Overwhelmed by Paperwork

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from Merritt Hawkins, a Texas-based physician recruiting firm, show 45% of their 2008-2009 physician search assignments were for settings where the hospitals employed the physician, up from 23% in 2005-2006.

Meanwhile, according to a 2009 survey of graduating residents conducted by the American Academy of Family Physicians, most of these young doctors plan to work in either family medicine group practices (42%) or multispecialty groups (14%). About 10% indicated they would pursue work in either a solo or two-person family medicine practice.

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DR. LUPOLD

A little over a quarter of residents surveyed by AAFP said that their level of medical school debt influenced their choice of practice arrangement.

Family physicians exiting residency generally face an average debt load of around $200,000, which puts opening their own practice out of reach for many. Imagine facing a six-figure educational debt and then taking out a mortgage to open a new practice, said Dr. Lupold, who serves as the new physician member of the AAFP board of directors.

While the AAFP does not have data on whether established physicians are changing their practice patterns, Dr. Lupold said it's not just the young physicians who are considering employment models.

Physicians of all ages are becoming overwhelmed by the changes in the business of medicine and the enormous increase in paperwork. In addition, in many cases family physicians can make more money by going to a larger group, he said.

But Dr. Lupold doesn't see this shift as negative for patients. Whatever the practice setting, physicians have the ability to develop relationships with patients, he said, adding that removing physicians' business management duties can provide more time to focus on patient care.

While these trends may reflect the difficult practice environment faced by primary care physicians, the move to an employer model could lead to more clinical integration, a plus for health care quality and patient care, said Dr. Kenneth R. Bertka, a member of the board of directors for the AAFP and a family physician in Toledo, Ohio.

Integrating care is essential for patients as they move between the hospital and the physician's office, he said. And it's what AAFP and other groups are looking to address through the patient-centered medical home. But it's certainly easier to accomplish when everyone is working in the same system, Dr. Bertka said.

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DR. BERTKA

But working in a hospital-owned practice isn't the only model for integration. Family physicians can still achieve this in private practice whether it's by establishing an accountable care organization, setting up an informal partnership with a hospital, or even through a joint venture with a hospital system.

Dr. Bertka, who was in a small practice for 20 years, is now employed by the Northern Division of Catholic Healthcare Partners in Toledo. The switch was a good fit for him, he said, because he wanted to be more active with AAFP and work on policy issues such as health care reform. He predicts that more physicians will follow his lead in the next few years, but the majority will still be in private practice.

"The bottom line is that both environments are important and the future of medicine really depends on both," he said. "For the foreseeable future, it's not going to switch to one model or the other."

Despite the challenges, Dr. Saccocio said that she believes family physicians shouldn't give up on private practice.

"Don't let anyone tell you that you can't do it," she said. "If it is something that you want to do, you just have to have an interest in your own practice. Don't expect that someone else is going to take care of it for you."

Today, Dr. Saccocio teaches her residents about the business of running a practice, from how to code effectively for what you do to the need to open your own mail so you know how much revenue is coming in the door. And she tells them that they can run a practice and still have time to devote to patients.

When Dr. Saccocio ran her micro practice in Fort Lauderdale, she spent 40 minutes with new patients and 20 with established patients. She was able to do it by keeping staff and overhead low. The trap that some private practice physicians fall into is that as their practice and overhead grows, they are under pressure to see more patients and earn more money, she said.

"Solo practice is not dead," she said. "It just needs to be restructured into a manageable model." ■

Calif. Emergency Departments Share State's Budget Woes

BY ALICIA AULT

Already struggling from California's diversion of funds meant to pay for uninsured patients, the state's emergency departments may be facing an even grimmer financial scenario when fiscal 2011 begins in July, say California emergency department directors.

Physicians have already been coping with either no pay since last July or with a huge reduction in how much they are paid from county funds for care of uninsured patients. Now, with the state's ongoing budget crisis, some counties have decided to slash reimbursement rates even further. And that scenario could be repeated again in a few months, Dr. Robert Rosenbloom, president of the California chapter of the American College of Emergency Physicians (CAL/ACEP), said in an interview.

Uncompensated care in the state's private emergency departments has been reimbursed primarily through a combination of tobacco taxes and the Maddy Fund, which was created in 1987. The Maddy Fund law allows counties to collect a portion of fines from traffic violations and criminal offenses and dedicate them to emergency medical services. Fifty-eight percent of the fund's revenues must go to reimburse physicians, 25% to hospitals, and 17% to other emergency medical services.

However, physicians can be reimbursed only up to 50% of the losses incurred from uncompensated care.

So far, 50 California counties have established Maddy Funds. Some of those counties have been aggressive about collections, accounting, and distribution. But others have done a poor job of collections or accounting, which means that not all the monies are properly distributed—or distributed at all, said Dr. Rosenbloom.

CAL/ACEP is supporting a bill before the state legislature that would require counties with Maddy Funds to be transparent in their accounting so that proper amounts go to emergency services.

Budget Crisis Drains Maddy Funds

The California budget crisis has clouded the already uncertain Maddy Fund picture. In 2009, Gov. Arnold Schwarzenegger (R) used statutory discretion to redirect $25 million of emergency services money into the state's general coffers. That was out of a total $60 million, said Dr. Rosenbloom.

The move had immediate repercussions. Los Angeles County lost $9 million, and as of July 1, 2009, it halted all uncompensated-care payments to the county's private facilities and their physicians. Emergency physicians in the county were already receiving only 27% of their costs of caring for the uninsured.

In February, the Los Angeles County Board of Supervisors voted to give physicians and hospitals back pay, but at a further reduced rate: 18% of the cost of care.

Despite the low reimbursement, CAL/ACEP has fought to keep the system in place, said Dr. Rosenbloom. It ensures that the uninsured get some kind of care and reduces the pressure on public emergency departments, he said.

However, the low to nonexistent pay rates are exacerbating the difficulties in finding physicians who will take emergency department call, Dr. Rosenbloom said. Many specialists find the pay "insulting," he said.

The latest reductions in funding have had "a huge effect on the willingness of private physicians to back up emergency departments," said Dr. B. Thomas Hafkenschiel, an emergency physician at Santa Clara Valley Medical Center.

When the county's Maddy Fund is working, it at least ensures a minimal payment, which is better than nothing, said Dr. Hafkenschiel. But now the pay appears even more uncertain. Although he works at a county facility, he is monitoring—and feeling—the effects of the reimbursement cuts for private facilities.

Dr. Hafkenschiel has been working with a group of ED directors in the south San Francisco Bay area to get a better accounting of the criminal penalties being collected by the Maddy Fund and their distribution. As other funding sources have shrunk, including tobacco tax collections, "we have to make sure this is being done properly, or we're going to be in deep trouble," Dr. Hafkenschiel said.

Uninsured Patient Visits Rising

The lack of funds for uncompensated care is a growing problem because of the increasing numbers of uninsured patients in California. Dr. Hafkenschiel said that the patient volume at his ED has grown from 82,000 visits in 2007 to 128,000 in 2009, largely due to people losing their health insurance. That trend may be accelerating in 2010—ED visits in the first 2 months of 2010 exceeded the volume seen in the same period of 2009.

Other ED directors in the county have noticed the same rise in uninsured patients, he added. In Los Angeles County, the percentage of uninsured patients in the ED has risen from 16% to 19% in the past year, said Dr. Rosenbloom.

At Arrowhead Regional Medical Center, a county facility in San Bernadino County, volume has gone up 6% in the past year, said Dr. Rodney Borger, medical director of the ED at Arrowhead. The number of physician claims to the county's Maddy Fund has gone up 15% over the past 2 years, but the revenues have been flat or decreasing, said Dr. Borger, a member of the fund's oversight board.

When Gov. Schwarzenegger diverted the $25 million, San Bernadino lost $900,000, Dr. Borger said. In October, the county coped by cutting reimbursement by 24% to physicians at private EDs for uninsured care. Another 25% cut may be around the corner in July, said Dr. Borger, who added that he was hopeful that it could be averted. ■