



# The Ideal Podiatric Practice Model

It's all about improving efficiency, quality, and the doctor-patient relationship.

BY MARK TERRY

If you are planning to open a podiatric practice, you probably already have some idea of the type of practice model you want. Although the title of this article includes the word “ideal” in it, there probably is no such animal. Much of it will depend on what your interests are, what your priorities are, and what your ultimate goals are.

If you already have a podiatric practice, no matter what your business model, where you are in your career will undoubtedly affect your thinking on what an “ideal podiatric practice model” is.

This article presents some insight into how your practice model can affect your income and how you practice podiatric medicine. It also looks at how efficiency, quality, and the doctor-patient relationship are entangled with your practice model.

### Basic Practice Models

In an April 2012 *Podiatry Management* article, David N. Helfman does a thorough job of breaking down the different types of podiatric practice models and their pros and cons. The three primary models are: solo practice, group practice, and super group practice.

**Solo Practice**—This, of course, means a single podiatrist, and almost four years ago Helfman noted that solo practices were disappearing every year. It’s also clear he isn’t a fan, indicating there were few benefits with relatively little upside. “The types of physicians whom I still see in solo practice are the ones who are creatures of habit,” Helfman wrote. “They are comfortable and do not



David Helfman

feel the necessity to change. They need to be in control of every aspect of their practice and cannot think of turning the reins over to someone else who might offer them a more efficient solution.”

**Group Practice**—Helfman defined a small group practice as three to five physicians, sort of skimming over the possibility of two physicians, which might be more accurately defined as a partnership. Helfman noted, “This model works better in some areas where you do not have much competition. This type of model leverages ancillaries the most when all physicians work out of one facility.”

**Super Group Practice**—Helfman noted his own bias because he’d

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spent 20 years in a super group practice. He defined it as having at least 20 to 30 physicians, saying that it is not an independent physicians' association or a group practice without walls.

Helfman says, "You can truly leverage just about every ancillary possible. You can leverage your balance sheet and not have to personally guarantee debt. You can also



Annette Joyce

generally organize with a single tax ID number and split administrative and management costs, but otherwise have separate practice locations that are run independently.

### Specialty & Mixed Specialties

In determining your practice, it's generally a good idea to decide what type of practice you want in terms of specialty—sports medicine, diabetic, elderly, general, etc. Annette

having a practice that mixes surgery with non-surgical specialties has other challenges, "because a person doing only surgery isn't to make as much as, say, the doc doing podiatric dermatology. The non-surgical practice has lower malpractice, and they don't have people they're married to because they did an ankle fusion three years ago and the person keeps coming back with chronic pain for opiates or whatever."

He adds, "The other thing with a surgical practice—for the next 90 days, they don't see a dime for seeing that person in the office, so they're consuming resources."

This does bring up something of a dichotomy in podiatric medicine. Rem Jackson, president and CEO of Top Practices, LLC (Lititz, PA), says, "There's currently a disconnect between podiatrists that are in their 40s, 50s and 60s, and podiatrists that are just coming out of residency. Podiatrists that are just coming out of residency have



Rem Jackson

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leverage your size to obtain the best managed care contracts."

The downside, however, is a higher level of management. And although running any medical practice like a business makes sense, the bigger the practice, the more demanding the business requirements are going to be. "Many physicians have a hard time adjusting to this size of a practice structure," Helfman wrote. "You lose your autonomy and rely on a board of directors, which the shareholders vote in to make decisions on your behalf."

Three other types of podiatric practice models are:

**Multispecialty Groups & Hospital Employment Models**—Essentially, you're part of a big group of various types of physicians connected to a hospital or insurance company.

**Independent Physicians Association**—Typically, these are set up, wrote Helfman, "to organize independent practices into contracting entities." These may be with HMOs, vendors, and possibly, given the changes in healthcare since he wrote the original article, Accountable Care Organizations (ACO). These types of group practices fall under a lot of state and federal laws.

**Group Practice Without Walls**—In this entity, independent practices

M. Joyce, of Carroll Foot and Ankle Surgery Center in Maryland, focuses on podiatry dermatology. "I really have a nonsurgical practice, at least my half of the practice," Joyce says. "My partner is a surgeon. My practice is based on a strong dermatology model. I base my practice care for pa-

## "Consider the first three years of going into private practice as going into an internship/externship to learn."—Jackson

tients similar to how a dermatologist would run their practice."

She points out that, generally speaking, a dermatology focus pays better overall than surgery. "Surgery is not paying our overhead," she says. "It's labor intensive. We get reimbursed a low dollar amount for a patient that we have to see probably an average of six to 10 times for one payment, because we're not paid for post-op care."

Mike Crosby runs a practice management consultancy in Brentwood, TN, Provider Resources, LLC. He observes that

been trained to be surgeons. They have been told they are surgeons. And they are expecting to come into a big-time surgery practice. Now, if they come into a hospital, they may very well end up being able to do that."

This may bring up a consideration when creating a partnership or multispecialty practice. It's entirely possible that two or three or four podiatrists will say, "Hey, let's go into practice together." It might work, although there could certainly be problems if the subspecialty mix doesn't quite mesh.



Mike Crosby

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“In a podiatric practice,” Jackson says, “everybody knows that surgery’s not what pays the bills. What I’ve said to the young residents when they’re coming out is they should look and find a podiatrist who has a well-run practice and really understands how to be a successful private practitioner. And do everything they can to learn. Consider the first three years of going into private practice as going into an internship/externship to learn.”



Larry Maurer

The point, however, is to consider the subspecialty mix in setting up your practice model. But then again... maybe not. Larry Maurer, of Washington Foot & Ankle Sports Medicine in Kirkland, WA, is in a two-person practice; both are surgeons, and they focus on sports medicine.

He notes, “Surgery doesn’t pay very much and it takes a lot of time. So something like podiatric dermatology can involve quick procedures that pay a couple hundred dollars, which is a lot better than a bunion procedure that takes an hour and a half and pays a couple hundred dollars. The quick procedures pay better.”

Which brings up issues of effi-

ciency, quality and the doctor-patient relationship.

patient times, put everybody on a schedule so you could increase your efficiency, see more patients and make more money. I didn’t like that at all.”

He felt that the patient was getting lost in the process. “I think there’s value in the patient-doctor-human relationship. In the face-to-face time, sitting there talking to the patient, getting to know them, seeing the visual cues and having some social interaction. I think there’s value in that. So, in terms of practice model, I pushed my practice towards more of

hand on the door. You’re sitting down, talking to the patient, looking them in the eye, and they have 100% of your attention.”

Maurer presents the provocative idea that efficiency, quality, and the doctor-patient relationship are like three hubs on a wheel. As you push for one, the others suffer. He admits, however, that it’s not a perfect analogy. “Maybe you don’t move away from quality when you move toward the doctor-patient relationships, maybe those two are closer together. But efficiency... that doesn’t mean I’m not trying to be efficient, but just not at the expense of quality.”

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If Maurer is pushing back on the idea that being overly focused on efficiency is good medicine, Jackson pushes back that it isn’t, “There is this whole pushback that somehow being a good doctor means being a lousy manager or practice owner. That somehow you have to subordinate your success and your profits, and if you actually run an efficient,

Although it does suggest that, from a practical point of view, there needs to be some balance point and that a focus on one aspect of the practice can undercut others. And that seems like a reasonable assertion.

### **More Thoughts on Efficiency and Quality**

When asked about efficiency, everybody interviewed for this article mentioned appropriate use and numbers of medical assistants.

Joyce says, “We’re able to increase our efficiency by running two schedules with the medical assistants doing a lot of the hands-on labor. Traditional podiatry might get a lot of x-rays, but that’s about it. In my (dermatology-focused) practice, techs are doing patient care alongside me as I’m able to bill and manage the evaluation of management codes.”

She notes that a dermatologist can see 60 to 80 patients per day. In her practice, it’s about 30 to 40, “as long as you have that strong medical assistant model where they’re able to perform treatments side-by-side with the doctor.”

Maurer agrees, noting that he utilizes “scribes and my medical as-

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### **Efficiency, Quality and the Doctor-Patient Relationship**

Maurer notes that when he was taking his fellowship, the hospital where he was training went through a lean practices transition. “They went over to Japan,” he said, “and studied the Toyota car plant and decided, hey, we’re going to employ more lean practice models: shortened

well-run practice, you’re somehow shortchanging your patients—nothing is further from the truth. It’s the exact opposite.”

Jackson cites research into how much time a physician needs to spend in the treatment room with the patient for that patient to feel well-cared-for. “It’s some ridiculous number like three minutes. It has to be three minutes when you’re not distracted, you’re not looking at the computer, you’re not having your

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sistants more aggressively. I have two with me and my associate has two, so we have four medical assistants running all the time. We dictate while we're seeing the patient, so if I'm seeing someone for heel pain, while I'm doing the exam, I'm focusing on the patient, examining the patient, and telling the scribe what I'm seeing. In general, as much as I can, I try to make decisions and focus on the patients and let the medical assistants do as much of the busy work as possible."

Crosby notes that there needs to be a balance. "For a doctor to have one other employee and not have the right staff around is incredibly inefficient. For a doctor who has seven people and sees 20 patients a day, he's not making any money. If a doctor sees 20 patients a day and has seven staff members, he'll be lucky to make \$50,000 a year; he has too many staff and the practice can't support it."

Jackson says, "One of the things we teach our doctors is you can have a very effective practice and move the right number of patients through—about four per hour is about the right number—if you utilize your medical assistants. Most doctors run with one medical assistant. But my top doctors have four medical assistants running at all times in four rooms. They are able to see a very large number of patients in a short period of time, extraordinarily profitably."

He notes, however, "When you first discuss this number with physicians, they say, 'You've got to be crazy, I can't afford four medical assistants per doc.' The fact of the matter is, medical assistants aren't that expensive and when you start looking at what that can do for your bottom line, it's kind of stupid not to do it. It's like one of the greatest kept secrets in medicine."

As for quality... what exactly is it? Crosby says, "Of all the things in the world, how do you measure quality in healthcare? Your patients don't complain, your patients are seen quickly... the problem is that the definition is really kind of mushy."

Of some concern is that as part of the Affordable Care Act, the government will soon be requiring that physicians report quality metrics. Crosby says, "All providers, podiatry or otherwise, have been put on notice that in three to three-and-a-half years, they're going to have to start reporting about clinical outcomes, about efficiency or effectiveness of care, about patient satisfaction. And being able to do that in a way that allows their story to be compelling to the payers, in partic-

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same as it is with four doctors.”

Joyce pressed for the need for diversity. “Think of orthopedic groups. They have a hand guy, they have a shoulder guy, they have a feet guy, but they all work together on joints. We refer to each other

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anyway, but to have a practice with multiple specialties, maybe one surgeon, one non-surgeon, maybe one who’s pediatrics, one who likes sports medicine. I think that’s a definite advantage in terms of revenue and attracting more patients to your practice.”

Jackson offers two broad ideas.

One is for podiatrists to incorporate more cash-based services. “Because you don’t have all the rigmarole you have with your payers, it’s paid right there and it’s very profitable. So a lot of doctors are doing more things that they can do that are cash-based.”

But he offers a thought that’s also very focused on the uniqueness of podiatry. “There has been a lot about podiatrists turning their backs on biomechanics, and that doctors coming out of residency don’t understand biomechanics at all; they don’t think about them. But biomechanics and orthotics can be a wonderful, fantastic part of a practice. Most of my practices that really understand it and prescribe orthotics find that their results are at the heart of what a podiatrist is. At the moment they’re so concerned about parity, about the DPM being equal to the MD, there’s an obsession with surgery, which by the way doesn’t pay any money—it’s important to remember what a podiatry practice is all about.”

So what practice model is right for you? Obviously there are a lot of factors and it doesn’t benefit anyone, patients or podiatrists, to have only a single type of practice model. Crosby puts it a little differently. “In my opinion, efficiency is gained when people have the ability to maximize their cash flow at a comfortable level. You don’t read that in business books. I’ve worked with clients that see 45 patients per day and I’ve worked with clients that see 20 per day. I won’t say one is happier than the other if they’re both making the kind of money they want to make,” said Crosby. **PM**

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**Mark Terry** is a freelance writer, editor, author and ghostwriter specializing in healthcare, medicine and biotechnology. He has written over 700 magazine and trade journal articles, 20 books, and dozens of white

papers, market research reports and other materials. For more information, visit his websites: [www.markterrywriter.com](http://www.markterrywriter.com) and [www.markterrybooks.com](http://www.markterrybooks.com).