A successful group practice retreat isn’t just a field day or another business meeting but a carefully balanced combination of both, producing results greater than the sum of the parts.

GPS spoke with two consultants and a physician about this topic. All agree that camaraderie-building topped the list of reasons why groups should go on retreats. “It really creates bonding,” says business coach Terri Levine.1 “It lets people slow down, get together, and get back to knowing each other as human beings again.”

A Texas-based practicing physician and frequent retreat attendee, Randall Grimshaw,2 MD, says it’s often difficult to really get to know your colleagues—especially in large practices. Retreats help match names and faces.

And as a new doctor, he recalls that the opportunity to mingle socially with his superiors was not only amusing but also inspiring. “You think, ‘Wow, these are pretty smart people [who] I’m associated with,’” Grimshaw says.

In addition to making group members and staff feel more connected to one another, retreats foster feelings of connectedness to the practice, Levine says. By gathering as a group outside the practice, people become more energized, creative, and engaged in improving the practice, she says.

Change of scenery a must

To achieve the results you want, make sure you set the retreat scene appropriately. A retreat can take place any time of year and at any location, but it is ideally away from the practice, according to our experts.

To optimize everyone’s creative energy, look for a setting as different from your practice as possible, Levine says, even if that just means going down the street.

For example, she has brought practices on retreats everywhere from the Pocono Mountains to a less-expensive local conference center that was part of an art museum. “You can be creative and not have to spend a lot of money,” she says.

Include everyone in the practice in the retreat, Levine says. “If you’re really looking at your practice as a group of people working together to create a vision, every single person, even if it’s someone who only works a few hours a week, should be there.” Although she advises against making attendance mandatory, Levine recommends hyping the event so no one wants to miss it.

Build interest and help plan your agenda at the same time by distributing a preretreat survey to everyone in the group.

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Sample springtime retreat agenda

Design a retreat that will fulfill your objectives and make attendees to look forward to next year's. Depending on your goals, the retreat location, and the amount of time you have, include some or all of the ideas in the following sample agenda:

1. **Icebreaker activity: Bridge challenge.** (60 minutes) Divide the group into teams of five people. Ask them to build a bridge using only three implements (e.g., a rope, a wooden board, and a brick) and get everyone across. To accomplish this task, teams must listen to one another and think creatively to solve the problem as a group.

2. **Discussion: Vision for the practice.** (60 minutes) During day-to-day life at a busy medical practice, it’s easy to lose sight of your vision. As a group, revisit your purpose and goals. For the benefit of both new and long-time members, briefly cover the group's history and mission statement. Do the goals of your mission statement and your vision coincide? Determine whether you’ve veered away from your mission and whether you need to rethink your goals or vice versa. “The process of thinking through your mission statement—what you are trying to achieve as a business and as a practice—always gives me energy and helps trigger a new line of thinking as to how I can apply these goals myself,” says Randall Grimshaw, MD.

3. **Discussion: Each group member’s role in carrying out vision.** (45 minutes) As Grimshaw explained, getting people engaged in thinking about the group’s vision will naturally lead them to ponder their own roles. Don’t break this momentum. Ask attendees to stand up and share their thoughts. Write down what people say.

4. **Activity: Scavenger hunt.** (30 minutes) Have fun with this. For example, have teams search for the pen that keeps mysteriously disappearing from the front desk.

5. **Lunch break.** (30 minutes)

6. **Discussion: Reputation of the practice.** (30 minutes) How do you think the community sees your practice? What do you suspect patients say to their friends and family about you? Do they refer you to their colleagues or dissuade them? Assess where you stand and discuss how to obtain more glowing reviews.

7. **Discussion: Existing best practices and how to replicate them in other areas.** (60 minutes) What qualities or accomplishments make you the most proud? Have you minimized waiting-room time substantially, or launched a successful ancillary service? Why do they work? How can you use what you learned implementing one goal to improve other aspects of your practice?

8. **Activity: Ropes course.** (45 minutes) This activity will challenge some more than others. Don’t let anyone quit. If people get scared, tired, or intimidated while on the course, cheer them on as a group and share in the pride of their accomplishment.

9. **Award ceremony: Recognize individual contributions.** (30 minutes) Take the time to thank everyone for their contributions to your group’s success. If your group is too large to honor each person individually, do so by department. Remind everyone listening of how much your front-desk staff accomplishes every day, for example, and present the group with a certificate. “Make sure you acknowledge everybody,” says business coach Terri Levine, because leaving people out will do more harm to your morale than the good of recognizing just a few people.

10. **Open brainstorming session.** (30 minutes) Allow attendees to speak freely about anything: ideas that didn’t fit in your agenda, feedback about the retreat, concerns about carrying out goals, etc. This takes openness and trust, Levine says. Unlike your other sessions, the goal here isn’t to resolve or even address issues that come up right away, but to listen, take notes, and revisit these problems during the year as necessary.

11. **Wrap up: Review, confirm day’s decisions.** (30 minutes) Finally, recap the highlights of the day, especially any decisions you make and individuals’ roles in carrying them out.
Spring fever

< p. 1

says consultant Judy Capko. Consider asking the following questions:

- How do you envision the practice?
- What do you see as the practice’s purpose?
- If you were to explain to the community what the practice represents, what would you say?
- What do you see as the practice’s strengths?
- How would you describe any weaknesses in the practice you’d like to overcome?

Don’t allow one doctor or individual to plan the retreat. Either outsource a facilitator or make sure you plan it as a group. “Otherwise, only the strong personalities will come out,” Capko says. “You want to make sure you get divergent personalities speaking up and participating.”

Business and pleasure do mix

Retreats should incorporate activities that will both help attendees feel relaxed and foster team-building. Don’t spend too much time with fun and games or just meetings, Levine says. Instead, alternate active exercises with discussion sessions (see sample agenda on p. 2).

For example, divide the groups into teams who have to build a bridge using only three implements and must strategize and work together to get everyone across.

Begin your next discussion session by reminding them to use the same skills—creativity, ingenuity, determination, trust—in addressing the topic at hand.

It’s crucial to leave the retreat having made some final decisions (e.g., whether to merge with another group) and to bring those learned skills (e.g., creative problem-solving) back to the office.

“At the retreat, you’ve got them fired up, you’ve given them the information, and it’s a call to action,” Capko says.

If you decide not to meet again for another month about an issue you discussed at the retreat, you may lose your opportunity to affect change, she says. You will most likely wind up discussing the same ideas—and problems—during the next year’s retreat, Levine says.

Capko recommends creating a flip chart of your retreat agenda.

At the end of the retreat, go back to your first chart, review what you discussed, and ask whether everyone still agrees.

As you repeat back to the group that you will, for example, align the practice with an expanding hospital, select or repeat who you chose as a point person. This way, you get agreement, assign responsibility, and force individuals to take ownership of particular initiatives all at the same time, she says.
Legal issues can seriously disrupt the daily routine at your practice by creating rumors that affect your office atmosphere, morale, and patient care. Safeguard your office by creating uniform policies and procedures to handle common legal difficulties you may face. Handling them appropriately can minimize disruptions and protect your practice.

Professional liability claims, in particular, involve critical legal concerns that you must manage, such as insurance coverage, confidentiality, and protection of certain information.

An office policy about the management of professional liability claims can help you maintain office efficiency, quality patient care, and confidentiality. (See sample policy on p. 5.)

Remember to address your state laws in your policy about how to manage professional liability claims because state laws vary.

Follow best practices
When faced with a professional liability claim, adhere to the following best practices to ensure handling the claim goes as smoothly as possible:

1. **Notify your insurance company.**
   Immediately after you receive a liability claim, notify your insurance carrier (in the manner that your carrier prescribes). Doing so will protect your coverage. However, note that in some states, the documentation you give to your insurance carrier may be discoverable in a professional liability action.

   Therefore, follow your insurance carrier’s instructions regarding how to notify the company and what information the notification should include. Send all records to your legal counsel, who then can provide additional relevant information to your insurance carrier.

2. **Secure the patient’s medical chart.**
   Keep the chart in a locked file cabinet where no one can access it. Never alter this chart. Create a separate file for all legal correspondence and related information (which is protected by the attorney-client privilege), and never make any of it part of the patient’s medical chart.

3. **Be aware of discoverability.**
   Note that once the practice receives notice of a professional liability action—whether a complaint, writ, or “intend to sue” letter—any conversations will be discoverable in court, so refrain from any internal or external discussions about the case. Appoint a designated contact person, such as the business manager, to schedule meetings and calls between the affected healthcare providers and their counsel.

4. **Be open with staff.**
   A key risk-management strategy involves talking openly with staff about the lawsuit and your expectations going forward. Doing so prevents rumors from circulating.

   Tell staff that they can ask the business manager any questions they have, which should decrease speculation, but also be clear on your expectations of them, which include the following:

   - Avoid discussing the lawsuit, especially in front of patients
   - Be aware of potential evidence that could be destroyed innocently (e.g., sample schedules or policies) and do not destroy them
   - Refrain from speaking about the issue with friends, family, and the media

Editor’s note: The above article was excerpted from HCPro’s new book, The Top 15 Policies and Procedures to Reduce Liability for Physician Practices, written by James W. Saxton, Esq. For more information or to purchase the book, go to www.hcmarketplace.com/Prod.cfm?id=3389 or call our Customer Service Department at 800/650-6787.

Questions? Comments? Ideas?
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Sample management of professional liability claims policy

Your practice name: Policy number:

Subject: Management of professional liability claims  Effective date:  Page: 1 of 2

Approved by:  Review date:

Revision date:

Purpose
To provide internal guidelines and procedures for managing professional liability claims to maintain office efficiency and confidentiality.

Policy
It is our policy to manage promptly any notices we receive for lawsuits in a professional liability action and to provide the utmost in confidentiality related to the same.

Procedure
1. Upon receiving a complaint, writ, or “intent to sue” letter, immediately note the date on the first page of the document, as received, and give the document to the office manager.

2. The office manager will forward a copy of the document to the practice’s professional liability counsel and include a cover letter that sets forth information about the suit. He or she also will include a copy of the medical chart in its entirety.

3. The office manager will telephone the practice’s professional liability insurance carrier to confirm that the practice received the complaint, writ, or “intent to sue” letter.

4. Once the center receives the complaint or writ notice, discussion about the care and treatment involved in the matter or any other issues related to the matter will occur only with legal counsel or with legal counsel present. We will keep discussions among providers/staff to a minimum, as these conversations will be discoverable in any legal action. No discussion should occur within the earshot of patients.

5. The office manager will immediately secure the medical chart(s) associated with the patient claimant/plaintiff and keep them in a secure location to prevent both the chance of alterations to the medical chart and any unauthorized access. The chart will be available to the relevant healthcare providers for patient care and treatment, as necessary.

6. The office manager will create a separate legal file in which to keep all legal correspondence and related information and will keep it separate from the patient’s medical chart.

7. The office manager will serve as the key contact between the practice’s office and legal counsel or the insurance carrier to schedule any phone calls to further discuss the claim with the named defendants in the lawsuit or providers referenced in the letter.

Related policies
Responding to request of records/medical records release, handling subpoenas.

Plan ahead when creating a central billing office

Today’s environment of declining, slower reimbursement coupled with increased regulatory oversight and higher expenses challenges groups to think differently about how they function. For multisite group practices, one solution to streamline billing and enhance collections is the creation of a central billing office (CBO).

A CBO may require fewer staff to perform all your back-office billing functions in one location. As appealing as that may sound, potential personnel savings pale in comparison to other advantages such as vastly improved charge/collection percentages at each site, says consultant John W. McDaniel.1

Boost collections via enhanced expertise, oversight

“The most overwhelming reason for creating a CBO is to improve the adjusted charge/collection percentage [calculated by dividing net payments by net charges over a number of months],” McDaniel says.

For example, say you have three clinics with an average adjusted charge/collection percentage of close to 90%—80%, 94%, and 95% respectively. That means if the lowest-performing group has adjusted charges of $1 million, it only collects $800,000. By raising that to 90% with a CBO—and increasing collections to $900,000—you have a $100,000 benefit.

However, “you can’t figure out billing problems by looking at statistics [alone],” says consultant Randy Bauman.2 “Sometimes you have to get down into the systemic aspects of billing and collection.” For example, in the above scenario you might first look at why one practice’s collections fall so far below par.

Examine factors such as how the practice distinguishes between contractual adjustments and write-offs, who approves write-offs, etc. You may be able to adjust the one clinic’s processes, staffing, or training and correct the problem without a CBO.

But if you want a way to better ensure that all of your sites maintain peak performance, a CBO may indeed be your answer, Bauman says. “By having [billing] centralized, it is easier to standardize, monitor, and make sure follow-up is done consistently. Better centralization of oversight and management is almost always going to help you,” he adds.

Strive for the best structure

In addition, CBOs deliver dramatic results because they bring together a concentration of expertise. Instead of having your billing personnel spread out at several clinics, you have all of your best and brightest in one place and thus better able to collaborate with and complement one another, says McDaniel.

To optimize this effect, consider how you structure staff within your CBO. There are two common options:

1. By third-party payer. Although there is no perfect configuration, McDaniel is partial to dividing the office by payer. For example, a practice that works with Medicare, BlueCross, and Aetna may have six people in the CBO—two people per plan.

   By having staff specialize in dealing with one payer, they get to know the nuances of the plan and become familiar with its policies, contracts, and even personnel. Establishing personal relationships with health plan personnel can be especially helpful to staff conducting claim follow-up over the phone because they can batch their calls and have one health plan staffer handle several matters at once, Bauman says.

2. By medical specialty. Bauman has seen CBOs structured by medical specialty, particularly in multi-

Anticipate CBO impact on cash flow

As with any new endeavor, you may need to spend money to make money with your central billing office (CBO). Before deciding whether to create a CBO, answer the following questions. Will

- you require additional office space?
- you convert to a new billing information system?
- clinicians need to obtain new provider numbers and tax identification numbers?

If you answered yes to any of the above questions, anticipate a slowdown in cash flow and plan how you will fund it, either through current operations or by obtaining a line of credit.
specialty groups. Like staff who know the nuances of each payer, these staff are familiar with the coding rules unique to their specialty.

However you decide to set up your CBO, try to staff the office with the right number of “experts” in each area to suit your patient base. For example, if you structure your CBO by insurer and 40% of your patients are on Medicare, calculate how many Medicare specialists you need to process all of those claims.

Another important decision is to whom your CBO staff will report—your chief financial officer (CFO) or chief operating officer (COO). Just because billing involves money does not mean that oversight truly belongs with the CFO, Bauman says. It’s really more of an operational issue.

Whoever leads the effort will interact regularly with physicians and nurses at the clinic sites—possibly not the best role for a COO, whose primary expertise is in accounting and finances. Although there are no hard and fast rules, it’s something to think about because operational efficiencies are critical to a CBO’s success, Bauman says.

Ensure efficiency with planning, accountability

“A CBO can create a lot of efficiencies in a practice if you hire the right manager and . . . establish the right policies, conduct the proper training, and monitor those policies and retrain as you need to,” Bauman says.

Especially if the CBO does not have access to patients’ medical records, it is crucial for the front-desk staff to thoroughly and accurately collect data needed by the “back office” CBO to resolve claims (e.g., insurance eligibility, provider number, patient demographics, etc.). “Historically, probably 95% of all claim denials and rejections are because of misinformation gathered at the front desk,” McDaniel says.

A CBO will also make it easier to hold staff at individual sites accountable. “It’s one thing to tell staff to make sure they collect copays,” Bauman says. “It’s another to have a report every week or month that shows how many copays were not collected.” A CBO will allow you to collect this information and connect it back to particular people and sites.

Beware resistance to change

Although front-desk and CBO staff job descriptions won’t necessarily change, their day-to-day work lives will. Front-desk staff can expect to hear patients complain about now having to call a central phone number to resolve billing problems and that they can’t discuss these matters with people they know.

“You do lose a little bit of personal touch,” McDaniel says, noting that medical practices resisted automated telephone systems for years for that reason. However, most patients are now generally accustomed to such systems. Remember that taking collection responsibilities (other than copays and deductibles) away from staff who interact with patients can allow your practice to become more businesslike, Bauman says. For example, pre-CBO, a practice could lose thousands of dollars through lax collection policies and staff who felt uncomfortable pressing sick patients for cash.

A CBO also means that you will either have to let go of your back-office staff or move them to the central office. At the CBO, staff will generally perform the same duties—billing, handling denials and rejections, following up with insurers, managing accounts receivable, monitoring payer contract compliance—but they will do so in a totally different environment. Instead of interacting with doctors, nurses, and patients, they will interact with accounts, McDaniel says.

Be up front with staff about what this change will entail and get a good sense of whether your practice culture will be able to adapt. “On paper, CBOs make all the sense in the world,” McDaniel says. “But like every concept, it takes people to execute it. It’s in the execution where failures come in” if you’re not prepared, he adds.
Consultant’s perspective

Retain the right to terminate a partner

Consider amending group documents that ‘lock in’ coowners

By Leif C. Beck,1 JD, CHBC

In May, I wrote about how to make sure your group has the power to terminate a nonpartner’s (associate’s) employment. Due to the nature of the relationship, this right should be fairly straightforward (although it’s not always the case), and you should feel free to exercise it quickly and easily if appropriate.

However, for firing a coowner, groups’ documents—as they should—usually make it far more difficult. Some employment and shareholders’ agreements make it virtually impossible to do so unless the partner committed a major sin, such as conviction of a crime or loss of medical license. Don’t let this happen at your practice.

Avoid lock-in agreements

Founding or senior partners may feel great comfort in bylaws or ownership agreements requiring unanimous consent to terminate their employment, but such lock-in provisions represent bad practice policy. Any organization must ensure that at all times, it has the right people—professionally and personally—to further its success. More important, it must be able to protect against the wrong people interfering with its efforts.

Unfortunately, even a valuable partner who once deserved protected status can change stripes through the years. That’s why I point to this overriding principle: A medical group’s ongoing success is more important than any one of its member’s personal priorities.

Even if you foresee no particular partner-level problems, check your corporate bylaws and shareholders’ and employment agreements to learn your structure. If your group is a limited liability company or limited liability partnership, check your “operating agreement” or similar document. Termination provisions “locking in” a partner deserve your attention before it’s too late.

For example, I recall an 11-doctor anesthesia group in which three of its best long-time physicians left because the group’s documents protected a badly behaving, clinically lazy partner from getting fired and none of the other doctors could convince him to leave. One year later, the group lost its hospital contract and its remaining partners scattered at a time when anesthesiologists in the region were in serious oversupply.

Make termination an ‘at will’ power

Appropriate partner-level provisions on terminating a partner depend on your group’s size. If you have only a handful of partners (but more than two), a unanimous vote not including the affected partner usually suffices.

If your group has more than five partners, consider requiring a majority plus one or a super-majority of 60% or even 75% (with the affected partner not voting). Many super-majority rules call for counting all unaffected partners, including any who abstain or are absent.

Even though partners deserve greater protection than associates, don’t fall for any lawyer’s suggestion to limit the right to terminate their status. Make it absolute—essentially an “at will” power, even though you will almost surely exercise it more reluctantly than with an associate.

Use grandfathering as a last resort

Group documents that lock in a partner typically lock out the ability to soften such a power. Members, often founding or senior partners, who value their protection against being voted out will likely refuse to sign any amendment to permit it. What should you do then?

One approach may be to water down the amendment so it requires a near-unanimous vote, perhaps approval of all but one partner (usually the partner being voted on). If even that doesn’t pass, or if watering down the power doesn’t serve the group, then try grandfathering in the hold-out(s).

Grandfathering establishes the group’s authority to terminate all but the one or two members who refuse to go along with the change. It’s not ideal, but it’s better than nothing and it establishes for the longer term the concept of group authority.

As a principle of good leadership, don’t propose an amendment to your documents unless you know or strongly believe the partners will vote it in. Even though it’s important to seek protection against a future bad partner situation, there’s no sense in fighting a losing battle over a problem that may never arise.

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