

Maximizing Income While Controlling Costs

It is getting tougher to make money practicing medicine, according to a recent report by the Medical Group Management Association. The MGMA's 2005 Cost Survey reports that from 2003 to 2004, the margin (median total medical revenue after operating expenses) per full-time-equivalent (FTE) physician for primary-care medical group practices shrank by 5.5 percent to \$201,896 for internal-medicine practices; by 3.9 percent

to \$217,315 for primary-care, multi-specialty practices that are not owned by hospitals, and by 0.6 percent to \$214,377 for family-medicine practices.

In this environment, medical practices must maximize their income-generating opportunities. Many physicians try to do this by squeezing in as many patient visits as possible into every hour of every day. While that's certainly one approach, experts say that there are many other effective techniques.

MGMA attributes this trend to rising employee costs and deeper discounts to payers. "You have to be a lean, mean operation, but primary-care practices are just trying to stay in business," says Deborah D. Milburn, administra-

tor of the eight-physician Dublin Primary Care in Colorado Springs, Colo.

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For example, practices can improve the bottom line by reviewing and controlling operational costs. This process should go far beyond ordering all your supplies from the same vendor to achieve economies of scale. There are many small things you can

do that add up to huge savings.

Your first step is to determine what your baseline is or how much income you need to generate to operate your practice, says Martin Moll, director of the healthcare consulting practice at Aldrich Kilbride & Tatone, a certified public accounting firm in Lake Oswego, Ore.

“You’d be amazed at how many physicians don’t even know what their baseline is,” he says. “If you don’t have that, then it’s hard for you to understand whether you’re in the fiftieth or ninetieth percentile.”

Determine how much income you need to generate to operate your practice, says Martin Moll of Aldrich Kilbride & Tatone in Lake Oswego, Ore. “You’d be amazed at how many physicians don’t even know what their baseline is. If you don’t have that, then it’s hard for you to understand whether you’re in the fiftieth or ninetieth percentile.”

He refers to one practice with three physicians that was earning \$750,000 each year but could have been earning at least \$1 million. Because the doctors never established a baseline, they had no idea what other practices their size were earning or spending. Once Mr. Moll and his staff compared their numbers with

standard production benchmarks of other, similar medical practices, this practice fell drastically below the median, he says.

Their problem wasn’t a matter of seeing too few patients. He says that they were simply doing “fundamental things wrong.” For instance, they did not raise their fees for three years, which is not an uncommon practice. While Mr. Moll believes that physicians need to increase their fees every other year—or at least review them—he has worked with some medical practices that haven’t done so for as long as eight years.

However you look at it, that is a lost opportunity. As an example, he says, suppose you charged \$60 for an office visit when your practice first opened its doors five or 10 years ago. Although you still charge that same price today, your contracted rate with insurance companies has since risen to \$70. So when you multiply that \$10 difference by the number of office visits you have each day—well, you do the math.

For the most part, raises in service fees are transparent to patients. The idea here is to make sure that you are being fairly

compensated. One way to find out is to check with local medical associations that can provide you with pricing guides and benchmark data.

It is also important to identify your payer mix. Where is most of your income coming from? Are you dealing with mostly Medicare patients or a managed-care population? Maybe your area supports a fairly good private patient base that you haven't yet tapped into for additional earnings.

The last scenario happened to one primary-care physician who lacked a steady stream of patients. Mr. Moll suggested this approach: Have the nurse flag every private-pay patient. At the end of the office visit, the physician should say to each private-pay patient, "I've really enjoyed working with you. If you know of other people who would enjoy having me as their primary-care doctor, please pass along my name."

The doctor followed Mr. Moll's advice, and within six months the doctor had increased his revenue by almost 30 percent, all because he focused on one patient population that would increase his revenue.

Another medical practice earmarked patients who had not yet scheduled their annual exam. The receptionist would call them and say, "Mrs. Jones, it's time for your annual checkup. Do you want me to schedule an appointment?" Mr. Moll says that the practice dramatically increased its earnings by using this approach instead of sending a postcard as a reminder.

No matter what type of medicine you practice, he says, the key is to focus on volume. "Physicians all the time want to add ancillaries, then look at their numbers and realize that they can actu-

System Yields Immediate Savings

Can't afford an electronic medical record system? You may want to re-evaluate your decision. Dr. Kelly Ahn, an internist at Sandy Springs Internal Medicine in Atlanta, Ga., says that his practice, which supports six physicians, immediately saved \$65,000 on transcription costs alone, once a limited electronic medical record was implemented.

What's more, the practice was able to reduce its medical records staff by one member. At least another \$30,000 was added to its bottom line.

ally have a better practice before they [offer] exotic techniques,” Mr. Moll says.

Still, he says, a growing trend is for physicians to create specialized practices like oncology clinics that focus on women’s health, or an arthritis clinic staffed by orthopedists and gerontologists to treat arthritic patients. Such specialization can help

A growing trend is for physicians to create specialized practices like oncology clinics that focus on women’s health, or an arthritis clinic staffed by orthopedists and gerontologists to treat arthritic patients. Such specialization can help you develop a reputation for being the best in your region, which in turn may draw private-pay patients to your practice.

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Often physicians ignore such opportunities and believe that cutting costs is the answer to maximizing profits. This isn’t always the best solution. Ask yourself, “How efficient is your back office in collecting revenues or following up on problem accounts? Before building more revenue, you must maxi-

mize the business you have; otherwise you’ll be spinning your wheels. Your problems will just grow bigger.”

Recently Dr. Eric Goldberg, an internist at Murray Hill Medical Group in New York City, began exploring different ways to maximize his practice’s technology and infrastructure. “About three years ago, we started looking at ways to leverage what we had already built,” he says, adding that his practice supports 25 internists, each of whom sees between 10 and 18 patients per day. “We created a lot of self-service mechanisms to improve our response time to patients.”

Patients schedule their appointments over the Internet, which he says has been a “big boon” because it enabled the practice to cut its staff by five and to save more than \$250,000 a year on salaries and benefits. What’s more, he says, the Internet doubles as a marketing tool.

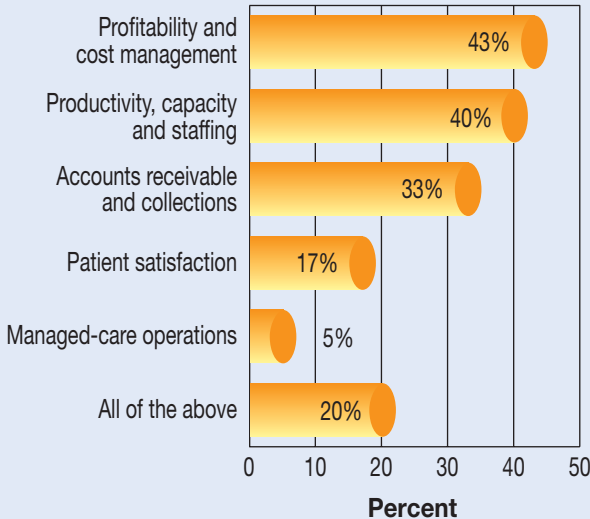
“I’ve had multiple patients who, when I ask, ‘How did you hear about us,’ say, ‘Somebody told me I can make my appointment on-line, so I want you to be my doctor,’” he says. “It separates us from other practices.”

The group also makes an effort to be featured in the media. Dr. Goldberg, who is also the assistant director of clinical informatics at New York University Medical Center, says that all the physicians at Murray Hill are also on staff at the medical school and take advantage of every media opportunity that comes their way through the university's press office. He says that it is another way to recruit new patients.

As the practice grew over the years, it added 12 specialists including cardiologists, gastroenterologists, endocrinologists and dermatologists. It also designed a stress-testing lab in the office and introduced more services like colonoscopies, Botox and other elective procedures, all of which generate roughly 25 per-

What Needs Improvement?

A survey by the Medical Group Management Association asked where practices are working the hardest to improve operations.



Source: MGMA Pulse Check survey, March 8, 2005. Pulse Check questions are posted on the home page of the MGMA Website (www.mgma.org).

cent of the practice's bottom line.

In 2005, Dr. Marc Kayem, an otolaryngologist in Los Angeles, began offering allergy testing and allergy shots. "My associate—the other doctor in the office—has a lot of interest in this," he says. "She has a degree in immunology. This is something that can be a significant income generator when established."

He says that allergy departments can generate income for very little cost. For example, in the seven- to eight-month period since the allergy services were introduced, the practice's income has increased by between 3 percent and 5 percent. Eventually, as word catches on, he hopes that number will jump to between 30 percent and 40 percent.

One part of his office is also certified by Medicare as a surgical room. The accreditation was very difficult to obtain, he says, explaining that it took roughly one year to achieve this status. Some of the deficiencies that had to be corrected were "ridiculous," he says, recalling that one door had to be moved three feet over on the same wall.

But in the end, the headaches were worth it. Now the pair can perform minor surgery right in their office rather than using the facilities at the local hospital. Not surprisingly, their reimbursement is usually higher than the surgeon's fee alone. For example, he says, whenever he or his partner would perform surgery at the local hospital, the insurance company or Medicare would pay them about \$1,000. But now, when the surgery is performed at their own office, the practice receives anywhere from \$2,000 to \$4,000. The in-house set-up is also advantageous for patients. If they were sent to the hospital for the same procedure, he says that their bill would typically be two to three times higher.

Small Changes, Big Savings

Some physicians expect their office manager to control office expenses. Whoever handles this task should start by reviewing the practice's five highest costs: salaries, rent, professional liability, professional services and supplies, says Mr. Moll.

Start with the highest expense category, which is staff compensation. He suggests that you evaluate every employee's responsibility and value. Maybe you can reassign tasks while still maintaining a harmonious operation. But be careful not to

go overboard. Sometimes firing a staff member to save money can backfire. Mr. Moll says that he has known physicians who focused too much on cost savings and fired a worthy employee, a decision that quickly proved disastrous. Savings can be achieved by simply redeploying employees, giving them new or additional tasks.

“Don’t simply flush costs without understanding the revenue picture,” says Mr. Moll. “Physician clinics are a fixed-cost business. Focus on the revenue side, not on the expense side.”

Still, there are times when it makes sense to analyze your spending. Good examples are costs related to office or equipment rentals. Does it make more

Does it make more sense to buy the building you are in and lease out office space to other health-care providers? Perhaps you refer a lot of patients to a nearby medical facility for CAT scans. Is it more efficient to own the imaging device? Compare and contrast the benefits of owning versus renting or leasing.

sense to buy the building you are in and lease out office space to other healthcare providers? Mr. Moll says that he recently created a medical complex for a physician who bought the building, then leased space to other healthcare providers in the field of women’s health.

Perhaps you refer a lot of patients to a nearby medical facility for CAT scans. Is it more efficient to own the imaging device? Compare and contrast the benefits of owning versus renting or leasing. You may be surprised by what you discover.

Dr. Bonnie Sunday found eight small ways to save money at her family practice in Orchard Park, N.Y. “Some physicians leave it up to their office manager,” she says. “A lot of them ignore that part of their practice altogether. They go with the flow, do whatever everyone else seems to be doing. They don’t think outside the box or look at alternative ways to set up the practice or to manage costs.”

Here are some of her strategies:

■ Like most medical practices, Dr. Sunday’s biggest expense is payroll. Her practice supports two full-time staff members and one part-time employee. To help control salaries, she created weekly schedules in which no one worked overtime, closed her office on Wednesdays and staggered employee schedules.

- The practice orders business supplies from a vendor who matches the lowest prices of its competitors. Staff doesn't negotiate price or order supplies from multiple vendors, which saves a lot of time and is more convenient.
- Co-payments are always collected at time of service. Employees do not waste time invoicing patients for \$5 here or \$10 there, which also saves money in the use of letterhead, envelopes and stamps.
- The practice no longer rents a postage meter. Letters are mailed the old-fashioned way—by weighing them on an office scale if needed and placing the appropriate amount of postage on each letter. Dr. Sunday says that going back to basics has saved several hundred dollars a year.
- Patients are encouraged to pick up their prescriptions instead of having them mailed. She says that much of this boils down to training the patient. “We tell patients if they need something they didn't tell me about in the visit, they need to come back and pick it up,” she says, adding that it saves both staff time and postage. “It also encourages patients to bring up things during their visit, rather than afterwards.”
- By switching from using a national telephone company to a

Working Side by Side Produces Savings

Doctors at University Primary Care Physicians, an internal medicine practice in Augusta, Ga., optimized their income by being innovative with office space.

When they designed their new office three years ago, they explored ways to limit the amount of square footage that didn't produce any income. At most medical practices, that would mean eliminating each doctor's office.

After a bit of soul-searching, the four full-time physicians and one part-timer abandoned their egos and built a common work area for all the doctors, nurses and medical assistants, explains Dr. Charles Shafer, an internist at the practice.

“My medical assistant and I sit side by side in a work area that also includes our charts,” he says, adding that they built efficiency into their office setup. “Every chart I need is no more than three steps from my chair.”

This design produced benefits that no one could have predicted.

small, local phone company, the practice receives more services for less money. Dr. Sunday says that the savings reach almost \$400 a year.

■ The practice does not accept credit cards or bank debit cards. Patients are instructed to pay with cash or a personal check. She says that patients tend to use their credit card if available, which cuts into the practice's co-pay. On average, she says, only four checks a year bounce. When that happens, patients are notified and are charged the bank fee.

■ Dr. Sunday opted against using an answering service, which charged roughly \$100 a month. When her office is closed, a recorded message provides patients with her cell-phone number for emergencies. This approach offers two benefits: patients are comforted by the fact that they can contact her directly when needed, and important messages are not delayed or lost.

"All of these things are small savings, but they add up over time," says Dr. Sunday, who sees approximately 19 patients a day.

Similarly, Dr. Irwin Benuck no longer uses an answering service. As a pediatrician and partner at Traisman, Benuck, Traisman and Merens in Chicago, he says that his practice began using an

When his patients call with questions, his assistant simply turns to him and relays the question. Often the patient can hear his response.

"What we hadn't anticipated were patients perceiving that they just had direct involvement from their doctor," he adds, explaining that the new setup eliminates the need for his assistant to walk back and forth to his office with patient messages or questions. "All of a sudden, I'm not having to take separate calls from Mrs. Jones. She's totally satisfied because she realizes she's just had a one-on-one interaction with me."

Because of the increased efficiency, the physicians are able to work with a lean staff and have avoided hiring the same number of personnel usually found in traditional practices of this size. The practice, which employs four and one-half providers, schedules about 120 patients a day and employs only 11 people. Other medical groups with the same number of physicians operate with as many as 18 on staff. And with more space for exam rooms, Dr. Shaefer adds that the practice saves between \$500 and \$1,000 every month.

automated phone system in 2004. When patients call after hours, the system directs them to the physician on call. He says that the system is efficient and saves the practice about \$8,000 a year.

But that was just the beginning. There was still another expense that had grown way out of control.

Since the early 1990s, the practice had performed all of its own billing, which required fairly expensive computers with dedicated

A group practice in Chicago saved \$8,000 a year by eliminating an answering service and installing an automated phone system. Outsourcing the practice's billing saved another \$2,000 a month. And replacing its generous Keogh retirement plan with a 401(k) plan saved the practice an estimated \$35,000 a year.

personnel, Dr. Benuck says. In the early days, the billing department represented close to 40 percent of the practice's overhead. But as each year passed, that number continued to climb higher and higher, until it reached almost 75 percent of overhead. By 2002, it had to be harnessed.

After evaluating all its options, the practice chose to outsource billing. Like anything else, he says that it pays to shop around

since billing services charge different collection fees. (The practice's vendor charges a 2.5 percent collection fee.) Almost immediately, he says, the situation improved. The practice's cash flow grew because it wasn't dependent on one or two people in the office to process all bills and to work with a variety of insurance companies, each with a different set of policies. Likewise, it no longer needed expensive computers or software. According to Dr. Benuck, outsourcing saved his practice roughly \$2,000 a month.

Next on the list came its retirement plan. For years, Dr. Benuck says, the practice was very generous to its employees, but it could no longer continue to be so. With its former Keogh retirement plan, the practice matched employee contributions up to 21 percent. Now the practice offers its eight employees a 401(k) retirement plan, matching up to 3 percent of employee contributions. With this change, he says, the practice has been able to save an estimated \$35,000 a year.

"Employees knew it was going to come sooner or later," says Dr. Benuck. "They had a really good deal for many years. There wasn't another practice or employer that was using this kind of Keogh sys-

tem. They appreciated what we did over those years and understood that we had to make some changes. Nobody quit over it.”

The practice also introduced a series of other changes that added to its bottom line. At the end of the workday, one of the physician partners reviews each superbill to maximize coding and ensure that the CPT codes line up with the ICD-9 codes, which also avoids insurance headaches down the road. The practice also introduced dermatology services, such as removing warts and other common growths, which has contributed between \$5,000 and \$10,000 to the practice’s annual income. He says that patients appreciate the one-stop shopping, especially since there is a waiting period of several months for appointments at some local dermatology offices.

Some Chicago pediatricians are exploring a new income avenue: they are charging their patients \$25 for each after-hours call. While those fees can certainly add up, Dr. Benuck says that he feels uncomfortable with this approach since he believes that after-hours calls are a part of the job. While some people may gripe about it, he says that it hasn’t driven any patients away from those practices that are charging such fees.

While you may belong to an association that helps you leverage your medical practice’s buying power, you still may be missing out on other opportunities that reduce the size of your monthly bill for office supplies and equipment.

Consider standardizing your supply or equipment list. For example, do some doctors in the practice favor felt-tip pens while others prefer fine points—and does the practice accommodate all by ordering several different types of pen? Whatever the product is, a consensus has to be reached—select one pen in order to achieve economies of scale.

This concept applies to almost every product found in your practice, from the type of paper used in the copy machine to envelopes or floppy disks. The same holds true for medical equipment and supplies, especially in subspecialty areas, such as orthopedics, which utilize high-cost items like prosthetic devices.

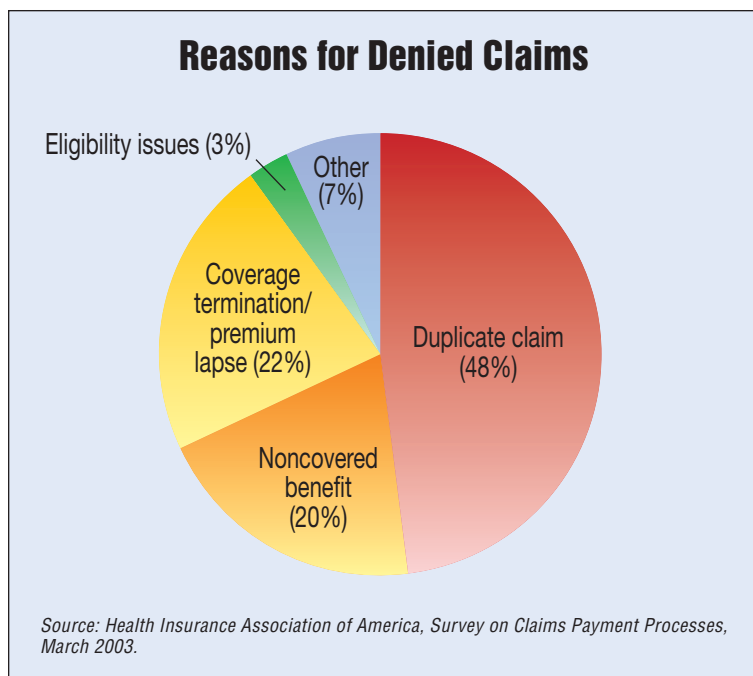
“You have 10 orthopedists, and they all want to use a different artificial knee or hip,” explains Sarah Hull, vice president and chief financial officer at Ministry Medical Group, a multi-specialty group practice based in Wausau, Wis., that supports an

estimated 175 doctors throughout central and northern Wisconsin. “You’re going to pay a lot more for your prosthetic devices than [you will pay] if you can standardize one or two.”

Stay on Top of Claims and Contracts

Ms. Hull advises medical practices to be sure that the income derived from insurance carriers is the correct amount. If you are supposed to receive \$45 for a specific procedure, does your billing system automatically raise a red flag if your payment is only \$42? If you signed a multi-year contract, will that same system alert you if you do not receive that scheduled 4-percent fee increase? If the answer is no, then make some changes to your system; or at the very least, assign a staff person to keep track of reimbursements and contract details.

Ms. Hull says that these scenarios happen more often than most people think. Years ago, when she worked at a small medical practice, she discovered that an insurance-company clerk



accidentally inverted two numbers when entering data from the practice's contract into its system. So instead of paying the practice \$54 for a specific procedure, the carrier actually was reimbursing the practice only \$45. While the difference is only \$9, the procedure was performed hundreds of times each year, she says. And if this happened once, she believed that it could happen multiple times, so she cross-checked all payments with the negotiated contract fees.

Another priority is management of claims denials. Regardless of why an insurer denies a claim, someone should act on the denial right away. "You really have to manage those as soon as they come in because you don't want them to end up in the pile of 'I'll work on it when I get a chance,'" says Ms. Hull. "Build safeguards into your system.

You'll increase the money you collect, will not run into timely filing delays and actually have more money more quickly."

Medicare and all managed-care plans have detailed procedures for physicians to follow when appealing a claim denial. Sometimes the denial is the result of a simple error in coding or a typo in the patient's date of birth, or the claim may be denied because the payer requires more documentation. In these cases the claims can be corrected quickly and resubmitted. If you outsource your billing, make sure that the service you use can handle the follow-up on claims denials.

Even abandoned phone calls are potentially lost income opportunities. Every office has them, but few practices research why they happen. Ms. Hull suggests purchasing technology that will monitor the number of abandoned calls to your practice. If you believe that your abandoned-call rate is too high, create phone rules or specific procedures for staff to follow that will minimize the number of abandoned calls. Otherwise you could end up losing not only new patients, but existing patients.

Sometimes practices are so concerned with spending money that

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they end up losing money. For example, some medical practices are reluctant to spend money on collection agencies and continue to send out unpaid invoices month after month for more than one year. Since the charges for collection agencies are typically based on the date of the unpaid invoice, follow the three-strike rule. Send patients only one bill per month over a three-month period, says Marian Costello, president at Costello & Associates, a 20-year-old healthcare consulting firm in Bethel Park, Pa.

Since the charges for collection agencies are typically based on the date of the unpaid invoice, follow the three-strike rule. Send patients only one bill per month over a three-month period, says Marian Costello, president at Costello & Associates in Bethel Park, Pa. "Once you send three bills out, it's time to send it to collections," she says.

"Once you send three bills out, it's time to send it to collections," she says, explaining that, at that point, collection agencies will usually charge the medical practice 25 percent of what they collect.

That's also why it's important for staff to run monthly accounts receivable (AR) reports. Frequently, she says, doctors solicit her help to determine why their

practice's AR is so high. She typically discovers that no one bothered to review an AR report for months, revealing how the amount can climb so high without notice. After running the AR report, she says, staff can analyze the outstanding claims and act on them in a timely manner.

Some physicians try to fix problems by hiring more staff, which may only exacerbate the situation. Ms. Costello recalls one primary-care doctor who had approximately 12 employees. "When I looked at his staffing, it was really way out there," she says, adding that 2.5 employees per physician is a standard benchmark to follow. "They kept saying, 'We need more.' They kept adding on without evaluating what everybody was doing. It was a practice that was out of control."

In this case, the culprit was lack of training. She says that physicians or office managers must look at how employees have been trained to perform their job responsibilities. Sometimes, she says, one trained employee paid at a higher salary can be worth three staff members who aren't trained and are paid at much lower wages.

It's no different with software. Ms. Costello shakes her head

every time she walks into a medical practice and finds that the doctor has purchased the least-expensive, off-the-shelf billing software system. Since such systems are responsible for bringing in the practice's income, she says that it makes little if any sense to go the cheap route. While you should be economical, it's more important that your system be fast, efficient and easy to use. Another way to look at it is to compare it to a car. If you buy junk, expect problems, down time and more service calls. Staff may become so frustrated with the system that they may skip running daily or monthly reports that are needed to assess your practice's outstanding bills.

Other considerations: stay on top of Medicare's reimbursement changes. You never know when a fresh opportunity can present itself. For example, Medicare has begun paying for many preventive services, such as smoking cessation, so physicians can now help people quit smoking and get paid for it.

Every Word Counts

Chances are, your transcription company charges you between 10 cents and 14 cents for every line, including the patient's name or report titles that appear at the top of every page. But why pay for retyping the same information when technology is capable of automatically placing it on the top of every page?

One transcription service operates this way. Instead of providing you with a Word document, its system displays a variety of database fields or built-in templates for specific procedures—like physicals—that automatically populate with information and reduce the amount of dictation time.

"Our system places the patient's name at the top of every page so doctors only have to pay for the transcription to type a patient's name once," explains Steven Palmisano, chief executive officer at Emdat, in Covington, La. "We average four to six lines less of transcription per transcript. If the doctor is seeing 20 patients a day, that's at least \$10 a day savings or \$200 a month."

The savings definitely add up. He points to the Southern Illinois University Medical School, which slashed its transcription costs from \$110,000 a month to \$40,000. The service also faxes transcriptions to referring doctors.

However, reimbursements for lab work have decreased. Ms. Costello says that it is cheaper to send patients out to a lab rather than to set up an in-house lab. But with other services, some physicians may not have a choice. She points to an orthopedic practice. Buying or leasing an X-ray machine may not make economic sense, but the practice couldn't function without one. So it needs to explore creative ways to maximize volume of usage.

If your practice has already extended itself into multiple service areas, then review office expenses for salaries, employee benefits and business insurance.

"There's no rhyme or reason to staff salaries," says Ms. Costello. "Doctors just keep on giving raises without looking at what the staff is doing. A lot of times, [employees] are getting paid a lot more than they should."

Sometimes physicians automatically give staff raises even

Timesheets at Your Fingertips

When his ear, nose and throat practice first opened in Los Angeles back in 1994, Dr. Marc Kayem had heard a lot of horror stories about employees at medical practices who embezzled funds. So in the early days, he decided to handle everything—including payroll. Every two weeks, he spent up to two hours counting the number of hours each employee had worked and printed out a check. It was tedious work but manageable because his staff was so small.

Then his practice began to grow. In addition to hiring another physician, it now supports five full-time employees and two part-timers. Eventually Dr. Kayem handed that responsibility to his office manager but continued to review employee timesheets. He found that task to be cumbersome, so several years ago, he implemented a fingerprint timecard system called Count Me In.

Employees clock in and out with their fingers. The system automatically calculates overtime, breaks, vacations and sick time, and offers a report detailing the exact hours each employee worked. Then it exports the data into a file format and e-mails it to Dr. Kayem's home.

"It's fantastic—it does everything for you," says Dr. Kayem. "It saved me money in terms of accuracy—people being overpaid—as it did in less work. I trust my employees, but you never know when someone says, 'I'm going [downstairs] for a cup of coffee. Can you clock me back in?'"

though the practice or physician's revenues may have declined. Consider a secretary who has worked at the practice for five or 10 years and earns \$30,000 a year when the position is worth only \$22,000. In such cases, she suggests that physicians periodically reward staff with small bonuses in lieu of raises.

Patient no-shows can be costly. Do you know what your no-show rate is? While it is unlikely that your practice will ever completely eliminate no-shows, you can minimize them by probing why they occur. Maybe your office staff is not consistent about making reminder calls to patients a day or two before their scheduled visit. Or maybe you are better off calling patients rather than mailing them reminder postcards. Dig deep. Get to the root of the problem, and make appropriate changes.

While it is unlikely that your practice will ever completely eliminate no-shows, you can minimize them by probing why they occur. Maybe your office staff is not consistent about making reminder calls to patients a day or two before their scheduled visit. Or maybe you are better off calling patients rather than mailing them reminder postcards.

Many physicians don't know what it costs per hour to operate their practice. According to Ms. Costello, that figure is a good benchmark since it can offer physicians a realistic perspective on everything from setting staff salaries to deciding whether to introduce new services.

To create this benchmark, she says, you need to do a little math. Add up all expenses for the month, ranging from office supplies to rent, and determine how many hours your practice is open. Then divide the number of hours into total expenses to obtain your benchmark. If, for instance, your practice spends \$200 every hour, are you earning that \$200 simply through patient visits? You may need to schedule more patients or expand your service offerings. As a general rule of thumb, she says, primary-care doctors typically need to see five patients per hour while specialists need to schedule four patients per hour.

Consider New Ideas

With so much work and so little time, every doctor develops specific habits and short cuts to accomplish daily tasks. But

sometimes these can have the opposite effect and may actually cost more money or time than they save.

One internist was complaining that the other physicians and staff at her practice were “getting on my case” about blocking out two hours a day to get caught up on charts. While Dr. Michael Stark was listening to her story, he knew that she was stuck in one perspective.

Some practices get in a rut when it comes to purchasing. Year after year, they use the same office supplier and phone service or buy their vaccines from the same vendor. But practices need to make cost comparisons between their vendors and others at least once a year, says Dr. Michael Stark, an internist in Perrineville, N.J.

“I said, ‘Let me guess, you don’t fill out your charts while you’re in with the patient,’” says Dr. Stark, an internist at Jersey Shore Associates in Internal Medicine in Perrineville, N.J.

The doctor replied, “No. I save them all.”

He told the doctor that this was one of the worst habits she could develop. He suggested that she set up the exam rooms so that she could look at patients

and write information on their charts at the same time. This way, her data would be fresher, her charts would be more accurate and she could possibly see 10 more patients on a daily basis.

Some practices get in a rut. Year after year, they use the same office supplier and phone service or buy their vaccines from the same vendor. They rarely check out other vendors because it takes time. Besides, Robert from XYZ office supply has been working with them for years and has always been responsible. Still, that’s not enough reason to give any vendor your business without question. At least once a year, Dr. Stark says, practices need to make cost comparisons between their vendors and others.

But don’t just go by a price list, which sometimes acts as only a guideline. Inform your favorite vendor that another supplier is offering the same product at a lower price. Ask if it can match that price.

Don’t be shy. Check with other practices or physicians for more cost-saving ideas. Don’t ignore any area of your practice. For example, some internal-medicine practices perform EKGs. However, the paper that the machine uses is very expensive. At

Dr. Stark's office, which offers EKGs, he says that his office ran across an EKG module with a spirometer—which measures pulmonary functions—and a Holter module, both of which work from a laptop computer and print from a regular laser printer. So now his office uses plain paper, which is significantly less costly than heat-sensitive EKG paper.

Almost any idea is worth considering, especially renting out office space to other specialists. Dr. Stark says that a cardiology group comes into his office every Tuesday afternoon. Since his practice makes referrals to the group anyway, renting space to them was a simple way to earn additional income. The practice has a similar arrangement with a gastroenterologist. Besides the extra revenue, he says, the presence of this additional specialty is convenient for patients.

Back in 2001, Healthcare Associates of Irving, a family practice in Irving, Texas, realized that focusing on coding via an electronic medical records system was not enough to maximize its revenues. Insurers continued to ratchet down their reimbursements. So the practice began to diversify its services, says Dr. Walter Gaman at the medical practice, which supports six doctors and six physician extenders in three locations.

The first area on which the physicians and staff concentrated was imaging. After realizing that they were referring a large number of patients to other healthcare facilities for MRIs, they bought a MRI machine for the office, hired trained technicians to run it and outsourced the radiologist. Although the radiologists they used were excellent clinicians, he says, the results weren't immediate. But the practice couldn't afford to hire its own radiologist—yet.

With a growth plan in place, the practice then added nuclear medicine. It began offering nuclear stress tests and other scans.

It didn't take long before the practice introduced CAT scans and ultrasound tests. With the

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additional income from these tests, the practice could then afford to hire its own radiologist.

Over time, more services were introduced—two sleep labs, nerve conduction velocities (which measure the electricity traveling through a patient’s nerves) and an in-house IV infusion clinic. While the practice actually breaks even on the clinic, Dr. Gaman says that no one minds because it’s highly beneficial for patients with pneumonia who need IV antibiotics on a daily basis. They can simply come into the office, rather than the hospital. Besides, he adds, because the on-site clinic occupies office space, the share of the rent allocated to the other doctors in the practice is less.

After the first several years, Dr. Gaman says that the practice doubled its income. Since the machines were under warranty, the

Successful Groups Invest in New Services: Report

Medical group practices that invest in new service lines and technology may be more productive and successful than their peers, according to a recent report on successful group practices by the Medical Group Management Association (MGMA). The report outlines performance indicators for what it deems “better performers” and compares the behavior and outcomes of those practices with other groups that do not perform as well.

“It seems that more successful groups are strategically investing in their practices to help support the practice in the long term,” says Daniel P. Stech, director of MGMA Survey Operations. “These top performers also demonstrate a commitment to patient satisfaction, benchmarking their practice and generally place value in leadership and strong governance.”

Of those investments commonly made by the more successful practices, the MGMA report indicates that these groups more readily adopt new ancillary services and technologies and that it was a strong factor in improving patient satisfaction, practice efficiency and profitability. More than 40 percent of the “better-performer” groups acquired equipment and materials to provide new services in 2004 compared with 33 percent of other respondents; and 32 percent of “better-performer” groups acquired new information technology or billing systems. Conversely, only 7.4 percent of “better-performers” said they hadn’t made any capital investments within that year.

practice's only expense was the actual cost of the equipment. But after the warranties expire, he says that the practice will end up purchasing service contracts, which will eat into its profits. At that time, he anticipates that the practice's income will still increase, but by 30 percent.

Smaller practices typically don't have enough patient volume to support imaging. "In this day and age, I think it's really imperative that if you're a small group [practice], to look at merging or expanding so you can justify all of these modalities," Dr. Gaman says.

To help manage its growth, the practice hired a chief executive officer who earns a six-figure salary, says Dr. Gaman. He believes that practicing doctors don't have enough time or business savvy to manage their business office effectively. Even though it's a big expense, top-notch professionals can make a real difference and more than pay for themselves, he adds.

In today's healthcare environment, medical practices must be proactive and change their perspective, says Dr. Gaman. He refers to two oncology practices that are within driving distance of each other as an example. Since reimbursements for chemotherapy have dropped precipitously over the last several years, he says that both practices were hurting financially.

One group complains about the shrinking reimbursements. While the practice has increased the amount of hematology work it performs, it still sends patients to the hospital for imaging. "They're giving patients away," says Dr. Gaman.

But the other group saw what was coming and took action. Several years ago, it purchased a PET scanner. Reimbursement is limited, and the practice spent a lot of time and effort learning how to operate the machine. But the effort has paid off, Dr. Gaman says, and the practice is now thriving.

"Clinging to the past and complaining about the present is just not going to get you anywhere," says Dr. Gaman. "You have to continually adapt, continually reassess your practice situations, especially in this day and age. Things are changing so quickly that if you don't constantly reassess, you are going to be left behind."