How to Improve Patient Care and Your Bottom Line

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Reinventing Podiatry, Again!

More and more podiatrists are rethinking their approach to the services they provide their foot-suffering patients. Periodic reevaluations are not new to the podiatry profession, as it has been evolving and redefining itself for the past 50 years. During the late 1960's and early 1970's, practicing podiatrists flocked to seminars and workshops all over the country to learn about the newly organized and emerging science of "podiatric biomechanics". These practitioners sought more effective, predictable means to treat their patients. They had graduated from podiatry schools before Dr's Root, Weed and Orien had presented their works and needed to obtain this information elsewhere. In my first few months working in the podiatric arena, I interacted with four hundred podiatrists as they converged on an airport hotel in New York. They were there to learn how to evaluate foot function, perform range of motion studies and take a neutral position plaster cast.

Comprehensive biomechanical examinations and the use of custom-made prescription foot orthotics flowed into the treatment rooms of practitioners across the country, and the use of cookies and arch supports quickly became a relic of an earlier era. Throughout the 1980's, the developing surgical skills of the profession began to take center stage of our professional consciousness. The editorial content of professional publications was monopolized by stories of minimal incision procedures and reconstructive surgery and the practice management impact of both. Again, practitioners who had received their podiatric education prior to the formalized training in this genre, sought out post-graduate training opportunities. The Podiatry Institute Programs, Hershey Surgical Seminars and ACFAS educational events were standing room only.

During the past three years, it would appear that podiatry is once again retooling its collective thinking and attempting to position itself as a more comprehensive provider of footcare solutions. This time, the buzz is focused on diabetic care, footwear, durable medical equipment, ankle foot orthotics and in-office dispensing of efficacious foot remedies. Unlike previous expansions of patient care, this new set of professional skills has not been the result of any technical or educational advances. All of these treatment modalities have been readily available to podiatrists for decades. What have changed are the perceptions of the practitioners rather than their tools of the trade.

Of course there have been a number of podiatrists who incorporated this more comprehensive approach to patient care a long time ago. These "early adapters" have unknowingly created the blueprint that hoards of their colleagues have been feverishly trying to emulate for the past several years. The effect of expanded, more comprehensive care in these practices has been profound, both in terms of patient outcomes and financial performance.

A Tale of Two Practices

Recently, I had the opportunity to get an interesting peek into two Langer client practices. The two podiatrists had become professional friends of mine and were willing to let me study the financial performance of their practices. Both the similarities and differences were astonishing. Let's call these podiatrists Doctor Smith and Doctor Jones. First the similarities: they practiced 12 miles apart from each other, both podiatrists were in their mid 40's, both had attended a one year residency, both had privileges at the same hospital, both were on the majority of insurance plans in their area, both were solo practitioners and both averaged between 125 – 150 patient visits per week.

Doctor Smith's revenue (billings) averaged approximately $250,000 per year more than Doctor Jones. I found this surprising and assumed it was the result of a sizeable difference in the surgical loads of each podiatrist. However, upon closer scrutiny, I found that while there was a

small difference in surgeries, it only accounted for about $25,000 of the billing difference. I was intrigued. How could two otherwise identical practices be operating at such dramatically different financial performance levels?

It took a little digging to find the answer to that question. Even though these colleagues looked identical on paper, a patient would have an entirely different experience in Doctor Smith's office than they would in Doctor Jones' office. And although I found many small differences in approach to care, I have narrowed my list down to four primary reasons for the financial differences between the practices.

Utilization of custom-made prescription foot orthotics

In-office Dispensing

Medicare Diabetic Footwear Program

AFO and other Durable Medical Equipment modalities

It has always been somewhat of a mystery as to why there is such a huge disparity between podiatrists regarding the utilization of functional foot orthotics. Doctor Smith consistently ordered 30 pairs of lab-fabricated appliances each month (approximately 5.5% of patients treated). By contrast, Dr. Jones averaged about 5 prescriptions per month (approximately 1% of patients treated). The annual revenue contribution for custom for orthotics was $135,000 for Dr. Smith and $22,500 for Dr. Jones. So, in this one category alone there was an $112,500 difference.

In order to better understand why these variances in utilization exist, I conducted an informal survey among other orthotic customers. Patterns emerged. The podiatrists who only dispensed orthotics to 1%-2% of patients relayed three common concerns:

1. Financial concerns
2. Time consuming hassles with devices
3. Lack of confidence in biomechanical skills

Dr. Jones stated to me that he didn't think that many of his patients were able to or willing to pay $375 for orthotics. As a result of *his perceptions*, he either neglected to present that option to his patients or gave them a very equivocal presentation to which they declined orthotic therapy (thereby proving his theory). Dr. Smith on the other hand, who practiced in the same town presented the orthotic option to all those who would benefit from them, without regard to their financial status or insurance coverage. To his surprise, Dr. Smith related that the patients who could least afford it, often said yes because of the confidence that he was able to instill in them of the benefits of the therapy. Remember, these two podiatrists practiced in the same town.

Adjustments and repairs of orthotics were another place where our two DPM's differed in their viewpoints. Dr. Smith felt that he had relatively few problems with devices considering the number of patients he ordered them for. He attributed this to ongoing staff training, managing patient expectations and selecting a high quality laboratory that was willing and able to understand his specific needs. Dr. Jones relayed a disproportionate percentage of problems and found himself switching labs frequently.

The respective biomechanical skill levels were what you would expect. Dr. Smith had such a vast amount of experience in this area, that he was much more comfortable with all aspects of orthotic therapy. Dr. Jones relayed his overall level of discomfort with orthotics and particularly his understanding of functional foot biomechanics.

The second practice component causing substantial revenue differences was in-office dispensing. Dr. Jones simply didn't do any, and therefore dispensing made no contribution to practice income. Dr. Smith estimated his annual revenues at $25,000 for foot products dispensed in his office. Dr. Smith shared with me, that he initially started dispensing a few items because his patients had implored him to do so. They had always asked him for

recommendations but then complained about having to run around town to source the recommended items. He quickly realized that there were three important benefits to providing this service in his office. The first and most important is *patient compliance*. He believed that he was able to more fully manage his patient's care by providing the right products with the right set of instructions for their use. Next was increased patient convenience. This is an important part of patient retention. And finally, practice revenue. Although a little sheepish originally, this has become an integral part of his practice.

These two colleagues also look upon the Medicare Diabetic Footwear Program differently. Dr. Jones doesn't provide his patients with these products. He refers some of his diabetic patients to a local shoe retailer. When I queried him about his reasoning, he stated that, "he didn't go to podiatry school to become a shoe salesman". Dr. Smith looked at these patients completely differently. He felt that these people were his most "at risk" patients and felt that it was his obligation to provide a protective environment for their feet. He further believed that none of the local shoe retailers had the same working knowledge of foot function that he possessed so he invested the necessary time to better understand footwear. Since 15% of his patient population had diabetes, he also realized that there was a significant financial opportunity. Currently, this program represents a $35,000 annual contribution to practice revenues.

Ankle Foot Orthoses and other DME items represent the fourth practice component that was handled quite differently. This is an area that Dr. Smith only recently got involved in, but has committed himself to learning everything he can about the utilization of these products. He currently prescribes only two AFO's each month as well as a few night splints and prefabricated ankle supports. Even at these low quantities, Dr. Smith estimates that this category will generate $25,000 in practice revenue. Dr. Smith relayed to me that he anticipates that he will double the revenue is this area when he gains more experience. Dr. Jones refers all of his patients who need these products and services to one of several local sources.

How Comprehensive is Your Footcare?

The lesson that these two podiatrists teach us is simple yet compelling. Your definition of "comprehensive footcare" in your practice will have a great impact of patient care and practice income. Within the range of your professional training and statutory scope of practice, there is a tremendous amount of variation in the care given to your patients. These two podiatrists treat the same patients (from a socio-economic standpoint). However, a patient of Dr. Smith will have a completely different treatment experience than that of Dr. Jones. And the thing that drives these differences are the doctors own perceptions…and in some cases misperceptions.

I have helped hundreds of podiatrists overcome fears about getting involved in these practice areas. I have found that many of them have misread their patients. They are fearful that their professionalism will be questioned as a result of dispensing programs. Experience shows that the opposite is true. Patients always want their doctors' recommendations and do not want to be inconvenienced when it comes to sourcing the products. This is especially true in the podiatric community where patients tend to be older, and they have trouble getting around because of foot problems.

The hardest part about starting down this road…is the start itself. We all like to operate within our comfort zones. We like to say the same things to our new patients tomorrow that we did yesterday. We like to offer them the same treatment options that we always did. But like it or not, approve of it or not, the definition of podiatric care is shifting toward a much more comprehensive approach. And like those podiatrists in the late 1970's who traveled across the country to hear Sheldon Langer, Justin Wernick, Lowell Weil and others speak about the utilization and incorporation of orthotic therapy, today's DPM's are opening themselves up to new ideas regarding care.

If you can relate more to Dr. Jones than Dr. Smith, it may be an appropriate time to reevaluate your own practice. Start with foot orthotics. It has been well documented that over 85% of patients treated by podiatrists present themselves with some kind of biomechanical deficit or abnormality. So it would stand to reason that the utilization of prescription foot orthotics should represent a substantial treatment option. But a look at the numbers tells a different story. Dr. Jones dispensed foot orthotics to less than *one percent* of his patients. *Consistency is the key to changing this*. You should establish a clinical protocol that applies to all patients. You should not let the economics of the situation change your treatment presentations. If you believe that orthotic therapy is the best solution, then this needs to be communicated in a direct unwavering manner, every time.

Use Your Resources

Also, you should invest in in-office training. This can be for yourself and your staff. Patient selection, casting and prescription writing skills will go a long way to reduce the numbers of adjustments and other problems with orthotics. I would suggest that you speak to colleagues whom you know are very successful in this area to find out what they consider an acceptable rate of repairs and adjustments is. Then track your own performance against this target. If you want to grow this part of your business, the selection of the right laboratory is critical. The right one can provide or assist you with much of the necessary training. Also, having an on-site DPM consultant is critical. The profit margins that are inherent in dispensing these items are substantial. Pay the slightly higher costs and take advantage of the many services offered premier laboratories. The labs can also work with you to enhance your own technical skills.

In-office dispensing has a place in most podiatric offices. I have observed many reluctant podiatrists make the transition from “I would never do that in my office”, to becoming some of the strongest advocates for providing patients with the appropriate foot remedies. The concern over professionalism is based upon a general misperception of patient expectations. Patients want to be relieved of foot pain. Plain and simple. They also want convenience. In-office dispensing provides many podiatric patients with both. If you are going to begin this in your office, pay attention to the two golden rules in dispensing:

1. Make certain the products are clinically relevant to what you do as a podiatrist
2. Make certain that the products are efficacious and deliver the intended benefit to your patient

Medicare’s Therapeutic Footwear Program is truly one of the best win-win opportunities for podiatrists and their at risk patients. Over 50% of diabetic foot amputations can be prevented from the timely incorporation of preventive care. Footwear is an important part of this care along with pressure reducing insoles. Even after 10 years of offering this benefit, over 90% of eligible patients do not receive it. How many of these at risk patients are yours? Once again I would strongly urge podiatrists who want to begin dispensing footwear to diabetic patients to use one of the full service footwear distributors. Companies like Langer assist podiatrists in the entire process of incorporating footwear into their practice. Valuable services include assistance in obtaining your Medicare DME number (necessary to bill Medicare), staff training, billing assistance, comprehensive array of branded shoes (this is very important), administrative and marketing support. Anyone can ship you a pair of shoes, but these other valuable services help create office efficiency and minimize the potential problems associated with footwear.

Custom-made AFO’s and other Durable Medical Equipment can represent an entire new area of care for your practice and practice income. The most important step in bringing this into your practice is education. It is imperative that you have a clear and detailed knowledge of how and when to use these products, how to cast correctly for them, how to bill correctly for them and how to maintain proper documentation in your patient’s charts. While this sounds like a lot, once again I would suggest that much of the educational process can obtained from your supplier.

There are also a growing number of Association sponsored weekend workshops being organized. The American Academy of Podiatric Practice Management organized its first ever three-day DME course this August in Philadelphia. Others are sure to follow.

So, if you find yourself in a practice rut, consider expanding the service base of your business. Start by evaluating where you are today. I recommend that you keep a running list for one month of all of the patients that you send out of your practice to buy goods or services from others. Go through that list and decide which of those products or services you think you could effectively bring into the practice. Approach it slowly, building one product or service expansion on top of the other. Each successful will lead to greater confidence and patient satisfaction. It has been extremely rewarding for me to witness podiatrists gain an entire new or renewed level of enthusiasm for patient care after these kinds of changes have been fully adopted by the practice and all the members of the patient care team. If you want to discuss the process with those who have gone through it, the best resource is the American Academy of Podiatric Practice Management (AAPPM). This APMA affiliated organization is comprised of some of podiatry's most successful practitioners who openly share practice management strategies with any colleague. The AAPPM is a unique, mostly undiscovered gem in podiatry. They have a mentoring program and a resource center that is second to none.

"The difference between a rut and a grave is its depth"