

AMERICAN  
PSYCHIATRIC  
ASSOCIATION



# Building A Career In PSYCHIATRY

**Part 2:** Transitioning to Practice

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## Choosing Wisely—Assessing Practice Options And Demographic Locations

Perhaps the most significant lesson is that there is no single strategy or set of questions that will help you make every decision you will face after training. However, this document provides resources that will assist you in making two of your most important decisions: choosing a practice setting and then finding the most desirable geographical location in which to practice and live. The perfect practice opportunity would be a combination of one's ideal practice setting, an attractive compensation and the most desirable geographical location for you and your family. The reality is that most choices involve a number of compromises and selecting the overall best mix of advantages and disadvantages.

### PRACTICE SETTING OPTIONS

The following charts highlight the advantages and disadvantages of the following practice setting options: solo, group, hospitalist, academic and employment. While you may categorize the listed advantages and disadvantages differently, the goal is to consider all of these issues. The APA also publishes a book titled *“Handbook of Career Development in Academic Psychiatry and Behavioral Sciences.”* The Handbook is a guide to everything that they don't teach in traditional medical and psychiatric training about how to begin—and further develop—an academic career.

**Solo Practice**  
Start or purchase your own practice

Appeal	Downside
<ul style="list-style-type: none"> <li>▪ Significant control and autonomy</li> <li>▪ Ability to create/manage a practice the way it suits you</li> <li>▪ Individualized benefit packages</li> <li>▪ Set one's own schedule</li> <li>▪ Entrepreneurial freedom</li> <li>▪ No worry about being dragged down by less successful partners</li> <li>▪ Sometimes have lower total overhead, but higher per capita than a small group practice</li> <li>▪ May be able to hire one person to be responsible for all office functions: billing, collections, appointing, records management and HIPAA compliance, and general office management</li> <li>▪ Can be a less complicated, and therefore less costly, practice to run</li> <li>▪ Buying an established practice may mean an established patient base, and an equipped and staffed office</li> </ul>	<ul style="list-style-type: none"> <li>▪ Need to be a good business person</li> <li>▪ Sole financial responsibility</li> <li>▪ Greater personal risk</li> <li>▪ Need to have a diverse and loyal regional network</li> <li>▪ Coverage difficulties</li> <li>▪ Unpredictable work hours/schedule</li> <li>▪ High startup and overhead costs</li> <li>▪ Difficulty establishing patient base</li> <li>▪ Administrative burden</li> <li>▪ Because of patient volume, may not attract pharmaceutical trials</li> <li>▪ Increasingly difficult to find one or two people who can do everything required to meet local, state and federal requirements</li> <li>▪ Existing staff may be used to doing things the way the departing physician wanted them done</li> </ul>

**Group Practice**  
Single-specialty or multi-specialty group

Appeal	Downside
<ul style="list-style-type: none"> <li>▪ Often has an established patient base</li> <li>▪ Shared patient responsibilities</li> <li>▪ May offer more predictable income and schedule</li> <li>▪ Camaraderie among fellow physicians</li> <li>▪ Greater potential for internal patient referrals</li> <li>▪ Decreased per capita office overhead</li> <li>▪ Increased coverage flexibility</li> <li>▪ Increased scheduling flexibility</li> <li>▪ Better internal quality assurance</li> <li>▪ More leverage in dealing with managed care</li> <li>▪ More ancillary assistance</li> <li>▪ More vacation</li> <li>▪ Potential to become a partner at some point</li> </ul>	<ul style="list-style-type: none"> <li>▪ Personality differences</li> <li>▪ Income division conflicts</li> <li>▪ Income distribution/overhead allocation may be unfair</li> <li>▪ Less autonomy</li> <li>▪ Senior physicians may control scheduling; junior physicians often perform disproportionate share of the work</li> <li>▪ Decreased ability to individualize benefits package</li> <li>▪ Little influence on governance issues, office management</li> <li>▪ Must comply with group utilization review and quality assurance standards</li> <li>▪ Increased risk of interpersonal conflicts</li> <li>▪ Lack of control over cross-coverage of patients</li> </ul>

## Academic Medical Career

Appeal	Downside
<ul style="list-style-type: none"> <li>■ Youthful and renewing environment</li> <li>■ Opportunity for research</li> <li>■ At cutting edge of knowledge and skills</li> <li>■ Challenging days, never boring</li> <li>■ Toughest patients to diagnose and treat</li> <li>■ Many opportunities to take on new roles and responsibilities</li> <li>■ Multiple specialties in close proximity</li> <li>■ Can transition to private practice; the opposite is not as easy</li> <li>■ Former trainees may be your future colleagues or employers</li> <li>■ Academic medical centers have a rich intrinsic culture that values wisdom and experience</li> <li>■ Opportunity to teach/mentor</li> <li>■ Appreciative students and residents</li> <li>■ Trainees provide a real service—additional hands and eyes</li> </ul>	<ul style="list-style-type: none"> <li>■ Complex leadership structure often creates bureaucratic inefficiencies</li> <li>■ “Publish or perish” dictum at many institutions</li> <li>■ Salaries usually lower, but no overhead costs</li> <li>■ Numerous committees</li> <li>■ Many institutions financially struggle</li> <li>■ Resident duty-hour limits are forcing many attending faculty to work longer hours to fill in gaps in patient care</li> <li>■ Advancement may require geographical moves</li> <li>■ Some academic institutions are very hierarchal</li> <li>■ You’re accountable for the mistakes of your trainees</li> </ul>

## Employment Setting

*Managed care organization, hospital-based specialty, primary care network, locum tenens, VA hospital, corporate health department, public service (military, Indian Health Service, etc.)*

Appeal	Downside
<ul style="list-style-type: none"> <li>■ Possible income guarantees and set hours</li> <li>■ Fewer billing hassles</li> <li>■ Fewer coverage difficulties; sometimes have greater opportunities for flexible scheduling</li> <li>■ No startup costs</li> <li>■ Potential prestige of being associated with a well-known institution</li> <li>■ More ancillary assistance</li> <li>■ Established patient base</li> <li>■ May have enhanced opportunities for expanding into other aspects of health care delivery (serving on governance committees, working in nonclinical positions, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>■ May have little, if any, ownership interest</li> <li>■ Little actual control over practice finances</li> <li>■ Decreased opportunity for entrepreneurship</li> <li>■ Referral restrictions</li> <li>■ Limited control over workload</li> <li>■ Must comply with organization’s quality assurance, privileging and utilization issues</li> </ul>

## SELECTING A GEOGRAPHICAL LOCATION

There are several important geographical market factors to consider when choosing where to work and live. Consideration of the following questions may influence your choice:

- Is the community the right size?
- Are there reasonable population increases, or is the population stable year-round?
- What are the selling points of the community?
- How close is the nearest large city?
- Is the climate acceptable?
- Is it close enough to extended family?
- Is the quality of schools acceptable in terms of adequate teacher-pupil ratio, special programs, curricula and extracurricular activities?
- Are appropriate recreation/hobby opportunities available?
- What types of social organizations (e.g., fraternal, professional, religious, business) are available?
- How is the economy?
- What type of physician would fit best in the community?
- Is it close enough to scheduled airline service or other transportation services?
- Is the crime rate acceptable?
- Is adequate housing available?
- Is affordable housing available?
- Are shopping opportunities adequate?
- Are there environmental concerns of importance to you (air, water, etc.)?
- Are there employment opportunities for a family member or domestic partner, if applicable?
- When evaluating an offer, consider your potential quality of life in that community. It may be beneficial to talk to school officials, religious leaders, civic associations and other physicians who have recently moved into the area.

You may also want to discuss opportunities with a physician mentor. A seasoned physician may be able to offer objective advice or pose additional questions that will steer your thinking. His or her input can be extremely valuable when considering non-compensatory factors such as reputation of the practice and key partners, malpractice liability issues, opportunity for professional development and relating the job to long-range goals.

## LIFESTYLE, FINANCIAL AND COMMUNITY RESOURCES

If you have a position in mind in a given geographical area, the following resources may help you in your decision process.

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- [Homefair.com](#) and [Move.com](#)
  - ◆ Salaries—see salaries in different locations (also see [cost of living comparisons between locations.](#))
  - ◆ City reports—obtain information on cost of living, climate, demographics and more by location.
  - ◆ School reports—get in-depth reports on local schools and child care centers.
  - ◆ Crime statistics—get crime indexes for thousands of U.S. cities and Canada.
- [Check home prices](#)—find out home prices in particular areas.
- [Rentals](#)—obtain contact information for rental placement services.
- [Moving calculator](#)—check out this tool and other resources, including information on neighborhood merchants.
- [U.S. Census Bureau](#) and [ZipSkinny.com](#) View demographics of the patient population in the areas where you are considering practicing medicine.
- [Bankrate.com](#) View state information about income and sales taxes levied in each state.
- [Weather.com](#) Get detailed information about local weather conditions, including average temperatures, rainfall and sunrise and sunset times.
- [Kaiser Family Foundation](#) Resources on the latest state-level data on demographics, health and health policy, including health coverage, access, financing and state legislation.

## STATE-SPECIFIC INFORMATION

### [Business resources](#)

View a collection of links to state government websites with useful information about starting a business or obtaining information about local businesses.





## Entering into a Physician Employment Agreement

### 5 TIPS FOR NEGOTIATING YOUR CONTRACT WITH CONFIDENCE

- **Consult an expert.** It's true, hiring a lawyer to review a contract is an added cost. But the consequences of signing a long-term contract you don't understand can be much more taxing on your career and your pocketbook. An experienced healthcare attorney in the state in which you plan to work can help you identify and resolve problematic contract provisions before they become an issue. To search for attorney, go to [www.martindale.com](http://www.martindale.com) and specify employment contracts in the practice area of the search. Additionally, find a physician mentor who has been through this process before. Ask them what they believe they did right and things they would have done differently. Their perspective may help you avoid common pitfalls.
- **Get it in writing.** No matter how smooth and cordial your negotiating process, you should insist on getting all of the terms of your employment or practice membership in writing. This significantly reduces the potential for mistakes, misunderstandings, and amnesia.
- **Check out the benefits.** Additional benefits can add substantially to both your base compensation and how content you are in your new position. Learning what's included is an important step in the negotiating process. Examples of benefits include payment of licensing fees, payment of dues to professional societies and time off to participate in organized medicine functions, midweek time off, time and money to complete Continuing Medical Education requirements, liability insurance, disability insurance,

and payment of student loans. Understand how these benefits work and, importantly, what's required of you in accessing them. For example, in return for your employer paying your student loans, are you expected to stay within the geographical area for a certain number of years? As another example, liability insurance is often included for employed physicians. Does the coverage extend to include acts you performed at the practice after you leave, also known as tail coverage?

- **Understand your compensation and know what you're worth.** You need to fully understand and be comfortable with how your compensation is structured. If not, ask someone to walk through it with you using numeric examples. Before you enter negotiations, you should be familiar with the median salary range in the desired geographic area. If you don't know what you're worth, you won't know if the compensation offered by the practice or employer is fair.
- **Model contracts.** Although no substitute for an attorney, the American Medical Association (AMA) does provide an Annotated Model Physician-Hospital Employment Agreement to AMA members. It includes a description of basic contract terms typically found in such employment agreements, in addition to explaining the significance of such provisions and language that benefits the physician employee. In addition, the resource offers examples of language that may be problematic to the physician employee.

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## Credentialing, Privileges and Authorization Numbers

### HOSPITAL AND HEALTH PLAN CREDENTIALING

A managed care organization (MCO)—such as a health maintenance organization (HMO), preferred provider organization (PPO) or physician/hospital organization (PHO)—must select and retain qualified health care providers who will provide quality services to its subscribers. This process of selection and retention is known as credentialing, through which the information of a health care provider interested in participating with an MCO is reviewed and verified. Information reviewed and verified through credentialing includes:

- Current professional license(s)
- Current Drug Enforcement Administration and Controlled Drug Substance certificates
- Medical education, graduate training, hospital staff privileges and levels of liability insurance

Credentialing also includes review of the physician's office, also known as a site review or an office audit. An insurance company employee, usually a health care professional who is a member of an MCO's quality improvement or provider relations department, carries out such visits, using a long checklist of items to be examined for compliance with the MCO's standards. Each office is rated on individual items such as quality of clinical records, cleanliness, training and the overall condition of the medical office. Information from a practitioner's site visit is considered in determining whether the practitioner is accepted into the MCO's practitioner panel.

The primary purpose of credentialing is to ensure that applicants meet the minimum requirements

for a requested status and to determine whether the applicant's credentials are appropriate for the requested privileges within the MCO. Laws, regulations and accreditation standards increasingly require MCOs to carry out the same level of credentialing that hospitals have long been required to carry out. Most MCOs now establish requirements that practitioners must meet to become members of their practitioner panels, and review the qualifications of applicants for panel membership against these requirements. Because MCOs typically handle many more applicants than most hospitals, the credentialing process must be done quickly and inexpensively. Many MCOs have found themselves changing the way in which they do credentialing to respond to the demands of the constant changes in the health care industry.

Credentialing can be a burden for any medical practice. In fact, many office managers say that completing health plan credentialing application requirements is one of their biggest administrative headaches.

To help ease this burden, the Council for Affordable Quality Healthcare, which represents the nation's leading health plans, networks and industry trade associations, has developed Universal Credentialing DataSource, a single, national process that eliminates the need for multiple credentialing applications. Providers complete one standardized online application to meet the needs of all participating health plans and other health care organizations. Periodic electronic updates raise the standard on quality and timeliness of data. Universal Credentialing DataSource has achieved support among health plans, providers, accrediting bodies and other stakeholders nationwide. Access [Universal Credentialing DataSource](#).

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## PHYSICIAN AUTHORIZATION NUMBERS

**1. National Provider Number (NPI)**—your standard unique identifier as a health care provider. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the adoption

of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of Medicare- and Medicaid-related health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System to assign these unique identifiers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA, including Medicare and Medicaid plan participation.

The NPI is a 10-position, intelligence-free numeric identifier (i.e., 10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. [Apply for your NPI](#).

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**2. Drug Enforcement Agency (DEA) number**—a series of numbers assigned to health care providers allowing them to write prescriptions for controlled substances. Legally, the DEA number is to be used solely for tracking controlled substances. However, the DEA number is often used by the industry as a general “prescriber” number that is a unique identifier for anyone who can legally prescribe medication. [Complete a new or renewal registration application](#).

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## HOSPITAL PRIVILEGES

Once in practice, you will need to obtain hospital privileges to admit patients to the hospital. Your hospital should have a privileging process that is fair and grants privileges based on documented training, experience and current clinical competence. Privileging based on any other factors is contrary to Joint Commission written standards. Each hospital's medical staff bylaws should describe the privileging process that is used. The Joint Commission recommends that hospitals develop

specific privileging criteria for most procedures and apply those criteria hospital wide. For example, criteria for electrocardiogram interpretation, pneumonia management or colonoscopy must be the same for all physicians in the hospital, regardless of departmental affiliation or specialty. There should not be one set of criteria for family physicians and another for internists. If your hospital does not have hospital wide criteria for the major procedures, work with your department and credentialing and executive committees to develop them.

Applying for hospital privileges is a process similar to many others that you have already gone through. Most hospitals will have a form for you to fill out. Details of your education and practice to date might be asked, including:

- Residency, fellowships
- Clinical positions
- Teaching positions
- Previous hospital privileges
- Any previous denial, suspension or revocation of privileges
- Any involvement in malpractice suits or medical school investigations

Items requested may include copies of your:

- MD degree
- Curriculum vitae
- Board certification documents
- State medical license

- Evidence of successful completion of advanced training
- Reference letters
- Recent photograph

Hospital privileges usually require approval by the medical staff and possibly others. Check with the hospital about how long you should expect this process to take and plan accordingly. If your request to obtain privileges has been denied, request a written explanation of your denial. Familiarize yourself with the hospital's appeals process and seek the support or assistance of colleagues.

### CONTINUING MEDICAL EDUCATION

After completion of graduate medical education, physicians are required to maintain competence in their field through participation in educational activities to improve their practice of medicine. These continuing medical education (CME) activities may include live events; enduring materials such as written publications, online programs, audio, video or other electronic media; journal-based CME; structured performance improvement CME; point of care CME; approved test-item writing; and manuscript review. Content for these programs is developed, reviewed and delivered by faculty who are experts in their areas. Similar to the process used in academic journals, any potentially conflicting financial relationships for faculty members must be both disclosed and resolved. Most states require a minimum number of CME credits for medical professionals to maintain their license.



## Disability Insurance

Physicians often pay attention to life insurance needs, but fail to consider the possibility of a debilitating incident. Statistically, however, a professional is far more likely to suffer a severe disability that damages the ability to work, rather than die prematurely. While some people have the financial resources to fund a disability on their own, most need disability income insurance to cover the risk.

Disability insurance planning has changed dramatically over the past decade, and the insurance industry is offering many options to help professionals protect their most valuable asset: the ability to earn an income.

### HOW POLICIES ARE OFFERED

Disability insurance can be purchased on an individual or group basis. Group insurance is usually provided by an employer or purchased individually through a sponsoring professional association. Individual insurance plans, on the other hand, are typically purchased through a local insurance agent and in some cases can now be purchased over the phone or through a company's Web site.

Most insurance companies will issue disability insurance coverage equal to approximately 60 percent of earned income. The most common



maximum monthly benefit currently available to professionals is \$15,000. However, some companies, depending on occupation, may allow a professional to purchase up to \$20,000 in coverage combined with group long-term disability insurance provided by the professional's employer.

### COST OF DISABILITY INSURANCE

Premium rates are based on factors such as the insured's age, gender, monthly benefit, optional riders and the insured's occupational classification. As a general rule, the younger the policy owner, the lower the cost. The occupational classification assigned to a medical specialty by the insurance company will also affect premium rates, as will the policy provisions made available to the insured.

### WHAT TO LOOK FOR IN A DISABILITY POLICY

The following provisions should be carefully considered when comparing disability insurance policies.

- **Definition of disability**—probably the most important aspect of a disability policy. Professionals must pay careful attention to the definition of disability found in their policies because it ultimately determines how any claim for benefits will be judged. There are three definitions of disability commonly found in the insurance industry, with significant differences between them.
- **Own-occupation**—also known as true or pure own-occupation, this is the most liberal definition of total disability available. It pays benefits if one is “not able to perform the material and substantial duties of [one’s] occupation.” An insured would collect full disability benefits if he or she could no longer work in his or her occupation, even if he or she decided to transition into another occupation, earning the same or more income prior to disability.
- **Modified own-occupation**—the most prevalent type of disability policy in the insurance industry and typically pays benefits if an insured is (emphasis added) “unable to perform the substantial and material duties of your occupation and not working.” Although benefits are still contingent upon the insured’s ability to work in an occupation, this definition will not allow an insured to continue receiving full disability benefits if working in another occupation.
- **Any occupation**—the most restrictive of the three total disability definitions and is often found in group or association policies. Under this definition, an insured is eligible to receive benefits only if found to be “unable to work in any occupation which you are reasonably suited to by your education, training or experience.” This determination is usually made by the insurance company, and professionals—being generally well-educated and well-trained—may find it very difficult to collect benefits under this type of policy.
- **Renewability provision**—a key feature of an individual disability income insurance policy. The provision defines an insured’s rights when it comes to keeping the disability policy in force. In general, a disability policy can be guaranteed renewable only, or both non-cancelable and guaranteed renewable.
- **Guaranteed renewable**—if a policy is guaranteed renewable only, the insurance company cannot cancel or change any provisions of the policy as long as the insured continues to pay premiums. In the event of poor claims experience, however, the insurance company does reserve the right to increase premiums, with state approval, for an entire class of policies.
- **Non-cancelable and guaranteed renewable**—if a policy is both non-cancelable and guaranteed renewable, the insurance company cannot cancel, change provisions or increase the premiums for the life of the policy. Such a policy is preferable because it provides insureds with an added level of security.
- **Residual disability rider**—unless a policy contains a residual disability rider, insureds may have to be totally disabled to collect any benefits. While

an own-occupation policy protects an insured's ability to work in his or her occupation, it may not sufficiently protect the insured's income level. Many disabilities might allow someone to continue working in his or her occupation, albeit on a limited basis while suffering a loss of income. Adding a residual disability rider to the policy would allow a disabled person to continue receiving benefits proportionate to the loss of income if he or she returned to his or her occupation on a part-time basis.

Furthermore, with policies such as modified own-occupation or any occupation, a residual disability rider might allow an insured to continue receiving benefits if working in another occupation, or if the insurance company determined that the insured could work in another "reasonable" occupation with reduced earnings. Generally, to qualify for residual disability benefits, one must experience an income loss of 20 percent or more (as compared to pre-disability earnings). Additionally, if the loss of earnings is greater than 75 or 80 percent, then, depending upon the rider's provisions, 100 percent of the monthly disability benefit might be paid.

## RECOVERY BENEFITS

Self-employed professionals whose incomes are based solely on the number of clients or patients they see must understand how recovery benefits work. While some policies have an unlimited recovery benefit built into the residual disability rider, others make the recovery benefit available as a separate rider.

Consider the example of a physician in a small group practice whose income is based solely on the business generated and number of patients seen. She had been totally disabled for one year, and after a full recovery she has returned to the small group practice. She can now perform all of her job duties and work the same number of hours as before.

However, the patients who had depended on her have gone elsewhere. Additionally, referral sources with whom she had built relationships had no choice but to refer clients elsewhere. Obviously, it would be difficult to take the business away from the

practitioner who had been providing these services during her disability.

As a result, rebuilding a practice and income level might take years. Without a recovery benefit, she would no longer qualify to collect any benefits at all. With an unlimited recovery benefit, however, the physician would continue to receive benefits until her income reached 81 percent or more of her pre-disability income. For a self-employed individual, this can mean the difference between surviving financially or not.

- **Cost of living adjustment (COLA) rider**—designed to help an insured's benefits keep pace with inflation after a disability has lasted for 12 months. The adjustment can be a flat percentage, or tied to the consumer price index (CPI). Ideally an insured wants a COLA that is adjusted annually on a compound-interest basis with a catch-up feature and no cap on the monthly benefit. This rider is important, but if reducing the cost of coverage is an issue, professionals should consider excluding it from a policy because it is expensive and would be a significant benefit only when a disability lasts several years. Because one cannot predict or choose the length of a disability, excluding this provision can be risky.
- **Future increase option rider**—offers the ability to increase an insured's disability coverage, regardless of future health, as income rises. It is important to know when coverage can be increased, as well as by what increments, on any given option date. Some companies may allow an insured to use the entire option in one year, as long as the insured's current income warrants the increase; others, however, may limit the amount that can be purchased based upon the original monthly benefit in place when the policy was purchased.
- **Tax implications**—according to IRC section 104(a)(3), personal disability insurance benefits are received free of income tax, provided that premiums are paid with post-tax dollars. If an employer provides coverage and takes a tax



deduction for the premiums paid on the insured employee's behalf, however, the benefits are taxable when received. This means that an employee could lose as much as half of the benefits when they are most needed. A better alternative would be for the employee to forgo the tax deduction, or for the employer to give the employee an annual bonus equal to the policy's premium. The employee will owe taxes on the bonus, but the employer will retain its tax deduction, and the insured employee's benefits remain untaxed.

- **Catastrophic disability rider (referred to as a CAT rider)**—this rider was introduced by many insurance companies to pay additional benefits if an insured is unable to perform two or more activities of daily living (ADL) without human standby assistance, or if the insured suffers a cognitive impairment or an irrevocable disability. The ADLs are bathing, dressing, eating, transferring, toileting and continence. This same definition of disability is often found in a long-term-care insurance policy. The CAT rider works well when the insured has already reached the maximum benefit level in traditional insurance policies and is still looking for relatively inexpensive ways to supplement coverage.

Take the example of a young professional who loses both legs in a car accident. He would meet the definition of disability if he were unable to perform the material and substantial duties of his occupation or is considered presumptively disabled. However, he does not require a physician or other skilled health care provider to take care of him—he simply needs help performing ADLs. As a result, this would not be covered by health insurance. The additional benefits of a CAT rider would pay for the cost of the caregiver and preserve the value of the insured's disability benefits to meet monthly expenses. Generally, this rider can provide up to \$8,000 a month in benefits, not to exceed 100 percent of the insured's prior monthly income, in addition to the monthly disability benefits under the policy.

- **Maximum monthly benefit**—someone who has an old policy with a future purchase option rider might be subject to the rules that applied at the time the policy was purchased. In such a case, the insured might be able to purchase coverage in excess of the maximum monthly benefit (typically \$15,000 per month). Other possibilities might be to supplement an existing individual policy with a group disability policy or to purchase additional disability policies that protect the insured's retirement plan contributions, overhead expenses or ownership interest in a practice.

## GROUP LONG-TERM DISABILITY INSURANCE

An individual whose employer makes group long-term disability (LTD) insurance available, or who is changing employers, may have the opportunity to supplement individual disability insurance coverage. Once purchased, an individual policy would not be affected by subsequently enrolling in a group LTD plan. If, however, an individual policy is not already at its maximum benefit level, this strategy might prohibit the insured from further increasing an individual policy.

## DISABILITY INSURANCE PROTECTION FOR RETIREMENT PLAN CONTRIBUTIONS

Group and individually owned disability insurance plans traditionally are designed only to replace a portion of the insured's current income, not to replace monthly contributions into company or individual defined-contribution retirement plans. Nevertheless, a few disability insurers have developed programs designed specifically to replace lost retirement savings.

One approach is to use an individual disability insurance policy that pays benefits into a trust set up specifically for the insured's benefit. If a disability occurs, monthly benefits are paid directly into the trust. The trustee, with input from the disabled individual, then invests the money in mutual funds or individual securities until the insured (the trust beneficiary) reaches age 65. At that point, the trust's assets are distributed to the individual to provide supplemental income for retirement.

Policy benefits and trust earnings are subject to the normal rules that govern the taxation of trusts and individual disability income insurance. Trust earnings are generally taxable to the insured as the beneficiary of the trust. As noted above, disability insurance policy benefits may be taxable or tax-free, depending on who paid the premiums.

## PROTECTING PROFESSIONAL PRACTICES AND PROFESSIONALS

To protect your practice and partners, the following policies should be considered.

- **Disability overhead expense insurance**—a professional responsible for some or all of the monthly expenses required to keep an office open should consider purchasing a business overhead expense (BOE) policy in addition to a disability policy. A BOE policy provides reimbursement for the expenses of operating a practice if one of the practice owners is sick or hurt and cannot work. These expenses may include staff salaries, rent or mortgage payments, utility bills, professional liability insurance premiums, and other fixed costs normal to the operation of a professional practice. In addition, some policies may even provide benefits for disabled professionals to hire a temporary replacement to fill in during a disability. This way, the practice's expenses are covered until the disabled partner returns to the practice or until the disabled partner's share in the practice can be sold. Premium payments for BOE insurance are tax-deductible as a reasonable and necessary business expense (Revenue Ruling 55-264, 1955-1 C.B. 11). Benefits received during disability, while taxable upon receipt, are used to pay practice-related expenses, which are tax-deductible. As such, the net tax result is a wash, meaning no taxes are owed by the practice on the money received from the policy.
- **Disability buyout insurance**—partners in a group practice will also want to consider a policy known as disability buyout (DBO) insurance, which is designed to help provide funds toward the purchase of a disabled partner's ownership interest if, due to a lengthy disability,

the individual is no longer capable of being a productive member of the practice.

Due to the specific skills each individual brings to a practice, attorneys often recommend a buy-sell agreement that details what is to occur upon the death, disability or retirement of each partner/owner. Having a proper buy-sell agreement in place before disability occurs can avoid the hard feelings and the conflicts of interest that often result from a partner's disability. The agreement should set forth the purchase price to be paid or should provide a formula for determining the price. Perhaps most important, the agreement must have a mechanism for providing the funds needed to make the purchase.

Furthermore, in conjunction with a disabled partner's individual disability income insurance and BOE insurance, a DBO policy will allow the business to continue to generate an income for the healthy partners, while a disabled partner is supported by the benefits from an individual disability policy. Any continuing share of business expenses is reimbursed by the disabled partner's BOE policy until the buyout is in effect. Premiums paid for DBO policies are generally not tax-deductible, whether paid by corporations, partnerships or individuals. The benefits, therefore, would not generally be subject to tax.

## PLANNING OPTIONS

Purchasing high-quality disability insurance has never been easy. Although the additional options available today create more flexibility, they also mean that the individual disability insurance marketplace has become even more complicated for professionals. Policies vary greatly in terms of the quality of the insurer, definitions offered, maximum benefit limits and premium rates. It is more important than ever for professionals to take the time to compare the contractual provisions of the policies under consideration and to understand how and why they differ. A professional insurance adviser or financial planner who specializes in working with physicians or other professionals will be familiar with which policies are best suited to the needs of an individual physician or the physician's practice.



## Medical Professional Liability Insurance

Purchasing professional liability insurance is one of the most important—and expensive—decisions you may make in your medical practice. The current environment of increased litigation makes this decision more important than ever. Before purchasing a policy, you should try to learn as much as possible about the types of coverage, carriers and other options that are available.

### INSURANCE—WHAT IS IT?

Insurance takes many forms but generally serves to provide security to those who purchase it in an attempt to provide predictability in uncertain

situations. Insurance makes dollars available to compensate for losses incurred from unpredictable or undesirable events. Insurance is one mechanism used to protect individuals and organizations against the risk of loss by distributing the burden of losses over a large number of individuals. Based on the law of averages, actuarial projected losses drive formulas for premium dollars that are then paid to contribute to the coverage reserves. These reserves are used to provide compensation for any member of the group who suffers from a defined loss.

**Medical Professional Liability Insurance (MPLI)** is purchased to protect a physician or health care

institution from the financial liabilities of practicing medicine. More specifically, it protects the physician from the consequences of a patient's claim that he or she was injured as a result of the physician's negligence. This insurance is purchased through a contractual agreement with an insurance company—called the policy—in exchange for a premium paid to the insurance company. Through this agreement, the insurance company agrees to financial responsibility for the defense and payment of claims against the policyholder (i.e., physician) up to a fixed ceiling of coverage (i.e., liability limit) for a specified length of time (i.e., the policy period). When physicians purchase insurance they **transfer risk** to the insurance company. That is, with the payment of premium dollars, they transfer responsibility for any claim against them and place the insurance company instead of themselves at risk for any dollars paid on claim defense or resolution.

In spreading the risk of loss, insurance companies seek to insure a broad group and collect appropriate premiums. In the case of MPLI, premiums are based on numerous issues including physician specialty, practice patterns, past claims history and geographical location. It is common for insurers to consider **experience ratings** of a physician based on claims experience, with higher premiums charged for physicians with greater claims experience. Premiums are calculated using complex formulations that consider how much the insurer believes it will have to pay in losses, when payments may be required, costs of business, desired financial margins and returns on invested premium dollars. A predictor of future claims is a history of past claims. Once collected, premium dollars are invested by the insurance company in order to generate additional reserve dollars and maximize investment income.

## TYPES OF COVERAGE

MPLI may be purchased in two forms: **occurrence** or **claims-made**. Where an occurrence policy covers acts of negligence that occurred while the policy was in effect (regardless of when the claim may be filed), claims-made policies cover claims reported against physicians while the policy was in effect (regardless of when the negligent act occurred). Occurrence policies are much less common and

more expensive because events that occurred while the policy was in effect will be covered, even after the policy period has ended. Rates for occurrence may vary significantly because they are based on actuarial projections of the cost of future claims and do not take into account current experience.

A claims-made policy is the most common type of MPLI coverage currently carried by physicians. The premium for a claims-made policy may initially be small, because patients usually do not sue for malpractice for at least a year after an alleged act of negligence has occurred. After the first year of a claims-made policy, premiums may increase incrementally, accounting for the risk of lawsuits spanning each year the policy is in effect, until a mature premium is reached. If a physician terminates a claims-made policy, he or she may purchase **extended reporting endorsement coverage**, or **tail coverage**, allowing the physician to continue reporting claims related to negligent acts that occurred during the years he or she was insured under the original policy. Although expensive, tail coverage may be well worth the investment if you change insurers, move to a different state or stop practicing. Some policies include provisions for free or prepaid tail coverage in the event of death, disability or retirement. Alternatively, physicians may be able to obtain nose coverage from their new carrier, which covers the physicians for incidents that occurred before the inception of the new policy.

A variation on claims-made coverage is a claims-paid policy. Under claims-paid coverage, all the events associated with a claim—the triggering incident, the filing of a lawsuit, the reporting of the suit to the insurer, and the final resolution or settlement of the claim—must occur while the policy is in effect (usually a 12-month period). Although it is inexpensive, claims-paid coverage can be risky. If a claim is not settled during the term of the claims-paid policy, the insurer may look for a legitimate reason to refuse coverage or to refuse to renew the policy.

## COVERAGE AND LIABILITY LIMITS

Limits are provided in accordance with the stipulated terms and conditions of the policy. You



will need to ascertain whether the state, hospital or managed care plan with which you may be associated requires a specific coverage limit.

### Exclusions

Every medical liability insurance policy has an exclusions section, which sets out specific circumstances under which coverage will not apply. Such circumstances may include liability assumed by contractual agreements with managed care organizations (MCOs), actions by employees of the medical practice other than the physician, practicing outside of certain standards of care and others. It is important to understand what is covered and what is excluded. The following are some exclusions you may encounter.

- **Hold-harmless clause**—some MCOs require physicians to agree to hold the company harmless if it is sued by a patient because of the physician's alleged actions or failure to act. Many policies, however, exclude coverage for liability a physician assumes by contract. A physician who agrees to a hold-harmless clause may be forced, in the event of a lawsuit against an MCO, to assume liability not only for his or her own defense costs (and, possibly, monetary settlements and judgments) but also for those of the MCO. Because the MPLI policy may or may not specifically mention the term hold harmless, it is important to carefully review the exclusions section in the policy to ensure that there is no gap in coverage. Ask your carrier whether you will be protected if you sign a hold-harmless clause or whether this restriction can be waived.
- **Defense costs**—these include the fees of the attorney hired by the medical liability insurer to defend a claim, the fees of expert witnesses, as well as court reporters' fees and clerical expenses. Not all policies fully cover defense costs, and those that do sometimes place a limit on such costs. In this case, the physician is responsible for costs that exceed the policy's limit. Other policies require a deductible amount to be paid by the insured physician, in which case the MPLI insurer pays only the amount exceeding the deductible. Be sure your policy adequately covers defense costs. Defense costs

that are subject to a deductible or are capped can be costly for a physician. In the event of a lawsuit, be sure to review defense costs carefully.

- **Vicarious liability**—a policy may also exclude vicarious liability, which arises from the actions of a third party (such as a physician's employees). For example, an employed laboratory technician's labeling error may result in treatment that harms a patient, resulting in a lawsuit against the physician for the employee's error. If the physician's policy excludes vicarious liability, the physician may be liable for defense costs or any damages awarded. Some policies provide coverage for the actions of employees other than allied health practitioners. If requested, some insurers may add coverage for vicarious liability for an additional premium. Examine your policy carefully to ascertain who in your practice is not covered, and purchase vicarious liability coverage as necessary.
- **Mandated standards of care**—in some MPLI policies, physicians are required to adhere to certain standards of practice. Such mandated standards may include, for example, requiring the use of only board-certified anesthesiologists rather than certified registered nurse anesthetists or use of certain equipment. Although it is important to abide by your MPLI policy, it also is vital to be aware of any mandated standards of care before you agree to it. Be sure that any mandated standards of care in your policy do not restrict your practice style or significantly increase overhead expenses.

### Other exclusions

Most policies exclude coverage for claims arising from the following factors:

- Sexual misconduct
- Practicing under the influence of alcohol or illegal drugs
- Antitrust violations
- Criminal or grossly negligent acts
- Libel or slander

- Practices for which you have not received credentials
- Newly developed or experimental procedures
- New drugs still under investigation
- Accidental injury of an assistant during a medical procedure
- Violations of patient confidentiality
- Failure of medical devices
- Inadequate quality control of medications

Physicians should be aware that not all MPLI insurance is the same. It is important to understand what is covered under the policy and what is excluded. Some policies only cover direct patient care and exclude care outside of geographical boundaries (i.e., state or nation). Some policies allow for coverage in work-related activities such as emergency medical service (EMS) supervision, committee work or peer review. Some insurance may assist with legal expenses related to adverse actions against the physician's credentials or license. Many physicians desire coverage for activities outside of direct patient care, such as supervising residents, providing community services for events, or while serving as an event physician or a good Samaritan. In the current litigious environment, with insurers sensitive to high-risk exposures to litigation, it is best to ensure associated activities are covered through a policy by having a letter stipulating the activity is covered under the policy. Often it is necessary, and safest, for the physicians to have the event's sponsor provide the physician coverage.

### SETTLEMENT CLAUSES

Any settlement of a case can adversely affect a physician's insurance status and ability to participate in an MCO. Yet the decision to settle, rather than contest, a lawsuit often is not up to the insured physician. The MPLI can provide various degrees of control over whether, how and when to settle a dispute. These issues may be addressed by options written into the policy, such as the following:

- **Right to consent to settlement**—some MPLI insurance policies contain a clause guaranteeing the physician's right to consent to settlement.

If this clause is absent from the policy, the insurer can settle a case against the physician's wishes, even if the physician is blameless. Disagreements between the physician and the insurer concerning settlement are sometimes referred to a committee for resolution, in which case the insurer usually evaluates the case and determines an appropriate settlement figure.

- **Hammer clause**—instead of a right-to-consent-to-settlement clause, a policy may contain a hammer clause. This clause takes effect in the event that a physician refuses an insurer's settlement recommendation and an ensuing trial results in a higher award. Under a hammer clause, the insured physician is required to pay the amount exceeding the insurer's original settlement recommendation.

### TYPES OF INSURANCE CARRIERS

There is considerable variability among medical liability insurance companies. Different companies are legally structured to provide an array of services by offering products with varying benefits and costs. These are marketed and sold to physicians directly by company representatives (i.e., agents). Insurance agents are often the first contact in purchasing insurance. The agent acts on behalf of the MPLI insurer and solicits purchasers of insurance. However, an agent for an insurance company is different from a broker. A broker acts as the agent for the insured and assists the purchaser in determining the policy best suited to the purchaser's needs. An agent of the insurance company typically has the authority to bind the company to policies, to accept payments on behalf of the company and to represent the interests of the company in other authorized ways when dealing with the insured.

All insurance carriers operate on the principle of distributing, or **pooling**, risk. They may be owned or sponsored by commercial enterprises, physician groups, state medical societies or self-insuring organizations. Insurers also vary in terms of how they are organized, who owns or controls them, their financial stability, and whether and how they



are regulated by state laws. The following describe the structures and potential advantages and disadvantages of medical liability insurance carriers.

- **Commercial carrier**—the most commonly known medical liability insurers, commercial carriers have been known as traditional line companies that offer numerous lines of insurance, including MPLI. These carriers are typically regulated, in various degrees, by state insurance departments. Commercial carriers are typically large companies and have traditionally offered better rates, since their volumes were higher; been safer because they typically have higher reserve accounts to protect the insured against large judgments and awards; and have been able to transfer policies between states, allowing flexibility for the provider who might choose to change practice locations.

A drawback of commercial carriers is that most are for-profit organizations whose primary directive is to make a profit for stockholders. Multi-line companies tend to view MPLI as a product line with great fluctuations and high risk. Like any profit-making business, commercial carriers may increase rates according to market demands or pull out of a market if it becomes unprofitable. Because of their large financial reserves, big companies can generally do this more easily than smaller organizations. Large commercial carriers also may exert more control over defense strategies and settlement decisions than a smaller company.

- **Captive insurance company**—a wholly owned subsidiary of an association or group (e.g., a university hospital, a physician group or a medical association). Unlike a commercial carrier, a captive company is formed with the express purpose of insuring the association or group that has formed it. Since captives do not have to make a profit, premium rates can be adjusted to claims experiences and actual expenses. Many physicians choose captive companies because they are owned and directed by health care professionals, who are more likely to understand and be supportive of their colleagues' professional problems than are commercial

carriers. Captive companies also may afford the insured greater input into decisions concerning defense strategies and settlements.

Some captive companies, however, may not be as financially stable as their commercial counterparts. Because captive companies generally cover fewer policyholders, their distribution of risk is spread over a smaller population. This increases the risk of failure if the income from premiums is too low to cover expenses or if the company sustains losses that are higher than expected. Also, these companies are not typically protected by state guaranty funds.

Beware of captive companies domiciled in offshore sites. Initially, many captive companies were formed in locations such as the Caribbean Islands to take advantage of tax breaks and relaxed regulations. Be sure you know who formed and operates a captive company before signing on.

- **Mutual insurance company**—set up as a cooperative activity by a group of people who share in the profits and losses of the business. This type of insurance company has no stockholders or capital stock. Size and financial stability can vary.
- **Risk-retention group (RRG)**—a nonprofit, self-insuring corporation or association formed for the sole purpose of providing insurance coverage to members or shareholders. An RRG must be owned by its members, or by a company that in turn is owned by its members, who contribute capital to the group. RRGs are incorporated and licensed in at least one state and are subject to the insurance regulations of that state. Once licensed in a particular state, an RRG may provide coverage to members in any other state and only has to abide by the regulations of its home state.

The premiums offered by RRGs may be lower than those of other insurers. However, RRGs are not covered by state guaranty funds and, like insurance trusts, they may increase member premiums if losses are higher than expected.

- **Risk-purchasing group (RPG)**—a group of individuals or entities with similar or related liability risks that forms an organization to purchase liability insurance coverage on a group basis. It is not an insurance company. The group does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state. The RPG can take many forms, and states cannot impose a specific structure on an RPG so it operates more freely than an RRG. Many state protections afforded to other insurance vehicles are not applicable to RPGs, and, therefore, the financial viability of the insurance product must be carefully researched.
- **Insurance trust**—a legal entity that provides another way of spreading risk among policyholders. Medical liability trusts administer insurance programs on behalf of members. These companies may operate without the large cash reserve that is required of other carriers. For these reasons, trusts may have the advantage of lower premiums and operating costs.

Members of a trust place their personal assets on the line if claims exceed the funds available to pay them. This means that the trust may assess its members for additional payments—more than the cost of their premiums—if losses are higher than expected. Because they are typically regulated through the state’s department of corporations rather than the department of insurance, trusts are not protected by state guaranty funds. Trusts also generally have more stringent requirements for joining than do traditional companies, because of the higher risk involved in operating without a large reserve.

- **Physician-owned company**—such companies have proliferated in recent decades. Like other insurance carriers, these companies also may be formed as trusts, captive companies, mutuals, risk-retention groups or profit-making corporations. Many physician-owned companies are sponsored by state medical societies, and most are regulated under state insurance laws in the states where they were formed. Physician-owned insurance companies tend to be sympathetic to and supportive of the

professional problems of physicians, and they typically will defend them vigorously in the event of a lawsuit. This makes physician-owned carriers an appealing choice for physicians who wish to have a greater say in claims decisions than that afforded by commercial companies. Disadvantages of physician-owned companies include the fact that they generally provide coverage in only one state. However, with the continuing consolidation of the physician-owned medical liability insurance industry, a number of these companies are now licensed and offer coverage in several states. Physicians who move to another state or who practice in more than one state should determine whether they need to purchase additional coverage.

- **Joint underwriting association (JUA)**—the name for nonprofit risk-pooling associations that were created by many state legislatures in response to the insurance availability crisis of the 1970s. JUAs are operated as a branch of state government and have appropriated funds to ensure that insurance will be available. JUAs operate by charging premiums for operating expenses and indemnity obligations but allow additional premium contingency assessment if a deficit is experienced. Therefore, retroactive adjustments may be charged to individuals. Often the JUA may not reject applicants and must accept even higher claims histories. This can result in a rise in premiums across the board and has led to the insolvency of some JUAs, particularly during times when other insurance products are more affordable and predictable.

## THE BOTTOM LINE

Before choosing an insurance carrier and purchasing a policy, you should investigate the company’s background, reputation and services. *The American Professional Agency, Inc.* provides medical malpractice coverage exclusively for APA members. If you’d like to inquire about the coverage they offer, their toll-free number is 800-421-6694.

Independent insurance consultants (who are neither agents nor brokers) may also offer helpful advice, counseling and assistance in negotiations with insurers.



## Weighing Options: Medical Practice Startup, Purchase or Buy-In

### STARTING A PRACTICE—12 BASIC TIPS

Starting a practice is complex and can consist of many variables. The following 12 tips provide important points to consider when starting a practice:

- 1.** First, decide where you want to live. You may be there a long time, so you want to enjoy your limited free hours. You can make money almost anywhere. Most people find themselves most comfortable in situations similar to what they experienced in childhood (e.g., urban, suburban or rural, semitropical or desert).
- 2.** Ask whether anyone wants to sell their practice to you. You may get lucky. Buying a practice at the right price can be an excellent investment. Don't buy or buy into a practice without a professional valuation. Starting a practice, buying a practice or joining a group usually costs around the same amount of money, either in reduced income or startup costs.
- 3.** Drive around the hospital neighborhoods and identify the medical office buildings. Look for "office for rent" signs. Too many or none may indicate a problem. Find out what the problem

is by asking the hospital administrator, chief of staff or other local physicians.

4. Be cautious about hospital income guarantees (forgivable loans) if offered. They differ widely and may or may not be a good deal for your individual situation.
5. Rent—don't build or buy—an office if at all possible. If you want a nicer office than is currently available, one will probably become available if you are patient. You may be able to get a month-to-month tenancy to start, or a sublet. If you are buying a practice, don't move it for at least one year.
6. Rent housing the first year, so you get to know the neighborhoods and the market. Alternatively, buy a modest house or condo needing minimal maintenance in a modest neighborhood with easy resale. You will be too busy your first year to enjoy your house, won't have time to do maintenance, and in a year or two you will probably be able to afford a better house anyway.
7. There are lenders that specialize in medical practice purchase and startup and that offer up to 100 percent financing, including living expenses for up to a year. Seek them out to save yourself hassle.
8. Hire the best staff you can find, one that knows more about running a practice—and has more experience—than you do. You will spend more waking hours with your staff than with your family.
9. Become a master at International Classification of Diseases, Clinical Modification (most commonly known by the abbreviation ICD) and Current Procedural Terminology (CPT®) coding, and teach the topic to your peers. That knowledge is the best investment you can make, and it will keep your name out of the newspapers and you out of jail.
10. If this is your first practice, and you are coming out of residency or fellowship, you will be

experiencing the biggest personal economic change of your life. Plan your budget to live on no more than 75 percent of your after-tax income. It's how much money you keep, not how much you make, that counts! Fund your retirement plan through withholds from day one so you won't be tempted to use it for other things.

11. Get good advice from a medical-specialist consultant, certified public accountant and an attorney. Ideally, practice startup is something you will only need to do once, so do it right the first time.

### CONSIDERING YOUR OPTIONS

Many physicians decide to start their own practice, not just new physicians fresh out of residency or fellowship. Some are early-career physicians who decide they made a mistake in choosing an employer or a location in which to practice, or who found that the position they were planning on evaporated. Some planned from the beginning to work for someone else until they were more comfortable with their clinical and business skills before going out on their own. Some are midcareer doctors whose groups broke up, or those whose groups are acquired by a bigger group with whom they find they disagree. Some divorce from their marital/practice partners, have a midlife crisis or relocate to follow a new spouse. Others leave their current situations to form new groups. Even senior physicians sometimes find themselves in a situation where going independent is the “lesser of the evils” they face prior to retirement in a few years.

There are quite a few resources available to the physician starting solo practice. The APA has created resources on [starting a private practice](#). Some medical societies also sponsor annual practice management symposia around the country with applicable content. Private consultants, most of whom are members of the [National Society of Certified Healthcare Business Consultants](#), offer personalized guidance and support. There are lenders with special financing programs available for startups. Plenty of books also have been written on various aspects of private practice applicable



to startups, including marketing, staffing, coding, computerization and systems.

*(This link will take you off the APA website. The APA is not responsible for the content of other websites.)*

These resources can be combined to satisfy virtually any startup situation; moreover, this section of the guide provides the basics to assist you with a startup practice.

### WHERE IS THE RIGHT LOCATION?

There is no magic city that will ensure success. The best place to start a practice is where you want to spend the rest of your life outside of practice. In other words, when you leave the office at the end of your day, lock the door and turn around to face the world, you should be where you want to live irrespective of economics and income. Most places in the United States are in need of psychiatrist.

Therefore, why not open where you want to live, or live where you would otherwise want to vacation? Even those locations that might be considered grossly over-doctored probably will have a niche community that would work within less than an hour's drive.

This is not to suggest you make a radical, untested change. If you grew up in Florida and have always had an interest in Alaska, then take a job for a year before investing in a startup, just in case you didn't realize what 22 degrees below zero in February really feels like with only two to three hours of semi-daylight day after day. A very high percentage of doctors end up in practice either near or where they grew up, near family, or in an environment (e.g., urban, suburban or rural) they have become accustomed to. If you vary from one of those environments, and if there is a question as to whether you will like your locale, you may want to rent an office and home for the first few years rather than buying or building one, just in case you end up moving.

It is also advisable to do your own research of community need rather than just buying a demographic survey. Check with medical offices in your specialty to find out the wait for a new appointment. Patients like to be seen within a week

of calling for an appointment. For every two weeks of wait, there is room for approximately one more physician. If the only physician in town has a two-week wait, then adding another physician would likely result in two physicians having a one-week wait. If all three physicians in a community each have a four-week wait, then there is likely room for six to nine more physicians.

### START OR BUY AN EXISTING PRACTICE?

The answer depends on the price of an available practice for sale. It is less expensive to buy a practice at or below fair market value (FMV) than to start your own, but it is less expensive to start a practice from scratch than to overpay for a purchase. Both scenarios not only compete with each other but also balance each other out financially, which is what keeps FMV fair.

When buying a practice, the purchase price gives you the advantage of quicker cash flow, fewer marketing expenses and less work to assemble the components of the practice. On the other hand, a purchased practice may have features or pitfalls you may avoid if starting from scratch. Perhaps the lease is too short or the hospital is moving across town.

When starting a practice, you may have to spend a substantial amount of time getting everything assembled, obtaining financing to build and outfit the office, spend money on marketing to let referrers and patients know you are there, then wait the lag time until accounts receivable and patient traffic builds up to give you cash flow. A new doctor should give serious thought to which scenario would be most cost-effective, which is part of what holds down the price of practices for sale. In fact, it might be worthwhile to a physician starting a practice to ask the older doctors in the community whether they might be interested in selling their practices. Buying a practice at the right price could be a very economical way of starting your own practice. There are specialist medical practice appraisers available to calculate the FMV so both parties have confidence in a value that is fair to both parties. Read more on this specific topic in the *Medical practice valuation for purchase* or buy-in section of this guide.

## FORMING OR JOINING A PARTNERSHIP

Another variation in starting a practice is to form or join a partnership. When done correctly, this strategy can give the new doctor a lot of independence in practice, some of the benefits of being in a group, and the ability to share in some ancillary services. Other benefits can include separate retirement plans, centralized administration, shared and more-expert billing, shared electronic health care records, less staffing hassles, etc. If you are considering joining an established organization, you must critically examine the established entity. From many perspectives (e.g., operating policies and administration, governance, compensation, benefits, risk and insurance) the assistance of skilled tax and legal advice is strongly encouraged.

Surprisingly, some partnerships are not set up correctly, which can lead to a lot of trouble later if there is a professional-liability incident, a

disagreement over operational issues, or in the event of the death or withdraw of another member of the partnership.

One of the most common mistakes physicians make is to worry about the wrong things, or establishing priorities incorrectly. Enormous amounts of time can be saved by either getting a consultant or reading one or more of the startup books in advance. For example, worrying about office design and layout before even deciding where to locate, and whether to have a midlevel provider or partner, makes little sense.

In summary, there are many ways to start a medical career. First decide where you would like to practice, research community need, then look around for available options and support resources. One way or another, with a little bit of thought and planning you will greatly enhance your likelihood of success.

*(Written by Keith Borglum who is a licensed health care practice broker, appraiser and practice management consultant nationwide.)*





## What is Integrated Care

To view a video titled “Integrated Care: connecting the body and the brain” go this [APA website](#).

The following is the definition given by the Agency for Healthcare Quality and Research in *Lexicon for Behavioral Health and Primary Care Integration* (concept and definition developed by expert consensus):

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address

mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”

Integrated or collaborative care is the coordination of care for patients who have psychiatric disorders, which includes substance use disorders, and general medical illness. There is a higher rate of psychiatric illness in patients with chronic medical illness, and a higher rate of chronic medical illness among patients, with psychiatric illness, especially with serious and persistent mental illness. Patients with these conditions have increased morbidity and mortality and

are costly, but because of the way our service systems have evolved over time, the prevailing tendency has been to treat medical and psychiatric illness as if they occur in different domains. That simply is not true from the standpoint of patients, and if we are going to have patient-centered care, it needs to encompass all of their needs.

—Paul Summergrad, M.D.

What are the predominant models of integrated care? In the primary care setting, the model with the most robust evidence base is *IMPACT* (Improving Mood—Providing Access to Collaborative Treatment), which was developed by Jürgen Unützer, M.D., Wayne Katon, M.D., and colleagues at the University of Washington. The patient’s primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy). *IMPACT* care managers use the PHQ-9 to screen for symptoms of depression at the start of a patient’s treatment and regularly thereafter. Psychiatrists serve as expert consultants to the patient and care team. Treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm. A number of organizations in the United States and abroad have adapted and implemented the *IMPACT* program with diverse patient populations. See *Psychiatric News* for more information.

In the public mental health setting, there are several models being tested to improve health in the SMI population. The PCARE (Primary Care Access, Referral, and Evaluation) model, developed by Benjamin Druss, M.D., and colleagues at Emory University, employs a medical nurse-care manager to provide education and care coordination to help patients with serious and persistent mental illness engage in primary care. In the PCARE study, care managers provided communication and advocacy with medical providers, health education, and support in overcoming system-level fragmentation and barriers to primary medical care. At a 12-month follow-up evaluation, the intervention group received an average of 58.7% of recommended preventive services, compared with a rate of 21.8% in the usual-care group. They also received a significantly higher proportion of evidence-based services for cardiometabolic conditions and were more likely

to have a primary care provider. See the *American Journal of Psychiatry* for more information.

New York State, among others, has implemented clinical quality improvement efforts that emphasize integrated approaches, including improved standards for screening and monitoring general medical conditions among individuals with serious mental illness; incentives for integration between behavioral and general medical providers; and redesign of state financing, licensing, and regulatory policies. For a description of these efforts, see *Psychiatric Services*.

The Substance Abuse and Mental Health Services Administration has 93 grantee sites providing services in the Primary and Behavioral Health Care Integration (PBHCI) Program. Through this program, SAMHSA provides support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings. For descriptions of models around the country funded by the PBHCI program, [click here](#).

A number of states are developing behavioral health homes—a behavioral health agency that serves as a health home for people with mental illness, including substance use disorders—as a Medicaid waiver option under the Affordable Care Act. For more information, [click here](#).

## WHY IS INTEGRATED CARE IMPORTANT FOR PSYCHIATRISTS AND THEIR PATIENTS?

It is important because it speaks to the care and well-being of people for whom we have clinical responsibility. It speaks directly to our ethical and professional responsibilities. Independent of any other consideration, it is the right thing to do to improve the care and quality of life for people we take care of.

There is a growing body of evidence to indicate that people with serious psychiatric and substance abuse illnesses are more medically compromised than people who don’t have these disorders and they have a shorter lifespan. Suicide is an important contributor, but so are the ravages of both medical and psychiatric illness. There is also evidence that the total cost of care is greater, and the cost of

general medical care is greater, often because it is often unconnected to a comprehensive care system for patients' total psychiatric and other medical needs. We cannot improve the quality of patient care, improve patients' experience of care, and reduce the total cost of care—if we ignore psychiatric and substance abuse disorders. It's not just a matter of integrating systems into one venue, but changing the way we think about mental illness and substance use disorders. Behavioral care is central to the management of all illness. All of this speaks to the unique expertise that psychiatric physicians bring to patient care.

—Paul Summergrad, M.D.

In this audio interview, Dr. Summergrad summarizes the importance of integrated care to psychiatry. Psychiatrists need to make themselves relevant in the health care reform arena. It is well known that psychiatric comorbidity contributes to poor outcomes and increased cost. It is also a given that we do not have enough psychiatrists to cover current needs, and so we need to leverage the expertise we have in different ways. By implementing population-based care models such as IMPACT (see “Other Resources” at end of newsletter), we can assist primary care in better identification and treatment of mental illness by acting as consultants and performing caseload-based registry reviews, guiding the process primarily from behind the scenes. This conveys a new sense of importance to our profession as it allows us to better meet the needs of the larger population.

—Lori Raney, M.D.

### HOW WILL I GET PAID?

Payment for services has been identified as one of the barriers to the implementation of evidence-based collaborative care programs. Large-scale implementations of collaborative care use a number of different payment approaches ranging from fully capitated payment (for example, Kaiser Permanente, VA, Department of Defense) to case-rate payments (for example, in Minnesota's Diamond Program) that cover the costs of primary-based care managers and consulting psychiatrists. In the Washington Mental

Health Integration Program, a health plan provides direct payments for the psychiatric caseload reviews and consultations based on the number of clinics, caseloads, and care managers supported by the psychiatric consultant. Traditional fee-for-service payment arrangements do not yet pay for psychiatric consultation and case reviews that do not involve direct patient contact, but several health care systems pay for such services similarly to the way that they cover liaison psychiatry services. This kind of systematic caseload-focused psychiatric consultation may become increasingly relevant as health care organizations develop patient-centered medical homes and accountable care organizations that are charged with providing comprehensive care for defined populations of patients who often have limited access to or use of traditional mental health services.

—Jürgen Unützer, M.D.

### WHAT ABOUT LIABILITY FOR INFORMAL CONSULTATION?

The issue of liability in integrated settings can be considered along two lines. The first is whether a doctor-patient relationship is established. Legally, this is usually determined by whether there is direct evaluation of a patient (in person or by televideo) and subsequent documentation of findings. Indirect or “curbside” consultations do not establish a doctor-patient relationship, so involve minimal liability. An additional area of consultation in collaborative settings in primary care is between the consulting psychiatrist and the behavioral health provider. Liability in this situation can depend on the role of the psychiatrist, which can range from consultative to collaborative to supervisory. Liability is increased if you are the supervisor of the behavioral health provider and are ultimately responsible for the care provided.

The primary care provider retains overall responsibility for the patient and may choose to use the consultant psychiatrist's advice or not. The PCPs also write all orders based on the consultations — not the psychiatrist, who is just in the consultation role.

—Lori Raney, M.D.

### **WILL I STILL BE ABLE TO PROVIDE PSYCHOTHERAPY IN A PRIVATE PRACTICE SETTING OR WILL I BE ABLE TO WORK ONLY IN INTEGRATED SETTINGS?**

Yes, you can still do psychotherapy and maintain a private practice. Working in integrated settings is often an additional job, and much of the work does not have to be on site in the medical setting. For example, a psychiatrist working full time could choose to work in his or her private practice 24 hours a week and be the consultant psychiatrist for a primary care clinic 16 hours a week. These roles would overlap to the extent the psychiatrist wants to be accessible to the primary care team; he or she would need to adjust his or her schedule to return phone calls in a timely manner, perform caseload review with the behavioral health provider, and potentially conduct on site visits to provide education to the team on various topics.

—Lori Raney, M.D.

### **WILL I NEED TO HAVE AN ELECTRONIC MEDICAL RECORD (EMR) SYSTEM TO PARTICIPATE?**

You do not need your own personal EMR to do this work; however, if the primary care clinic has an EMR system, you may need to enter documentation in that EMR system, many of these systems can be accessed through the Internet. The [SAMHSA-HRSA Center for Integrated Health Solutions](#) has an excellent section on HIPAA/privacy in integrated settings and other information-technology issues around integrated care (see “Other Resources” at end of newsletter). EMRs in primary care settings are used to collect aggregate data (in databases called “registries”), and regular review of these data by the consulting psychiatrist is important because they can be used to discover care gaps and adjust treatment. Although spreadsheets can accomplish this, use of the registry feature of an EMR is the data-gathering choice of the near future.

—Lori Raney, M.D.

### **TO WHAT EXTENT WILL I BE RESPONSIBLE FOR THE MEDICAL CARE OF PSYCHIATRIC PATIENTS?**

Psychiatrists are responsible for “not making people sicker” and have a responsibility to minimize the risk of medications such as second-generation antipsychotics by choosing those with less cardiovascular disease risk when possible, as this is the major driver of early mortality in the SMI population. There is a responsibility (and current standard of care) to screen all patients for the iatrogenic effects of these medications including monitoring BMI changes, blood pressure, cholesterol, and blood sugar. Psychiatrists are medically trained and have the skills needed to counsel their patients about lifestyle interventions to reduce risk of cardiovascular disease, including smoking cessation. Given the numerous barriers to obtaining primary care, and the continued early mortality despite our efforts, there is a growing movement for psychiatrists to treat some common medical problems such as dyslipidemias, hypertension, and diabetes. This will require appropriate retraining, use of algorithms, and back-up PCP consultation to be effective and address the liability that will come with this change in scope of practice. In some models, primary care providers are now acting in the role of consultant to the psychiatrist, reflecting a kind of flip side of the consultation we provide for them in primary care—a reciprocal relationship. Finally, psychiatrists, by virtue of their training in the full range of medicine, are in a unique position to lead teams in public mental health settings to address this health disparity in the SMI population. From the behavioral homes funded through the Accountable Care Act State Plan amendments and other initiatives, psychiatrists should seek and welcome opportunities to head these initiatives to improve the quality of life and lifespan of the SMI population.

—Lori Raney, M.D.

## WHAT NEW SKILLS WILL I NEED, AND WHERE CAN I GET TRAINED?

Psychiatrists need to know the models of integrated/ collaborative care and the role that psychiatrists play in them. They need to understand the importance of population health and how a collaborative care team might use data to monitor the health status and medical utilization patterns of a defined population of patients.

Psychiatrists who want to work in integrated care settings need to enhance their understanding of common chronic medical conditions. This does not mean that psychiatrists would necessarily be directly treating hypertension or diabetes, but they should be comfortable consulting with primary care and other specialists about these conditions.

Emerging integrated care models also need clinicians with leadership skills. Psychiatrists are in a unique position to lead these teams because they have training in general medical and psychiatric care.

The *AIMS Center* at the University of Washington offers individual and group-based learning in in-person and online formats.

Next year American Psychiatric Publishing Inc. will publish *The Psychiatrist's Guide to Integrated Care*, edited by Lori Raney, M.D.

Each year at APA's *Annual Meeting* and at the *Institute on Psychiatric Services*, a special "Integrated Care Track" provides training symposia on a wide range of integrated care topics.

## IS WORKING IN INTEGRATED SETTINGS PROFESSIONALLY REWARDING?

There are many psychiatrists across the country who have been working in a variety collaborative care models (both in primary care and public mental health settings) for the past several years. Their experience in this work is a nice alternative from the hamster wheel of 15-minute "med checks." It is really rewarding to extend psychiatric expertise across a much larger population of patients, knowing you can reach patients who had not been in treatment or were getting ineffective care. They can get effective treatment through a model that allows you to review the care they are receiving and offer timely suggestions to adjust treatment. For those working in bringing primary care to the seriously mentally ill population, the collaboration with primary care is helping to raise psychiatrists' comfort level with general medical skills, and these patients are beginning to show signs that their health status can be improved. Many psychiatrists report these experiences as not only professionally rewarding but also "fun." If we can show medical students and residents how exciting this work can be, then maybe we can recruit more to join us in this effort.

—Lori Raney, M.D.

Source: *Psychiatric News*, Volume 48, Number 18





## Medical Practice Valuation for Purchase or Buy-In

### WHY VALUE A MEDICAL PRACTICE?

There are many reasons to value a medical practice, including but not limited to:

- Sale or dissolution
- Consolidation with another practice or a hospital
- Buy-in of a new partner or payout to a retiring partner
- Divorce
- Insurance and estate planning
- Damages in litigation
- Curiosity

### THE QUESTION OF VALUE

Medical practices can have different values for different reasons. You should know in advance that there is no perfectly accurate answer when it comes to the value of a medical practice; appraisers can only offer their opinions. This isn't to say you can't come up with an opinion of value that will be useful and/or acceptable to a third party.

However, people can differ on their opinions of value based on their different assumptions. The same practice might have a different value depending



on the motivation of the seller and the percentage offered for sale. Consequently, “value” is an opinion that should not to be confused with a “price,” which is negotiated between two specific parties, each with their own unique situations and needs.

### **ASSUMPTIONS ARE ESSENTIAL**

Valuation experts commonly disagree because of the differing assumptions they use to determine value. The methodology of a valuation should be clear in the narrative text of the appraisal. Professional appraisers will lay out for a reader exactly how they came to their opinion so any non-expert reader can follow the assumptions, reasoning and mathematics employed. An example of an important assumption is whether Medicare and other insurance reimbursement will go up or down in the future.

### **PITFALLS OF SELF-VALUATION**

Most business owners are proud of their businesses. They have spent years of “blood, sweat and tears” building it up, and believe there is much value to that effort. The success of the business may be a large part of the owner’s ego. Therefore, most owners will value their practice higher than the market does, as represented by knowledgeable buyers. On the other hand, some physicians have the belief that medical practices no longer have value. Neither opinion is based on fact. The real answer to whether a practice has value is “it depends.” How much a practice is worth is what the topic of valuation is about.

### **THE COMPETENCE OF APPRAISERS**

Medical practice valuation is typically not a licensed activity, like medical practice brokerage in most states or even real estate valuation. It is important to ascertain that the appraiser whose opinion you are seeking and relying upon has actual experience in valuing a medical practice. Applying generalized valuation formulas that are typically applied to other enterprises, such as restaurants, body shops, franchises and hairdressers, is unlikely to yield the best valuation. Also, it is important that an appraiser appreciate the difference between a

general practitioner and a general surgeon, and be up to date on Stark laws, proposed Medicare reimbursement reductions, ancillary services, etc.

Even though business appraisal is generally not a licensed activity, there are a number of professional trade associations that recommend standards of compliance and ethics or provide credentials. You should expect your appraiser to belong to one or more of these associations: the Institute of Business Appraisers, the American Society of Appraisers, the National Association of Certified Valuation Analysts and the American Institute of Certified Public Accountants.

However, being a “certified” appraiser does not ensure competence in the specialty of medical practice valuation, nor does lack of certification indicate incompetence. Check the credentials, experience and references of the appraiser. Knowing the business, in this case the medical business, is a key ingredient of competence for a specialty appraiser.

### **THE COMPETENCE OF THE OTHER PARTY**

Expect the other party to a transaction to have competent advisers, including a qualified appraiser. Bogus valuations from either side will be discovered by competent appraisers.

### **USING MEDICAL PRACTICE BENCHMARKS**

A medical practice valuation requires a comparison of the subject practice’s statistics to specialty benchmarks. It is inaccurate to lump all physician practices together as a common entity, as financial statistics differ radically by specialty. Also, beware using outdated benchmark reports to save money on buying the current reports—another common error—as the accuracy of your valuation may suffer.

### **SCIENTIFIC METHOD**

Using a scientific approach to value a practice is an excellent way to lead a buyer and seller to a mutually agreeable price (or to a respectful, knowledgeable disagreement) by carefully reviewing all the facts and assumptions. A valid

assumption to disagree upon, for example, is whether capitation will come to a particular market and what its effect will be on profits.

Physicians typically respond well to scientific inquiry, just like having a good physical exam, vital signs, lab reports and imaging on a patient is valued prior to rendering a confident medical diagnosis.

### REALITY CHECK

In the end, a valuation should be reasonable. A common test of reasonableness is that the purchase of a practice should pay for itself, above the income available from simple employment, within five years at most. Another is the “principle of substitution.” A buyer (investor) will not pay more for an asset—and get a lesser return—than that available from purchase of a substitute asset. In other words, knowledgeable medical practice buyers won’t pay more for a practice than the cost of starting a substitute competing practice, nor will they pay money to buy a practice with income equal to or less than employment without purchase. They would just put the money into the stock market or start a practice across the street.

Strategic value exists when a specific buyer brings synergy to the transaction. For example, a half-full practice might pay more than fair market value for another half-full practice next door, because it would make the purchaser’s practice full without extra fixed overhead.

### BUY-IN, PURCHASE OR STARTUP—WHICH IS THE BEST VALUE?

The principle of substitution also applies to buy-ins. A practice buy-in may require initially working for an income less than the existing owners, plus purchasing a percentage of the furnishings and equipment. The value of this type of buy-in can be compared to the value of an outright purchase of an existing practice or the expense of starting a practice from scratch.

When considering a buy-in to a minority share, the issue of a discount for lack of control can be very important. The bigger and more democratic the group, the less important it becomes. It is critically important if the solo seller is offering a 49 percent ownership share for buy-in, because that share may be worth as little as zero due to what is referred to as “senior doctor rights.”

Consider this case: The senior doctor won’t give up any income and gets all the new patients that walk in the door, respond to the Yellow Pages or come from existing referrers. The senior doctor also has 100 percent of the decision-making authority, including changing the new doctor’s hours, staff, income and expense formulas. The new doctor gets no salary and has to find his own patients somehow, plus pay 49 percent of all the expenses which could include the senior doctor’s car, health insurance or home computer. In this setting, 51 percent ownership is equal to 100 percent control. Is 49 percent of this practice worth anything at all?

*Written by Keith Borglum who is a licensed health care practice broker, appraiser and practice management consultant.*



## Practice Startup: Corporate Structure and Asset Protection

The formation and conduct of any medical practice raises numerous factual and legal issues which necessitate personalized legal advice. Accordingly, physicians should contact their personal attorney and accountant for advice on how to proceed in a particular situation. The following information is meant to provide some helpful guidance about commonly used business structures of physicians.

### CORPORATIONS

Corporations are a form of business organization permitted by law in every state. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

A unique feature of a corporation is that it issues shares of stock. A share of stock entitles a shareholder to vote in the election of a board of directors, which is charged with the overall management of the corporation. The board of directors elects the officers—president, secretary and treasurer—who are authorized to conduct the day-to-day business of the corporation. Many states permit a single individual to serve as sole director and to hold all of the corporate offices.

Another unique feature of a corporation is that it is intended to have a perpetual existence. The death of an individual director or officer does not terminate the existence of the corporation. Instead,

the corporation carries on indefinitely until it is dissolved by a vote of the shareholders.

A corporation is legally formed and begins its existence upon the filing of Articles of Incorporation with the secretary of the state of incorporation. You can choose to incorporate in any state you wish. It is not necessary to incorporate in the state where your business is located. Some states have laws that benefit corporate owners, such as no state income taxes. The advantages and disadvantages of incorporating in a state in which you do not reside needs to be discussed in detail with your attorney.

### **Limiting Personal Liability**

Many physicians choose to establish a professional corporation (PC), which is an entity with special features determined by the state where the practice is conducted. You should be aware of the fact that personal liability for malpractice cannot be limited by using a corporation. Regardless of whether you conduct your practice through a PC, you will not be shielded from any asserted claims for injury to a patient. If you lose a case, any amount not covered by your medical liability insurance can be taken from your personal assets.

Although the PC won't protect you from claims by a patient you treat, it can be used to defend against the negligence of a partner. This is an appealing protection that is not available through some of the other structures. Because the PC limits your responsibility to only those acts committed by you, this creates a necessary degree of protection for those in practice with other doctors.

A PC also offers protections from other potential sources of liability. All corporations are characterized by the concept of limited liability, which protects the officers, directors and shareholders (the principals) of the company. In a properly organized, maintained and capitalized corporation, the principals have no personal liability for the debts of the corporation. If a corporation breaches an obligation or causes injury to a third party only the corporation—not the principals—is legally responsible. If the corporation does not have sufficient assets to satisfy the liability, the creditor is not entitled to seek satisfaction from the personal assets of the principals. This protection

is distinct from other businesses operated as sole proprietorships, partnerships or trusts. In those cases, the owner, partner or trustee, respectively, have unlimited liability for debts incurred by the business.

Limited liability protection also covers an act by an employee that causes injury to someone and to claims filed against the corporation by an employee. When a person is employed by a corporation, the corporation—not the officers or directors—is held liable for an injury caused by an employee. This same concept also applies in cases involving an employee's claim of discrimination or wrongful termination. Any such lawsuit will be filed against the corporation as the employer, instead of you as an individual. Essentially, the formation of a PC provides the principals of the company protection from being held personally liable for these types of activities.

### **Effect of Personal Guarantees**

When a corporation buys goods or services, liability for payment will be limited to the corporation, unless the principals have signed a personal guarantee of the obligation. A person or entity doing business with a corporation may require that the principal of the company give a personal guarantee of a corporate obligation. In simple terms, the person signing a guarantee promises to pay the corporation's debts if the corporation is unable to do so. For example, if you wish to take out a bank loan, the bank may request a personal guarantee of the payment obligation. If the corporation fails to make its payments on time, the bank can then collect directly from you. In this manner, a personal guarantee eliminates the benefits of the corporation's limited liability.

### **Double Taxation**

The way corporations are taxed provides some interesting and challenging planning decisions. A corporation is a taxpaying entity; it must file an annual tax return and pay taxes on its income. If those earnings are distributed to a shareholder, the distribution is treated as a dividend and it is then taxable to the shareholder. The effect of this is that corporate earnings are taxed twice—once at the corporate level and once at the shareholder level.

The problem of double taxation may be solved in two ways. First, the corporation can pay out as salary an amount equal to its net earnings. This is called zeroing out the corporation. For example, a medical corporation might have a profit of \$150,000. If this amount is paid to one or more officer of the corporation as compensation for services, the corporation would get a tax deduction for the \$150,000 in salary. This would reduce the corporation's taxable income to zero and it would owe no federal income taxes. As a result, the \$150,000 would be included in income and the tax paid by the recipient(s).

The Internal Revenue Code imposes certain limitations on the zeroing out technique by allowing a deduction to the corporation only if the amount of compensation paid to a particular individual is "reasonable." Your accountant will have these guidelines and can provide guidance on this rule.

The second method for eliminating double taxation is the use of a device called an "S Corporation." This is a type of corporation specifically provided for in the Internal Revenue Code (26 U.S.C. §§1361 et seq.). An S Corporation has all of the lawsuit protection features of a conventional corporation (known as a "C Corporation"), but is treated differently for tax purposes. If elected by the shareholders, an S Corporation will not be subject to tax at the corporate level. Instead, all corporate income is included directly in the income of the shareholders. There is no need to zero out the corporation with salaries because corporate income is subject to tax only once, at the shareholder level. Additionally, if the corporation has a net loss, that loss can be used by the shareholders to offset other business income.

In order to qualify, the stock of an S Corporation must be held by 35 or fewer individuals and all shareholders must consent to the election. If unreasonable compensation is an issue or the corporation is expected to show net losses, an S Corporation may be a worthwhile structure to consider.

## MAINTAINING THE INTEGRITY OF A CORPORATION

The lawsuit protection features of a corporation apply only if the integrity of the corporation as a separate and distinct entity apart from the individual is respected by a court and by the Internal Revenue Service. In matters involving a lawsuit, especially if a corporation has no significant assets, plaintiffs will attempt to convince the court that the corporate entity should not be respected and that the principals (i.e., the owners) of the company should be personally liable. In these cases, the plaintiff is attempting to pierce the corporate veil in order to obtain a judgment against the principals, who may have personal assets sufficient to satisfy a judgment. The outcome of this strategy is usually determined by whether the corporation conducts its business as a separate and distinct entity, and meets all the legal criteria that is required of that entity. If these and other required criteria are met, the court will usually uphold the status of the corporation and will not find personal liability. However, if various corporate formalities are not consistently observed, the corporation will be disregarded and the individuals may be held personally liable.

If you use a corporation, you must pay attention to the following formalities which courts have determined to be of particular significance:

- **Corporate bylaws**—the corporation must adopt a set of bylaws that provide a written statement of how the internal affairs of the corporation will be handled. The bylaws set the time and place of regular shareholder meetings and meetings of the board of directors.
- **Corporate minute book**—the corporate minute book contains a written record of actions by the shareholders and directors of the corporation. At a minimum, there must be annual minutes reflecting the election of directors by the shareholders. Any significant corporate activities, including corporate borrowings, purchases and the payment of compensation to officers, should be properly reflected in the minutes from the meetings of the directors and shareholders.



- **Stock ledger book**—the corporation must maintain an accurate stock ledger book. This book shows who has been issued stock certificates and the amount received by the corporation for the issuance of its stock. The stock ledger book should also contain a current record of shareholder names and the number of shares they each own.
- **Conducting business in corporate name**—when doing business with third parties, the officers and directors must make it clear that they are acting on behalf of the corporation and not in their individual capacity. Correspondence should be sent out under the proper corporate letterhead, and contracts should be entered into only with the corporation as a signatory. Unless the documents clearly reflect that a transaction is entered into on behalf of the corporation and all necessary agreements are entered into under the corporation’s name, the corporate entity will not survive a challenge in a lawsuit.
- **Bank accounts**—corporate bank accounts and accounting records must be separate and distinct from the individual. A corporate bank account cannot be treated as a personal account by an individual officer. Corporate income and assets must be separately accounted for in the corporation’s books. One of the biggest mistakes made is when the principals feel free to move money and property back and forth between themselves and their corporation without properly accounting for such movement in the records of the corporation. This can be a fatal mistake, and under these circumstances the corporate entity may fail a court’s scrutiny.

## PROTECTING ASSETS

A physician should discuss with his or her attorney and accountant the “what if” factors. What if the corporation is sued—will the assets that the corporation has accumulated be protected? What if I am pulled in the lawsuit by a creditor as a principle owner, as happens with small businesses—how can I protect my assets? What if I am faced with a malpractice suit—how do I protect my corporate and personal assets? When establishing an asset protection plan, remember:

- The strategy should be tailored based on your personal circumstances, what you are trying to protect and from what you are trying to protect it.
- There are costs, which vary by state, associated with establishing corporate entities. You must weigh the anticipated benefits to you against the complexity, cost and administration of any proposed strategy.
- There are tax consequences associated with the creation of any entity and the implementation of any strategy. Be aware that while they can have very beneficial and intended consequences, some entities can also have hazardous and unintended tax consequences.
- All strategies should be carefully planned and continuously monitored. The objective is not to let yourself be surprised.
- Any asset protection strategy should be in place before the threat of a lawsuit. An asset protection strategy implemented after a lawsuit is filed or even anticipated generally will be struck down in court as a “fraudulent conveyance.”
- Obtain advice from an attorney and accountant who have experience with this type of planning. Bad advice can cost you substantial time and money.



## Writing Your Business Plan

The benefit of developing your business plan is that it forces you confront the realities of starting a medical practice, where you want your business to be in the future and how you will achieve that future. There are numerous resources available to assist you in developing your business plan. State agencies often provide seminars on developing business plans. Also, by doing a simple Internet search, you can access software programs that will help write the plan for you. [Click here for a list of state government websites](#) with useful information for businesses. (This link will take you off the APA website. The APA is not responsible for the content of other websites.)

When writing your business plan, it is important to keep your audience in mind. If you are writing a business plan for an investor or a bank, you should assume that they know little or nothing about your business and industry. Bankers and investors want all the facts, but just the facts. So keep your business plan short and to the point. On the other hand, if you are writing a business plan just for yourself, construct it to suit your needs. It should include your goals and the strategies you will implement to achieve the goals.

Writing a good plan is hard work. It involves a lot of analytical work looking at customers,

competitors and the market, and charting a course for your business.

## TABLE OF CONTENTS

This is a list of the major sections a business plan should cover. Be sure to include the page number where each section begins, and number the entire plan for reference.

- Table of contents
- Executive summary
- The plan:
  - The business
  - Customer, market and industry analysis
  - Strategy and plans
  - Information and analysis
  - Management and personnel
  - Products and services offered
  - Financial data

## THE EXECUTIVE SUMMARY

This is a short—usually one page—summary of your plan. Keep in mind that this may be all that some people read, so it should emphasize your personal strengths and the power of your plan. This section should be written last, after you finish writing the total plan. It should include:

- A short history of the business
- The amount and type of financing you will need
- The amount of equity (money) already invested and the collateral you offer
- How you will use the money
- A summary of your or the owner's experience in the industry and why the business will succeed

## A SAMPLE PLAN

The following describes the components of a business plan.

### 1. The business

This section describes your business and the industry you are in. It should include:

- ◆ The current status of the business (startup, existing, acquisition)
- ◆ The business structure (sole proprietor, corporation) and ownership structure
- ◆ The products and services your business offers
- ◆ What differentiates your business from your competitors, if any
- ◆ A description of location and hours of operation
- ◆ Why you are in business and what you want to accomplish
- ◆ Special regulations that affect your business

### 2. Customer, market and industry analysis

This section is one of the most important parts of your plan. It is imperative that you understand your business environment by being specific and citing numbers and statistics, as well as sources for your projections. The primary components of this section are:

#### Your Market

- ◆ What industry are you in?
- ◆ Describe the market in terms of dollars, number of patients and geographic area
- ◆ Describe any recent changes in the size of this market
- ◆ List other important market factors (technology, business cycles, barriers to entry or exit)

#### Your Customers

- ◆ Who are your customers and what are their principal requirements?
- ◆ Provide demographic makeup (age, sex, profession) (This link will take you off the APA website. The APA is not responsible for the content of other websites.)
- ◆ Explain why they will buy from you (wait times of competing practices, unique services you offer and why these matter)
- ◆ Detail how you will determine customer satisfaction.

### Your Competition

- ◆ Research how long they have been in business
- ◆ Examine approximately how much business they do, their wait times, and their identifiable strengths and weaknesses
- ◆ Discover any changes they are likely to make in the future
- ◆ Outline other reasons customers will come to you instead of your competition

### Your strategy and plans

This section describes your plan for success. It should include:

#### The Business Strategy

- ◆ Lay out your short- and long-term goals, with a timetable for achieving them
- ◆ Explain how these goals compare to those of your competition
- ◆ Determine critical success factors (hospital privileges, referral network, prime location of practice, etc.)
- ◆ Outline the principal strengths and weaknesses of your business
- ◆ Present your facilities and principal equipment— include a map clearly identifying the location of the business and photos of any existing buildings that will be used

#### The Marketing Plan

- ◆ Detail how you will advertise (e.g., fliers, Yellow Pages, radio spots, newspaper ads, direct mail, Internet, etc.)
- ◆ Describe the frequency and cost of advertising
- ◆ Research how many potential patients you will reach
- ◆ Determine your payment terms for those with insurance and without (credit, cash, accepted insurance carriers, copayment, etc.) and when you will collect (at time of service or billed)

### 3. Information and analysis

Data collection and analysis is key to managing the day-to-day operations of your business, making good decisions, identifying needed improvements and staying ahead of the competition. This section looks at the data you will collect and how you will use it:

- ◆ Describe the data you will use for day-to-day operations and decision-making
- ◆ Explain the competitive data you will track
- ◆ Briefly describe the hardware and software you will use to provide timely, accurate and reliable data to those who need it

### 4. Management and personnel

Your business is only as strong as the people running it. This section showcases the key members of your team and their responsibilities.

#### Key Personnel

Write a short description of each position in your practice.

#### Work Environment

- ◆ Describe your employee compensation system (*learn about salaries in different locations*)  
(This link will take you off the APA website. The APA is not responsible for the content of other websites.)
- ◆ Explain how you will recognize and motivate your employees
- ◆ Detail the training your employees will receive
- ◆ Outline how you will recruit, hire and retain employees
- ◆ Describe your benefit package
- ◆ Present your anticipated salary and benefit package
- ◆ Detail your ongoing training
- ◆ Describe your approach to workplace health and safety

#### Your Professional Team

Identify your accountant, business counselor, attorney, etc.

## 5. Services offered

This section describes the services that your business provides and how you manage your key processes. Write a short description of your primary services so that a lay person can easily understand what you do. A well-designed work process that employees follow will reduce mistakes and produce consistent results, as well as help you avoid wasting time addressing problems later.

### The Product/Service

- ◆ Include a brief description of the services your business will provide
- ◆ Outline the price, cost structure and drivers (set fees to be determined through negotiations with payers)
- ◆ List any special technology needed for your practice
- ◆ Detail any service changes you foresee over the next few years
- ◆ Describe how well your service addresses the customer requirements for quality, response time and price

## 6. Financial data

Sources	
Cash from owner	\$ _____
Investor contribution	\$ _____
Bank loan	\$ _____
<b>Total</b>	\$ _____
Uses	
Remodel space	\$ _____
Equipment	\$ _____
Rent deposit	\$ _____
Utilities deposits	\$ _____
Office supplies	\$ _____
Initial inventory	\$ _____
Loan initiation fees	\$ _____
Working capital	\$ _____
<b>Total</b>	\$ _____

This is the most important part of your plan. Lenders have different requirements for financial data. Ask where you will be applying and be sure

to provide the data they need to process your application. The data in this section should refer back to other sections of your plan. Some of the data that might be requested is described in the following sections and templates can be located at this external website.

### Loan Request

This section briefly outlines the business request and includes the loan purpose, loan collateral (with documentation) and expected source of repayment. Collateral may include your house, boat, stocks or, in the case of an existing business, your accounts receivable or other assets. The costs for initiating the loan and the various documentation fees (typically 2 to 3 percent) should also be specified.

### Sources And Uses Of Funds

This basically states where the funds for running the business will come from and where they will be spent. The document should look similar to this example:

The totals of the sources and uses of funds must be the same.

### Cash Flow Projection

The cash flow projection shows how cash flows into and out of your business on a monthly basis. This table will be of particular interest to the bank as it shows that your business will have the ability to make regular monthly loan payments in addition to your other expenses. Many lenders will want this projection prepared by an accountant. The period covered by the cash flow (one year, two years, etc.) will also depend on your lender. For assistance creating these and other tables, go to this [external website](#).

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### Contingency Plans

A contingency plan identifies your back-up strategy. What you will do if one of your major assumptions does not work out. For example, what if your revenues fall short by 15 percent or more? What is your “plan B” in such an instance? Where will you get the funds to tide you



over—loans from relatives, a home equity loan, refinancing your home, using your pension plan as security for an additional loan, etc.?

If you or a key partner dies or becomes disabled, how will the business continue and repay the loan? Often, this part of your contingency plan requires a life and disability insurance policy.

### **Balance Sheet**

The balance sheet states the business's assets, liabilities and net worth. It is a snapshot in time of your business's financial strength. As a start-up, you may not have this information. Lender requirements for balance sheets differ, so ask about the requirements before undertaking this task. A balance sheet prepared by your accountant should be similar (although more detailed) than the following:

### **Financial Assumptions**

The strength of your financial assumptions will be a key factor in evaluating your loan application. The numbers specified above must be validated by your research. Explain your computations in detail if it's not obvious to the reader how you came up with the numbers in a given category. Specify the source for each of your assumptions (e.g., industry data, previous experience, etc.). An example of this section might look like this:

- ◆ **Gross income/margins**—projected income is based on: (1) the average income of three practices in the same market area, (2) national average of gross income per practice of a similar size or (3) independent surveys of practices in similar demographic areas.

- ◆ **Payroll**—payroll expense includes a salary for the owner, one full-time manager and secretary (specify anticipated monthly and annual salary of each, including yourself).

### **Personal Financial Statements**

A signed personal financial statement for each loan guarantor with supporting attachments.

### **Income Tax Returns**

Signed personal federal income tax returns for each loan guarantor. Generally lenders want to see two or three years of personal returns. If this plan is for an existing business, then federal tax returns for the business should be provided for the last three fiscal years.

### **Current Business Statements**

For an existing business, many lenders require the most current accounts receivable, accounts payable and inventory valuation reports. An interim profit- and-loss statement for the fiscal year to date and a comparison statement for the same period prior year may also be required.

### **Other Supporting Documentation**

Depending on your lender, the following information should also be included:

- ◆ Curriculum vitae and recommendation letters
- ◆ Board certification
- ◆ Medical liability insurance
- ◆ Corporate structure
- ◆ Required applications/forms/privileges
- ◆ Copies of leases, contracts, building blueprints, etc.
- ◆ Map and photos of building site



## Building Your Practice Through Marketing

A rapidly changing health care environment constantly challenges physicians to adopt strategies that will attract new patients and maintain the loyalties of existing patients. If the term marketing has negative connotations for you, think of these as strategies that will help build or expand your practice. Regardless of the term used, these actions are a vital part of your success.

### DEVELOPING MARKETING STRATEGIES

The strategies that are employed to attract new patients are generally very tangible such as advertising on websites that target the local area

and putting advertisements in the Yellow Pages or newspapers. These are called external marketing strategies. Internal strategies are directed toward retaining the patient base and increasing loyalty through subliminal activities. The physician and staff accomplish these through friendliness and efficiency, expressed by communication and concern. This section provides some suggestions on both internal and external marketing strategies.

### ESTABLISHING A MARKETING BUDGET

As you establish your operational budget during the first year, be sure to include a specific amount for

marketing expenses. Establishing a marketing budget is an extremely important step in the development of the practice's promotional efforts. There are many ways to advance your practice and every method has its costs and rewards. Do not consider these expenditures to be optional—they are as vital to your practice's success as having the proper equipment. If you do not expend the necessary time and money, you may suffer the consequences in loss of patients. Obtain quotes on the development and printing of a practice brochure, appointment and business cards, letterhead, other stationery and educational materials. Also include the costs of any other marketing expense you might have, such as a newspaper announcement and a Yellow Pages listing.

### **SAMPLE MARKETING PLAN TIMELINE**

Just as you have planned for the furniture and equipment needs in starting your practice, you will want to establish a marketing plan. The plan need not be complicated or formal, but it is imperative that it is committed to paper.

Share this plan with your staff as they will become an integral part of your marketing efforts.

#### **Four Months Before Opening**

- Check sources and groups that present information to new residents. Supply handout items for distribution.
- Set up a system to track how patients are referred to the practice. One method is to use a referral log, a simple grid that lists the various sources of referral. Referrals come from many sources (e.g., a website, the newspaper, Yellow Pages, a presentation made at a civic group, another physician or patient, etc). Always ask patients the name of the patient, physician or other individual who referred them to you. Send that person a thank-you note.
- Attend meetings and join civic groups that will enhance your presence in the community. If you have children in the local school system, join the PTA. Offer to speak to these organizations on medical topics. Tell the medical staff secretary at your hospital(s) that you are available for public speaking engagements.

- Check with local hospitals to see if these institutions have planned health fairs or health screenings in the future, and offer to participate.

#### **Three Months Before Opening**

- Develop a brochure for your practice. An attractive, well-written brochure provides your patients with all the information they need about the practice. Include a short paragraph about yourself, your specialty and your education. Add a photograph for a visual touch. If the budget does not permit a professionally prepared brochure, use computer software and a laser printer to print information about your practice.

#### **Two Months Before Opening**

- Design and place an order for announcement cards to send to local physicians and other health care professionals. These announcements should show your name, specialty, address and telephone number. Mail them at least two weeks before opening.
- Order small amounts of stationery and appointment cards with your practice's letterhead and logo, if one has been developed (changes may need to be made later).

#### **One Month Before Opening**

- Order patient education materials for the practice. Use a rubber stamp to imprint your name and address on the front of every piece of educational information that is handed out or placed in the waiting room. This information may find its way to another potential patient.
- Visit the hospital(s) where you will be on staff. Introduce yourself to the department heads and nursing staff.

#### **Two Weeks Before Opening**

- Draft a newspaper advertisement and submit it to the local newspaper(s). The advertisement should give your name, address, telephone number and hours of operation. It should also define and briefly describe your specialty and the services you offer.
- Meet with your staff to share the marketing plan and ask for ideas. Patients who call for an appointment will want to know a little about you.

Give each employee some talking points and a copy of your curriculum vitae. Tell them about yourself so they can discuss your credentials with potential patients. Keep in mind that your staff is marketing the practice's services to patients as well.

- Conduct office staff training on telephone communications to patients and referring physicians. If you receive a referral from a physician you have not previously met, it is a good idea to speak to that physician yourself. Put these protocols in writing and make them a part of the policies and procedures manual. Tell your staff how much time is needed for specific types of appointments. Allow extra time for any first visit as you will be building relationships during this time.

## PRACTICE-BUILDING GUIDELINES FOR THE FUTURE

With any marketing effort, it is important to develop guidelines. Clarify your thoughts and plans on paper and follow these suggestions:

- **Define your objectives.** Define these for the short term (less than one year), then define them for the long term (more than one year). Express them in a way that they can be quantified and tracked, so that successes and failures can be measured.
- **Set realistic goals.** Nearly all professionals automatically say, "I'd like to double my practice," but it is not as simple as that. Determine how much time and energy can be spent to achieve that goal.
- **Remember cash flow.** Many strategies call for 50 percent to 75 percent of the marketing budget to be spent in the first 25 percent of the time. This usually means that the first large sum of cash needs to be in the bank at the start of the program, so it cannot come out of unexpected cash flow.
- **Identify the target groups.** Define the groups your practice is trying to reach. Describe the target populations by the chief characteristics of age, sex, location, educational level, income, ethnicity, religion and lifestyle. Choose only those factors that are most important, usually income, education, sex, age and location. If a business is targeted, describe it by industry position, yearly sales, number of employees and location.
- **Create a different marketing plan for each target.** Set up one-page marketing plans for the different groups. For example, create one for other practitioners from whom to generate referrals, senior citizens, blue-collar workers, 18- to 34-year-old females, and so on. Then rank those groups, targeting the easiest first.
- **Determine what your target groups want.** What are the characteristics most important to the target group in selecting a physician in that specific field? Is it experience, hours, location, price or a combination?
- **Define the physician.** What are your strengths or weaknesses? What is different or special about you concerning your education, expertise, years of experience, credentials? What does your practice offer in terms of location, hours, pricing or specific services?
- **Analyze your main competitors.** Analyze just the competitors with whom the practice will compete in the service area, but do not ignore the indirect competitors outside the profession to whom prospects could turn as a substitute, such as psychologists. Chart each competitor's strengths and weaknesses.
- **Learn how to compete.** How does your practice rate against the main competitors? Where can your practice best compete? List primary points, then secondary points. Assume that you as a physician have good, solid experience, but that your competitor has more. If that competitor does not promote experience and your practice

does, you will have the reputation for experience with the public.

- **Determine the budget.** How much can the practice afford now? Reconcile the budget with the goals.
- **Choose a strategy.** Should you go with internal promotion, the Yellow Pages, newspapers, websites, public relations or seminars? Weigh the pros and cons of various vehicles against each other.
- **Choose the timing.** List events, both external and internal, that will affect the campaign over the period that has been specified. Choose the time of year, which months, and what week to take action. If the practice has seasonal peaks, promote heavily during those busier periods. Dollars and efforts must work a lot harder in low periods when prospects are not already looking for services.
- **Plan the execution.** Assign responsibilities and set deadlines for all steps on a master timeline.

## BUILDING PATIENT SATISFACTION

In a pure fee-for-service market, a patient's dissatisfaction with a physician generally amounts to the loss of that one patient and possibly the loss of another family member.

In a market dominated by managed care organizations, however, patient dissatisfaction can result in the loss of an entire patient population. Managed care organizations gather a tremendous amount of data from their enrollees and use this information as a component in grading the plan's physicians. If a physician fails to make the grade, he or she may be dropped from the plan. Be proactive in your attempts to increase patient satisfaction. After the practice has been established about six months, conduct a patient satisfaction survey. Survey at least 100 patients, or if possible, every patient. Invaluable opinions about the practice, the staff and the physician's own success up to this point can be gained. Take patient suggestions

seriously and carry out any changes that will increase patient satisfaction.

## PRACTICE SERVICES AND AMENITIES

Marketing can be as simple as making every patient feel comfortable and appreciated. Differentiate your practice from others by providing a personal touch to patient relationships. Follow these guidelines as a part of the practice's approach to patient service:

- Assign someone in the office the responsibility of managing the practice's relationships with its most important customers.
- Send a welcome letter to a patient after they have made the initial appointment. Thank the patient and enclose a practice brochure.
- Acknowledge patients immediately upon arrival.
- Always address a patient by name. Be sensitive to the patient's feelings in deciding whether to use formal or informal terms of address.
- Explain all lengthy delays and make sure patients are given the opportunity to reschedule if they so desire. The physician should be encouraged to be punctual and attentive to the appointment schedule. Remember, the patient's time is valuable, too.
- Let elderly patients and those with disabilities know that pre-arrangement can be made for a staff member to meet them at their car to be escorted into the office. Have a wheelchair available.
- Provide educational materials to help patients become more able and willing to assume responsibility in the healing process. Many forms are commercially available, or the practice can write its own educational materials, produce videos or audio cassettes, and establish a lending library.
- Spend adequate time with each patient. Surveys show that patient satisfaction directly correlates



with how much time the physician spends with the patient.

- Create a pleasant reception area. Provide a living room effect by decorating tastefully. Use table lamps and put out fresh flowers. Play educational videos on interesting health topics or offer patients something to do while they wait (e.g., current magazines, crossword puzzles). Provide a tasteful distraction, such as an aquarium, and play soothing, easy-listening music.

### **STANDARDS OF PATIENT SERVICE FOR MEDICAL STAFF**

Each member of the staff should render services to patients with the highest professional standards. The following guidelines serve as effective reminders of how best to treat patients.

- Acknowledge patients promptly and courteously with eye contact and a pleasant expression and tone of voice.
- When talking with patients and/or other employees, use words that express respect, patience and understanding.
- Care for people with kindness and gentleness, rather than with cold professionalism.
- Address adult patients by their proper title and last name, unless the patient requests otherwise.
- Display visible identification and introduce yourself by name and title when first meeting a patient.
- Answer the telephone quickly and courteously, and identify yourself by name. Provide callers the opportunity to respond to a request to be placed on hold and explain to them if their call is being transferred.
- Be sensitive to reducing noise levels near patient care areas.
- Respect patient privacy by knocking before

entering the room if the door is closed, and by not discussing one patient in front of another.

- Protect the confidentiality of patients, co-workers and others who use the facilities.
- Be attentive to patients and their families who are kept waiting for extended periods.
- Consider the effect of what is said and done in the presence of patients. Refrain from conducting personal (not work-related) conversations in front of patients.
- Refrain from discussing other employees, organizational policies, problems or medical care in public areas.

### **ONLINE AND YELLOW PAGES ADVERTISING**

A well-designed advertisement can work for the practice 24 hours a day, 365 days a year.

Before placing an ad, evaluate what other colleagues are doing. Look through the online and Yellow Pages advertisements from surrounding areas and compare styles, design, size and text. What makes an ad stand out? Which ads are more attractive?

The goal is to make your practice's ad unique and to grab the shopper's attention. Achieving this without discrediting the practice with a cluttered, distasteful ad is very important. A simple, clean and professionally designed ad that is 2 inches by 3 inches can be very effective. Use the following checklist to create an effective, powerful and attractive ad.

- Are the practice's name, specialty and telephone number the most prominent elements in the ad?
- Has the name of the practice been included with the name(s) of the physician(s) in the practice?
- Have any special qualifications, such as board certification, been included?
- Are area locators, such as cross streets or building names, mentioned?

- Have all extended hours been listed?
- Have all special services been included?
- If the practice has a logo or slogan, was it included in the ad?
- Have you reviewed your competitor's ads to determine an appropriate-size ad for your practice?
- Should boldface type be used to call attention to the ad?
- Does the chosen typeface correspond to the character of the practice?
- Does the ad reflect the image that the practice hopes to project?

## CREATING A MEDICAL PRACTICE BROCHURE

A practice brochure creates many marketing opportunities. It creates an image of the practice to current and prospective patients and referral sources. The brochure provides information about available services, office policies and practice philosophy. It also saves the staff's time by addressing repetitive questions, such as where the physician has hospital privileges or how insurance is billed. The brochure will serve as a compact reference about the practice.

### How To Create A Brochure

The best resources for creating a brochure are colleagues and other professional businesses. To obtain ideas, collect samples of attractive brochures. A typical brochure has six to eight panels of information and is 3½ by 8 ½ inches. The goal of the brochure is to clarify practice policies, written in language that is clear and concise. Hire a professional to help with the copy if you are not comfortable writing it yourself.

## BROCHURE CONTENTS

The practice brochure should contain the following information:

- **Introduction to the practice**—begin by including the name, address and telephone number of the practice. Provide a brief history of the practice and your patient care philosophy.
- **Professional profile**—introduce each physician in the practice and include details on training, board certification, areas of special interest and personal information. For example, “Dr. Doe is married and has two school-age children,” or “Dr. Smith enjoys working in underserved countries one month each year.” Include a picture of each physician to help patients with name and face recognition.
- **Explanation of specialty**—include a description, in simple terms, of the practice specialty and the special services and procedures that can be provided. The more informed a patient is before the visit, the more confidence he or she has in the care that is received.
- **Office policies**—one primary objective of a practice brochure is to educate and inform patients about practice policies. They can serve as a reference and reminder to established patients and provide guidelines and standards for new patients before incurring services.

### Key Areas to Highlight Include:

- **Office hours**—this is especially critical if appointment times are beyond the typical practice hours (e.g., evening, Saturday hours). Stating office hours will also reduce after-hours calls to the answering service and consequently reduce overhead expenses.
- **Scheduling and canceling appointments**—if patients are asked to use a different telephone number for scheduling appointments, publicize it. If there are a lot of no-show patients, it is very important to establish and state the policy that will discourage this abuse and encourage compliance. Charging \$50 for a no-show or a late cancellation is customary for practices (within 24 hours of scheduled appointment). If a patient abuses either policy three times, he or she should receive a letter discharging him or her from care within a reasonable period (e.g., 30 days). To protect the practice, send the letter via certified mail, return receipt requested.

- **Hospital affiliations**—the insurance industry may influence a patient’s selection of both a hospital and a physician. Therefore, including hospital affiliations in the practice brochure is important.
- **Financial policies**—generally, the most frequently asked questions pertain to the practice’s financial policies. Document these policies in the brochure to inform patients about their financial responsibility.

Be sure to include the forms of accepted payment (e.g., cash, check, credit card). Most practices follow the policy that they expect payment when they render services unless the patient makes other arrangements. This policy should be stated.

Your brochure should also identify the insurance plans in which the practice participates (e.g., independent physician association (IPA), preferred provider organization (PPO), health maintenance organization (HMO). Also state whether or not the practice accepts Medicare assignment. Include billing information, such as when the patient should expect to receive a statement, after what period an account will be placed in collection, and so forth. Be sure to include the telephone number to call regarding billing questions.

Health care consumers will often look for practices that offer one-stop shopping. List all the services your practice offers.

If the practice has an established office policy regarding prescription refills, print it in the brochure. Patients need to know how to handle routine prescription refills. Informing them of the policy

makes the office more efficient and responsive to the patient’s request.

Notifying patients that an answering service will respond to calls after normal office hours is important. Patients appreciate knowing a voice is always on the other end of the line and that the physician will get their message. Consider printing the answering service telephone number for the rare occasion the office forgets to sign off to the service after hours. Printing the physician’s pager number is not advisable.

Including a map of the office location is as important as printing the name and telephone number of the practice. The map should include nearby landmarks, such as a hospital, a lake, a park or something else with which the patient may be familiar. If the office is close to the hospital, it adds a competitive marketing edge, and it is to the physician’s benefit to include this information.

Building a medical practice takes a concerted effort and careful planning. Typically in the early stages of practice startup, marketing funds are limited. Be sure to spend all marketing dollars wisely and appropriately in the area and specialty. If help is needed, get assistance from a reliable and experienced health care consultant who can keep the practice focused on initiatives that are most likely to be beneficial.

#### **Other Resources:**

##### **Marketing Plan Software/Templates**

- [OfficeReady™ marketing plans](#)
- [Marketing Plan Pro](#)
- [PlanWrite® for Marketing](#)

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## Employment Law: Questions to Ask and Avoid When Hiring

Both federal and state laws limit the types of questions employers may ask of potential hires. As a general principle, hiring questions must be job-related. Troubles can arise when the prospective employer asks questions that do not pertain to the requirements of the job and the questions touch on criteria which are prohibited by law from consideration in the employment arena.

To learn more about these topics, visit the [U.S. Equal Employment Opportunity Commission](#).

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In addition, if you conduct background checks, you have to adhere to federal credit reporting laws. Once employees are hired, you must also comply with other employment, labor and benefit laws applicable to the jurisdiction where employees work, including state and federal versions of Family Medical Leave Acts, Fair Labor Standards Acts, Occupational Safety and Health Administration (OSHA) guidelines, state workers' compensation laws, etc. These topics are covered in a variety of sources, and are not detailed in this material.

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## Federal Tax Workshops and Information for Businesses

The Internal Revenue Service (IRS) has various resources for small-business owners on topics including the legal and tax aspects of starting a business, estimating taxes owed, filing/paying taxes, guidelines on hiring/withholding taxes and obtaining a federal employment tax number, among others. [See a list of business topics from A-Z](#). It also offers free of charge a [Virtual Small Business Tax Workshop](#).

In addition, the IRS provides on its Web site a collection of links to [state government Web sites](#) with useful information for businesses.

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Whether you are just starting a business, already in business or expanding to a new state, the resources offered by the IRS will be very useful. However, there is no substitute for good legal tax and financial advisers who have the knowledge and experience to take full advantage of the law for your benefit.





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## Practice Management Assistance & Resources

*APA Practice Management Guidelines*

*Diagnostic and Statistical Manual of Mental Disorders*

### **APA-endorsed Malpractice Insurance Program**

Provided by the American Professional Agency, Inc. This leading provider of mental health professional liability insurance offers policies exclusively to APA members. For more information, call 877-740-1777 or [click here](#).

### **Payment Processing Program**

TransFirst (formerly Solveras Payment Solutions)

provides negotiated group discounts on MasterCard, Visa and American Express credit card processing in addition to other benefits. Call them at 800-613-0148 for a FREE savings analysis or visit their [website](#).

### **Online Drug Alerts**

Register to receive drug alerts online through the HealthCare Notification Network (HCNN), a service of PDR Network. The service was developed with the FDA, AMA, state medical societies and liability carriers to deliver FDA mandated drug Alerts to physicians instantly and securely online. The HCNN



also delivers drug and medical device recalls, replacing the current paper process that is both slow and error-prone. [Register here](#).

#### **APA Legal Information and Consultation Plan**

For an annual fee the Plan offers legal consultation and information related to your psychiatric practice. It provides APA members with practice-related legal consultations and contract reviews (the Legal Consultation Plan is not available in the state of North Carolina). [Click here](#) for contract and pricing at or contact Plan administrator, Anne M. “Nancy” Wheeler, J.D., at [apaplan@verizon.net](mailto:apaplan@verizon.net) or by calling 301-384-6775.

#### **EPOCRATES Discount**

APA members receive discounts of 20% off retail pricing on clinical reference applications at the point of care through Epocrates. To receive your APA member discount, you must [order here](#) (requires log in at the APA website with your Member ID and password.) For more details on this member benefit, please call 650-227-1700 or visit [www.epocrates.com](http://www.epocrates.com)

#### **APA JobCentral**

APA’s JobCentral, the career hub for psychiatry, allows you to search for jobs by specialty and geographic location. You can also just post

your resume online and let employers find you. Employers list open opportunities online and can access the candidates’ database. Access [JobCentral](#).

#### **Magazine Subscription Services**

APA members can receive discounts on subscriptions to hundreds of popular magazines for their home or office. Call 800-289-6247 or [click here](#).

#### **APA’S Managed Care Help Line (800) 343- 4671**

Call this toll-free phone number or send an e-mail to [hsf@psych.org](mailto:hsf@psych.org) for assistance with questions, to register complaints, or for information on managed care organizations (including Medicare) and/or managed care issues.

#### **Answer Center (888) 357-7924 or (703) 907- 7355**

The APA Answer Center is the place to start if you want general information or do not know with whom you need to speak for specific information. An Answer Center coordinator will either provide you with the information you need or direct you to the person in the APA who can best address your questions or concerns.

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For additional information about this resource, please contact Jon Fanning, Chief Membership & RFM-ECP Officer at [jfanning@psych.org](mailto:jfanning@psych.org).

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