



In this issue:

Maximizing exam room profitability with floor controller/managers
Page 1

Key details in practice mergers
Page 2

Considering the practice benefits of clinical trials
Page 3

Practice strategies for getting through tough financial times
Page 3

Coping with the "on call" conundrum
Page 4

Every industry has little details that management would rather not deal with. Some are larger industry-specific issues and others are just the little aggravations of running a business, such as operating through tough financial times. For businesses in the health care profession, controlling the flow of patients, handling on-call duties, contemplating mergers, and trying to add new services are a few of these potentially frustrating areas.

In this issue of *VitalSigns*, we give advice for practices trying to get through challenging financial patches. In addition, we provide advice for managing patient flow, dealing with the dreaded on-call duties, making mergers a smooth transition, and adding clinical trials to your roster of services.

With the right approach, you can turn these health care concerns into worries of the past, and possibly even profitable ventures for your practice.

Could your practice use an air traffic controller? Floor controller/managers can maximize exam room profitability

You have just come out of one exam room and are ready to head into the next one. But, when you get there, there is no patient inside. Does this happen often at your practice? Does it frustrate you?

An empty exam room with a physician ready to see a patient can cost a practice between \$45 and \$125 a day in lost revenue. And that's revenue that you may never recoup. Sure, you can see the next patient in the waiting room, but the dollars lost when a walk-in or hospital consult is pushed to the next business day are often unrecoverable without additional expense.

What many practices need is someone to ensure that exam rooms are being filled, covered and then cleaned as efficiently as possible. They also need someone to handle any unforeseen problems that may arise to inhibit patient flow into and out of exam rooms.

Typically, this isn't the job of a practice manager, whose role is usually to oversee operational areas such as payroll, accounts payable, purchasing, billing, the front desk and human resources. So whose job is it? For many medical practices, it could be that of the floor controller/manager.

Job description

The primary objective of a floor controller/manager is to ensure all exam rooms are cleaned and turned over in a manner that allows the physician on duty to comfortably and efficiently perform his or her duties. This is not unlike an air traffic controller who identifies which planes are:

- Ready for takeoff (patients leaving and being scheduled for future services),
- Landing (patients being roomed),
- On the runway (rooms being cleaned and prepared), and
- Being handed off to the next controller (scheduling tests and referrals).

A floor manager/controller can also serve as a concierge for patients who encounter unusual situations during a visit, such as lost labs, charts or correspondence, or unscheduled tests or test reports.



Optimal conditions

A floor controller/manager won't work for every practice. Before attempting to implement this position, consider the specialties of your practice, the number of physicians who typically see patients at the same time, the number of patients the practice usually sees during a four-hour period and whether you perform ancillary testing.

Practice specialty is a very important consideration. While a floor controller/manager could work in any practice with sufficient volume, specialties such as ophthalmology, orthopedics, general surgery, ob/gyn, primary care that performs procedures, and dermatology work especially well, and such an employee will likely provide a good return on investment.

In addition, a practice should generally have at least two physicians working in the practice at the same time and seeing at least 10 to 15 patients per hour. Practices that provide ancillary services or perform in-office procedures are also particularly good candidates.

The pertinent numbers

Perhaps the most analytical method of determining whether a floor controller/manager is feasible involves reviewing the pertinent numbers involved.

Again, key figures will relate to the volume of patients your practice sees daily, the number of ancillary services you provide (and the revenue generated by these ancillaries), and the number of physicians in the office per four-hour session. You should also measure the average new appointment waiting period.

Essentially, you want to calculate the average revenue per patient and then develop a pro-forma to estimate the amount of revenue you could gain by increasing the exam room utilization rate by a reasonable percentage as well as the additional revenue you could generate from ancillary services.

You should likely consider the position if all of the additional lost revenue recouped is greater than \$42,000 (2,100 hours x \$15 per hour and 25% benefit costs). This number (\$42,000) is your practice's break-even cost (560 patients at \$75 per patient) or 11 patients per week. If your practice can see 11 additional patients per week, you should consider hiring your own air traffic controller.

A worthy effort

As mentioned, it's not a given that a floor controller/manager will benefit every practice. But looking into the possibility of adding such an employee — and crunching the numbers to put a finer point on the decision — is well worth the effort.



Practice mergers

No detail is too small to consider

Your practice needs to diversify its subspecialty offerings to attract more patients, decrease overhead, expand your geographic presence, increase negotiating clout for contracts and expenses, gain financial clout, become more attractive to young physicians, or add ancillary services. Your options are to borrow money and begin to recruit physicians, join a larger medical group owned by a health system, or merge with a like practice. Have you considered the last option lately?

All businesses must plan for the future to maintain low cost structure, continued revenue growth and capital replacement. And, indeed, many physician practices are dealing with strategic issues to assist them with challenges such as decreasing reimbursement, competition from hospitals, decreased leverage with managed care payors and increasing government restrictions. All these things make it difficult to maintain adequate capital to keep the practice moving in the right direction.

Many nonmedical businesses use mergers as a means to grow and meet strategic needs. The medical community, however, typically doesn't engage in mergers for a number of reasons:

- Physicians are often less strategic in thinking than nonphysician business owners,
- Physicians tend to be more competitive with colleagues than other businesses, and
- Physicians tend to have compensation models that are more "eat what you kill" than do other businesses.

Indeed, it's interesting to note that many physicians will consider a change of employment before reviewing opportunities for a practice merger.

Why to merge

A merger isn't a strategy to use because it looks or feels like a good idea. Valid reasons to merge practices include the following:

- To obtain economy of scale advantages,
- To increase geographic coverage and referral base,
- To increase market share, managed care contracting and diversification of services,
- To make sure referrals to physician subspecialties are kept in-house instead of being sent to other practices, and
- To improve recruitment of young physicians and retain good staff.

Whatever the initial reason, however, a merger should be considered a realistic option only after a well-thought-out strategic plan determines growth is necessary for the practice to achieve its goals. These goals must be clearly identified, researched and achievable, and they must be shared with potential merger partners. After all, the goals must achieve positive growth for all parties involved if the merger strategy is to truly succeed.

Potential merger issues

Mergers aren't easy. Practices may encounter many bumps in the road and should expect to confront issues such as:

Staff anxiety and buy-in. Staff will likely be anxious, managers will probably worry for their jobs or posture for new positions and some surprising staff personality traits may emerge. Some of these issues will be perceived and some will be real. It's vital that physician owners maintain open communications with staff to keep them informed and to hear about pending issues that can be dealt with before disaster strikes.

To obtain staff "buy-in" regarding a merger, physician owners need to assure everyone that the merger will benefit all parties. You may have to clarify that benefits may not be equal or the same. For some, the benefits may be financial while, for others, they may be more related to an improved clinical environment or a more enjoyable work environment. In any case, all must feel that they will benefit and eventually see these benefits come to fruition.

Compatibility/operational details. Personal compatibility is vital to physician practices — it's the nature of the profession. Therefore, be sure that personalities, as well as clinical styles and communication channels and styles, will fit together. Take the time to make sure that staff are compatible, because an unhappy staff can doom a merger.

Trust of all parties is vital. Take the time to discuss issues such as practice culture, philosophy, and work and clinical styles before the merger. Discuss all the hard issues up front — doing so will save legal bills later if the merger goes through and you run into conflicts. A bad merger is not worth doing.

Additionally, consider the practical issues of the merger, such as daily activities of billing, patient scheduling, benefits, staff coverage, physician call schedules, staff compensation, human resource procedures and employee rules. No detail is too small to discuss.

Physician compensation. All physicians must understand and agree to the compensation model. Talk about issues such as time off, call coverage, cross-hospital coverage, procedure referrals, ancillary income distribution and income discrepancies. (Note that there are legal issues related to ancillary services that need to be discussed with legal counsel.)

Risk management. Physician owners should consider risks, including ownership conflicts. Buy-sell issues must be thoroughly investigated and agreed upon. Also, noncompete provisions will require significant discussion. To draft both a buy-sell agreement and any noncompete agreements, the physician partners will need to engage a team of professional advisors. All physician owners involved in the merger will need to agree on who these advisors will be.

Thorough and honest

In choosing a merger partner, it's critical to thoroughly and honestly evaluate what each prospective partner can bring to the merger. Dealing with any potential problems before the merger can prevent spending significant capital on merger-related issues that could well have been prevented.

Granted, even with much preparation, there will still be many legal and financial issues to deal with. These include how to structure the merger for tax purposes, what retirement accounts/profit-sharing plans and health care benefit packages to offer, and which personnel laws or regulations you may need to start complying with. Fortunately, good advice is available from your accounting and legal advisors.

Bring both direct and intrinsic value to your practice with clinical trials

Pharmaceutical and medical device companies represent a more than \$30 billion industry, according to national statistics. To test the safety and efficacy of their new products, these companies rely on clinical trials — a required step in securing FDA approval for market retail. In fact, they make significant investments to get their drugs and devices to market as quickly as possible.

Because of the prestige and publication rights of the trials, clinical trials have historically been centered in academic medical settings. Yet because of the motivation to get products to market within a reasonable time frame, the industry has turned to working with private physician groups to expedite the process.

Many physicians have research experience through their residencies, internships and fellowships. If you count yourself among them, offering clinical trials to your patients can bring both direct and intrinsic value to your practice.

3 keys to success

The keys to conducting and succeeding with clinical trials in a private practice are as follows:

1. Physician/provider commitment and involvement,
2. An experienced research coordinator and staff, and
3. A large, diverse patient base.

Pharmaceutical and medical device companies are looking for physicians (principal investigators) with experience and proven success rates. What they aren't looking for is any trend of patient recruitment failures. Thus, having a support staff with experience and contacts within the local pharmaceutical and medical device market will help in bringing studies to your site.

Benefits for patients

Many patients are willing and eager to participate in trials because doing so can bring them a better quality of life in coping with their respective medical conditions. In addition to the

opportunity for improved outcomes and better disease/condition management, the patient can benefit from the trials by receiving:

- Free medications,
- Increased medical attention and counseling,
- Reimbursement payments (in most trials) to help offset the costs of travel and time, and
- Free doctor visits specific to the disease or condition being analyzed in the trial.

All of these benefits reflect positively on the practice and the specific physician involved. And when the patient's physician directly recommends that he or she participate in a particular study, the patient tends to be more compliant and participatory in the trial.

Benefits for the practice

Not only does the goodwill of the physician/patient relationship improve as a result of the patient trial experience, but the physician and practice also receive both direct and intrinsic value for hosting the trials. Such benefits may include:

Net profit to the practice. Profits may come slowly and inconsistently to start. Once a practice conducts a consistent flow of studies, cash flow will likely even out and positively impact the practice's bottom line.

Physician development and networking. Most studies require the principal investigator to go to informational meetings. In doing so, the physician is versed on the study protocol and desired outcomes. In addition, he or she is able to network with other physicians hosting the same protocol.

Professional recognition. Results of studies are typically published. Principal investigators who are high enrollers will be recognized. In addition, in some instances, principal investigators can publish an article (with the express consent of the pharmaceutical or medical device company) on the outcome of their own respective studies.

Marketability. Conducting clinical trials can bring prestige to the practice and assist with recruiting other physicians to the group as well as new patients. Clinical trials bring a new service to the practice that many other practices may not have. To eliminate competing patient bases, a study granted to one physician group will customarily not be placed with another group in close proximity.

Initial investments pay off

Physicians and patients are the two key components in the clinical trial process. And seeing as how physician practices have both, often in abundance, they are fast becoming essential to research and development in the pharmaceutical and medical device industry. Make no mistake, though: Developing a reputable clinical trial program in your physician practice, and becoming an experienced principal investigator, will require an investment in time, effort and patience. Nonetheless, an established clinical trial program can bring value to your practice that will endure over time — as long as your commitment remains consistent.

12 strategies for getting your practice through difficult financial times

As of this writing, a recession has been predicted for 2008. In addition, the Medicare (CMS) reimbursement is scheduled to decrease up to 10% in the summer and, come this fall, the nation will face a presidential election.

On a more human level, some of your patients may have lost their jobs — and insurance coverage — recently. Meanwhile, managed care plans haven't increased fees and are negotiating discounts, and expenses are increasing.

What this all adds up to is that turbulent financial times are, if not here, at least threatening. Here are 12 strategies that your practice should implement annually but that are especially important when times get tough:

1. Develop a written practice budget for 2008 and conduct a thorough review of all expenses. A simple budget can be developed by reviewing the last financial statement of 2007 and setting a goal for each line item, revenue, expense and physician compensation amount.
2. Assess each position to determine whether each person is really needed to achieve your practice's goals.
3. Reduce staff retirement funding costs. Look at the feasibility of offering 401(k) plans or cross-testing plans that could decrease costs.
4. Review loans and credit lines. Interest rates are generally low — ask your bank about what opportunities it might offer you for decreasing your interest costs.
5. Review all maintenance and extended service contracts for telephones, computers and copiers. Compare the cost of repair vs. new equipment. Check the age of each piece of equipment and its cost of maintenance. In many cases, physicians are better off without these contracts.
6. Review staff health insurance costs. Institute a policy to have staff contribute to the cost of health insurance. Other options include increasing deductibles, instituting a waiting period for new employees, covering only full-time employees, or allocating a fixed dollar amount contribution to employees annually for a medical spending plan.
7. Review all business, life, and disability insurance annually and solicit bids for new policies to replace any not providing adequate value.
8. Develop a marketing plan and devote 2% to 4% of the aforementioned budget to marketing to new patients.
9. Take advantage of practice slow periods (down time) to call back inactive patients for physicals or screenings.
10. Bring in an outside consultant to analyze opportunities and address weaknesses in the practice for potential improvement.
11. Review the billing and collections area for potential revenue that you may be missing. Look particularly at denials, and make sure days revenue outstanding is less than 45 days.
12. Conduct a review of all procedures to determine the most frequent CPT-4 codes used. Examine coding and charting to be sure that the practice is billing appropriately.

When it comes to revenue and expenses, successful practices pay attention to every detail. And you must be extra diligent during difficult financial times.

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On-call duties remain a contentious issue for many hospital physician groups

Many hospital physician groups dread the day that a senior partner informs the other partners that he or she is no longer interested in being "on call." It may be that the physician has reached a certain age (usually 55 or older), has developed an elective practice that prevents him or her from taking calls, or may simply want to work fewer hours. Whatever the case may be, most physicians, regardless of age, look forward to the day when they can stop taking night and weekend calls.

Why? For starters, there's the Emergency Medical Treatment and Active Labor Act (EMTALA), which Congress passed in 1986. It requires hospitals to treat patients regardless of their ability to pay, significantly increasing the demand for emergency department services. And with the increase in patients seeking treatment has come a rise in the number of calls from emergency departments to on-call physicians.

So, in addition to having concerns about disruptions to family or social life, physicians are concerned that the additional call volume from EMTALA puts them at greater risk for malpractice litigation as well as for not getting paid for services provided to uninsured patients.

Historically, physicians provided on-call services to hospitals for free in exchange for membership on the medical staff. But even this has changed. Because of the increased risk of malpractice litigation, changes in overall reimbursement and heightened work hours, hospitals are compensating some specialties for on-call work at fair market value rates. Yet, despite the trend toward reimbursement, most physicians still don't look kindly on having to be on call.

A tense situation

As mentioned, to remain on staff at a hospital, most physicians are required to provide on-call

services. The problem, of course, is that, if one member of a group doesn't wish to take calls, the remaining group members must make sure the calls are covered. And how does a group react when one member decides being on call is no longer part of his or her practice?

The difficulty is that most groups haven't developed a policy regarding on-call services before a physician requests special dispensation. When that does happen, the initial discussions are usually tense: Young partners begin to calculate the additional nights and weekends they'll have to cover — and physicians tend to put a high value on any additional on-call nights and weekends.

Meanwhile, the physician requesting the decrease or elimination of on-call duties usually has well-thought-out reasons for the request. Nonetheless, the remaining physicians, who are typically younger and lack the more senior physician's years of service, see only the additional burden placed on their respective lifestyles.

Potential solutions

There is no single correct way to deal with the on-call conundrum — there are many options. The first question to discuss among partners is whether the group can even handle the additional calls. For example, say a four-person group suddenly has only three on-call physicians

when a partner decides to no longer take calls. The group may not be able to handle the additional calls without hiring another physician.

Second, the group should review its compensation model and the effect calls have on partner compensation. If the group shares compensation equally, an adjustment is appropriate for a decrease in, or abolition from, on-call duties. If physicians are compensated based solely on production, however, the pay rate isn't relevant to the amount of calls he or she is required to take.

Third, the group may choose to place a value on each call night or weekend. Bear in mind, however, that calculating the actual value may be just as difficult as dealing with the on-call issue as a whole. No formula fits every group.

The right fit

Generally, the most advisable way for dealing with the on-call issue is to set the rules before a decision is needed. No physician group can anticipate all of the potential circumstances that may affect the on-call rules.

Nonetheless, having some kind of plan — even if it's that all active physicians must continue to take calls — is better than having none at all. Ultimately, every group needs to find a solution that fits its distinctive culture, financial situation, specialty, age distribution and payor mix.