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As a health care provider, you advise patients to schedule regular checkups and come in for an exam if they have any health problems. You should follow the same advice when it comes to your business.

Your practice needs regular checkups to ensure a clean bill of health. Additionally, if an area of your practice isn't healthy, a more thorough exam and special attention are needed to cure the ailment.

This issue of *VitalSigns* can help you examine areas of your practice that might be ready for a checkup — staffing and fee schedules. If it's time for your practice's annual physical, you might find our checklist to be useful. We've also provided more detailed advice for practices that are experiencing trouble and discuss what's new concerning health system physician groups.

If you can keep your practice healthy, you'll have a much easier time doing the same for your patients.

Winning the battle for adequate staffing

It's a constant battle. Adequately staffing your practice means being able to service patients, bill for services, collect money, get all the paperwork finished, follow the government's rules and make a fair living. Staff costs are very large investments. Adding one full-time employee could add \$20,800 to \$39,000 in expenses to a practice, assuming \$8 to \$15 per hour plus benefits and taxes. This does not include adding equipment, phone lines, computer terminals and licenses.

One too many staff members can take a profitable practice into a loss. Yet too few staff members can cost the practice money in a lack of collections, patient dissatisfaction and employee turnover. Having the right mix of employees doesn't take an advanced degree, but it's all too easy to make expensive mistakes.

Signs of staffing woes

The decision on staffing requires planning, reviewing costs, benchmarking your staff against those of similar practices, adequately knowing what each staff member is currently doing and making the right decisions regarding levels of service. Signs that your practice may be understaffed include:

- Fielding constant patient complaints about long office waits,
- Booking new patient appointments more than six weeks in advance,
- Hearing from physicians that they can't keep up with their patient volumes,
- Charging entry delays greater than 48 hours from patient visit or hospital discharge,
- Dealing with a large or growing accounts receivable load, or
- Suffering gross collection rates of less than 45% to 65%.

For example, patient complaints of long office waits can point to an overworked receptionist who causes delays in checking patients in or out of the practice. Long office waits can also point to a problem with the medical assistant(s). Understaffed or unproductive medical assistants can cause a backup in patient flow and physician productivity.

4 positions to review

When reviewing your staffing needs, there are a variety of factors specific to each position that you can assess. Here are four examples to consider:

1. Receptionists. These staff members are the front door to your practice, and their position is typically underpaid. The receptionist position wears many hats and is the first step in the process of a patient visit. Receptionists handle the patient appointment scheduling, phone calls for refills or clinical questions that need to be routed to the appropriate person. Some receptionists also handle patient check-out and patient chart filing and locating.

Some general rules of thumb for staffing receptionists are: one to two physicians need one receptionist (and perhaps a part-time backup); three physicians need two receptionists; and five or more doctors need three full-time receptionists. (Note that different specialties tend to need different levels of support.)

2. Medical assistants. These workers coordinate patient flow, prepare patients for the exam, set up exam rooms, record new patient histories, record chief complaints and assist in minor procedures. A lack of medical assistants can tie up exam rooms and decrease patient flow through the visit.

If your practice is struggling to keep up with patient volume, return phone calls and administer relatively simple tests (such as ECGs and pulmonary function tests), it may be time to augment your staff with a well-trained medical assistant (or another one).

3. Physician extenders. A practice that continuously schedules new patient appointments six weeks or more from initial patient or referring physician contact should consider adding a physician extender, such as a nurse practitioner or physician assistant, to facilitate patient access to the practice.

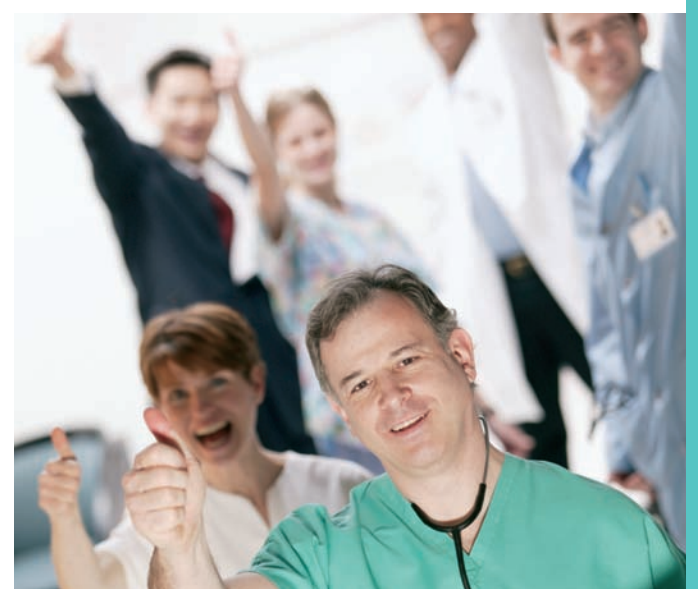
To determine whether to hire a physician extender, it helps to perform a calculation involving the potential hire's salary, a percentage of practice overhead and a 10% to 15% profit margin. For instance, if the extender costs \$80,000, and the practice has an overhead of 50% to 55%, plus an expected profit of 15%, the extender would need to generate \$140,000 to \$150,000 of collected revenues to make the investment worthwhile.

4. Billing staff. Charge entry delays, accounts receivable problems and low gross collection ratios may indicate a lack of adequate billing and collection staff. Many practices neglect this very important area. It's vital to have adequate, well-trained staff members performing your billing and collection functions.

A good benchmark for billing in an average practice is one full time staff person per \$1 million in collections, assuming charge entry is performed by other staff.

Balanced needs

Appropriate staffing calls for striking a balance between meeting the needs of your patients and the profitability needs of your practice. If you are growing concerned that you're either retaining too many or too few employees, take a step back and look at the performances of the people you employ and consider whether they're doing too little — or too much.



Afraid your practice is washed up? Try SOAP!

When a practice (or any business) is failing, it takes special attention to resolve the problem. Unfortunately, practices in trouble won't just fix themselves. To turn things around, a careful process of diagnosis and treatment is called for. One approach familiar to many medical professionals is the SOAP method. Let's take a look at its four components.

Subjectively describe the problem

A subjective description of the problem may come from a staff member, patients, accountants, attorneys or one of the physicians who are concerned about pay decreases or not fully funding the pension. Listen to the issues and symptoms the individual describes.

Even if the problem seems obvious, it's worth reviewing the practice as a whole to be sure that, by fixing the "obvious," you haven't overlooked a major contributing factor. This is similar to reviewing multiple organ systems of a patient before declaring a final diagnosis. It's more than likely that the practice is suffering from multiple "system" failures and not just a simple process problem. A practice in severe financial distress did not get into trouble overnight — it was a slow process over time.

Objectively identify the problem

Just as you would in an objective assessment of a patient, it's important to objectively review elements that you can measure — such as cash collections, patient volume, expenses, charges, accounts receivable, benefits costs and internal controls — when reviewing your practice and its problems.

A good idea is to perform a diagnostic survey and review each of the areas against physician practice benchmarks. Benchmarking information can be obtained from the Medical Group Management Association (MGMA), consultants, publications and other professional organizations. Software from vendors such as Pathways to Success and MGMA is also available to assist in the benchmarking process. During the objective assessment, perform a detailed review of the financial statements and cash status. If necessary, develop a cash flow projection for the next three, six and 12 months. You want to measure the nature and extent of the problem and any other potential areas of concern.

For instance, a diagnostic survey may find issues in the billing area, such as denials not being processed, or you might find staffing problems, such as a physician who is failing to maintain his or her productivity or simply has an excess of full-time staff members. You also may discover expense issues. These are typically found in three categories: 1) Direct expenses, such as rent, 2) Variable expenses, such as supplies, and 3) Employee expenses, such as salaries and benefits.

Assess the problem

The assessment follows the findings of the objective examination. It's the diagnosis portion of the turnaround. In some cases, the benchmarks and study of the financials show a clear diagnosis of the problem. In other cases, they may help guide to a number of issues but not a clear diagnosis.

As you do with your patients, don't stop searching until you can determine a treatable diagnosis. (You may find more than one.) Be honest with yourself and your partner(s), and get outside help if you need it.

Plan a solution

The final step is to develop a plan to solve the problem. Order more information (tests), if necessary. Define the plan in detail by putting it in writing. Assign dates and responsibilities to the appropriate staff and partners. As you're carrying out the plan, and even after you're finished, be sure to bring the patient back in for regular checkups. You may need to adjust the patient's "medications" following one of these checkups.

8 steps to a successful turnaround

- 1. Perform a diagnostic survey.** Determine all the problem areas in the practice through a systematic review of all operational and revenue areas. Benchmarking should be performed as part of the survey.
- 2. Determine physician productivity.** Review the compensation models to determine whether they're designed to promote productivity and financial responsibility. Implement changes to enhance productivity. If necessary, change the compensation to recognize administrative duties of managing partners.
- 3. Assess the value of midlevel providers.** Parties such as nurse practitioners and physician assistants can enhance physician productivity and enhance profitability. If not used correctly, however, they add unnecessary expense.
- 4. Consider the number and mix of support staff.** Staff costs are typically a practice's most substantial expense next to physician salary and benefits. Be sure you have what you need — and only what you need.
- 5. Review all expenses.** When deciding whether to cut items not critical to the survival and profitability of your practice, managers and physician leaders shouldn't hesitate to use the technical term "No!"
- 6. Evaluate cash generators.** These include factors such as physician productivity, volume, billing and collections. Collect all the money that is due to your practice.
- 7. Develop an action plan.** It should be a detailed strategy for success complete with dates, assignment of responsibilities and expected results. This plan will be the road map for the turnaround.
- 8. Create a turnaround budget.** A budget based on the plan can keep the plan from spiraling out of control. Identify specific categories and, of course, numbers to achieve the financial goals you have set.

A checklist for your annual practice physical

As a physician, you no doubt recommend that your patients get an annual physical to avoid major health concerns. Well, we recommend that you follow much the same approach when it comes to your practice and perform an annual operational physical to head off major business concerns. Here's a checklist to get you started:

Yes No

- Practice has a clear organizational chart.
- Practice has meetings to discuss operational policies/procedures.
- Physician partners meet regularly to discuss business issues.
- Practice manager meets regularly with the managing physician(s).
- Practice has an annually updated budget and business plan.
- Practice has specific plans for HIPAA/other compliance matters.
- Practice annually updates personnel manual and benefits policies.
- Job descriptions are current for all employees.
- Practice has a formal staff orientation program.
- A current pay job deck is used by the practice for each position.
- Staff is formally evaluated at least annually.
- Staff raises and bonuses are based on performance.
- Practice has a dress code policy.
- Office manager follows principles of managing by walking around.
- Office signage is clearly visible and easy to understand.
- Waiting room is clean, accessible. Check-in window is easy to spot.
- Reception staff greets patients promptly/maintains good eye contact.
- Practice has written emergency policies, procedures, staff training.
- Patient waiting times are logged and reviewed at least quarterly.
(Waiting times should not exceed 20 minutes.)

Yes No

- Practice annually conducts and reports patient satisfaction surveys.
- Practice's hardware and software are less than five years old.
- Critical data is backed up daily (stored in secure, fireproof location).
- Staff is provided OSHA training at least annually.
- Phone system can adequately handle patient call volume.
- Practice performs and analyzes annual benchmark surveys.
- Practice provides patients with a detailed receipt when they pay.
- The practice has written standards for entry of charges.
- Physicians are there at least 15 minutes before scheduled appointments.
- Superbill is easy to use and updated in the last 12 months.
- Patients called 24 to 48 hours in advance to confirm appointments.
- Patient information is updated (copies of insurance cards; copays/deductibles collected; outstanding balances requested and payment received at check-in).
- Practice's missed appointment rate for patients is less than 5%.
- Accounts receivable are within normal limits for days outstanding for the specialty (generally less than two months).

Each "No" answer should trigger an action plan that includes a specific employee assigned to correct the problem.



Health system physician groups are a two-way street

With hospitals and health systems all over the country building hospital-owned physician groups, it seems like the 1990s all over again. Many systems are implementing a strategy of group building. Some are adopting the strategy because changes in laws have narrowed the methods that hospital and health systems have to assist their physicians with recruitment and expansion. For others, employment models are the only way to recruit and retain specialties such as trauma, orthopedics and neurosurgery. Finally, some have come to believe that the only way to stem the tide of competitive free-standing centers is to develop large groups that can control the market.

Yet, for smart health systems and physicians, there is a difference between the 1990s and the new physician models of 2007. Nowadays, these groups are a two-way street. Both the health systems and physicians are equally vested in the long term success of these groups. And both parties can benefit if each fulfills the other's expectations and financial, operational and quality goals.

Key differences and challenges

Today's hospital and health systems have learned from the mistakes made in the 1990s. Successful employment models mimic private practice arrangements in many ways.

Unfortunately, too many hospitals and health systems still leap into physician employment models and try to manage them as they manage other hospital product lines. They often fail to grasp that running a physician practice as you run a hospital product line could very well lead to substantial financial losses and unhappy physicians and administrators.

In today's successful health system physician groups, contracts are short term (usually one year). Guarantees, if used at all, are only for one to two years, and then the models become productivity based. Productivity is measured using RVUs, cash collections or modified cash collection formulas. Productivity and expenses are carefully measured on an individual physician basis.

Financial reporting is the single most important aspect of successful employment arrangements. It's also the most difficult to achieve for the hospital and health system. Individual physician financial statements are produced monthly and in great detail.

In addition, physicians are charged with running their practices with appropriate administrative assistance. Successful employment arrangements don't group physician financials, nor do they charge the individual physicians for excessive management fees or space.

Best practices

Experienced management is vital to the success of employed physician groups. A practice manager who has worked in a physician practice isn't necessarily the best person to run a hospital-employed group.

Rather, an experienced business person who understands hospital policies, financial management, practice operations, JCAHO regulations, and physician relations can be a better choice. These individuals, however, are difficult to find. Some hospitals have begun to outsource this function to management companies.

Billing, collections and electronic medical record systems also must be implemented and fully functional to capture all revenue opportunities, patient referrals and quality information.

The single most important aspect of developing an employed physician model is a detailed physician business plan for each individual physician. Most hospital and health systems perform a financial model on the practice being acquired, but only the most successful hospital and health systems develop a business plan for each physician and then follow up to see whether the plan is fulfilling initial projections.

The plan should begin with the initial hire. A winning hospital system doesn't start a physician until he or she is fully credentialed. The plan also needs to consider factors such as practice volumes, payor mix, expenses and hospital contribution margin.

The physician's responsibility

Physicians can do very well in employed models as long as they understand all that's expected of them and as long as they're partnering with a well-organized hospital or health system that understands and appreciates the complexity and difference of running a physician practice.

The positive for an astute physician joining an employed model is that the relationship with the hospital can smooth out the capital restraints of running a private practice, increase managed care fee payments, and decrease malpractice and benefit costs.

Yet, when negotiating their contracts, physicians should resist the urge to "get greedy" and ask for financial considerations beyond what the practice can sustain. To attain long-term stability, the practice must be able to carry itself financially. Physician contracts must be clearly written to outline the exact method of productivity measurements. Conversely, physicians must ensure that they won't be charged for extraneous expenses or needless administrative overhead.

Once the contract is signed, physicians should manage their practices as they did (or would) a private practice. In other words, they need to:

- Continue to review financial, accounts receivable and expense data,
- Demand detailed information from the hospital or health system and expect to question results,
- Request marketing and practice development from the group,
- Ensure that staff treats patients in an acceptable manner and continues to follow other processes and procedures, and
- Implement ideas that improve the practice.

In addition, physicians must meet regularly with the administrative staff to discuss operational and financial issues. They should also stay involved in the budgeting process, signing off on the business plan and ensuring that what is planned can indeed be achieved.

A fruitful partnership

If both parties take the goals of the employment model seriously and work in concert to achieve the financial, clinical and community objectives, they can create a fruitful partnership. But, as with any partnership, the basics of running a business must be followed.



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Fee schedules: An important practice function

Do my fees really matter? Many physicians are growing increasingly frustrated with their fee schedules and are either totally ignoring them or reviewing them only annually. The reality is that a physician fee schedule typically reflects a price that few, if any, patients actually pay. Yet, in truth, fee schedules are an important practice function worthy of your attention.

Understanding the purpose

From a business perspective, the practice fee schedule should reflect what a physician believes his or her service is worth. Its prices should be based on a combination of factors such as the physician's skill, the practice's location, the type of patient population the practice attracts, and its office aesthetics.

But this is only the retail price. Also important is the discount price, which is the price you're willing to accept in return for some concession by the payor. Too many times physicians accept any fee schedule sent to them by payors, agreeing to accept any discounts of their fee schedules without negotiating specific volumes or service issues.

When was the last time you reviewed a fee schedule that was attached to an agreement and set up a meeting with the payor to discuss what they will do in return for the discount?

In addition, the concept of Health Savings Accounts (HSAs) is growing rapidly. HSAs will expand the concept of retailing and cash in the life of a practice.

Physician practices (note: we specifically did not use the term "health care" because the other segments in health care typically do not discount as easily) agree to accept discounts of their fee schedules without negotiating specific volumes or service issues. Physicians have made this a regular habit, so much so that their retail fee schedules do not mean very much.

Assessing your area

Before you attempt a negotiation, however, you need to know how not to set your fee schedule. Most physician fee schedules are schizophrenic in nature, with fees varying across the board.

For starters, EOMBs that show whether the insurer has paid at or close to your current fee schedule or the Medicare fee schedule shouldn't determine your fee schedule. Nor should you adjust your fees only when the fees paid on EOMBs equal those of the best payor in the market.

A better approach is to assess the fees in your area in the context of a detailed revenue enhancement plan that's integrated with your practice's overall business plan. Try to set your fee schedules between the 50th and 90th percentile for the doctor's ZIP code or 150% to 200% of Medicare

fees. The exact level depends on a variety of factors, including your patient demographics, location and specialty.

Fee schedules are available from a number of sources that are localized by ZIP code and specialty.

Discounting your fees

The next step is determining how you want to discount your fees. And before you can agree or disagree to any discounts, you need to know where you stand with your current reimbursement patterns. Never agree to a contract without consciously understanding why you're willing to accept the insurer's fee schedule. "Because it's all that's offered" isn't an acceptable answer.

Begin by analyzing what major insurers in your market are paying you. To do so, examine 20% of the CPT codes that make up 80% of your practice's revenue. Depending on your specialty, you'll likely need to look at about 15 to 20 CPT codes. You can obtain this data from each payor's EOMBs.

From there, you have to analyze the biggest payors in your practice. Doing so will give you important information on the volume of patients and revenue from each payor. This information coupled with the fee analysis will help you plan the negotiating strategy and the volume discounts you're willing to give the payor.

After agreeing to a fee discount, be sure that the payor indeed pays what you agreed to. Develop a system for auditing insurer payments. This can be automated through the practice billing system or done manually. Remember, it's your money and insurers do make mistakes.

Planning for the coming year

Review your fee schedule annually. The best time to do so is in December or at the end of your fiscal year. In either case, you want the review to coincide with your practice's budget so you can negotiate your fees effectively for the coming year.

Ultimately, you can't blame managed care or even your individual insurers for a poor fee schedule. It's nobody's fault but yours. Fortunately, there's plenty you can do about it.