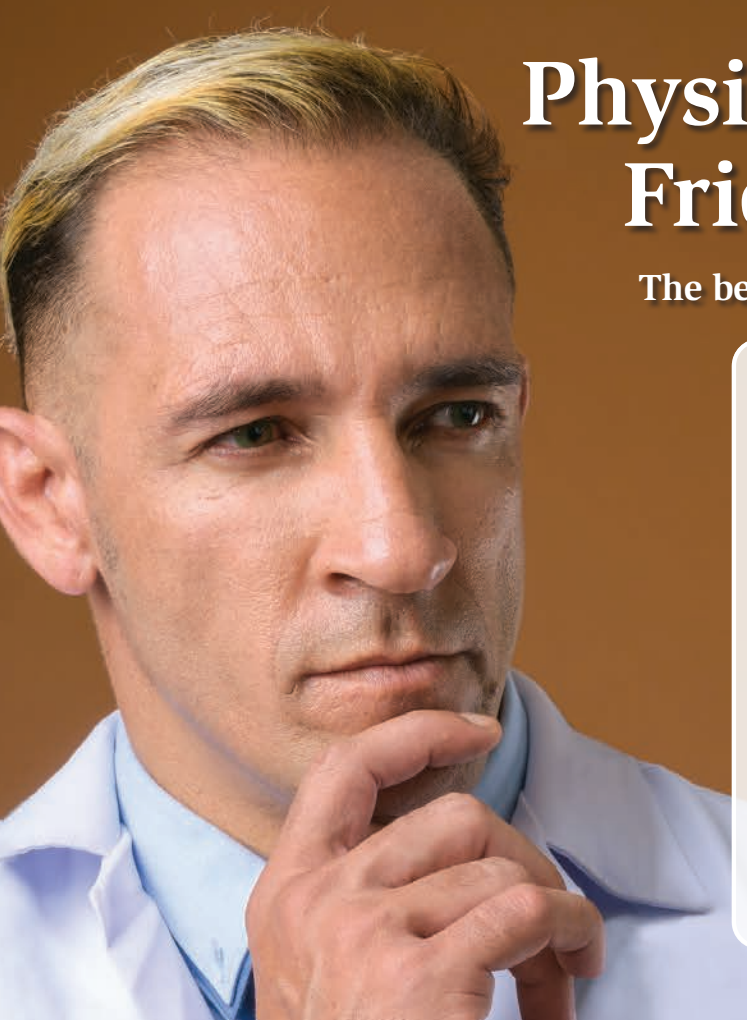

Physician Extenders: Friends or Foes?

The benefits likely outweigh the risks.

Medical Assistants
Certified Foot Care Nurses
Licensed Vocational Nurses
Registered Nurses
Physician Assistants
Nurse Practitioners
Advance Practice Registered Nurses

BY JON A. HULTMAN, DPM, MBA

Following my 1972 appointment as Assistant Clinical Professor at the UCLA School of Medicine, a prominent orthopedic foot surgeon made it his life's mission to fight me at every inroad our group pursued within the UCLA medical system. In 1976, he approached me in a hallway to let me know that the Orthopedic Foot Society (as it was then known) had a plan that would "eliminate the need for podiatrists." He said they were going to begin a training program for foot care nurses who would provide routine services in orthopedic offices. I replied, "Let me know when there are graduates from this program because I could use four of them."

Although I was saying this tongue-in-cheek, his facial expression upon hearing it was priceless. That footcare program never became a reality. Interestingly, at the same time, there was talk amongst podiatrists that, perhaps, we should establish a similar program. Those who supported this type of training compared its potential trainees with dental hygienists who were providing services in dental practices—significantly, services that were being billed for. This program never got off the ground because, at that time, many DPMs were more concerned about what they perceived to be the "risks" associated with it than the opportunities that it might create.

Over the years, I have consulted for various medical and surgical specialties. From what I have observed, there is no question that physician extenders have made many doctors in various specialties far more productive than they would have been without them. These extenders often produce revenue many times their base salaries. Likewise, there is no question that medical assistants (MAs) who assist DPMs are able to significantly increase those doctors' productivity. MAs enable practitioners

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to treat more patients and provide a greater number of services. The problem is that the typical services that can be delegated to MAs is limited—ones such as rooming patients, taking x-rays, applying bandages and providing instructions post-operatively, applying padding for palliative care, etc.—few of which can be billed by either the MA or the DPM. As to certain categories of extenders who are allowed to provide billable services, DPMs in many states are not authorized to supervise them.

About ten years ago, I received a call from a dermatologist practicing in Texas. He wanted to retire and was asking me to value his practice. This doctor related that he employed two physician assistants (PAs) and informed me that in his state, PAs specializing in dermatology were difficult to find. He said that he paid each of his PAs a salary of $180,000 but that, together, they produced $1,100,000 in additional revenue for the practice—approximately three times their combined base salaries!

In many specialties, the differential between what a PA is paid and the revenue s/he produces is even greater than this multiple of three. Given the continued decline in the number of students entering podiatric medical school, the number of DPMs who will be retiring over the next ten years, the continuing increase in demand for podiatric care, and the rapid growth of podiatric group networks throughout the United States, it seems to me that the opportunities to be captured through employing and training physician extenders in podiatric groups far outweigh the "risks."

Physician extenders include: (1) Medical Assistants (MAs), (2) Certified Foot Care Nurses (CFCNs), (3) Licensed Vocational Nurses (LVNs), (4) Registered Nurses (RNs), (5) Physician Assistants/Associates (PAs), (6) Nurse Practitioners (NPs), and (7) Advance Practice Registered Nurses (APRNs). DPMs were working with medical assistants long before I entered practice, but as healthcare became more and more complex—especially its billing process—most of our MAs were shifted to business offices and were no longer able to assist in increasing productivity in the clinical area.

Challenges and Concerns

The challenge today is to gain authorization to supervise and employ physician extenders who can (1) be delegated services that produce more revenue than the salaries they are paid and (2) reduce a DPM's workload—thus preventing burnout as well as improving the practitioner's work-life balance. Certainly, employing a physician assistant can achieve these two goals, but only a few states allow DPMs to employ and supervise PAs who can actually bill for what they do. DPMs in most states, however, are permitted to employ nurses. Of these, which type of nurse would be optimum for meeting our goals?

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A significant number of participants posting on *PM News* have expressed concerns about foot care nurses—especially ones who, in a few states, are setting up independent practices. Before I discuss the pros and cons of these concerns, I want to return to my earlier discussion about the foot orthopedist at UCLA who worked diligently to limit the inroads that DPMs were making into their turf. In 1972, one of this doctor's strategies was to suggest that orthopedic residents carry nail clippers with them in case a hospitalized patient needed their nails cut. He felt that residents should provide this service in order to avoid a request for a podiatry consult from a patient's doctor or a floor nurse. As it turned out, the orthopedic residents were unwilling to carry nail clippers with them.

How well did this orthopedic resistance fare? Going forward, the number of foot orthopedic surgeons at UCLA declined, while the number of DPMs multiplied several fold. I mention this story because, today, in an attempt to prevent the advancement of competition rather than recognizing the opportunities to be gained through working together, many DPMs want to completely eliminate certified foot care nurses. There is no question that having the opportunity to work together at UCLA would have been a win-win for both orthopedic and podiatric surgeons. Likewise, I feel that working together with foot care nurses would be a win-win for both podiatrists and the nurses.

Benefits of the One Stop Shop

Today, it appears that fewer and fewer DPMs are willing to provide services that could be deemed "routine care." While there are a number of reasons for this trend, my opinion is that every podiatric practitioner should be able to offer all foot care services whether s/he be in solo practice or a large podiatric group. For those types of routine foot care services that do not need to be provided by a DPM, a foot care nurse would be an option. A parallel to this is the way that dental hygiene service is seldom provided by a DDS, but rather by a dental hygienist.

This is but one type of service offered by dental practices; yet, it is essential. Would you want to go to a separate practice at a different location to have your dental hygiene needs taken care of? Additionally, if the hygienist working within a dental practice identifies a problem, s/he is able to have the dentist immediately evaluate it. In my opinion, certified foot care nurses present this same opportunity for our specialty. The ideal for patients is that podiatric practices are "one stop shops" for their feet. They should not be inconvenienced by needing to find another provider and go elsewhere for "routine" foot care services.

Long before foot care nurses were providing routine foot care, my practice witnessed an explosion of nail sa-

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lons in our geographic area. Driving north on Westwood Boulevard to UCLA from my home, I counted ten nail salons along that short 1.6-mile route. The salon price for a pedicure in the United States ranges from $15 to $135, plus tip. Walmart offers pedicures for $45 to $60. Compare this with the routine foot care being provided by certified foot care nurses. Their price for routine care (trimming corns, calluses, and toenails) ranges from a low of $70, to a high of $150, and their average hourly salary is $26.60 per hour with the top salary being $47.84. If a certified foot care nurse were employed by a podiatric practice at even the highest rate of $47.84 per hour, performing only two services per hour, they would produce 2.9 times their hourly salary at the $70 routine foot care rate. At the top $150 rate, they would produce 6.3 times their hourly salary.

The American Foot Care Nurses Association presents the following comments on their Website under their "About Us" section:

With changes in the healthcare system, it is increasingly important to expand avenues of care to underserved communities. And by its very nature … those requiring professional foot care are underserved!!

While Podiatrists and other physicians are the first line providers of this care, access and reimbursement issues necessitate those services such as "routine foot care" be provided by other qualified providers.

Nurses, PAs and other clinical staff are reaching out to obtain the education and skills to fill the gap and provide this critical care.

We are not trying to replace Podiatrists and other Physicians. We are trying to be their clinical associates. *We examine the feet that others overlook. That allows us to make referrals for the more advanced care that the Physicians can provide. And by performing the "routine care" on senior and high-risk feet, we not only recognize and refer problems, we can help keep feet healthier and prevent problems.*

Associates or Competitors?

The sentences above (in bold) clearly state that foot care nurses are not trying to replace podiatrists. Rather, they want to be our clinical associates. Is it possible that there is a potential win-win here in employing certified foot care nurses as physician extenders? Given the costs that a foot care nurse must spend to set up a practice—along with the ongoing fixed cost of overhead s/he would assume, it makes economic sense for that nurse to, instead, establish a working relationship within an existing podiatric practice.

Physician assistants are pursuing the same strategy as foot care nurses. Rather than being supervised by physicians, they prefer to be considered associates, and some even seek independent practice. The constraint DPMs have in establishing a relationship with a physician assistant is that there are only a few states in which podiatric physicians are legally allowed to supervise PAs.

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In most states, it is only MDs and DOs who are allowed to do this.

Obviously, DPMs should be able to employ and delegate services to any type of physician extenders that make sense for their practices. It behooves us to continue working on legislation that will open these opportunities in every state. In the meantime, we can focus on the types of physician extenders that we are currently able to employ and the type of services that can legally be delegated to them.

Given the decline in the number of students entering our profession and the concurrent expectation that demand for foot care services will continue to increase, there is no question that employing physician extenders would have a positive impact on our practices. They would significantly leverage each physician's productivity without increasing his/her workload. If a DPM does not enjoy providing routine foot care services—or other specific services for that matter—employing a physician extender who is able to provide these services presents an opportunity to delegate them to a provider working within his/her same facility with patient care being evaluated using the same quality benchmarks.

DPMs should be able to employ and delegate services to any type of physician extenders that make sense for their practices.

This enables the DPM to focus more attention on those services that s/he most enjoys providing. Employment of physician extenders not only presents a financial opportunity but also an opportunity to avoid doctor burnout created by the opportunity for physicians to treat fewer patients and focus on these services that they are most skilled at and enjoy providing. When the DPM and physician extender are providing services that they both most enjoy and are most skilled at, the patient is better served. An outcome such as this is optimum for the doctor, physician extender, and patient alike—thus, a win-win-win. As to the question of whether physician extenders are "friends or foes"—my opinion is that because there are mutual opportunities to be captured through working together for both the extender and the physician, they are our potential friends. PM

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