During their formal educational training, physicians generally receive little or no instruction on how to set up and manage a medical practice. As do specialists in other areas, geriatricians work in different practice models. The description of practice models below is largely based on practice finances. Consider visiting or requesting a financial consultation with providers from a successful geriatrics practice.

Select from the most common models listed below for more information.

- **Office Practice** Scroll down to page 1
- **Traveling Practice** Scroll down to page 1
- **Academic Health Center** Scroll down to page 2
- **Program of All-Inclusive Care for the Elderly (PACE)** Scroll down to page 2
- **Capitated Model** Scroll down to page 3
- **Hybrid Model** Scroll down to page 3
- **Practices Types** Scroll down to page 3

An important consideration in addition to the practice model is whether you would like to work solo or with other physicians and healthcare professionals in some type of group arrangement. Consider the following types of practices and their **advantages and disadvantages.** (page 3)

- **Solo Practice** Scroll down to page 3
- **Expense-Sharing Association** Scroll down to page 3
- **Group Practice** Scroll down to page 3
- **Employee Physicians** Scroll down to page 3

### Office Practice

- An independent, primarily office-based practice is uncommon in geriatrics.
- The financial liability of this model is limited by poor rates of Medicare reimbursement combined with high overhead office costs.
- Because a specialized geriatrics office (e.g. a practice specializing in memory disorders) receives a higher payment for consults, this type of practice has a greater likelihood of being self-supporting. However, such specialty practices are rare outside of academic health centers or multi-specialty group practices.
- Some geriatric office practices are set up within a congregate setting such as a large retirement community. The practice may rent space and use facility staff to run the office at reduced costs.
- Using mid-level providers (e.g. Physicians Assistants or Advanced Nurse Practitioners) can also help make an office-based practice financially viable. In addition, performing minor procedures in-office and operating an office laboratory can generate additional revenue.
Traveling Practice

- Some geriatricians practice without a clinical office by seeing patients in nursing homes or assisted living facilities, on home visits, or while hospitalized.
- Practice overhead is extremely low because there is no need to rent space, buy office equipment and supplies, or hire clinical support staff. Practice expenses are limited to a billing and collections service, an answering service, and malpractice insurance. Therefore, this can be a financially successful practice model.
- Mid-level providers are often used to help provide care and to cover after hours.
- Most geriatricians who practice in this model contract with the facilities where they see patients to provide medical director services. *(See also Contracting Your Services in chapter 3)*

Academic Health Center

- Clinical geriatrics in the United States began in academic health centers, in which the geriatricians’ duties are split between clinical practice, research, education, and administration.
- In some academic health centers, the costs of running a geriatrics practice are partially offset by other benefits that accrue to the center, e.g. hospital admissions, referrals to other group practices, a geriatrics fellowship program, recruitment of medical residents, and clinical research. However, academic health centers are under increasing financial stress, and there is a growing expectation for clinical operations to break even financially or, ideally, be able to provide research or endowment funds to help support their unit.
- To be successful in this model, the geriatrics practice must either be self-supporting financially or be able to prove its value to the system within which it functions. This may be through generation of revenue to the center (e.g. hospital admissions, referrals to a group practice), reduction of costs (e.g. case management for managed-care patients), or improved quality of care (e.g. reduced length of stay, reduced numbers of early re-admissions).
- In a primarily fee-for-service healthcare system, a consultative geriatrics practice is particularly vulnerable when finances of the parent institution are tight. Administrators may see little benefit to the overall mission if the geriatrics practice is losing money, and the practice may be “down-sized” or closed.

Program of All-Inclusive Care for the Elderly (PACE)

- PACE programs serve an elderly patient population, and their approach to care espouses prevention of disease and disability. Therefore, they are a natural match for geriatricians.
- PACE programs are associated with high start-up costs and ongoing financial risks that generally preclude geriatrics practices from being the owner/operator. However, many PACE programs are financially successful, in no small part because of the expertise and efforts of the geriatricians who provide care to these frail, older patients.
- Most PACE programs employ both geriatricians and mid-level providers to help deliver care.
Capitated Model

- Some healthcare systems operate their own managed Medicare health plans and assume full financial risk for the patients they serve. Other healthcare systems provide care for large numbers of managed Medicare patients without insuring that care. Both systems can benefit from the input of clinical geriatricians.
- In this model, geriatricians are most effective by providing consultative input and not assuming primary care responsibilities for the patient.
- Geriatric assessment and management centers, Acute Care for the Elderly (ACE) units, and post-hospital case management can improve care and reduce use of expensive services, especially hospital care.
- Geriatricians working in this model should collect data to demonstrate their positive fiscal impact on the health system.
- Geriatricians working in this model should collect data to demonstrate their positive fiscal impact on the health system.
- Geriatricians working in this model can be an important link between the health plan and medical group by. He/she can do this by educating the plan about the unique clinical elements required to manage a geriatric population, and by being the source of education for the clinicians in the medical group about the principles of care for elderly patients.

Hybrid Model

- Geriatrics practices may also be a hybrid, or combination, of any of the other models described.
- Hybrid models can evolve by design or, more commonly, as opportunities arise.

Practices Types

- Solo Practice: In a solo practice, a physician works independently and has a direct relationship, both medically and financially, with patients.
- Expense-Sharing Association: In an expense-sharing association, several solo practitioners may share on-call coverage, office space, billing systems, employees, and overhead expenses, but each physician maintains his or her income independently of the others.
- Group Practice: A group practice is a legal partnership in which both income and expenses are shared. The members of the group have joint liability as in any business partnership.
- Employee Physicians: An employee physician is one who is hired by a health system, government agency, or other business without the opportunity to become a partner.

What are the advantages and disadvantages of these different types of practices?

- Solo Practice: Physicians who practice solo enjoy a great deal of independence, from professional, business, and personal standpoints. They also can build a community image. On the other hand, solo practitioners may feel isolated and must provide coverage and handle all business matters themselves. Start-up costs can be a major issue.
- Expense-Sharing Association: The advantages of an expense-sharing association include reduced overhead and shared call coverage. In addition, there are no legally
binding contracts among the practitioners. However, because the physicians generally practice independently of each other, the potential for feeling isolated still exists. Professional and personal conflicts may arise, and practitioners can leave the sharing arrangement unexpectedly.

- **Group Practice:** Group practices allow physicians to share coverage as well as start-up and overhead costs. In addition, depending on the specific arrangement, the physicians may share income and find they have more flexibility in personal and professional matters. However, in a group practice, it is inevitable that professional or personal conflicts will arise at some point, and compromise will be required.

- **Employee Physicians:** An employee physician typically enjoys the advantages of fewer work hours and increased free time, shared coverage, ready availability of multiple physician specialists for referral purposes, and fewer business responsibilities. Disadvantages include the lack of opportunity to become a partner, ease of possible termination, the difficulty of effecting change within the organization, and possibly limited referral options.

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