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No-frills space gives docs luxury of time

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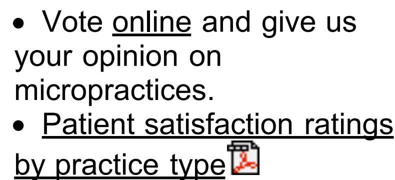
By Ryan DuBosar

Patients walking into general internist Soma Mandal, MD's, Manhattan office in New York City see her immediately—she's the only person in the practice. She relies on patients to complete their histories before their visit and she verifies insurance in advance. With all the paperwork addressed, she can then devote anywhere from 20 minutes for a routine visit to 40 minutes for a new patient—all of it clinical time.



Sidebars:

- Vote online and give us your opinion on micropractices.
- Patient satisfaction ratings by practice type

The luxury of such long visits is a welcome shift from her previous work at a hurried Lower East Side community health clinic. Treating the underserved was rewarding, but the overhead of a large facility demanded she fit patients into 15-minute slots, leaving only five to seven minutes for clinical work. She moved to a large Brooklyn medical practice, but 40- to 50-hour weeks were similarly frenzied. So she began plotting how to strike out on her own.

"I realized that the only way I could take control would be to start my own practice," she said. Unable to get a bank loan, she covered the $20,000 in startup costs herself and opened her scaled-down practice in September 2006.

By moving to a tiny office with no staff and minimal equipment, she lowered her overhead costs to an income-to-overhead ratio of 8:1. This allows her to restrict her patient load per week to about 20 patients in four half-day sessions, even while continuing to practice in New York's Gramercy Park neighborhood.

Dr. Mandal isn't alone. So-called "micropractices" have caught on in recent years, fueled by physicians' increasing frustration with reimbursement and administrative hassles coupled with pressure to see more patients in less time. Many follow a model established by Rochester, N.Y., family practitioner L. Gordon Moore, MD, based on the idea that efficient use of technology can speed up or eliminate anything about a medical practice that gets in the way of actually practicing medicine.

"When I talk to people who are looking at this, and ask them, 'What's driving you?'" said Dr. Moore, "the thing that absolutely rings true with me and with them is they say, 'I want to feel like I'm making a difference, and I'm losing that in my current environment.'"

Dr. Moore, who opened his solo practice in 2001, helped crystallize a movement that was already under way in the primary care community.

"I knew there were people, very few iconoclastic individuals, who were swimming against the tide and setting out their own practices, as opposed to being purchased by large organizations, but I didn't have a specific model," said Dr. Moore, who went to part-time practice after receiving a grant to help others implement the micropractice model. He and John H. Wasson, FACP, professor of community and family medicine at Dartmouth Medical School in Hanover, N.H., have since started a new way of educating doctors interested in the model online.

A practice of one

Only one criterion truly defines a micropractice; they are bare-bones.

A micropractice's overhead consumes about 35% of revenue, while a traditional practice's overhead can be as much as twice that. The typical office is a few hundred square feet—often just big enough for an exam room. They're often, but not always, single-physician practices. They may have medical assistants on staff but technology fulfills administrative functions, such as scheduling, prescribing, medical records, insurance coding and billing. Non-tech-savvy doctors rely on off-the-shelf software and a network of colleagues for advice.

Administrative systems can be automated. While a fully integrated system is expensive, automation saves time that micropractitioners can then devote to doing all their own clinical functions, further reducing the need to hire nurses or medical assistants.

"Why have a waiting room?" asks Eugene C. Nelson, DSc, MPH, professor of community and family medicine at Dartmouth Medical School in Hanover, N.H., who has studied micropractices as part of his research into developing patient-centered health care practices. "Why have all this paper floating around? Why not have the review of systems be generated by the patient and simply verified by the clinician?"

Dr. Nelson came to his conclusions in 1992, after reading James Brian Quinn's business book Intelligent Enterprise, about knowledge services and technology. He and others, including Drs. Moore and Wasson were studying the logistical issues of health care delivery when they realized they could apply the concepts of retail and service businesses to medicine.

They were skeptical about Dr. Moore's solo experiment at first, said Dartmouth's Dr. Wasson. "Everyone was able to watch him start out from the very beginning with the chance of failing, but he didn't. He grew. It was very public and it worked very well."

Breaking away

A small but growing group of physicians is following Dr. Moore's lead in trading higher incomes for greater job satisfaction by opening high-tech, low-overhead micropractices.

John Haresch, MD, a family practitioner in Kill Devil Hills, N.C., was working into the early morning hours to keep up with the patient reimbursement demands placed upon him as medical director of a community health center. He wanted off the treadmill. After hearing about the work of Dr. Moore, he rented a 500-square-foot office from a pain management practice and began seeing patients in June. He has no staff, and applies technology to handle billing, record-keeping, chronic care reminders and refills.

He relies on his contacts from the community health center to refer patients who need

diabetes education, mental health resources or alcohol and drug counseling. And he can direct patients needing lab tests to locations just up the street. It's not one-stop service, but it keeps his overhead to a minimum.

Dr. Haresch is steadily building his practice through referrals from other offices that are not accepting patients. A key hurdle was working with insurers on credentialing. Although he was ready to open in April, insurers wouldn't begin credentialing him until he was already seeing patients.

He accepted Medicare, which allows delayed billing, and spent months working with Blue Cross. He's now building on a 40-patient panel. He covers a college health clinic but intends to devote himself to his own practice as it grows larger.

Kevin and Angela Egly, ACP Members, a husband and wife team, worked for a large multispecialty group in Aurora, Ill., just west of Chicago, before starting their own micropractice in 2004.

"You could not take enough time to review the charts to make sure what they needed," Dr. Kevin Egly said of working at the multispecialty practice. "You would do the best you could in the 15 to 20 minutes you had to see the patient."

Like Dr. Haresch, he'd read articles by and about Dr. Moore, and contacted him about creating a micropractice. No insurance carrier in their area would write a new malpractice insurance policy for a startup, so they moved 20 miles west to Sandwich, Ill., a community of 6,600, where a hospital needed internists and an insurer would write a policy.

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—Kevin Egly, ACP Member

"[A consultant] wanted me to set up the standard practice with a receptionist, a medical assistant, a nurse, a biller, three to six exam rooms—and higher overhead," he said. A medical center was opening nearby, and the developer recommended they lease 1,800 square feet, a typical office size, which Dr. Egly estimated would cost $52,000 annually.

Instead, they share 600 square feet at $10,000 annually. They alternate days in the office, which halves their malpractice insurance. Overhead runs about 35% of revenue, which allows them to spend an hour with each new patient, 40 minutes with each follow-up patient and 20 minutes for acute care visits. And they didn't have to take a salary cut to do it, Dr. Egly said.

They calculated that adding one full-time nurse to check blood pressures, take lipid levels and refill prescriptions would mean seeing 24 patients a day instead of 12. In order to take care of patients more comprehensively, they chose efficiency instead, installing electronic health records to set up reminders for chronic care. For example, diabetics are flagged to get a microalbumin test one visit, in addition to their lipid panel and their cholesterol, then a diabetic eye exam at the next visit, and so on. No-shows get calls reminding them to make up the appointment.

"It's not uncommon that we'll get a diabetic whose HgA1c is around 12 and within six months they'll be below 6.5, which is unheard of in many standard practices," Dr. Egly said. "We can devote the time and attention where it's needed."

Building on 'micro'

Thomas Hastings, ACP Member, built a micropractice in Chesterfield, Mo., that today handles an estimated 3,000 patients. Unlike many other micropractices, which added only what they need to practice, Dr. Hastings pared himself down but kept what he felt was needed in order to offer additional procedures and services. He was part of a six-physician group, but when his partners sold out to a hospital system to solve overhead and practice management issues, he opted not to go.

“I was nervous. I did a lot of hand-wringing,” he said. “Can I make it on my own? Will I be able to make it day to day? Will I survive? Will finances work out? That was part of the reason I tried to hunker down and make things small and efficient.”

He had been in practice for 17 years and did not have a micropractice as a goal. But he learned about micropractices through a local collaborative, the Ideal Missouri Practice Program. They taught patient-centered collaborative care, increased self-management skill for chronic disease patents and provided online tools to help physicians strengthening these skills.

Today he employs three medical assistants in a 1,600-square-foot office. He needs extra room for dermatologic procedures, EKGs and pulmonary function tests, but the space is still a little too roomy, in his opinion. He’s almost eliminated paper records and is looking for a new space of about 1,000 square feet.

“There are a lot of extra things that we do to provide service in the office that it might be too hard to do if you pare it down too much,” Dr. Hastings said. “If you make it too micro, you do reach a point of diminishing returns.”

He sees an average of 15 patients a day, scheduling them for a half-hour, most of which is clinical time with a few minutes for coding the visit.

Although Dr. Hastings and his three medical assistants are a micropractice, he joined a large, independent multispecialty group practice with 75 other physicians in the St. Louis area. He pays 15% of his revenue to take advantage of the group’s ability to buy supplies, negotiate insurance rates and run a lab for tests he doesn’t do in the office.

In this context, Dr. Hastings said, his micropractice is a unit of primary care delivery, inside a larger setting. The term micropractice may be outliving its usefulness, although the ideas remain, he added.

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—Thomas Hastings, ACP Member

Contentment

Lifestyle choices, as much as frustration with reimbursement and scheduling, play a role in many physicians’ decisions to go solo. Many are willing to trade higher incomes and the promise of a steady paycheck for the freedom to spend more time with family.

Micropractices allow physicians a way to remove the hassles of affording to practice medicine. And they are succeeding. Dr. Mandal can now hire a secretary at her Gramercy Park office to greet new patients and handle the mail.

“Most of my colleagues at NYU think I’m crazy,” Dr. Mandal said. “A couple of my colleagues

insist that I join their practice. But I can't ever see myself doing that. I've never worked this hard in my life, but I've never been this content practicing medicine."

Top

Patient satisfaction ratings by practice type

Satisfaction measure	Median patient ratings for traditional practices (n=50), %	Median patient ratings for Ideal Micropractices (n=12), %
Very easy access	49	69
Efficiency: My time is not wasted	74	92
Perfect care: There is nothing about my care that needs to be improved	35	62
Overall: I receive exactly the care I want and need exactly when and how I want and need it	32	59

Source: Rating based on patient self-reports using HowsYourHealth.org, developed by John Wasson, FACP.