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Special Report:
The Top 3 "Diseases" Killing Physician's Practices And a Proven Prescription For Curing Them

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INTERVIEW:
Richard Gant, CEO
Innovative Healthcare Systems, LLC

An Interview with Richard Gant, CEO of Innovative Healthcare Systems

The Top 3 "Diseases" Killing Physicians' Practices And a Proven Prescription for Curing Them

By Nils Shapiro

It's not easy being a physician in today's healthcare climate. Proof can be found in the number of physicians who report declining satisfaction in their jobs. Or, worse, are planning their exit strategies. The sources of unhappiness are plentiful. Some may seem minor, or appear more as an inconvenience than an actual problem. But those inconveniences, when piled on top of one another, become major time-wasting, money-draining, dissatisfaction-inducing situations that are leaving many physicians questioning their decisions to stay in medicine.

Over the past 35 years, the principals of Innovative Healthcare Systems, LLC has served as medical practitioners, marketing consultants and equipment distributors, working with thousands of doctors and their practices. Increasingly in the past several years, its CEO, Richard Gant, has heard much about the pain and frustration that physicians, their practices and families are enduring. He and his associates wanted to find out if these concerns were isolated situations, or if their feelings were systemic to most doctors. So, they decided to study these complaints and identify what the majority of doctors were experiencing, and to see what, if anything, could be done to fix them.

After several months of research under the supervision of Richard Gant, including countless interviews with physicians nationwide, the study found that there are three major areas of concern — which it refers to as diseases —each with its own set of symptoms and ailments that are threatening the financial health and sustainability of physician practices nationwide. The following interview with Mr. Gant provides the results of this research:

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Innovative HealthCare: What did your research find are the major financial diseases — or areas of concern — afflicting physician practices?

Richard Gant: There are three that we can identify. The first, to put it in medical terms, is "Acquired Revenue Deficiency Syndrome." In other words, not enough revenue! Again, to keep it in medical terms: The Symptoms and Ailments are that four in ten physicians reported their take home pay decreased from 2011 to 2012. More than half expected their incomes to continue to fall dramatically over the next one to three years. The percentage jumps to 68 percent among solo doctors.

Because physicians have no control over the rates they are paid by Medicare, and to a large extent, private payers, there are few remedies physicians have for this problem. If they want to keep their incomes steady, they have to see more patients, but most are already working themselves to the point of burnout.

I'm sure many doctors can relate to that.

RG: It's even worse. The industry is also moving toward an outcomes-based compensation model for physicians. This model requires physicians to spend money on new technology capable of discrete data collection as well as personnel able to analyze the data and act upon it. If the models work as planned, the focus on preventive health will mean fewer patient visits —a noble enough goal, but one with unavoidable economic impact. Unfortunately, the majority of physician income is still based on fee-for-service arrangements. What this means is, the amount of uncompensated care physicians provide will certainly increase.

Is that the worst of it?

RG: Hardly. Adding to the angst physicians are feeling about these emerging care models is that even if the reimbursement trends move in the physicians' favor, they will lose some control over their earning potential in an outcomes-based model. Even if physicians do all they can to encourage patient engagement and compliance, ultimately patients will be responsible for more of their own care, leaving fewer opportunities for physicians to improve their reimbursement levels.

What's another of the physicians' major concerns?

RG: The second of what we have referred to as diseases is "Oppressive Overhead Inflation Disorder," which simply means that the cost of a medical practice's overhead is increasing. So, just as revenue is decreasing, costs are going up. Here the Symptoms and Ailments are that not only are doctors being paid less, but when they do experience a financial surplus, it is going back out to cover the cost of running a practice.

What kinds of costs are we talking about?

Among the costly changes physicians are required to adapt to are: (1) The conversions to ICD-10, which is expected to cost physicians between $56,639 and $226,105 with the price tag growing each time there is another delay to the conversion deadline date; (2) The rise in payroll expenses. Physicians must provide good salaries and cost of living allowances to staff, or lose them to other practices. This means less money in their own pockets. Because of mandates handed down by the Affordable Care Act (ACA), and the demand of a growing patient population, many practices are being forced to add to their staffs; and (3) Technology costs. Physicians must adopt electronic health record systems or face a payment penalty from Medicare. But technology adoption isn't a one-time cost, it involves ongoing maintenance expenses. In other words, a permanent increase to overhead.

Well, I can clearly understand why physicians are feeling financial pressure from both sides. But you stated at the outset that there are three diseases, or areas of concern. What is the third?

RG: Apart from the financial, there is what we call "Obsessive Time Deficit Disorder," the loss of time and freedom! And it's just as important as the other two. Here are the Symptoms and Ailments: Because reimbursements are going down, if physicians want to continue bringing home the same amount of money each month, they have to see more patients. Even if they don't want to take on more patients, they may be forced to anyway, resulting from the influx of an estimated 30 million patients from the ACA, and an aging population.

How does that work?

RG: Physicians may be contracted to take on new patients who gained coverage through the insurance exchanges and not even be aware of it because of insurers invoking "all-product clauses." This, despite 48% saying they will be unable to accept any of the newly insured patients because they are already overwhelmed with the demands of their current patient populations.

In addition to the growing patient demands, physicians are facing regulation overload. More than half say they are now spending one day a week or more on paperwork. All of the stresses and burdens are leading to physicians experiencing burnout at a much higher rate than other U.S. workers. They are spending more time at work and less time with their families and in their communities.

Most people in the general public would be very surprised by all this; they envy doctors and believe that they make a lot of money and live the good life.

RG: Many physicians have decided this is not what they signed on for when they entered private practice. They are closing their private practices and taking employed positions with large health systems. This is taking them away from the administrative burdens, but causing many to feel a loss of independence. Some are taking it one step further and hanging up their lab coats for good— leaving medicine altogether. While these challenges are all unique, they all boil down to this: Physicians feel they must work harder to bring home less money and their quality of life is suffering in the process.

After all is said and done, what is the solution —the "cure" —for this problem?

RG: The industry has been rife with suggestions on how to combat the mounting problems. However, many of these solutions either create new challenges or don't go far enough to really make a measurable impact. Among them: Adopt new technology and processes. The promise of EHRs is that they will drive efficiencies. Many practices have found this to be true, but with caveats and the investment of a great deal of time and money.

Are there any other ideas?

RG: Improve billing processes and systems. This can be handled in two ways: better technology to help the practice collect at the time of service, or by outsourcing — both of which cost more money. Plus there is the added stress on physicians due to fear of losing control of their money.

That's an understandable concern. Is there another option?

RG: Increase the patient base. This assumes practices have open appointment slots waiting to be filled, which simply isn't the case. Physicians are already dissatisfied with the limited amount of time they have to spend with each patient and the longer hours they have been forced to work to meet the demands of those patients. In addition, there is the added paperwork, administrative time, and staff necessary to handle them.

I suppose it's up to each physician to decide which of these options is most suitable.

RG: Whether a physician has tried some of the above or alternatives, he or she may have found that solutions being promoted today are not living up to expectations or the promoters' promises. Everyone seems to have his or her own view point as to what can help solve existing challenges and make life a little easier. No matter what is offered, the physician will have to decide if it will work and if it fits in with his or her way of practicing medicine.

What primary care physicians say are the most satisfying factors about practicing medicine.

Factor	% of PCPs Who Ranked This #1
Patient Relationships	35%
Protecting and Promoting the Health of Individuals	38%
Intellectual Stimulation	16%
Financial Rewards	3%
Prestige of Medicine	3%
Interacting with Colleagues	2%

Deloitte 2013 Survey of U.S. Physicians

It's our understanding that Innovative Healthcare Systems has identified a "cure" that is able to solve all of the concerns expressed by physicians in your research.

RG: Yes, that's right. A recent survey from Deloitte found that only 3% of physicians say financial rewards are the most satisfying aspect of practicing medicine. This could be because they aren't experiencing the financial rewards they had expected when they decided to enter medicine.

The fact is that financial rewards, returns on investment (of time and money) and making a profit should be #1. But not for the greedy, self-serving reasons one might think or others might accuse you of. The reason is: More money solves up to 95% of all of the problems discussed so far!

So, in other words, money is not a "dirty" word to you. But how do you accomplish that?

RG: It is our belief that there are only two proven ways to increase revenue, so physicians can have the time and energy to help more people and increase their patients' — and their own — quality of life. The first solution could be called a "treatment" and the second one a "cure".

What is "the treatment?"

RG: Quit the practice, do a 2-3-4-year fellowship, and become a "Specialist" (i.e., ENT, Neurologist, Cardiologist, Orthopedic Surgeon, etc.). These types of specialties typically command 50%-100% more revenue for often times fewer hours and with less staff. This also means their net profit or personal income can be double, triple or even quadruple that of a regular physician (i.e., Internal Med, Family Physician, Primary Care Doctor, etc.).

Even though some Specialists are experiencing some of the "diseases" mentioned earlier, most of them have a higher standard of living, a better quality of life and are maintaining their professional independence.

That sounds like a very major step, especially for a doctor who has already invested many years in his career and practice. What is "the cure?"

RG: Here is the key to everything we have learned from our research. Instead of becoming a Specialist, it is our contention that physicians need to "specialize" in something in addition to what they are currently providing.

There is already evidence of general practice and family physicians attempting to earn more

revenue by adding cosmetic services such as Botox and dermal fillers to their offerings. Some doctors are offering laser hair removal, skin resurfacing, and body contouring. Many have added EMG and NCV testing, ultrasound tests, and bone density scans.

While these services have their limitations, a growing number of physicians continue to try to make these choices work. Unfortunately, most of the "success stories" are few and far between. We have all heard the stories about how "the sales person lied to me," or "I thought it was going to be X, but it turned out to be Y" and "I lost a lot of money..."

That sounds like they certainly had the best of intentions.

RG: Even though these doctors may have been on the right track, we feel that they were probably on the wrong train. Or, as Will Rogers once said: "Even if you are on the right track, you'll get run over if you just sit there." It is understandable why this can occur: Physicians have spent years learning about medicine and far less time studying business. To that end, we suggest that any ancillary services a doctor decides to prescribe to eliminate his or her ailments should follow certain protocols.

By protocols, you mean that physicians should consider a service that meets certain important guidelines?

RG: Exactly. Before adding any in-office ancillary service to a practice, we suggest that it be compared to specific criteria to make sure it can live up to the physician's expectations…then decide!

First, of course, *it should help existing patients.* Physicians went into medicine to help keep patients healthy. Services that can be offered to the existing patient population mean better care without the need for extensive marketing to attract a new patient demographic.

Next, it should be *offered to a growing patient population.* One of the fastest growing populations is Medicare-eligible Americans. As of 2012, there were nearly 50 million Medicare beneficiaries. An estimated 10,000 turn age 65 each day and will continue to do so until 2030.

That's a trend that is certain to continue.

And that's an important aspect of this program we're talking about. One of the guidelines for any successful "cure" is that *Medicare and other insurance companies should be willing to pay for it.* In tough economic times, patients tend to put off care, especially care that is not covered by insurance. Insurance coverage reduces the cost barriers to patients receiving a service.

Another guideline is that it should be *something no one else or very few other physicians in the same area are offering.* Many physicians have already started offering cosmetic services such as Botox and dermal fillers, as well as some of the other services I mentioned.

In addition, it should be *easy to learn or provide and add to the practice.* Two of the biggest complaints about new technology in a physician practice are its usability and the space neccessary to implement it. One of the reasons some technology is not considered user-friendly is because it requires expensive and time-consuming training, which practices can neither afford nor have time for. As for space...ideally the equipment should be small and portable, so it can be easly moved from office to office.

More money solves up to 95% of all of the problems discussed so far!

The challenge is: How do you accomplish that?

In other words, it shouldn't be another added major expense for the practice?

RG: Right. And *it can't take up much of the doctor's time to do or implement.* Services that don't require a medical degree and can be provided by existing staff in a matter of minutes will have minimal impact on the practice workflow and won't take physicians away from regular patient visits.

Physicians should be willing to refer their patients for the service. When physicians find a service that has proven value and benefit to their patients, but don't offer those services themselves, they are likely to send those patients to someone who does.

It can be marketed to the community as valuable and professional. It should not be experimental or investigational and should be a medically necessary service with a proven track record that addresses a growing problem. This will not only bring extra revenue, but will be considered an asset to patients and the community.

It doesn't significantly increase overhead or cost a lot of money. During tough economic times, many practices have depleted their capital funds on things such as EHR systems or advanced practice management systems. Another large investment or one with a low ROI is not an option for many practices.

It is profitable, yet low risk for doctor and patient. Investing in something not guaranteed to produce a return on investment is not something many physicians are willing to do, nor should they be.

Finally, and very important, *it fits into the current healthcare models.* Reform efforts have placed a focus on keeping patients healthy, improving outcomes and reducing healthcare spending. Offering services that address these goals will help physicians see the benefits of reform efforts in their own practices.

That's quite a set of guidelines. Is there really a service that meets all of those requirements?

RG: Yes, and most importantly, if the above protocols are followed, the physician will be guaranteed to have the desired outcome, with great benefits to the patients, as well. The solution, or "cure," that I am referring to here is being used by more than 1,000 physicians in the U.S., who are finding more joy in the practice of medicine and more time for a better quality of life.

What more can you tell us about this solution?

RG: Physicians who are interested in learning more about this won't have to simply take my word for how much it can add to their practices, and their lives. They can watch a video by going to www.vngwebinar.com...or visit our website at www.innovativehealthcaresystems.com. If they would like, they can call me and I will be happy to refer them to any of the more than 1,000 doctors who have already "taken the cure" and who I am certain would provide outstanding testimonials for this program. All it takes is a phone call.

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