was the beginning of employer-sponsored health insurance.

For many years, following World War II, in the USA, physicians and hospitals were paid using a fee-for-service model. Physicians, clinics, and hospitals billed the patient's insurance company for services rendered, and were paid accordingly. Such a system gives the incentive to provide more care as payment is based on quantity. Similarly, if patients are blinded to cost as bills are paid by a third party, they are more willing to accept nearly every treatment offered. Fee-for-service is, by its very nature, inflationary. For economic reasons, this system could not last indefinitely.

Because of rising costs and recognition of the inherent inefficiencies in the fee for service model, in 1973, the USA enacted the Health Maintenance Organization (HMO) Act which encouraged managed care to manage costs. The act dictated that a federally qualified HMO could charge a fee to subscribers that would allow them to see a panel of physicians in a network of facilities. In this model, payments were capitated at a per member per month amount, and care was coordinated. Every member was assigned a gatekeeper primary care provider that was responsible for managing referrals and procedures with a strict emphasis on cost. In capitated managed care, physicians assume risk as they are given a set fee regardless of the quantity of services they provide. They run the risk of potentially spending too much money on patient care such that there is less to support their income. In the mid-1990s, capitation became much less popular when it was recognized that neither patients nor providers were enamored with the model. Many of the managed care companies were for-profit, and the cost of overhead actually led to higher healthcare costs in some situations. Additionally, the pressure to provide less care risked decreasing the quality of care provided.

Another change in physician payment, intended to help control costs, was developed in the 1970s by two management professors at Yale. They developed a system, called diagnostic-related groups (DRGs), to categorize units of hospital care. In this system, third-party payers, rather than paying fee for service, could reimburse hospitals based on a category of care. This system was quickly adopted by Medicare and later by states and private insurers. As an example, looking at heart failure as a DRG, a single reimbursement would be provided for this discharge diagnosis regardless of the tests and services provided during the hospitalization. The DRG system encouraged doctors and hospitals to take on risk as reimbursement was no longer dependent on the volume of services provided, but rather on a disease category.

Other examples of changes in payment models that occurred in the 1990s and 2000s involved insurers creating a network of providers for their members. Independent practice associations (IPA), one such example, are legal entities that contract with a group of physicians to provide services to HMO members with a governing board to determine the best practices. IPAs developed in response to capitated HMOs, to make sure that quality and evidenced-based care was provided. Similarly, preferred provider organizations (PPOs) developed where access fees were charged to insurance companies to use a network of physicians who discounted their services for members. This subscription-based care arrangement offered patients and employers more flexibility with slightly higher premiums than traditional HMOs.

The Patient Protection and Affordable Care Act (PPACA), also known as Obama Care, was passed in 2010 and included many provisions including expanding Medicaid eligibility, provision of coverage for preexisting illnesses, and allowing dependents to remain on their parents insurance

until age 26. From a payment model perspective, the PPACA expanded the notion of pay-for-performance (P4P). Conceptually, in a P4P model, healthcare providers are provided an incentive for providing quality care and are assessed a penalty when their care falls below certain standards. Incumbent in such a system is proper attribution of patients to providers and an electronic health system to gather information on patients and care parameters such as blood pressure, hemoglobin A1c measurements, lipid levels, flu vaccination rates, and the like. The PPACA also allowed for the creation of Accountable Care Organizations (ACOs) which are groups of doctors, hospitals, and providers who strive to deliver quality care to Medicare beneficiaries. ACOs were allowed to use a fee for service billing model and received bonus payments for cost savings and for achieving quality benchmarks.

Traditionally, Medicare payment rates were determined annually based on a calculated sustainable growth rate formula enacted by congress. In 2015, this was replaced by the Medicare Access and CHIP Reauthorization Act (MACRA) which attempts to pay for health services based on value and quality of care rather than by volume. These programs are administered through the Quality Payment Program (QPP). The two branches of the QPP are MIPS (Merit-Based Incentive Payment System) and APM (Advanced Alternative Payment Models). The overriding goal of these payment systems is to convert Medicare payments from fee for service to quality-based payments.

Medicare P4P models rely on the assumption that the use of a robust electronic health record (EHR) allows for better patient care and allows for tracking of data to determine the quality of care delivered. Medicare's incentive program for the use of an EHR was originally termed "meaningful use" and transitioned into a part of MIPS, which took effect in 2018, providing incentives not only for EHR use but also for using the physician quality reporting system (PQRS) to track quality metrics which are in turn used to create incentives for quality care and disincentives for care that does not provide quality. Examples include keeping blood pressure within range, managing hemoglobin A1c levels in diabetics, providing flu vaccinations, and making sure that patients with coronary artery disease receive aspirin therapy. In MIPS, the four performance categories include quality, resource use, clinical practice improvement activity, and advancing care information. These are combined to give a total composite performance score (CPS) for a physician or group out of 100 maximum points. Clinicians with CPS scores higher than the national performance threshold earn a bonus in Medicare payments, whereas those with low CPS scores incur a reduction in Medicare payments.

APMs are also Medicare programs designed to incentivize quality and value of medical care designed for ACOs. Providers qualify for either MIPS or APM, but not both. To qualify as an APM, at least 50% of physicians in the practice must use an EHR during the first year and 75% must use one thereafter. As in MIPS, there are incentive payments for quality care and penalties for substandard care.

Looking toward the future, it is likely that physician payment by third-party payers will be more and more dependent on value-based care. Value is increased with quality and decreased by cost. Healthcare providers that can demonstrate that they provide care with high value will be rewarded not only with a large panel of patients provided by employers but will also receive bonus payments. The days of simple fee for service are likely over.

Back to the Case

Adil met with his practice manager and did some reading about value-based care. He was able to obtain a list of patients attributed to him and made sure that the list was correct and complete. He was able to create a dashboard in his EHR for himself and his partners that would provide timely data on their quality metrics. The dashboard also allowed Adil to compare himself to other members in his group practice. During the first year, Adil's practice was able to earn a bonus from Medicare based on their outcomes.

Bottom Line

1. Moving forward, physician payment will depend on value, not volume.
2. Having a robust EHR will be essential to receive proper reimbursement for services.
3. Healthcare remains a commodity, but employers are likely to prefer providers who both save money and maximize outcomes.

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13 Obtaining and Maintaining Referrals from Other Physicians

Marc J. Kahn and Neil Baum

Wishing to be friends is quick work, but friendship is a slow ripening fruit.
Aristotle

The Omar Story
Omar is fellowship-trained urologist who joined an academic practice. His practice consisted of hundreds of patients from the previous urologist. However, he complained of having few physicians in the area refer patients to his practice. What should he do?

The mainstay of any successful practice is the patients you already have and the ability to attract new patients which includes referrals from other physicians. Maintaining positive relationships with both patients and colleagues is key to a successful healthcare practice. Specifically, establishing and preserving connections with physicians are essential to creating a strong referral network and a steady supply of patients. This chapter will discuss methods and techniques to enhance referrals from your colleagues.

Talks on medical marketing often begin with the three A's of marketing: availability, affability, and affordability. Since all physicians probably think of themselves as available, as likable, and as offering appropriately priced services, how do you differentiate yourself from the competition? Just using fancy stationery, having a fancy three-colored brochure, a practice logo, or having a slick website will not generate referrals from your colleagues. Perhaps the last thing to consider is a logo and slick brochure.

One of the biggest misconceptions about marketing is that you must spend lots of money on peripherals and advertising to do it well . There are many other steps that are far more effective and essential to marketing than logos and gifts you send out at Christmas. The most essential element of your marketing plan is to make your practice user-friendly. Nowhere is this more important than in the area of working with your referring physicians.

The traditional methods of obtaining physician referrals usually involved trial and error. These hit and miss methods were seldom discussed, and some were almost unquantifiable. Perhaps you went to school with another physician in the area and later he or she referred patients to you. Another source of referrals may occur when you join a group practice and receive the overflow patients. Maybe you went to emergency rooms and made yourself available to treat patients who did not have their own physicians.

One of the cardinal rules and appropriate advice, especially for new physicians, is to always be available. If a new physician does an excellent job with every new patient that was

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referred to him\her, gradually the word-of-mouth method will start working and new patients will be forthcoming. The word gets back to the referring physician that the new physician is available and is truly competent. The new physician could slowly build a good reputation in this way.

By relying on word-of-mouth and outstanding service, it could take from 2 to 3 years to get a practice up and running. These methods worked in the past because there were enough primary care doctors, enough patients, and enough referrals to go around. Today we are seeing fewer physicians start out by themselves in private practice. Many physicians are opting to join large group practices or are employed by hospitals or are joining with mega groups consisting of large numbers of physicians all in the same specialty and may have physicians who are fellowship trained and are subspecialists with very unique, specified areas of medical interest. That means you have to be a lot more organized about getting those physician referrals.

This chapter will take the concept of physician referrals out of the realm of hit or miss—you will not have to use the shotgun or scattershot approach but can focus your efforts like a laser in order to obtain physician referrals. If you follow the steps outlined in this chapter, you will have a guaranteed plan for making your name visible and your reputation known within the medical community in a shorter period of time than it takes word-of-mouth to spread your name and reputation within the physician community. By targeting your efforts, your practice, in essence, will become user-friendly—your colleagues will want to refer patients to you and will enjoy doing so. And, as the quote from Aristotle makes clear, this is a deliberate process which also requires patience and tenacity over time.

The main strategy for achieving physician referrals is to have your name cross the minds and desks of referring physicians and their staff members frequently and in a positive fashion. If you can do that, physician referrals will come your way. This strategy derives from the tactics of William Wrigley, the chewing gum magnate, who, at the turn of the century, set down this dictum: “Tell ‘em quick, and tell ‘em often.”

All the 26 techniques outlined in this chapter, from prompt reporting to gift giving, are designed with this strategy in mind. There should be good chemistry between you and your referring physicians. If they have good feelings about you, they will want to refer patients to you. You can make yourself more attractive to referring physicians by making it easy to do business with you and your staff.

Almost all the techniques described in this chapter require minimal amounts of time and energy and negligible expense; however, their effectiveness in generating physician referrals is quite significant. Remember, you must have a staff capable of handling patients, and you must ensure follow-up and develop excellent communication with referring physicians.

1. Promptly report to referring physicians. The adage for selling real estate is location, location, location. When it comes to increasing your attractiveness to referring physicians, your mantra is communication, communication, and communication. If you are looking for the best way to make yourself accessible to your referring physicians, consider prompt reporting. When primary care physicians were surveyed about why they make referrals, prompt reporting was at the top of the list [1]. You must always keep your referring physicians informed about their patients’ progress. You need to make them feel that they are the captain of the patient’s healthcare ship.

When you see a patient by referral, follow this cardinal rule: Never allow the patient to return to the referring physician’s office or call the referring physician *before* your report has reached the desk of the referring physician. Nothing is more embarrassing to the primary care doctor than to be in the dark about your opinion or management plan that you have instituted on his\her patient. If the patient or the patient’s family calls the referring physician before he\she has had a full report from you, it makes you both look bad.

The following story is an example of what must never happen: A primary care physician

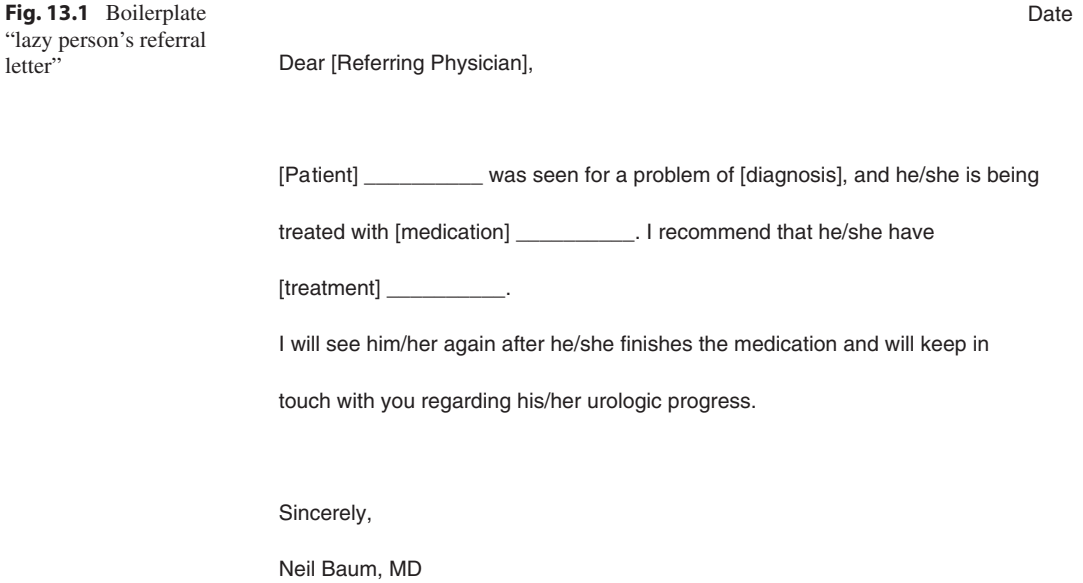
called his patient's relatives at home to tell the family that the grandfather, in the intensive care unit, was not doing too well. The family said, "Yes, we know that, he died last night!" This was a gross lapse in communication that resulted in embarrassment for a primary care physician. You must avoid communication failures with your referring doctors as well.

When a physician sees a patient referred by a primary care physician, it is often seven to 10 days before the primary care physician receives the referral letter. Even with electronic medical records, primary care physicians will not receive follow-up communication for several days which increases the possibility that the patient will contact the primary care doctor before the referral letter arrives. The older method consisted of report being dictated, transcribed, and mailed. Frequently the patient will beat the referring letter back to the primary care physician.

How user-friendly are you when a patient returns to his or her primary care physician and the referral letter has not arrived? The primary care physician asks the patient what the specialist said or did. The patient responds, "I don't know, but he gave me a large yellow pill and now I have a rash and am itching all over." Now the primary care physician has to ask his nurse to tell the receptionist to call your office, have your receptionist or nurse locate the paper chart or open the electronic medical record, and then track you down if you are not in the office to discuss your management of the patient. That scenario does not endear you to the referring primary care physician as you are wasting the referring physician's time and the time of his\ her staff.

Our solution for avoiding this scenario is to use what we call the "lazy person's referral letter." This is a referral letter that requires absolutely no dictating. Here is how it works: as soon as you have seen the patient, write down, at the end of your office notes, your impressions, the medications you prescribed, and the plan of treatment. For instance, if the doctor sees Mrs. Smith for cystitis, recommend that she take a course of antibiotics and suggest that you see her again in 2 weeks; you circle these three words in the notes or highlight them in the EMR.

When the nurse or medical assistant goes through the electronic medical record after Mrs. Smith's visit, she sees that you have circled or highlighted these words. She uses a boilerplate referral letter, which has blanks to complete (see Fig. 13.1). The nurse types in the appropriate referring physician's name, the diagnosis, the medications, and treatment plan. The letter closes with the statement, "I will keep in touch with you



Date

Dear [Referring Physician],

[Patient] _____ was seen for a problem of [diagnosis], and he/she is being treated with [medication] _____. I recommend that he/she have [treatment] _____.

I will see him/her again after he/she finishes the medication and will keep in touch with you regarding his/her urologic progress.

Sincerely,

Neil Baum, MD

Fig. 13.1 Boilerplate "lazy person's referral letter"

regarding her medical progress." We then print out the letter and fax it directly to the physician's office.

This letter delivers the essentials to the referring physician. What are primary care physicians looking for? Most primary doctors will tell you that there are three ingredients of an effective referral letter: the working diagnosis, the medications you have prescribed, and the treatment plan. You can bank money on this one—they are not interested in the depth and detail of your history or the fine nuances you detected on the physical examination. For the most part, they are as busy as you are and do not have the time to read a lengthy two- to three-page report that you dictated and conduct a treasure hunt to find the diagnosis, prescribed medication, and treatment plan. You can create a user-friendly referral letter that meets the three necessary criteria and that lands on the primary care physician's desk before the patient returns for an office visit. If your practice is using an electronic medical record, sending a copy of the EMR notes that can often be coded to an E&M of level four or five does not constitute an effective letter. The typical length of these notes—three to four pages—is far too long. Often, the vital information (i.e., diagnosis, medication, and treatment plan) is hidden in the notes and not easy for a busy primary care doctor to locate. Today, most EMRs allow you to create a template where there are fields that include diagnosis, medication, and treatment plan. Then, with a few mouse clicks or taps on a touch screen computer, you can generate a very effective referral letter that can be faxed immediately to a referring physician while the patient is still in the examination room. Now it is virtually impossible for the patient to be seen by the primary care physician or make a call to the primary care physician before the referral letter has arrived. This level of communication with the referring doctors is so effective that if a patient is seen by the specialist and then goes directly from the office of the specialist to the referring physician, the letter is in his\her office before the patient arrives. You and your practice become very user-friendly by telling the patient that a letter has been sent to the referring physician and that he\she should mention this to the receptionist when he\she checks in with the referring doctor. (Fig. 13.2 is an example of a referral letter created on EMR.)

Because the letter is sent out immediately, if the patient calls with any questions, the referring doctor can answer any question without having to contact the specialist. Furthermore, the letter can usually be generated without any dictating. For those who must dictate the two- or three-page traditional referral letter, consider underlining or boldfacing the essential information, including your impressions, the medications, and your recommendations. Nearly all referring physicians indicate that they prefer a timely computerized referral letter over a delayed three-pager. Doctors may be concerned if referring physicians are upset when they receive a computerized, impersonal form letter. Surveys indicate that referring physicians prefer timely information as opposed to a delayed personal letter.

Although the majority of visits can be handled in this manner, some of your examinations will uncover a problem that is complicated or has ominous implications. If your examination turns up a significant finding or you need to make a decision regarding the patient's treatment plan, you should contact the referring physician by phone and notify him or her of your findings. Failure to do so can potentially result in embarrassment for both you and the referring physician. If the patient calls the referring physician to discuss your suggestions, and you have not yet informed the physician about your treatment plan, it makes him or her appear uninformed or even uncaring. The referring physician will likely think of you as unprofessional and will probably stop referring patients to you.

If you operate on a patient, call the referring physician's office immediately afterward. Notify the physician's nurse that the surgery went well and everything was successful. A stat operative note that notifies the referring doctor of the outcomes of the patient's surgery, the pertinent findings, and what postoperative treatment will be instituted is very appreciated by the referring doctor. This stat operative note is faxed to the referring physician and arrives long before the dictated operative note from the hospital or ATC.

Fig. 13.2 Physician referral letter from an electronic medical record

January 22, 2015

Alfred Colfry, MD
4224 Houma Blvd.
Metairie, LA 70006

RE: XXXX
DOB: XXXX
DATE OF VISIT: XXXX

Der Al,

XXXX was seen for a problem of: XXXX

Chief Complaint: Urinary retention after hernia surgery. The catheter was removed and he was able to void albeit with a weak urinary stream.

Current Impression:

RETENTION OF URINE UNSPECIFIED (788.20; New Without Added Workup.)

BPH WITH OBSTRUCTION OR LOWER UT SYMPTOMS (600.01)

He asked to transfer his urologic care to this office because he is elderly and it is difficult for him to travel to your Metairie office. I told him you have an office at Napoleon and he was going to speak to you about those days you are in that office. I also hold him that he had to speak with you before he could make an appointment here and he told me he would give you a call.

Sincerely,

Neil Baum, M.D.

(Fig. 13.3 is a sample of the stat operative note.) Also, if you realize before or during the procedure that the surgery is going to be significantly delayed, notify the primary care physician's office. The doctor will then be up-to-date on the patient's progress in case he or she runs into the family on the way over to the hospital. However, if a complication develops during surgery or if the patient has changed rooms or has been sent to the intensive care unit, we suggest that you notify the referring physician via a phone call or text the doctor if that is a preferred form of communication. If there is a significant lab or pathology report, call the referring physician and let him or her know what has been found. In those situations, the patient or the patient's family may contact the physician immediately. If you have not apprised the physician of the situation first, then he or she will not be well informed.

There are other economic considerations involved in using the lazy person's referral letter. Do you know that the typical referral letter can cost you anywhere from $13 to $25 or more every time you pick up the tape recorder to dictate a referral note? How can this be, you ask? Let us do the math: Today most physician time is valued at $250–$350 an hour. The typical referral letter requires three to 5 minutes of physician time. So, for your time alone the cost would range from $7.50 to $16.65. The charges of a transcriptionist,

Fig. 13.3 Sample of a stat operative note

Neil Baum, M.D.
3525 Prytania, #614
New Orleans, LA 70115
Phone: (504) 891-8454

Date: _____

Your patient _____had the following procedure:

_____

The pertinent findings included: _____

_____

I recommended_____

You will be receiving the dictated operative note. Please call me if you have any questions.

Dr. Neil Baum

who makes $25,000 to $35,000 a year plus benefits and charges you $2 to $3 a page, must be added to the equation. Finally, there are costs for stationery and postage. This works out for $13 to $25 or more per letter. Using the lazy person's referral letter, you reduce your costs to less than $1 per letter. Plus, it satisfies the needs and wants of your primary care physicians and referral doctors—the letter arrives before the patient returns.

You will find that most of your colleagues will be delighted with the letter and often say they "hoped that our other colleagues would learn to use the same technique." However, if you find a referring doctor who does not wish to receive the lazy person's referral letter, then send the longer version referral letter to one of those doctors. Should you decide to send the longer referral letter, then underline the three necessary areas consisting of the diagnosis, medications, and treatment plan. Remember, one size does not fit all.

2. Make your referring physicians look good. Your objective should be to keep the referring physician involved and functioning as the captain of the healthcare ship. I am reminded of the story of a patient who went to see an orthopedic surgeon. During the history and physical examination, the doctor asked the patient, "What have you done for your problem?" The patient said, "I've been to a chiropractor." The doctor asked, "What did that fool tell you?" The patient responded, "He sent me to you!"

Whenever possible, compliment the referring physician. Of course, you do not want to appear unnatural or superficial. When the referring physician's name comes up in conversation with the patient, you can make a comment such as, "He is such a fine doctor and is very knowledgeable about your medical problem," or "She is one of the best doctors in our community."

Often you will receive complimentary notes from patients referred to you by other physicians. These special notes are often discarded or placed in the patients' charts. Thank you, complimentary notes, placed in a nice scrapbook, can add favorable advantage to the patients' perception of the physician and the office. According to local, state, and national medical societies (including the American Medical Association) that have been contacted, it is stated that there is no violation of patient privacy or confidentiality if you are sure to obtain the patient's permission for placing the letters or notes in your reception area scrapbook.

We also suggest that you photocopy each note and send it back to the referring physician with an accompanying note that reads, "Thought you might like to see that your patient had a positive experience at my office." After all, the kind of experience the patient had reflects back on the referring physician.

If a patient tells me, "I sure am glad that Dr. Jones sent me to you," I have a response. "Do me a favor," I say. "The next time you see Dr. Jones, mention that you had a good experience at my office." The patient is more than happy to oblige, which increases the positive feedback received by the referring physician. Also, if the patient gives you a compliment, ask him\her if she would submit that compliment to the online reputation review sites such as Healthgrades.com, yelp.com, or RateMDs.com.

Also remember that the patient's perception of you is partly determined by the patient's opinion the referring physician. If you make the referring physician look good, then you are really enhancing your image as well.

3. Vary your referral patterns. Today, the number of patients referred to specialists is decreasing. One of the reasons for this is that certain specialists (for instance, gynecologists and general surgeons) are doing more primary care and keeping the patients in their practices. When patients go to a multispecialty group practice or preferred provider organization (PPO), they are kept there and do not circulate in the community looking for other healthcare providers. Also, primary care physicians are treating more medical conditions that were once referred to specialists. Finally, there is an emphasis on cost-containment means that many primary care physicians now treat adult-onset diabetes, arthritis, benign enlargement of the prostate, urinary incontinence, and even common dermatological conditions.

Often, referral patterns are cut in stone, and specialists refer to only one or a few groups of primary care doctors. One of the benefits of your marketing efforts will be that patients will come directly to you. As a result, you will become the primary care doctor and control the referrals. For example, if a patient comes to a urologist with urinary symptoms, she needs to see a gynecologist or a cardiologist, and the urologist becomes the referring physician and has the opportunity to direct the referrals.

It is important that specialists make every effort to send new patients to primary care doctors who have frequently referred patients to them. Now more than ever, it is important to acknowledge referrals from primary care doctors and other specialists. The best way for you to do this is to take advantage of your marketing and send colleagues new patients. They will appreciate new patients more than a fruit basket at Christmas.

4. Provide courtesies to your referring physicians and do not inconvenience them. One of the best ways to prevent inconveniences for your referring physicians is to assist with the hospital paperwork on patients you share. For example, have your office notify the referring physician when you are admitting his or her patient. If you do this, then the hospital secretary will not be calling the referring physician late in the evening, which may require the physician to see the patient even later that evening or early in the morning. Likewise, contact the referring physician when you discharge his or her patient. By doing this, you ensure that the referring physician will not make a needless trip to the hospital to see a patient who has been recently discharged.

You can fill out the prescriptions that apply to your specialty and leave them in the patient's chart or with the patient so that the referring physician does not have to write all the prescriptions.

This also applies to hospitalists who are caring for referring doctors' patients in the hospital. Hospitalists are also marketing themselves to the PCPs and the specialists, and they want to be user friendly. Hospitalists also need to keep the avenues of communication open between the hospitalists and the referring doctors by being certain

that what was done to their patient was sent to the referring doctor so that continuity of care will take place after the patient is discharged from the care of the hospitalists.

Remember, you want your referring physicians to feel that it is easy to work with you and that you will go the extra mile on their behalf.

5. Recognize your referring physicians' accomplishments and those of their children. There is no better way to enhance your relationship with your referring physicians than to acknowledge their accomplishments. It is a nice gesture to cut out articles from local newspapers that mention your referring physicians or their families. Whenever one of your referring physicians receives an appointment or promotion, acknowledge it with a written note.

A nonmedical story that emphasizes this concept: A doctor's son was 4 years old, and he rescued a bird from the backyard swimming pool. The family took the bird to the zoo, where it was saved. The family's rabbi, on hearing the story, sent the four-year-old boy a letter:

> I just heard the story of your wonderful good deed in saving the bird from drowning in the pool. You should be proud of yourself. I am proud of you for doing such a wonderful thing. Whenever you hear the birds chirping to themselves, you can be sure they're singing your praises.
> Well done, Craig.
> Rabbi Cohn

Can you imagine how much Rabbi Cohn's stock escalated when the four-year-old boy received that letter? The parents could not wait to contribute to the synagogue's annual fundraising campaign!

Doctors like to hear positive comments about their children. Taking the time to find out about their children is a guaranteed way to let your referring physicians know that you are thinking of them. (This is also a nice gesture to do for your patients.) If a referring physician's child just received a scholarship or an athletic award, send a note. Your staff are usually familiar with the names of your referring physicians, and they can call them to your attention when reading the newspaper or finding evidence of accolades on the Internet. This is a simple little thing to do, but it is universally appreciated.

6. Send birthday cards. Sometimes it is difficult to find out your colleagues' birthdays. You can try calling their hospitals or the county medical society. Ask for the birthdays, not the birth years, and you should have no problem. You will not be given the years—that is confidential—but frequently you will find out the days. You might want to compile a list and ask for all the birthdays at the same time.
7. Do not intrude on your referring physicians' turf. Today, many physicians are trying to generate additional practice income by performing procedures or diagnostic tests in their offices. You need to be aware of who performs which tests. Avoid performing tests or procedures that your referring physicians are equipped to handle. For example, if you plan to admit the patient of a referring physician to the hospital, ask the patient to have the preadmission blood work, EKG, and chest X-ray done in the referring physician's office rather than at the hospital or a third-party laboratory. If blood work is all you are requesting, have your office draw the blood, send it by courier to the referring physician's office, and ask for a copy of the results for your records. When you use the referring physician's facility or laboratory, you are being considerate and allowing the physician to maximize the use of his or her equipment and employees.
8. Show an interest in your referring physicians as people\friends in addition to their role as a source of patients. Make an effort to know about your referring physicians' nonmedical interests and hobbies. Whenever you see or read something that is of interest to one of your referring physicians, take the time to send it to them or call it to their attention. This is one way of saying that you are interested in your referring physicians even when you are not professionally relating to one another. For example, if one of your colleagues is a fly fisherman and you see a book on fly fishing

offered in a catalogue or on Amazon.com, send him the book especially if you know he plans to leave to Alaska to go salmon fishing. This simple and inexpensive gesture will endear you to your referring physicians.

9. Invite your referring physicians to participate in support groups or seminars. This increases their exposure in the community and also provides them with an opportunity to attract more patients.

If a referring gynecologic physician is an expert in hormonal issues in menopause, invite him\her to participate in one of your programs on women's health issues. This can be a plus for both of doctors in terms of exposure in the community and will likely result in new patients for both doctors.

If you try to involve colleagues in your specialty, they will be less likely to try to torpedo your marketing efforts. You will create allies, not adversaries, in the medical community.

10. Do not forget your referring physicians' staff. In addition to building a good relationship with your referring physicians, you must include their staff. Whenever you have contact with them, make it a point to be pleasant, cooperative, and interested in them as people. Learning their names will go a long way toward building a good working relationship. You will be surprised how many physician's staff have the ability and the permission to make referrals to other physicians.
11. Ensure that you are easy to contact. You can make it easier for your referring physicians and their staff to contact you and your office by supplying each office with a colored Rolodex card. The card can be made more visible by making it slightly higher than the standard Rolodex card. It should contain your telephone number –private line, office hours, answering service number –and the names of your office manager, secretary, nurse, and any other employees who may be requested by the referring physicians or their staff. Most practice management software programs contain physician directories where the contact information is located. You want to be certain that your information is correct in those directories. A nice gesture is to provide referring doctors with your cell phone number so they can easily reach. Remember, you do not want to make difficult for a referring doctor to locate you.
12. Start a journal club network. As every physician knows, it is no trivial pursuit to stay abreast of the medical literature. With the literature doubling or tripling every decade, it is nearly impossible for the busy practitioner to read all the journals in his or her areas of interest and expertise. There are over 5200 medical journals indexed on Medline, and the National Library of Medicine search service now has access to nine million articles.

By developing a journal club network with your fellow physicians, you maintain an awareness of the literature and help your colleagues at the same time. For example, there were reports in the medical literature on the ophthalmologic side effects of Viagra and other phosphodiesterase-5 inhibitors. If you see articles that might be of interest to your ophthalmologic colleagues, send them copies and also to any other doctors who might be prescribing phosphodiesterase-5 inhibitors.

You can start your journal club network by sending a letter to about ten of your colleagues. Explain what you are doing and what they can gain from participating. Figure 13.4 is an example of the letter which can be used to start a journal club.

The network is best kept informal—you do not want to add work to your colleagues' loads. The easiest way to accomplish this is to email the articles to your colleagues and they can read it online or print it if they want a hard copy. Your staff can also be alerted to look for articles in newspapers and lay magazines that relate to your colleagues' specialties. This helps keep your colleagues informed on what their patients are reading.

Fig. 13.4 Letter for starting a Journal Club Network

Date _____

Dear (Physician)_____,

With the rapid pace of developments to medicine today, it is difficult for most physicians to keep up with the progress. As a way to stay abreast of all the changes, I suggest that you and I establish an informal journal club.

I will be reviewing the (name of interest or specialty)_____ literature on a regular basis. If I see article that are pertinent to you and your practice, I will make copies or send you an email of the file. I hope you will do the same for me.

Perhaps in this way we can extend and increase our coverage of the medical literature.

Sincerely,

Dr. Neil Baum

13. Target your colleagues' reading. As with the journal club network, targeting their reading can facilitate your colleagues' continuing medical education and yours as well. If you send a referral letter that mentions a new diagnosis or treatment modality, attach an article that contains the new information. By doing this, you increase the likelihood that your colleague will actually read the article. Consider using a yellow highlighter pen and mark the one or two sentences most pertinent to the patient and the referral letter. For example, the use of thiazide diuretics is associated with the side effect of erectile dysfunction. The use of ACE inhibitors or calcium channel blockers is less likely to produce erectile dysfunction (ED). Before a patient starts on one of these antihypertensive drugs associated with ED or stops the thiazides because of the fear or presence of ED, make an effort to educate your referring doctors by including a copy of the journal article with the referral letter. To ensure that referring doctor reads the article, underline the one or two sentences describing the efficacy of the medication you recommend.

To further direct a colleague's attention, you can apply a note to the front page of the article with a message (e.g., "Please see page XX"). Although this might seem like you are setting up a treasure hunt, you can be sure your colleague will appreciate being directed to the appropriate information. You have supplied new information and saved your colleague time.

14. Identify interests that you share with your referring physicians. Another way to let referring physicians know you care about them is to send them books, CDs, cartoons, and even nonmedical articles that may be of particular interest to them. For example, if one of your colleagues graduated from Notre Dame and was a fan of Lou Holtz, when he was the head coach of the football team, and you have a copy of a speech by the famous Coach Holtz, send a copy of the speech or the link of the speech from YouTube.

Suggested books you might send colleagues include Tim Russert's book, *Big Russ and M*e, Richard Carlson's *Don't Sweat the Small Stuff—and It's All Small Stuff*, and Rabbi Harold Kushner's *When Bad Things Happen to Good People.*

15. Hold on to old friends. When physicians retire, their former patients often continue to call them. They still have a lot of clout in the professional community. And, of course, their patients ask them for referrals to primary care physicians and to specialists. Acknowledge a colleague's retirement in some way, by sending a note of appreciation or taking him or her to lunch. Then, continue to remember your colleague on the same

dates as before. This will help you maintain a referral source even after your colleague's shingle has been taken down.

16. Keep tabs on the movers. When a physician moves to another area of the country, it is important to maintain communication. If you send a "good luck" letter, cards at the holidays, and your blog\website information, this will encourage the physician to send you patients when someone from the old community asks for a referral.
17. Develop intra-specialty referrals. You can do this by finding niches in the marketplace. Just because you are a specialist does not mean you cannot get referrals from other doctors in the same specialty. You may be doing procedures or diagnostic tests that they are not doing and that may be helpful to them. You may have equipment or training that they do not have, allowing you to develop referrals from colleagues in your specialty.

The key to these referrals is to make sure you send the patients back to your colleagues and that you do not operate on these patients for other problems that the original doctors can handle. Treat the patients only for the problems that the referring physicians requested.

Let your colleagues know that you are willing to see their patients and send their patients back. The easiest way to do this and make your colleagues feel secure is to offer to work at their institutions. In that way, the referring physician gets to see the procedure and has the security of knowing that you are not taking the patient away.

Another way to get referrals from specialists in your field is to refer patients who call when you are not available. Sometimes patients call with a problem that cannot wait. Rather than have your staff say, "I'm sorry, the doctor is not available," and let that patient go back to the Internet to find a doctor, you can have them referred to one of your colleagues. For instance, if you are out of town, have your staff call the covering doctor's office to get an appointment for the patient. Your colleague appreciates getting a new patient and hopefully will return the favor.

18. Develop cooperative projects with referring physicians. For example, a urologist worked with a group of gynecologists who were interested in treating urinary incontinence. They did a project comparing the use biologic materials to synthetic materials for vaginal slings. It was a small project, but it created a nice opportunity to work together and learn what worked best for our patients with this condition. If you collect the data and write a paper, all of the doctors receive recognition and publicity. This collaboration has the potential to bring all of the participants new patients.
19. Personally meet every physician who refers a patient to you. Many times, in the doctor's lounge, you may hear the following remark: "You know, I have a referring doctor down in St. Elsewhere. He's sent me two to three patients a month for the past five years, and I've never even met the guy!" If you do not go out of your way to meet that physician and invite him to your office, somebody else will, and that referral source will soon dry up.

If a physician refers two to three patients a month to you, you need to visit his or her office and meet him\her personally. Offer to give a talk at the physician's hospital. Make an effort to make your paths cross. Otherwise, that golden goose (your referring physician) will cease laying the golden egg (referring patients to you).

20. Meet all new physicians in your area. Every July and August, when physicians announce they are starting their practices, you will receive announcement cards in the mail or you will see these announcements in the paper. Most doctors throw those cards away. Some doctors write "congratulations" on the cards and send them back to the sender. It is best to take this gesture one step further.

Write a welcoming letter to each new physician. Offer to get together for breakfast or lunch. Then offer to share resources. If the new physician is in private practice, make a visit to the

office with your office manager. Indicate that you would be more than happy to have your office manager assist the new physician's office manager.

Frequently, new physicians will have lots of questions even if they join a group or are employed by the hospital. You can offer to be of assistance, and this will be appreciated by your colleagues.

21. Refer patients to physicians new to the area, especially those just starting their practices. Send patients to new physicians as soon as possible. Everyone remembers who his or her first few patients were, and if you are the person who referred those patients, you will be forever appreciated by the primary care doctor. First, patients make an indelible impression.
22. Offer marketing advice to new physicians. In addition to sending new patients to new physicians, you might consider referring them to the one of the best books on ethical medical marketing, *Marketing Your Clinical Practice-Ethically Effectively, and Economically* Jones and Bartlett, 2010 [2]. This book provides ideas for new physicians just starting their practices, and the marketing chapter discusses ethical but effective methods of practice promotion. Another good resource is an article entitled, "Ten Action Steps to Transition from Residency to Private Practice." This article includes a segment on marketing a medical practice, especially for the physician just entering practice [3].
23. Keep your referring physicians abreast of changes in your specialty or your practice. If you attend a meeting or convention and there is new information that may of interest to your colleagues, email a single-sheet informal newsletter about the latest developments in your practice and in your field. These short newsletters are often much appreciated by referring physicians.
24. Give your referring physicians useful and unique gifts. Giving gifts to your referring physicians is not the most effective method of generating referrals. However, there are techniques of giving certain types of gifts that will make you stand out from the others at holiday time. If you send wine or a fruit and cheese basket between Thanksgiving and Christmas, it will most likely get lost among the dozens of similar gifts the physician received.

If you know your colleagues' reading habits, you can consider giving them subscriptions to their favorite magazines such as *Architectural Digest, Connoisseur, or National Geographic* as gifts.

Another nice gift is a Lucite cube that could be used either as picture holders or as holders for motivational quotes by such people as Winston Churchill ("Never give in, never give up, NEVER, NEVER, NEVER"), Vince Lombardi ("If you strive for perfection, you may not always reach it, but you will achieve excellence."), and Abraham Lincoln ("Success may come to those who wait, but they will receive only the things left by those who hustle."). Then each month send another motivational message to insert in the cube, as well as a story or comment about the author and how the quote applies to the contemporary practice of medicine. Experience has demonstrated that colleagues really seemed to appreciate this unique gift. You know that this is an appreciated gift when you visit the office of the referring physician that you spot those Lucite cubes with the motivational quotes on their desks.

One of the best gifts is laminated and personalized luggage tags. The tags are bright red with the colleague's last name in white type, and laminated, with gold-colored plastic cords to attach the tags to the luggage. The owner of the luggage with these tags will not have any trouble recognizing their suitcase when it comes down the baggage chute at the airport.

By varying the time of year when you send your gifts, you can also make them stand out. For instance, consider sending your gifts and holiday wishes at Thanksgiving instead of during December. People are usually not as rushed at this time and chances are that they will remember your gifts.

One very generous and effective gift is to make a donation to a charity or civic organization in the name of one of your referring physicians. Of course, it really helps if you know your colleague well and choose a charity or foundation that he\she has worked for or supported.

We do not consider gift giving essential to a successful marketing plan or effective physician referral program, but if you decide to give gifts, make them timely, unique, and one that will last the entire year.

25. Provide suggestions and recommendations to your primary care doctors for referral to your specialty. For example, not every UTI or enlarged prostate requires a consultation with a specialist. Provide the primary care doctor with a short monograph on suggestions for specialist referral. This monograph reviews the most common urologic conditions and gives evidenced-based medical guidelines for management and referral.
26. Finally, go the extra mile for your referring physicians. Make it a pleasure for them to work with you. Find the little extras that make it a convenience instead of a chore. These little extras can make a big difference in your relationships with your referring physicians.

For example, a referring physician once asked about the office's unique uniforms. The office manager sent a copy of the catalogue which was used to purchase the uniforms to the doctor and his office manager. Both of them were extremely appreciative of this gesture, and all it took was a little effort from us.

Facts of Life Discussion

All of us would like, whenever possible, to have a bilateral referral arrangement with our colleagues. Have you ever experienced a situation in which you are sending patients to another physician and getting no reverse referrals? Of course, you can change your referral source, hoping that the other physician will notice that there is a decrease in referrals and will call you to ask what happened, but do not hold your breath. Chances are the physician is busy enough and will not notice the decrease.

A better alternative is to have a discussion about the facts of life with the physician. During your meeting, recall for the physician the number and names of patients you have sent him or her in the last 6 to 12 months. Ask whether the quality of patients was satisfactory and whether the physician would like to continue receiving your referrals.

If the physician answers yes to both questions, ask how he or she feels about your quality of medical care: "Do I enjoy a good reputation in our community? Have the patients I have sent you, as well as any others we may both be treating, been satisfied with my medical services?"

If the answers are again yes, then it is time to initiate the "facts-of-life discussion." At this time, you should suggest that you would like to see some patients in return if you are to continue referring patients to that physician. If he or she does not agree, it is time to find another referral source.

A facts of life discussion story: An internist contacted a urologist when one of his patients from the intensive care unit was in urinary retention and need the insertion of urethral catheter. For several years, the urologist went to see these patients, often in the middle of the night, hoping to demonstrate that he was available to provide urologic care for all his patients. However, when this internist had patients with nonemergency urologic problems, the internist referred them to another urologist. After a few years of being inconvenienced in this way, the urologist requested a meeting with the internist. The urologist started the discussion by saying, "I am capable of seeing patients not only in the middle of the night but also between 8:00 AM and 5:00 PM as well!" The urologist did not request all his referrals, but he did ask for a few. If that was not acceptable, then the internist should call another urologist to come in the evening hours to insert catheters. What was the worst that could happen? He would receive no referrals; however, he would have a good night's sleep!

As it happened, this discussion brought about a change in that internist's referral pattern, and the urologist began receiving a few daytime referrals as well. This hard- ball approach is not for everyone and in every circumstance, but whenever you feel exploited or that referrals are a one-way street, consider having a tactful discussion before abandoning the potential referral source. Remember not to go into such a discussion with a defensive attitude. It may be that there is a very simple reason for the physician's behavior and that you simply were only seeing it from your point of view.

If you are worried that marketing is going to leave you all alone, perhaps even generating contempt from your colleagues, remember that effective marketing includes rather than excludes your colleagues.

Omar's Story and Physician Referrals

Omar recognized that staying in the office and not making an effort to meet the potential referring physicians in the area was the best place to start his marketing efforts to his colleagues. He visited all the physicians that were his age in the community and made an effort to know their staffs as well. He arranged to give several grand rounds presentations on his areas of interest and expertise. Omar created an informal journal club with his fellow colleagues. He sent effective referral letters to the local doctors including articles he authored demonstrating his areas of expertise. He made every effort to be available when called for a consult or for a patient in the emergency room. Within a few months, he noted the fruits of his labor and started receiving referrals from the doctors in the area. In essence, he took the advice from Aristotle and recognized that obtaining physician referrals was metaphorically "a slow ripening fruit."

The Bottom Line

Marketing yourself to your colleagues does not mean that you are trying to take away "market share." When you open up possibilities, you actually increase their business as well as yours. The way in which you do this does not take away, it just adds—to your stature in the professional community, to the respect you get from your peers, and to the bottom line.

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14 Branding Your Medical Practice: How to Make Your Practice Distinctive and Unique

Marc J. Kahn and Neil Baum

Case: Kaila

Kaila is a junior associate practicing primary care in a multispecialty practice located in a moderate-sized community. Kaila joined the multispecialty group practice immediately after residency and receives the majority of her patients from specialists in her group. Kaila has an interest in nutrition and weight loss and chose her residency because of its focus on wellness. Kaila would like to put those skills to use to broaden her referral base. Kaila plans to attend some practice promotion and marketing seminars to learn more about branding her practice.

It was not so long ago that the concept of branding referred to using a hot iron to make your cattle look different from all other cattle on the range so that you could distinguish your cattle from others. Today, in the business world, branding is used to create the perception that a product or service is superior to other business in the community, the region, and even the nation. This chapter will define branding from a medical practice point of view and discuss the importance of branding a medical practice and inexpensive and ethical methods of branding for the contemporary medical practice.

How does a passenger train differentiate itself from the behemoth airline industry and keep market share in the transportation market? One distinction is all it takes—Amtrak's singular competitive advantage against airlines: scenery!

Flying to a distant destination certainly takes less time and may even cost less than taking a train. So why does passenger train travel still exist when an airplane ride takes less time and is cheaper?

As an example, the Northern Pacific rail line has a new "Vista Dome" car, and passengers can marvel at a 360° view from inside the dome. Amtrak carefully schedules its rides so that passengers can see the best vistas during the prime sunlight of the day. Their subtle message is "You can't see the same scenery from an airplane." This distinctive branding, and their scenery message, cannot be duplicated by multibillion-dollar airlines.

Another example which nearly everyone has experienced is the marketing and promoting of bottled water, i.e., Evian®, Fiji®, and Smartwater®, just to name a few of the many brands of bottled water. In contrast to many areas

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of the world, in our country, most tap water is free and safe to drink, yet there are millions of Americans paying $1.69 or more for a liter of bottled water. The price of bottled water is 20% more than the same volume of Budweiser beer, 40% more than the same volume of milk, and three times the cost of gasoline! Now that's the power of branding: motivating people to pay more for water than what is available for free at the tap. Let us provide some examples how physicians can make their practices the Evian of healthcare.

Most of our choices—from the coffee shop we frequent for our jolt of java to the company that provides the medical supplies for a medical office—are based on a branding strategy. Doctors may not even be aware of it, because subliminal suggestions, social media, and word-of-mouth marketing can be as contagious as a multimillion-dollar advertising campaign.

A medical practice is a business too, and in order to thrive, a practice needs brand recognition. In fact, if a practice doesn't take the time to build a unique brand, patients will seek care elsewhere and may create opinions of the doctors and the practice that may not be what the doctors or the practice were hoping for. Perhaps the practice has had the unfortunate situation of just one "negative online review" giving the practice a "one-star rating" or the practice may have a label or reputation that can't be erased or prevented. Long wait times, unfriendly front desk, and can't get through by phone because of the phone tree are some examples. As in other businesses, the most successful hospitals and practices usually have a strong brand that clearly differentiates them from all others that provide similar services. This chapter will define the concept of branding and show how any practice, regardless of size or budget, can create a brand.

What Is Branding?

The American Marketing Association (the other "AMA") defines a brand as a "name, term, sign, symbol or design, or a combination of them intended to identify the goods and services of one seller or group of sellers and to differentiate their product from those of other sellers." Branding is actually more than that. It is everything you do to attract and maintain quality patients. Branding allows for a practice to emotionally attract the type of patient they want in their practice. Such a "fit" creates patients who choose you over your competition.

Branding allows you to differentiate your medical practice from all other practices in the community. Branding takes into account the "look and feel" of your office, your staff, your materials, you, and every other detail that gives your patients clues as to who you are, what you value, and how the patient might be treated if they become a patient in the practice. The business side of healthcare is swiftly changing. Both physicians and office managers are looking for new ways to connect with patients. In not too distant past, a new physician would place an announcement in the paper and a listing in the Yellow Pages™ of the local phone book and then she was ready to practice her craft. Physicians would promote themselves by meeting colleagues in the physician lounges, going to the emergency rooms, and just waiting for patients to arrive. Today, with managed care plans, healthcare reform, the Internet, and social media, it is much more difficult to build a practice using these antiquated techniques. Now it is necessary to build a brand for your practice.

Questions you need to ask *and* you need to answer include: What makes your medical practice unique and special? What is your sustainable competitive advantage? Everyone believes that they are members of a truly unique practice or organization, but how do we convey that to our existing patients and to potential new patients? Have you thought of yourself as the best in your field in your community? Or are you the best physician in treating a specific disease or condition? Are you the best surgeon in your area or region? Do your patients see you as the superstar, and, most importantly, do they know about your areas of interest or expertise? If not, you need to build a more cohesive image using branding. Branding is the art of attracting your preferred patients using very specific messaging that will

get their attention and motivate them to select your practice for their medical care.

Branding is also an opportunity to create a name, a term, a symbol, or design that identifies and defines your practice and will differentiate your practice from others.

In fact, branding is more critical than marketing or sales. Branding is influencing and changing the way people think. Branding appeals to desire and touches emotions. The goal of branding is to emotionally predispose potential patients into entering into a relationship with you because they believe you are the best choice for them. With more medical information available to existing and potential patients at their fingertips, today's medical consumers are too sophisticated and skeptical to be sold. They want to arrive at their own decision on their own terms. Branding is helping them get there. Branding "presells" your expertise, or your practice, before the patients even meet you or open the door of your office and enter the reception area. These potential patients call to make an appointment because of the aura or the impression that you have created that you are, indeed, the best at what you do and that you are the best fit for them. Your patients also believe they will receive outstanding care and attention from you and your staff. Branding offers you an opportunity to sculpt your practice exactly as you would like. Your brand can attract only cash-paying patients, patients of a certain demographic such as age or location, patients with the disease or conditions that you would like to treat and patients with the disease or conditions where you truly are the expert, and, finally, patients who provide you with the greatest satisfaction of providing them your medical care and your medical expertise.

Just as successful practices and businesses have a mission statement that serves as a road map or motivation for employees and a guarantee to customers or patients, a brand is your opportunity to declare your promise to your patients about the outstanding service that they will receive when they are part of your practice. Your brand can attract patients to the practice as long as the promise that you make is kept and that you deliver on that promise. This ability to find a unique distinction also applies to the healthcare profession and even to a medical practice if the practice can identify its unique distinction in its marketplace.

Benefits of Branding

Branding allows you to become your patient's first choice as their physician even before they need a doctor. Branding can attract and then maintain quality patients who have had a positive experience with you and your practice.

Attracting and maintaining quality patients happens by promising and then delivering on the promise to give your patients a stellar medical experience. Then, patients return to you again and again, and they brag about you and your practice to their family and friends creating invaluable word-of-mouth buzz about you and your practice. If you are in a competitive environment, you need to attract patients by creating visibility for you and your practice. Frankly, your visibility brings more prospective patients to you, but your ability to keep them depends on the quality of service you provide them when they are with you and when they interact with your staff. So, your name, as well as your face, needs to be circulating in the community in a tasteful, professional way that your preferred patient base will see.

Branding is all about perception and visibility which builds credibility in the eyes of your prospective patients. If they see something in the media a few times, it sounds familiar to them and they get the impression it must be good. When prospective patients recognize you and say to themselves, "gosh, he looks familiar" or "I've heard that name before," you are on your way to developing a brand. All things being equal, the more positive visibility you create, the more likely you will attract patients to your practice. Patients want to feel comfortable with their choices and familiarity breeds that comfort.

Your patients' and prospective patients' perceptions are your reality, and they define their decision to go to you versus all the others due in large part to your branding. They have made this

decision not based on real evidence but on their perception that you are the best choice for them. They did not get to that choice using logic—they made the decision emotionally and then justified their decision with logic. Perhaps they saw you on the news or they saw your photo in the social column at a fund-raiser or their friend passed along the informative newsletter you distributed to your patients. It can be the monthly column you wrote for a local magazine or publication or your appearance on the local news where you are interviewed about a new procedure or treatment that you offer your patients. Branding also occurs if you sponsor a health-related event such as walk or run to cure a specific kind of cancer.

Another benefit of branding occurs when your website is at the top of the search engine list on Goggle, Yelp, or Yahoo. Today it is far too competitive to rest on your laurels. Your name needs to stay in front of your preferred patient base, so they visit you when they have a present medical need now or in 6 months or next year. You cannot assume they will stay loyal to you if you do not keep your relationship current with them. If you are not visible, you give your competitors the opportunity to redirect your patients to their practices. This situation must be avoided at all costs.

Getting Started to Brand your Practice

Begin by letting your patients know why you are unique such as your specific fellowship training or your advanced medical skills. Inform your patients what you offer beyond what most of your competitors don't—such as evening and Saturday morning appointments or a technology or treatment that others don't have or offer. Do things differently to stand out—provide transportation for your older or housebound patients to and from your office or the hospital (as long as this is legal in your practice area).

Clearly convey your personality in your marketing tools—you can portray yourself as the "Top Doc to the Stars," the professional team in your community as their doctor, or "The Local Neighborhood Doctor."

- Specialize and be selective. It is not possible to be everything to everyone. Instead, select an area of interest or expertise that is unique and special and that makes you and your practice special.
- Be where your prospective patients are—have offices in various parts of the community or region where your preferred patients live. This means making it convenient for your patients to become part of your practice without traveling at a great distance to receive their medical care.
- Build rapport and trust with every patient—use the patient's name when speaking to them in person or over the telephone. Make the patient feel special and not just a diagnosis or a medical condition. When a patient calls for an appointment, your receptionist should conclude the phone call by stating the patient's name at least twice before terminating the call: "Mrs. Smith, it is nice to speak with you. Dr. Strangelove looks forward to meeting you a week from now at 2:00 P.M. Do you have any questions before that appointment?"
- Stay in contact with your patients throughout the year—send them a practice newsletter, birthday cards, and thank you notes when they refer a patient to you.
- Refine your patient relations processes—have your staff introduce themselves by name to new patients and then walk all new patients from the reception area to the exam rooms. Of course, make sure you see them on time!
- Stay consistent with your message. Don't try to be all things to everyone. Select an area or areas that you deem worthy of your brand, and then make sure you relate that message to existing patients and also to potential new patients.

For those physicians who take branding seriously, the payoff can be huge. The difference between a good practice and a great practice is in the details. Pay attention to every aspect of yourself, your staff, and your practice to ensure it is consistent with your personality and the image you are trying to portray. Don't think of branding as taking patients from your

colleagues or your competitors. Think of branding as the opportunity to have your existing patients and potential new patients have your name and the name of your practice come to mind whenever a medical problem that you treat or you have as area of expertise come up in any conversation.

For starting the branding process, you will need to gather your staff and conduct a brainstorming session. You begin by writing down what you want to achieve and who is your target market. For example, if you are an orthopedist and want to specialize in sports medicine, then write down the ages of patients you want to treat, the nature of injuries that you want to treat, and the ability of this patient population to pay for your services.

Be as specific as possible to define not only medical condition(s) but also the demographics of the patients, payer mix, and what you can reasonably deliver on a consistent basis. It is this latter situation or consistency that is vital to the success of your branding process.

Your branding must stay in sync with your skills, your staff, your facility, your operating systems, and your guiding principles. Set aside at least an hour for a branding brainstorming session with your team. Ask your staff to write down as many concise core messages they can think of that pertain to your practice in each of these categories:

- Courtesy (how you will treat patients, colleagues, and fellow providers).
- Punctuality or your level of commitment to being on time. We believe that this is one of the basic ingredients of branding and that is providing patients access to the practice and seeing patients on time. You can be the greatest expert in the area, but if patients have to wait 4–6 weeks to obtain an appointment and when they come to the office and wait 60 minutes to see the doctor, all of your branding efforts will be wasted.
- Expertise or what you stand out for or specialize in. This is where the rubber hits the road or how you differentiate yourself, whatever that may be, from others in the community.
- Referrals or how you will accept or forward communications and recommendations for care or services. There is no excuse today with all of the technology available to every practice that you must place communication with your referral sources at a high priority. For the most part, this means sending a referral letter within 24 hours after you have seen a patient referred by colleague.

Next, consider what it is that your target market needs. If you are an obstetrician specializing in infertility and you need to establish a reproductive laboratory, you need to think about the technicians and other specialists who you will need to have in place to achieve these goals so that patients can conduct all of their care at one facility and not have to go to the endocrinologist in one building and a lab in another location and then undergo the IVF in still another office.

You have to identify your competitors. Don't think just of your local competitors but also consider those in the region, the rest of the nation, and depending upon areas of expertise you may want to consider your global competitors. For example, practices who want to attract patients from all over the world to come to their country for orthopedic procedures, which are significantly cheaper than the same procedure performed in America, are setting up medical tourism industry in their countries. They are making it possible for patients to have visas, airline reservations, hotel reservations before and after their surgery, and even doctors who will participate in the postoperative care once they return to their home towns. This concept is branded to make it not only less expensive but to make it hassle-free for patients who are willing to have surgery in such a setting. How are you different from the competitors? What is that makes you unique from those who offer the same services?

For example, there is a urology practice in New Orleans that is branding itself to provide urologic oncology care for patients from South America, a form of "reverse tourism." They have Spanish-speaking doctors and staff; they meet patients at the airport and provide them transportation to the medical center. They essentially

choreograph every aspect of the patient's care by providing outstanding customer services in addition to the clinical skills of caring for the patient. To make this work, you want to make a list of the unique benefits that patients might experience from being a patient in your practice.

As another example, there is an academic practice in Boston that specializes in the treatment of urinary incontinence, and they are able to evaluate the patient in one visit and conduct a complete history and physical exam, do all of the diagnostic testing, have a discussion on the treatment options, obtain the consent, and do the pre- and post-op teaching on the very first visit. This is in contrast to the three or four visits that are typically needed by many other urogynecology practices because they can't charge patients for diagnostic studies on the same day as the initial office visit when the E/M (evaluation and management) is generated. This Boston practice has branded itself as a "one-stop shop," which makes them attractive to the patients as well as the insurance companies and the payors.

During brainstorming sessions, to get the best ideas, it is important from the first session to avoid making any judgments on those who offer suggestions. You want to have as many unfiltered ideas and thoughts offered at this first brainstorming session as possible to work from. After this first brainstorming session, we suggest you publish your branding statement and share it with all of your staff before your next meeting. Your next meeting will provide an opportunity to refine your responses to the answers to the questions that were answered in your first meeting. At that second meeting, you will want to fine-tune your branding statement and then use it to create your strategy and tactics for implementing the branding message.

Displaying Your Brand

You need to look for opportunities to display your brand. If you have a website, take an objective look at it. Is there a way to add your updated brand message? What about your business cards? Perhaps you can have them redesigned to include your brand message. You might even create signage for your office to set the tone or display your brand. But more important than any of those tactics, find ways to share your message through your words, attitude, and behavior. Because no matter what you display externally, it's who you are internally that is your real brand.

Every successful business, including your medical practice, benefits from having a strong branding message. When creating your brand, make sure it's a proclamation and a promise and not a pitch. Because what you're really delivering is a promise, and that's what the branding buzz is all about.

Kaila's Story

Kaila's branding experience consisted of creating a website, with the permission of her multispecialty group, that focused on nutrition and the role of good nutrition on maintaining good health and using nutrition to improve many medical conditions. Kaila also began a monthly blog highlighting the importance of good nutrition. Kaila prepared a newsletter which she sent to existing patients and referring physicians. The newsletter was sent to her target market on a quarterly basis. Kaila created a slogan, "Kaila loves kale" which was used on her website, her stationery, and her blogs. As a result, Kaila enhanced the number of patients which were sent to her from existing patients and other primary care physicians. She soon found herself seeing patients with nutritional needs and using her skills as a nutritionist and meeting the unmet nutritional needs within her community. She had a real sense that she was seeing the types of patients she wanted to see and felt that her practice was becoming a good fit for her skills and interests. This was a real branding success story.

Bottom Line

Branding is not just for soft drink companies, bottled water, Amazon, and Nike shoes. Also, branding in healthcare is not just for the Mayo Clinic or the Cleveland Clinic. Nearly every practice and every hospital have the potential to create a brand or an area of expertise that sets the practice or hospital apart from all the others in the community or the region. Einstein said, "If you can't explain it to a 6-year-old, you don't understand it yourself." Look to what you do know about the very essence of your practice and emulate that in a simple statement that can guide your brand in every aspect of your practice. Be consistent and use that brand to define the visual image, verbal communication, and the patient experience in all encounters.

If you fall short in maintaining the promise to the patient of your brand at any stage, the relationship and implied trust will be at risk. Instead, create the best possible experience for your patients and establish a long-lasting brand that generates new patients and maintains the loyalty of existing patients.

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Legal Considerations in Hiring and Firing of Nonphysician Staff

15

Walter Christy

Case: Rochelle

Rochelle is working with a small pediatric group practice and has recognized that she needs a medical assistant. Rochelle's partners agreed with her request and suggested she do the necessary screening and evaluation to find the medical assistant. Rochelle has never had to hire an employee. What should she look for? Where should she start? She realizes that she was never taught about hiring or firing in any of her training

Hiring the right employee that meets the requirements in the job descriptions is vital to the success of the practice. It is important to find the best employee available among the applicants for job openings in the practice. There will certainly be occasions where an employee must be terminated. This also requires tact, knowledge of the labor laws, and sensitivity to avoid further bruising egos and hurt feelings.

This chapter will discuss the hiring process that has worked in the healthcare sector as well as other industries and professions and also provide a guideline for the termination of an errant employee without running afoul of labor laws.

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Finding the Match Made in Heaven

Like any other business, for the health and ultimate success of your practice, you must have high-quality, efficient, and dedicated staff. Someone not suited to your practice can create a negative impression among your patients and cause the morale of your staff to quickly decline.

With today's tight healthcare labor market in the majority of metropolitan communities and competition from large hospitals and other industries that are offering higher salaries and more benefits, i.e., that individual practices, being akin to small businesses, often have trouble competing with larger employers. The challenge of finding the right person for the job is made even more difficult. Does this mean that you should settle for a less-than-qualified employee? Certainly not!

Despite other opportunities, job seekers still seem to find the idea of working at a medical practice attractive. A position with a private practice offers status as well as the gratification and enjoyment that come from helping others. By offering fair salaries and challenging working conditions, you can build a top-notch staff. This chapter will discuss the hiring process to find that match made in heaven and then conclude with the proper methods for terminating an employee.

Finding and hiring the right person to fill a staff position requires a great deal of time and attention. Hiring staff members is a delicate

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process and one that you will probably keep improving upon as you and your practice matures. However, hiring is a process that requires time and patience. Being in a hurry to hire someone to fill a vacancy and making the wrong decision can lead to expensive turnover and a very uncomfortable work environment. Studies have shown that the average cost of employee turnover, whether you are correcting a hiring mistake or replacing a longtime employee, is two and a half times the salary of the worker you are losing. But turnover also brings hidden costs in addition to the tangible costs of salary and benefits. The time it takes to do interviews, the overtime you pay others to pick up the slack, and the impact on morale of your existing staff can wreak havoc with your practice.

One way to find your candidates is word of mouth using multimedia. You might consider taking advantage of job-listing services at local schools, universities, and professional organizations. Today there are websites where you can post job opportunities. One of the most popular job-listing sites is Craig's list, <name of your city>.craigslist.org. This Internet site features job postings, classifieds, etc. and is favored as a networking tool for the younger generation of savvy job seekers.

Screening Your Applicants

Begin by requesting applicants to submit an electronic resume to your email address. You might ask your office manager to screen the resumes and then call the applicants to schedule an interview. Your office manager should speak to each applicant personally when they call your office the first time. This phone call is too important to be screened only by your receptionist. The office manager should specify the time of day when he or she can receive calls from applicants or set a time to return calls to the applicants. After the office manager has screened applicants and narrowed down the choices, the doctor should interview the finalists.

Talking with an applicant personally allows you to evaluate:

- The applicant's telephone manners
- The applicant's curiosity about you and your practice.

You want an active, vibrant individual who exudes enthusiasm. If you do not sense vitality and enthusiasm in a phone conversation with the applicant, your patients will not either.

Ask the applicant to send a handwritten letter along with his or her resume and application. Suggest a topic for the letter. For example, you might suggest that the letter explain why the applicant wants the job, why the applicant is qualified for the job, or how the applicant could enhance your practice. You might also suggest that the letter address a nonmedical topic, such as the applicant's hobbies or last vacation. The letter can be scanned and emailed, faxed, snail mailed, or hand delivered to the office.

This letter will serve several functions:

- It allows you to see how quickly the applicant responds. In most medical practices, a speedy response can often be vital.
- It allows you to analyze the applicant's writing and spelling skills. (Obviously, you do not want to hire someone who cannot spell correctly or whose handwriting is more illegible than yours!) If the applicant is emailing the letter, this also allows you to evaluate his or her "email etiquette" – an important feature these days, when too many people fail to proofread or edit before they hit the send button!
- Finally, a written letter will frequently reveal something about the applicant that is not available in his or her resume.

The Interview Process

Encourage preparation. The interview will be more productive if you allow applicants to prepare. Before an interview, send the applicant a job description and information about you and your practice. If you have a primary care practice, you may want to send information on what you do, what kinds of patients you see, and what typi-

cal situations that someone who works in your office might encounter. If you are a specialist, send the applicant information on the nature of your specialty or some educational material that you give to patients about the various diseases, illnesses, and conditions you treat. I am impressed when applicants demonstrate that they have read this information, or have visited the practice's website, and ask questions about anything that they have not understood.

Make the most of each interviewing session. You can do this in several ways: the first few minutes of the interview can be used to break the ice. For example, you might tell the candidate about yourself, your practice, and the job description. Next, consider providing the candidate at the time of his or her visit with a written list of questions (Fig. 15.1). Using a written list encourages candidates to do the talking. It is a good idea that you interview promising applicants more than once. First impressions are important, certainly, but most couples do not get engaged on their first dates! Many applicants will be eliminated after the phone call or first interview. Those still in the running need a second, third, or even fourth interview before the job offer is made.

Consider asking "curve ball" questions. At least one time during the interview process, ask the candidate a difficult to answer question. In any medical practice, circumstances will often arise that require the staff to think creatively and to respond quickly. Failure to react quickly can adversely affect the health of patients and might even lead to litigation. If the candidate has worked in a medical office or has healthcare experience, you might ask a question such as, "What would you do if a patient called with a medical emergency and the physician could not be reached or located immediately?" Fig. 15.2 contains additional examples of curve ball questions you might consider asking.

Give a potential hire a "homework assignment." In addition to the curve ball questions, which require immediate answers, we suggest that you present each applicant with a more involved problem and allow him or her time to work on the answer after the interview is over. For example, you may ask the applicant to propose a solution for a problem at the practice. How quickly the applicant responds to this "homework assignment" tells you a lot about the applicant's creative problem-solving abilities as well as the strength of the applicant's desire to get the job.

Encourage the applicants to ask questions. This allows you to evaluate their level of interest in and curiosity about the job. If an applicant fails to ask any questions, this suggests that the applicant is intimidated by the interview process or is not very curious. If either is the case, you are learning something important. You want to hire people who are both curious and not easily intimidated. For instance, if an applicant's only question is about the salary or vacation pay, that would be a clue to their priorities. If an applicant

Fig. 15.1 List of questions to ask job applicants

Name

1. What are your strengths?
2. What are your weaknesses?
3. Why are you interested in changing jobs?
4. What was your best job? Your worst?
5. Tell me about your best boss.
6. Tell me about your worst boss.
7. What do you think your references will say when I call to inquire about your past employment?
8. What do you want to be doing one year for now? Five years from now?

Fig. 15.2 List of "Curve Ball" questions to ask job applicants

1. If I did a procedure that did not have a CPT code, how would you attempt to obtain insurance coverage from a third-party payer?

2. How would you handle it if a patient began arguing with you in front of other patients about the cost of his visit?

3. If a patient called on the telephone and demanded that he be seen the same day as he called, and you knew that the problem was not an emergency, what would you tell him?

4. What would you say to a patient who requested that his records be sent to another physician?

5. Suppose that you saw a patient in the grocery store and you were with your spouse or significant other. How would you introduce them?

asked about furthering skills through seminars, night classes, and so on, this might be an indication to put this applicant on the short list.

References

There is an unwritten rule regarding references: Do not give references out, but do not hire without them.

Many employers will make the mistake of calling the previous employer without any introduction and expect the previous employer to tell all about the applicant and their employment history. Accept that the information you receive will likely not be complete and should not be the determining factor of whether you hire the individual. You can obtain information on an applicant through a background check (with proper authorization from the applicant), but you should not use criminal background information until after a conditional offer of employment has been made.

Many employers only give out a name, job title, and pay rate but will not provide specific information on performance and the applicant's termination because they are fearful of a lawsuit.[1] This situation can be avoided by asking the applicant to sign a release-of-information letter (see Fig. 15.3) and emailing or faxing it to their previous employers before your call. This avoids your cold calling a reference and not receiving any useful information.

Applicants will often not give you names of references unless they expect them to respond favorably. To get around this hurdle, ask applicants for additional references during later interviews. The length of time it takes them to respond will tell you something about the quality of the references.

Applicants will not give you names of references unless they expect them to respond favorably. To get around this hurdle, ask applicants for additional references during later interviews. The length of time it takes them to respond will tell you something about the quality of the references.

Have your existing staff members interview each applicant. They will let you know whether or not that person will be a team player and will make a good fit with the existing staff.

Pay attention to follow-up. Did the applicants return your phone calls promptly? Did they send you thank you notes after their interviews? Remember that the way they handle the business of looking for work today is how they will handle the business of working for you tomorrow. More important, the courtesies and manners they extend to you will be a barometer of how they will treat your patients.

[1]Many states, including Louisiana, have adopted legislation protecting an employer from civil liability in providing accurate information about a current or former employee's job performance or reason for separation. The statute also protects employers who rely on such information in hiring from civil liability. See La. R.S. 23:291.

Fig. 15.3 Release-of-information letter

Release Form

I am an applicant for employment with Dr. Baum. I am submitting a signed release form that provides you with permission to speak with Dr. Baum or one of his representatives regarding my previous employment and experience with you.
I have read all the information in the attached request concerning your experiences with me as an employee. I am in agreement with the content on the form and give you permission to release the information to Dr. Baum. I hold you harmless for any information you furnish regardless of the outcome of my application for employment.

Date:

Signature:

Notary Seal and Date

Back to the Case of Rochelle

Rochelle got the word out in the medical community that she was looking for a medical assistant. She also posted a job description on Craig's List, but her best candidate came from one of her patients who had a daughter who was a trained medical assistant and looking to change jobs because of the great distance she had to travel from her home to her office. After thoroughly vetting Rochelle and a paid day to shadow her, Rochelle was hired and both Rochelle and the middle assistant were happy with the decision.

Bottom Line on Hiring

Although the hiring process is time-consuming and stressful, it is essential for creating an excellent practice where outstanding service is provided by both the doctor and the staff. The costs of taking the time to hire the right employee are much less than the high costs of employee turnover.

Ready, Aim, Fire! Tactfully Terminating an Employee

The remainder of this chapter will discuss the legal process of terminating an employee and how to avoid going afoul of the labor laws and potentially risking a law suit if the termination is not done properly.

Case of Terminating Theresa

Theresa was serving as office manager for a small group oncology practice. She had been with the practice for more than two decades when the practice merged with two other oncology groups in the community. Although Theresa was an excellent employee and was respected by the staff and the doctors, her skill level was not going to be adequate for managing a multimillion-dollar large group of oncologists. It became apparent that Theresa would have to be terminated. How does the practice terminate a good employee after so many years of service?

Termination of Employees: Dot Your *i's* and Cross Your *t's*.

The overwhelming majority (95%) of private employers, which includes medical practices, are nonunion. Unionized employers, those that have contracts with unions covering wages, hours, and working conditions of their employees, are generally required by the contract to show that they had "just cause" to terminate an employee. This situation normally develops where an employee has been terminated and files a grievance with the union which ultimately goes to arbitration. Arbitrators typically rule that the employer has the burden to prove just cause by a preponderance of the evidence, a high standard. Arbitrators often send terminated employees back to work even though the employer felt it had good reason to terminate the person.

Why do we speak about unions in the context of this book given that most clinics and medical practices are not covered by union contracts? Since the enactment of the National Labor Relations Act of 1935, 29 USC §§ 151–169), and the Taft Hartley Act of 1947, 29 USC §§ 141–197, there have been significant changes in the laws affecting employment such that employees no longer need the help of a union to challenge their termination. Those laws include:

- *Title VII of the Civil Rights Act of 1964 (Title VII)* (42 USC §§ 2000e–2000e-17), prohibiting discrimination on the basis of race, color, sex (including amendments by the *Pregnancy Discrimination Act* and the Civil Rights Act of 1991), national origin, and religion.
- *Age Discrimination in Employment Act (ADEA)* (29 USC §§ 621–634), prohibiting discrimination on the basis of age (40 and over).
- *Title I and Title V of the Americans With Disabilities Act (ADA)* (42 USC §§ 12,101–12,117), prohibiting discrimination on the basis of disability (including amendments by the Civil Rights Act of 1991 and the *Americans With Disabilities Act Amendments Act (ADAAA)*).
- *Genetic Information Nondiscrimination Act (GINA)* (24 USC §§ 2000ff–2000ff-11), prohibiting discrimination on the basis of genetic information.
- *Uniformed Services Employment and Reemployment Rights Act (USERRA)* (38 USC § 43), prohibiting discrimination on the basis of past, current, or prospective military service. Protects civilian job rights and benefits for veterans and members of reserve components.
- *Section 1981 of the Civil Rights Act of 1866 (Section 1981),* prohibiting discrimination on the basis of race, color, and ethnicity in the area on contracts.
- Most states and some municipalities have their own laws which mirror many of the federal laws and some provide protection beyond them, e.g., LGBT status.
- *Family and Medical Leave Act (FMLA)* (29 USC §§ 2601–2654) protects employee rights to take up to 12 weeks of leave for medical and family medical care purposes.
- *Workers' compensation laws* prohibiting retaliation against employees for making worker's compensation claims.
- *National Labor Relations Act (NLRA)* (29 USC §§ 151–169) prohibits termination because of an employee's protected and concerted activity on behalf of a group or for organizing or union activity.
- *Fair Labor Standards Act (FLSA)* 29 USC §§ 201–219) prohibits termination for exercising wage and hour rights.

How do these laws affect your decisions to terminate employees? Let's consider the Bones Are Our Business Orthopedic Clinic, a clinic that has been in practice for 5 years and has 5 doctors and a support staff of 20. The clinic has been experiencing a decline in patients as well as the retirement of the head of the clinic. To meet these financial demands, as well as to deal with certain personnel issues, the clinic has taken the following actions:

1. Martha, an x-ray technician, is pregnant and has been restricted to lifting no more than 50

lbs. The clinic advised her that she needed to go home, have the baby, and come back within 12 weeks. Walter, a 61-year-old maintenance worker, had a heart attack and was restricted from lifting over 40 lbs. The clinic assigned Henry to help him when such lifting was needed. Martha heard about this and quit threatening to sue.
2. Horace, an African-American male technician, had arrived late for work five times and had two unexcused absences within the past 3 months.
3. Sharon, a white female nurse, had eight arriving late for work days and three absences within the same time frame. The clinic terminates Horace but does not terminate Sharon because it deems her an essential employee.
4. William, a physician's assistant, went on active duty with his reserve unit 6 months ago and is now seeking to return to work. The clinic eliminated his position during his absence.
5. A patient complains that she does not want to be treated by Willie, a transgender male nurse, and she threatens to leave the clinic and take her large family, who are also patients, with her. The clinic terminates Willie to comply with the patient's request.
6. The clinic holds clinic-wide meetings for all employees and doctors every Friday morning. At one of the meetings, Jerry, an x-ray technician, complains that he and the rest of the staff are not being treated fairly because they are not allowed to leave the clinic during their 45-minute lunch break for which they are not paid. Dr. Arthur, the head of the clinic, tells him that these are the rules, and if he doesn't like it, he can leave. Jerry responds that the clinic doesn't care about the employees and he urges the rest of the staff to protest. Dr. Arthur terminates Jerry on the spot.
7. Nick, a Muslim physician's assistant, tells you he must pray five times a day. You tell him this would be too disruptive to the workplace and patient care at the clinic and he should look for other work.

What problems do you see with the above actions and what laws do you think might apply?[2]

So how can a doctor or a clinic avoid termination problems such as befell Bones Are Our Business Orthopedic Clinic? The following steps are recommended:

1. Be familiar with the laws which may apply to your employees.
2. Develop appropriate policies covering termination as a part your employee handbook and/or personnel manual.
3. Educate the staff, especially the doctors and supervisors, as to the policies and legal ramifications covering employment termination.
4. Have the employees acknowledge in writing receipt of the policies and agreement to comply with them.
5. Consistently apply policies and procedures to all employees without any exceptions.
6. Evaluations – be honest – do not sugar coat the employee's performance deficiencies – this can well come back to haunt you when you are considering termination. Train your evaluators to be objective.
7. Consider placing a problem employee on an improvement plan, for example, 60 or 90 days, to achieve satisfactory performance. Review performance every 30 days and document the improvement or lack of improvement.
8. Document disciplinary actions as they occur and make sure that you have sufficient documentation to support a termination.
9. Insure that the decision to terminate is based upon objective criteria and does not involve personal feelings.

[2]Martha – Title VII violation – making accommodation for Walter, but not for Martha

Horace – Title VII and Section 1981 violation – different treatment based on race

William – USERRA

Willie – Title VII – sex

Jerry – National Labor Relations Act – protected activity

Abdul – Title VII – religion

10. Before making a decision to terminate, conduct an impartial internal investigation and properly document the results of the investigation.
11. Determine if any employees have engaged in similar conduct and what disciplinary action was taken.
12. Analyze whether termination of the employee will have an adverse impact based on race, sex, age, or any protected category.
13. Where circumstances call for termination, take action, do not delay.
14. Delivering the message to the employee:
    (a) Have a witness with you.
    (b) Arrange for the meeting with the employee to be private.
    (c) Collect and review the employee's personnel file with particular attention to disciplinary write-ups.
    (d) Be prepared and rehearse for the meeting.
    (e) Discuss any employment agreements with the employee including offer letters.
    (f) Present the termination decision in a direct and forthright manner and avoid arguing with the employee.
    (g) Have the employee's final pay and benefits prepared and pay him. Decide beforehand if the employee is going to receive severance and whether a waiver and release will need to be signed. For this action, you may need the advice of a labor or employment lawyer.
    (h) Be sensitive to the termination and recognize that this will be an emotional situation for the employee.
    (i) Allow the employee to speak, but do not argue with him or allow him to go on at length. If possible, do not interrupt the employee while he/she is talking.
    (j) Document the termination and have the witness also sign off on the document.
    (k) Obtain all clinic property from the employee such as computer, parking pass, and keys to the office.
    (l) Disable electronic resources the employee had including email, voice mail, passwords, and log-ins.
    (m) Remind the employee of any continuing obligations including noncompetition and non-solicitation agreements and protection of confidential information and trade secrets.
    (n) Escort the employee to his desk, allow him to gather his belongings, and politely escort him from the premises. If you anticipate resistance or violence, you may want to ask for a security officer from the hospital to accompany you and the employee.
    (o) Advise the remaining employees of the termination either directly by the person who handled the termination or through other supervisors or managers.
    (p) Consider how to inform patients of the action.
15. Determine what information will be provided to inquiries or references concerning the employee's employment and termination. You cannot go wrong if you provide the dates and titles that the employee worked in the practice.

Following these guidelines will help you make the right decision and defend that decision if you are challenged by a discharged employee who is seeking damages for wrongful termination.

Terminating Theresa

Theresa had been a loyal employee and certainly did an excellent job when the practice was small and prior to the merger with the other two oncology groups. Theresa was given 4 months of pay and was told that her health insurance would be paid for 4 months after she left the practice. She was also informed that the practice would provide her with a favorable letter of recommendation and she could use her previous employer as a reference. Theresa accepted the "goodbye gift" and left on good terms from the practice.

Bottom Line on Hiring and Firing

You may find the hiring process time-consuming and stressful, but that does not come close to comparing with the time and stress it will cost you if the candidate you hire is not a good "fit" with your practice. Follow the suggestions in this chapter and you are much more likely to hire right the first time!

Circumstances surrounding hiring and firing is a source of angst among doctors, office managers, or human resources in the healthcare setting. It is imperative that the practice develop skills and techniques to find the right person for various positions in the practice. Hiring takes time and energy and mistakes can be very costly to the practice. Having the wrong employee in a position can significantly impact the efficiency and productivity of the practice. When the employee is not working out and fitting in with the practice, then comes the difficult process of terminating the employee. Termination can result in deterioration of morale and can be very costly to find a replacement. Also of concern is the potential risk of liability for wrongful termination if the termination process isn't followed as we have shared with you in this chapter. This process of hiring and firing should not be minimized or delegated to a doctor or manager who doesn't have the skills to find the right person or the skills and knowledge to terminate an employee.

Suggested Reading

1. Falcone P. The hiring and firing question and answer book. New York: American Management Association. AMACOM; 2002.

Malpractice

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Marc J. Kahn and Neil Baum

The Story of Tomika and the Tail

Tomika is completing her training as an internist and plans to join a large group practice in the same community where she trained. She is married and her husband is finishing his training and they plan to move in 2 years closer to their families. Tomika knows she will be employed for only 2 years and her contract stipulates that she has a claims-made policy and that there is no tail coverage after she and her husband leave the community. What are Tomika's options?

One issue that every new physician must contend with is the subject of malpractice insurance. Medical malpractice insurance is one of the largest expenses a young physician will face as he/she launches their career. This subject is often shrouded in mystery and can be very time-consuming especially if it is the first time you are confronted with this expensive decision.

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We believe that young physicians who take the time to understand and buy malpractice insurance will not only save money but also ensure that they will receive the right type and amount of coverage. This chapter will discuss the concept of malpractice insurance and what every young doctor needs to know about this issue.

Most malpractice polices cover the expenses incurred while defending and settling a malpractice suit. These include attorney fees, damages, arbitration, settlement costs, court costs, and punitive and compensatory damages.

Types of Malpractice Insurance

There are two categories of malpractice insurance: (1) claims made and (2) occurrence. A claims-made policy provides coverage only if the policy is in effect both when the incident took place and when a lawsuit was filed. Occurrence policies cover any claim for an event that takes place during the period the policy was in effect, even if the claim is filed after the policy lapses. Because a claim can be filed years after an event and after a claims-made policy expires, these polices often include a "tail" that extends coverage for a specified number of years beyond the expiration date. If it's not part of the original policy, tail coverage can be bought separately.

For example, if a physician has a malpractice claims-made policy and that he/she receives a malpractice lawsuit during the period of his/her

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employment, the doctor will be covered under a claims-made policy. If, however, the doctor has an occurrence policy and is sued *after* he/she leaves the practice or retires but the policy was in effect while the doctor was in the practice, the doctor will be covered and protected by the policy.

Tail coverage offers protection when a physician is changing jobs or retires. Sometimes the cost of tail coverage will be covered by a previous employer to protect itself or can be negotiated with a new employer. Occurrence polices generally don't require tail coverage but are not available in all states.

If you or your employer is buying a claims-made policy, be certain that the beginning date for coverage is accurate and matches the date on the prior policy to ensure there are no coverage gaps between policies.

The amount of coverage can vary by state, specialty, and arrangements with hospitals or your employer. Some states require doctors have a minimum coverage but you can request additional coverage depending on your specialty.

In general, standard coverage limits are $one million per claim and $three million aggregate, which is the most the policy will pay in a year for all claims. However, certain states require different limits based on medical malpractice caps on damages. States with more litigious climates might require additional coverage.

Some states have patient compensation or catastrophe loss funds, which provide an additional layer of coverage over the primary policy limits. Doctors are required to pay into these state-run funds through a surcharge on medical malpractice insurance premiums. If a lawsuit is filed and found to be credible or legitimate, malpractice insurance will cover the injured patient's costs to a limit set by the state. The rest is paid by the state's fund.

Finding a Malpractice Carrier

Most states have a few carriers that are licensed to sell insurance in the state. We want to emphasize that price certainly is one factor, but it shouldn't be the only one. If you just focus on price, you might be hiring an unreliable or financially precarious carrier.

We suggest that you make certain that the policy has a consent to settle clause. This clause prevents the insurer from settling a claim without the permission of the doctor. Insurance companies find it much cheaper to settle a claim than to actually litigate the claim. However, the doctor's reputation is at stake and doctors are often reticent to settle a claim if there was no evidence of malpractice.

The very best malpractice carriers will act as resources for their physician clients. They will offer advice on how to avoid claims and will hold the hand of the doctor during the process of any litigation.

A few suggestions for screening potential carriers include:

- Ask colleagues in the state where you plan to buy insurance about the malpractice carrier's reputation.
- You want to know their history on settling claims.
- Go to AM Best and check the carrier's financial position. AM Best provides the financial stability of the carriers and rates each carrier. Using this service you can compare apples to apples (www.ambest.com).
- Check how long the carrier has been in business.
- Does the carrier specialize in certain medical fiends such obstetrics, neurosurgery, or anesthesia?
- Where is the carrier located? Do they have an office close to where you are going to practice?
- Do they want to have a relationship with you and meet you personally or is it only through the Internet they communicate with their clients/doctors?

To Broker or Not to Broker

A broker has the depth of knowledge and the experience to know the coverage a doctor or practice needs and the best insurers to provide.

A broker helps keep us informed of what our needs are and what changes have to be made. For example, if a practice bought a general insurance policy 10 years ago, there was probably no provision for cyber insurance in case of a hack and loss of your data. A good broker will contact the doctor/practice and suggest that cyber insurance be added to the policy. Other risks that require insurance coverage include regulatory requirements such as compliance with the Health Insurance Portability and Accountability Act (HIPAA).

We suggest that you contact your broker every 2 to 3 years and make sure you are up to date and are adequately covered or if there have been new developments since the policy was purchased. Examples of a need for evaluation and changes in the policy include:

- Adding a provider
- Starting a new business, joint venture or adding ancillary services
- Forming a new entity, i.e., sale of the practice to a hospital or merger with other practice
- Adding new services or equipment

Our take-home message is that if you can find a broker who is knowledgeable, it's a lot easier to hire them to do the heavy lifting, get the quotes, and inform you, the managing partner, or the office manager.

Tomika's Story

Tomika approached her employer and asked about tail coverage. The large group practice said that they couldn't make any exceptions regarding tail coverage for her. Tomika contacted a broker who found a tail-only policy at a reasonable premium that would be in effect for 5 years after she left the practice. Tomika purchased this policy and was able to receive some additional compensation from the large group by offering her a "moving allowance" to help defray the extra cost of the tail insurance. Lesson learned: you can always get your own way if you have more ways than one!

Bottom Line

Malpractice insurance is a requirement in every state and most hospitals; ambulatory treatment centers or outpatient surgery centers will require you to have a malpractice policy in order practice. For most employed physicians, medical liability coverage is usually provided as part of the employment contract by hospital or the health system. It is important to check your contract and make certain you have coverage if you leave the practice for any reason. The old CYA is now CYT or "cover your tail!"

The Role of Mid-level Providers

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Marc J. Kahn and Neil Baum

Case: Cassandra

Cassandra is a recent family medicine graduate who worked for 3 years in a primary care medical practice. She found that she was soon overwhelmed and was required to see more patients than she was comfortable. As a result, she and the staff had to work overtime which was increasing the practice's overhead. What were some solutions to her dilemma?

Health care has encountered a situation where the demand for our services is greater than the supply of physicians. In the very near future, the shortage of physicians will become even greater. At the time of writing this book, primary care physicians are already in short supply. The American Academy of Family Physicians predicts a shortfall of 40,000 primary care physicians by 2020. Moreover, the US Bureau of Health Professions projects a shortage of 109,600 physicians in all specialties by 2020. One thing is certain – following the passage of the Affordable Care Act (Obama Care), 32 million additional Americans are going to have health insurance, and someone will need to take care of them. Who will provide medical care to millions of newly insured people? Upon passage of the Affordable Care Act, physician practices were overwhelmed by the increased demand. Many doctors stopped taking new patients; the concept of concierge medicine, also called direct primary care, has decreased the availability of primary care physicians; and those physicians who continue to accept new patients have seen waiting times for appointments lengthen significantly. Visits to emergency rooms have increased by 7%, adding unanticipated costs to the program. To resolve this situation, physician practices and hospitals must proactively add capacity to treat large numbers of new patients. This chapter will identify mid-level providers and describe the role they can assume to increase the care we want to provide our patients.

Ideally, every American will have access to a primary care physician they see on a regular basis to help them maintain good health and to prevent unnecessary emergency room visits. But primary care physicians are already in short supply.

One of the solutions to this dire situation is to use mid-level providers (MLP). This is an idea that is receiving recognition by the medical profession as well as patients. However, it is an area of controversy. However, mid-level providers are in our offices and in our hospitals and the numbers are increasing rapidly. There is no going back and we are not going to change that momentum.

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Who Are the Mid-level Providers?

There is a confusion among the medical profession and, of course, the public, of the names and titles associated with MLPs. Other terms that have been used for MLPs include limited-license providers, nonphysician providers, allied health providers, midwives, advanced practice providers, and even medical assistants.

Where Are MLPs Working?

Today, roughly 80,000 NPs and 30,000 PAs work in a variety of settings around the country [1]. They have traditionally provided supervised care in rural and underserved settings, where they work under the supervision of a physician who may or may not be located in the same office or community. In these settings, mid-level providers diagnose and treat a broad range of routine medical conditions under supervision, referring the more complicated cases to the supervising physician. In our modern healthcare marketplace, clinics located in pharmacies and other retail locations are often staffed with MLPs.

Over the last 30 years, roles of MLP have expanded well beyond the primary care environment. Additionally, many states now allow some MLPs to practice independent of supervising physicians. Today, mid-level providers work in hospitals, emergency departments, and inpatient and outpatient surgical facilities and in specialty practices such as cardiology and oncology, as part of the team that serves patients receiving ongoing treatment. It is often a mid-level provider who monitors fragile diabetics, sees cancer patients between treatments, reduces bone fractures in the ED, or closes the surgical incision for the doctor at the end of surgery.

MLPs include two distinct groups, physician assistants (PAs) and nurse practitioners (NPs), and their educational requirements and training are quite different. PAs receive three times more clinical hours in training than NPs. On the flipside, NPs usually have more clinical work experience, which frequently balances out their lack of clinical training hours and perhaps levels the perceived training gap between the two groups.

The big difference between PAs and NPs lies less in training and ability, and more in a cultural difference, or a difference in practice expectations. Depending on the state where MLPs practice, NPs increasingly are being delegated as independent practitioners free of the requirements of physician supervision. In contrast, PAs appear to have a career goal that takes them along a path to work dependently with practicing physicians. The cultural, clinical training and competencies of the two groups, (PAs and NPs) are often nuanced, and the difference between NPs and PAs is subtle [2].

Training aside, it is important to understand that for lower-acuity patients, beyond the diagnostic work, 80% of the tasks (and time) to manage these patients does not require the skill sets of a physician. These tasks involve data gathering, reviewing past history, EMR input, and documenting the patient encounter, tracking and reviewing results, writing prescriptions, and other routine patient management tasks.

The job of the physician is to engage in the critical portions of the patient encounter, that being the diagnostic decision-making, management, and treatment planning. By off-loading or delegating the perfunctory work, physicians gain leverage in productivity, at the same time providing that critically important contribution to quality of patient care. This is the direction we should be adopting regardless of whether the mid-level provider is a PA or an NP. Since the advice from physicians regarding medical care is oftentimes critical and time-sensitive, the MLP allows physicians to be more productive and more available for patients. This results in improvement in the quality of care and, from the patient perspective, improves the patient's experience and satisfaction with their care and will probably decrease healthcare costs. MLPs work throughout the entirety of health care from health promotion and disease prevention to diagnosis that prevents and limits disability [3].

Clearly it is important to understand the productivity and workflow advantages generated through the employment of MLPs. The average range of a mid-level provider in 2014 was $90,000–$114,000 per year. That is less than the

cost of even the lowest-paid physicians. The average productivity of an MLP in the office setting is 1.6 patients per hour or about 80% of the productivity of a board-certified physician in the same environment. Adjusting the cost of an MLP for this variance in productivity generates at a minimum of 50% improvement in the cost of care for this lower-acuity subset of patients. That is a significant improvement in financial margins. Theoretically, should we choose to reinvest those margins – one could significantly increase the number of providers available to evaluate patients, thereby reducing wait times and improving both patient safety and patient satisfaction. This is where this workforce strategy begins to solve our demand management dilemma balancing cost and service.

Compensation for MLPs

MLPs are nearly always paid a base salary based on years of experience, with extra compensation for overtime pay, and additional payments for taking call. MLPs participate in standard, all-employee benefit plans and receive additional continuing medical education benefits including some combination of tuition reimbursement/repayment, paid time off for exams and certification, expenses for attending medical conferences, professional dues and subscriptions, and reimbursement for exam or licensure fees.

At the national level, Pas and NPs are paid fairly similarly, as shown in the Table 17.1.

MLPs in surgical and other select medical subspecialties are paid 5–15% more than their primary care counterparts. Even so, salaries for MLP are far lower than those of physicians. This suggests that mid-level providers may represent an option for increasing the capacity of physician specialty practices without greatly increasing payroll costs.

Some economists would argue with the ROI of MLPs by pointing to increased costs associated with their higher utilization of tests and labs. However, there is little data to support this argument. This does not mean that overutilization of resources is not an issue for many physicians and practices who make a decision to utilize MLPs. What is important is that oversight and appropriate supervision allows the physician to reduce this risk. The best advice is to have "rules of engagement" for the MLPs that flag both complicated patients requiring complex workups and to monitor high-cost procedures triggering physician engagement and oversight.

Table 17.1 Total annual cash compensation

	25th Percentile	50th Percentile	75th Percentile
Nurse practitioners	$79,900	$91,500	$105,900
Physician assistants	$77,300	$88,600	$102,200

Outcomes and Liability of MLPs

Malpractice costs for mid-level providers are 10–20% of the cost of emergency physicians. There is no evidence in the literature supporting increased litigation or larger malpractice claims related to independent MLPs in medical offices. In fact, the overall incidence of malpractice claims per provider has been shown to be fairly similar between mid-level providers and physicians and payments for claims involving MLP appear to be lower than claims against physicians. Also, the data suggests that patient outcomes for MLPs are comparable or better than that of physicians [4].

It is necessary in some states to have physician oversight. While many MLPs have their own schedules and see patients autonomously, it is important to remember when physician oversight is necessary. State regulations dictate what degree of physician oversight is necessary for MLPs, so it is essential to be knowledgeable of these requirements.

Credentialing an MLP

Checking any medical professionals credentialing is essential and MLPs are no different. The majority of states require that MLPs be certified in order

to practice. State regulation requirements can vary considerably so it is important to verify what your individual state's regulations require for licensing. National certifications can be verified at:

- American Academy of Nurse Practitioners National Certification Board
- National Commission on Certification of Physician Assistants (NCCPA)

Where Do MLPs Come fFrom?

Hospitals and medical practices can recruit mid-level providers directly from the medical schools and nursing schools that train them or can identify good candidates from their own staff and offer them the additional training they need to step into the role.

There are several recruiting organizations that can find MLPs for your practice. Examples include ihireMidLevelPractioners (https://www.ihiremidlevelpractitioners.com/jobs/titles) and StaffPoointe (http://www.staffpointe.com/),

In the near future, the medical community will be expected to serve more patients with fewer physicians. This reality will require a redesign in the way medical care is delivered, and mid-level providers will likely play a bigger role than they do today. Every practice that is going to consider hiring an MLP should ask several questions:

- Does your practice have a backlog and inability to accommodate new patients? If a practice cannot see a new patient for 4–6 weeks, this may be ego-gratifying for the doctors, but this situation results in patients seeking their health care elsewhere.
- Is the practice paying costly overtime in order to see patients at the end of the day?
- Are there signs of burnout of the physicians and the staff? (See Chap. 22).
- Are there delays seeing patients in excess of 20 minutes? Twenty minutes is considered by patients as the upper limit of a reasonable wait time. Longer wait times to see the doctor results in deterioration in patient satisfaction and poor online reviews.
- Where will your practice find MLPs to see an influx of new patients?
- Will MLPs be part of the solution to physician shortages in your practice?
- What strategies will you adopt to recruit and retain the MLPs you need?
- How will your organization compensate physicians for supervising mid-level providers?

The way your hospital or practice answers these questions will determine your need for an MLP.

Benefits of Hiring MLPs

Physician assistants have become increasingly popular over the last two decades, quickly becoming a valued member in many medical hospitals and medical practices.

Patient satisfaction is one of the greatest benefits of MLPs. Patients frequently report high satisfaction levels when it comes to visiting with an MLP. Many patients report that MLPs are more empathetic and MLPs seem to have more time for them during the visit when compared to physicians [5]. These benefits of MLPs may be due to the fact that they are able to spend more time per patient on health education and answer questions than other medical providers.

A big advantage associated with hiring MLPs is that they can boost the practice's revenue [6]. If you compare an MLPs salary versus their revenue, they can produce three to four times their salary for a practice depending on the specialty. Hiring MLPs can also have the benefit of freeing up physician time. This free time can then allow physicians to provide more focused and often higher grossing procedures and services.

Having another healthcare practitioner helps if you are looking to increase your practice's productivity. Hiring an MLP can allow for patient care in tandem with physicians on a separate schedule or in a satellite clinic. There are a variety of scheduling options available to help boost your revenue.

Hiring MLP can help expand your organization's services. For example, MLPs can be a part of a walk-in clinic and provide specialty procedures or patient educational services. Their clinical flexibility also allows them to adapt to a variety of medical specialties without the need for additional certifications. Many MLPs moonlight in specialties that are different than their primary employment and provide care for pediatric, adult, and geriatric patients.

Hiring MLPs can help augment clinical coverage for overextended physicians on holiday, or if the doctor is delayed in surgery or has a backlog of patients in the clinic. It can be reassuring to know you will have backup coverage when you need it most.

There are compelling reasons to consider expanding the roles of MLPs in both hospitals and physician practices. The timeframe for educating mid-level providers is much shorter than the timeframe for educating physicians, making it easier to increase their presence in the workplace quickly. Practices can recruit MLPs directly from the medical schools and nursing schools that train them or can identify good candidates from their own staffs and offer them the additional training they need to step into the role.

Including MLPs on the clinical staff can enhance scheduling flexibility and make it easier to offer part-time jobs without compromising quality of care. This may help attract and retain physicians beyond normal retirement age and women physicians who are reluctant to commit to full-time schedules.

As MLPs take on expanded roles similar to those of physicians, there will need to be incentive plans which become a standard component of pay, although awards will be more modest in size than those of physicians. Like physicians, we expect mid-level providers to receive incentive awards for productivity, patient satisfaction, adherence to quality standards, and achievement of other organizational goals. The design of compensation programs for mid-level providers will also influence the design of programs for the physicians who supervise them.

MLP-Lite or Using a Scribe to Improve Efficiency and Productivity

One of the challenges that is impacting nearly every physician is the need to improve the efficiency of our practices. In the past we had the luxury of low patient volumes and fat, juicy profit margins. Today, it is the reverse: large patient volumes and razor thin profit margins. As a result, in order to maintain our incomes, we are motivated to improve the efficiency of our practices. One of the most effective methods to enhance the efficiency of any practice is to consider bringing an MLP into the practice.

A frequent complaint by physicians pertains to the increased amount of nonclinical administrative tasks they are asked to perform. Forty-six percent of physicians think that EMR use distracts them from patient care [7]. By utilizing scribes, physicians are able to concentrate on patient care and obtain relief from the administrative burden. Employing scribes has also been shown to improve physician satisfaction and productivity [8].

How Does the Scribe Work?

The scribe interacts with a new patient after the doctor introduces himself/herself to the patient. The scribe then takes the history of the present illness (HOPI) and records the past medical history and the review of systems. The scribe then presents the HOPI to the physician and then accompanies the physician into the room. At this point the doctor may ask a few additional questions or probe any aspects of the HOPI that are not clear or need a more in-depth questioning. The doctor conducts the physical exam and the scribe then records the positive findings in the chart or the EMR. At this juncture the doctor can have a discussion with the patient regarding the diagnosis and the plan of management with the patient and the scribe records the doctor's plan of action. The doctor can then answer any questions the patient may have and the scribe can give the chart or the computer to the nurse who will make

the necessary arrangements for any lab tests, studies, or surgeries, provide the patient with sample medications and written instructions for the use of the medications, provide pertinent educational materials, and make the follow-up appointments. While the nurse is taking care of one patient, the scribe has moved to the next patient, staying one patient ahead of the physician.

Advantages of the Scribe

Most of all, the scribe improves the efficiency of the practice. You are now able to be eyeball to eyeball with the patient and focus on communicating with the patient instead of writing or using the computer. As a result of using the scribe, physicians are able to see five to six additional patients each full day in the office. Also, coding may increase from a previous Level 2–3 to Level 4–5 as the scribe is more thorough conducting the review of systems and past medical history and recording the fine nuances of the physical exam that are often neglected.

How Does a Physician Find a Scribe?

Good scribes who aspire to be physicians can be found in students taking a gap year between undergraduate school and medical school. It is our opinion that the scribe does not need to have a medical background. You are looking for someone with people skills and the ability to communicate with patients in a sensitive and compassionate fashion. The cost of a scribe is roughly $10–$15 an hour. We recommend starting at the lower end and move up as the scribe becomes trained and comfortable in the scribe position.

The disadvantages of having a scribe are cost, time to train the scribe, and the fact that the physician has to change habits from writing in the chart or working the computers to allowing someone else to do the transcription. In the beginning, this can be frustrating, but when you see how efficient you become, you will enjoy the luxury of having a scribe. As a matter of fact, when the scribe is absent or on vacation and you have to use the computer, you will realize how invaluable she is and how effective the technique is to enhance my practice.

Getting Started Using a Scribe

First, decide if you need a scribe. If patients need to wait more than 4–6 weeks to make an appointment for a routine visit, then you have a backlog of patients and a scribe will help you reduce that backlog. If your last patient is scheduled at 4 or 4:30 and you are not finished with patients until 5:30 or 6:00 and your staff is working overtime, then a scribe will help improve the efficiency of the practice. If the majority of your codes are Level 3 or less, then you can improve your productivity by having a scribe. Finally, if you are considering a move to an EMR but are technophobic, then a scribe might be a natural segue to implementing the EMR.

Take-home message on scribes: Few of us can increase reimbursements or make large cuts in overhead without impacting quality of care and patient satisfaction. However, all of us find ways to improve our efficiency and our productivity. A scribe may be just what the doctor ordered.

The Economics of a Scribe

It is very easy to calculate the return on investment of a scribe [9]. First, multiply the hours by the scribe's salary. For example, if the scribe's salary is $15/h and the scribe works 8 h, the cost of the scribe would be $90/day. Next, add the cost of benefits: insurance, parking, taxes, uniform, or about 25% of the salary. In this case it would be $22.50 or $112.50/day.

Next calculate the incremental increase in revenue by having a scribe.

This requires determining how many more patients the provider can see in a given period of time by using a scribe. In most circumstances, the scribe makes it possible to see an additional ten more established office patients a day and an additional four new patients/day. With an average reimbursement for a typical office follow-up patient of $75 and average reimbursement of $125 for a new patient, the daily incremental revenue is $750 for established patients plus $500 for new patients or a total of $1,250/day. Subtract the cost of the scribe $112.50 and that is an ROI of $1,137.50/day. This is perhaps the best investment you can make.

A scribe's economic benefit is usually seen after one to two additional patients a day as that is the breakeven for a scribe. If the scribe can increase productivity beyond two patients a day, then the added income will go right to the practice's bottom line.

Take-home message on using a scribe: There are advantages and disadvantages to the use of a scribe. Your adoption will depend on your comfort after weighing the pros and cons. There is no one right answer for everyone, and we encourage you to explore your options to maximize your practice efficiency.

Case of Cassandra

Cassandra looked into bringing on an MLP. She ran the numbers and showed the office manager that it was in the economic interest of the practice to hire an MLP. She was able to show that she could see at least four additional patients each day and that any patients beyond the breakeven rate of two extra patients a day would make more money for the practice, increase access for patients in the practice, reduce overhead costs, put less stress on Cassandra and the staff, and would ultimately be a win-win-win for patients, staff, and Cassandra.

The Bottom Line

Despite the issues and controversies surrounding the use of mid-level providers or scribes, this option is going to continue to grow. There is no question that hospitals and physician practices will need to change the way they deliver care as the healthcare environment continues to evolve. The aging of our population, looming shortages of physicians and nurses, and increasing access to health insurance all point to needing to care for more patients with fewer providers. Physician practices and hospitals will need to redesign work processes and introduce new technologies to increase efficiency, effectiveness, and employee satisfaction; retain employees and avoid turnovers, and attract a new generation of employees which is going to include MLPs. There is an anticipated shortfall of 40,000 primary care physicians by 2020. Moreover, the US Bureau of Health Professions projects a shortage of 109,600 physicians in all specialties by 2020 [10]. Given the long timeframe required to educate new physicians, it seems certain that MLP will be needed to fill the gap.

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Use of Technology

18

Hunter L. Bohlen, Aakash P. Amin, Thien V. Ninh, Neil Baum, and Marc J. Kahn

Case Study: Ibia

Ibia is a 35-year-old family medicine physician in Virginia. After completing residency 5 years ago, he accepted a job with a mid-sized physician group to establish himself in the area and start earning a living. Ibia paid off his student debt, developed relationships with a sizable patient base, and became a respectable physician in the community. Despite the positives of working for a physician group, Ibia felt as though a number of the group's processes could be better, particularly with regard to technology. His current practice used paper charts and records, which he knew would need to quickly change. Additionally, he felt that the practice was behind the times with rapidly advancing technologies in health care, including wearables, smartphone applications, telemedicine, and precision medicine. Feeling confident that he could make use of these technologies to better and more efficiently care for his patients, Ibia knew it was time to execute the next move: open his own practice.

A number of aspects of the move have already been planned, including a new location and hiring office staff. However, many questions with regard to technology implementation remained. Ibia felt overwhelmed with decisions such as which electronic health record (EHR) vendor to use, which phone applications to incorporate, and how to reach his patients more conveniently using telemedicine. Weighing all these decisions, Ibia felt in need of a guide to help him make prudent, economic choices for his practice.

In this section, we will discuss important considerations in evaluating new medical devices as we find ourselves immersed in a world of constantly evolving technology. Later in this chapter, we will go into more detail on patient wearables, precision medicine technology, and smartphone applications, areas of ongoing technological innovation that affect healthcare delivery.

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"I For One Welcome Our New Computer Overlords"… Not Quite

Imagine being able to recall all the wealth of information that exists in the world within seconds. Envision the ability to read every medical text ever written instantaneously and then select the most likely diagnosis and treatment according to a calculated level of certainty. Picture yourself as IBM's Watson, a question answering computing system capable of interpreting human language, sifting through mountains of data, and providing answers accurately and quickly that it gained its fame by beating the two most decorated game show contestants to have ever played on *Jeopardy*.

Development began in 2004, after one of IBM's project managers witnessed a group at a restaurant gathered around a television to watch Ken Jennings compete on *Jeopardy* during his historic 74-game winning streak [1]. This observation served as the impetus to develop IBM's chess-playing computer named Deep Blue that had defeated grandmaster and world chess champion Garry Kasparov in 1997. In 2011 Watson competed in *Jeopardy* against both Ken Jennings and Brad Rutter, defeating both with a two-game total score triple that of either contestant. It was a resounding victory that quickly made apparent how far computer technology had become. The new computing system had the ability to search for answers better than the most brilliant humans, compelling Ken Jennings to famously quip as his Final Jeopardy answer, "I for one welcome our new computer overlords [2]."

Whether or not we can characterize Watson's abilities as intelligence or thinking can be debated philosophically into perpetuity. Nevertheless, its potential to solve complex issues has produced optimism, particularly within health care. Since its inception, Watson has been adapted to meet the needs of healthcare providers in real time or when the physician is eyeball to eyeball with his/her patient. Watson uses treatment guidelines, electronic medical records, research studies, journal articles, and patient data to formulate hypotheses and provide a list of recommendations including differential diagnoses and suggested treatment algorithms. The excitement surrounding Watson led first to its rapid incorporation into the field of oncology, where it was employed to provide the most effective treatment options for individual patients.

Despite the immense promise offered by Watson and similar AI computing systems, such technology is not without its limits. Unfortunately, recent reports noted that Watson has limited impact on patients and proven ineffective at identifying some cancers, sometimes going so far as to even recommend unsafe and incorrect cancer treatments [3]. This shortcoming is not unprecedented with just computer technology. Both Google and Microsoft have previously built tools ill-equipped to handle the real-world circumstances of health care. Despite the immense computing power of these machines, failed attempts have demonstrated that these tools serve best as an aid to physicians and cannot be relied on to overhaul health care or replace physicians and the doctor-patient relationship. They cannot, for example, offer the best guidelines if they do not understand a patient's price range for treatment or whether staff is available for a given procedure. They also cannot offer recommendations without supporting data. In other words, when faced with uncertainty, they are unable to act on a hunch or a gut feeling which is something that the art of medicine uses to make the best treatment or plan of action for our patients.

Humans are still indispensable in the healthcare process; a condition made evermore apparent by the shortcomings of artificial intelligence – arguably the most advanced piece of technology we possess. That AI cannot supersede physicians is a testament to the intricacies of health care, a complex system requiring both objective and subjective considerations to navigate. It is therefore paramount that humans use technology to our advantage and serve as a compliment to the health care we provide and that physicians remain in control of new technologies and not an attempt to replace the physician.

Electronic Health Records (EHR)

The era of paper charts is over. The first step in the replacement of this age-old system occurred in the1970s, when the first electronic health system, known as the Decentralized Hospital

Computer Program (DHCP), was developed by the Department of Veterans Affairs [4]. Though initially far too expensive and cumbersome for a medical practice (or even a hospital), it was the increased affordability of personal computers and the rise of the Internet that turned this early vision into a reality. In 2011, Medicare introduced monetary incentives for practices that demonstrated "meaningful use" of their EHR. This signal proved a harbinger of how the decade would unfold. Now, electronic records are commonplace in most medical practice, and compliance with "meaningful use" is required to avoid costly Medicare reimbursement penalties. Any physician looking to start a new practice will need to form a contract with an EHR vendor. In this section we will review key considerations one should weigh before making this consequential decision.

Major Players

The electronic health record industry is highly fragmented, with hundreds of different companies offering services in a variety of niches within the medical field. As of 2017, Epic Systems Corp., Cerner Corp., and Allscripts Healthcare Solutions, Inc., occupied roughly 60% of the market, with Epic leading the group at 25.4% market share [5]. Although these companies continue to grow and dominate smaller companies, it should be noted that there is no perfect system on the market, as all of them have flaws and pitfalls. This leaves the door open for revolutionary advancement in the future.

Key Considerations

As a practice evaluates different EHR vendors, several factors need to be considered. A recommended first step is consulting colleagues. This can provide clarity on the pros and cons of different systems and help you narrow down a list of vendors to evaluate.

- Cost: Vendor fees can range between a few hundred to over $1000 per provider per month. Remember, with so many different EHR providers available, they are competing for your business. Like buying a new car, there are ample opportunities to negotiate favorable terms for your practice.
- Ease of Use: Conduct demonstrations with the vendor, as it is important that the program feels intuitive for you and your practice. This is a service they should provide and allow you to "kick the tires" of the program.
- Integration: If you plan to see patients outside of your own practice, it may make sense to have the same vendor as affiliated hospitals in the area. Additionally, make sure that you can e-prescribe to local pharmacies.
- Cloud services: Many vendors offer a cloud-based hosting option, meaning that all hardware outside of your personal computers will be elsewhere. Consider this as an option to outsource IT maintenance costs and also ensure the safety of your data in case of a computer crash that can erase your files and data.
- Customer support: Good vendor customer service is key. Look for a program that provides strong training for your staff and can quickly fix any problem that arises or have tech support that can promptly answer any questions that you or your staff may have.
- Meaningful use: Ensure that your provider has systems in place to comply with Medicare meaningful use to avoid costly penalties. (Marc et al., does this need elaboration and definition of MU?)
- IT security: Security of stored health information is becoming increasingly important as we depend on computerized data for our daily operations. Look for a provider that is cognizant of AMA guidelines for IT security and can help you implement them in your practice.

Medical Devices

For better or worse, we are becoming increasingly reliant on technology to deliver health care. At the time your pediatrician started practicing, he or she may very well have never seen an MRI

image. The first demonstration of MRI as a diagnostic imaging tool was published in 1971, but it was not until 1977 that the first study was performed on a human [6]. It is difficult to imagine that a diagnostic tool considered essential in the workup of many diseases was introduced a generation ago, and that in just 40 years, we have moved from developing our basic imaging modalities to constructing a computer capable of competing with the human mind.

As of 2019, the US medical device market had an estimated value of $39.2 billion, with hundreds of competing companies ranging from behemoths like Medtronic PLC to companies of 20 people or less working on a specific invention [7]. For reference, the 2003 market was occupied by only a few major players and valued at $3.5 billion. The FDA divides medical devices into classes I, II, or III. Class I includes basic items such as gloves or stethoscopes, moving up to class III which includes high-tech devices that have the potential for significant patient harm. FDA regulation and premarket testing requirements are more arduous as a device moves up the chain from class I to class III.

The three main drivers behind adoption of a new technology in health care include patient perception, physician perception, and financial reimbursement [8]. Often, patients will request treatment with a recent technology or drug they read about or saw advertised. These requests may alert you to a new innovation; however, patient perception should not be a driving factor for adoption without underlying scientific proof of concept. Early adopting physicians serve as the second driver while the reimbursements that often incentivize hospitals and physicians to adopt in the first place are understandably the third. We recommend healthy skepticism when encountering a new technology, particularly those in FDA category III that have the potential for patient harm. Many devices have become rapidly popular only to prove harmful down the line. Be wary of financial incentives that company representatives or other physicians may have in advocating for a new technology. The key factor that should influence adoption of new technology is the same factor that underlies our medical training: look for innovations that have been studied with prospective, randomized, controlled trials and have demonstrated efficacy compared to what is currently available.

Medical Wearables

Did you meet your step goal today? Fitbit, a major player in the health fitness tracker market, starts their consumers off with a daily 10,000 step goal. For an average person, this amounts to almost 5 miles of walking a day. Health benefits of this trendy endeavor are inconclusive, but nevertheless, the concept has captured the minds of the public, swaying millions of registered Fitbit users to be more active than they might be otherwise. If we had to select one invention or device that has motivated Americans to get off of their chair in their sedentary job, it is the Fitbit.

This example above highlights the current fervor for health fitness trackers. Yet, this enthusiasm represents only a portion of the larger craze for an array of technologies now labeled as medical wearables. Defined as worn autonomous devices that provide medical monitoring or support over a prolonged period, medical wearables are already being touted as positive disruptors of the healthcare industry. This claim rests largely on the potential benefits of these technologies, namely, the ability to collect data in real time, continuously monitor patients, empower patients, improve medical compliance, serve as a motivator for physical activity, and predict the risk of developing conditions.

One emerging category of medical wearables is for diabetic patients. Continuous glucose monitors (CGMs) track glucose levels throughout the day using a tiny wire placed under the skin. Glucose levels are measured through the interstitial fluid, and readings are then sent wirelessly to a receiver. These real time measures allow patients to closely monitor how their body reacts to meals, certain foods, activities, and medications. Ultimately, this data helps diabetic patients better understand their condition, allowing them to take a more proactive role in their care. In 2018, these devices were further improved

through the combination of closed-loop insulin systems, effectively creating an "artificial pancreas." New devices, such as the MiniMed 670G, can monitor glucose in real time and automatically adjust the delivery of basal or long-acting insulin. According to a clinical trial following the use of the MiniMed 670 G in 129 patients, A1C levels dropped from 7.7% to 7.1% in adolescents and 7.3% to 6.8% in adults [9].

The wearable industry is also innovating in cardiology with the Zio patch, a single-channel continuous-recording ECG monitor that is powered by the world's largest heart rhythm database. The creators, iRhythm, aim to reach maximum patient compliance through the device's miniature size (5 by 2 in) and waterproof, wireless design [10]. In obstetrics, the AVA bracelet, or the "Fitbit for fertility," is a FDA-approved wearable that monitors a female's menstrual cycle with an 89% accuracy [11, 12]. Worn at night, the bracelet monitors a woman's skin temperature, pulse, and sleep [13, 14], factors the company believes are correlated with the hormonal changes in a woman's cycle. In ongoing research, the AVA bracelet may eventually capture the physiological changes that stem from pregnancy [15]. Further progress in this technology may change the way pregnancy is routinely detected at home.

The market for wearables will continue to expand. These devices are appearing in all realms of health care, and although some may fall short of their goals, physicians must be prepared for their advent. Particularly, physicians must decide how they will incorporate wearables in their practice and how they will handle patients that employ wearables at home. Presently, the elephant in the room regarding the value of wearables is how should practitioners handle the data? One of the major benefits of wearables is to continuously monitor patients, collecting information in real time. However, most doctors would agree on the importance of the reliability and consistency of this data, traits that cannot be guaranteed with current technology. Without confidence in the data, physicians will, and should, employ caution in utilizing the data for the counseling of their patients. Therefore, it is vital for clinicians to be aware of the popular wearables their patients may use and understand the limitations and benefits of these technologies. This underlying knowledge will help doctors decide the extent in which wearables may be utilized in their practice. In 2016, a survey of 1300 physicians by the AMA found that 85% of the physicians believed there is potential in improving care through wearables, but less than 30% of the doctors had incorporated it into their own practice [16]. Nowadays, wearables have picked up tremendous momentum, and regardless of their opinions on the technology, clinicians will soon encounter patients who bring in their wearables and want an explanation of the data it collected. Physicians should consider how they will approach the situation: allow the data to influence the management of their patient, treat the data as inconsequential, or something in between.

Precision Medicine

Approximately 3 billion base pairs in size, the human genome required an international effort to sequence the first time. The Human Genome Project was conducted by 20 research institutions located on 3 separate continents. Even so, the ambitious project spanned 13 years beginning in 1990. This sequence, finally published on April 14, 2003, ultimately cost a staggering $2.7 billion [17].

Today? Now, anyone can go online and purchase a personalized sequencing for $999 with a turnaround of results in 3 months [18].

In no small part, the Human Genome Project and subsequent technological advancement have created a new era of medicine: one that emphasizes care for the individual rather than a "one-size-fits-all" medical approach. This concept is labeled, often interchangeably, as personalized or precision medicine. Precision medicine describes the customization of medical care based on a patient's individual genetic content, environment, and lifestyle. Although the term may be new, the idea is not. Doctors have matched blood types in patients before transfusions ever since blood groups were discovered in the early twentieth

century. However, the potential to individualize medicine across the board has never been greater due to the breakthroughs in genetic research and cost reductions. Already, companies promise patients the ability to be more proactive in their health by offering insights into their disease risks and drug sensitivities.

These claims by sequencing companies may appear fantastical, but gene studies have been affecting patient care for decades, particularly in the realm of prevention. Looking at risk factors, researchers discovered the BRCA genes in 1990 and extensively studied their association with breast cancer. Now, guidelines encourage patients with mutated BRCA genes to consider breast cancer risk-reducing mastectomy and ovarian cancer risk-reducing oophorectomy [19]. Besides breast cancer and its association with BRCA, several other diseases are also significantly linked with specific gene mutations, including Lynch syndrome and familial hypercholesterolemia. In all these cases, sequencing data allows physicians to customize the health care to each patient and maximize disease prevention.

Beyond prevention, gene sequencing can also optimize treatment of disease for certain individuals through the identification of more effective medication. For example, cystic fibrosis (CF) is caused by mutations in the CFTR (cystic fibrosis conductance regulator) gene, creating over 1900 CFTR protein variants. Although cystic fibrosis is usually treated symptomatically, Ivacaftor is a rare drug that can not only treat the underlying cause of CF but also works on patients with specific mutations.

Similarly, cancer management has benefited from gene sequencing and subsequent precision medicine. Treatment of cancer is generally through a combination of surgery, chemotherapy, and radiation therapy based on the type of cancer and its staging. However, with sequencing, targeted therapies have been designed to employ specific cancer markers against tumors, such as with imatinib and the BCR-ABL kinase in chronic myelogenous leukemia. Today, the availability of drugs that can target specific markers found on a tumor is quite limited. Furthermore, several recent studies have found that targeted therapies fail to help 90% of cancer patients [20, 21]. Regardless, the hope is that one day the treatment of cancer will be guided largely by sequencing, allowing clinicians to effectively individualize medicine to combat each individual patient's tumors.

The promise of precision medicine remains bright, but the initiative is still in its infancy. The way forward will require significantly more research into the impact of genetic variation on a patient's health and the overall efficacy of precision medication. Currently, conclusions drawn from variations on risk factors are often imprecise, as demonstrated by an experiment published in 2016. Vanderbilt researchers asked three labs to select variants in two genes with known associations with heart rhythm abnormalities. Of the 57 different variants the labs chose, only four were selected by all three labs. When using the data to examine 2022 patients' health records, the scientists found that only 35% of the patients who possessed these variants had any abnormalities [22]. Clearly, the research has not progressed far enough for clinicians to accurately predict risk factors from a patient's genetic sequence. Therefore, with the current technology, precision medicine may simply be of limited use for the average patient.

Nevertheless, practitioners need to be aware of the ongoing research into precision medicine and sequencing. Data on genetic variation has already influenced medical management in certain realms, such as in CF, and this trend will likely expand with newly developed drugs and treatments. Of recent significance, the novel CRISPR-Cas9 system and its powerful functionality in editing genomes may usher in an exciting revolution in genetic therapy and precision medication. Now, more than ever, physicians will need to counsel patients on their genetics and personal risk factors. Of course, the imprecision of current data and treatment should be stressed. Still, clinicians can now open discussions with patients on the possible implications of their sequencing data and encourage patients to continue being proactive in their health and disease prevention.

Applications

Smartphones have revolutionized society and industry. Smartphones provide an array of applications that provide previously unimaginable assistance and convenience in managing our everyday lives. Among these applications are those designed specifically for health care. Some of these are geared toward patients, while others contain such a wealth of information that is indispensable to a physician's daily operations. This section will address the latter, exposing the reader to various applications that can assist physicians with dosing medicines, diagnosing illnesses, and more. Given the sheer volume of information in medicine, any medium that streamlines the information for ease of access is a benefit to our industry. The best tools are those that easily provide accurate information – thoroughly researched and peer-reviewed facts.

Enter UpToDate, a database of comprehensive articles based on the most up-to-date research, curated and updated by teams of expert physicians. A subsidiary of the Dutch global information services company, Wolters Kluwer N.V., UpToDate is an evidence-based clinical resource founded in 1992 by Dr. Burton Rose, a nephrologist who sought to convert his textbook into a computer-based clinical tool [23]. Since then and with the help of over 6000 physician authors, editors, and peer reviewers, the database has expanded to contain information relevant to 25 medical specialties and counting. The database has evolved into one of the foremost repositories in the medical field, and the amount of usage is staggering: over one million UpToDate topics are viewed daily around the world. Many practitioners agree that this tool is most effective if used at the point of care, influencing immediate decisions when doctor and patient are eyeball to eyeball. So useful is this information database that it is often made available for free in countries following a natural disaster, specifically after the 2010, 2011, and 2015 earthquakes in New Zealand, Haiti, and Nepal, respectively. Important to note is the offline capabilities of this application. Simply having an operational smartphone, whether or not with cellular data, is sufficient to access the plethora of articles and features – perfect for societies with limited resources.

Though well-endowed with a wealth of information, the database would be irrelevant if the information were inaccessible. A resource is only as valuable as its availability, which UpToDate excels. The home screen of UpToDate is organized into five tabs: [1] My UpToDate, [2] Contents, [3] Calculators, [4] Drug Interactions, and [5] Settings. The "Settings" tab provides relevant account information but more importantly enables users to customize the application and select their specific language. The "My UpToDate" tab similarly allows customization by providing access to the user's personally bookmarked and most viewed articles. The remaining three tabs contain the wealth of information that make the application an incredible resource. The "Drug Interactions" tab allows users to enter the drug of interest and then populate a list of other substances that interact with that drug alongside a risk rating for that substance. The "Calculators" tab leads to a vast, alphabetically ordered list of both clinical criteria and medical equations for almost every medical specialty. These specific medical specialties – immunology, anesthesiology, cardiology, dermatology, emergency/family/internal medicines, endocrinology, gastroenterology, general surgery, geriatrics, hematology, oncology, infectious disease, nephrology, neurology, obstetrics and gynecology, palliative care, pediatrics, psychiatry, pulmonology, and rheumatology – are listed under the "Content" tab, along with a subcategory titled "What's new" that allows users to access the most recent content for each specialty. Lastly, one of UpToDate's greatest assets is its search bar. Because UpToDate was designed to answer the most pressing questions a physician may have, its search bar is exceptional at populating lists of relevant articles based on keywords that may be vague or abstract.

Two other applications similar to UpToDate in that they serve as virtual encyclopedias are Epocrates and Medscape. Epocrates' Drugs, Calculators, and Guidelines tabs and Medscape's Drugs, Drug Interaction Checker, Conditions, Calculators, and Latest Clinical

Guidelines tabs reflect an abundance of reputable content. Basically, all three websites provide a treasure trove of medical information, but each one emphasizes a different attribute. Where UpToDate concentrates on amassing articles, Epocrates excels more than any other application in terms of its mastery and presentation of drug information, including suggestions based on symptoms. Likewise, Medscape differs from UpToDate by being more interactive, offering users Cases, Quizzes, and Trends as well as a Pill Identifier feature that allows users to identify a pill based on its shape, color, form, and markings. Perhaps the most important attribute that differentiates Medscape is its pricing and savings tab. This feature begins the segue into applications that addresses more individualized patient needs.

While UpToDate and Medscape are more or less concerned with providing users with the entire cache of medical science knowledge, these individualized applications have an extremely narrow focus, choosing instead to provide just one function. For example, the sole purpose of GoodRx is to direct patients and providers toward affordable medication. It does this in two ways: by providing coupons and by locating the nearest pharmacies offering the lowest prices for a particular medication. It is readily apparent how useful this could be to any practitioner but especially those whose patient population are impoverished or struggling with medication adherence. Another application with singularity of focus is MDCalc, which concentrates solely on performing calculations that can diagnose a patient, provide a prognosis, or accurately dose medicines for specific medical conditions.

The rapid procession of technology can be terrifying and for good reason. With it has come immense destructive potential and a threat to our very sense of self and position in life. We fear we may become subservient to technology, and one can argue that we have indeed become overly dependent upon technology. As health care has shown, however, humans are irreplaceable. The most sophisticated, advanced computing system has proven incapable of completely revolutionizing medicine, so the need for competent, well-trained physicians is as important as ever. The most capable physicians are those who embrace technology and use those very tools that remain firmly in the palms of their hands.

Telemedicine

Since the time of Hippocrates, doctors were eyeball to eyeball with their patients. Telemedicine or telehealth, in which patients are diagnosed and treated remotely by the use of telecommunication, offers to change this age-old paradigm. Though first introduced nearly 20 years ago, telemedicine has been slowly adopted by the medical community, as many physicians and patients feel uncomfortable about patient care taking place without both parties physically present. Though this and other barriers exist before incorporating telemedicine into your practice, it offers an exciting new technology that can help you reach more patients, manage certain patient groups more effectively, and make your practice more profitable. Telemedicine is a growing field. Improved technology, increased cost efficiency, and doctor shortages make this technology appealing to patients, providers, and the healthcare industry as a whole. In 2018, 12% of telehealth visits replaced traditional office, and this figure is projected to expand in the years to come. In this section we will discuss important aspects you will need to consider while incorporating telemedicine into your practice.

Vendor Considerations

Forming a vendor contract with a telehealth provider is an essential first step. This phase can be approached similarly to how it was approached when forming a contract with an EHR provider. We recommend designating a point person in your practice to lead this transition. This makes

the whole process smoother, with one person bearing responsibility and managing issues that may occur. Consider the following questions when evaluating potential telehealth vendors.

- Does the software's functionality fit your intended use case?
- Is the software highly secure and is the vendor knowledgeable about patient privacy protections?
- Is the platform easy to use, for both staff and patients?
- Does the vendor offer ongoing technical support after purchase?
- Does the company offer help with implementation and patient adoption of the telehealth solution?
- What's the vendor's pricing model? Is the cost affordable and will it bring you an ROI?
- Does the solution require purchase of addition equipment, training packages, and IT setup?

Practice Considerations

A number of barriers exist before implementing telemedicine services in your practice. Know that none are insurmountable, but conquering them will cost time and money. Fortunately, organizations such as the American Telemedicine Association (ATA) have established clear guidelines for using telehealth in a variety of specialties, helping to knockdown these barriers to entry.

- How will you use it: The first step is to identify your purpose for using telemedicine. Will you be offering video chat appointments or using it for brief encounters such as medication refills? Will you target a specific patient population, such as rural or homebound patients, or perhaps only those with certain medical conditions? Identifying a goal is necessary to focus your efforts as you incorporate this technology.
- Mastering the technology: Telemedicine offers a different clinical workflow that provides a stumbling block for some providers. Consider how these appointments will differ from your in-office appointments, and how your diagnostic and clinical skills will need to adapt to treat patients in this new context.
- Logistics: Consider how you would like the flow to work for your telehealth appointments, from the point a patient first indicates they would like an appointment, all the way to filing a claim. Make note of key differences between telehealth appointments and in-office visits and prepare accordingly.
- Encouraging patients: Marketing your telehealth program to your patients is a crucial step in building the program. If patients don't know you are offering telehealth visits, there is no way they will participate. Common tactics include adding a recorded statement about this service to your phone message, updating your practice website, and having your receptionists mention the service when they are calling for appointment reminders.
- Telehealth policies: Public policy regarding use of telemedicine varies from state to state and will affect how you connect with patients using this technology. Issues that may arise include patient informed consent for telemedicine visits, prescription restrictions, interstate licensing issues, or initial patient encounter restrictions. Familiarize yourself with laws for your state using the resources available on sites such as the ATA's state policy webpage (http://www.americantelemed.org/policy-page/state-policy-resource-center).
- Billing: Beyond state policy guidelines, the major payers (Medicare, Medicaid, and commercial health insurance companies) have their own requirements regarding telehealth reimbursement. Navigating reimbursement guidelines for each payer requires time and effort but is an important step before launching your program. Fortunately, Medicare and most commercial plans have been expanding coverage for telehealth services in recent years.

Bottom Line

1. Use technology to your advantage. Coexisting with available technologies will make your practice more effective.
2. Pay attention to disruptive technologies that alter the paradigm of patient care. Adapt or become obsolete.
3. Do not be blindsided by new technology. Not all new technologies will mature, so evaluate technology with the same scrutiny you would new research in your field.
4. Remember that high tech is not the solution to modern medicine; it is high tech plus high touch!

Return to the Case

After careful consideration, Ibia felt as though he had made prudent decisions that would help him incorporate new technologies into his medical practice. He met with a number of EHR providers and ultimately selected one that he felt was affordable, easy to use, and well-tailored to the needs of his practice. Based on his prior experience, he knew which patient wearables were popular in the community and trained his staff to be aware of these technologies. Further, he developed a plan with his EHR provider to have data from these patient wearables uploaded into the patient record. Ibia equipped his smartphone with applications that he felt would help with day-to-day workflow, purchasing subscriptions to UpToDate and Epocrates. He did more research on innovations in precision medicine, familiarizing himself with technologies that are likely to affect his patient population in the near future. Lastly, he appointed his nurse practitioner as the project leader for the telemedicine branch of his practice, putting a plan in place to incorporate this technology over the next year. As a result, Ibia had a state-of-the-art medical practice. His patients were very impressed with his cutting-edge application of technology to their healthcare needs. In short, his practice was pioneering the marriage of clinical practice and technology.

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Academic Practice

19

Marc J. Kahn and Neil Baum

Case: Tucker

Tucker is in her final year of her pulmonary/critical care fellowship at a major academic medical center on the West Coast. She graduated in the top of her class as both an undergraduate and as a medical student and was asked to be chief medical resident prior to her fellowship. Tucker is trying to decide the next step in her career. She enjoyed teaching medical students and residents, but does not like conducting research. Her training has prepared her for a career in academic medicine, but she is not sure if this is the right career path. She has heard discussions about salary from last year's fellowship graduates and is well aware of the difference between an academic and private practice salary. Is academic medicine right for her?

In 1765, the first allopathic medical school in the USA was founded by Dr. John Morgan who received his MD degree at the University of Edinburgh Medical School. Morgan and Dr. William Shippen Jr., a fellow Edinburgh graduate, convinced the Trustees of the University of Pennsylvania to start the first medical school in the 13 colonies. By the mid-1850s, the University of Pennsylvania School of Medicine had a distinguished faculty including Benjamin Rush, Philip Syng Physick, William Pepper, and Joseph Leidy. When the AMA was founded in 1847, Nathaniel Chapman, a professor of medicine at Penn, was named the first president. From this auspicious beginning, academic medical centers (AMCs) currently number over 140 and provide 20% of the country's medical care and 40% of US charity medical care [1]. AMCs manage 60% of the country's Level 1 trauma centers, graduate over 17,000 doctors, and train over 30,000 residents and fellows. Unlike other professions, medicine is one of the few that combines education, research, and operations in a single organization. Law schools do not operate law firms, and business schools do not manage corporations. Vertical integration of AMCs allows for some efficiencies but also can be a source of stress. Of the three missions of an AMC, patient care, research, and education, only patient care generally has a positive margin and these are forever decreasing.

When investigating why physicians choose careers in academic medicine, the literature suggests that medical school graduates with other advanced degrees (PhD, MBA, MPH) or advanced fellowships are more likely to choose academic careers [2]. The desire to teach, con-

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duct research, and the influence of a positive role model also contribute to a physician choosing an academic career.

A career in academic medicine can follow several paths; not all academics are specifically involved in scientific research, but academic physicians support the tripartite mission of an AMC: clinical care, education, and scholarly productivity.

One of the biggest differences between an academic job and one in private practice is the way that the physician's salary is supported. In private practice, income is derived primarily from clinical care—seeing patients, billing for procedures, and managing complex hospitalized patients. In academic medicine, income is still fundamentally derived from clinical care, but academic physicians have the opportunity to substitute teaching, research, or administrative responsibilities for clinical time. Because these other activities produce much less revenue than clinical care, in general, the salary of an academic physician is moderately lower than that of a private practice doctor working in the same field.

There are basically four types of academic physicians: physician scientists, clinician educators, physicians working in academically based practices, and physician administrators.

Physician scientists are paid for doing research. Their salaries are typically supported by external grants and contracts. Using the clinical care model, physician scientists *buy back* their clinical time with grant support. The physician scientist model is what is most commonly thought to represent academic medicine, but in fact, physician scientists are a small percentage of most medical school's faculty due to the difficulty in obtaining grants. Currently, the NIH funds much less than 20% of grants are submitted. In addition to directly contributing to the reputation of a medical school through published work, physician scientists also add value to their institutions through grant overhead. Grant overhead is used to support the research infrastructure of a medical school and could amount to 50% of the total grant support. However, research dollars are not a windfall for AMCs. A recent report for the Association of American Medical Colleges (AAMC) concluded that AMCs spend an additional 53 cents for every dollar of sponsored research that they receive [3].

Clinician educators buy back clinical time through teaching medical students, interns, and residents. Although they are still expected to participate in scholarly activity, this is typically accomplished through curricular development and assessment. Clinician educators sometimes have additional administrative titles such as course directors, program directors, or vice-chairs for education in departments. Because clinician educators are relatively expensive, their positions are limited. Many medical schools, recognizing the value of clinician educators, have established specific academic tracks for these physicians in order to get promoted.

As medical schools have struggled to provide clinical material for their trainees over the past 10 years, there has been an increasing number of faculty who have their clinical practices affiliated with a medical school. Sometimes, these physicians are employed by the medical school. Sometimes, they have a faculty appointment without salary. Academically based clinicians are vital for the success of the educational mission, and these physicians typically enjoy working with trainees, enjoy keeping up to date through their trainees, and value an academic appointment at a medical school. Many practices use clinical affiliations to market and promote their physicians. The public sees value in medical school faculty assuming they are up to date and assuming that they are experts in their field.

Finally, every medical school has physicians that are hired to serve administrative roles. Such roles include the dean, the associate and assistant deans, and department chairmen and women. These physicians substitute administrative time for clinical duties. As with the clinician educators, physician administrators are expensive and typically limited in number. Typically, administrators are hired through an external search. Less commonly, they are hired from within the institution. The typical "head hunter" is less knowledgeable about academic physician leadership positions. Information on academic jobs can be found on the AAMC Career Connect website

(https://careerconnect.aamc.org/jobseeker/search/results/) and through search firms who specialize in such positions.

Although we have divided academic careers into four groups, in fact, many academic physicians play multiple roles and may overlap between the four aforementioned groups. One word of caution, to be successful, an academician should spend a majority of their time in one of the roles. Spending 25% of time in each of these roles is not likely to lead to success in any one area of academic medicine. Additionally, to be a successful academician and get promoted, you must demonstrate some type of scholarly activity. This may be not only through publishing in peer-reviewed manuscripts but may also be through developing novel curricula that are used by other institutions. National or regional presentations at specialty societies are other examples of scholarly activity. Finally, do not forget that there are platforms for publishing education-based research. These include journals such as Academic Medicine (https://journals.lww.com/academicmedicine/pages/default.aspx), Teaching and Learning in Medicine (https://www.tandfonline.com/loi/htlm20), and Medical Teacher (https://www.tandfonline.com/loi/imte20). Additionally, the AAMC sponsors a repository for curricular design called MedEdPORTAL (https://www.aamc.org/services/445540/mededportal.html). Submissions are peer-reviewed and are assigned a unique PubMed number so that they can be searched and accessed.

In addition to the obvious differences in job responsibilities, academic physicians typically have lower salaries than those in private practice. One positive aspect of looking for an academic job is that academic salaries are published annually from the AAMC and are broken down by specialty and geographical location and are further divided into private and public schools. Having this information makes negotiation easier (see Chap. 5).

Academic positions may also come with unique benefits such as tuition coverage for yourself and your dependents. This can be a very valuable incentive as college tuitions continue to rise. Also, academic positions tend to come with a more generous allotment for continuing medical education and conference attendance. Universities typically have a matching program for money put away for retirement. As an academician you are hired by a hospital, AMC, or medical school. You do not incur the costs of setting up an office, marketing, or getting malpractice insurance. Typically, these are provided by the academic practice and are paid for through overhead charged on clinical revenue. Benefits such as these can make an academic salary more attractive.

Academics are divided into faculty ranks. Typically, a new academician is appointed as either an instructor or assistant professor. The differences between these two positions include job responsibilities and salary.

Often the goal for an academician is to achieve tenure. A tenured appointment is an indefinite appointment which can only be terminated for cause or under extraordinary circumstances, such as program discontinuation. A physician scientist may prefer to start out as an instructor because often the "tenure clock" does not start until a faculty member is an assistant professor. This allows the faculty member to get a running start on grant funding to help insure promotion at the proper time. After a prescribed period of time typically outlined in the faculty handbook, assistant professors can be promoted to associate professors and finally to full professors. The promotion process is dependent on scholarly activity, grants and contracts, clinical care, teaching ability, and letters of recommendation from external peers. Universities have a promotion and tenure committee who make such determinations. Some academic positions are eligible for tenure, some are not.

Tenure or Not?

Tenure began in US colleges and universities in the early nineteenth century when professors were under the auspices of the board of trustees of universities and influential donors could have professors removed, censured, or demoted. In 1900, Harvard University, Columbia University, and the University of Chicago entered into a pact and decided that donors could no longer exert influence over a professor's hire or employment.

In 1915, the American Association of University Professors (AAUP) established principles of academic freedom and tenure. Tenure was originally granted after 10 years (hence its name) for distinguished scholarly activity and value to the university. In 1940, the AAUP recommended the probationary period without tenure be decreased from 10 to 7 years.

Tenure remains a contractual right that grants a professor a permanent position, yet the guarantee of salary is often murky. Tenure provides protection against termination without cause and allows for academic freedom. However, currently, most universities have provisions for academic freedom outside of the tenure process. So, is tenure important for academic physicians? Yes and no. The vast majority of academic physicians are not tenured. This is because many universities reserve the tenure track for those professors who are involved in research and leave the nontenure track for clinicians and educators. Because most academicians do not have external grant funding, they tend to be on nontenure tracks. Tenure is less important for physicians who can typically find another job quickly in case of separation. Job security is less important for a cardiologist with specific expertise in electrophysiology whose services could be used at a number of health facilities. In contrast, this is not the case with a professor of English or folklore who may have difficulty finding another job, especially if they are looking off cycle as most academic jobs start in the beginning of the academic year. As stated, academic freedom is afforded to all, so this is also not a good argument for tenure. Further, tenured professors can be terminated for cause or in case of financial necessity. Because the association between a position and salary is unclear, most universities do not guarantee a full salary indefinitely to a tenured professor.

What is the value of tenure? Tenure is an accomplishment like any other. In many universities there are benefits to being tenured including the opportunity to serve on certain committees and the sense of accomplishment that tenure affords. It is more difficult to terminate a tenured professor and typically termination requires a much longer notice than for nontenured faculty. One of the risks of being considered for tenure is that if you are denied, theoretically, you would have to leave the university. In all, academicians often do not have the choice of academic track as it is usually determined by the responsibilities of the individual faculty member.

Regardless of track, every academician should closely review their faculty handbook, faculty bylaws, and faculty constitution to understand expectations for promotion. We recommend doing this at the time of employment. Sometimes, it may be possible to switch from a nontenure to a tenure track. The specific procedure for a track switch and the rules for doing so are typically articulated faculty handbooks. Sometimes there is a time limit for a switch such as prior to year seven of employment, and sometimes there is an approval process that must be signed off upon by the dean or chair. The faculty handbook is an academician's contract that dictates rules, procedures, and remedies.

Finally, because of the very real salary differential between academic and private practices, academic physicians have to find some value in their jobs so as to not become frustrated. Academicians who are basically in private practice with a reduced salary do not tend to stay in academics very long.

Back to the Case

After much introspection, Tucker decided that a career as a clinician educator was the right decision. Tucker realized that a job that did not involve teaching would be less fulfilling. Tucker met with the business officer in her department and was able to get a copy of the AAMC Faculty Salary Survey. She believed this would be very valuable to have with her upcoming salary negotiations. Tucker also realized the importance of reviewing the faculty handbook once she settled on a position. She expected that she would not be on a tenure track, giving her flexibility to spend more time with patients and more time teaching. Tucker looked forward to the months ahead.

Bottom Line

1. There are basically four types of jobs in academic medicine: clinician educator, physician scientist, academically affiliated clinician, and physician administrator.
2. Although academic positions generally pay less than private practice, there are benefits to becoming an academic physician.
3. The Faculty Handbook is your friend in academics. Make sure you are familiar with it early in your career.

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Part III

Growing a Practice

Gaining Recognition in the Community

20

Marc J. Kahn and Neil Baum

Case: Valda

Valda is a dermatologist with fellowship training in MOHs surgery. She has been in practice 18 months and wants to do more MOHs surgery than general dermatology. Valda believes that she does not have to depend on referrals from primary care physicians or internists. Rather, she believes that she can reach out to patients directly and inform them of her areas of interest and expertise. How should she proceed?

Today, more than ever before, the new physician has the opportunity to carve and sculpt their practice using ethical marketing techniques. This chapter will focus on the new physician and how to grow and actually use marketing techniques to create an ideal practice.

Everyone who went to medical school has learned how to diagnose and treat medical conditions. However, there are few doctors who received training on how to market and to promote their skills in an ethical, yet effective fashion. The reality is everyone is going to be required to use ethical marketing techniques in order to be successful.

There are four ingredients of a successful marketing program: internal marketing, external marketing, the internet/social media, and the ability to attract referrals from colleagues and other referral sources.

Internal Marketing

Internal marketing is considered the low-hanging fruit, which is readily available to every physician before considering larger, more expensive marketing opportunities. It is much easier to start in one's own backyard by making certain that current patients have a positive experience. If they do have a positive experience, those patients will share their opinions with others who may subsequently become patients in the practice

Most physicians are probably very familiar, and also comfortable, with internal marketing because they are already doing it but may never have thought of it as marketing. The tactics associated with this sphere of marketing include informing and educating patients about available services and actively asking them to refer family and friends. For example, if a doctor performs a new office procedure, and the patient has a good experience, then it is easy to give the patient educational materials to share with friends who

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might be interested in the same procedure. You can expect that one of every three patients will pass the material to family, friends, and others, and this will result in new patients who call to schedule an office visit and inquire about the procedure.

Treating patients with respect and improving patient satisfaction is another aspect of internal marketing. So, too, is upgrading the decor of the reception area and avoiding a robotic phone tree answering system, so that every patient can easily speak to a human in the practice, not a computer. Even employees are part of the internal marketing program as your employees will tell their friends, family members, and others about the physicians in the practice and their areas of interest and expertise. It is therefore important to educate, train, and engage staff so they are knowledgeable and enthusiastic about the practice and can pass that enthusiasm onto the patients.

Internal marketing can be relatively inexpensive, but it is a slow process that requires daily attention to the numerous details that help patients recognize that their physician is highly skilled and that the medical practice is friendly, accessible, caring and compassionate.

External Marketing

External marketing is nothing more than making potential patients aware of practice services and areas of expertise. The public truly does not mind marketing if they believe the information is honest and clear and provides educational value. However, external marketing or getting the word out to the public is the component of any marketing program that makes some physicians uncomfortable. It is not uncommon that physicians often think that marketing is synonymous with advertising. It is possible to inform the public about a physician's areas of interest and expertise without spending large amounts of money—and doing it in an ethical and professional fashion that certainly does not violate the Hippocratic Oath.

There are inexpensive techniques to increase a physician's visibility within the community, the region, and even on a national level that do not require additional staff or anything more than minimal assistance from the hospital's public relations and marketing departments. The essence of external marketing is writing and speaking. The rest of this chapter will focus on these two components of external marketing.

Examples of External Marketing

The physician can offer public seminars on popular topics like wellness, nutrition, and cancer prevention that are almost universally appealing. The practice can sponsor support groups that match the interests and expertise of physicians in a practice. Support groups can be created to target audiences according to specific diseases, diagnoses, and treatments and even specific demographic groups such as senior citizens, certain ethnic groups, or millennials.

If you are conducting a seminar on a disease or condition, it is a good idea to have a patient with the specific diagnosis or condition—preferably treated by a physician conducting the seminar—attend the seminar or the support group. This patient can describe how the problem affected their quality of life, any details about procedures that they have undergone they care to share, and their experience following the procedure—of course with kudos to their doctor. Potential patients will get to know the physicians that sponsor the support group and their areas of expertise, and they will know where to go when a medical issue arises. Support group meetings or lectures can take place in the hospital, in an ambulatory treatment center lobby, or even in the practice's reception area.

Charity auctions and similar community events are another low-cost marketing opportunity. The physician may wish to offer his or her services as part of an auction for a school or local charity. For example, one can consider a donation of a no-scalpel, no-needle vasectomy to a local school's annual auction. The title in the auction book could be, "School Tuition Getting You Down? A No-Scalpel, No-Needle Vasectomy Is a Solution." Even if those attending the auction do not respond on the day of the auction, a few men

will probably be calling the office to make an appointment for the procedure weeks, months, or even a year later. Even for physicians who do not do procedures, a charity auction might be a great opportunity to offer a free wellness visit, or a free smoking cessation consultation. The cost of this kind of external marketing to the practice is negligible.

Targeted Marketing

Serving the health care needs of various ethnic populations presents a unique marketing opportunity to the culturally competent physician. It is best to begin by identifying the particular community to target. That may depend on area demographics, a physician's own ethnic background, or the languages you or your staff speak. There are community websites specific to a particular ethnic group and directories that offer the physician the opportunity to be included. For example, the Vietnamese Yellow Pages can be easily reached through http://www.yellowpages.vn.

Most cultural groups also have an effective word-of-mouth network. If a physician is accepted by a few members of an ethnic group in the community, word will travel fast, and the physician can expect to become a lifelong provider of health care to their community. Another benefit to marketing to various ethnic communities is that grateful patients will often refer family members from their native countries who come to the United States for their medical needs. If they know that the physician can communicate with their relatives, they are likely to use that practice for their medical care. An advantage of attracting patients outside of the United States is that there are no insurance issues to contend with and all of the medical expenses are typically paid on a full fee for service basis.

Writing for Community Recognition

It is not likely that a physician will receive many referrals from an article that was written for *JAMA* or the *New England Journal of Medicine*. However, writing articles for local newspapers and magazines can effectively promote a physician's practice and areas of interest and expertise and bring in new patients. For example, a physician can create compelling and interesting articles about new procedures, new treatments, a unique case with excellent results, or the use of new technologies, such as stem cell transplants to treat multiple myeloma. An advantage of writing articles is that they have a long shelf life compared to radio and TV appearances, which only reach those who are listening or watching the program. Writing articles for the lay press will increase the physician's visibility, credibility, and, ultimately, profitability.

Why Write?

Anyone who has published in professional journals knows that an article may require hundreds of hours of time and energy. Although these efforts may add to your prestige within the medical community, the return on your investment, money-wise and marketing-wise, is very low. Writing an article for a local magazine or newspaper takes only a fraction of the time required for a peer-reviewed article and can generate dozens of new patients. For example, an article called "The Prostate—A Gland of Pain and Pleasure" that appeared in a senior citizen bulletin generated nearly fifty office visits, five minimally invasive procedures, one radical prostatectomy, and one penile prosthesis surgery.

Our take-home message: By writing articles for local newspapers and magazines, you can effectively promote your practice and your areas of interest and expertise. Published bylined articles in the lay press increase your visibility, credibility, and, ultimately, your profitability. People are more likely to believe what you say if you have written it down first and had it published.

By writing articles for the local press, you can easily become a media resource. Reporters and editors will notice your printed work. Often, they will contact you for additional articles or ask you for quotations to be included in articles they are writing. And, if you are responsive, they will

keep you in their databases as a contact person to call on whenever your specialty is in the news. For example, when Lance Armstrong developed testicular cancer, the local paper was contacted and information was provided about the importance of testicle self-examination and how early detection of testicular cancer can result in cure of this disease. Several years later, when Senator John McCain developed a brain tumor, the newspaper called the physician who wrote the article on testicular cancer for information for a story on the treatment of brain cancer. Because this was not his area of medical expertise, the urologist contacted a neurosurgical colleague who was happy to be quoted as the local expert on the subject.

Selecting a Topic

Topics of interest to lay readers in your community undoubtedly include wellness, nutrition, weight loss, cancer prevention, sexually transmitted diseases, such as AIDS, and sports medicine. You can create an interesting article about new procedures, new treatments, a unique case with an excellent result, or the use of new technologies, such as lasers to correct vision problems.

Do some research before you select your topic. Take note of what medical stories receive local and national attention on television. When a public figure, such as an athlete, entertainer, or politician, has a medical problem that is making national news, you might contact the local print media and offer to serve as a local expert on the subject. In most instances, newspapers will prefer to print an article with a local twist rather than use wire service articles. Give some thought to the demographics of your surrounding area. If, for instance, there is a substantial population of aging baby boomers in your area, you can be sure that topics related to menopause, bone health, heart disease prevention, and joint preservation will be of interest. If, on the other hand, there are lots of young families in your community, any topic related to pediatric medicine or parenting will get their attention.

Study the health news section of your local newspaper. Read national women's magazines, such as *Redbook*, *Family Circle*, *Allure*, *Self*, and *Vogue*, which often have excellent coverage of health issues. The print media is interested in personality profiles of healthcare professionals and of exceptional people coping with disability, illness, or the unique circumstances surrounding an illness.

Ideally, you should try to select a topic that is familiar to you and is identified with your practice. Then either find a new angle that will excite the readers in your community or tie the subject matter to a current event. The purpose of any article is to inform, entertain, or persuade the readers; the best articles will do all three. Characteristically, physicians are capable of writing to inform the reader. Your challenge will be to arrive at a style and content that elevate the information above simple explanation. If your article contains appropriate anecdotes and humorous stories, it will be more likely to attract and hold the reader's attention.

One caution in selecting a topic: avoid subjects that are controversial, such as abortion and euthanasia, unless you are willing to take the heat.

Titles Are Terrific

A title should be like a billboard on the highway. With a billboard you have 3 seconds to capture the attention of a driver. The same applies to a title of your article. In this age of information overload, you just have a few seconds to entice the reader to look at the headline and then decide if they deem your article worthy of further reading.

Chris Garrett, www.chrisg.com, a guru on the business of new media and online business, provides ideas and suggestions on creating titles that can attract viewers and keep them viewing your material.

The great advertising genius David Ogilvy said, "It has been found that the less an advertisement looks like an advertisement, and the more it looks like an editorial, the more readers stop, look and read."

This has to be a goal of every writer. We need to make our material have the feel and look of editorial and not a sales pitch for our areas of interest or expertise.

Think About Station WIIFM, or "What's in It for Me?"

Without a compelling headline, you will not attract attention and your article will not be read. If you do write a killer headline, you will get more readers, and your readers will be compelled to share it with their friends and contacts.

Your title should grab the attention of the reader. This can be done using a statistic, a claim, a fact, a jingle, or a rhyme, or best of all, indicating a benefit.

It is important to be as specific as possible. Highly specific approaches work much better to draw attention and create belief than generic and vague statements that can come across as untrustworthy. Rather than saying "Get great results," try "New treatment reduces risk of cancer recurrence by 75%" or "Treatment results in 15% weight loss."

Make an effort to create curiosity. "Are you having a problem in the bedroom? If so, below are suggestions to put energy into your love life." It is well known in the media that the topic of sex has an allure and will almost guarantee viewers wanting to know more information. One of the best examples is the title "More Sex Is Safer Sex" by Steven Landsburg. Who could resist picking up this book about the "unconventional wisdom of economics!"

Another suggestion is to include positive benefits to a medical problem in your title. Does the headline offer a solution to patient's problem? If so, you can be sure that your title will take the viewer to the next level, which is reading the rest of your blog and hopefully picking up the phone and making an appointment (or, if you have a well-constructed website, they can make an online appointment from your website).

New discoveries in health care or stories about celebrities and politicians with certain medical conditions are always hot topics for articles for local publications. For example, there was an announcement that fish oil could be a promoter of prostate cancer. An article "Something Fishy About Fish Oil and Prostate Cancer" was of interest to many men who were taking fish oil to protect against heart disease. This kind of article received dozens of comments and patients calling for more information because it was so current.

How-to articles share a technique to achieve something practical and beneficial. A example of a how-to article would be "Ten Steps for Preventing Diabetes," which is far better than the "Diagnosis and Treatment of Diabetes."

The take-home message is that titles that work create a trigger and an emotional reaction. Remember we do not just want interest: we want the reader to take an action, which means becoming a patient in your practice. You can do this by writing terrific titles.

Pitching to Publish

If you have met the health editor of a newspaper or magazine, you can contact him or her with your suggestion for a story. Otherwise, the standard approach is to send a query letter (Fig. 20.1 is an example of a query letter). This is a short letter that describes the subject of your article, indicates the angle you will take, and includes some information about yourself. The query letter is the equivalent of a sales pitch. You will need to spend some time studying the publication to which you submit your query. Is your article appropriate? Are you targeting the right audience for your article?

Once you have written a query letter, you must ensure it gets to the appropriate editor. If necessary, you can call the editorial desk and ask for the name and title of the correct editor for the section you think is appropriate for your article or where you have seen other related articles appear. Take that one extra minute to ask for the correct spelling of that editor's name and title—nothing is more indicative of amateurism than misspelled words, names, or titles. Whether your community is a small city or a large metropolitan area, keep in mind that the editor is a very busy person. Your

January 25, 2017

Mr. Michael Lafavore
Executive Editor
Men's Health
Box 114
Emmaus, PA 18099-0114

Dear Mr. Lafavore,

Did you know that even after the introduction of the "miracle drug" Viagra, some men are still suffering the tragedy of the bedroom?

I see these men by the scores every week. I am a urologist in private practice in New Orleans, Louisiana, and one of my areas of interest and expertise is the diagnosis and treatment of impotence. I have written a number of articles on this subject in both the professional and lay literature. With Dr. Steve Wilson, I have coauthored a book for men entitled,
ECNETOPMI: (Impotence) It's Reversible.

Dr. Wilson and I would like to suggest an 800- to 1,000-word article for your publication, Men's Health. We are suggesting an article that is positive, upbeat, and reassures men that help is available for nearly all men who suffer from this problem. Our message is that in the year 2017 "no one needs to suffer the tragedy of the bedroom."

I am enclosing my curriculum vitae, several articles that I have written on this subject, and a copy of our book.

I look forward to hearing from you.

Sincerely,
Neil Baum, MD

Fig. 20.1 Sample query letter

query letter should be written to make an immediate impression on the editor, who probably receives dozens every day.

Your query letter should really be a condensed version of your proposed article, with a beginning (or lead), a middle, and an end. The editor will be looking for a "hook" or unique opening to attract the reader. After all, if your query letter is dry and uninteresting, how can the editor expect the story to be any different? Start the letter with the most interesting aspect of what you want to write about. Start with an eye-opening statistic, such as the number of people in the community affected with the health problem that you are going to discuss. The next paragraph might describe the benefits of the article to the reader. The third paragraph mentions your qualifications to write the article. (In most cases, having the initials MD after your name will qualify you as a reliable source.) The last paragraph offers additional information, including how and when to reach you. Limit the query letter to one page.

One of the best hooks for an article was in a query letter by an executive from ChemWaste Corporation, a recycling company that was concerned with environmental issues. The letter began: "It takes 75,000 trees to provide the paper for a single edition of the Sunday New York Times. Perhaps we should take a picture of the forests so our children can see what they look like. Better yet, if we recycle, we can preserve the trees and our children can even climb one." [1] That hook will likely capture the attention of the reader and motivate them to read the rest of the query letter.

Once you have sent the query letter, you must be prepared to track it. Unless you have a scientifically proven cure for cancer, a better drug than Viagra, Cialis, or Levitra to treat erectile dysfunction, or a truly miracle cure for obesity, a follow-up call is a necessary part of the getting-published game. In many cases your query letter will not be looked at for weeks, so find out if the editor received the letter and had a chance to read it. Some writers send a self-addressed, stamped envelope or request to reply to an email submission with the query letter to make it easier for the editor to reply. An excellent suggestion is to include with your query a stamped, self-addressed postcard with boxes next to the following statements:

- Received your query and will reply in __ weeks.
- Received your query but we are not interested at this time.
- Received your query and want to talk to you right away.

If, when you call the editor, he or she is "still thinking about it," offer to provide additional information. Make the call short and call back in a few weeks. If you do not get an answer within 2 months, politely let the editor know that you intend to submit your idea to another publication. Then do it.

The etiquette regarding email is still evolving when it comes to contacting an editor whom you do not know personally. If the editorial desk will give you the editor's email address, then by all means use it, but do not abuse it. Common sense should prevail in an email conversation, as it does with phone conversations. Do not annoy the editor with frequent messages sent too soon after your query. If you have established a personal connection with a local editor, it is perfectly fine to send your query letter as a Word document attachment to an email. Just make sure you proofread, proofread, proofread all e-mails and attachments before hitting the send button! It pays to take the extra time to make a good impression.

Remember, there are other places to publish besides the local newspaper. If you are targeting senior citizens, contact the local branch of the AARP (American Association of Retired Persons) and offer to write an article for its newsletter or write a query letter to AARP The Magazine, the national magazine of AARP (www.aarp.org; the editorial office is located at 601 E Street NW, Washington, DC 20049; call toll free at 800-OUR-AARP). If parents are your target audience, contact parenting and children's magazines. There are also many city and regional magazines that accept articles written on healthcare issues. The Writer's Market, edited by Robert Brewer and published every year by Writer's Digest Books, is an excellent resource for possible outlets for your writing. It is available at bookstores, at your local library's reference desk, or through the Internet at Amazon.com and other booksellers [2].

Once the article is written, personally deliver it to the editor in order to establish a face-to-face relationship. This latter advice certainly applies if the publication is a local one. If you do not hear from the editor within a few weeks, follow up with a telephone call. Always make sure you deliver your article on time and in the format requested (hard copy, CD, or digital file via email). That is the most valuable commodity to a busy editor. If an editor has assigned you to write your masterpiece and has to badger you for the final copy, it is likely that you will never be asked to write again for that editor or publication.

Capitalizing on Your Clips

You can get additional marketing mileage from your articles long after they have been published. For example, the articles can be framed and hung in your reception area or examination rooms. Remember, your patients would probably rather read articles written by you than see your diplomas on the wall. Copies of the articles can be sent to your referring physicians and to patients as bill stuffers along with their monthly statements. Add the articles to your website and have your staff mention to patients when they call for an appointment that information on their condition is on the website.

If you have negotiated to keep all reprint rights, you can submit the articles to other publications for a second printing and usually get paid a small fee for giving them the right to reprint your article. Add the articles to your CV. They can be placed in a bound book in your reception area, and you can offer to provide photocopies to any patient who requests them. Finally, you can send copies to the local radio and TV stations and suggest that you be interviewed for a story on the subject.

Rejection Is Not a Four-Letter Word

Do not expect to publish every article you write or to get a positive response on every query. Never forget that John Grisham, the lawyer

turned best-selling novelist, sent his first book manuscript for The Firm to dozens of publishers before it was accepted. Also, JK Rowling, the author of the blockbuster Harry Potter books, did not publish her first book right away. Rowling has a rag to riches story going from a welfare recipient to a billionaire in less than 5 years and currently stands as one of the richest women in Britain.

Everyone hates rejection. Physicians are programmed to get people well and to expect quick results from our interactions with our patients. As a consequence, many of us are reluctant to attempt to use the print media for the purpose of marketing our practices. However, you will find that getting published is not especially difficult once you learn to accept the rejections that come with the territory.

Our take-home message: Like medical skills, writing skills can be learned and polished. The more you do, the better you get. The better you get, the more patients you will attract to your practice.

Public Speaking

Most doctors are out of their comfort zone when it comes to public speaking. We are very comfortable one on one with patients, but when we stand in front of strangers, our palms become wet, our voice tightens up, and we grip the podium as if we are hanging on cliff. Jerry Seinfeld humorously described the fear of public speaking this way, "People's number one fear is public speaking. Number two is death. This means to the average person, if you go to a funeral, you're better off in the casket than doing the eulogy."

Most doctors and healthcare professionals pride themselves on their communication skills. After all, that is how we take a history and then discuss our findings with our patients and then provide them with advice for restoring or maintaining their health. Except for bedside presentations to faculty or a presentation at grand rounds, we have received little training on public speaking. Few of us are able or comfortable in front of the TV camera. For the most part, public speaking is a learned skill, and with just a little practice and preparation, all of us can become good or even excellent public speakers. As a result, we can learn how to make a presentation in front of peers and before lay audiences and not be uncomfortable when we are in front of the TV camera. It is through public lectures that the audience has an opportunity to learn more about a specific medical topic and how it applies to their health. This can drive referrals and generate business for a practice.

A physician can also start researching lecture opportunities by contacting meeting planners at various church groups, service organizations such as Rotary, Kiwanis, Lions Club, Knights of Columbus, and AARP, as well as patient advocacy organizations such as the American Cancer Society, American Diabetes Association, American Heart Association, and Us Too.

Next, the potential speaker can send the meeting planner a brief biography which outlines their credentials, a list of previous groups where one has presented, and can include a few testimonials from meeting planners or audience members. It is also helpful to attach a fact sheet (Fig. 20.3) and relevant articles, especially those you have authored.

To benefit from the presentation, it is important to collect email addresses of everyone who attends the program and continue to keep in touch by sending out a quarterly newsletter. It is also necessary to have business cards available to give to any potential patients, as well as a handout that includes a few important facts from the presentation and has all of the speaker's contact information. Handouts should be distributed after the program so that the audience focuses on the speaker instead of reading the handout during the presentation.

There are three important areas of concern for public speakers: (1) preparation for the program, (2) the actual program, and finally (3) follow-up after the program is over.

Before the Program

You need to know and review your slide material thoroughly. It is important that you understand every slide in the slide deck and that you are comfortable with the material on every slide. We have found that the best speakers are so comfort-

able with the slides that they can discuss the slide without having to look at the slide. You should be so comfortable with your material that you do not need to read from the slides. Reading from the slides results in boredom and loss of interest on the part of the audience. If you are looking at the slides, you are not looking at the audience and you will lose your ability to connect with the audience. If you are not familiar with your material, we can assure you that your audience will be able to tell immediately that you are giving the talk for the first time, and this will be unlikely to generate confidence and competence that will inspire patients to pick up the phone and call and make an appointment in your office.

You need to know the time frame for the meeting and how long you are allowed to speak. We suggest that you practice with a timer and be absolutely certain that you do not exceed the allotted time.

Audiovisual Requirements

Before the program communicate with the meeting planner and find out who will be responsible for the audiovisual equipment. Find out if the venue will provide the computer, the projector, and the screen. If not, let them know what you will bring and what kind of a computer you have and make sure it is compatible with their projector. You can learn this the hard way, for example, if you bring a MAC computer that doesn't have the appropriate cable to connect to the LCD projector which was only PC compatible. Also, you will probably not require a microphone for a small group, but if you are speaking in a loud restaurant, a microphone may be helpful.

We recommend that you arrive first at the program. This way you can be sure that the computers, LCD project, screen placement, and seating are all in order before the program. Nothing can sidetrack a speaker, even the best seasoned speaker, if they find that there is a problem with the computer or the equipment and that your flash drive with a USB port does not load onto the facility's computer or that your program created on a MAC computer does not work on their PC.

It is a good idea to find out the agenda from the meeting planner before the program. Are you speaking before a meal? This is the least favorable time to speak as you are holding the audience hostage to hear the program before they can eat. Are you speaking during the meal? Or are you speaking after the meal, when it may be difficult to hold the audience's attention.

We think it is a good idea to prepare a handout for the program. We suggest that you do not distribute the handout before the program as you want your audience to focus on you and your slides and not on the handout. Tell the audience that you will be providing a handout of your presentation after your talk so that it will not be necessary for them to take notes during your presentation.

Prepare an Introduction

You need to prepare an introduction. We suggest you write your own introduction and send a copy by email to the person who will be introducing you. Tell the introducer that you are providing them with the introduction as a "suggestion" and that they are welcome to modify it if they wish. The majority of introducers or meeting planners are delighted to have your introduction and will use it just as you have written it. It is a good idea to bring a hard copy as you can be sure that many of the introducers will not have downloaded a copy and remember to bring it with them. Figure 20.2 is an example of an introduction that you can easily modify for one of your programs.

The Opening

It is the first and last 30 seconds of any speech that has the most impact. Therefore, give the opening and closing of your talk a little extra thought, time, and effort. Avoid opening with this humdrum line: "Ladies and Gentlemen, it is a pleasure to be here tonight." It is wasting too much of those precious 30 seconds.

Opening a speech with a joke or funny story is the conventional wisdom. Before you do, ask yourself these questions:

- Is it appropriate to the occasion, for the audience?
- Is it in good taste?

Fig. 20.2 Sample bio and introduction to submit to meeting planner or introducer

Neil Baum Bio and Introduction

Dr. Neil Baum is a urologist in private practice in New Orleans, Louisiana. He is Professor of Clinical Urology at Tulane. He has written ten books and one of his books, *Impotence It's Reversible,* has sold thousands of copies and has been translated into Spanish. His presentations are famous for providing useful information on common medical conditions such as prostate cancer, urinary incontinence and impotence.

Dr. Baum is also an amateur magician and usually includes at least one special effect in his presentations.

His talk today is also the title of his new book, *What's Going On Down There-the Complete Guide to Women's Pelvic Health.* Please help me welcome Dr. Neil Baum.

Fig. 20.3 Example of a fact sheet on possible topic for women's group

Overactive Bladder: You Don't Have to Depend on Depends!™

Overactive bladder is a common disorder that affects millions of American men and women. Most people who have this condition suffer in silence and do not seek help from a health care professional. Fortunately, most sufferers can be helped.

- Affects 33 million American men and women
- Can result in reclusive behavior
- Source of tremendous embarrassment
- Cause of recurrent urinary tractinfections
- Hinders workplace interactions
- Limits personal mobility
- Causes skin infections
- Leads to falls and fractures
- May lead to nursing home institutionalization
- Expensive—economic cost exceeded $35 billion in 2015
- Help is available. No one needs to depend on Depends™!

If you would like additional information on this topic, or you are interested in having Dr. Baum speak to your group about overactive bladder and other urologic problems, please call (504) 891-8454 or write to Dr. Baum at neilbaum@hotmail.com.

- Does it relate to me (my practice) or the event or the group? Does it support your topic or its key points?
- Am I a comedian?

A humorous story and an inspirational vignette, which relate to your topic or audience, are sure ways to get an audience's attention. However, it may take more presentation skill than you possess in the beginning. It is safer and more effective to give the audience what you know.

A good way to open your speech is by giving the audience the information they most want to hear. By now, you know the questions you hear most at a cocktail reception or professional society meeting. Well, put the answers to those questions in your speech.

For example, a scientist was preparing a speech for a woman's group. Since most of the

audience didn't know what scientists are like or what they do, he told them what it was like to be a scientist. "Being a scientist is like doing a jigsaw puzzle in a snowstorm at night…you don't have all the pieces…and you don't have the picture to work from." You can say more with less.

The Closing

The closing should be one of the highlights of your speech. Summarize the key elements to your presentation, i.e., overview of the medical problem you discussed, what preventive measures can be taken, what are effective treatments especially emphasizing the least invasive treatments. If you are going to take questions, say, "Before my closing remarks, are there any questions?" Finish with something inspirational that ties into your theme.

The scientist told of the frustrations of being a scientist and he closed by saying, "People often ask, 'why should anyone want to be a scientist?'" His closing story told of a particularly information-intensive medical conference he attended. The final speaker of the day opened with, "I am a 32-year-old wife and mother of two. I have AIDS. Please work fast!" The scientist got a standing ovation for the speech.

After your talk, be available for one-on-one questions and do not be in a hurry to leave. Be available to answer questions and have plenty of business cards to hand out as well as your practice brochure and articles that pertain to the topic that you have presented. You want every member of the audience to leave with a piece of paper with your contact information.

Valda's Story

Valda contacted her hospital's public relations department and offered to speak at any local service organization, club, church, or school. She started with speaking engagements at the local Junior League (www.ajli.org) and at an independent living facility with dozens of residents that would likely need her services for MOHs surgery. She wrote several articles in local publications on the importance of sunscreens and seeing a dermatologist for the early warning signs of melanoma. Within 6 months, she doubled the number of MOHs cases that she did in her office all done with minimal expense and no paid advertising.

Bottom Line

Public speaking and writing for local publication are the best ways to achieve local recognition. It is an ethical way of communicating with your peers and the public and an opportunity to showcase your areas of interest or expertise. It all begins with reaching out to local editors and meeting planners, sending a compelling query letter, and then writing or preparing a program that has a call to action such as see give us a call if you have any questions or would like additional information.

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Internet and Social Media Marketing

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Marc J. Kahn and Neil Baum

Case: Sammy

Sammy joined a five-man orthopedic practice following residency. He had an undergraduate degree in business with extensive knowledge in computer science, as he spent his younger years as an avid video game player and developer. The practice hired a high school student to convert the three-colored practice brochure into an electronic format and the student cut and pasted the document into the free WordPress.com website builder in less than 1 hour. Despite trying to have a presence on social media, the site has remained idle for more than a year. What is Sammy's next action step regarding social media?

It was just a few decades ago that placing a shingle or a sign on the door of a doctor's office was all that was necessary and that was all that was allowed for a doctor to identify their practice. In 1847, when the American Medical Association (AMA) was established, it included a ban on physician advertising as part of its original code of ethics. In the years since then, great disapprobation was shown toward physicians who in any way attempted to promote their services to the public. Some physicians—particularly young ones—became concerned when their attempts to advertise met with censure from local, state, and national medical societies. In 1906, the Missouri Medical Society rebuked a local newspaper for publishing an ad by a physician: "…not one line of this obscene advertising would be possible without the publishers also being liable to a prosecution. The publisher is as culpable as the physician who prostitutes his profession."

Very little progress in physician marketing was made until the 1970s and 1980s, as doctors were limited to inserting a small ad in the local newspapers as an acceptable method of announcing their practices. In the late 1980s and early 1990s, doctors learned ethical methods of marketing and promoting their practices. This was the beginning of patient brochures, newsletters, and local presentations to service organizations. In the late 1990s, doctors developed web pages. The first medical web pages were brochure-ware, when the tri-fold, colored brochure was transferred electronically to the web page. These were static web pages and there was no interaction between patients and their doctors.

Then, in the 2000s, large group practices like Cleveland Clinic, Mayo Clinic, and the Lahey

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Clinic developed a presence on Facebook, YouTube, Twitter, and other social media sites. This launched a new era of practice promotion. This new era is referred to as Web 2.0. Now, there was a two-way interaction between the viewers and the medical practice. Dialogue and communication take place and allow patients to become more involved and true participants in their health care with their physicians. The exciting part of Web 2.0 is that small medical practices with a few doctors or only one doctor can compete with the large groups. Social media is now very affordable which levels the playing field and allows solo practices to market just like the large group practices and medical centers. The days of the Yellow Pages are now caput, i.e., over!

Today, every medical practice will need to participate in the world of social media. This chapter will discuss the advantages of social media and the role of online reputation management which is so critical to the success of any physician and medical practice.

This chapter is written with the small practice in mind. We will teach you how to start your own blog site as well as how to generate fans and followers on Facebook and Twitter. We will share how to develop a YouTube presence for under $200, which includes the camera and editing software. We do not want to mislead you, as you will not have a Steven-Spielberg-quality video, but you will have a video that showcases your areas of interest and expertise and will direct patients to your website and to your practice. After reading this chapter, you will be able to have a social media presence in a very short time, and you can anticipate generating several new patients every day who will be calling your office for appointments. This is a very exciting technology that is not as daunting as implementing an electronic medical record (EMR) into your practice. This is more like adding a new clinical technology, like ultrasound, into your practice. However, the return on the investment for social media is far greater than any clinical technology that is currently available.

We think that this is a very exciting time for young physicians. With reimbursements decreasing and overhead costs rising, it is imperative to find new methods to improve practice visibility using ethical methods of marketing and promotion of the doctors and the practice. Social media is that opportunity and it is available to everyone. We would like you to think of this new technology as the new shingle for ethically marketing and promoting your practice.

Why Use Social Media

When Wayne Gretzky was asked about his great hockey skills, he said, “I skate to where the puck is going to be, not to where it has been.” If you ask a successful medical practice that makes good use of social media, where they place their marketing materials, they will tell you they create and post where the patients and potential patients are hanging out, i.e., on the Internet through social media. Practices need to be where the patients are. Having a presence on a social media site is like locating your office in a prime location with easy access to highways or mass transit. With a presence on Facebook, LinkedIn, and other sites, you create more opportunity for more people to learn about you and your medical practice.

With a social media presence, which includes your website, you have the opportunity to reach potential patients. These potential patients can search for you on social media sites as well as review the recommendations of friends and family. Social media allows you and your practice to stay in touch with existing patients and offers a way to provide value to your existing patients. You can even use social media to enhance your professional relationships and partnerships by networking with colleagues and groups throughout the nation and even the world who are focused on medical issues. Ultimately, social media allows you to raise your stature in the profession.

It is through the use of social media that you generate more traffic to your website by providing links to your website. Also, your social media pages and the pages of people connected to you can all generate more traffic to your website and ultimately to your practice. You can expect that

social media will increase your ranking in search engines which translates to more links to you, which results in raising your rankings in search engines, such as Google.

One of the best applications of social media is the opportunity for interaction with patients such as answering questions, providing advice, and giving existing and potential patients a sense of what kind of physician you are. And it does not hurt to convey an appearance of being tech savvy, especially if you are reaching out to a millennial audience. Finally, ratings from patients on social media sites can be an important way of supporting the all-important word of mouth that builds a medical practice. This is particularly important for a young physician who would like to establish themselves in the community with a positive reputation.

Examples of Social Media for Healthcare Practices

LinkedIn

LinkedIn is considered the largest social media site devoted to the needs of educated professionals including physicians. LinkedIn was launched in 2003 and has more than 135 million members in over 200 countries.

More than two million companies, organizations, and practices have LinkedIn pages, and there are more than one million LinkedIn Groups devoted to specific topics or professions.

LinkedIn is a way to promote yourself and network, and it is great if you are searching for a job. But LinkedIn is used in literally dozens of other ways: to communicate and share insights with like-minded colleagues, to do market research on new ideas, and to form business partnerships.

It is easy to get started on LinkedIn: simply set up your profile and then invite other people in the LinkedIn network to connect with you (most often starting with people you know well). Dozens of medical practices have LinkedIn accounts. Prospective patients can search for you on LinkedIn, or they make seek you out because you share a mutual connection with another LinkedIn member. You can join a group of like-minded physicians on LinkedIn or form a group yourself to share ideas and insights.

You can set up a free LinkedIn profile. The free version is a great way to get started. However, if you become an active LinkedIn user and regularly exchange communications and links with other members and other leading groups, you may want to consider one of the paid plans.

Because it is designed for educated professionals, LinkedIn is the social media site that most closely meets the needs of physicians. But LinkedIn does not have the mass of users that will make it truly valuable as a form of patient outreach. For that you need to look at Facebook.

Facebook

With more than 2.27 billion users and 1.15 billion users every day, Facebook is almost synonymous with social media [1]. After becoming popular among college students, Facebook entered the mainstream and is now the primary way that many people keep up with family and friends: providing updates, posting photos, arranging meetings, and the like.

With so many Facebook users spending hours on it every week, it was inevitable that medical practices would use Facebook to promote their products and services, to provide customer support, to test ideas, and to let patients and potential patients know what is happening in their practice. Facebook does accept advertising, but more importantly, when a Facebook user declares that they “like” a product, they in effect advertise that fact to all of their friends and followers. For the medical profession, and especially for the new physician, who has always relied primarily on word of mouth, this is a critical way that Facebook can help build a practice.

Overall, doctors have not been leaders when it comes to using Facebook. but that is likely to change. Various surveys have shown that well over half of all doctors graduate from medical school with both a diploma and a profile on Facebook. Organizations like the Mayo Clinic

have given it their seal of approval. The American Medical Association and many medical specialty organizations all have Facebook pages.

Facebook offers numerous benefits to a healthcare practitioner. A well-designed Facebook page becomes almost like another website. You can have all the key information about your practice on Facebook: address, phone, office hours, services provided, etc. The hundreds of millions of users and the hours they spend every month is a major market for your practice. Many people now do their web searching on Facebook on either the site itself or by asking friends and family for referrals.

The ease of posting new information on Facebook makes it easy to educate patients by providing interesting, accurate health information and advice. And then there is the potential for interactivity including the ability to answer questions, have patients set up appointments, and refill their prescriptions.

We caution against "friending" patients. The American Medical Association has taken a particularly strong position on this, advising medical staff and students to reject any approaches by current and former patients, to avoid the risk of blurring the boundaries of the doctor-patient relationship.

Because of these issues, the right approach to Facebook is typically to keep a business or practice page completely separate from your personal page and to monitor it closely. Another option is to look at a social media vehicle where you are in more complete control, such as Twitter.

Twitter

Every day, more than 500 million "tweets" (messages of up to 140 characters) are sent by more than 326 million active Twitter users. Twitter was initially popular with politicians, celebrities, and sports figures, who use it to stay in touch with thousands of fans.

But for easy and fast mass communication, Twitter is excellent. As a result, it is also another example of a social media tool that can be used in your practice.

You can tweet messages about newsworthy issues and provide links to interesting content. You can let people know of your involvement in events and activities such as national meetings that you are attending and can tweet what new information is being presented. One of the beauties of Twitter is that it is possible to tweet while the meeting is taking place in real time. What you do with Twitter is limited only by your imagination.

Getting started is easy, go to Twitter.com and sign up. Choose a short, descriptive name and put a good description of yourself under the "bio" section, so people will know your background and so that followers can differentiate yourself from marketing spammers. If you register as "skindoctor," then your Twitter name becomes @skindoctor.

The best way to make the most of Twitter is to first "follow" some people on Twitter. There are lots of places that give you lists of current Twitter users, including lists of physicians. (Try twellow.com or twibes.com.) Also, once you get started with Twitter, it is easy for it to get out of control. A program like TweetDeck or Hootsuite, which is available for free, can help organize your tweets.

All of the same issues with patient privacy and the patient-doctor relationship that are generated by Facebook apply to Twitter as well. It is imperative to pay attention to professional, ethical, and patient privacy concerns which should preclude all other considerations in your use of any social media platform.

Blogging

A blog (the word is blend of the terms "web" and "log") is a type of website where new content is posted on a regular basis. In many ways, blogs are the most personal and free form of all the social media outlets. There are easy-to-use blogging templates, and when you write your blog postings, you are not limited to a specific word count, as in the 140 characters of Twitter.

Before blogging became popular, interactive discussions online typically occurred (and still do)

in online forums where participants created running conversations devoted to specific topics.

The first blogs often took the form of an online diary or journal. The evolution of easy-to-use blogging software such as WordPress, Movable Type, and Typepad are all easy to produce and manage. It is estimated that there are over 164 million active, public blogs in existence today, with over one million posts each day being added.

Typically, blogs are interactive. You write a blog post and allow visitors to your blog to leave comments. A typical blog combines text, images, and links to other blogs, web pages, and other social media related to its topic.

Of all the social media vehicles, blogs give you the greatest opportunity to establish your own voice and expertise. The ideal scenario is that your blog posts are seen as valuable such that people send a link to your blog to others. This increases your rankings in search engines, attracting more patients, thus making the investment of time worthwhile.

Getting Started

Before launching your own social media presence, spend a few minutes every day reading, listening to, and watching what others are writing and doing. Start by paying attention to what gets noticed by others (blog, posts, comments, and retweets) and what appeals to you and identify your comfort zone. We recommend that you participate in other people's conversations before you start your own social medial presence.

When you are ready to take the social media plunge, start slowly, build a foundation, and then add more media to the mix. Start by connecting with people you know in real life and then broaden your set of connections.

Let us share a bit of advice: take private conversations offline. Never mention a patient by name or even allude to a patient so that the patient could possibly be identified in the content.

It costs nothing upfront or relatively little to take advantage of social media tools. But social media is far from free. Allocating the time to manage and keep them up to date is your biggest cost.

Plan on allocating about several hours a week on social media, including research and writing, providing the content for tweets, Facebook, and blogs. If you cannot spend that kind of time cultivating your social media strategy, consider hiring a social media freelancer or agency to assist you with creating compelling content.

You cannot maintain a social media presence by being absent on your social media sites. If you are going to be involved in social media, plan on contributing regularly. We suggest that you publish content to your blog, Facebook page, or LinkedIn group at least weekly

Just as you cannot disappear, you cannot be wildly inconsistent in the kind and quality of information that you provide. Variety is great, but your goal is for your audience to view you as a consistent, reliable source for medical information.

One unique aspect of social media is that it is a conversation, not a monologue. You need to hold up your end of the conversation, try not to dominate it or expect that you can maintain the conversation with material that is interesting to you, but not to your audience.

Keep the needs of your target audience in mind. What do they want to know and what do you want them to know about you and your practice? Develop a unique perspective with core messages that you communicate on a regular basis. Remember, content is king. To be successful, your content must attract and hold the viewer. The word used by technophiles is "sticky" and your goal is to attract and then inform viewers, have them stick on your site, and to eventually call your office for an appointment.

YouTube for Medical Practices

A wonderful opportunity to showcase you and your practice is by making videos and uploading those videos onto the YouTube site. There are nearly 150 million viewers on YouTube each

month. Every 60-seconds, more than 300 hours of HD quality video being uploaded to YouTube contribute to already massive collection of 1.3 billion videos [2].

YouTube is a medium where people can upload and share their videos for free. YouTube is not always a platform considered to be social media, but because you are able to interact with your viewers through videos, comments, and even video responses, it certainly qualifies.

Video is an increasingly important aspect to any Internet marketing campaign. Video attracts people to your website, engages them, and keeps them on your website longer. Many people use YouTube as a search engine, preferring to have their answers in video and audio form, rather than reading text.

Why Is Video Important?

Video is an important medium for representing your practice on the Internet. Along with your website, blog, and various forms of social media, your mission is to provide your patients, both potential and existing, the best and most comprehensive information in the format that works best for them. Video has a high perceived value in this arena.

Just as people are inclined to understand and believe what they see on television, video on the Internet has the same effect. Allowing a potential patient to find a basic answer to a medical question in a form where you as the physician are able to talk to them is a very powerful opportunity.

One of the goals of social media is to be on the first page of a Google search and search engines love video. At the time of writing this book, search engines are only able to catalog that a video exists on your website. However, in the future, search engines will have the ability to scan the audio of your video file for keywords. This will provide even better results from your videos. Adding your videos to video sites, such as YouTube, will further increase your visibility on the Internet.

Getting Started on YouTube

Video is not difficult or expensive to do. While there is a place for both professionally created and self-recorded video, we will provide you with guidelines that will help you achieve the best results without having to make an enormous investment in equipment or professional services.

Producing Your Own Videos

A video camera does not have to be expensive. In fact, many portable video cameras now record in high definition. Smartphones, such as the iPhone, have a video camera incorporated that records in high definition. iPhones even feature the ability to upload directly to YouTube without the need to move the file to a computer.

We also suggest purchasing a universal or flexible iPhone holder which contains a Bluetooth remote shutter. The cost is $5.00–$10.00 [3].

Self-produced videos require you to control your own sound and lighting. If there is a well-lit area of your home or office, that could double as your video studio. You also can record your videos outside in order to have natural light.

If your camera is able to use an external microphone, invest in a lavalier microphone. This will allow for superior sound quality of your video.

Editing a video that you shoot yourself should not be difficult. Most computers come with software to simplify the editing process. This software makes it possible to add a title frame, text subtitle, images, and anything else you wish to add to your clip.

Once your video is edited, you are ready to upload to YouTube. Visit www.YouTube.com to sign in. If you have not yet used YouTube, then click “Create Account” to proceed.

It is also important to make sure your channel and videos are public. This way, they are catalogued by the search engines and viewable by prospective patients.

Once your account is created, you are ready to begin adding content to YouTube.

Start by uploading your first edited video by clicking "Upload and Share Your Video."

By clicking "Upload Video," you will navigate to the video file on your computer.

Aside from having your videos on YouTube, it is also helpful place the videos on your website, in a blog post, or on Facebook for additional availability to your patients and potential patients.

You can also place a link to your video in an e-newsletter, on your website, referenced in an article, or in a blog post with a similar topic. We suggest that the video also be loaded onto your EMR to show patients while they are in the exam room preparing for the doctor-patient encounter. Finally, we encourage your front office or receptionist to guide patients to the YouTube site to watch videos prior to coming to the office on various medical topics that would be of interest to patients.

Like anything in medicine, there is a learning curve and you will find the first foray at video production will be time-consuming and may take several hours. If you stick with it, you'll see how easy it is to create a 5–7 minutes video which can drive new patients to your office.

Online Reputation Management

Although social media is powerful marketing and practice promotion opportunity, this tool is also a double-edged sword as a patient with a computer and access to social media can now easily and effortlessly comment on your practice and your services. Most comments about physicians are positive. However, a negative one may be posted by a disgruntled patient. The remainder of this chapter will focus on protecting your online reputation.

Patients are relying on referrals and word of mouth to make decisions about their health and choice of doctor—that is nothing new. Much of this process can now be done online. From social networking and instant Google searches to online review sites, like Healthgrades, Yelp, RateMDs, and ZocDoc, patients can research and find information about their physician almost instantly.

Individual consumers also rely on their personal networks and peer recommendations. Overall, one study found that 72% of patients ranked the reputation of the healthcare provider and personal experience as the top driver for choosing a provider [4].

We live and die by our reputations, our most precious possession. Our reputations are created the minute we receive our medical diploma and take years to build but are so fragile that they can crumble in a matter of seconds or a few mouse clicks. Look at what happens to athletes and movie stars who use a phrase that is politically incorrect or get caught driving while intoxicated? They tumble from their pedestal in a nanosecond.

This is due largely in part because in today's digital age where news is instant, thanks to social media, blogs, and search engines, your practice reputation can take a turn for the worse almost instantly. The Internet has dramatically altered the way people gather information. Social media has impacted governments, nations, and societies.

With the ease of using social media and online reviews, it is likely that a patient, or even a fellow physician, can target your practice and wreak havoc on your reputation. We will provide you with methods that you can use to protect yourself.

First, most online reviews of physicians are positive 70–90% of the time [5]. However, most physicians have five or fewer reviews on any one site [6].

At a minimum, a physician should be monitoring their practice reputation by conducting periodic searches or "Googling" their name to identify what information about their practice is already visible online. If you are like most of our colleagues, these reviews will be positive. However, do not be surprised if one or two are negative. Let's face it; even the most well-known and experienced physician cannot possibly satisfy every patient that walks through the door. The easiest way to see what others are saying about you is to sign up for a Google Alerts (www.google.com/alerts) which is free.

The advantage to these alerts is that you can get immediate reports and can take a quick glance to see if it is important or something you need to investigate further or respond to. You can also set up alerts on Facebook, LinkedIn, YouTube, and Twitter to notify you when messages are posted.

The Topic of Online Reviews

One common patient complaint is the wait time to get an appointment and another common complaint is spending too much time waiting in the reception area and exam room to see the doctor. Both of these issues can be resolved by careful attention to your scheduling process. Patients will even make judgments on their medical experience by the way the phone is answered, how long they were left on hold, and if there is ample parking near the office.

If you hear a complaint on more than one occasion, you can be sure that multiple patients are having that same negative experience, but they are not vocalizing or writing about that negative experience. Therefore, it is imperative to take notice of these negative responses and take action and correct them.

Ethically Creating Positive Reviews

The facts remain that most patients are very satisfied with their medical care from physicians. However, 40% of negative reviews are related to poor telephone technique and etiquette, failure to obtain access to the practice, and general patient service issues not involving the doctor [7].

Whether we like it or not, online reviews are here to stay and they can significantly impact the perception of your practice from both new and existing patients.

In the past, my staff and I have tried to encourage patients to provide an online review. We provided them with a small card requesting they go to the review sites and give us a favorable review (Fig. 21.1). This approach was an abysmal failure with a response rate of only 1% and was hardly worth my staff's time to give out the cards.

Thank you for helping us to serve you better!

Was it easy for you to get an appointment in this office?

_____ Yes _____ No

Is your general impression of this office favorable?

_____ Yes _____ No

Was the office staff friendly and concerned?

_____ Yes _____ No

Did the doctor adequately answer your questions?

_____ Yes _____ No

Would you recommend this office to someone else?

_____ Yes _____ No

Do you have any additional comments?

Fig. 21.1 Card given to patients to rate their experience with the practice

It is a reality that, by far, most physicians are appreciated by most of their patients. There isn't a day that goes by that most of us receive glowing compliments from our patients. (It happens to be one of the best reasons to become a doctor as no other profession enjoys receiving so many compliments from their customers or clients!) When a patient offers a compliment about the doctor or one of the staff members, we ask them if they wouldn't mind posting this on a review site, such as healthgrades.com. Most patients who offer a flattering remark will agree to provide the comment to the online review site. In order to capture the compliment at the point of service (POS), we use a free kiosk in our office provided by outcomeshealth.com and direct them to leave a review while they are in the exam room.

Finally, to make these reviews really impactful, we ask the patient to add their name to the review. A review by Kate Smith is better and much more credible and believable than "KS."

When patients compliment the staff or the physicians in the practice, ask the staff if they ask the patient to make their comment public by submitting their positive comments to one of the many review sites. You will be amazed that a

patient pleased with your staff's service will be happy to take 5 minutes to review your practice. You might consider posting a sign in a prominent place within the office that you appreciate an online review.

Just imagine that if you have 20–30 positive reviews for every negative review, what impact that will have on the potential new patient? If the scale swings to the predominance of positive comments, the few negative ones will be drowned out in a sea of compliments that really reflect the true nature of your practice.

Managing a Negative Review

A bad online review is inevitable just like a lawsuit is part and parcel of the medical field today. Our advice: do not panic and do not overreact. The reality is try as hard as you may, you cannot make everyone happy.

If your rating is mostly positive, there is often little reason for concern. It is likely that a majority of favorable ratings with a smattering of bad ratings is perceived as being more credible than uniformly good ratings. It is likely that a couple of negative ratings balanced by mostly positive ratings may have the unintended consequence of increasing the positive perception of you and your practice.

If the review is off the wall or inappropriate, you should check to see if the comment violates the website's terms of use. Many sites have formulated rules constraining how reviewers should behave. For example, the use of inflammatory language is prohibited. If you identify that the comment violates the terms of use, you can submit a respectful letter to the site calling to the site's attention that there was a violation. The site is not obligated to take down the post but might consider honoring the terms of use policy.

Suppose you believe by the nature of the post or the content of the negative comment that you can identify the author of the post, what should you do? If the post is inaccurate, we suggest a letter or a phone call calling to the writer's attention that their post was not entirely correct. Then politely request that the writer could amend or review the negative post. Often a polite request will remedy and correct a negative review. Some sites, like Yelp, allow doctors to privately respond to patient reviews without making their comments public.

We suggest that you respond to negative reviews especially if the complaint is nonclinical. You are allowed to do this without violating privacy laws. You can explain how your practice works but refrain from publicly talking about the specifics of any one patient's experience.

To be perfectly safe, you should ask patients for their permission to reply publicly to their reviews or, if appropriate, post an apology. Once you have received a written consent from the patient, a public response or apology can show others who might review the negative comment that you are listening to patients and taking steps to address their concerns. Going public with your apology potentially turns the negative situation of a bad review into a more constructive experience [8].

Patients are seeking and leaving reviews about you and your practice online. It's time to embrace this digital age and actively manage your online reputation. Do not to let one disgruntled patient ruin your reputation. Our advice is to take an active role and generate positive reviews to drown out any negative remarks made by an occasional disgruntled patient. Remember your reputation is elastic and can be changed

Sammy's Experience with Social Media

Sammy quickly recognized that he did not have the time, energy, or skills for developing a website and a social media presence. He contacted a marketing company that had extensive experience in medical websites and social media. He then divided the responsibility of creating content for the website and social media to two other younger doctors in his practice. He committed his practice to creating one YouTube video a month. Within a few months, his practice was on the first page of Google and, more importantly, was receiving two to three calls or responses every day from the website and from viewers on Internet requesting appointments.

Bottom Line

The days of Dr. Marcus Welby have disappeared forever. Today's physicians have more in common with Mark Zuckerberg and Bill Gates than with Marcus Welby. It is the advent of technology that differentiates the doctors of today from the doctors of decades ago. We have grown comfortable with computers in the diagnosis and treatment of diseases; now, we have to get comfortable using computers and social media to help communicate with patients.

At the present time, there is one primary care physician for every 1500 patients. It is estimated that, by end of this decade, there will be 1 primary care physician for every 5000–6000 patients. The challenge facing every doctor is how to see and care for additional patients in the same amount of time and educate them and yet preserve the quality of care that patients are accustomed to while avoiding the ever-present threat of litigation. That is where the Internet and social media come in as a solution to some of the problems impacting physicians today.

There is good news. With all of the statistics that suggest that the doctor-patient relationship is changing and patients will not receive the kind of care offered by Dr. Welby, doctors will have to embrace the digital age, which includes social media, and will have to think creatively about how to communicate with patients, how to educate them, and how to teach them about wellness instead of being available for treating only illness. Doctors are going to have to utilize the new digital solutions in a way that will lead to a complementary relationship between the doctor and the patient.

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Crisis Management

22

Marc J. Kahn and Neil Baum

Case: Ben

Ben had been the dean at a southern medical school for 2 years when a Category 4 hurricane struck his city. The storm lead to massive destruction of the infrastructure of his city, and the resulting flooding damaged many of the facilities on his campus. Two days after the storm, Ben had evacuated to a city 350 miles from home and was trying to plan for the future of his school. Unfortunately, the storm had disrupted major communication systems including cell phone service and email. The easiest course of action might be to suspend his school for a semester, an idea favored by the president of his university, but Ben was concerned that this course of action might have dire consequences as faculty and students may choose to go elsewhere, costing the school loss of tuition, loss of grants, and loss of clinical dollars. How should Ben proceed?

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Every institution and business go through a crisis at some point in their operation. These crises include financial crises, personnel crises, public relations crises, and even natural disasters. Although some crises can be predicted, such as a downturn in the economy, or the implementation of new federal regulations that alter Medicare payment, many crises like natural disasters are completely unexpected. Surviving a crisis involves a management style that is quite different from that of managing typical business operations. Successful crisis management often results in a stronger institution following the resolution of the crisis.

The first step in managing a crisis is to identify your leadership team. James Collins, in his book, *Good to Great*, describes this process as "getting the right people on the bus." It is often less important to identify specific job descriptions for the leadership team at the beginning of a crisis, because the right team will usually effectively solve problems. Recovery from crisis is not achieved through the micromanagement of a single leader but through the creation of an empowered team that is able to make decisions, to solve problems, and to think out of the box. When Tulane University School of Medicine was recovering from the devastation of Hurricane Katrina, a group of leaders were assembled in Houston, Texas, to plan for the reopening of the medical school. The small group worked closely, and each was empowered to make decisions that were consistent with the overall goal of reopening the

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school. Although the dean had the final say on decisions, the success of the recovery was closely linked to teamwork and cooperation [1].

The next step, once your team is identified, is to quickly establish a recovery plan with clear objectives. The public, your employees, your students, and your patients expect to know what is happening and want to feel that the situation is under control and being managed adeptly. This involves establishing a single thematic goal that is clear, concise, and consistent throughout the organization. Goals such as "our goal is to be back in business by January 1st" or "our goal is to increase referrals to compensate for a change in payment and to be back on track to meet budget by June 1st" are examples of thematic goals. Although crisis management is complex, raising the tendency to have multiple goals, a thematic goal should identify the single top priority. If everything is important, then nothing is important.

A thematic goal requires a definable action and a time frame for results. The thematic goal should dictate the actions the organization will take during the recovery and the time frame in which milestones are expected to be reached. The thematic goal becomes the defining rationale for strategic planning. If the thematic goal is to open a new clinic to recover market share by a particular date, then the business strategy should center around this goal. Any change in operation that is inconsistent with, or worse irrelevant to the goal, should be questioned and dismissed. In crises, management needs to be coordinated, iterative, and precise. Since time is of the essence, efficiency and agility are essential in the planning process.

After a thematic goal is established, the team needs to set objectives that are measurable. Crisis requires quick action. Having measurable outcomes insures that there is accountability for all management decisions at all levels.

Almost as important as establishing the crisis team and identifying a plan with goals is establishing an effective and comprehensive communication plan. In any crisis, stakeholders need to know who is in charge; they need to understand the processes being undertaken toward recovery; and they need to be confident that the leadership team has everyone's best interests at heart. To properly communicate during crisis, understand who your stakeholders are, identify a spokesperson, preferably someone with training on how to communicate with the media, and communicate often. In a medical practice, your stakeholders include your patients, your employees, the hospitals in which you work, other referring physicians, your community, and the public. Think broadly. Are there other stakeholders who may feel left out if not directly contacted?

In 2017, Adidas sent an email to all finishers of the Boston Marathon stating, "Congrats, you survived the Boston Marathon!" [2] Unfortunately, this e-mail was sent just 4 years after 3 people were killed and over 260 people injured in the 2013 Boston Marathon bombing. Adidas recognized their mistake and quickly apologized for their perceived lack of sensitivity. Their quick response and apology prevented a worse public relations disaster. In the aftermath of Hurricane Katrina, leaders at Tulane University School of Medicine created a "war room" where the team would meet at the end of each day to discuss each objective (obtaining housing for their students, bringing faculty to Houston, providing financial resources for students in need) and where they were in the process of accomplishing this objective. Frequent communication kept the team on task and also helped them feel accountable for the overall thematic goal of getting the school back into operation [3]. During time of crisis, frequent status updates are imperative.

Nothing is better at breaking down silos than a crisis. Silos are bad in business because they lead to distrust, inconsistent goals, and turf wars where people on the same team can actually work against each other. Nearly every silo can be attributed to leaders who have not fostered interdependence between different units of an organization. The silver lining of a crisis is that it brings people together toward a common goal. When a country goes to war, typically a president's popularity increases due to a sense of loyalty. To break down silos, identify key goals, gather consensus, and involve as many constituents as possible.

During crisis, honesty is essential. Successful recovery depends on the ability of leaders to communicate recovery plans and to have people trust their decisions. Many of us remember during the first Iraq War in 2003, Iraqi Information Minister Mohammed Saeed al-Sahaf, nicknamed "Baghdad Bob." He appeared on TV daily to predict an Iraqi victory and to deny the American Baghdad invasion even when US tanks appeared behind him on the screen. Sahaf did not waiver from his story until Baghdad fell, and he was captured and interrogated by American forces and ended up in Abu Dhabi where he sank into obscurity. The term "Baghdad Bob" is now used colloquially to refer to a leader who confidently attests to something that everyone else sees as false.

If you are a leader in time of crisis, lead by example. Be honest, show integrity, and take charge. The mayhem imparted by crises requires people to act quickly and to follow through with plans. You need to be the first to volunteer and the last to go home. It is also important to show emotion and empathy when appropriate. No one wants a leader who appears detached from their organization. Some crises are emotion driven by their very nature. As an example, physician suicide is an unfortunate reality that confronts practices, medical staff, and medical schools. Suicide produces feelings of guilt, sadness, and anger among survivors. A good leader in this type of crisis is not one who appears detached, but one who is warm, consoling, and emotionally involved in such a time of sorrow.

An example of not showing leadership and understand occurred in May 2010 when the British Petroleum Deep Water Horizon rig exploded in the Gulf of Mexico killing several roustabouts on the rig. During the crisis the CEO of British Petroleum, Tony Hayward, opted to take time off to go sailing with his son instead of dealing with the Gulf of Mexico oil spill. This was an example of a leader MIA just when his company, the families of the men who were killed, and those who injured in the explosion, needed to see a leader demonstrate ethical principles of responsibility, accountability, and humanistic care. The case of BP oil spill in 2010 provides an important example for understanding how these principles are valued by public opinion in a crisis situation and how the communication actions by a corporation in this type of circumstances might have long-term effect on the brand image of the organization. This is a textbook example of how not to conduct a crisis management resolution. Tony Hayward was relieved of his CEO position a few months later.

Finally, with any crisis, plan for next time. What will you do the next time your competitor opens an office down the street from you? What will you do with the next market crash? The next product recall? The next drug shortage? In his book, *The Black Swan*, Nassim Taleb describes a black swan as an event that is unpredictable and carries significant impact, and after the event, the facts are interpreted such that the event appears less random. The term "black swan" comes from the notion that if you have never seen a black swan, you assume that they represent a rare species mutation, yet they are actually reasonably common. The danger of black swans is that the human brain uses black swans to create the illusion that we know more than we actually know. The human brain is programmed to focus on specifics rather than generalities. For example, following 9/11, every airport has instituted a rigorous screening process under the assumption that the specific event, using airplanes as weapons, would be used in future attacks on American soil. Preventing such an attack was the targeted goal of airport security and remains so today. Unfortunately, the specific is not what is important, and in fact, the next terrorist attack is probably less likely to be via a weaponized airplane than a mass poisoning of our water supply. But we do not focus on generalities, such as making our world safer for everyone. When planning for the next crisis, do not assume it to be a black swan. In New Orleans, the next hurricane is not likely to be complicated by levee breaches, so in planning ahead, a narrow focus will not make the next crisis easier. In health care, the next epidemic will not be AIDS so to assume that efforts to reduce the spread of HIV will be effective for a future epidemic is foolhardy. Plan ahead with a general approach. This includes planning for

personnel changes, financial stresses, and changes in hospital management through mergers and acquisitions. Do not plan ahead for specifics such as planning for the next merger with a for-profit or planning for a shortage of one particular medication.

Back to the Case

Ben decided that he would not suspend operations of the school for the semester. Ben gathered a management team including his associate deans, key chairs, key faculty, and key students. Realizing that his city would not be ready for a medical school for at least 6–12 months, a decision was made to temporarily move the medical school to a city 350 miles away. His management team communicated with students, faculty, and staff, assembled a curriculum, organized housing, and created an alliance with other medical schools in the new location to train clinical students and residents. The school remained in the new city for the entire academic year and even recruited a new medical school class from their new location. Finally, after moving back home after 10 months, the team marveled at what they had accomplished with so little resources.

Bottom Line

1. Crises happen and by their very nature are unexpected.
2. Crisis management involves deliberative steps including identification of your leadership team, articulating a plan for recovery, communicating effectively and often, breaking down silos, being honest, leading by example, and planning ahead for the next crisis
3. In planning ahead, do not be deceived by black swans; the next crisis will never be identical to the last one.

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Physician Burnout: Don't Get Caught in the Flame

23

Marc J. Kahn and Neil Baum

Case: Lancelot

Lancelot is the youngest member of a five-person neurologic practice. One of the senior members, Arthur, appears to be detached from the practice and his patients. Arthur is consistently late to start his clinic and has been delinquent in filling out his medical records, leading to delays in payment that are adversely affecting the practice. Arthur is receiving negative comments on his lack of compassion and caring on online review sites. Arthur recently was involved in a lawsuit involving a patient who contends that he missed the diagnosis of a brain tumor. Lancelot worries that Arthur may be depressed. What is Lancelot, the young doctor in the practice, to do?

Most articles report a prevalence of burnout in approximately 50% of all physicians. As a result of physician burnout, our profession is witnessing a trend of young doctors making the decision to take alternate career pathways in technology, consulting, and healthcare policy instead of pursuing a career in clinical medicine. Also, we are seeing a rise in online communities of dissatisfied and disaffected doctors looking to change careers and even have their own "club," the Drop Out Club and Physicians Nonclinical Career Hunters (www.docjobs.com and www.nonclinicaldoctors.com) are two such examples [1].

Additionally, burnout is more common among physicians than among other US workers and other nonmedical professionals [2] (Ibid). We have a crisis on our hands; as physicians are becoming disillusioned and depressed and because of burnout, our profession has a very high rate of suicide. The burnout rate is emblematic of the problems facing our profession. We want to emphasize that burnout isn't just impacting older or near retiring physicians. More than 50% of medical students, residents, fellows, and early-career physicians are already experiencing burnout [3].

Definition of Burnout

Burnout is characterized by a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. Although burnout can occur in any profession and any field of work, burnout occurs most frequently among people in the caring professions of medicine, nursing, social work, counseling, and teaching.

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Causes of Burnout

Physician burnout is most often attributed to external influences such as work load, loss of autonomy, increase in paper work, and navigating the electronic medical record. For the most part, physicians are able to manage difficult situations especially in the clinical arena. However, external factors that are perceived as outside of a physician's control increase the stress that physicians have to face on a regular basis [4].

In the not-too-distant past, it was common in the medical education process to emphasize the concept of high touch to physicians in training. Many went into medicine in order to spend time talking to and providing counsel to patients. Today that concept of high touch has been replaced by high tech. Young physicians today are being micromanaged by many outside forces that make all physicians feel a loss of control and feel less valued

Autonomy is the basic ability of physicians to exercise their judgment in terms of how to spend their time, attention, and resources. In the past, doctors were in control of many decisions including when to see each patient, how much time to spend with each patient, what questions to ask patients, when to see the patient next, what kinds of tests to perform, what medications to prescribe, and what kinds of treatments to recommend without asking for permission or obtaining authorization. Today, the control and autonomy no longer exist. The current methods in medical reimbursement and technological advances are constantly mandating that physicians spend less time with each patient, more time spent looking at a computer than at the patient, more time spent with voluminous regulations and compliance guidelines to follow, and large amounts of information to process on behalf of our patients. Doctors become discouraged when caring for patients requires focusing on the monitor rather than on the actual patient. Most physicians complain of the tsunami of electronic paperwork. Filling out paperwork is not the reason that anyone decided to become a doctor. Most physicians remain altruistic and have a mission to treat patients and change the world—not to check boxes on paper or an electronic record. We often hear doctors feel that they are treating a computer and not a patient.

Young physicians experience an element of sticker shock when their training teaches the young doctor to focus on the patient, and then there is a transition to the real world of private practice which requires an adjustment to a new environment and learn the facts of business life, which include rules from government, insurance companies, and hospitals that limit the time physicians can spend with a patient. Those rules also require that the patient's visit comply with the Health Information Portability and Accountability Act (HIPAA), Accountable Care Organizations (ACOs), quality indicators, MIPS, and MACRA (see Chap. 12 for more information on MIPS and MACRA).

If we had to select one of the major causes of burnout today, it would be the electronic health record (EHR). Physicians who had to transition from paper charts to electronic records often describe the computer shackles or handcuffs and that every "additional click of the mouse inflicts a nick on physicians' morale." [5]

For many physicians, the EHR has become the final straw. Although intended to overcome the flaws inherent in a paper-based system, the EHR has produced its own set of problems; the greatest impact is a loss of eye contact with the patient. A recent article in *JAMA* tells it all (Toll E. The cost of technology. *JAMA*. 2012;307(23):2497–2498). The article included a drawing by a 7-year-old girl after a recent visit to her doctor. It showed the girl on the examination table. Her older sister was seated nearby in a chair, as was her mother, who was cradling her baby sister. The doctor sat staring at the computer—his back to everyone—including the patient. The message of the 7-year-old patient was crystal clear: Technology is making physicians less human and places focus on technology and not the patient.

Another complaint of young doctors is the time involved completing the electronic record long after the encounter with the patient is completed. One study involved ambulatory care in four specialties (family medicine, internal medicine, cardiology, and orthopedics) in four states

(Illinois, New Hampshire, Virginia, and Washington). For every hour the physicians spent facing their patients, they spent nearly two additional hours facing the computer, entering data. They also spent 1–2 hours working at home each night to keep up with their paperwork [6].

What a sad commentary to our profession that prides itself on high touch in addition to high tech that comes at the cost of loss of interaction with our greatest commodity, our patients. The electronic record requires the doctor to be a government collector of data and focus on the processes of care rather than outcomes. This is compounded by the fact that most electronic medical records are built and created with the primary purpose of billing and not caring for patients. It not surprising that the technology that is intended to improve health care, i.e., the EHR, is generating burnout and one of the most common reasons for doctors deciding to leave the practice of medicine.

Symptoms of Burnout

Burnout is reasonably easy to recognize. Usually, it is not possible to see it in yourself, but others can easily identify doctors who are experiencing burnout and can lead them to help.

In the early stages of burnout, doctors appear anxious and will be worried and sad. Uncontrolled anxiety may become so serious that it interferes in the doctor's ability to work productively and may cause problems in their personal life.

Partners and colleagues of the burned-out doctor may notice irritability between the doctor and the staff and the doctor and their patients. The burned-out doctor has a short fuse, and unexplained outbursts may occur. If anger reaches the point where it turns to thoughts or acts of violence toward family or coworkers, then this is a sign that professional help in needed.

Burned-out doctors will often complain of chronic fatigue. They may note a lack of energy and feel tired and lethargic on most days. If burnout goes untreated, the doctor may feel a sense of fear and anxiety and unable to function in the office or hospital setting.

Another symptom of burnout is insomnia. The doctor often reports trouble falling and staying asleep. As a result, the doctor is exhausted upon awakening in the morning.

The burned-out doctor will complain of loss of concentration and forgetfulness. It is common for those doctors who are experiencing burnout to forget to attend meetings, to be chronically late for clinic, to have marked delays reporting for surgery, and to miss significant events in their personal lives.

When burnout is untreated, doctors may experience physical symptoms such as chest pain, palpitations, shortness of breath, vague abdominal pain, and headaches. These are often confused with medical illness.

Burnout, even in its earliest stages, is often accompanied by a loss of appetite. As a result, unexplained weight loss occurs.

In the early stages, the burned-out doctor may feel mildly sad and occasionally hopeless and may experience feelings of guilt and worthlessness. In later stages, the doctor may experience frank depression and hopeless which puts those who suffer from depression at risk for suicide. The depressed doctor needs to obtain professional help as soon as possible.

The colleagues and partners of a burned-out doctor will notice an erosion of the doctor's productivity. The burned-out doctor is not able to complete projects on time. Burned-out doctors are those that have incomplete medical records in the office and at the hospital. The burned-out doctor does not complete charge sheets resulting in delays in receiving compensation. The doctor will have a litany of excuses but never seems to "climb out from under the pile" of work or responsibilities.

Solutions for Burnout

In Patrick Lencioni's book, *The Three Signs of a Miserable Job* [7], job satisfaction is discussed from a management perspective. Lencioni identifies three characteristics that make a job untenable: anonymity, irrelevance, and a term he coined, "immeasurement." Anonymity among

employees leads to feelings of frustration and isolation. Irrelevance leads to a loss of sense of meaning with work. Immeasurement, defined as the lack of accountability standards and metrics, leads to a lack of sense of how one is doing their job and a lack of a sense of fulfillment. All three of these, anonymity, irrelevance, and immeasurement, lead directly to physician burnout.

When looking for solutions to physician burnout, each of the three signs of a miserable job needs to be addressed. To protect against anonymity, we suggest getting involved in organized medicine (see Chap. 9). This can be done on the local, regional, or national level. We suggest starting by getting involved in hospital committees. Become the "go-to" person for questions of quality, credentialing, or pharmaceutical approval. At the regional or national level, get involved with your specialty or subspecialty societies. Develop a reputation. Develop specific expertise.

Become Relevant

Create the situation where you have decision-making capacity, either as someone who is part of a committee that writes guidelines for medical conditions for your hospital or as someone who helps decide strategy through allocating funds for projects. Many hospitals and healthcare systems now employ a chief wellness officer. Perhaps aspiring to be this person or at least to be on a wellness team can increase your sense of value. Teaching medical students, residents, fellows, or mid-level providers can provide a sense of job satisfaction and can help you keep up to date with your specialty. Additionally, psychosocial theorists suggest that we all seek to gain mastery over internal and external forces to establish as sense of wellness. Teaching allows us to feel competent, confirming our sense of worth.

We also recommend that you insist on measurement. Ask your supervisor or your group, "What is expected of me in the upcoming year?" Develop a 1-, 5-, and 10-year plan with milestones, and keep yourself on schedule. Demand feedback. Work on improving those things in which you are deficient, and work on being even better at those things you do well.

As for other solutions to the burnout crisis, recently, investigators have related the exposure to arts and humanities to decreased burnout among medical students [8]. The authors of this study speculate that the humanities stimulate part of the brain that is associated with pleasure which in turn improves quality of life. Interestingly, in this study, there was no difference between active participation in the arts (playing an instrument, writing a play, painting a picture) and passive participation (listening to music, going to see a play, going to an art museum). We do not suggest that the entire problem of physician burnout can be solved with a single rock concert, but personal wellness is certainly part of the solution.

Finally, create safe places for physicians to talk. Like a battlefield, the hospital workplace can be demoralizing and difficult to control. Feeling part of a team, or feeling connected, can relieve feelings of isolation and talking with others experiencing the same problems and provide support. Narratives are powerful communication tools and people typically feel good about talking about themselves. Sometimes talking about an operational inefficiency can provide a sense of control, even when control is not present.

Of course, perhaps the best solutions to physician burnout are to create systems, including the process of making entries into the electronic health record, that are efficient with respect to time and effort. Limiting work hours, providing time off, and allowing for work-life equilibrium are also important strategies. Sharing decision-making among hospital leaders and physicians also helps create a sense of control. The burnout issue among physicians is complex, and there is not a one-size-fits-all solution. Addressing the issue of physician burnout is something that all of us—physicians, hospitals, and health systems—need to address in order to provide the best care for our patients.

Case of Lancelot

It was clear to Lancelot that he was dealing with a burned-out doctor. Since Lancelot was the youngest doctor in the practice, he was uncomfortable confronting Arthur about the recognition of burnout. Lancelot approached two of the other older physicians in the practice and made sure they were aware of Lancelot's observations. The older doctors appreciated Lancelot's observation and met with Arthur and strongly recommended he receive professional help. Arthur saw a psychiatrist who specializes in substance abuse and burnout in physicians. Arthur received treatment and took a recommended leave of absence for 2 months. His partners were very supportive, and Arthur was successfully able to return to practice and remained very appreciative of Lancelot recognizing the reality of the situation.

Bottom Line

Burnout is not a condition we can ignore. Nearly 50% of doctors including medical students, residents, fellows, and young doctors are experiencing the signs and symptoms of burnout. The causes are a feeling of powerlessness, loss of autonomy, and the intrusion of technology that is intended to improve health care but actually detracts from the care we provide our patients. The signs and symptoms are easily recognized, and treatment is available for the impaired physician.

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"Divorcing" Your Business Partners

24

Marc J. Kahn and Neil Baum

Case: Phillipe

Phillipe is a nephrologist who joined a small practice in a rural community in the Midwest 3 years ago. He had an income guarantee for his first 2 years and was very productive earning a bonus during his third year in practice. However, his wife, a social worker, was unhappy in the community and could only find part-time work leaving her professionally unfulfilled. As a result, Phillipe considered terminating his relationship with the practice.

Physicians are under a tremendous amount of pressure in today's healthcare environment as costs escalate, reimbursement declines, and the threat of malpractice continues. Normal workplace stresses are exacerbated by longer hours, less pay, and less tolerance for error, which can lead to disappointment and ultimately the decision to leave a practice.

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Reasons for a medical divorce or termination of employment agreements are usually divided in two categories: "for cause" and "without cause." For-cause termination generally means that a party to the agreement can terminate the agreement, often immediately, if the other party breaches or violates the agreement in some way. The employment agreement should clearly spell out each of the causes for which the employment can be terminated. The causes for termination should be objective and reasonably within the employed physician's control but not so restrictive as to leave the employer without recourse if some unexpected behavioral or performance issue arises.

Common causes for termination with cause may include loss or suspension of a medical license, losing medical staff privileges at the hospital, failure to obtain or maintain insurance participation, failure to obtain or maintain board certification, conviction of a crime or felony, patient safety-related issues, or use of illegal drugs or abuse of controlled substances. For some types of cause, a physician may negotiate a provision requiring that the employer provide advance written notice of the complaint that, if uncorrected, will lead to termination, thus allowing the physician adequate time either to change the objectionable behavior or to find new employment.

Physician employment agreements can also be terminated without cause, which means that either party can terminate the agreement at any time. Without cause termination usually requires a notice of a certain number of days without

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having to identify any specific reason for the termination. It is common for contracts to state that termination without cause may be invoked by either party following a specified period of advance written notification, which is usually 90 or 180 days.

This type of termination provision can offer protection for both parties since, in the absence of a without cause provision, each party is obligated to abide by the terms of the initial agreement for the entire term unless they are able to find a cause for termination or are willing to breach the contract. If a departing physician chooses the latter option, this may result in a lawsuit for breaching the contract.

If you are planning to terminate your relationship with your employer, we suggest that you follow these steps to make the medical divorce as painless as possible [1].

1. Prior to notifying your employer of your decision to depart, review all documents especially the contract you have signed. It is best to do this with an attorney. Documents will most likely include an employment agreement, a shareholders' agreement (if the practice is a corporation) or an operating agreement (if the practice is a limited liability company), and, in some cases, a deferred compensation arrangement. During your review, pay careful attention to information about advance notice provisions, retirement plan details, and noncompete restrictive covenants, which are the key components of your contracts.

   It is critical that you understand and adhere what you have promised to do and what has been promised to you via these contractual agreements.
2. Next, review the practice's policies with your attorney. In addition to reviewing any documents you have signed, you should review any of the practice's policies applicable to employment and departures. Some employment agreements indicate that the practice's general policies and procedures may be applicable even if they are contrary to the physician's employment agreement.
3. One of the most important aspects of your departure is to develop a plan for notifying your patients of your departure. Many states have a requirement that all patients be notified when a physician is departing a practice. Some states even require or suggest 30 days prior written notice before a departure so that patients will have sufficient time to transfer their record sand care if they desire to change physicians. If you are not familiar with your state's requirements, contact a healthcare attorney in your area for advice.

In addition to sending letters to your patients, think carefully about how you will address your departure when you speak with patients in person. For example, you would never want to be in a situation where you felt compelled to lie to a patient. Often practices and departing physicians will agree on what to tell patients who inquire about the tenure of the departing physician. Some practices display placards in the reception area informing patients of a physician's departure. Voice mail systems can also be modified to provide new contact information after the physician has departed.

Think about patients first. When scheduling your departure from the practice, take reasonable steps to ensure that you are not leaving any patients in a bind. For example, if you are an obstetrician, you would not want to plan your departure during a week in which you are anticipating five deliveries. The key is to prevent patients from falling through the cracks because of tensions between the departing physician and the practice. You and the practice have an obligation to provide proper care for your patients. The take-home message is to consider the patient first and do not do anything that puts the patient's health in jeopardy.

High-risk patients should be sent a letter by certified mail, with return receipt requested to confirm their receipt of the notification. High-risk patients are those who are more likely to experience adverse outcomes and feel that they have been abandoned if their departing physician is unavailable for ongoing care. Examples would include recent postop patients and those currently

being followed for serious or chronic conditions. Keep a copy of the notification letter and certification material in the patient's record.

Active patients who are not high risk should be sent a letter by regular post. Examples of active patients include those seen within the last 12–18 months. Again, we suggest that you keep a copy of the notification letter in the patient's record.

Finally, notify other patients who will not be receiving a letter by placing a notice in the local newspaper with the largest local circulation. We also recommend placing a sign in the reception area about any changes in physician employment.

The practice should also provide a script for phone receptionists on what to say. This should include information on how to contact the departing physician.

If the departing physician will not be available for ongoing care if they are moving out of the area, the letter should provide this information but should also explain that care is available at the same location from other physicians in the practice. You should tell those patients who choose to seek care elsewhere that, upon their written authorization, a copy of their medical record will be forwarded to their new provider.

If the departing physician will be available for ongoing care, explain to patients that the physician is leaving the practice but is still available in the area. Tell patients that they have the choice of staying with the practice or continuing to see the same physician in his or her new location. Instruct patients who choose to follow the physician that, upon their written authorization, a copy of their medical record will be forwarded to the physician at his or her new location.

To expedite the transfer of records, you should consider including an authorization form with the letter of notification. If your practice is going to charge the patient for the photocopying costs, you should inform the patient what the fee will be. Any material that is related to patient care should be considered part of the medical record, should be considered confidential, and should be provided to the new physician. Both the practice and the new physician should keep a copy of the medical records.

For patients who stay within the practice, the patient should be notified about the change in provider. The patient's preferences should be honored either to stay in the practice or continue with care with the departing physician.

If the care will be provided by another practitioner with the same scope of practice as the departing physician, simply inform the patient of the new provider's name. However, if the care will be provided by a practitioner with a different subspecialty, you should verify that the patient's clinical needs can be safely met by the new provider.

Figure 24.1 is a sample of a letter you might consider sending to your patients announcing your departure

4. Review advance notice provisions. Your contract may require that you give your practice advance written notice of your departure. If you fail to give notice, the practice could claim breach of contract, and you could be held legally responsible for the cost of hiring a locum tenens physician or the cost of recruiting a new physician to fulfill the remainder of your term. Further, many deferred compensation arrangements are linked to the amount of notice given. Some require an extraordinarily long notice period (such as 1 year) before the physician can qualify for any deferred compensation payments.
5. Review your retirement plans. This will ensure that your departure date does not result in unnecessary forfeitures. For example, some retirement plans require an employee to work the entire year prior to becoming eligible. While it may be convenient to resign shortly before Christmas so that you can spend the holidays at home, it could be a monumental mistake if it results in losing nearly 1 year of retirement benefits. Further, many retirement plans have vesting schedules that depend on the number of years you have worked with the employer in order to receive your deserved retirement compensation. You and your attorney should review the details of your plan so that you do not unwittingly forfeit significant amounts of retirement money.

Fig. 24.1 Sample letter to patients from a departing physician

Notice of Leaving Practice (Patient)

Dear (patient's name):

It is with mixed emotion that I am [announcing my retirement from active practice; relocating my practice; etc.] as of [date]. This decision has not been made lightly, as I have enjoyed working at _____.

As of [date], Dr. _____ will be taking over my practice. [Describe the new physician's background in 1-2 sentences]. Dr. _____ can be contacted at the address below:

[Name of Physician and/or Clinic] [Address]
[Telephone number]
[E-mail]

If you prefer, you may obtain the services of another physician. If you choose to do so, I would recommend proceeding as soon as possible to ensure a smooth transition for your health care. The local Health Region keeps a list of physicians who are accepting new patients.

Your medical records are confidential, and a copy can be sent to another physician or released to you or another person only through your consent. I will be pleased to provide a summary of my care while you have been my patient, and with your consent, will arrange to have a copy of your file transferred to your new physician's office. Please sign the enclosed authorization form and return it to our office as soon as possible before (date) so that we may make the appropriate arrangements concerning your file.

It has been my great pleasure to have provided you with health services in the past, and I am grateful to have had the opportunity to meet some wonderful people throughout my years in practice. Best wishes for a healthy future.

Sincerely,

Dr. _____ [title]

6. "CYT" or cover your tail! Many practices obtain "claims made" malpractice insurance policies that insure you for claims made during your term of employment. This means that if a malpractice event occurs while you were employed but the claim was not filed until after you have left the practice, the malpractice insurer will not cover that claim because it was not made during your employment. To prevent this, you need to procure a supplemental policy, commonly referred to as "tail coverage," which insures you for claims made after your employment terminates. While some employers will contractually agree to pay tail insurance, a thorough review of your employment agreement will determine who is responsible for procuring tail coverage.

Whether the practice pays for tail coverage often depends on the type of termination. For example, practices often agree to pay for tail coverage in the event that employment is terminated by the practice without cause, meaning there was no violation on your part. For example, if the practice was sold or merged with another group, the malpractice might not cover you in the event of a claim after the practice is sold or merged. Likewise, physicians often agree in their initial contract negotiation to pay for tail coverage if the physician terminates their employment without cause.

This tail coverage can be significant, especially if you are an obstetrician or in another high-malpractice-risk field. Thus, regardless of who is responsible for procuring tail coverage, that party should provide a certificate of insurance to the other party. Do not be seduced into foregoing the purchase of tail coverage. The cost of successfully defending a medical malpractice action is lifestyle altering, and you do not want to do this on your nickel.

While you can purchase tail coverage that has no end date, many malpractice carriers offer 1-year, 2-year, 5-year, or 7-year tail coverage

policies. These finite tail coverage policies as opposed to lifetime coverage are generally less expensive. If you live in a state with a limited statute of limitations on medical malpractice insurance claims, these finite tail coverage policies can save you money without leaving your tail exposed.

If you are responsible for tail coverage, you may be able to negotiate with your new practice to provide you with sufficient funds to purchase it. Or, in limited circumstances, the new practice may provide coverage through a new policy with a retroactive endorsement date. This is referred to as "nose" coverage. Our take-home message is to check out both your tail and your nose so that you are covered in the event of a malpractice suit after you leave a practice.

There are several companies that will provide you with free quotes on tail coverage (https://www.cunninghamgroupins.com/request-a-free-quote/ or 866-213-3035) or The Doctors Insurance Agency, http://www.doctorsagency.com/blog/entryid/1137/-the-cost-of-tail-the-doctors-company-, 800-553-9293).

7. Parting with the patients' charts. Be aware that patient lists, patient charts, and other patient demographic information are property of the practice, not the departing physician. Employment contracts usually reinforce this stipulation in the contract. Rarely do practices agree that patient charts are the property of the departing physician. These assets belong to the practice and cannot be taken by the physician without the practice's consent. You should note, however, that most states allow the patient to request that his or her chart be forwarded to a departing physician, in which case the physician can, at that time, receive the chart from the practice. Usually the practice will charge the patient for copying the chart. Importantly, the departing physician cannot merely request a copy of the chart be sent to them in their new practice.
8. Taking employees with you is a no-no. Your contract may contain provisions against your soliciting the employment of existing employees of the practice. Even without these prohibitions, you should not actively solicit the employment of existing employees, especially prior to your departure. Some states would consider this behavior an egregious act, and courts would find favor with the employer if a physician were to "raid" the practice for employees. It is, however, not uncommon for employees to solicit the departing physician prior to departure. This creates a quandary because although you may need new employees, you do not want to appear to be soliciting from the existing practice. Before you make any decisions, revisit your employment contract and your state's laws regarding the issue. This is another area where a healthcare attorney can be very helpful.
9. Review noncompetition covenants. A noncompete covenant may prohibit you from practicing within a certain geographic radius of your current practice for a designated period of time, often 2 years. The radius is usually determined by your practice's location and could range from 5 miles in a suburban area to 50 miles or more in a rural area. Many departing physicians are of the opinion that these covenants will not be enforced; however, the courts in most states will uphold them if they are reasonable. For this reason, you should review the covenant as though it will be enforceable in accordance. Litigating a covenant, either from the employer or departing physician's perspective, is expensive. Do not hesitate to contact an attorney if you have any questions.
10. Even when leaving a position under less-than-ideal circumstances, the departing physician should leave adequate forwarding information. Patients may need to contact the departing physician. Payors may need to contact them as well, especially where audits and adjustments that are the responsibility of the departing physician are concerned. If the practice has to respond it does not know where the departing physician is located, complaints to the medical board are a certainty. And a physician does not want a

complaint when they are trying to obtain license in another state or obtain hospital privileges at another institution.

Dependent upon the provisions of contracts and state law, both the departing physician and the practice may need to notify various third parties:

- The malpractice insurance carrier that needs to know of any changes in order to ensure coverage of the care rendered in both the prior and future practice settings.
- Managed care companies with whom you have contracts.
- The medical staff committee of hospitals where the departing physician has privileges. If he or she is on-call at the hospital, notify the emergency department as well.
- The state board of medicine (if required by state law).
- Legal counsel for assistance as needed in contract provisions and employment law.

Figure 24.2 is a letter you might consider using to notify colleagues of your departure from a practice.

We strongly advise securing the counsel of a healthcare attorney with any contract-related matter. Just as the words cure, remission, and no evidence of disease are pleasant words to the ears of the treating physician and their team, divorce is a pleasant word for healthcare attorneys. Although physicians are transitioning from volume to value, attorneys are still reimbursed by the volume of cases they have, and they will be just delighted to help you through a potentially

Fig. 24.2 Sample letter to colleagues and professional associations, payors from a departing physician

Dear (name of individual or agency):

It is with mixed emotion that I am [announcing my retirement from active practice; relocating my practice; etc] as of [date]. This decision has not been made lightly, as I have enjoyed working at _____.

As of [date], Dr. _____ will be taking over my practice, as well as the bulk of my medical records. [Describe the new physician's background in 1-2 lines]. Dr. _____ can be contacted at the address below:

[Name of Physician and/or Clinic] [Address]
[Telephone number]
[E-mail]

[Use this paragraph to indicate any committees, appointments, and other positions from which you will be stepping down that could be relevant to this individual or organization, or any other message you wish to convey to referring physicians, etc.].

If you need to contact me for any reason, please don't hesitate to give me a call or send me an email and I will respond quickly.

[Your Name and/or Clinic]

[Address]
[Telephone number]
[E-mail]

It has been my great pleasure to have worked with you in providing quality health care in Saskatchewan. I am grateful to have had the opportunity to meet and work alongside some wonderful and remarkable people throughout my years in practice.

Sincerely,

Dr. _____ [title]

expensive experience. That is why we suggest that you seek the counsel of an attorney with healthcare experience and an attorney who has experience managing medical termination on behalf of an employed doctor. We also recommend that you ask your attorney who you are considering hiring for an estimate of the charges for managing your case. You cannot hold their feet to the fire, but they should provide you with a ballpark cost of managing your case. If the attorney comes back with a response that they just "log in their hours" and then give you an hourly fee, then we suggest you walk to the next healthcare attorney as they are many of them available who will provide you with an estimate of the fees you will likely be paying.

Phillipe's Case

Phillipe contacted his employer, and his attorney discussed the situation with his family about his desire to leave the practice. Phillipe made a point to his employer that he was generally happy with the physicians and employees in the practice and wished to leave on good terms but that he had to think about the happiness of his family first. Phillipe sought the counsel of a respected healthcare attorney in his community, who helped him to write a letter to all of his patients several months before his date of departure, and then made certain that he had tail coverage in the event of any lawsuit filed after he left the practice. As a result, Phillipe had a reasonably amicable separation from the practice and moved to a large community where his wife was able to obtain full-time employment, and they lived happily ever after!

Bottom Line

Most young physicians do not have the knowledge or the skills required for departing from a practice. It is for that reason that we suggest contacting a healthcare attorney who has experience with medical contracts before deciding to leave a practice. Leaving a practice can be a stressful time in any physician's career. A clean departure will save you headaches and possibly dollars in the immediate future and in the long run. Your careful attention to these details will ensure a smooth transition to a new practice.

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Life-Work Equilibrium

25

Marc J. Kahn and Neil Baum

Case: Ivan

Ivan is an orthopedist who has been in practice 5 years. He has a very productive and growing practice; yet he feels guilty for not spending more time with his young family. His wife has informed him that his adolescent son is having behavior problems at school. Ivan is faced with the double conundrum of feeling guilty about not spending time with his family when he is at work and also feels remorse when he is with his family and not at the office or taking care of patients.

As doctors we are on a high wire between two buildings trying to hold on and knowing that one mistake can result in tumbling to despondency and even depression. Life is very much a balancing act, and we are always just a step away from a fall. We are constantly trying to move forward with our purpose, help others to achieve optimum health, all the while trying to keep in balance our personal and professional lives. Here are a few suggestions that we have found from our balanced colleagues that they have used to help them stay on the high wire.

1. Always be a student. Medicine is a lifelong commitment to learning. No doctor can be on top of their game if they are only using the knowledge and skills that they received when they completed their education or training. Balance is achieved if you continue to follow a lifelong pursuit of knowledge. Maintenance of certification programs for specialty boards help to ensure that keeping current is a physician's responsibility. A medical career is a journey and not a destination. You should always make time to be a student for your entire career. Sir William Osler, honorary professor of medicine at Johns Hopkins University, recommended to physicians and students at the end of the nineteenth century, "In order to receive the education of not a scholar, at least of a gentleman, you should read for a half hour before you go to sleep, and in the morning have a book open on your dressing table. You will be surprised how much can be accomplished in the course of a year" [1]. After all, learning new things is fun.

   Options for continued learning include the regular reading of journals, attendance and participation at specialty society meetings, or teaching the next generation of physicians. Remember, you need to be student of

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medicine, but do not forget about learning about things outside of medicine through participation in book clubs, taking community college classes, or joining interest groups in things such as astronomy, cooking, rock collecting, and the like. The secret of a good life is the eternal quest for knowledge.

(Several learning opportunities are available at the end of this chapter.)

2. Be ethical. A recent report in a pediatric journal states [2] that "44.7% rated their ethics education during residency as fair or poor." The facts are that most physicians have received very little training in medical ethics. All physicians will have or will be faced with ethical decisions that we will have to make for or on behalf of our patients. Examples include end of life care, AIDS care, care for underaged patients (children), release of sensitive information, or termination of the physician/patient relationship. Balance in our lives includes making the right ethical decisions at the right times on behalf of our patients. Perhaps the best advice we can offer when confronted with an ethical issue is to do what is in the best interest of the patient, and you will probably make the right decision. The secret of good patient care is providing outstanding caring for the patient. Most state licensing boards now require that continuing medical education include regular courses in ethic. Doctors should regard this not as a burden but rather an opportunity to look at your patients and your profession through a lens from a different and balanced angle.
3. Take active control of your finances. Most young doctors today enter practice with nearly $250,000 of debt, which will take years to pay off. (See Chap. XXX on debt repayment.) However, balance comes from having the expectation of financial security at the end of your career when you can practice because you truly enjoy the practice of medicine not because you have to work to earn an income. In order to have that security and that balance, we recommend that you start the saving process early. Even in the face of daunting debt, you need to start a savings plan for your children's education and for your retirement long before they will need those funds for their tuition. (See Chap. 11 on Basic Personal Finance and Investing.)
4. Learn to say "no." There is no faster road to imbalance than taking on too many projects and accepting too many responsibilities. The next time you are called to join a hospital committee, to become a member of a board in the community, or to accept an invitation for an evening dinner ask yourself these questions: Will the obligation enhance my career? Will the commitment take away from my time with my family and friends? Will this obligation lead to balance or imbalance in my life? If the answer is that you aren't furthering your career and if it distracts from your family time, then you should probably turn down these requests. Remember it is not a sin to say no. Sometimes it is advantageous to have a mentor to rely on to help you make the decision to say no.
5. Set your priorities. For most physicians who have balance in their lives, they place their religion, their family, and then their practice as the order of importance in their lives. Rabbi Harold Kushner, author of *When Bad Things Happen to Good People*, pointed out that "He never met a man on his death bed who said he wished he spent one more day at the office," "or saw one more patient" (italics is my addition). This is good advice and it is never too late to spend one more day with your significant other, your children, and your grandchildren. Another saying that emphasizes this concept is "when you climb the ladder of success, make sure your ladder is facing the right wall." Many a doctor has worked diligently and provided outstanding care for their family but did not remember the concept of balance. As a result, when they climbed that ladder and were medically successful, they were saddened by an unhappy marriage or children who did not turn out quite like they had hoped.
6. Find a niche. Ross Perot, entrepreneur and candidate for the president of the United

States in 1992, described success as finding an unmet need, becoming an expert, and filling that unmet need. The philosopher Hegel wrote, "every occupation has reference to some want." If you can identify an unmet need and fill that need, others will be knocking on your door to be your patients or to do business with you. It is amazing how successful you can be if you focus your energies on a single area of interest or expertise. Finding a nice applies to all areas of medicine. A primary care doctor can focus on nutrition and weight loss, an orthopedist can direct his attention to sports medicine, or a radiologist can narrow his practice to patients with head injury or back pain. All of us have some areas that we enjoy and have expertise. It is possible to seek out those special areas and use marketing and practice promotion skills to attract those patients to our practices. When you become an expert in a narrow area, you become more efficient and more productive, and focus will ultimately provide more balance in your life.

7. Hang out with people one generation older or younger than yourself. If you are a young, new physician, then meet older more seasoned doctors who can function as a mentor and show you the ropes, share their valuable experiences, and give you wise counsel when you need it. Every young doctor needs to learn to avoid the potholes when they move from training to the real world of medicine.

   Find a mentor with an experienced physician who works with you to help you to develop professional goals and plans to support your growth and development.

   The traditional mentor is a physician with whom you have created a formal or even informal relationship for helping a younger doctor become acclimated to the medical community. To have a successful mentoring relationship, meet on a regular basis for sage advice to discuss topics that are of concern. Use your mentor as a sounding board to answer questions and to receive feedback on issues of concern.

   There are two ways to structure mentor relationships. First is the formal or structured relationship. In this type of relationship, you arrange specific times each week or month to meet with or speak with your mentor. In these meetings you can report on your progress and specific challenges and even develop an action plan. The second type is the more common or informal relationship with the mentor. Either the mentor or the young doctor may check in periodically to discuss current challenges and also to report accomplishment without a set schedule or predetermined frequency of connecting. We believe the structured approach to be better, but because physicians are busy, we recognize that sometimes a less formal structure is necessary.

   In finding a mentor, select someone who you admire and respect because of their age, stature, or position within the community. If possible, you want to select a mentor who has considerable expertise in your specialty or who is a leader in the field. The mentor should have a reputation as being a good communicator. You also want a positive person who is enthusiastic about their profession. Look for an individual who has a caring attitude and is known for their compassion and empathy with patients. Finally, look for a physician who has the time to dedicate a few minutes each month with you so that you will not feel like you are imposing on their time.

   Entering private practice can be a daunting experience. One way of softening the shock is to find a mentor who will help you learn the ropes and avoid the potholes that are sure to confront every doctor who moves from training into the real world of medicine.

   Just as a mentoring relationship with an older physician is beneficial for a younger physician, the opposite is also true. If you are an older physician, hang out with the Gen Xers. Contact with younger people can keep you current, keep you energized, and keep you on top of your game. The advice is to

balance your friendships which will bring balance in your life.

8. Exceed patients' expectations. To truly enjoy your medical practice, it is important to not just meet patient's expectations but to go beyond what is expected and exceed those expectations. We suggest that you adhere to "the extra mile philosophy." This philosophy requires you to go the extra distance for your patients, to exceed their expectations, and to provide a little more than other doctors. Your patients will remember you for it. Many businesses, from office product suppliers to upscale department stores, have found that providing deluxe services to their customers ensures that those customers will keep coming back. A medical practice is no different from other businesses in this respect. In today's healthcare market, it is very difficult to compete on price. What you can do is to make sure you're your appointment book is full. This can be accomplished by asking and then answering two questions: (1) What do patients want? Then give them more of it. (2) What do patients not want? Then make every effort to avoid it. It is just that simple.
9. Be a disciplined doer and a decider, not a procrastinator. Nothing adds more anxiety to our lives than having deadlines and commitments that we are having trouble meeting. If you have several projects looming in the future, break them down into smaller projects and make a calendar marking off the completion of these little projects. That way you will not be left with a huge project with only days to complete. Discipline can bring balance to the busy professional: clean out your inbox, fill up your outbox, complete your medical records before the delinquency notice arrives, and look for an end point to your day. There will be a new set of mail, results, and problems tomorrow; a clean slate creates a balanced perspective. Confront those challenging decisions: a professional who can decide in a few minutes to recommend radical extirpative cancer operation to a relative stranger ought to be able to decide about the new 3-year lease with a few day's reflection.
10. Have fun. The best advice to achieve balance is to take your profession seriously, but not yourself. Find ways to inject a little humor into your daily activities. Start your day by listening to a humor CD of Jeff Foxworthy, George Carlin, or an old Abbott and Costello routine. Smiling releases endorphins, and there's no better way to trigger a positive feeling in the body and reduce stress than to smile. A smile is contagious, and you want to make sure that yours is worth catching!

    Let us not forget that medicine is the most enjoyable profession and it can be the most fun and rewarding especially if we add a dose of humor.
11. Consider having an unplugged day. As physicians we spend an inordinate amount of time on computers and watching screens on EMR, iPads, and cell phones. It is not unusual for a physician to start every day looking at emails and also checking the computer inbox when they arrive in the office. Most physicians are tethered to the Internet and cell phone for 24/7, and that includes days when a physician is on vacation. As a result, most of us have become slaves of social media, email, texting, and apps.

There is a solution to this enslavement: it is called getting unplugged and having an electronic sabbatical. This electronic sabbatical occurs when you are totally unplugged from the Internet, mobile phone, computer, iPad, and other electronic devices for just 1 day a week.

To prepare for your unplugged day, you can begin by thinking of a solution to move Internet or computer tasks or projects to a different day. Then answer your most important emails before the unplugged day starts. Finally, setup an automatic email responder that you will not be answering emails until Monday if your unplugged day is Saturday or Sunday.

If you have a blog, send out blog posts on Thursday or Fridays so you can connect with your readers.

If you have a Facebook account, do not respond on your unplugged day. Do not be surprised if your friends still like you on Monday!

Do not post on Instagram or Snapchat. Your photo can wait to go viral for one day!

There are other benefits of becoming unplugged. After an unplugged day when you are free from the shackles of the digital world, you will notice dramatic changes within yourself. You will think differently, you will act differently, and you will see things from a new or different perspective.

You will notice that time will actually slow down. You will pay more attention to the priorities of your life, and you will be more receptive to new ideas, new concepts, and even new friends that are coming your way. Becoming unplugged will make you feel like time is in abundance.

By being unplugged for just 1 day, you'll create room for ideas and insights. You'll gain real inspiration from life and circumstances that is different from the usual online inspiration. You may find this is the best time for stimulating your creative juices.

You will soon appreciate that the positive effects from being unplugged for a day are felt long after the unplugged day is over.

As Thomas Friedman said in his book, *Thanks for Being Late*, the world is always in a state acceleration. Mr. Friedman advocated taking a regular scheduled pause and reflection instead of being in a constant state of acceleration. As a result of slowing down and unplugging, you will increase the odds that you will better understand and engage the world around you and, yes, even become a better and balanced doctor.

Remember what the good book says, "Thou shalt work hard for six days a week and rest on the seventh day." I think in 2018 and beyond that means getting unplugged for just one day a week!

Ivan's Story

Ivan recognized that he was becoming a successful doctor, but he was missing having balance in his life. As a result, he started scheduling time for his family just as he had a schedule for his practice. Ivan and his wife set a date night each week and even arranged to have an in-town vacation for just one night at a local hotel. Ivan volunteered to be an assistant coach on his son's soccer team and made arrangements to attend every game with the only exception of his absence was if he was in surgery. As a result, Ivan's son's behavior problems improved due to being able to spend time with his mother *and* father. He and his wife were back on track as a team and able to enjoy their lifestyle.

Bottom Line

No one ever said medicine was easy or fun. But it can be both and even more if you have made an effort to place an emphasis on balance in your professional and personal lives. It can be done; just follow these 10+ suggestions. The best ending for this chapter comes from Rabbi Harold Kushner, author of *When Bad Things Happen to Good People,* who said, "I never met a man or woman on their death bed who said, "I wish I would have spent one more day at the office."

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Marc J. Kahn and Neil Baum

Case: @rayco

@rayco graduated medical school in 2020, and she has been in an equity fund-owned primary care practice since completing her residency with Healthcare American (HA) 15 years prior. HA is the country's largest healthcare conglomerate, being initially formed from the nation's largest independent insurer, a large hospital system, a pharmacy benefits company, and a major retail outlet. @rayco enjoys the coaching aspect of primary care. The group has enrolled 8000 patients. The patients she sees have already used HA's proprietary software to receive their diagnosis. The software boasts an error rate of less than 5 per 100,000 patients. The software immediately feeds to HA's proprietary electronic health record (EHR) and prescribes a therapeutic plan for each patient. In fact, the EHR feeds information to the on-site pharmacy so that patient's current medications as well as OTC medications and supplements are available prior to the patient's appointment. During residency, @rayco learned how to modify patient behavior and provide healthcare coaching, which are key skills for an effective primary care provider. @rayco is thrilled that her calculated value score, based on both the quality of her care and her costs per patient, places her in the top 10% regarding patient satisfaction, productivity, and cost-effectiveness of all of the primary care providers in her network. As a result, she enjoys a 12% bonus on her base annual salary.

In 1957, three agricultural scientists, Joe M. Bohlen, George M. Beal, and Everett M. Rogers, at Iowa State University published a model of technology adoption that continues to have relevance today. In this model, the process of technology adoption is defined as a bell curve. The first group to use the product, on the far-left tail of the bell curve, is called *innovators*. The next group, moving left to right, is called *early adopters*. These are followed by *early* and *late majorities*. On the far right are the *laggards*. This model has several limitations, the least of which is that it assumes a linear and continuous model for technology adoption (see Fig. 26.1).

Clayton Christenson, a professor at the Harvard Business School and considered the

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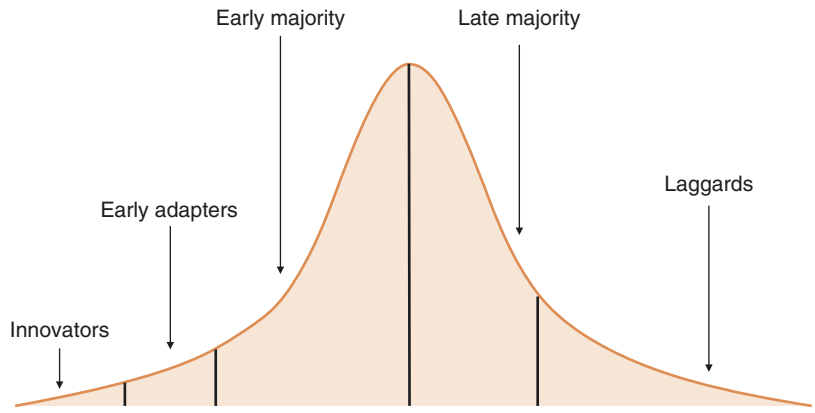

Fig. 26.1 Rogers model of technology adoption

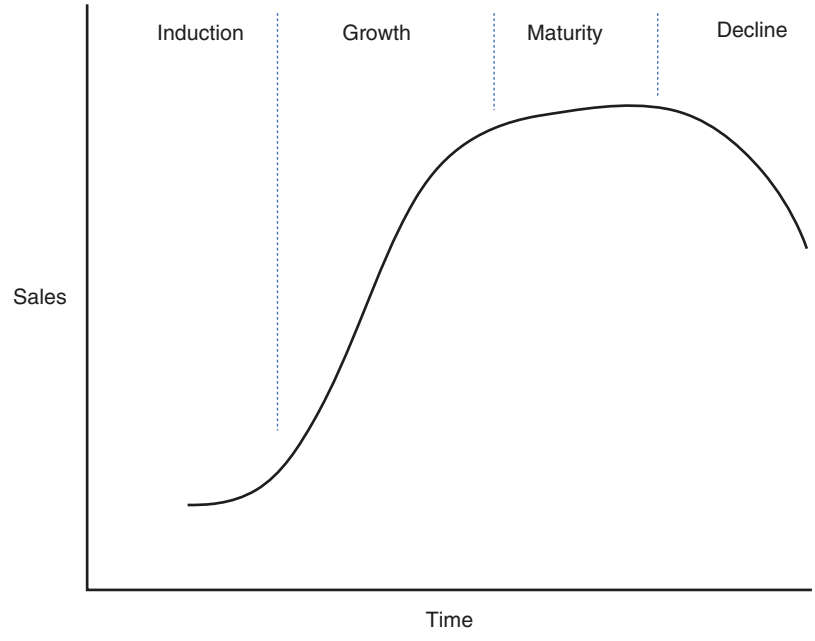

Fig. 26.2 S-shaped model of technology adoption

foremost authority on innovation and technology, in his classic book, *The Innovator's Dilemma*, described "disruptive technologies." One of the key features of disruptive technologies is that their adoption is not linear, but rather S-shaped such that initial adoption is low, followed by rapid adoption that eventually levels off (see Fig. 26.2). This is because improving an innovation is slow and iterative. Initial improvements provide minimal value to the customer. However, over time, these improvements become drastically better than previous enhancements, leading to rapid product adoption. At the end of the product's lifestyle, the improvements are marginal. For example, consider the mobile phone, which was initially large, expensive, cumbersome, and unreliable. Few people had them. The Apple's iPhone was dramatically better. Apple has sold more than 1 billion phones since introduction in 2007! Next consider the most recent iPhone models; they are better than the last, but not by much. As such, sales have slowed considerably; thus, they are on the right of the S-shaped curve.

Disruptive technologies are defined as innovations that interrupt or displace a traditional technology or existing market in order to solve or

improve upon a problem that is currently in use. This in turn creates a new market by displacing an older technology. In health care, these disruptive innovations will often come at a lower cost, with an enhancement in quality over the product, treatment, or technique that it replaces. Over time, these disruptive innovations improve on quality and performance and eventually take over a market space. For example, in medicine, ultrasound was originally developed as a less expensive alternative to standard X-rays. Over time, ultrasound technology improved providing enhanced images such that today, point of care ultrasound is a necessary skill and requirement in many specialties.

In health care, retail outlets such as Walmart have opened urgent care clinics staffed mostly by midlevel providers, i.e., physician assistants, nurse practitioners, or medical assistants. These are cheaper alternatives to hospital-owned clinics or staffing these clinics with graduate medical doctors. Assuming that the level of care and the quality provided to a patient are related to the number of hours of clinical training completed by the provider, the outcomes may be of lower quality. However, looking to the future, assuming these clinics are disruptive innovations, we can predict that they will disrupt the market for primary care services. They will become the dominant model. For example, pharmacies are monitoring patients' blood pressure and offering to provide vaccines such as flu and shingles vaccines to patients. This is a convenience to patients and is provided at a lower cost than going to a traditional bricks and mortar physician. And then consider the ease of access for patients seeking medical care at Walmart, Costco, or their local pharmacy compared to the long waits for an appointment to see a doctor in their office. You can easily see why patients are moving in large numbers to these disruptive delivery systems of health care.

The danger of disruptive innovation is that established companies typically view the disruptive technology as unattractive, and consequently it is initially ignored. The established market leaders can be blindsided as the technology takes off, leaving them far behind. Remember what happened to Blockbuster video stores with the arrival of Netflix, or observe what is happening to retail stores which are being replaced by Amazon. Fast forward, Amazon is continuing to disrupt the market and is now competing with FedEx, UPS, and the United States Postal Service by delivering its own packages. Because of the size of the healthcare market, currently more than $3 trillion per year, and the rising cost of medical care and medications, health care is ripe for disruption.

What Are the Traditional Forces That Define and Shape US Health Care?

Health care in the USA is distinguished as a predominately private, complex, multi-payer system that has focused on scientific and technologic advances. In the recent past, insured patients did not bear the full cost of their medical care due to coverage often paid by the employer, and so patients were not incentivized to consume less services, nor were their providers incentivized not to provide more medical services. In addition, competing special interests from physicians, hospitals, insurers, pharma, and patient advocacy groups have all worked to strengthen their position in the policy landscape, sometimes to the detriment of high-value care. Each of these components contributes to the higher costs, with little accountability regarding quality or outcomes.

Although the rate of healthcare growth has slowed somewhat in recent years [1–3], it does not appear to have reached a ceiling yet. As more of the economy's resources are devoted to health care, less is available for other goods and services. While jobs within the healthcare sector are generally higher paying, if the overall growth of health care outpaces that of the rest of the economy, Americans will find themselves less able to access and afford the medical care they need. American businesses are also faced with the burden of growing healthcare costs as they struggle to provide benefits to their employees and remain competitive internationally [4].

Future Changes in Reimbursement

The fee-for-service (FFS) model often results in over-utilization of low-value and unnecessary care [5]. FFS can also impede coordination of care for patients across the healthcare system [6]. This service model does not appear to be sustainable, especially with an increase in the baby boomer population as 10,000 boomers turn 65 every day [7], and those with chronic and complex health needs [8, 9] are also increasing. As long as providers are rewarded for the volume of care delivered, as in FFS arrangements, instead of the value provided, they are pressured to deliver more care, and population healthcare costs will continue to rise without regard to improvement in patient outcomes. Both private and public payers of health care have recognized this and have begun to shift their payment models that are soon going to be tied to outcomes and to quality of care.

The old paradigm was for doctors to provide a service, perform a procedure, or order a test. The more tests and procedures that the doctor did, the greater was their compensation. That payment method, fee-for-service (FFS), had worked for many decades, but the future of that fee-for-service model is no longer tenable. There is probably no greater disruption to modern health care than the movement from payment for the volume of care provided to the value of care delivered.

Every young physician knows that there are multiple changes occurring every day. Today, the healthcare environment is exceedingly complex and potentially very difficult for young or new physicians to navigate.

In the past, physicians received compensation for the services provided to care for patients. This is the traditional fee-for-service (FFS) method of reimbursement. For employed physicians, FFS may be computed as the relative value unit (RVU) metric, but it is still based on "you get what you kill." (Isn't that a moronic term applied to the healthcare profession where we take an oath "to do no harm" and to restore health and certainly not to kill patients?)

In addition to changes in physician reimbursement, employers have recently started shifting costs to employees by requiring employees to contribute a percentage of their insurance premiums and offering employees a high deductible health plans (HDHPs) which reduces the annual insurance premiums [10]. Enrollment in HDHPs currently consists of about to 29% of insured workers, up from a mere 4% in 2006 [11]. As more patients are enrolled in HDHPs and face the full cost for at least their initial care, these patients are more likely to demand transparency of healthcare costs and want to see better results or outcomes. Ultimately, today's employees want to more fully understand what they are getting for their increased payments.

The Department of Health and Human Services is striving to have 90% of all Medicare FFS payments tied to quality or value by 2020 [12]. Medicare's new payment reform system, The Medicare Access and CHIP Reauthorization Act (MACRA) will help the organization to reach that goal. MACRA consolidates previous quality reporting systems to streamline tracking and reporting, thus further encouraging value-based care over volume of care provided. (See Chap. 12 on MACRA.) If previous policy changes are an indication, as Medicare goes, so too will private insurance, and it will do so very quickly.

Indeed, the future of medicine is moving from volume. If a young physician can demonstrate that they can adapt to new incentives by shaving costs while maintaining and improving their quality and their outcomes, these young physicians will be more competitive in the changing marketplace.

Future Importance of Medical Quality Assessment

The importance of quality in health care may seem obvious. It is underlain by the Hippocratic Oath that physicians take attesting *primum non nocere* or, first, to do no harm. Poor quality of care can also mean higher costs—whether it be through providing unnecessary care that results in iatrogenic disease or forgoing important preventive care that ultimately results in greater disease burden requiring more expensive

medical care. Of course, quality matters to patients as well. Despite not always knowing how to assess quality, patients want to receive it. To this end, providers are likely to face competition based on the quality they provide. As the forces at play continue to transition incentives from volume to value, quality of care will also increasingly be tied to provider payment, and properly measuring quality will be of primary importance.

Defining quality in health care is not a simple task, because quality holds different meanings to different stakeholders [13]. However, the widely used Institute of Medicine (IOM) definition of quality encapsulates a broad understanding of quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." [14] The IOM further specifies that high-quality care should be safe, effective, patient-centered, timely, efficient, and equitable [15].

How Will We Improve Outcomes in the Future?

Proper measurement is the first step to improve outcomes. Tracking how patients fare can largely be achieved through electronic medical records. Many physicians overestimate their performance on quality measures until they are provided with their performance data [16]. To this end, continuous feedback on improvement also needs to be available to providers. From this feedback, payers can reward providers not only for achieving specific quality standards but also for incremental improvements. By providing ongoing feedback for progressively better results, instead of continuing to penalize for not meeting a benchmark, providers may be encouraged to find innovative ways to improve.

Other approaches to improve quality include public reporting of outcomes, although research is mixed on the effectiveness of this method [17, 18]. If patients can see how providers compared to their peers, it may promote competition or at last an incentive to improve quality. One of the problems with this method is that providers may find ways to game the measurement process.

How Can We Continuously Improve Quality?

- Continuously assess and revise metrics to accurately reflect quality that matters to stakeholders
- Assess whether process measures continue to accurately reflect outcomes
- Revise standards and clinical practice guidelines concurrent with new evidence
- Promote a learning atmosphere—less punitive, more encouraging of success
- Promote effective communication within and between organizations
- Maintain and improve IT systems to accurately and efficiently capture care and outcomes
- Use outcomes that are easiest to track and difficult to manipulate

The healthcare profession is about to experience a tsunami. No longer will volume of patients seen or number of services provided be the metric for payment and reimbursement. Providers, payers, patients, and also the government will have to make a big adjustment by moving from volume to value. We believe that the success of a medical practice is going to depend on the speed at which the healthcare profession can make these transitions.

Future Outcome Metrics

In the past, outcomes consisted of measuring survival, length of stay, or readmission rates. Those certainly are metrics that are important, but now it will be necessary to go beyond those basic outcome measurements and start recording and documenting additional data that will clearly demonstrate superior outcomes.

Outcome measurement plays a pivotal role in medical decision- making for physicians, payors, and for patients who are searching for high- quality

medical care. It is outcome measurements which quantify the components of quality such as clinical outcomes, patient satisfaction, and functional status of our patients.

The end results of outcome measurement identify patterns and trends and provide the healthcare profession with the effectiveness, or even the lack of effectiveness, of our medical interventions. By recording outcomes, we can maximize favorable outcomes and can minimize poor outcomes. As result of obtaining and recording outcomes, we can demonstrate quality of care and will hopefully lead to improved medical care.

The benefits of outcome measurements prevent the overuse, underuse, and misuse of healthcare services, as well as enhance patient safety. Outcome measurements also drive innovation and research and development, which enhance disease control and improvement in patient's quality of life. By tracking outcomes, payors and providers are held accountable for providing high-quality care. When the outcomes are made available to the public or transparent, patients can make informed choices regarding their care and can select providers who have stellar outcome data. Also, when outcomes are truly measured, there is competition among payers and providers, and with increased competition, prices are certainly going to decrease. Finally, patients with improved outcomes are more engaged in their care, more committed to treatment plans, and more receptive to medical advice.

Back to the Case of @rayco

@rayco continued on with Healthcare American. She participated in seminars and workshops offered by her specialty society and improved on her coaching skills. Because she was able to significantly modify some of the high-risk behavior evident in her patient panel, she continued to receive bonuses for her outstanding care. In addition to improving the quality of her care, she also learned more about the cost structure of her care through participation in several hologram-based learning exercises. This led to further improvement in her value scores. @rayco went on to produce several hologram-based exercises on her own so that her colleagues could benefit from her innovations.

Bottom Line

Yogi said, "You've got to be very careful if you don't know where you're going because you might not get there." The future of medicine will include alterations in payment with a focus on value rather than volume. Quality measurement and assessment will be critically important features of these newer models. You need to know that the quality train is leaving the station….all aboard!

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Conclusion and Five Essential Metrics You Need to Know

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Neil Baum and Marc J. Kahn

As early career physicians, you have joined a very exclusive club. You are in rare air and you should celebrate this milestone. There are very few professionals who have reached your level of success, and you should be cheered and enjoy all of the accolades that are sure to come your way. We know that you have heard doctors in the physician's lounges or lunchroom complain about the current state of American medicine and say they wouldn't choose to become a doctor if they were to start all over again. We want you to know that your authors and the colleagues that we know are happy and content with their decision to select medicine as their profession and their life's work, and if they had to start over, most physicians would make the decision to remain in health care.

Here are some of the reasons you should feel assured that you chose to become physicians:

As physicians, you have the opportunity to care for the entire spectrum of age groups, from newborns to geriatric patients. You have the opportunity to care for children with their congenital problems, as well as the opportunity to care for patients in their declining years. You can even delve into the emotional problems of your patients and with your empathy can provide them with support and solutions.

Let's be honest that even most medical doctors who care for patients find that most of our patients do well and get better as a result of our intervention. We have many skills at our disposal including being able to prescribe medicines and perform surgery and the ability to use a combination of both treatments to make our patients better off after they interact with us. The knowledge that we can solve many, if not most, of their medical problems is very rewarding and satisfying. Even in the instances where we cannot treat or correct a medical problem, we can be empathetic and a good listener in order to provide solace for a patient where we cannot cure. As a result, patients continue to hold their doctors in high esteem and are very grateful for the care we provide.

We are fortunate that medicine is a profession where the patient's problem is almost always clearly defined. For example, when a patient presents with a complaint of weight loss, a tremor, or shortness of breath, we can usually pinpoint the etiology and locate the locus of the problem within millimeters and locate the defect and arrive at an accurate diagnosis. With all of that information, we then offer a solution. Medicine is not vague, nebulous, or ill-defined where the solution may be cloudy or unclear. We can be exact and narrow the range of diagnoses

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and options. Patients genuinely appreciate knowing that they are in the hands of an expert who can guide them to their treatment or their cure.

Let's be thankful that there will always be a demand for our services and that demand will become even greater now that the baby boomers are reaching age 65. In fact, 10,000 people reach the age of 65 every day. That translates into a lot of work for nearly every American doctor as most of the aging baby boomers will eventually need our services. Even pediatricians can care for their grandchildren.

Medicine is broad in scope, although the organ systems we treat are relatively finite. We have an opportunity to focus on a single, defined area of medical conditions. Consequently, if we choose, we can become experts in a single field or subspecialty.

As we read the journals and look at the job boards, we are pleasantly surprised at the wide range of opportunities available for graduating residents and fellows. A newly minted physician can become an academician, join a large group practice, join a small group of physicians, or even become a solo practitioner. Young physicians can select from a wide variety of geographic locations and can always find something that fits their practice style and personal lifestyle. We will always be able to find a job even if the first job does not work out as we have planned.

Our profession offers multiple opportunities for entrepreneurship and creativity. Most of the new devices and interventions in the field are developed by practicing physicians. We can turn our creative juices to developing new ways of treating medical diseases more efficiently and with less pain and discomfort. The current trend of bringing care from the hospital setting to the office setting, where the physician is more in control of his or her schedule, has been largely advanced by our peers and colleagues.

For those physicians who wish to segue from clinical practice to non-clinical endeavors, there are numerous non-clinical opportunities such as joining the ranks of pharma, becoming a medical director for industry or a hospital, and even going into politics and creating healthcare policy.

Our profession enjoys having a good sense of humor. We have never met a doctor who does not have a cute story or joke to share with colleagues and patients. Maybe that is why we can cope with our career choice; if you are laughing, you cannot be sad or unhappy.

In short, the next time you think about what you would do instead of becoming a physician, just stop and be thankful you chose to become a doctor. You have many reasons to be grateful.

The reality is that few of us have received the necessary skills to effectively participate in the business side of our practice. However, if we want to be successful, becoming involved in business is going to be a necessity for having a successful practice. We are, regardless of the size or nature of our practice, small business professionals. We must understand the basics of business, and that is what we hope we have given you. We are eager to hear from you, and any ideas you have will be most appreciated when we write the second edition of the book.

We would like to close this chapter and this book with a few numbers you need to know. We are not recommending that every doctor has to have a business background, an MBA, or a degree in healthcare policy. We do recommend that every doctor understand a few metrics or key performance indicators that will definitely impact the success of their practice regardless of the size of the practice, the geographic location, or the hierarchy of the organization. Reviewing these five numbers will require less than 10 minutes each month but will be an essential barometer of the direction your practice is going to take. These metrics are available in any practice management software and can be viewed in graphic format so that you can see trends that are impacting your practice. Also, as a young doctor, you will impress your colleagues and office manager that you are taking an interest and understand the basic business aspects of your practice.

The five important metrics you need to monitor on a regular basis are (1) charges/receipts, (2) revenue value units (RVUs), (3) accounts receivable, (4) charge lag, and (5) denials.

Charges and Receipts

The total charges of the practice are the gross charges or the total amount of charges for services provided by the practice. This number represents total work that is submitted for payment to patients and third-party insurance companies. It would be a wonderful world if we could receive compensation for those gross charges. Guess what? It is not a wonderful world!

The real-world number to know and follow is money *collected* for your services. This is referred to as the *net receipts* which consist of the gross receipts minus the refunds to patients and insurance companies. This is probably the most important number to know. We want to emphasize that it is far easier to collect money at the point of service, that is, when the patient is in the office. Why? Every time you try to collect an amount more than 6 months after the service was provided, it will cost the practice about 30 dollars for each collection attempt. You are not very likely to collect amounts owed to you that are older than 108 days.

The gross collection percent is the payments received divided by the charges. For example, if the practice collected $750,000 in payments and the charges were $1,000,000, then that would translate into a 75% gross collection rate. This is a metric that you will want to compare each month, each quarter, and each year.

You will also want to look at charges and net collection percentage (NCP). The net collection percentage is the total payments divided by the charges minus any contractual adjustments. For example, if the payments are $750,000 and the charges are $1,000,000 minus $200,000 in adjustments, the NCP is 93.77%. A well-run practice should have an NCP >97%. This metric can be used to compare your practice today to your past performance.

How is the charge data helpful? If you see a decline in gross collections, you need to look into why this metric of gross charges is declining. Was there an increase in Medicaid charges which are considerably lower than third-party payer charges? Was there an increase in contractual write offs and an increase in adjustments? If that is the case, do you need to consider renegotiating your contracts with the insurance companies? Why was there a decrease in gross collections? Was there an increase in costly staff turnover? Staff turnover, especially in the billing departments, is likely to result in a decrease in collections. Therefore, it is incumbent upon you or someone in your practice to look for the reasons that staff are leaving the practice and fix that problem.

RVUs

Next look at the relative value units or RVUs. RVUs measure physician productivity across a designated time period such as a month, a quarter, or a year. This metric is often used to calculate compensation for employed physicians. This number is also useful for negotiation with hospitals and insurance companies. The calculation of RVUs takes into consideration the complexity of service or the procedure, the time to do the work, the labor involved, the materials or equipment required for the service, the supplies that are needed, and consideration of the malpractice expense. The Centers for Medicare and Medicaid Services (CMS) then multiplies the RVUs for each service or procedure by a "conversion factor" which was $35.89 in 2017. For example, if a physician generated 700 RVUs in the last quarter, their RVU value is 700 times the conversion factor of $35.89 or $25,123. The hospital or the employer will often use this calculation representing the physician's productivity minus the agreed upon overhead expense and determine the physician's salary or compensation.

Accounts Receivable

The metric of the accounts receivable (AR) is also a necessary metric to monitor. The gross accounts receivable is equal to the charges minus the payments or the receipts. The net AR is the charges minus any contractual allowances or discounts minus the receipts or what has been collected. This number is what the practice is likely

to collect in the future. It is the AR that distinguishes good management from poor financial management. For example, if the charges are $1,000,000 and the contractual allowances are $200,000 and the practice has received $750,000 in payments, then the net AR is $50,000, and this represents the fees that are likely to be collected.

The aging of AR is also a very important metric to review regularly. Most practice management systems will place AR in buckets of 1–60 days, 61–120 days, 121–180 days, and more than 180 days. Ideally, you would like the bulk of the AR to be below 60 days as these ARs are likely to be collectable. ARs greater than 180 days or 6 months will seldom be collected. Therefore, it is imperative to monitor these three or four buckets of AR and to keep the majority of the ARs in the 1–60 days category.

Days in AR are part and parcel of the AR metric. The days in AR are equal to the total AR divided by the average daily charges (ADC). This latter number is equal to the quarterly charges divided by 90 days. This metric monitors the efficiency of the practice's billing and collection. The greater the days in AR, the less efficient the practice. If you are watching the trend in days in ARs, and notice a rising days in AR, you might consider looking at how quickly charges are posted by physicians or how fast the billing staff is submitting charges to the payor after the charges have been received from the physician. Another possibility is that a payor is delinquent or delayed in paying the practice and the payor needs to be notified that this is unacceptable.

The AR ratio is the ratio of the total accounts receivable divided by the average monthly billings usually using the last 3 months of charges or billings. For example, if the last month's AR was $448,000 in uncollected fees and the prior 3 months' billings was $396,000 ($132,000 per month), then the AR ratio is $448,000/$132,000 or 3.4 months (102 days). The AR ratio of 3.4 represents 3.4 months of payments that are due to your practice. The goal for a primary care practice is to maintain an AR ratio of 1.5–2.5, and for a specialty or surgical practice, the goal should be less than 2.0–3.0. The difference between a primary care and a surgical practice is that surgical practices perform more expensive procedures and you have to collect these higher fees from insurance companies who are not as prompt at paying at the time of service when compared with a primary care practice.

Charge Lag

Monitoring the charge lag, or the time between the date the service is performed and the date the fee is submitted to the insurance company, is another important metric. Ideally this number should be close to zero or one day. A delay means that the practice is not efficiently transmitting charges to third-party payers. If the charge lag is too long, checking on the process of filing claims in a timely fashion would be appropriate to solve the problem.

Denials

Denial is not a river in Egypt! A claim to an insurance company must be submitted accurately in order to receive compensation for your services. A "clean claim" refers to a claim that is processed and paid without being returned because of errors. Historically 10–15% of claims are "dirty" and denied because of errors in submitting the claim. Also, it is of interest that nearly 50% of denied claims are never refiled which means you are leaving money that is honestly owed to you on the table. The good news is that more than 90% of denied claims are preventable. This requires meticulous attention to details. For example, if the patient's insurance number is not keyed in accurately or if the patient's name is misspelled by a single letter, the claim will be rejected and will be denied, and the insurance company will be holding your money, and your practice will spend additional time and money to refile the claim. Therefore, the billing clerk has to be a perfectionist, or you will be losing money that honestly belongs to you and your practice.

Bottom Line on Business Metrics

Without understanding these concepts, you will not understand the value of the services that you provide. The minimum metrics to follow regularly are charges, receipts, RVUs, accounts receivable, charge lag, and denials. Remember the "buck" starts and stops with you the doctor! Finally, medicine is a business and if you want to be a successful doctor, you need to understand the basics of business. We hope that we have instilled in you the need for being a small business person and that you will have a very enjoyable and profitable practice.

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