Your toughest practice

Our roundtable experts have the cure for declining reimbursements, billing bottlenecks, long hours, and unhappy patients.

By Robert Lowes
SENIOR EDITOR

problems SOLVED

Doctors solve other people’s health problems all day long. Meanwhile, they’re often desperate for somebody to solve their practice management problems.

Health plan hassles, hectic schedules, coding rigmarole, efforts to grow the practice are familiar challenges of modern medicine. To find a cure for what’s plaguing your practice, Medical Economics convened a roundtable panel of practice management experts at the 2007 annual meeting of the National Society of Certified Healthcare Business Consultants in Nashville. Each panelist presented a chief complaint he’s heard from doctors, then offered a treatment plan. In the following roundtable presentations, you may see a plan of action that could work for your practice.

DOCTORS’ PROBLEM: Declining third-party reimbursements are eating away at profits, and more Medicare cuts are on the way. How can a doctor generate extra revenue to offset the losses?

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Doctors’ problem: Declining third-party reimbursements are eating away at profits, and more Medicare cuts are on the way. How can a doctor generate extra revenue to offset the losses?

Ancillary services can give you the raise you’re not getting from Medicare and third-party payers for office visits, and regularly help doctors launch them.

A solo FP in Pennsylvania invested $2,500 in a spirometer a year ago. Spirometry now grosses roughly $1,000 a month, almost all of it profit. Likewise, a seven-doctor internal medicine group in the same state nets $50,000 a year—more than $7,000 per physician—from a refurbished bone densitometer purchased three years ago for $20,000. The numbers are bolstered by bone scan referrals from other practices.

However, you can lose money on ancillaries if you don’t do your homework. You have to consider what’s needed in your community, calculate the cost of offering the service, and estimate how much revenue the service will generate based on projected volume. Is it enough to break even? Remember, you may need to hire a specialized technician. There’s also the hidden cost of lost productivity associated with staff and physician training. (To learn more, read our series, “Adding Ancillaries” at www.moneymag.com/addingancillaries.)

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Many physicians are beset by overwhelming patient demand and long waits for appointments. They often respond by working more hours without earning much more income.

A better approach: Execute a "triple play": Leverage midlevels, leverage hours, and leverage plans.

I've never found a practice that didn't make money when it hired midlevels to meet patient demand. Physician assistants and nurse practitioners are more profitable than associates, producing more revenue in proportion to their salary. Most of my clients practice at least $50,000 per year per midlevel.

However, when I recommend midlevels, the response often is "I don't have enough space." If you're a solo practitioner with two or three exam rooms working from 9 a.m. to 5 p.m., that may be true. That's where leveraging your hours—by expanding your schedule—comes in. Patient demand typically runs from 7 a.m. to 7 p.m., peaking before work, during lunch, and after work. Most doctors aren't accommodating that demand.

If your office is open from 7 a.m. to 7 p.m., you can see patients from 7 a.m. to 1 p.m. and schedule the midlevel from 1 p.m. to 7 p.m. You may need to spend a few hours supervising your midlevel in the afternoon, depending on your state's supervision requirements. However, both of you won't see patients at the same time, and you won't have to stay until 7.

Once you leverage your midlevels and your hours, leverage your payer mix by dropping poorer-paying plans. Unfortunately, many doctors accept any plan that comes along. I've walked into the manager's office at practices that take 300, 400, 500 plans, and the only visible place on the floor is the path between piles of paperwork. However, in most practices, five plans account for 80 percent of patient volume. So do an analysis to see where you can afford to slim down.

You're not just dropping plans; though you're becoming an out-of-network provider, which has certain advantages. Patients in dropped plans can still come to you, and you usually will, even though their out-of-pocket expenses go up. With the network discount no longer in effect, they'll pay the full amount of your fees.
plumbing up revenue. You'll also reduce your workload and overhead because, as an out-of-network provider, you'll no longer have to check eligibility, secure preauthorizations, or submit claims. You can't execute a triple play overnight. After identifying the worst payers, gradually drop them, perhaps at a rate of one plan every month, according to your comfort level. In time, leveraging payers, midlevels, and hours will move your practice into a healthier, more manageable situation.

**BORGULM'S SUMMARY: To meet patient demand**

- Hire one or more midlevel providers.
- Extend your office hours to cover early morning, early evening, or both.
- Drop health plans that pay poorly, one at a time.

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**FRANK COHEN, CPA Health Partners, Clearwater, FL**

**DOCTORS' PROBLEM:** Visits take so long that patients often walk out before they're seen, and no-shows are increasing. Would a second midlevel provider solve the problem, or should the doctors look elsewhere for a cure?

I recently encountered a three-doctor internal medicine practice that seemed to be a victim of its own success. To cope with its phenomenal growth, the group had hired a physician assistant to handle low-complexity visits, freeing up the doctors to see more new patients. However, patients had begun to complain that office wait times were too long. Some walked out in frustration. Others canceled or skipped follow-up appointments.

The doctors were adamant that new patient visits were the root cause of the backup. The physicians were certain they were spending more time in the exam room with new patients than with established patients. They wondered if they needed to hire a second PA to at least lighten their established patient load.

To test the doctors' assumption, our consulting team used a stopwatch to time visits for new and established patients. We did this for five days a week over a four-week period. We tracked the number of minutes from patient sign-in to exam room, exam room to physician encounter, and physician encounter to checkout.

The findings pointed to another problem entirely. There was no significant difference in the time spent with new and established patients, it turned out. The true bottleneck occurred from the time new patients checked in to when they actually saw the doctor—it was, on average, 25 minutes longer than for established patients. The main reason for the slowdown was patient registration.

We mulled over the idea of having new patients register online, using an abbreviated form. But when we surveyed patients—a mostly older population—we discovered that less than half had Internet access.

So we experimented with mailing registration packets to half the people who called to schedule new-patient visits. Seventy-five percent mailed back the completed forms. That simple act cut wait time from check-in to a doctor's handshake by nearly 20 minutes, making it only six minutes more than that of established patients. The group found its solution.

Registration by mail has greatly reduced cancellations, no-shows, and walk-outs. The streamlined process also lessens the three doctors and the PA one extra patient a day. With the average visit grossing $122, nine patients translate into an additional $1,098 a day, or $285,480 a year based on 250 days of work. If we hadn't tested the doctor hypothesis or performed our timed analysis, the group might have hired a second PA for $70,000 a year, without ever fixing the real problem.

**COHEN'S SUMMARY: To reduce in-office waiting time**

- Time each stage of a visit to pinpoint logjams.
- Mail new patients registration packets, with return envelopes.
- Offer online registration for the Internet-savvy.
- Streamline registration forms for ease of use.

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**DOCTORS' PROBLEM:** A four-physician specialty group has hired a fifth member, but cramped quarters and short office hours are hampering efforts to integrate the newcomer. The doctors won't move or expand, and need to figure out how to maintain productivity.

A four-doctor urology practice wanted to add a new doctor. I'll call Jeff D. Plumbeur, the physicians' expectations created obstacles. They wanted no more than three doctors in the office at any given time so they wouldn't be smothered over each other. To complicate matters, they wanted to continue working the same number of hours each week as they always had. But there were only so many hours in the schedule, which ran from 9:15 a.m. to 4:30 p.m., to divide among five doctors. And, with the office space jam-packed, where was Plumbeur going to work? Both he and his secretary wanted private offices, and an extra exam room would allow each doctor to maintain his current level of productivity.

One obvious way to solve the space problem would be to build or rent a larger facility. But the doctors quashed that idea as too expensive. They owned their current building free and clear. Besides, they liked their location, across the street from their hospital's outpatient surgery center. The only other option was to reallocate their existing space. But how?

The group had recently implemented an electronic health record system. We realized this eliminated the need to store paper charts on site. We emptied out the chart area and used it to create workstations for two staff. The space they vacated became private offices for Dr. Plumbeur and his secretary. We converted another room, used occasionally for patient consultations, into an extra exam room. The space problem was solved at minimal cost.

Finding a scheduling solution was much simpler. We expanded office hours by starting at 8 a.m. and walking in 3:00 p.m., adding 135 minutes of patient care each day. The extra time allowed the group to stagger physician schedules and avoid over-crowding. As a bonus, the extended schedule made it possible for the doctors to put in more time and increase their productivity.

By rejiggering the use of space and re-examining what files or papers needed to be kept in the doctors' quarters, we integrated Dr. Plumbeur into the group without the expense of moving or getting larger quarters.

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**BRADY'S SUMMARY: For adding a physician**

- Assess the existing space and its uses.
- Make room for additional staff or providers by moving paper versions of computerized records off-site.
- Ensure that each doctor has an adequate number of exam rooms.
- Extend office hours and stagger physician schedules.
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Frank Cohen,
CPA Health
Partners,
Clearwater, FL

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Mike Brady,
Healthcare
Business
Consultants,
Asheville, NC

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