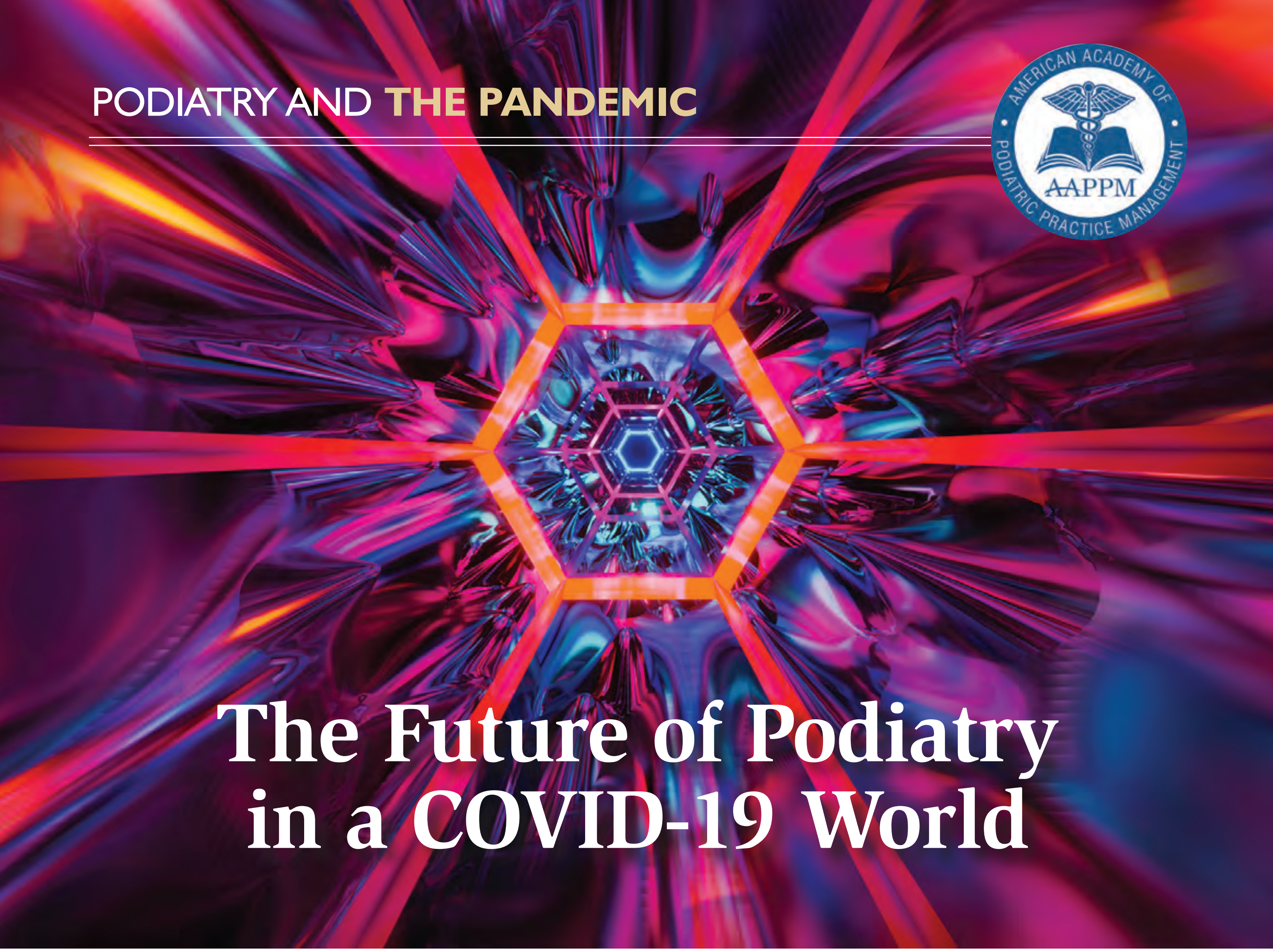

The Future of Podiatry in a COVID-19 World

Here are some tips for practicing during the pandemic era.

BY LUKE HUNTER, DPM

This article is written exclusively for PM and appears courtesy of the American Academy of Podiatric Practice Management. The AAPPM has a fifty-plus year history of providing its member DPMs with practice management education and resources. Visit www.aappm.org for more information.

Let's talk about COVID fatigue. We're not talking about the physical fatigue associated with the COVID-19 virus. We're talking about how tired we all are from dealing with the ramifications of this pandemic. From arguing with distant family members on Facebook on how the COVID vaccine works, to constantly having to find sitters for your kids or employees' kids every time there's an exposure to COVID, these challenges have been present for nearly two years now and likely will continue for the next year or two at least.

Looking at the financial impact of COVID-19 on physicians, according to an AMA survey of PCPs in 2020, revenues on average were 32% lower than pre-pandemic.[1] According to a different survey by the Physicians Foundation, 8% of physicians who responded to the survey said they were closing their practice due to the pandemic, 43% have reduced staff, and nearly 75% had a reduced income.[2] Many of these physicians felt that the private practice model would be affected permanently, and that hospitals would begin to play an

Continued on page 46

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Future *(from page 45)*

even more predominant role in providing healthcare.

There is some optimism for podiatry, though. According to IndustryResearch.Biz, a platform for firms to publish market research, the global Podiatry Service market size is projected to reach USD 5 billion by 2027, from USD 4 billion in 2020.[3]

Let's discuss the future of podiatry and the "new normal" of dealing with COVID from four different perspectives: residents, new practitioners, established practitioners, and retiring practitioners.

Graduating Residents

Graduating residents have an unprecedented challenge facing them in the next year. With inflation nearing 7% (highest since 1982), lower patient volumes, and the consolidation of healthcare services, the job market isn't nearly as robust as it has been in the last few years. It's reminiscent of when Obamacare (aka Affordable Care Act) rolled out and many hospitals and practices weren't willing to take the risk of hiring an expensive physician with so much uncertainty for the future of healthcare.

There needs to be a little temperance re: how much new graduates think they're worth right out of residency, as revenue generators. Unless you're joining a large group with a steady list of patients, it takes months to build up a full patient load for a new hire. Payments for primary and secondary insurances can take two to two and a half months to fully settle; and payments for which patients are responsible take even longer.

So a hiring physician, who appropriately prepares for a new hire by hiring and training new staff, paying sign-on bonuses, moving expenses, etc., knows it may be six or more months before a new hire starts to break even, and nearly a year before the start-up costs are paid back.

Until a new graduate learns to read EOBs and understand denials, does one actually start learning how to bill and code? Unfortunately, it's something that isn't, or honestly can't be, taught during the busy resident years. It takes years to become proficient in billing and coding, and constant diligence to stay on top of the ever-evolving changes in the billing and coding world.

When some new residents were interviewed in 2019 for a position, there were a few who thought they should make a guaranteed 180-200K a year in private practice the first year out of residency. Recent-

Continued on page 47

Need Something to Do?

Are you in need of something to pursue while your practice is slow? Here's a check list of a few things you can do:

Medicare DME Supplier Checklist

If you dispense DME for Medicare, you *have* to have a complaint log for *each* location. Make sure each binder has an updated copy of your license and business liability insurance in it too. Do the hours on your door/sign match the hours listed on your DME application? Do you have "By Appointment Only" on both your door/sign and application?

OSHA Manual

Do you have an SDS (Safety Data Sheets) binder with a list of all the chemicals in your office? Well, you're supposed to!

Emergency Contact List

Does your staff know whom to call if there is a problem with the power? Gas? Internet? Phones?—Or need the sheriff or a plumber? If the worst occurs and you weren't there, would your staff know whom to call and account numbers to address the problems? Create an emergency contact list with account numbers, and post it in a well-known location.

Inventory

When was the last time you inventoried your instruments? Do you have a drawer full of broken instruments that could be sent for repair and made useful again? Has it been more than three years since you completely cleaned out your storage closet? What about that shelf full of DME items you no longer dispense? What are you waiting for? Donate them to your favorite local charity and at least get a tax write-off!

Office

When was the last time you sat in every chair in the office? Are any unstable or wobbly? What do you see when you sit there? Dust on your blinds? Trash under a desk? How old are the magazines in your office? Assign a staff member to correct any potential complaint before there is one!

Staff Training

When was the last time your staff had any documented HIPAA training? A refresher on blood-borne pathogens and proper instrument disinfection? Check with your malpractice carrier, they might have some staff training resources you didn't even know about. PM

Future *(from page 46)*

ly, follow-up on Facebook revealed that three of the four interviewees had already left their first job within two years. With nearly 80% of new graduates leaving their first job within five years, new graduates should consider either finding a hospital/group job that pays them as much as they can or an associate position in a private practice that has good business and billing practices, where they can either succeed or "learn the ropes", and then take those skills and open their own practice down the line and have a greater chance of success.

The third option, opening on one's own, has become even more difficult in the COVID world. New graduates are finding it harder than ever to get on insurance panels, where everyone is "working" from home. There are

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stories of 2020 grads *still* unable to join open insurance panels due to the administrative backlog.

One benefit of joining an established practice is the ability to join an insurance panel much more easily as part of a group, and actually start making money, whereas if you open up on your own, you will be prepared to be able and willing to see patients, but unable to because of in-network status.

New Practitioners

If you started practice in the last two years, you're still probably struggling to get on insurance panels with so many insurance employees "working" from home. It's a difficult situation! The only things you can do are to maximize your advertising for the insurances you *are* in network with and be persistent. Fax your application in twice a week. Call the insurances CEOs' offices for assistance. Ask your local hospital to step in on your behalf; you're going to be bringing all these patients to their OR, using their MRI machines, etc.

As you build your practice, every dollar counts. Every dollar in, every dollar out. Keep your expenses down as much as possible. Use one phone line, minimal inventory, and a basic internet package. You don't need Netflix in your waiting room. Advertising should be you "hitting the pavement" (aka free) or online advertising with the greatest exposure per dollar spent. Collect those copays and estimated payments at every single opportunity.

Continued on page 48

Future *(from page 47)*

Established Practitioners

With inflation rates increasing, declining reimbursements, and decreasing patient volumes, you're likely looking for more services to offer and ways to save money. Depending on your practice locale and patient population, you've probably already considered different services, but now is the time to re-evaluate them.

Let's talk about cost savings first! Because it doesn't matter how much you make, it only matters how much is left over. When was the last time you looked at every subscription service you have? Gone over your credit card statement with a fine toothcomb? Have you shopped around for cheaper internet service providers or phone services? Does your sharps disposal service still charge you for weekly pick-ups but are coming two or three times a month?

Contact your vendor and email them other current prices advertised to see if they can beat them!

Do you track almost expired products or supplies? Remember FIFO—first in, first out! Reduce red bag waste with unnecessary supplies.

When was the last time you shopped for business liability insurance? Workman's comp? Med malpractice? Insurance companies are notorious for letting discounts lapse without letting you know.

Conduct an energy audit! Are all your computer devices shut down every night? Just having the monitors go to sleep accounts for more than half of the energy savings from shutting down a PC.

Regarding DME, you are likely struggling with keeping your DME inventory well supplied, as more and more vendors are backlogged. How many suppliers do you use? Do you have back-up suppliers? Find new suppliers! Ask your colleagues online for advice. Compare pricing and NEVER stop watching invoices. Contact your vendor and email them other current prices advertised to see if they can beat them!

Retiring Practitioners

So you're nearing retirement in

Continued on page 49

Future (from page 48)

the next few years and are looking for a way to gracefully leave the practice you've built up over the years. In the face of dwindling reimbursements, the increase of difficult-to-deal-with Medicare Advantage plans, and a host of other factors, the double six-figure price tag you thought your practice was worth becomes a more difficult sale to a new practitioner looking to purchase a practice. In the face of uncertainty, convincing someone to pay top dollar (as in past years) when we are in such a time of uncertainty is hopeful, if not delusional, at best. Despite whatever complex evaluation of a business's worth is calculated, similar to selling a home, it's only worth whatever a buyer is willing to pay for it.

Yes, times are tough and the term "unprecedented" keeps coming up, but as a whole, the podiatric profession is a resilient one.

Even if you find a willing buyer, it's difficult in today's world for individuals to take out large loans to buy a business. Banks generally want to see a practice at 85-90% of pre-COVID numbers before they make a loan, and generally don't want to lend more than 65% of the gross revenue of the practice.

Options for retiring practitioners could be: (1) hire a consultant to evaluate your practice to help find a potential buyer, (2) hire an associate with a clear delineated pathway to partnership or purchasing (having a pre-determined and agreed upon price PRIOR to hiring can greatly reduce the likelihood of a new hire walking away over purchasing), (3) approach another local podiatry group or hospital and negotiate a purchasing price for your well-established office, or (4) take out an ad yourself and hope you get the offer you want.

Conclusion

Regardless of the stage of your podiatric career, there is always some strategy to make it work. Yes, times are tough and the term "unprecedented" keeps coming up, but as a whole, the podiatric profession is a resilient one. We have fought discrimination, scope of practice, legislative barriers since our inception... and yet we continue to succeed.

Support your APMA as they are the main force for championing our cause. **PM**

Dr. Hunter has been in private practice for eight years and is on the Board of the AAPPM and APMA Billing and Coding Committee.