Which Practice Model Is Best for You?

One size does not fit all.

BY JON A. HULTMAN, DPM, MBA

"What is the best practice model for addressing the future?" This is similar to being asked which type of ship is better suited for sea travel—a luxury liner, a speed boat, a submarine, or a battleship. A distinctive type of ship exists that is most suited for each specific environment—one model is not necessarily "better" than another; rather, each type of ship functions best in the environment for which it was designed. The answer to this question will always be, "It depends." "It" depends on the 1) goals you want to achieve in your practice and 2) the environment you will be facing. Since goals are uniquely individual, you should already know your answer to number 1.

If you do not know your goals for the future, refer to Yogi Berra, who famously quipped, "If you don't know what you want, you're never going to get it." Assuming that your goals are set, this leaves the single question, "What type of future environment will I be facing?" Although the future always holds a great deal of uncertainty, it turns out that we do know enough about the environment in which we will be practicing to enable us to determine the models best suited to it. Let us examine the seven most important factors that any model will need to address in our predicted future:

1) Price Competition: Similar to every other mature industry, podiatric practitioners are facing price competition, and it is here to stay. We all recognize that the growing cost of the healthcare system is unsustainable and that the primary lever which payers have for controlling costs is the fees they pay to physicians and hospitals. When medical practices no longer have the option of raising their fees, the primary lever available to them for increasing profitability is to control, or lower, their costs through efficiency.

2) Increasing Volume: Podiatric practitioners have always dealt with high volume. When we examine podiatric practice revenue, we see that it follows volume in a linear fashion—the greater the volume of patients seen and services provided, the greater the revenue. Because of current factors boosting demand such as (a) aging "baby boomers" with a desire to stay active, (b) a "wellness" trend which encourages activity, (c) a focus on reducing the complications of chronic disease, (d) an expected physician shortage, and (e) health delivery changes aimed at reducing the number of uninsured patients, it is logical to expect that volume will only continue to increase. Timely physician access is an important success factor from both the payer's and patient's perspectives and it only becomes more difficult to provide as volume increases. To enable access, it will be important to focus on increasing practice efficiency since this is the primary lever available for maintaining timely access as volume increases.

3) Increasing Complexity: The practice of medicine is complex, and it is clear that it will become even more so in the future. The process of simply "getting paid" is already incredibly complex, and maintaining compliance with HIPAA, OSHA, employment law, regulation of x-ray equipment, quality initiatives, and a host of other rules and regulations can be daunting. Entering data and notes into electronic medical records adds another layer of complexity as well as extra time to almost every physician activity. This increased complexity compounds the challenge of managing ever-increasing volume, leading again to a need for even greater efficiency.

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4) Achieving Quality: Cost and quality are currently the primary

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forces driving change in healthcare. Improving quality has been the biggest challenge for every mature industry. As much as 50% of total healthcare costs align with "bad quality." This "bad quality" is created by: medical errors, unnecessary care (i.e., additional care that does not improve patient outcomes), necessary care not received, duplication of tests, inefficient bureaucracies, wide variation among protocols for treating the same condition, and inability to track care. Although fees are not increasing, every payer claims that they are willing to pay more to those who provide quality because of its current potential savings which could be as much as 50% of the total cost of healthcare.

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Every major industry has learned how to provide higher quality at lower cost. Much of what successful industries have done was developed by industrial engineers. A well-known example of this engineering is the work that W. Edwards Deming performed for Toyota. He focused the company on "efficient workflow" and "reduction of variation and errors" through statistical process controls. Deming recognized these as significant factors in achieving quality and lowering costs. Following his advice, Toyota became a leader in producing higher quality automobiles at a competitive price. These same industrial engineering principles can be applied to the workflow in medical practices and, thereby, increase quality while lowering costs.

5) Access to Contracts: The primary method for efficiently accessing contracts has been through the formation of large group practices and independent physician associations (IPAs). It is simply too inefficient for payers to contract with doctors "one at a time." The primary problem with IPAs is that they have been unable to control quality at the doctor or practice level and are unable to improve efficiency among their "member" practices. This is because the practices in an IPA are not integrated operationally, financially, or clinically.

Today, grouped practices can integrate effectively using new sophisticated information technology systems.

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The cost of these systems has declined to a point at which any size group should be able to afford and implement them—efficiently integrating their practices operationally, financially, and clinically. With size, efficiency, and the consequent ability to demonstrate high quality, a group of practices would be positioned to have increased access to contracts.

6) High Fixed Costs: All medical practice models are high fixed cost businesses. They also tend to be high volume businesses and, as such, can take advantage of the fact that volume can have a positive leverage on profit. The higher the volume of patients and services that can be spread over shared fixed costs, the higher the profit margin for the same output of work. Likewise, a disadvantage exists in the fact that negative leverage occurs when volume is low or declining. We saw this occur during the pandemic—a circumstance that we hope is a once-in-a-hundred-year event.

The high fixed cost structure of a medical practice can be compared to that of an airline. For the airline, the fixed cost of a scheduled flight is essentially the same whether a plane takes off with one, or three hundred, passengers. Each passenger added to a flight increases revenue while adding very little cost—a situation in

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which each additional passenger creates significant leverage on the profit margin. Further leverage is created by efficient "throughput," which, for an airline, is its rate of passenger turnover at the gate. The faster that turnover, the sooner the plane takes off to its next destination—making it possible to make more flights, per plane, per day. This increased efficiency at the gate reduces the total number of planes the company needs to accommodate its customers. Comparing this process to a medical practice, the "seats" are the number of treatment rooms the practice has available, and throughput is the length of time each patient spends in one of these treatment rooms. Efficiency, or throughput, is dependent on staffing ratios, staff training, technology, office policies and procedures, and the way in which all of these are utilized to create workflow efficiency in both the clinical and business areas of the practice.

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7) Competition: Doctors who can achieve the following goals will have a competitive advantage: (a) high quality, (b) quick patient access to their practices with short wait times after arrival, and (c) the ability to provide a wide array of services and convenient locations—thereby offering a "one stop shop" for patients seeking foot and ankle care and making the practice geographically accessible. In addition to offering supplies needed by patients, this competitive advantage can be expanded by developing ancillary services—many of which, themselves, are high fixed cost businesses and dependent on high volume for profitability.

Let us return to our original question, "What is the best practice model for addressing the future?" We see that we need a model that addresses a future environment in which a practitioner must 1) manage a large volume of patients, 2) deliver a wide array of high quality services in a complex, price competitive environment, and 3) secure a vehicle for accessing third party contracts. Since any practice model is a high fixed cost business, mergers will make great sense in this environment. Merging enables more volume to be spread over combined

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fixed costs, the total of which should be lower for a group of merged practices than the previous total of the costs of all the individual practices before the merger.

To capture the most value possible from increased efficiency along with the advantages of being able to compete on both quality and volume, it makes sense for practices involved in a merger to be integrated operationally, financially, and clinically.

The "size" of the merger is not critical at the beginning because combining as few as two or three practices presents a significant opportunity with little downside. Adding more practices over time continues to increase the advantages of a group—especially the ability to access contracts by offering any new practices the multiple location advantage of an IPA along with the quality and service advantages of an integrated group that is capable of controlling quality.

This future environment does not rule out the potential for solo practice. Niche solo practices are viable in any environment because a doctor with a niche practice is typically known well beyond his/her geographical area. Similarly, concierge or cash practices are viable in any market. If a doctor is in a "traditional" solo practice and offers comprehensive services, it would make sense to convert this practice to a low fixed cost business to make it less dependent on volume. A low fixed cost, solo model is known as a micro-practice—one in which the doctor prefers seeing a low volume of patients and is able to accomplish this goal by moving into a small office that is high tech, has only one employee (some have no employees), and is highly efficient. Significantly, this model does not preclude a merger option. In fact, a merger of multiple micro-practices can create a highly efficient group model that is well suited to the environment of the future.

Whatever you decide to pursue, make sure that your decision makes sense in this environment that we face and that meets your long-term goals. One size does not fit all. What you need to adopt is a model that "fits" both your goals and the environment in which you will be practicing. **PM**

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