

PRIVATE PRACTICE SUCCESS

Independent advice for building and running a top-performing private medical practice.

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Health literacy

Use language your patients understand Improve how you communicate to enhance patients' health literacy

Do your patients understand what your physicians tell them? Maybe, maybe not. What is certain is that misunderstood medical information may compromise patients' health.

A 2004 Institute of Medicine report, *Health Literacy: A Prescription to End Confusion*, found that nearly half of all American adults—90 million people—have difficulty understanding and using basic health information. The impact? Higher rates of hospitalization and use of emergency services.

Patients who have difficulty reading and writing are at risk, but they aren't the only ones. Even an otherwise highly literate patient may have low health literacy.

Various definitions of health literacy exist, but one of the most common comes from the U.S. Department of Health and Human Services report *Healthy People 2010* (www.healthypeople.gov), which defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." It includes the ability to understand instructions on prescription drug labels, appointment slips, medical education brochures, doctors' directions, and consent forms. It relates, in some way, to all aspects of navigating the complex healthcare system.

In light of consumer-driven healthcare, it becomes even more important that patients comprehend the information that's presented to them. After all, they are expected to become consumers and take more responsibility for their healthcare. Thus, health literacy becomes even more important than in years past.

The challenge for practices is to communicate information clearly to patients and overcome any barriers posed by low health literacy. And it's the practice that bears the responsibility, says **Helen Osborne, MEd, OTR/L**, of Health Literacy Consulting in Natick, MA.

In light of consumer-driven healthcare, it becomes even more important that patients **comprehend the information that's presented to them.**

Improving health literacy is important, but medical practices must also improve their own communication practices. In other words, the job of the practice manager and the provider isn't to change the patient, but to change the practice to communicate more effectively with the patient.

Identify different approaches to learning

People learn in different ways, Osborne explains. Ask your patient which approach works best for him or her and offer different strategies. Some people like to read, some like to touch, some like to listen. Trying to reach

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people by using the ways they learn best enhances communication and decreases frustration.

Such an approach benefits all patients. Osborne uses herself as an example. She likes to knit, and although she can read instructions and look at patterns, she doesn't really understand them until she has the needles and wool in her hand.

The point is to communicate in whichever ways work: pictures, videos, models, written instructions, etc.

To find out which approach is most effective, says **Archie Willard**, a literacy and health literacy advocate in Eagle Grove, IA, providers must ask only a couple of simple questions: How do you like to learn? How can we communicate better? If you need to give patients additional information, don't just send them to a Web site or hand them printed brochures.

Instead, provide a list of credible sources of information, Web sites, printed material, support groups, etc., says Osborne.

Confirm understanding

Osborne has written a book full of tips to enhance patient communication, especially with literacy-challenged patients. But if you can make only one change in your practice, this is the one she wants you to make: Confirm understanding.

This approach, sometimes called the teach-back method, involves asking patients to repeat in their own words what they need to do when they leave the office. As the provider or staff member is giving instructions or advice, he or she should periodically pause and say something along the lines of "Let me see if I explained this clearly. When you get home, how will you take this medicine?" It may mean repeating information or communicating it in a different format, but it's an effective way to assess comprehension without "testing" the patient.

What you don't want to do is say, "Do you understand?" The patient will probably say, "yes," regardless of whether he or she does, Osborne says. The teach-back method keeps the responsibility where it belongs—on the practice.

When simple words aren't so simple

Most providers know to avoid medical jargon when speaking with patients (e.g., using harmless versus benign, swelling versus edema). But some seemingly simple words can create confusion, explains **Helen Osborne, MEd, OTR/L**, of Health Literacy Consulting in Natick, MA.

» **One phrase, two interpretations.** Even commonly used words such as "may," "might," and "suggest" can be difficult to understand. For example, consider the phrase, "This treatment may help." To scientists, this is generally understood as meaning that there is no conclusive evidence. However, to patients, this same statement may be interpreted as "this treatment will help." Make sure to explain what phrases such as these really mean.

» **Acronyms and other new "words."** Acronyms are made-up terms that use the first letters from words in a phrase. Sometimes acronyms sound like familiar words, such as CAT for "computed/computerized axial tomography." Other times, acronyms form new "words" (which really aren't words), such as ADL, which stands for "activities of daily living." To help

patients better understand, write out the entire term the first that time you use it and put the acronym in parentheses alongside it (e.g., "blood pressure [BP]").

» **Common words used in uncommon ways.** Sometimes health professionals use common words in unusual ways. For example, providers might tell patients that they are "unremarkable," which is likely good news. But when providers talk about "positive" test results, this is probably not good at all. To improve communication, confirm that others correctly understand the concept that you are trying to convey.

» **Homonyms.** These are words with different meanings that sound alike. The words may or may not be spelled the same way. Be sensitive to the fact that patients may not know what you are talking about when you use homonyms such as "stool," "gait," and "dressing." As with all communication, make sure to clarify what your words really mean.

Source: Health Literacy from A to Z: Practical Ways to Communicate Your Health Message by Helen Osborne. Used with permission.

The same theory applies to forms. “People who struggle to read just know that it’s much easier to fill out all yeses or nos, whichever answer will lead to fewer follow-up questions,” says Osborne. And that, of course, has tremendous implications for diagnosis, treatment, and outcomes.

Watch for red flags

Sometimes, it can be difficult to identify patients who don’t understand what you’re trying to communicate, especially those with low literacy. There are some red flags to watch out for, including forgetting reading glasses or promising to read or complete forms later.

Identifying potential literacy problems can help providers find better ways to communicate, but don’t push it too far. “A clinical encounter is the time to build a relationship,” says Osborne. A group of new readers put it more bluntly during a 2004 Iowa New Readers conference, Health and Literacy Working together. “A doctor’s office is no place for a reading test,” they said.

Willard, who organized the conference, explains why. Creating yet another test for them to fail only makes the environment more unpleasant and humiliating. “It kind of tears you apart inside,” he says. To avoid the risk of further humiliation, some of these patients will simply avoid visiting the doctor. Osborne, equally adamant, is dismayed by the use of such tests in medical practices. It’s a controversial issue about which experts disagree, she acknowledges, but she strongly recommends against using them. She does make one exception for a health literacy test called The Newest Vital Sign, available at www.newestvitalsign.org. Although Willard makes no such exception, both agree in principle that medical practices should not be in the habit of shaming patients.

Create a shame-free environment

Practice managers should strive to create a welcoming, supportive environment that encourages patients to think, disagree, and ask questions, says Osborne.

This is particularly important for those with low literacy skills, says Willard, who has dyslexia. He learned to read at age 54 and has firsthand experience with the difficulties that many people face in the doctor’s office. He points out that many patients with low literacy have been shamed in the past, especially in school. They don’t want to face this shame as adults, especially in the already stressful environment of a doctor’s office. Unfortunately,

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Recommendations for providers

Participants in the 17th Annual New Readers of Iowa Coalition Conference, Building Health Literacy Leaders, developed a list of recommendations for providers. **Archie Willard**, a health literacy advocate based in Eagle Grove, IA, and a conference coordinator, shared them with **PPS**:

- » Create an environment where patients are encouraged to get involved in their healthcare. Allow patients adequate time with providers and eliminate the shame associated with literacy problems.
- » Use the teach-back method to ensure patient understanding of medical instructions. Review instructions both verbally and through written materials, ask patients to verbally repeat back instructions, and verbally review the risks of not following through with prescribed treatments.
- » Invite patients to ask providers questions to increase understanding. Use the Ask Me 3 program (www.askme3.org) to encourage patients to understand the answers to these three questions:
 - What is my main problem?
 - What do I need to do?
 - Why is it important for me to do this?
- » Work with professional colleagues to further disseminate health literacy information and materials.
- » Reduce the paperwork necessary to initiate medical treatment, make required paperwork easier to understand, and provide shame-free opportunities to review paperwork verbally.

The participants also recommended that providers become familiar with health literacy issues. In particular, they recommended that providers review and incorporate information from the following sources:

- » The Joint Commission
- » Partnership for Clear Health Communication
- » American Medical Association
- » Harvard School of Public Health
- » National Patient Safety Foundation
- » National Institutes of Health
- » Institute of Medicine of the National Academies

Health literacy

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he says, most doctors' offices are not shame-free environments. For example, patients often are rushed through the visit, and they aren't encouraged to ask the questions that they need to ask to better understand their own health issues.

Likewise, the amount and complexity of paperwork can be overwhelming for someone with limited literacy skills. He acknowledges that practices can't do away with paperwork, but giving patients the opportunity to have someone review it orally could go a long way toward creating a more comfortable environment. So, too, would simple, clear communication that avoids jargon. (See "Recommendations for providers" on p. 3 for similar tactics and strategies.)

Willard has another bit of advice for medical practices that want to improve how they communicate with their patients, especially those with literacy challenges. Talk to them. Ask them what they need. You can't solve health literacy problems if you don't talk to those with literacy problems, Willard says.

Osborne offers similar advice: Collaborate with the stakeholders. "Health literacy is more than any one person, program, or practice. We are all in this one together," she says.

Consider the reward

It doesn't take a tremendous amount of time or effort to implement most of the practices, says Osborne. For instance, some strategies, such as asking people how they like to learn, shouldn't take any extra time at all, and the teach-back technique takes just a minute or two, she says. But the extra

investment of time can more than pay off with fewer phone calls, decreased preventable errors, fewer emergency department visits, and greater satisfaction—"all because patients really understand what to do," she says.

In addition to the tangible benefits, there's also the knowledge that the practice is doing the right thing. "And 'doing the right thing' alone sounds like a good outcome to me. After all, we went into these professions because we wanted to help people. I think our original good will sometimes get lost in day-to-day hassles," Osborne says.

Weigh the ethics of simplicity

Although Osborne encourages providers and office staff members to communicate with patients clearly, she offers a caveat: Don't oversimplify to the point of providing incomplete information. Healthcare providers and their staff members often function as translators and interpreters. It's not necessarily translating English into Spanish, says Osborne. But it does involve taking complex, ever-changing health information and communicating it in simple terms. "Someone might make a life-and-death decision based on your interpretation," she says. "Appreciate the power you have." ■

PPS sources

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News briefs

Insurers get low grades

Family Practice Management published results of a *Consumer Reports*-style survey of physicians' experiences with 32 health plans. They were far from positive. Physicians gave low grades and expressed discontent with payment rates, timeliness, and payer accessibility. The average overall grade was a C-minus.

The areas receiving the highest ratings (an overall C average) were "timeliness

of payments," "member eligibility and benefits information," and "the payer's Web site." The category with the lowest overall score (a D average) was "the contracting process." The article, along with a few horror stories, is available at www.aafp.org/fpm/20070600/43arep.html.

More golf, fewer headaches?

One in three doctors over age 50 would retire today if they could afford

to do so, according to a survey released earlier this year by the American Association of Medical Colleges and the AMA. Physicians surveyed named increased regulation of medicine as the top factor influencing their retirement plans.

The survey also found that one in three doctors under the age of 50 would not choose to work longer hours for more money, with 70% of young

doctors saying that family and personal time are important in their lives.

Source: AAMC Physician Workforce Research Conference (www.aamc.org/workforce/pwrc/start.htm).

Fewer physicians disclose real-world errors

A University of Iowa study identified a potential gap in physicians' attitudes about disclosing medical errors and what they do in these situations. Although 97% of respondents indicated that they would disclose a hypothetical medical error that resulted in minor harm to a patient, and 93% said they would disclose an error if it caused major harm, only 41% of faculty and resident physicians reported actually having disclosed a minor medical error, and only 5% have disclosed a major error.

At least 19% of respondents acknowledged having made a minor medical error and not disclosing it. Four percent admitted failing to disclose a major error. The survey results appear in the July *Journal of General Internal Medicine* (www.springerlink.com/content/tb83172521204p43/fulltext.html [subscription only]).

Patients want, but don't get, a friendly introduction

Doctors do not address patients by name in half of first-time visits, even though nearly all patients want such a greeting, according to research from Northwestern University's Feinberg School of Medicine. The study, published in the June II *Archives of Internal Medicine*, found that 78% of survey respondents wanted their physician to shake their hand.

Nearly all patients wanted to be

greeted by name, including 50% by their first name, 17% by their last name, and 24% by both their first and last name.

About 56% of patients wanted physicians to introduce themselves using their first and last names, 33% expected their last name, and 7% expected their first name.

Reality doesn't match expectations: Although 83% of doctors shook hands in the videos, only half addressed patients by name. Based on the findings, Makoul recommends a greeting strategy that uses first and last names for both doctor and patient. For instance, if Dr. Robert Franklin is meeting Jane Smith for the first time, he might say, "Jane Smith. Hi, I'm Bob Franklin." This strategy communicates respect, and the videos showed that it was a comfortable form of introduction for most study physicians during first-time visits.

Booming practice opportunities?

A new report from the American Hospital Association and Alpharetta, GA-based First Consulting Group looks at the effect of aging boomers on healthcare. It predicts that one in four boomers will have diabetes by 2030, and more than six out of 10 will have more than one chronic condition. The report also looks at office visits.

As patients live with multiple chronic diseases, demand for services will increase. The number of physician visits has been increasing for all adults, up 34% over the past decade, and this trend is expected to continue. By 2020, boomers will account for four in 10 office visits to physicians. The report, *When I'm 64: How Boomers Will Change Health Care*, is available on the

American Hospital Association Web site. Go to www.aha.org and then click the Research and Trends tab.

AHRQ offers report card compendium

The Agency for Healthcare Research and Quality (AHRQ) has developed a new Web tool demonstrating a variety of approaches for health quality report cards. The new Health Care Report Card Compendium is a searchable directory of more than 200 samples of report cards produced by a variety of organizations.

The samples show formats and approaches for providing comparative information on the quality of health plans, hospitals, medical groups, individual physicians, nursing homes, and other providers. The Health Care Report Card Compendium can be found at www.talkingquality.gov/compendium.

Malpractice caps mean lower premiums, report finds

Caps on medical malpractice damages mean lower insurance premiums for doctors, according to a new review from two Alabama universities published in *The Milbank Quarterly*. How these caps affect patient care or costs is less certain. One effect of caps, according to the authors, is that they discourage lawsuits.

More than half of the states have damages caps, 13 states and the District of Columbia never passed laws instituting caps, and nine states ruled them unconstitutional.

Source: "Damages caps in medical malpractice cases," *The Milbank Quarterly* 85(2), 2007. ■

Practice management

Recognize the benefits and pitfalls of outsourcing

Experts urge practices to do their homework

Editor's note: This is the sixth in a 10-part series about applying the strategies of the world's top companies to your practice. Craig E. Samitt, MD, MBA, president and CEO of the Dean Health System and former COO of Fallon Clinic, Inc., presented "Learning from the Best: Applying the methods of the world's top 10 companies to drive the transformation of health care delivery" during the Medical Group Management Association's (MGMA) 2006 annual conference. This lesson, "The IBM Way (and Many Others): Don't Do Everything Yourself," focuses on the value of outsourcing.

If your practice is considering outsourcing—or if it's resisting it—Samitt has a question for you: Why does anyone who is not interacting with patients need to be in the office when better, faster services are available at a lower cost?

Successful medical practices focus on core competencies, and those core competencies are generally clinical in nature, not financial or administrative, he says.

Accordingly, among the most likely targets for outsourcing are HR, IT, transcription, and revenue operations. But just which functions are outsourced and to whom depends on the practice itself.

But before moving forward, a good practice manager will assess the status quo. A cost-benefit analysis is critical, he says.

Cynthia L. Dunn, RN, FACMPE, a former practice manager for 18 years, agrees. One of the biggest mistakes a practice can make is to decide to outsource on a whim or out of panic. It must be a business decision based on data, she says.

Assess your practice

Regardless of what function you are considering outsourcing, analysis is critical. A good manager will review return

on investment on each function that's being considered for outsourcing, Samitt says.

Dunn, now a Cocoa Beach, FL–based consultant with MGMA Health Care Consulting Group, takes a similar stand. "You can't make any decisions about your practice without data."

Before moving ahead, review all aspects of the revenue cycle. Look at your numbers and benchmark them for your specialty.

Ask—and answer—questions such as "Are you getting patient bills out on time?" and "How long are your accounts in accounts receivable?"

Dunn suggests a simple gap analysis. For instance, if your practice's collection rate is 90%, and the industry average is 98%, you need to look at that gap and the cost of outsourcing. Is it worth it? (If your net collection rate is 97%, it's probably not worth the effort and money.)

As technology becomes more refined and accessible to practices, outsourcing is going to be increasingly attractive to a larger number of them.

It's certainly changed Dunn's perception. When she ran a practice, she was convinced that no one could collect better than she and her staff. But that may not be the case today, she says.

The revenue cycle is much more sophisticated than billing and collections, and it can be "extremely difficult" to manage all of its aspects well. "Some practices do a good job, but others don't," she says.

Practice success today is not just about how good your physician is. "You have to know your data," Dunn says.

Assess satisfaction

If you are considering outsourcing some of the patient-facing functions, think about conducting a patient satisfaction survey. It can help identify areas in which your practice needs help. Dunn suggests a "busy study" to identify how many calls don't get through because the incoming lines are in use. Most local phone companies will do such a study at no charge, but be sure to check before asking for one. (For a new report on the impact on unanswered calls, see "Missed calls mean lost patients" on p. 7.)

Questions? Comments? Ideas?

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In general, having a receptionist who both checks in patients and answers the phone is not a good idea, she says.

It can be helpful to think about areas in the practice that need improvement; however, you then need to do the analysis. You want to document the benefits of outsourcing. Not only is it just smart business, but it will also help you make the case to your physicians, she says. Doctors are scientists, and if you can show them solid data, you are more likely to win them over.

Sometimes outsourcing can be the most viable option even when it costs more. Los Angeles Cardiology Associates outsources its nuclear tech functions, says **Dana Hunt**, director of finance and facilities. It costs more, but the vendor guarantees coverage—there's no down time due to vacation or illness. The nuclear program is always available.

Assess the local employee pool

You also want to look at the local employee pool, says Hunt. Her 12-physician practice outsources the transcription function, and one of the reasons she cites is the inability to find good transcriptionists to hire: They were all working for services or were independent contractors.

Increasingly, practices are finding that outsourcing transcription services is a way to save money, says Dunn. But it's not for every practice: "Some doctors will never agree to it," she says.

Balance IT needs

Hunt also outsources her IT. One of the greatest advantages is that Hunt can learn about the best practices of her vendors' other clients. They bring ideas from the "outside world"—ideas that haven't become common knowledge in the practice management community. Just recently, she implemented a very effective spam filter (www.mxlogic.com) that she learned about from one of her vendors.

Dunn is seeing an increasing move toward outsourcing IT functions, but she adds that it's important to have someone in house who is tech savvy to help troubleshoot common problems, move printers, etc. "You can't outsource software issues," she says. The in-house "super-user" ideally knows the different software packages that the office uses and can assist when needed.

Most practices have someone like that, says Dunn. And that's just what Hunt has. In addition to her "three IT guys" to whom she outsources, she has one in-house person

who splits his time between the business office and the IT department. Not only is he there to handle tech questions, but he provides a degree of continuity. It doesn't have to be an actual "tech person"—just someone who is comfortable with computers and the software packages that your practice uses. "You have to look at your practice and take advantage of the skill set you have," says Dunn.

Make it an ongoing process

So, once the tasks are outsourced, it's all over, right? Not at all, says Dunn. The practice manager needs to continue to review and assess the functions being outsourced. "You can't outsource it and forget it."

Transcription provides a good example, says Hunt. There are still a variety of housekeeping tasks involved beyond basic transcription, some of which must be handled in house (printing, editing, signing, etc.).

Dunn tells a story of a practice that diligently did a backup of its IT system each night, carefully archiving its tapes. The problem? No one ever checked the tapes, and when the system did crash, the practice had four years of blank tapes.

The same lesson applies to outsourcing, she says. "You still must be responsible for your practice." ■

PPS sources

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Missed calls mean lost patients

After analyzing more than 300,000 healthcare-related calls, researchers at The Beryl Institute have found that 75% of callers who are unable to make contact with a medical provider on the first try will not call back again. The institute's new white paper, *It's Not Just a Call, It's a Customer*, explores reasons why callers hang up before completing the call, lost revenue as a result of those abandoned attempts, and ways to decrease the number of callers who can't get through. Although the report focuses on hospitals, it includes insights for practices of any size. For details, visit www.theberylinstitute.net.

Medical staffing

Nonphysician providers can enhance profitability and flexibility

Successful deployment of NPPs requires attention to provider compensation, patient buy-in, and staff training

Are you thinking of expanding your practice by adding nonphysician providers (NPP)? Incorporating NPPs can be a smart move that results in enhanced profitability, satisfaction, and efficiency.

But it requires careful preparation.

PPS talked to experts to find out what you need to know about adding NPPs (also referred to as physician extenders and mid-level providers), such as nurse practitioners or physician assistants (PA).

"From a practical perspective, the way that NPPs can really contribute best to a practice is in **leveraging the physician's time.**"

—Jennie L. Campbell

Chris Tirabassi, chief operating officer at Internist Associates of Central New York in Syracuse, has been using NPPs since 1991. Currently the practice has seven NPPs—six nurse practitioners and one PA.

Jennie L. Campbell, a shareholder with Pershing Yoakley & Associates in Knoxville, TN, gives presentations on incorporating NPPs into a practice.

Enhanced flexibility and revenues

"From a practical perspective, the way that NPPs can really contribute best to a practice is in leveraging the physician's time," says Campbell.

With NPPs handling routine office visits, rounds, etc., physicians in the practice are freed to focus their efforts on more complex cases, she says. Managed well, adding NPPs can serve to enhance everyone's professional satisfaction as well as contributing to the practice's bottom line.

Generally, NPPs can provide a variety of services, including diagnosing and treating acute, minor, or chronic conditions; providing E/M services; ordering tests; and assisting during surgery. In some states, nurse practitioners can write prescriptions. (Be sure to check your state's scope-of-practice laws; more on this later.)

NPPs also give practices the flexibility to stay open for longer hours and on weekends, reaching more patients at times that are convenient for them.

Campbell offers a case study of an OB/GYN practice with 30 physicians that has a high delivery volume and a large Medicaid patient population. The NPPs focus on antepartum and postpartum care. On p. 9, **Figure 1** outlines the financial assumptions for the example, and **Figure 2** illustrates the costs using only physicians. **Figure 3** and **Figure 4** on p. 10 compare the various savings offered by three care models.

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It's a simple proposition, Campbell says. Because the practice is reimbursed a contractual amount for its services, regardless of who performs them, less-costly NPPs provide an opportunity to lower labor costs and enhance profitability.

The 2005 *Medical Group Management Association Physician Compensation and Production Survey Report* also identifies a strong connection to profitability, finding that practices with NPPs generally have better financial performance overall. And that translates into higher physician income. According to the report, practices with NPPs have higher physician compensation and a lighter workload (measured in hours worked per week).

Getting started

NPPs can't be added on a whim. It needs to be a sound business decision based on a business plan, says Tirabassi.

"Clearly define the scope of service and the economic expectations of the practice," he says. For Internist Associates of Central New York, "the average extender visit reimburses about \$65. How does that fit in with the business plan for the service and expectations for the MDs?"

Consider the following questions when deciding whether to add NPPs, Tirabassi says:

- » What additional resources are you willing to invest to bring the service online?
- » How will you announce the service to your patients and staff members?

- » Who will do the credentialing of the extenders?
- » Do you understand the 'incident to' rules? (See " 'Incident to' and Medicare" on p. 11 for details.)

It's also helpful to know your state's scope of practice laws before bringing an NPP on board. Nurse practitioners and PAs have a limited scope of practice; just how limited varies by state.

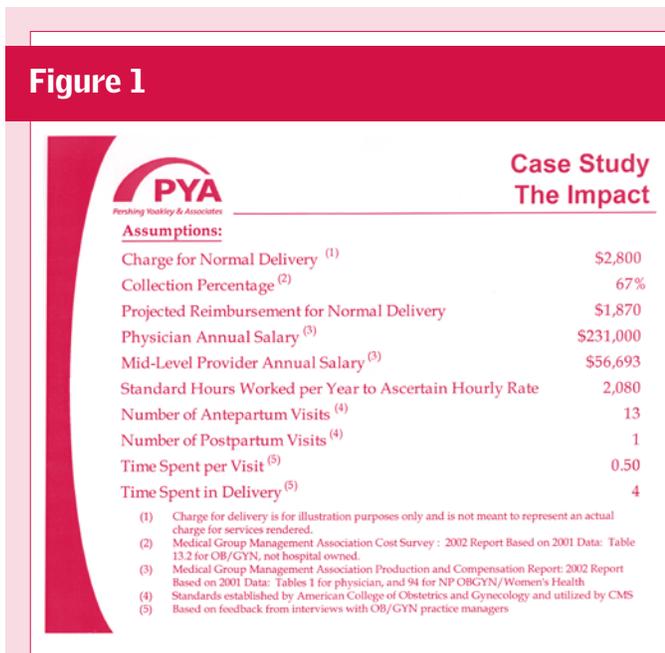
If you are considering using NPPs, it's important to check your state's laws. The American Academy of Physician Assistants summarizes PA-specific state laws at www.aapa.org/gandp/statelaw.html. The National Council of State Boards of Nursing offers a similar overview for nurse practitioners at www.ncsbn.org/515.htm.

Recruitment and compensation

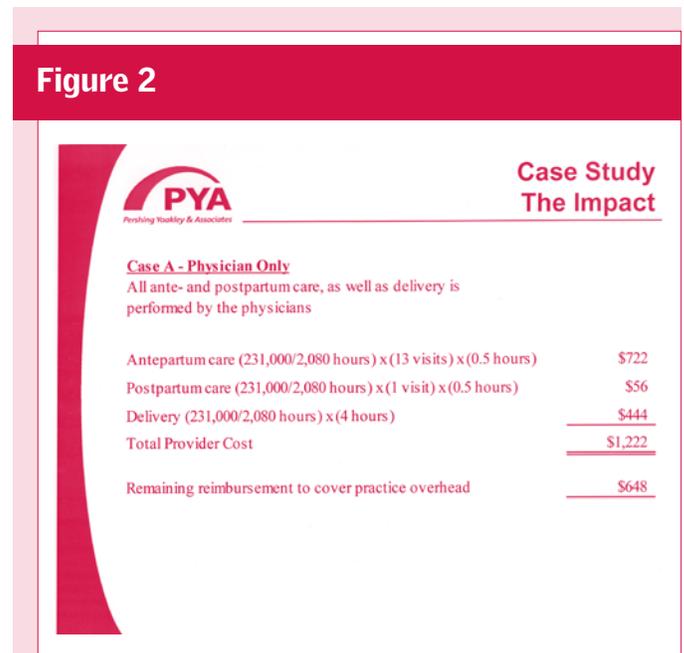
Campbell has seen the most success in practices that cultivate relationships with training programs. It's especially helpful if your senior NPPs also teach in the program, she says. This can enable your practice to recruit the best new graduates. Alternatively, a relationship that allows NPPs to rotate through your practice during their training program can also allow you first choice of new graduates, she says.

As for compensation, Campbell says the best approach is to treat NPPs as providers, not employees. Incentive pay based

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Medical staffing *continued from p. 9*

on productivity is a good way to accomplish this, she adds.

At Internist Associates of Central New York, Tirabassi has used various approaches to compensation. “Over the years we’ve tried several different combinations of straight salary, fixed bonus, and production-based gainsharing arrangements. There are pros and cons with each program.”

The difficulty with gainsharing, at least in his practice’s experience, is that if the extenders handle mostly acute visits, then their ability to influence the scheduling of patients is limited. Currently, the practice pays NPPs a competitive base salary with a discretionary bonus based on the overall performance of the group.

Patient acceptance

Patient acceptance is still an issue, but each year it becomes less of one, Campbell says. Patients are becoming more accepting, especially of nurse practitioners.

Women tend to be more accepting than men; in fact, some women even prefer nurse practitioners. In effect, using them boosts satisfaction.

One reason for that, she says, is that they may take more time with a patient, so the visit isn’t so rushed and stressed. (Nurse practitioners are common in practices focused on women’s health.)

Age is another key factor. The older the patient, the more likely there will be some reluctance to see an NPP.

But there are ways to help overcome resistance. A practice adding NPPs can ease the transition for patients by introducing them to their patients.

Ideally, it should be an in-person introduction by the patient’s physician during a regular office visit, Campbell says. However, many practices mail an announcement, and some may advertise in the local newspaper, she adds.

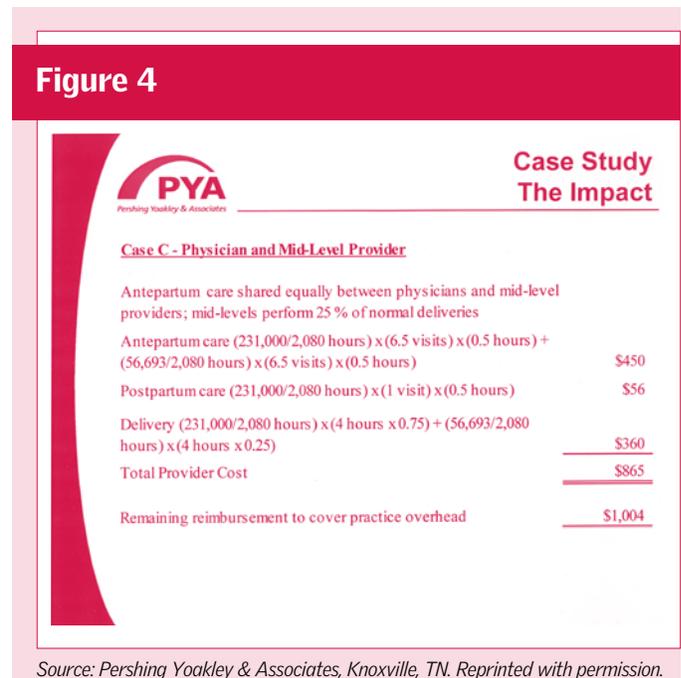
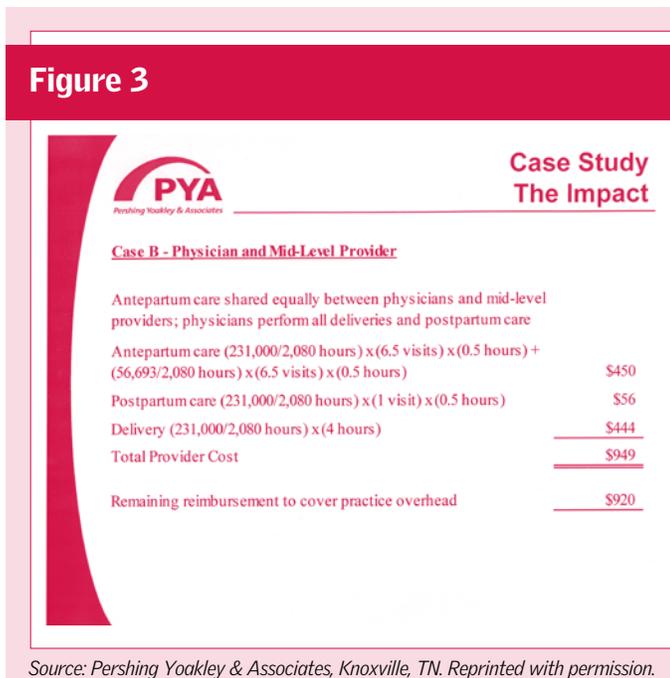
After the initial introduction, patients can be given the choice when they call for an appointment. (Sometimes, the NPP can see the patient sooner than the physician can, making the choice easier.)

At Internist Associates of Central New York, response has been positive, says Tirabassi. (In rare cases, patients request to see only physicians.)

The practice integrates the NPPs with the attending physicians to make sure that the patient continues to be serviced by the physician periodically.

Early in the adoption process, MDs should expect to have to “cheerlead” for patients who are uneasy about the change, Tirabassi says.

But for physicians to be cheerleaders, they have to be on board.



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Defining roles

In general, physician resistance is waning, and it will continue to do so, especially in specialties in which there are severe physician shortages, says Campbell.

Sometimes, doctors are wary when extenders come on board. They may perceive competition. That can happen when the NPP is “just set loose in a practice” without a clearly defined focus, says Campbell.

The bottom line is communication. Define the roles of the NPPs and make sure that everyone understands what’s expected of themselves and everyone else.

However, it’s an ongoing process. “Reviewing expectations in terms of service and scheduling requires ongoing attention and periodic meetings—meetings most providers [physicians and NPPs alike] would rather not have,” Tirabassi says.

It’s crucial that the staff members understand the role of the NPP. NPPs want professional respect and satisfaction, but when the staff members don’t understand the NPP’s place in the practice, they don’t provide the same support, and they may not give them the respect they deserve. And that, says Campbell, will drive off NPPs.

Campbell suggests holding a staff meeting to address what’s involved in adding a provider to the practice who isn’t a physician. Explain what their duties involve and why they need the same support as the physician providers.

Just as important is to make sure that the front-office staff can communicate that role properly to patients. How the front office describes the NPP can make a tremendous

difference in patient perception, she says. Simply compare the following:

“Dr. Smith doesn’t have an opening until next month. You could get an appointment next week with Mary, but she’s just a nurse practitioner.”

versus

“Dr. Smith doesn’t have an opening until next month, but our nurse practitioner, Mary Jones, could see you on Friday.”

Bringing the staff members on board contributes not only to the satisfaction of the providers but to the patients, as well.

It all comes back to clarity and communication. If everyone in the practice knows the NPPs’ roles and responsibilities, the likelihood of resistance and resentment diminishes. “The best way to deploy a mid-level in a practice is to really be clear about what you want that mid-level doing,” says Campbell. ■

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‘Incident to’ and Medicare

“Incident to” refers to the Medicare requirement (42 *CFR*. §410.26) that physician services billed to Medicare Part B be billed under the name and provider number of the individual performing the service. However, it includes exceptions that allow for limited use of nonphysician providers.

For instance, the services must be performed under the direct personal supervision of the physician as an integral part of the physician’s personal in-office service. The physician must also be physically present in the same office suite and be available to render assistance if necessary.

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Consultant's perspective

Does your practice have 'homeland security'?



by Jackie Anderson

Would you leave your car unlocked with your personal checkbook resting on the front seat in plain view? Obviously not. However, medical practices often expose themselves to similar vulnerability by leaving legal documents in unsecured places in the medical office.

To avoid this situation, you can implement straightforward office policies to protect your practice from dishonest people who may potentially help themselves to your property, cash, or legal documents:

- » **Blank/refill checks.** Although in many cases a practice administrator will place the practice checkbook in a secured location, he or she may not store the refill checks as securely as the checkbook itself. This seems very elementary in concept; however, refill checks that arrive at the practice in a cardboard box from your banking institution or printing company may get stuck on a shelf and often are not treated with the same degree of security as the checkbook itself. Just like the checkbook left in an unlocked car, your practice is now vulnerable to dishonest individuals. Anyone with access to your practice—a patient, staff member, service person, etc.—could potentially create a financial nightmare for your practice.
- » **Prescription pads.** Take a field trip and look at your work counter outside of your patient rooms. Are prescription pads lying out in public view? What would stop dishonest persons from helping themselves to your prescription pads? Current and refill prescription pads should be stored in an area that can be locked or otherwise secured. This security measure will go a long way to protect you from prescriptions being written in your name but without your permission.

» **Petty cash.** Although many practices do a good job of securing the cash drawer money, the petty cash fund may not be treated with the same vigilance. Many practices maintain a small pool of practice money, \$50–\$100 for example, that is used for small lunches, postage, or other miscellaneous items. Additionally, the number of staff members allowed access to the petty cash fund may jeopardize the security of this fund. Ideally, one designated staff member will have access to, and total accountability for, the petty cash fund. This standard policy is intended to eliminate a potential cash discrepancy that in turn diverts precious time and energy away from the delivery of medical care.

» **Medical supplies.** Have you had the unpleasant experience of reaching for a certain medical supply while performing a procedure or examination on a patient, and that particular supply is not available? Because medical supplies cannot grow legs and walk out of your office on their own, unfortunately, the reality of the matter is that patients and/or those individuals attending the medical visit can easily pocket medical supplies while unattended in the exam room. Although many supplies must be stocked in exam rooms for easy access, some more expensive or desirable supplies, such as scissors, dilators, or medications, could be stored in a locked cabinet or outside of the exam room.

A quick assessment of your office could be an opportunity for you or your administrative staff to tighten up on security. This easy exercise could prove to benefit your bottom line by securing cash and valuable items in your “homeland.” 🗝

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The **PHYSICIAN'S** *Personal* **ADVISORY**

EXCLUSIVE ADVICE ON FINANCIAL, INVESTMENT, AND OTHER ASPECTS OF THE SUCCESSFUL PHYSICIAN'S PERSONAL LIFE

Four steps to a more secure retirement portfolio

by Diane M. Pearson, CFP

The best way to ensure a financially secure retirement is to have a comprehensive plan. And that means having enough money to last for 30–40 years beyond one's working life, allowing for the possibility that you'll live to be 100.

Think that sounds like a stretch?

Within the next 10 or 15 years, it is widely expected that there will be a big leap in human longevity that will radically change our society, primarily due to advances in medicine, genetics, and technology.

With people living longer—and with about 76 million baby boomers nearing retirement—it is more important to plan much further ahead for retirement and beyond than ever before.

The following are four steps that you can take to help ensure a more secure investment portfolio for your retirement years.

Step #1: Understand the hidden risks in your portfolio

When asked to identify what forces pose risks on investment returns, few investors recognize inflation as a likely counterpart.

Yet for traditionally risk-averse retirees, increasing

consumer prices often pose the greatest risk of all.

Older investors have historically favored lower-yielding investments such as CDs, money market accounts, and treasury bills, which have a far lesser chance of maintaining purchasing power.

When asked to identify what forces pose risks on investment returns, few investors recognize **inflation as a likely counterpart.**

Inflation is expected to inch upward as the economy gains its footing. Therefore, investment portfolios must be tailored accordingly.

Step #2: Be willing to diversify

It is important for investors to look beyond traditional stock and bond allocations to find steady, low-risk returns. True diversification is the process of spreading noncorrelated investments across asset classes (they tend not to move in tandem).

Although large and small U.S. stocks move in nearly identical patterns, asset classes such as international real estate, commodities, alternative fixed-income investments, managed futures, currency investments, and hedge-like investments exhibit return patterns that are different from Standard & Poor's (S&P) 500.

The S&P 500—an index consisting of 500 stocks chosen for market size, liquidity, and industry grouping—is designed to be a leading indicator of U.S. equities.

The combination of these investments in conjunction with bonds and large U.S. stocks helps protect the overall

INSIDE

Financial planning

Learn the four critical flaws of physician-advisor relationships on p. 3

Portfolio

continued from p. 1

portfolio in troubling market conditions while allowing it to participate in market gains.

Portfolios built on this premise are likely to earn returns typically associated with stocks while exhibiting almost bond-like risk levels.

Even in retirement, the lack of tax efficiency remains one of the biggest detriments to **overall portfolio performance.**

Step #3: Understand the relationship between bonds and interest rates

There is no doubt that fixed-income investments play a critical role in the formation of a retiree's portfolio.

However, the pricing of nearly any fixed-income instrument is directly related to movements in interest rates. Prices of bonds go down as interest rates rise.

Unfortunately for those currently nearing retirement, this can have a dramatic effect.

However, it's important to note that not all fixed-

income investments have the same sensitivity to interest rate fluctuations.

Some alternative fixed-income vehicles, such as bank loan mutual funds, floating rate mutual funds, and Treasury Inflation-Protected Securities, adjust in value in the same direction as interest rates.

Investors facing retirement should examine the fixed-income investments in their portfolio to determine how sensitive they may be to shifts in interest rates.

Step #4: Make tax efficiency a priority

Even in retirement, the lack of tax efficiency remains one of the biggest detriments to overall portfolio performance.

The following are a few tips to increase efficiency:

- » **Keep detailed records of cost basis.** This enables investors to identify specific share lots for the tax-efficient selling of gains and the timely harvesting of losses.
- » **Do not reinvest dividends.** This allows for an easier and more tax-efficient portfolio rebalancing, provides cash to live on, and spares investors from a tax-basis paperwork nightmare.
- » **Be aware of asset location.** Fixed-income investments, hedge-like investments, and real estate investment trusts, when possible, should go into tax-advantaged accounts, because the majority of their returns are made up of ordinary income, whereas equities are prime candidates for taxable accounts.

Building a portfolio that takes into account both hidden and obvious risks, diversifying to minimize those risks, and avoiding unnecessary income taxes will provide a safe and secure retirement. ■

Editor's note: Pearson is the director of financial planning for Legend Financial Advisors, Inc., in Pittsburgh. Contact her by phone at 412/635-9210 or via e-mail at legend@legend-financial.com.

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Four critical flaws of physician-advisor relationships

by David B. Mandell, JD, MBA, and Jason M. O'Dell, CEO

Editor's note: This is the first in a two-part series about physician-advisor relationships. This month, we cover four common flaws in physician-advisor relationships. In September, we will discuss how to remedy these problems so you can move toward your goal of minimizing your exposures to lawsuits and taxes.

Most physicians do not get the maximum value from their professional advisors. The main reason for this is that although the typical specialty physician receives nearly 25,000 hours of training in his or her profession, he or she receives zero hours of training in financial issues related to the business of being a doctor.

The first mistake that most physicians make when choosing a financial, legal, or tax advisor is **how they make the selection.**

Nor do most doctors receive training in how to choose or evaluate an advisor whose advice and expertise will form the backbone of their financial plan for their entire career.

The following are four common flaws that most physicians make when it comes to physician-advisor relationships:

I. Failing to choose the right advisor. The first mistake that most physicians make when choosing a financial, legal, or tax advisor is in the way they make the selection.

Most doctors choose their advisors when they are in residency or fellowship. As this is the time when most doctors begin to make money or start a family, it is during this period when many seek help with preparing life or disability insurance, a will, and tax returns.

Working long hours and without any financial training or the means to evaluate an advisor, doctors typically do what other busy people do—they take the path of least resistance and spend the least amount of time on the task.

They might use the same advisor as the older residents, find someone the local medical society recommends, or hire a friend or family member.

This initial choice of an advisor might be acceptable based on a physician's life circumstances at the time. But staying with an advisor the rest of your career is not a wise decision to make.

We know an orthopedic surgeon who lived in Nevada and was using the same New York-based lawyer he hired to create his will ten years previously when he was a resident.

Not only was this attorney not licensed in Nevada, but he also continued to advise the physician in areas that were clearly beyond his expertise.

The advisor didn't understand the advanced techniques that would best serve a physician making over \$1 million a year, nor did he have any knowledge of nonqualified plans, asset protection planning, or other fairly routine planning for high-earning physicians.

Although this advisor may have been an acceptable choice for the doctor when he was a resident, it was a total disservice to this surgeon at this point to continue to use this attorney as his main advisor.

When analyzing your own situation, consider these questions: How did you choose the professional advisor you work with today? How many other professionals did you interview prior to choosing one? Have you periodically interviewed others as your needs have changed?

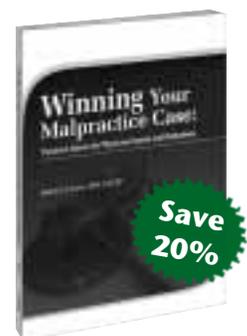
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Flaws

continued from p. 3

2. Failing to understand subspecialties in tax, law, and finance. Medicine is highly specialized. If you have a specific medical issue, you want a physician properly trained and experienced in that particular specialty to help you.

The same rule of thumb holds true for physicians who seek tax advice. The taxation issues that require guidance typically include issues such as:

- » Retirement planning
- » Estate tax planning and taxation on real estate sales
- » Individual tax returns
- » Corporate tax returns
- » Buying or selling the practice

All of these areas are actually particular subspecialties that require a unique knowledge base. Another common mistake physicians make is to ask their tax advisor to guide them in areas that are far outside of tax altogether (e.g., asset protection or investing).

To ensure that you have an advisor best suited for you, ask your certified public accountant (CPA) or attorney if he or she is an expert in the tax areas noted above, as well as how he or she would handle an issue for you outside of these areas.

3. Failing to get a second opinion. Of the four flaws discussed, failing to get a second opinion is the most damaging and, unfortunately, the most common.

Most physicians have not changed advisors because they have an “if it ain’t broke, don’t fix it” mentality. However, getting a second opinion is the only way to know whether your planning is broken.

Consider whether you’ve ever paid an outside advisor to review your current advisor’s work. If not, why not?

This is the only way for you to adequately judge an advisor’s performance.

4. Failing to insist on advisor coordination. Even if you have a team of highly experienced advisors in the fields of tax, law, insurance, and investments working for you, your plan can still be in complete disarray.

All too often, for example, physicians will pay a technically sound attorney to create a comprehensive living trust, but the family’s assets have not yet been titled to the trust, potentially making the document useless.

Even if you have a team of highly experienced advisors in the fields of tax, law, insurance, and investments working for you, **your plan can still be in complete disarray.**

Another common error is an advisor’s failure to take the proper steps to combine life insurance policies and trusts, which may result in the death benefit of the insurance being unnecessarily taxed at rates of 50%.

Like radiologists, surgeons, and anesthesiologists, your CPA, attorney, and financial advisors must work together.

If the surgeon never saw the films or charts, and the anesthesiologist and surgeon didn’t speak, it would be pretty difficult to successfully treat a surgical patient.

Consider how often your CPA, attorney, and financial and insurance advisors sit down to discuss and coordinate your planning, and then consider whether you need to arrange for better communication between them. ☒

Editor’s note: Mandell is an attorney, lecturer, and author of The Doctor’s Wealth Protection Guide and Wealth Protection, M.D. O’Dell is CEO of The O’Dell Group, LLC, and provides sophisticated business planning to physicians around the country. Contact Mandell and O’Dell at <http://wealthprotectionalliance.com> or by calling 800/554-7233. The information contained in this article is general in nature and should not be construed as comprehensive financial, tax, or legal advice. As with any financial or legal matter, consult your qualified securities, tax, or legal representative before taking action.

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