



CKD PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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Reform Forces Practices to Be More Efficient

Physicians nationwide are feeling the effects of changes brought about as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003. This year, the provisions of the act make it imperative that all physicians operate more efficiently than they have at any time in the past, says Robert Provenzano, MD, a nephrologist and chief operating officer of St. Clair Specialty Physicians in Detroit. Provenzano is a member of the editorial board of *CKD Practice Options* and is president of the Renal Physicians Association, in Rockville, Md..

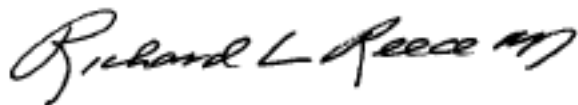
As our writer, Deborah Neveleff, explains in the article on Medicare Reform on page 6, some practices may be struggling as they are paid based on the new lower rate for medications they administer to patients. In the past, nephrologists were paid based on what the federal Centers for Medicare & Medicaid Services (CMS) calls the average wholesale price (AWP).

The Medicare reform act eliminated AWP, however. Starting this year, nephrologists are being paid based on what CMS calls the average sales price (ASP) plus 6%.

In the reimbursement article on page 9, we explain a strategy nephrologists can pursue to establish a pay for performance (P4P) program. While P4P is not widespread among nephrologists, our article explains that a nephrology group in Minnesota has been involved in a P4P program for the treatment of patients with CKD for two years.. Another way to increase efficiency is to hire additional providers or consider hiring a nurse practitioner or physician assistant. The Business Management article on page 12 addresses these hiring issues. Seeking to increase efficiency, a number of nephrology practices are using midlevel practitioners, rather than hiring new physicians. With some supervision, midlevel practitioners can assume some of the work that physicians would do otherwise, such as providing primary care, following up on office visits, and working with dialysis patients. These practitioners also are used to staff chronic kidney disease clinics and vascular access centers.

Nephrologists also can do an analysis of the practice's strengths, weaknesses, opportunities, and threats (SWOT). In the Strategy article on page 3, nephrologists and practice experts discuss the value of a SWOT analysis.

Over the coming months, *CKD Practice Options* will write about factors having a significant effect on nephrology practices and we will continue to include articles on how practices can operate more efficiently.



Richard L. Reece, MD

Contributing Editor

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

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Michael Germain, MD
Practicing Nephrologist
Western New England Renal &
Transplant
West Springfield, Mass.

Debra Lawson
Director of Reimbursement
Nephrology Associates of Tidewater
Norfolk, Va.

Suanne Petroff, NP
Registered Nurse
Western New England Renal &
Transplant
West Springfield, Mass.

Robert Provenzano, MD
Nephrology Chair
St. John Hospital Medical Center
Associate Professor of Medicine
Wayne State University
Practicing Nephrologist
St. Clair Specialty Physicians, PC
Detroit

Russell Silverstein, MD
Practicing Nephrologist
Dallas Nephrology Association
Dallas

Tom Turner
Practice Administrator
East Bay Nephrology
Berkeley, Calif.

Jeff Weintraub
Chief Executive Office
Southwest Kidney Institute
Tempe, Ariz.

James Weiss, MD
Renal Endocrine Associates
Monroeville, Pa.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

SWOT Analysis Leads to Nephrology Practice Success

By analyzing a practice's strengths, weaknesses, opportunities, and threats, nephrologists can make strategic business and clinical improvements that can enhance the strength of their business and improve the quality of care they deliver.

"Strategic planning is absolutely essential in enabling a nephrology practice to create a valued product for its community," says Robert Provenzano, MD, a nephrologist and chief executive officer of St. Clair Specialty Physicians in Detroit. Provenzano also is president of the Renal Physicians Association, in Rockville, Md.

Improving Relationships

Nick Fabrizio, PhD, FACMPE, a consultant with the Medical Group Management Association's Health Care Consulting Group, in Englewood, Colo., agrees that strategic planning for private practice physicians is important in all specialties. "Strategic planning and marketing are crucial to the success of a medical practice," says Fabrizio, who has worked with numerous nephrology groups and other practices. "Physicians are so busy with clinical care that they often do not focus on the fact that their practice is really a business. I have worked with nephrology groups that constitute million-dollar businesses. Having a business of that size without a strategic plan puts the group at a disadvantage."

This disadvantage is especially acute

in competitive markets. "Without a focus on strategic planning, physicians can lose track of who the competition is and what the competitors are doing," Fabrizio says. "In addition to monitoring competitive forces, strategic planning efforts help nephrologists optimize their contracting relationships with hospitals and determine how well they manage referral relationships. Finally, strategic planning helps nephrologists capture market share by pinpointing opportunities to develop new relationships with hospitals and dialysis centers and determining the practice's staffing and technology needs when expansion is desirable."

Most physicians, of course, are primarily interested in clinical quality. Still, there is a link between a strong business model and the quality of care physicians provide, Fabrizio explains. "No margin, no mission," he asserts. "If doctors do not have a profitable practice, they cannot do the things they want to do, such as purchase state-of-the-art equipment or expand into new patient-care services. Practices should generate sufficient profits both to cover overhead expenses and to enable the physicians to take advantage of exciting clinical opportunities that will help them enhance their care."

Provenzano agrees, saying, "A practice's business success gives physicians the opportunity to invest in expansion that will bring more services and greater access to patients."

Fabrizio notes that nephrology prac-

tices typically face several common challenges that strategic planning can address. "First, many nephrologists are spread too thin," he says. "They are constantly on the go, especially in larger cities, where they may have multiple office locations and serve patients in different hospitals and dialysis centers. A big challenge for nephrologists is trying to define the scope of their practice and their target market area, while remaining sufficiently flexible to accommodate marketplace changes, such as new business opportunities or competitive threats."

Declining reimbursement is a second challenge nephrologists face in virtually all markets nationwide. "Employing a good billing staff is one key to profitability and continued practice viability," Fabrizio notes. "In the face of declining reimbursement, nephrology practices require staff to handle billing and collections to ensure optimal charge capture and reimbursement. A competent and knowledgeable administrator is of great value as well."

Service Support

A third challenge is ensuring adequate revenue to support services that may be only marginally profitable. "For example, the care of patients with chronic kidney disease may generate only a limited margin, so nephrologists need to cultivate other revenue streams in order to create a viable business as a whole," Fabrizio says. "But if not planned properly,

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"A practice's business success gives physicians the opportunity to invest in expansion that will bring more services and greater access to patients."

—Robert Provenzano, MD, St. Clair Specialty Physicians

(Continued from page 3)

expanding into new service lines can create pressure for physicians, who are busy caring for patients.”

Strategic Planning

Such business challenges can be addressed through an analysis of strengths, weaknesses, opportunities, and threats (SWOT), commonly used as a framework for strategic planning in both small and large businesses in many industries. Fabrizio often conducts SWOT analyses in his work with medical practices.

St. Clair Specialty Physicians performs a SWOT analysis annually. “The SWOT analysis helps physicians determine what initiatives to pursue in the context of their practice’s business plan and ensure that they are investing their money wisely,” Provenzano says.

SWOT analyses are typically done with all physicians present. “Probably the most useful part of the whole exercise is that all the physicians are communicating with each other in real time, which is rare given the time constraints of daily practice,” Fabrizio says.

Defining goals is the key to performing a successful SWOT analysis. “Physician practices must define goals that are consistent with their mission and vision,” Fabrizio notes.

Assessing Strengths. Through a SWOT analysis, physicians first consider practice strengths. The strengths of a practice might include high quality care, a good reputation, good employee relations, and low staff turnover.

“A group might have strengths that the physicians don’t realize can be actively leveraged for business benefit,” Fabrizio says. “For example, quality care can be meaningfully parlayed into business success.”

Recently, Fabrizio worked with a nephrology group whose physicians were all in a magazine listing the community’s 100 top doctors. “That was a tremendous strength for this practice, especially since other nephrology groups in this large area did not have

Factors for Strategic Planning

Nick Fabrizio, a consultant with the Medical Group Management Association’s Health Care Consulting Group, in Englewood, Colo., lists several factors for nephrology groups to consider when embarking on a strategic planning process:

- Choose consulting assistance carefully, and ask for references. “The key is to get value for your time and monetary investment,” Fabrizio says.
- Require a pre-analysis of the group, including financial and market share analyses, and operational practices, so that the strategic plan is based on a framework of data.
- Divide all strategies into actionable steps that will help the group progress toward its goals.
- Commit the plan to writing and set clear deadlines and responsibilities. “The plan should specify who is doing what, when and how. Otherwise the plan will fall by the wayside,” Fabrizio says.
- Accept that strategic planning will require an investment of time on the part of the group’s physicians.
- Maintain the right attitude. “Physicians have to decide that they really want to develop a plan, and then be ready to implement it,” says Fabrizio.

—DJN

doctors included on this list,” he notes. “But the group had not been using this strength to its full potential. We developed an inexpensive marketing campaign directed toward hospital, dialysis companies, and referring doctors that highlighted the practice’s strong reputation for quality care.”

Broad coverage of an area is another strength that can be marketed successfully, Fabrizio continues. “First, practices must know their market share and the scope of their coverage,” he says. “Sometimes, hospital marketing departments can help medical groups by providing a ZIP code analysis of where patients live. Then, groups can work with the hospital to publicize their services within this market area, thereby ensuring that patients and referring doctors know who they are.”

Identifying Weaknesses. The second part of the SWOT analysis is to identify weaknesses. “Physicians should be candid in their assessment of the practice’s weaknesses,” Fabrizio asserts. “While it may be difficult to acknowledge weaknesses, seeing a list in black and white helps physicians take the next step in designing a plan

to ameliorate problems. Physicians should begin to resolve some of these issues before they build a plan. New strategies can easily be undermined if underlying weaknesses are not addressed first.”

Weaknesses may be relatively small and easily addressed, or they may be more complicated. “Most groups have a mix of weaknesses,” Fabrizio says. “Issues that require solutions to be implemented over a longer term might include ineffective group governance, ineffective billing practices, or ineffective hiring practices. In contrast, a relatively minor weakness may be the absence of a marketing plan, which involves a straightforward solution.”

A SWOT analysis helped St. Clair Specialty Physicians identify a major weakness: an inability to grow rapidly, causing a loss in market share. “Through the SWOT analysis, we developed a targeted approach to expansion by hiring a real estate attorney and developing direct recruiting initiatives,” says Provenzano. “As a result, over the last 18 months we have grown to a size that helps us meet our objectives.”

Seeing Opportunities. Next, the group assesses its opportunities. “Opportunities often include strategies related to expansion, such as establishing services at a new hospital, developing a new service line such as interventional nephrology, opening a new office location to prompt an increase in market share, or opening a dialysis center or a vascular access center,” says Fabrizio. “Other opportunities might be relationship-oriented, such as cultivating closer relationships with referring physicians or dialysis companies. Nephrology practices can build up their sources of revenue by carefully assessing the different opportunities that exist.”

A SWOT analysis helped the St. Clair physicians identify opportunities. “Our basic business model is patient-focused care for chronic kidney disease (CKD) and end-stage renal disease (ESRD),” explains Provenzano. “Using patient-focused care as our target, we identified vascular access as a major opportunity, and built two vascular access centers. We also wanted to streamline CKD care in the outpatient setting, so we created a nurse-directed, physician-supervised clinic based on clinical practice guidelines, data collection, and auditing for quality.”

A Hospital Presence

Having a strong presence in the local hospital is important to the business of a nephrology practice. “Like other specialists, nephrologists typically find that they need to be visible in the hospital in order to get new patients,” Fabrizio notes. “They get to know the internists and other referring physicians and need to be immediately available. Physicians do not want to spend excessive time making multiple

calls to get their patients in to see a specialist. If they see a nephrologist right there in the hospital, this nephrologist will start getting referrals.”

A more difficult part of analyzing opportunities involves assessing which types of revenue streams to pursue. “The group needs to examine its strengths and weaknesses and know what its competitors are doing,” Fabrizio says. “For example, physicians might decide to develop ancillary services because their competitors offer these same services. While that might be effective, timing must be considered. If the physicians open a new service line after the market is saturated, they may achieve only a small market share without much promise of gaining more, reducing their return on investment. Selecting a new business opportunity should be informed by clinician time availability, physician expertise, reimbursement levels for the service, patient demand, and competitors’ positions.”

Once nephrologists express interest in a new opportunity, the group must have a good administrator or business manager to help them pursue it effectively. “A business manager can perform an informed cost-benefit analysis of new investment possibilities as well as manage new relationships on behalf of the physicians,” Fabrizio says. “Furthermore, too often physicians try to pursue a new business opportunity without management assistance, and become frustrated by the amount of time diverted from patient care. This can delay implementation of the project, perhaps indefinitely.”

“Most doctors are busy doing what they are trained to do: taking care of patients,” Provenzano observes. “We may shy away from activities that don’t

naturally apply to our skill sets. More and more, successful practices are using practice managers to make their practices more efficient, which make them more competitive.” Provenzano says that practices can either hire a dedicated practice manager or assign practice management duties to one physician, who carves out specific time for this purpose and whose administrative role is subsidized by the practice.

Considering Threats. A practice’s final step in the SWOT analysis is to consider its threats. “Most obviously, other nephrology practices can be threats,” Fabrizio says. “Other threats can include non-nephrology practices offering nephrology care, hospitals, and dialysis companies.”

Making a Plan

The strategic plan for the practice should support the group’s goals. The plan also should reflect its strengths, address its weaknesses, and take into consideration opportunities and threats. The plan can then be developed into actionable initiatives as the group defines its top priorities. “We look at the group’s goals, priorities, and limitations in the context of the SWOT analysis and then move the group forward based on priorities,” Fabrizio explains.

It may be difficult for a group to find time to meet for one day and write a strategic plan. “In my experience, retreat planning sessions are necessary,” Fabrizio says. “Pre-retreat sessions include an analysis of the group’s financial circumstances and market share, and also involve one-on-one interviews with each physician who will attend the retreat.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

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—Nick Fabrizio, PhD, Medical Group Management Association

Practices Feeling the Effects of MMA

The Medicare Prescription Drug Improvement and Modernization Act (MMA) includes a number of provisions that are affecting nephrology practices. In some cases, the effect on practices is significant. The act is driving changes in how care is provided and causing nephrologists to renew their efforts to increase practice efficiency.

In particular, three aspects of MMA are having a significant effect on nephrology practices. They are provisions that call for reimbursement based on average sales price plus 6% (rather than the earlier method which was based on the average wholesale price). One of the most significant aspects of the act is Medicare Part D, the prescription drug plan for senior citizens. The third aspect of the act that may have a significant effect on practices is the competitive acquisition program, which would give practices a new way to acquire medications.

Average Sales Price (ASP)

As a result of the legislation, physicians are being reimbursed for the cost of medications based on ASP plus 6%. The ASP plus 6% rate for each drug is based on data provided by the manufacturers to the federal Centers for Medicare & Medicaid Services (CMS). ASP incorporates all aspects of sales prices, including any rebates, discounts, or other considerations that the manufacturer may give to its largest buyers. For nephrology practices, the move from AWP to ASP plus 6% affects all Part B drugs.

As mandated under MMA, reimbursement on bundled drugs in 2006 is 106% of ASP versus payment at 95% of AWP in 2003. As a result of these changes, total reimbursement to nephrologists has declined sharply since 2003.

“ASP has had a negative financial impact on nephrology practices,” says Jennifer Searfoss Miller, JD, the external relations liaison for the Medical Group Management Association, in Englewood, Colo. As external relations liaison, Miller coordinates MGMA advocacy efforts with other specialties and medical organizations. In fact, some practices that can no longer offer drug therapy services have shifted patients to a hospital outpatient setting, she adds.

Some nephrologists also have found a need to be more aggressive in negotiating the price of drugs, especially now that red blood cell growth factor has been added to the list of drugs reimbursed at ASP plus 6%, Miller adds. “Some practices are joining group purchasing organizations, while others are simply trying to bargain with pharmaceutical distributors more strongly,” she says. “Because they command a greater market share, larger practices are more likely to be able to negotiate successfully with the drug distributors.”

Robert Provenzano, MD, a nephrologist and chief operating officer of St. Clair Specialty Physicians in Detroit, agrees. “Larger practices may be able to negotiate a lower drug price,” he says. “If so, they will have to outlay less capital for inventory.” Provenzano is a member of the editorial board of *CKD*

Practice Options and president of the Renal Physicians Association, in Rockville, Md.

Those nephrologists who may feel the effects of MMA most significantly include those who treat patients with kidney or bladder cancer, Miller comments. The ASP plus 6% rates for the drugs used to treat patients with these cancers are significantly lower than the purchase price of these medications, she says.

Practice Analysis

Most MGMA members are analyzing their business operations to determine the effect of ASP on their practices, Miller explains. “Clearly, nephrologists need to understand the impact of the MMA in order to ensure the future viability of their practices,” she says. “But across specialties, some physicians are asking themselves, ‘Do I have the time and the resources for such an analysis?’ Clearly, because of the extent of these reimbursement changes, most practices are finding that it is well worth the time spent to analyze the cost of the provision of care so that they can determine the break-even point under the new reimbursement system.”

To accommodate ASP reimbursement, St. Clair Specialty Physicians has tried to maximize the number of appropriate patients with anemia who receive treatment. “We have a system to flag anemic patients for referral to one of our anemia clinics,” Provenzano says. “That way, we can maximize the percentage of our anemic patients who are treated, improving care quality as

As mandated under MMA, reimbursement on bundled drugs in 2006 is 106% of ASP versus payment at 95% of AWP in 2003. As a result of these changes, total reimbursement to nephrologists has declined sharply since 2003.

“Nephrologists need to understand the impact of the MMA in order to ensure the future viability of their practices,” says Jennifer Searfoss Miller, JD, of the MGMA. “But across specialties, some physicians are asking themselves, ‘Do I have the time and the resources for such an analysis?’”

well as optimizing the efficiency of our anemia management program.”

Medicare Part D

Medicare Part D is another aspect of the MMA that is affecting nephrology practices. “Patients of all physicians, including nephrologists, are asking for guidance regarding plan choice,” Miller says. “But physicians should definitely not recommend specific Part D plans to their patients.”

Physicians should avoid making plan recommendations because their objectivity could be questioned if they have relationships with pharmaceutical companies or health plans affiliated with the Part D plans they recommend, Miller comments. “Besides, physicians don’t really have the time for Part D plan analysis,” she adds. Understanding the appropriateness of the available plans for each patient could be quite burdensome, she says.

“CMS has very clearly stated that physicians should counsel patients to learn more about the plans themselves,” Miller says. For patients seeking information about Part D, physicians can direct patients and their families to the Medicare site on the Web (at www.medicare.gov) to review Part D plan formularies. “Physicians should encourage patients

to list all of the drugs they take and ensure that these drugs are covered by the formulary of any plan they are considering,” she adds.

Also, physicians can highlight a few important issues that patients should consider when selecting a plan. First, Medicare beneficiaries may not be familiar with utilization management features typical of managed care plans. Nephrologists may want to explain these features, which prescription drug plans are likely to incorporate. “For example, a number of drug plans require prior authorization,” Miller says.

Some plans may have tiered benefit levels, in which generic drugs would have a low copayment, preferred brand name drugs would have a higher copayment, and nonpreferred drugs would have the highest copayment. Step therapy is another pharmacy management tool. Under step therapy, a drug plan would require a patient to try the least expensive drug first when multiple drug options exist. The plan will cover a more expensive drug only if the physician can show that the less expensive drug is either harmful or not effective.

Some plans offer coverage when patients reach the doughnut hole in Medicare Part D coverage. The

doughnut hole occurs for patients who are not receiving subsidy once they use \$2,250 in prescription drug benefits and before they use \$5,100 in benefits. The patient is responsible for 100% of all costs between the \$2,250 and \$5,100.

Finally, Miller says, patients should also be aware that there might be an arduous appeals process if coverage of a drug prescription is denied.

Miller cannot say whether Medicare Part D has affected the care nephrologists provide. “But a scenario in which a nephrologist prescribes a drug for a patient and learns that the drug is not on the patient’s drug plan is likely,” she says. Although formularies must include at least two drugs from each class, nephrologists may have to use an alternative drug if the initially desired drug is not on the formulary and the alternative is equally effective.

Certainly, Medicare Part D has created additional complexity for medical practices, and nephrologists need to understand their own role in satisfying each plan’s specific utilization management requirements. For example, the need to obtain prior authorizations can increase the administrative burden on nephrology practices, Miller notes.

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Physicians may want to get information from the Web. Epocrates Inc., a company in San Mateo, Calif., (at www.epocrates.com) provides plan specific data, including formulary information and whether prior authorization is required. From the site, physicians can download formularies onto a handheld device.

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The CAP Program

As stipulated in the MMA, physicians will have the option of using the Competitive Acquisition Program (CAP) to acquire drugs. Once CAP is in place, physicians will be able to choose to accept reimbursement based on ASP plus 6% for most, but not all infusible and injectable Part B drugs administered in the office setting, or to participate in the CAP program. Practices choosing CAP will receive medications from BioScrip Corp., a specialty pharmacy company in Elmsford, N.Y. In April, CMS named BioScrip to be the specialty pharmacy provider for CAP. BioScrip will ship medications to a doctor and will bill the Medicare program directly.

CMS has said there are several benefits for physicians who choose to participate in CAP. For example, physicians would not need to tie up their capital in an inventory of drugs or collect beneficiary co-payments. Experts advise physicians, however, to evaluate the program carefully. "The CAP is meant to be an alternative for physicians who no longer want to be in the business of buying and billing for medications," says Miller.

The CAP program was scheduled to begin Jan. 1, but was postponed. In April, CMS said the program would begin on July 1, and that more information would be forthcoming.

Unless changes are made, Miller believes CAP may not be attractive to many practices. "Unless they are taking significant financial losses on drugs under ASP reimbursement, practices that have evaluated the CAP program have not found it appealing," she says.

Experts have a number of concerns

about CAP. "First, individual physicians within a group practice may not opt into the CAP program," Miller explains. "Either all of the physicians in the practice must participate for all of the drugs covered by the CAP, or none of the physicians can participate," she says.

Second, CAP participation would

one gets paid and the vendor can attempt to obtain reimbursement directly from the patient."

Provenzano does not expect CAP to be a viable alternative for most nephrology practices. "CAP is not likely to be attractive to large practices, because they would be foregoing the drug margins on Medicare

"In order to participate in the CAP program, a practice must maintain two different processes for obtaining drugs. One would be for the Medicare fee-for-service patients and one would be for private-pay patients," says Jennifer Searfoss Miller, JD, of the MGMA.

add to the practice's administrative burden. "In order to participate in the CAP program, a practice must maintain two different processes for obtaining drugs," Miller says. "One would be for the Medicare fee-for-service patients and one would be for private-pay patients and Medicare patients taking drugs not covered by the CAP," she adds.

A third concern relates to the complexity of the program and the physician's financial risk. "When physicians communicate with the vendor to obtain a drug, they are essentially submitting a claim," Miller says. "Then, another claim is submitted after administration to the Medicare contractor for the administration of the drug. The practice must include many modifiers and additional coding information. If the appropriate information is not included or if the information is incorrect in some way, no

patients and would still be responsible for keeping stock on hand for commercial patients," he explains. "If CAP is complicated or adds to the practice's administrative burden, even small practices may not choose to participate, but rather may simply stop offering anemia treatment."

"In general, most physicians probably do not fully understand the CAP program, and may make decisions based on incomplete information," Provenzano says.

Determining whether to participate or not will require a thorough review of the advantages and disadvantages of CAP. "Nephrologists will have to analyze the use of all drugs by all physicians in the group," Miller says. "Reimbursement will vary quarterly, but acquisition cost will not realistically vary each quarter."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

"CAP is not likely to be attractive to large practices, because they would be foregoing the drug margins on Medicare patients and would still be responsible for keeping stock on hand for commercial patients," says Robert Provenzano, MD, of St. Clair Specialty Physicians.

Minnesota Group Gets P4P

Many experts advocate paying more to physicians who meet performance measures and follow treatment guidelines. Toward that goal, health plans and the federal Centers for Medicare & Medicaid Services (CMS) are developing and using pay for performance (P4P) initiatives to improve quality.

While P4P is not widespread among nephrology practices, a nephrology group in Minnesota has been involved in a P4P program for the treatment of patients with CKD for two years. Michael G. Somermeyer, MD, a nephrologist with the 16-member Kidney Specialists of Minnesota in Robbinsdale, Minn., says the effort has been beneficial to patients and physicians. "We think it will be the wave of the future," he adds.

Improving Quality

"Whether physicians like it or not, it is quickly becoming the gold standard of many health plans and the government," Somermeyer comments. "Public statements from CMS officials are filled with allusions to the fact that CMS plans to go headlong into P4P. It's not a matter of if; it's when. Our experience with P4P has been very positive. We believe that it improves the quality of care."

P4P programs involve paying more to physicians based on their performance in meeting predetermined quality metrics. Most P4P programs provide modest financial bonuses of 1% to 5% of a physician's total revenue from a specific plan.

Since there are so few programs in place, some nephrologists are unsure

of what effect P4P will have on nephrology practices. "There are very, very few health plans offering pay-for-performance initiatives for the treatment of chronic kidney disease," says Robert Provenzano, MD, a nephrologist and chief operating officer of St. Clair Specialty Physicians in Detroit. "The few that have dabbled in it have yet to go into it a big way." Provenzano is also the president of the Renal Physicians Association, a professional organization in Rockville, Md.

Although more than 100 health plans offer P4P initiatives to primary care physicians, few have developed programs for specialists and fewer still have programs for physicians who treat patients with CKD.

Michael Germain, MD, a nephrologist with Western New England Renal & Transplant Associates in West Springfield, Mass., says, "In some very strong managed care markets, such as Minnesota and southern California, there are a few contracts for nephrologists treating patients with CKD. The devil's in the details, however. There hasn't yet been that much done in this area for us to know its effect on the quality of care."

Jeff Weintraub, chief executive officer of Southwest Kidney Institute in Tempe, Ariz., believes that effective P4P programs can lead to a significantly improved continuum of care and early diagnosis. "Good programs create a model structure of care," he says.

Some health plan executives agree. "Right now there are three ways we pay doctors, including specialists.

There's fee-for-service, capitation, and salary, and they are all bad," says Leonard Schaeffer, MD, who until he retired earlier this year was chairman of WellPoint Inc., a large managed care organization in Indianapolis. "Pay for performance can improve the quality of care, improve value in what we pay for, and encourage the adoption of information technology and electronic medical records."

Costs and Quality

The common goal of all P4P programs is to make evidence-based medicine the standard of care, says Schaeffer. Wellpoint pays performance bonuses to primary care physicians who demonstrate improved clinical outcomes, use evidence-based medical procedures, improve prescribing rates, implement information technology, and have high levels of patient satisfaction. The company is designing P4P programs for specialists, including nephrologists, Schaeffer says. Initial efforts have involved collecting data on end-stage renal disease (ESRD) treatment, and CKD likely will follow.

As Wellpoint is doing, Somermeyer's group began its involvement with P4P under an ESRD disease management initiative in 2002. "We believed we could apply the same principles to CKD, and the health plans agreed," Somermeyer says. Today, Kidney Specialists of Minnesota has P4P contracts for the treatment of patients with CKD with UCare Minnesota in Minneapolis and Medica, a nonprofit health plan in Minneapolis that is affiliated with

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"The few health plans that have dabbled in P4P have yet to go into it a big way."

—Robert Provenzano, MD, St. Clair Specialty Physicians

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UnitedHealth Group.

The group gets a bonus based on meeting specific measures, such as monitoring for and treating patients with anemia, Somermeyer says. Other measures include monitoring lipid levels and hypertension, and monitoring for comorbidities associated with CKD.

National Efforts

Somermeyer and other nephrologists believe P4P programs for CKD will become more common over the next several years. Later this year, CMS will start a P4P program for the treatment of patients with ESRD as required under the Medicare Prescription Drug Improvement and Modernization Act of 2003. The act requires CMS to develop a three-year demonstration project to test a case-mix adjusted payment system for a bundle of ESRD services. A portion of the payment will be linked to ESRD-related quality measures. The demonstration is scheduled to begin later this year.

CMS may follow the ESRD demonstration project with a similar project for the treatment of patients with CKD, says Barry M. Straube, MD, the chief medical officer for CMS Region IX (California, Arizona, Hawaii, and Nevada). For CMS, any proposed CKD demonstration projects would focus on chronic disease management, patient-physician partnership, reducing costs, increasing efficiency, and rural health delivery, Straube says. The quality of CKD services, as measured in a demonstration project, could lead to P4P, he adds.

National health plans also may move toward P4P for patients with CKD. "Many managed care organiza-

tions overlook important opportunities to improve care and control costs through disease management and P4P initiatives targeting CKD," says Michael Baxley, MD, regional medical director for AmeriChoice, a health plan in Chicago that serves government employees. AmeriChoice is part of UnitedHealth Group, the large managed care organization in Minneapolis. "Most managed care professionals appreciate the long-term benefits of successfully managing chronic illnesses," he says.

K/DOQI Guidelines

The guidelines from the National Kidney Foundation's Kidney Disease Outcomes and Quality Initiative would be ideal for implementation in any P4P program, says Somermeyer whose group follows these guidelines. Known as the K/DOQI guidelines, they have been in place since 2002.

Baxley agrees, saying, "The K/DOQI guidelines are a useful starting point for managed care organizations developing P4P initiatives. Health plans should expect nephrologists to use the guidelines to define the five stages of CKD and to follow the interventions prescribed for patients at each stage. The guidelines are still fairly new, so they are just starting to be in widespread clinical use." In addition, efficiency of care could be a factor in P4P programs, but health plans have yet to develop ways to measure efficiency among specialists, including nephrologists, he comments.

Guidelines, particularly those from K/DOQI, also are useful to physicians seeking to develop the internal disease management techniques applicable to meeting health plan quality initiatives, adds Somermeyer. "CKD

lends itself well to disease management and P4P programs because it has a predictable linear progression and has easily measurable, standardized laboratory markers on which to construct clinical pathways for monitoring disease progression and complications," he explains. "The K/DOQI guidelines for CKD provide explicit, proven approaches for delaying progression and treating comorbidities."

Experts agree that the K/DOQI guidelines could be used with any P4P program. "The progression of CKD can be kept under control, both financially and at the level of patient health, through the optimal use of guideline-driven treatment," says David B. Nash, MD, director of the Office of Health Policy and Clinical Outcomes at Thomas Jefferson University Hospital in Philadelphia. "The benefits of increased clinical attention to CKD guidelines extend to patients and the health plans that serve them." The goal of any guidelines is optimal care, he adds.

For patients with CKD, nephrologists delivering quality care would begin disease detection at an early stage, provide treatment aimed at delaying progression of the disease and prevent complications (such as anemia, malnutrition, osteodystrophy, and acidosis), and treat comorbidities (such as cardiac disease, vascular disease, and diabetes), Provenzano says. Guidelines are useful for each of these goals, he adds.

Words of Caution

Nash adds a caveat, however. "We have to remember, especially if we consider using guidelines for any pay for performance measures, that they are merely guidelines," he says. "They

"It's the wave of the future. Whether physicians like it or not, it is quickly becoming the gold standard of many health plans and the government." —*Michael G. Somermeyer, MD, Kidney Specialists of Minnesota*

should never be used as rigid rules.”

Guidelines are a good starting point for evaluating physicians, Provenzano adds, but could lead to rigidity of care. What’s more, the effectiveness of guidelines is unknown, he adds. Nephrologists also are concerned about using guidelines because they would likely need to implement sophisticated information systems, which can be extremely costly, he cautions.

“We don’t want to end up subject to the law of unintended consequences with a system that not only costs more but in which patients do worse,” Provenzano says. “What’s worrisome is whether nephrologists will place too much emphasis on complying with performance measures that carry rewards and not enough on important measures of appropriate care that do not.”

Officials of the American Medical Association and the Medical Group Management Association have voiced similar concerns, saying P4P programs impose unnecessary administrative burdens on physicians. They express concern that no one knows how big a bonus needs to be to make a difference in quality, and whether incentives will be sufficient to promote appropriate utilization without creating incentives to underutilize other necessary tests and services.

P4P critics also say that no one knows what information technology systems providers should adopt to comply with P4P guidelines, or who should pay for this technology. AMA and MGMA officials are concerned about what adjustments should be made to P4P programs designed for specialists as compared with those designed for primary care physicians.

While all of these issues need to be

UnitedHealth Group Develops P4P Metrics

UnitedHealth Group has long been a proponent of P4P initiatives, says Mark C. Rattray MD, national medical director for the UnitedHealth Premiums Designation program. “Our intention is to determine methods to reward specialists who demonstrate effective and cost-conscious treatment methodologies, including non-proceduralists such as nephrologists,” Rattray says.

The Premium Designation program uses various standards to measure performance and adherence to guidelines among physician practices. In the program, UnitedHealth divides medical specialists into proceduralists (such as surgeons), and non-proceduralists (such as allergists, neurologists, pulmonologists, and nephrologists). Those physicians who hit certain targets get rewarded with more referrals and bonuses. UnitedHealth defines the program as a P4P initiative, Rattray says.

The UnitedHealth Premium Designation program collects 24 months of national data on measures, applies quality screens to create specific metrics, designates physicians meeting the criteria, conducts subsequent analysis and analyzes regional efficiency benchmarks; and designates physicians who meet or exceed comparative market cost criteria.

Started last year, the program has focused primarily on hospitals. UnitedHealth is still collecting data on specialists, says Rattray. Non-proceduralists will be evaluated for treatment efficiency in episode treatment groups tied to a condition. In addition, they will be evaluated for compliance with guidelines and clinical rules developed by agencies such as the National Committee for Quality Assurance and professional organizations such as the National Kidney Foundation.

Quality metrics would be drawn from established national guidelines and standards. Efficiency of care would be measured at a local market level, Rattray says. The evaluation would be done by specialty, comparing individual physicians with other specialists in their own market. The data would be case-mix and severity adjusted to reflect individual physician practices.

The overall focus on specialty practices in any P4P initiative would be on patient safety, compliance with guidelines, sequencing of care, and procedural effectiveness. “Guideline compliance would be the single most important element of any P4P initiative at the physician level,” Rattray says. —MS

addressed, Weintraub of Southwest Kidney Institute expresses the view of many nephrologists and practice administrators. “We expect these programs to play an important and

inevitable role in CKD treatment,” he says. “They will grow in popularity among health plans.”

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

“The devil’s in the details. There hasn’t yet been that much done in this area for us to know its effect on the quality of care.”

—Michael Germain, MD, Western New England Renal & Transplant Associates

Recruiting the Best Nephrologists

When a nephrology practice is growing, the partners must work harder and at the same time recruit new practitioners to take up the slack. But before adding staff, nephrologists should consider the options carefully, because new staff will shape the practice's future direction, says Martin H. Osinski, president of Nephrology USA, a recruiting and consulting firm in Miami.

Practices have several options, says Osinski, who has 20 years of experience in nephrology recruiting. They can hire a young nephrologist out of fellowship training, a seasoned nephrologist, or a midlevel practitioner, such as a physician assistant or nurse practitioner. This third option is becoming increasingly popular.

A growing number of nephrology practices are turning to midlevel practitioners, rather than hiring a new physician. With supervision, midlevel practitioners can assume some of the work that physicians would do otherwise, such as primary care, following up on office visits, and working with dialysis patients. They also staff chronic kidney disease clinics and vascular access centers.

Finding a Match

It's time to start planning for recruitment when each nephrologist in a practice is seeing more than 75 dialysis patients, Osinski says. And, that number should be lower if the doctors have significant travel time to dialysis centers and hospitals.

Hiring a young nephrologist from a renal fellowship program can be difficult since the demand for nephrologists has been growing and supply

from training programs cannot keep up. The number of open positions for nephrologists far exceeds that of renal fellows entering practice.

The United States Renal Data Systems, in Minneapolis, reports that the prevalence of patients with end-stage renal disease is expected to increase to 650,000 by 2010, meaning there will be 160 or more ESRD patients for each practicing nephrologist within four years.

Meanwhile, Osinski reports that the supply of fellows is limited by funding for nephrology fellowship positions. In addition, more graduating fellows are specializing in interventional nephrology and transplantation than they were in the past, he adds. While many practices in desirable locations may have little problem finding nephrologists, practices in less desirable cities and towns are struggling to find new hires, he says. And, all practices will feel the shortage soon, he adds.

Upward Mobility

Another problem is that many new hires no longer wish to stay in one place, Osinski says. "There's a tendency for doctors to look at opportunities more as jobs than as careers," he comments. "They're apt to see a better opportunity elsewhere and move on."

Since physicians are willing to move, more seasoned nephrologists may be available for recruitment, Osinski says. About half the nephrologists he places are mid-career physicians looking for a new practice, and unlike new doctors, they tend to know exactly what they want. They focus on higher compensation, opportunity to become a partner, more

vacation time, reasonable call schedules, clinical work limited to nephrology, adequate support staff, and short travel times to dialysis centers.

Seasoned nephrologists also are interested in lifestyle considerations.

Recruitment Delays

But once a nephrologist is hired, it can still take 12 to 14 months to acquire a state license, find malpractice coverage, and get hospital privileges, says Bruce Guyant, manager of nephrology operations for CompHealth, a recruiting company in Salt Lake City. Also, the new physician will likely need time to sell a home, buy a home, and wait for his or her children to complete the school year. The wait will be shorter if the recruit is nearby, Guyant says.

In general, it is difficult to place nephrologists anywhere except the East and West coasts or in rural areas, Guyant says. Also, it is easier for a group to hire a new nephrologist than it is for a solo practitioner to hire one because candidates suspect solo practices are less stable than groups.

Practices having trouble filling positions can hire a locum tenens physician (which can be more expensive than hiring a full time physician) or might consider hiring a physician nearing retirement, Guyant says. Since older doctors generally want to go to the Sun Belt and are looking for less strenuous work, hiring one may not be a solution for every practice, he adds. "But every day that a spot is unfilled and patients are not being served, represents literally thousands of dollars to the clinic," he says.

Non-nephrologists will be needed to play a larger role as nephrology practices wrestle with higher patient volume.

Beyond Nephrologists

Recruiting another nephrologist, however, may not be the answer. Much of the work in a nephrology practice can be done by someone else, such as a midlevel practitioner or even a general internist, recruiters say.

Non-nephrologists will be needed to play a larger role as nephrology practices wrestle with higher patient volume. In addition to the rapid growth of patients with end-stage renal disease (ESRD), clinical practice guidelines call for a greater role for nephrologists in the treatment of chronic kidney disease (CKD).

The flood of patients will force nephrologists to reduce or eliminate their traditional role of primary care providers for ESRD patients, says Kurt Mosley, vice president for business development at The MHA Group, physician recruiters in Irving, Texas. For this reason, some nephrologists may consider using general internists to do primary care with patients, he adds. There are no significant obstacles to such a strategy, either in billing or obtaining hospital privileges, although the generalist should get some extra training from a nephrologist.

Robert Provenzano, MD, president of the Renal Physicians Association (RPA), says his multispecialty practice in Detroit, St. Clair Specialty Physicians, has 11 general internists along with 18 nephrologists. A general internist provides general medicine to nephrology patients, Provenzano says. One potential problem with using a general internist in a specialty practice is that referring internists in the community might view the general internist as a threat and send referrals elsewhere, he adds.

Midlevel Practitioners

To help share the workload, St. Clair Specialty Physicians has five nurse practitioners. "We're seeing more and more practices moving in this direction," Provenzano says of using nurse practitioners.

What Practices Want From PAs

The following are some required duties for nephrology physician assistants listed in recent job postings:

- On-call time
- Dialysis rounds
- ER evaluation
- History and physical
- Hospital rounds
- Management of anemia patients in a weekly clinic
- Office practice
- Transfer and discharge planning
- Work in a team with clinical nurse managers, social worker, and nephrologist.

Source: Job postings on the Web site of the American Academy of Nephrology Physician Assistants (at www.aanpa.org).

One key impetus for midlevels is Medicare's two-year-old payment system for treating dialysis patients. The new G-code system replaces a flat monthly fee with graduated payments based on the number of visits. Nephrologists who see patients once a month are paid less than they were before, but they are paid more if their practice sees these patients four times a month. Under the new rules, a mid-level provider can see these patient the other three times.

In this way, mid-level practitioners free up nephrologists to see more patients. "All physicians, and particularly nephrologists, are facing increased patient volumes and decreased time," Provenzano says. "They have to spend less time with each patient."

Among the assets of midlevel practitioners are the following, Provenzano says. They:

- Can perform a wide variety of tasks, such as working in dialysis facilities, seeing patients in office practices, making hospital rounds and even taking call.
- Are trained to cooperate collaboratively in a team. Collaboration is important because the midlevel practitioner is often used to take over office visits after the nephrologist makes the initial assessment.

- Are more likely to follow practice guidelines, and following guidelines is essential in meeting clinical outcomes, which increasingly are being tied to payments.
- Are hard workers. A 2004 survey by the American Academy of Physician Assistants found that, on average, PAs work 45.5 hours and have 80 to 85 outpatient encounters a week and almost one quarter of them shared call with physicians.

PAs or NPs

Nurse practitioners and physician assistants tend to get lumped together, but there are some key differences between them. NPs can work independently in some states and they earn somewhat more than PAs can earn. And since NPs started as RNs and often have worked for many years as front-line nurses, they tend to put a strong emphasis on patient care.

On the other hand, PAs are trained to support physicians and always must work under a physician's supervision. PAs can round and write notes on their own, but they cannot write orders, Provenzano says. "If they wanted to give an order they have to call a physician and the physician would have to personally convey the order to the unit nurse," he explains.

At last count there were 106,000

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NPs and 59,000 PAs working in the United States, but the greater ranks of NPs does not mean they are easier to hire. While NPs are available across the country and practice independently in some rural areas, PAs are concentrated on the East Coast and work exclusively with physicians.

Nephrology accounts for a tiny fraction of what midlevel practitioners do. In a 2004 survey by the American Academy of Physician Assistants, 0.5% of PAs said they worked in nephrology. The American Academy of Nurse Practitioners reports that most NPs tend to be in family practice and other primary care fields, and 20% are in adult care, which covers a wide variety of specialties including nephrology.

Focusing on Training

Since there are no formal training programs for midlevel practitioners in nephrology, they have to be trained on the job. "In training, midlevel practitioners will apprentice with a physician for a period of time, maybe three months," Provenzano says. "They go to the dialysis unit, the hospital, the clinic."

The RPA is considering a formal training program for midlevel practitioners, using nephrologists to mentor them, Provenzano comments.

Once trained, midlevel professionals tend to stay put for many years. The 2004 AAPA survey found that on average, nephrology PAs had been with their current practice for more than six years, and some had been with the same group for 10 years.

But some midlevel professionals move on, especially when they come from another specialty. Jeff Weintraub, CEO of Southwest Kidney Institute, Tempe, Ariz., says he once hired an

NP with a primary care background, but she was unhappy with nephrology and quit to return to primary care. Still, Weintraub wants to hire midlevel professionals. "We now have two NPs but I would be thrilled to have five," he says. "But NPs experienced in dialysis are hard to find right now."

One solution is to encourage in-house staff to get midlevel certification, Weintraub comments. Dialysis technicians and nurses would make ideal nephrology NPs because they are already familiar with the work and enjoy it, he adds. He is currently paying for one tech in his practice to train to be a nurse. He would consider paying for a nurse's NP training, he says.

Integrating Care

Nephrology practices report that when midlevel professionals are hired, they are typically assigned one specific job and then are given more tasks when physicians and staff become more comfortable with them. David Rathvon, a PA at Capital Nephrology in Raleigh, N.C., says he was the first midlevel professional the practice hired eight years ago. His first assignment was providing primary care for dialysis patients. Today, the six-nephrologist practice has four full-time midlevel practitioners and one part-timer. In addition to working with dialysis patients, he and other midlevel professionals treat CKD patients and handle follow-up visits in the office, but they don't insert lines or perform biopsies, he says.

"People used to be hesitant about how PAs and NPs would fit in, but there has been a huge shift in opinion in the past 10 years," says James Weiss, MD, a nephrologist at Renal Endocrine Associates in Monroeville, Pa.

The practice recently hired three

new midlevel practitioners when it opened a vascular access center. "We were looking for people who know that kind of work or want to learn it," Weiss says.

The group now has four NPs and two PAs, who coordinate the patient's transition from the hospital back to the dialysis unit, and the practice plans to use them for office follow-ups. "They explain or amplify what the physician is saying to the patient," Weiss adds.

A Team Approach

Since patients may feel slighted when they are handed off by the nephrologist to the midlevel professional, Weiss advises doctors to introduce the PA or NP to the patient as part of a team that will provide care. "For dialysis patients, I explain that I'll be seeing them once a month and the mid-level practitioner will see them three times a month," Weiss says. "Almost always, the patients accept the arrangement. The patients see that now two people (the PA and the physician) know them well."

Weiss challenges the widespread notion that midlevel practitioners, who are paid about one-third of what nephrologists make, can save money for the practice. "If you hire a PA or NP in order to make more money, you will be disappointed," Weiss says. "There are also some redundancies and inefficiencies when two people see a patient, no matter how well they work together," he explains. "But it's safe to say that NPs and PAs can do some clinical activities that would otherwise require a physician's time."

—Reported and written by Leigh Page, in Chicago.

"We now have two NPs but I would be thrilled to have five," says Jeff Weintraub of Southwest Kidney Institute. "But NPs experienced in dialysis are hard to find right now."

Practice Aims to Increase Efficiency

The nephrologists and endocrinologists in Renal Endocrine Associates in Pittsburgh, Pa., are developing several strategies aimed at increasing practice efficiency. Given that the greater Pittsburgh area has one of the highest concentrations of Medicare patients in the country, the group faces unusual challenges.

Reimbursement has declined as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and so the group has been forced to find ways to become more efficient while continuing to meet its commitment to provide high quality patient care, says James Weiss, MD, one of 16 physicians (11 nephrologists and five endocrinologists) in the practice. The group has 50 employees including six physician extenders (nurse practitioners and physician assistants). Some 80% of its patients are on Medicare.

“For a group like ours, Medicare is by far the dominant force in this market,” says Weiss.

Market Challenges

Lisa Simonton, the group’s executive director, adds that private payers also present hurdles. “The private payers bring their own challenges,” she says. “In recent history, as Medicare has changed its rules and regulations related to the care of dialysis patients, the private payers have had to catch up or decide if they were going to catch up with Medicare rates, and because they are so dominant in our marketplace you do what they want or you don’t participate with those plans.”

Another challenge that makes Pennsylvania unusual is that

Medicaid does not pay for dialysis care. Medicaid pays the dialysis facility for the services provided but does not pay for the physician’s care related to dialysis. Similarly, for patients who are eligible for Medicare and Medicaid, the practice gets paid only for the Medicare portion of the care, Simonton says.

“You get what you get from Medicare and you don’t get anything else,” she says. “But in other states, practices will get perhaps 20% from Medicaid for dual-eligible patients. These days, that 20% after Medicare can make a significant difference. If you have a reasonable Medicaid population, at least you know you’ll get that 20%.” But if a patient has Medicaid as a primary insurer or is in a Medicaid HMO plan, the practice gets no reimbursement for providing dialysis care to those patients.

“Our biggest challenge is trying to maintain high quality care and an acceptable lifestyle for the physicians and staff in this setting,” Weiss comments. “We often have discussions about how we can offer high quality patient care, while running a successful business, and also having some kind of a quality lifestyle. We want to have a good mix of all three. We need to be cognizant of the different needs of physicians who are at different stages in their career and family life.

“Of course the staff and physicians also want to feel some satisfaction so that at the end of the day they feel good about what they have done that day and not feel as if they’re further behind than when they started the day,” Weiss says. “There’s a percentage of your time that goes to patient care and there’s a large percentage of

your time that goes to all of the supportive efforts, especially the paperwork, malpractice issues, along with hospital requirements,” he adds. “If you work a 12-hour day, you’d like to feel that at the end of 12 hours, a significant number of the patients you’ve seen that day had received high quality care as opposed to feeling that you spent an excessive percentage of your time dealing with administrative issues.”

Evaluating Options

As a result of the administrative burden and decreased reimbursement, the practice has made changes. To offset the loss of income that it had before the MMA went into effect, the group has been developing a CKD clinic to treat patients, opened a vascular access center, is expanding a clinical research facility, and is seeking to generate revenue from real estate ownership.

“We started our vascular access center in January,” says Weiss. “That is going very well and it provides high quality care. It provides much better service for our patients than we could provide before and brings in some extra money that helps to offset the financial difficulties of delivering care in the office.

“We’re also seeking to improve the financial standing of the practice by getting involved in investing in properties and in joint real estate ventures,” he adds. “We’re early in the process. We’re the landlords for one of the dialysis units where we work.

“The other thing we’re doing is expanding our clinical research,” he says. “We are early in that process as well, but these are steps that we believe will help us to diversify the group’s

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“We started our vascular access center in January. That is going very well and it provides high quality care for our patients.”

CASE STUDY

(Continued from page 15)

activities and to support us in delivering quality patient care.

Clinic Visits

The CKD clinic offers an example of how the practice seeks to offer care more efficiently. "We have heard about other groups that have opened CKD clinics and we are looking to adopt some of those ideas," Weiss explains. "In the clinic, the physician would see the patient on the first visit. Then, if the patient fits into one of several categories, he or she would be seen during the year by a physician assistant or by a nurse practitioner on subsequent visits. Maybe on every third visit, the patient would see the physician. The clinic staff would have protocols and algorithms to follow that would mean we would monitor key care factors such as hemoglobin, blood pressure, and phosphorous. That would be the overall model.

"The protocols and algorithms

RPA Offers Practice Strategies

James Weiss, MD, and Lisa Simonton, MBA, of Renal Endocrine Associates in Pittsburgh, Pa., have been involved with the Renal Physicians Association for many years. Each one says the RPA has proven to be a valued resource for them in managing the practice outside Pittsburgh. The RPA is a national medical specialty association in Rockville, Md.

"We are indebted to what the RPA has provided us in terms of education about how to run an effective practice," says Weiss, the association's past president. "A large percentage of our ideas and resources have come through the RPA. We would be much further behind if we were not involved with the RPA."

would give providers the reassurance that we are all doing what we want to have done," explains Weiss. "And they help reassure patients too because the patients want to know that the care we're giving has been structured and reviewed by physicians. "Some patients express concern about being seen by a physician assistant instead of a doctor. These concerns almost always dissipate

with the initial contact with the physician assistant and once the patient sees that the doctor and assistant will be working as a coordinated team."

The CKD clinic would allow the practice to be reimbursed at the physician rate if there is a physician in the office who has a relationship with the patient even though the physician did not see the patient, Simonton says. ♦

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