PEDIATRIC MANAGEMENT

THE 10 HOTTEST ISSUES IN PEDIATRIC PRACTICE

As third parties slowly reshape the practice of medicine and society reshapes itself, pediatricians face many new challenges. Understanding what these challenges are is the first step toward meeting them with aplomb.

Today's pediatrician can't practice in peace. Health care has become a political and social issue, and the public debate and search for solutions touches every practice, often at its core. For example, the very basis of physician payment is being questioned and supposedly reorganized in a more equitable way, at least for Medicare. But, third-party payers' increasingly zealous cost-cutting tactics threaten the prospects of fairer reimbursement for the cognitive services that constitute most of a pediatrician's practice.

On the social side, the increasing number of women pediatricians, many of whom have to manage both work and a primary responsibility for child care, has created a need for more flexible practices. Many men pediatricians are also attempting to cut back the hours they spend working in an effort to lead more balanced lives.

That goal is made more difficult to reach by another social fact: Most families consist of two working parents. These parents pressure their pediatricians to stay open later during the week and to have office hours on Saturdays and Sundays. In order to stay competitive, many pediatric practices have done just that.

We asked pediatricians around the country to come up with a top-10 list of issues that face them today. In this article, we present a discussion of the issues. In future articles, we'll look at solutions.

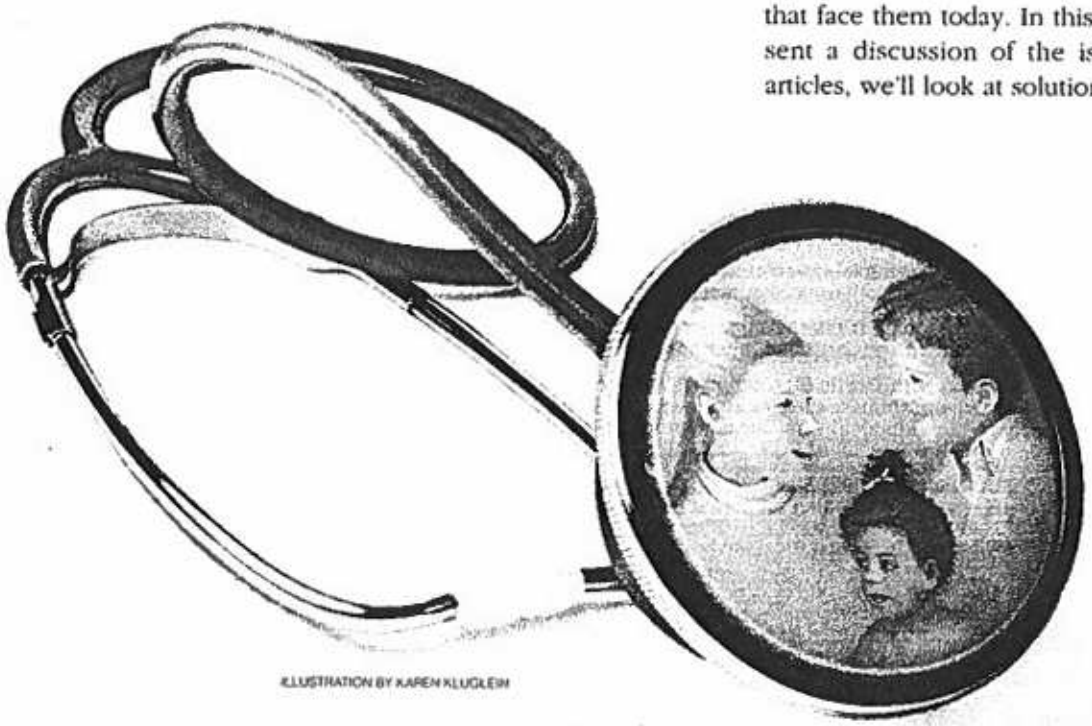

ILLUSTRATION BY KAREN KLUGLEIN

1. INADEQUATE COMPENSATION

Without a doubt, this is the hottest topic in pediatric practice today. "A key issue," says Michael Dickens, M.D., a pediatrician in Charlottesville, Va., "is the extent to which our livelihoods are being governed by business contracts with third-party payers, rather than exclusively by the doctor/patient relationship. We're under a lot of pressure to operate as entrepreneurs, and that runs counter to our human, ethical and professional impulses."

Fair reimbursement is more difficult for pediatricians to find than it is for other specialists because most of the care you provide is cognitive rather than procedural.

"When you want to talk about developmental assessments, toilet training, school problems, or which kind of nursery school is best," says Edward J. Saltzman, a pediatrician in Hollywood, Fla., "you get paid a pittance. On the other hand, if you put in three sutures, you get paid well. But pediatricians want and need to spend time on preventive care and guidance."

When the Government decided to use the resource-based relative value scales developed by Harvard economist William C. Hsiao, Ph.D., as the basis for its payments to physicians, things looked good for pediatricians. Finally, someone recognized that the cognitive services rendered by physicians are undervalued, and the Government wanted to do something about it. It decided to redesign Medicare fee schedules around RBRVS. Many speculated that it would be only a matter of time before private insurers followed suit. Then, the Government began to treat RBRVS as a cost-cutting mechanism, and the system's promise—along with pediatricians' hopes—began to fade. Private insurers began to hedge, saying they would wait to assess the fallout from the controversy surrounding the end result of the Government's efforts.

Even managed-care plans don't reimburse pediatricians adequately for cognitive services, although they're based on the premise that paying for preventive care makes more sense than waiting for illness to set in before covering medical expenses.

"Instead of reflecting the increased amount of cognitive time being spent on well-child care," says John Cohen, M.D., "reimbursements for well-child care are at best creeping up very slowly. In some cases, they're actually going down. Payments for sick visits, in contrast, have risen somewhat."

Cohen gives this example from his Wellesley, Mass., group practice: The pediatricians charge $9 more for a well-child visit than they do for an intermediate sick visit, which lasts about as long. Yet a typical managed-care plan reimburses them $2 less for the well-child visit than for the intermediate sick visit. And that reimbursement includes inoculations and screening blood tests, even though the practice charges separately for those services.

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"Clearly," says Cohen, "managed-care plans don't recognize, as we pediatricians do, that well-child care is as important or more important than sick care. We have found this to be an absolute."

A future threat to fair reimbursement for pediatricians is capitation. There are already a fair number of capitation plans in California and Minnesota, where HMOs are most common. "Pediatricians need to know how to analyze what capitation would mean to their particular practices," says Budd Shenkin, M.D., who practices in Oakland, Calif. That involves balancing expected income and expenses on a capita-

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This article was written by Maria Kassberg, managing editor of PEDIATRIC MANAGEMENT *and was reported by Jo David, contributing editor.*

tion plan against a fee-for-service situation and deciding whether capitation will work for you. "Ultimately," says Shenkin, "to get more, pediatricians will need to have the expertise and determination to demand more."

Sadly, low reimbursement has an impact on pediatricians' ability to treat indigent children. "We want to take care of our fair share of indigent patients," says Suzanne Corrigan, M.D., of St. Paul Pediatric Associates in Dallas, Tex., "but we're limited by the current reimbursement realities." At the beginning of each year, Corrigan's group decides how many charity cases, including Medicaid patients, it can accept. The pediatricians see Medicaid patients free of charge. "We don't file. The pay is too low and it just isn't worth it."

2. *SKYROCKETING EXPENSES*

"In pediatrics," says Budd Shenkin, "the overhead can simply eat you up." Generally, the top four expenses in a pediatric practice are salaries, office space, clinical supplies and uncollected accounts. "Overhead is a huge headache," agrees Suzanne Corrigan. "Our fixed costs were running about 40 percent in 1982. Now, just 10 years later, overhead accounts for more than 65 percent of gross income." Corrigan blames the increase on the spiraling costs of office space and vaccines. "Of course," she says, "personnel is a major cost. We feel that's a place you have to put your money."

Salaries eat up as much as 20 percent of annual billings. "One reason the personnel costs tend to run so high," says William D. King, a consultant with Doctor's Management in Gainesville, Fla., "is that pediatric practices need to attract—and keep—highly skilled nurses." King points out that in Florida, an RN working in a pediatric office can expect to earn about $24,000 in base pay and benefits. She could, however, make about $30,000 at the local hospital, before overtime for night and weekend work at about one-and-a-half times her regular pay. "That's pretty tough competition," says King.

Shenkin agrees that there's a lot of competition for good employees: "We lose our best people to the specialists, who can pay more."

Some speculate that the proliferation of managed-care plans will further increase personnel expenses. "You can't just send a patient for further testing anymore," says Shenkin. "You have to get authorization. The need to cut through all that red tape could eventually force us to create a whole new $25,000-a-year position."

After salaries, office space takes the biggest bite—usually about 8 percent—out of pediatric practice revenue.

You may have found that you aren't in a good bargaining position when it comes to signing a lease. As a pediatrician, your needs are specific, so you don't have a lot of flexibility about the type of space you rent. That's what John Cohen found when he and his four pediatrician colleagues outgrew their office space and had to move.

"The Boston area is in the middle of a tough recession," says Cohen, "but given our special requirements for fit-up, equipment and parking, we couldn't take advantage of the opportunities to get reasonably priced space as other small businesses could."

One specific requirement pediatricians have is that they need lots of space. Pediatrics consists of many short visits, and at least two people per visit (parent and child). That translates into more people in the waiting room than there are for other specialists, and more people in the examining room. So everything needs to be roomier, which, of course, costs more.

Clinical supplies cost the average pediatric practice about 7 percent of total annual charges. The cost of vaccines, which account for a large portion of clinical supplies, has skyrocketed in recent years: In 1983, says Corrigan, the series of vaccines from birth to age 2 years cost $22. Today, the cost to her office for the vaccines alone is $180.

Many pediatricians have to add student-loan payments to their practice expenses. "That sheet of figures the accountant hands you every month doesn't include all those student loans you're carrying," says Robert

Rohloff, M.D., a pediatrician in Milwaukee, Wis., "or the loan you had to take out to set up a practice. But those are overhead too. It all adds up to why most of us pediatricians have had to increase our patient volume."

3. PRESSURE TO EXPAND OFFICE HOURS

Competition for child patients is getting stiffer for a number of reasons: There are more pediatricians, more FPs interested in caring for children, more urgent-care clinics that provide continuous care, and fewer children. In this competitive market, and at a time when most families consist of two working parents, pediatricians are being pressured to stay open later during the week and to have weekend office hours.

"Whether to expand your hours into the evenings, weekends and even holidays is a tough question," says Michael Dickens. "Lots of pediatricians are torn by it because as you make yourself more available, you increase the stress in your life."

Once you've made the decision to expand your office hours, you've still got to find personnel to work the off-hours for a salary that you can afford. Because most managed-care plans don't pay extra for off-hours visits, it's difficult for pediatricians to match the night and weekend incentives that hospitals pay. Extended hours without those benefits means a lot of turnover. "It burns out the nurses and adds up to a lot of time spent training new staff," says Dickens.

And he should know. His office is open from 8 A.M. to 10 P.M., 365 days a year. Of the seven pediatricians who share call rotation, one is on call every night. "Clearly," he says, "you do get exhausted. It's particularly tough after you hit 40. And the more tired and stressed you are, the less empathetic you can be."

One problem with offering extended hours is that parents come to expect that you'll be almost constantly available to them. "People are less reluctant to call you at odd hours," says Dickens, "particularly in a prepaid environment. Parents feel it's their privilege."

Another problem with extended hours is that more and more parents start bringing their children to the pediatrician in the evenings because it's a lot easier for them. "We're afraid," says Jed Jacobson, M.D., whose Hollywood, Fla., group practice is open until 9 P.M. every night for emergencies, "that parents will bring in the kids during the off-hours for problems that can be easily handled during the day when we're fully staffed. That might also mean fewer patients during the day and the need for more physicians to work at night, which no one wants to do."

4. HOW TO IMPROVE LIFESTYLE

The combination of low reimbursement and high overhead expenses has forced many pediatricians to see more patients in order to maintain a reasonable income. That has implications for physician lifestyle both in and out of the office.

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In the office, pediatricians are finding that they can't always devote the time to each patient that they would like. "Seven years ago," says Robert Rohloff, "the rule of thumb was that seeing 25 patients a day would make you comfortable. Now, somewhere in the 30's is the lower end. I see an average of 30 patients a day. In the winter, that can easily jump to 40 or 50. When I'm up over 30 to 40 patients in a day, I'm really not able to provide all the cognitive services I'd like to include in a visit."

Outside the office, having enough time for family, for CME and for personal interests is becoming a big issue. "It has a lot to do with the fact that 38 percent of practicing pediatricians and 50 percent of pediatric

PHOTOGRAPH BY GERRY GROFF

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residents are women," says Kay Pinckard, M.D., associate director of the pediatric clinic at Phoenix Children's Hospital. "Clearly, a larger share of the child-rearing responsibility still falls on the women, and this is reflected in their need for additional time with their families. But more men are also looking to carve out a lifestyle that isn't so workaholic. They too want less stress and more time for their personal lives."

In larger practices, it's not too hard to work out a comfortable schedule, says Jed Jacobson, who's part of a 13-pediatrician group. He works four weekdays and a half day Saturday, plus one night every two weeks and occasional extra weekend hours.

5. *WOMEN'S ISSUES*

As Kay Pinckard pointed out, women are still largely responsible for childrearing. As a result, many women pediatricians want to work part time. This can be extremely difficult and stressful in small groups. "The smaller the group, the harder it is to accommodate women who have young children," says John Cohen. "In a group our size, with five pediatricians (of whom two are women), we can be quite flexible. It's relatively easy to move around nights on call or vacation time quickly and easily among ourselves."

Suzanne Corrigan, a mother who practices with two other women pediatricians who are also mothers, says that working extended hours puts a lot of pressure on her family. "One thing that's helped the pediatrician/moms who have preschoolers," she says, "is having the person who will be staying late come in at noon. At least there's some time for the mother to be with her child on the late day."

Maternity leave can be a trickier issue. Even when the length of leave is set out in the contract, when it comes down to the woman pediatrician being gone for a number of weeks, the men sometimes resent her. "When it actually comes time for the woman to take her maternity leave," says Edward Saltzman, "you'll often hear, 'There goes my vacation in Europe' from the men."

The issue is particularly difficult in small or solo practices because the overhead doesn't go away when the pediatrician is on leave. "The effect in one of the practices I work with," says consultant Bill King, "is that the woman pediatrician couldn't take a paycheck for the better part of a year, simply because she missed a few months of work after she had her baby. She was in solo practice and employed a nurse practitioner. The overhead was $20,000 a month, and during her leave there was no income to offset it."

6. *PRACTICE MANAGEMENT*

"Effectively, pediatricians are running small businesses, for which they're completely untrained," says Saltzman. "Today, you need someone with advanced skills in computers, marketing, personnel management and CPT coding."

Corrigan agrees: "It's no longer enough to be a good pediatrician. You have to be a

good business person too." Marketing, she points out, is something pediatricians aren't trained in. Yet they have to find ways to reach out to their communities because word-of-mouth is no longer enough to get people interested in a practice. Personnel management is another area in which pediatricians aren't trained. "We know how to pick out nurses," says Corrigan, "because we know what's needed. But we don't know what to look for in a bookkeeper."

Many pediatricians feel that hiring a practice-management consultant is the best solution to management woes.

Others think hiring a competent business manager to handle the hiring and firing and the day-to-day business details will do the trick. "I hired an office manager before I could even afford to do it," says John Cohen.

Do practices need professional managers? While managing a good-sized group is likely to be too much for one physician, Janet McLaughlin, a consultant with Practice Management Concepts in Burlingame, Calif., says she's seen many groups for which dividing the management responsibilities among all the partners—without a professional manager—was the best solution.

For help deciding whether a management consultant would be right for your practice, see "How a Consultant Can Help Your Practice," on page 31 of this issue.

7. FINDING TIME FOR HOSPITAL CARE

Finding the most efficient way to care for children in the hospital is an important issue in a specialty in which about 95 percent of the physician's income is generated in the office. It's difficult to leave a waiting room full of patients to attend a hospitalized child or a high-risk birth. "Although the parents left sitting in the waiting room understand and are compassionate," says Saltzman, "they're still unhappy."

Caring for children in the hospital can be very time consuming. "It takes at least twice as much time to see patients in the hospital setting because there's all that time spent walking the halls and reviewing the charts," says Kay Pinckard. There's also the travel time to and from the hospital. If you're seeing patients in two or three hospitals, or if you have to travel to a secondary- or tertiary-care facility, you run into the question of how to keep your office covered while you're away.

8. MALPRACTICE

Although malpractice isn't as much of an issue in pediatrics as it is in specialties like OBG, it's on the minds of most pediatricians. "Each step is fraught with fear of a suit," says Jed Jacobson. "You try not to think of it, but if a child doesn't get better quickly, or if there's a major illness or an unfortunate outcome, you assume you're going to get sued."

"To a large extent," says Donald Barich, M.D., a pediatrician in Parma, Ohio, "we've learned to live with the threat of malpractice, but it's with us all the time. We haven't lost a case yet, but we've almost always had one sitting out there."

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9. IMPENDING REGULATION OF OFFICE LABS

About 70 percent of pediatric practices have in-office labs (accounting for an average of 8.5 percent of practice income), so the specialty is waiting with bated breath for the final Clinical Laboratory Improvement Act regulations.

Under the proposed CLIA regulations, 40 percent of the tests performed by pediatri-

cians are classified as Level II. Any lab performing Level II tests will have to be headed by a pathologist and supervised by a medical technologist, and Level II tests will have to be performed by lab specialists. Needless to say, most pediatric practices will have to do their Level II testing outside the office.

However, thanks to intensive physician lobbying, it's hoped that the final regulations will place almost all of the tests that pediatricians perform in their offices in the waivered category or the Level I category.

The waivered group, which includes such simple tests as pinworm, dipstick urine, hematocrit and vaginal wet mount, is exempt from the regulations, except that a record must be kept of each test performed. Level I tests will likely include CBC, quick strep, urine cultures, hemoglobin, cholesterol and glucose. The only special requirements for a Level I lab are that it must be headed by an M.D., and that, as with the waivered group, a record must be kept of each test performed.

"A lot of effort will have to be directed at paperwork," says John Benjamin, M.D., a pediatrician in Charlottesville, Va., and an authority on the ramifications of CLIA for pediatricians. "Each lab will be required to produce its own procedure-and-safety manual specific to that lab. But the most onerous, time-consuming part will be keeping logs of every test and documenting what's happened in the lab."

"You're bankruptcy? That's even worse!"

While CLIA remains unfinalized, it's like a sword hanging overhead for many pediatricians. "We can't invest in new lab equipment because we don't know what will be allowed," says Jacobson.

Some pediatricians are planning ahead, just in case. "We've covered our bases by setting up a relationship with a hospital pathologist," says Robert Rohloff. "If CLIA were ever to shut down our lab completely, we wouldn't be that uncomfortable."

Others are more concerned: "If very strict regulations were to go into effect," says Cohen, "there's no doubt that it would have a negative impact on our ability to take care of our patients."

10. ADOLESCENT GYNECOLOGY

"Sexually-transmitted diseases, AIDS and contraception are being much more openly discussed in the pediatric setting," says Dickens, "and the physician needs to be prepared.

"Pediatricians traditionally have been undertrained in this area," he continues. "Now you need to go back and get training if you don't have it."

John Hill, M.D., a solo practitioner in Memphis, Tenn., agrees, and has himself taken CME courses in gynecology. He also raises the issue of who should care for a teen-ager after the birth of her child. He tells each pregnant teen-ager to come back after she's had her baby and that he'll treat them both. Sometimes managed-care plans resist sending her back to him for care, saying, "She's not a kid, why does she need a pediatrician?" "But," says Hill, "even if I don't get her back, basically I'm covering both kids every time I see the baby."

Pediatrics is clearly an evolving specialty. The next few years will likely bring a lot of changes—some forced on the specialty by government and third parties; others brought about by the specialty itself. By facing these changes head on, you can continue to have a fulfilling and prosperous pediatric practice. ■