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healthcare financial management association hfma.org

breaking even with hospital-owned practices

Hospital executives and physician leaders are often amazed—even incredulous—when we share our experience that hospital-owned medical practices can perform just as well as private practices.

Despite the efforts of these leaders, losses on hospital-owned medical practices have continued to climb in recent years. The reasons for poor performance are usually easy to pinpoint, and their solutions, fairly simple to identify. The challenge lies in the successful implementation of those solutions. Senior finance leaders can foster successful implementation by understanding and supporting five critical success factors.

AT A GLANCE

Performance improvement in hospital-owned practices requires:

- > The organizational will to sponsor change
- > Decision-making partnerships between physicians and executives
- > Effective implementers to drive change at the practice level
- > Relevant performance measures
- > A culture of accountability for all stakeholders

Going Beyond Cost Cutting

When hospital financial performance falls below budget, we normally focus on the expense side of the income statement and cost-cut our way back to budget. Unfortunately, when hospital executives apply this approach to hospital-owned medical practices, they often find that cost cutting exacerbates performance problems. Seventy percent or more of a medical practice's cost structure comprises people. Another 5 to 10 percent of costs are related to building occupancy—and are largely fixed costs. Implementing cost-cutting exercises soon begins to involve people—and people usually drive productivity.

Traditional hospital-centric hiring freezes or hiring delays usually affect lower-cost, high-turnover medical practice employees. When support staff are in short supply, physicians end up performing tasks they should delegate—and the productivity of our most expensive human resource drops.

The medical practice “game” is won or lost on the revenue side of the income statement. Senior finance leaders should consider the following.

Volume/capacity match. For primary care practices, is the potential volume in the “neighborhood” adequate to fill the available capacity of physicians and other providers? For subspecialty practices, are there enough primary care practice referrals to support the capacity of affiliated subspecialty physicians?

Payer mix. Are hospital-owned practices carrying a disproportionate share of Medicaid and no-pay patients? Is the organization managing its mission in

cooperation with federally qualified health centers or other designated mission-based practices located for the convenience of those they serve? Is the organization then maintaining a payer mix of remaining practices that is viable for primary care practices and the subspecialists to whom they refer?

Fees for service. Does the organization frequently review its fees against payments and contracts?

Customer service. Primary care practices grow by word-of-mouth from one satisfied patient to another. Subspecialty practices grow in the same way—from one satisfied referring physician to another. Are these practices meeting the needs, wants, and priorities of patients and their referring physicians?

Productivity. Although there is much talk about the shift from volume-based payment to value-based payment, volume will remain essential to the success of every ambulatory practice. Where there is no volume, there is no value—or at least not enough value to make payroll. The ability to effectively manage volume is the essence of access, which is critical to both clinical quality and service quality. Team-care approaches help address access, but it is the productivity of an organization's physicians and other providers that will ultimately determine its success. Access to the knowledge, skills, and experience of these trained professionals is the constraining factor.

Senior finance leaders should consider: Does the organization's physician compensation model promote and reward productivity above the 60th percentile, as calculated by the Medical Group Management Association? Does the compensation model reward clinical quality and service quality without detracting from productivity, volume, and access? Are the organization's physicians and other providers engaging only in activities that require their training and licenses—and delegating all other activities to competent clinical assistants and other support staff?

Coding and documentation. The ability to efficiently document and properly code the work of physicians and other staff is a constant struggle. Often, physicians find themselves working on documentation after office hours due to poorly implemented electronic

health record (EHR) solutions. Many struggle to reach previous levels of productivity even after years on an EHR system. The problem is epidemic and should be the concern of every CFO. Ensuring that the EHR is optimized to properly support clinical quality, service quality, productivity, and financial viability in the ambulatory setting—the setting that has, by far, the most transactions—is essential to the success of the entire integrated model. Does the organization's EHR software and installation support high physician productivity as well as improved clinical quality, coding, and documentation?

Revenue cycle. The revenue cycle for the ambulatory setting usually includes a large number of relatively small charges and balances. Ambulatory accounts receivable often look like revolving credit, and managing the ambulatory revenue cycle is a complex undertaking. Successful ambulatory revenue cycle management is all about what occurs in the medical practice, at the appointment desk, at the reception desk, and at the cashier's window. The central processing of claims and statements can truly be automated if the front-end work is appropriate. Are physician practice managers accountable to ensure effective demographic data verification, benefits verification, and point-of-service collections? Are coding and documentation optimized in physician practices?

Service mix. As more and more medical care becomes available outside the hospital setting, the services we provide, where we provide them, and when they are available become increasingly important to patients. Walgreens understands how important it is to offer its retail customers convenient access to medical services close to home. Is the organization's lack of access, convenience, or service availability driving patients to seek care elsewhere?

These and other related questions help identify potential areas for practice performance improvement.

Factors for Success

Driving performance improvement in physician practices is largely dependent on five key elements.

Organizational will. The literature documenting the challenge of managing change in organizations is

extensive. Human beings do not like change. They negotiate, resist, sabotage, reject, threaten, act out, and even quit when faced with changing circumstances—even when those changes are for the better. Having the will—the *organizational will*—to “sponsor” change starts with senior leaders, particularly the CEO. Sometimes the board must be involved to support a CEO who is likely to take fire as a result of proposed changes.

Physician engagement. Peter Drucker’s concept of “knowledge workers”—those whose work involves a degree of problem solving—and his thoughts on managing such workers are particularly relevant in managing change among employed physicians, who could be considered the epitome of knowledge workers (Drucker, P.F., *On the Profession of Management*, Boston: Harvard Business Review Press, July 2003). Employed physicians cannot be “bossed.” Instead, they should be engaged as partners in implementing change. That engagement starts with an effective partnership among senior hospital/health system leaders and employed physician leaders selected for their leadership skills and experience. Because most implementation must occur at the medical office, that partnership should extend to the physicians, clinicians, and local executives who jointly direct the efforts of practice managers. We call this process “operational governance.”

Skilled implementation management. Managers are, first and foremost, implementers. They don’t “boss” physicians; they support and work for operational governing partnerships at the practice level and across the medical practice network. Skilled implementers know how to effectively execute change that is properly sponsored by the operational governing bodies. They know how to evaluate systems, improve processes, and train, motivate, and evaluate support staff. They understand the principles of measurement and engage staff in improving performance.

Measuring for performance. The adage “We get what we measure” has never been more meaningful than it is in today’s medical practice. Unfortunately, some organizations have a difficult time producing financial and statistical performance information at the medical practice level. Others are caught up in providing so much data that physicians and managers

quit paying attention. Wise finance executives ask three critical questions when measuring for performance:

- > What are we trying to achieve?
- > What are the best indicators to measure the desired outcomes as well as the processes and behaviors leading to those outcomes?
- > What is the simplest way to express those indicators?

Successful integrated delivery systems (IDSs) will need to measure for performance in terms of clinical quality, service quality, physician and provider productivity, and financial viability. CFOs will need to become chief *performance* officers to ensure that operational governing bodies and implementers have the right information to effect change in the organization.

Development of a culture of accountability. Establishing a culture of accountability in an organization of knowledge workers involves three essential elements. First, operational governing partnerships should set performance targets (*what* we will achieve), and those who desire to remain with the organization must achieve the targets. The organization should part company with those who cannot or who choose not to keep pace. Second, decisions regarding *how* to achieve those targets should be made as close to the point of service as possible. Third, operational governing bodies at the practice level should document their performance improvement objectives and tactics in a practice site-specific action plan (SSAP) on a quarterly basis. The larger network operational governing body then should use each SSAP to hold practice-employed physicians and managers accountable to deliver the committed results.

IDSs cannot afford to drag money-losing hospital-owned practices into bundled payments and other risk-payment models. Hospital-owned medical practices should function just as well as private practices in the same specialties. Achieving this level of performance in ambulatory settings requires that organizations focus their performance improvement energies on all eight revenue factors, rather than attempt to cost-cut their way to success. ■

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