ASK THE EXPERT

Adding Ancillary Services to Your Practice

In an effort to revive shrinking profits and enhance their practices, rheumatologists in private and group settings are increasingly looking to the provision of in-office ancillary services. Among the more traditional ancillaries are medical imaging, infusion services, laboratory services, and physical therapy. Some less traditional services are also showing up, including weight-loss programs, smoking-cessation programs, and stress management.

KENT BLAKELY, M.D.

When well planned, the addition of ancillary services can substantially increase a practice's profitability and improve patient care. Poorly conceived plans can have the opposite effect, however, draining a practice's resources and impairing its reputation. "Ancillaries are not always the monetary cure they are made out to be," said Dr. Kent Blakely of the Kearney (Neb.) Arthritis Institute. "We usually hear about success stories at conferences and from salespeople, but this is dangerous and misleading, because every practice is different."

In a recent presentation at a state-of-the-art clinical symposium sponsored by the American College of Rheumatology in Chicago, Dr. Blakely discussed the challenges that he faced in setting up a successful weight-management program for rheumatoid arthritis patients offered through his group's practice. In this month's column, he offers tips for evaluating whether the addition of an ancillary service is feasible for a given practice and how to go about making it happen.

Rheumatology News: What are some of the key considerations when thinking about adding an ancillary service?

Dr. Blakely: Before you add an ancillary service, you have to ask a series of questions. Will adding a service line impact your ability to deliver existing rheumatologic care? Will you have enough space, exam rooms, parking, and waiting room space? Do you have the ability from your business office to handle more volume and the ability to track collections from your new service line? Will the additional program stress or overwork your current staff? Additionally, you will need to observe your own practice for referral patterns and patients who might potentially need the service you are considering. Small to medium-sized groups may not have the volume to support many ancillaries on their own. Practices that fail to conduct a thorough analysis of patient demand, costs, and potential reimbursement for new services can easily get in over their heads. The most important consideration is how your patients will perceive your new service. We are in the business of helping patients, so it is imperative to make sure that the service being offered is in keeping with your values.

RN: With respect to implementation, what are some of the biggest challenges?

Dr. Blakely: The greatest challenge is getting patients or referrals to utilize your service. Hopefully, in preparation for the addition of your services, you have produced a solid business plan and anticipated demand for your services. By tracking your own practice patterns, you should have a good idea of the demand for your ancillary service. It's best if the services can be supported by your practice demand alone. If the service requires outside referrals or expanding your patient base, you have to determine how to get patients there. Advertising can be helpful, but it must be carefully planned, because it can also be a burden on the bottom line. Word of mouth and reputation are the best advertisement, but they take time, so it's crucial that your business plan can withstand the time needed to develop a patient base and begin positive cash flow. Once patients do begin to utilize your service, the next challenge is determining how to handle the new volume to your practice. Implementation and selection must involve your partners, nursing staff, and support staff, because workflow involves the whole staff.

RN: With respect to the weight-management program that you began in your practice, what homework did you have to do before actually deciding on that service?

Dr. Blakely: Most rheumatology practices rely on services that are traditionally involved in the day-to-day practice of rheumatology, such as imaging services, a laboratory, and infusion centers. Unfortunately, reimbursement issues exist with traditional services, which is one of the reasons I chose to provide a service outside of the traditional offerings. Over the years, I found that many of my patients were overweight and presented with knee and back pain as a result. I had written information for a Web site and presented information to young hockey players about sports nutrition. I began to discuss some of the principles of sports nutrition that applied to weight loss to my rheumatology patients, and I found a real interest in my weight-loss advice. I then began to investigate and learn more about bariatric medicine and programs that could be provided to my patients, and I spent 2-3 years planning a program. I particularly reviewed medical literature for both weight loss and the effects of weight loss on the treatment of arthritis. A weight-loss program appeared to be a valuable service to add to the care of my rheumatology patients and many others in my community. Because most weight-loss programs are paid for privately and not covered by insurance, changing reimbursement issues is not a concern. Typically, patients are willing to pay for a service they feel is worthwhile.

RN: What have been some of the advantages and disadvantages with the addition of the weight-management program?

Dr. Blakely: The program has added a dimension to the treatment of my patients that has enriched my practice. Recent studies on cardiovascular risks of rheumatic diseases, the impact of obesity on the effectiveness of biologics, and the improvement of symptoms of knee and back osteoarthritis associated with weight loss have all confirmed my decision to add this service to my practice. It has led to the improvement in the overall health of my patients, has expanded my patient base, and has been a very enjoyable part of my practice. As the weight-loss program has grown, it has been a challenge to balance the rheumatology practice. I have added one evening a week and reserve early afternoons on Fridays to conduct the clinic. I have a separate corporation for the weight-loss program, and conduct it as a separate entity. Keeping separate books and expenses and staffing adds an administrative burden to my clinic manager.

RN: In hindsight, what, if anything, would you have done differently?

Dr. Blakely: Initially, I spent too much money using an advertising agency and some television advertising for the program. I learned that word of mouth and the results of a quality program speak for themselves. Also, I initially staffed the program with my nurse practitioner as the director, but the time required was too much for her without compromising our core business of the rheumatology clinic. As a result, I hired a full-time director who had a degree in health and fitness with a sales background. The full-time position was not needed initially and served to drag down cash flow, so another change in staff occurred. I hired my registered dietician as a part-time commissioned program director and the program has flourished. Just as in the medical practice, staffing and quality of service are the most important factors in the success of any business. ■

DR. BLAKELY is a rheumatologist with the Kearney Arthritis Institute. He opened a clinical weight-management program in conjunction with the practice in May 2006.

By Diana Mahoney, New England Bureau.

Both Candidates' Health Plans Murky on Cost-Cutting Details

BY ALICIA AULT
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WASHINGTON — While health care has been a key issue in this year's presidential campaign, plans from both Barack Obama (D-Ill.) and John McCain (R.-Ariz.) are light on details about the most important aspects of the health system, like controlling costs, and improving efficiency and productivity.

The candidates have presented a wish list with very little detail on how they would accomplish the "fundamental change needed for our delivery system," said Paul B. Ginsburg, Ph.D., president of the Center for Studying Health System Change, at a briefing sponsored by the Alliance for Health Reform. "They could have a debate over how best to do that," he said, adding, "We aren't hearing that."

Economists have estimated that over the next decade, U.S. health spending will double from $2.2 trillion to $4.3 trillion. Dr. Ginsburg, with Princeton (N.J.) University economist Uwe Reinhardt and former Centers for Medicare and Medicaid Services Administrator Mark McClellan, said that rising costs are being driven by variations in practice, growth in volume, and intensity of services.

Sen. Obama has said that he favors health information technology, transparency of price, promotion of quality care, chronic-care coordination, payment reforms for value, malpractice reform, and promotion of generics.

Most of these are old, but not worthless, ideas, said Dr. Reinhardt, James Madison Professor of Political Economy at Princeton. "These are not to be laughed off, but they won't get us out of the box," he said.

Dr. Reinhardt called Sen. McCain a "true radical" for his proposal to eliminate the tax exemption for employer-provided health insurance. Individuals who purchase insurance on their own would instead receive a $2,500 tax credit; families would receive $5,000.

"This is almost un-American—to take away a tax preference," said Dr. Reinhardt, adding that it is "a shocking idea and not easy to get through Congress."

Dr. Ginsburg called the proposal "a potentially powerful idea," saying that it could make consumers more sensitive to the cost side of insurance, and thus make them a more potent demand force.

Cost control is important because there will be no new federal money available to increase access to insurance or initiatives aimed at improving quality or productivity, said Dr. McClellan. "Next year is going to be a very tight year fiscally," he said. In fact, tax reform, the Iraq war, and the economy are likely to be higher up on the campaign agenda than health during the general election run-up this fall, said Dr. McClellan and his fellow panelists.

"I'm not personally persuaded that health care, in fact, will drive the campaign in the fall," said Dr. Reinhardt.

But Dr. McClellan said, "My hope is it doesn't get pushed to the back burner," noting that "it will be a major missed opportunity if we don't have health reform next year." ■