Many groups accept the time staff spend taking and leaving messages, chasing medical charts, and negotiating appointment times with patients as part of daily life in a medical practice.

But the problem with this mentality is that despite how hard physicians and staff work, they’re not nearly as productive as they could be, says consultant Rosemarie Nelson, who spoke during the Medical Group Management Association’s (MGMA) seminar, “Implementing Best Practices of Successful Medical Groups,” in Boston in June.

The groups designated by MGMA as the better-performing groups of 2004 excelled in one or more of the following: profitability and cost management, productivity (for surgical and nonsurgical specialties), accounts receivable and collections, and managed care operations. And these top performers all found ways to reduce inefficiencies. By adopting their tricks and strategies, you too can whittle away at wasted time.

Rethink routines

A hallmark of better-performing practices is their ability to think creatively, Nelson says. Start by analyzing the processes you follow out of habit. As in the examples below, you may discover that bending the rules can have its benefits.

Time waster: Morning telephone

Many offices turn the phones over to an answering service from 12 p.m. to 1 p.m., essentially training patients to avoid calling during that hour. As a result, the phones ring relentlessly first thing in the morning because patients are anxious to call the office before they become involved in other tasks.

Efficiency Rx: “Do” lunch. “Don’t put the calls on service over lunch,” Nelson suggests. Instead, have staff stagger their lunch breaks so a staffer is always available to take calls and schedule appointments. It may take some time to reprogram patients’ calling habits, but eventually, this small change will lead to a more manageable call pattern, she says.

Time waster: Phone faux pas.

Another intentionally created delay that groups can manage better is calling patients to remind them about upcoming appointments. Most practices attempt to make reminder calls two days before each appointment, but in reality, staff often don’t have time to make calls until the evening before the appointment, Nelson says. In addition, most patients aren’t home to answer the call and confirm the appointment, increasing the risk of no-shows.

Similar slowdowns stem from unplanned requests for test results. For example, even though many practices try to teach patients not to expect a phone call if a Pap smear comes out negative, several call every day “just to > p. 2
check,” Nelson says. Each time this happens, the receptionist must take a message for the nurse, who must then find the patient’s chart and call back. “Each chart pull alone takes five to 12 minutes,” Nelson says.

Efficiency Rx: Tech talk. Automated tools (e.g., automated phone systems, e-mail reminders) can help practices give patients timely reminders and the ability to confirm or cancel appointments without consuming staff time.

Similar technology can also provide test-result relief. Think of all the time staff could save (not to mention the increase in satisfaction patients would experience) by using phone and personal identification numbers. Patients could use these to access their test results, Nelson says. For positive tests, avoid giving bad news over the phone by having the recording tell patients to call the office, she adds.

Time waster: Appointment interruptions. To measure visit efficiency, track how many times each physician leaves the exam room during patients’ appointments, Nelson says. In one practice with which she worked, this tracking revealed that one doctor was absent from the room an average of six minutes per visit.

He would step out for simple tasks, such as to tell the nurse he needed an electrocardiogram on the patient or to retrieve medicine from the sample closet, she says. Inevitably, several people would stop him en route to ask him a quick question. Without these interruptions, the doctor could potentially see one or two more patients per day.

Efficiency Rx: Creative communications. Most of the excursions the doctor took were unnecessary, Nelson says, as the nurse could have easily taken care of these needs after the appointment. To alert the nurse to such requests, the doctor should simply write them on a pad of paper and hang the pad outside the door, she suggests.

The nurse can then check the messages as he or she walks by and order the necessary tests or prepare medication to have ready when the physician finishes the visit.

To cut down on interrupting doctors for scheduling questions, review the next day’s schedule as a group (i.e., physicians, nurses, and staff) to identify potential openings. Clinicians usually know which patients may take less time to see than scheduled, Nelson says. By communicating this information the day before, the receptionist will have a good idea of where to squeeze in same-day appointments without having to ask the doctor.

Time waster: Paperwork panic. Patients usually need a few minutes to fill out paperwork before seeing the doctor. If the receptionist gives a patient an 8:30 a.m. appointment—the same time the doctor expects to see the patient—and it takes her two minutes to dig out her insurance card, three minutes to fill out your forms, and another five to produce a urine sample, the doctor falls 10 minutes behind schedule.

Efficiency Rx: Early acceptance. “The time of the appointment doesn’t have anything to do with when the patient actually sees the doctor,” Nelson says. Either make the appointment time for exactly when you want the patient to come in (8:20 a.m. for the example above), or ask the person to come in 10 minutes early to fill out insurance forms, etc.
Dealing with managed-care companies can often be frustrating. But sometimes delayed or diminished payments are more than a nuisance and may even cost your practice money. Contracts that seem more trouble than they’re worth may lead you to consider terminating your relationship with the payer.

For example, the payer’s reimbursements for procedures you perform often may no longer adequately cover your costs or measure up to the average payment similar practices obtain in your area. Or a payer may not reimburse you according to contract provisions, causing your staff to spend too much time chasing reimbursement. Or you may just not serve enough of the plan’s patients to make the contract worthwhile.

Increasingly, practices now entertain thoughts of termination for nonfinancial reasons, says physician practice management executive John A. Deane. For example, the administrative burden of having the contract (e.g., systematic denials for no apparent reason or retroactive denials related to medical necessity) may give you cause to terminate a contract.

A payer’s lack of response to your inquiries on such unexplained denials or delayed payments could indicate a financially unstable payer, another valid reason to want out of a contract, says Jeff Milburn, vice president of managed care for Colorado Springs Health Partners, PC.

However, not all unresponsive payers are headed for bankruptcy. Often, a payer’s powerful stance in the marketplace puts you between a rock and a hard place when deciding whether your group should walk away from a contract, Milburn says.

Here, we provide six steps to arrive at the smartest solution—whether to stay with the payer or go—for your group practice.

**Step one: Analyze your leverage.**

First, determine how much leverage your group has with the payer. If you are a big fish with substantial market share in that provider’s pond, you may more likely get results through negotiation, Milburn says.

Also assess what the contract really means to your group—the percent of your business the payer represents and the potential consequences should you terminate, Deane says. Look at the major employers in your community and whether they offer alternative health plans. Could your patients easily switch health plans without changing jobs?

Weigh these factors collectively to determine whether you can truly afford to walk away, and consider terminating the contract as a last resort. “Contract termination should only be used when the negotiation process is broken down or the other party is consistently not living up to obligations,” Milburn says.

Think about what the payer would have to change for you to keep the contract. Then arm yourself with data to support your grievances. For example, if you have a fee-for-service payment arrangement, compare the maximum allowable fee schedule for frequently performed services in your practice to what comparably sized health plans pay in the marketplace, Deane says. If the payment you receive falls well below average or the payer reimburses you less than that to which you contractually agreed, proceed to step two. Don’t get hung up on what the health plan’s fee is for any one procedure or service, Deane says. “Focus on the weighted average.”

**Tip:** Always be aware of payer compliance. “Watch what the payer is paying relative to what it promised to pay,” Deane says. More sophisticated practice management systems have a module in which you input the fee schedule for any major health plan and the system flags claims paid at a lower than negotiated rate. If you don’t have a system like this, audit regularly for non-compliance, even if just by sampling frequently performed procedures, Deane says.

**Step two: Initiate preliminary negotiation**

With your analysis and an up-to-date copy of your contract in hand, meet with the payer to discuss your requests (e.g., fewer administrative burdens, higher reimbursement, more flexible contract language, etc.). Get a feel for what the plan is willing to modify to accommodate your medical group, Deane says.

If, after the first negotiation attempt, the plan won’t budge or agrees to changes and then doesn’t keep its promises, consider terminating the contract.

**Tip:** The ideal time to form your “escape plan” is while you negotiate the original contract, Milburn says.

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1 Deane is the president and chief executive officer of Southwind Health Partners, a physician practice management firm based in Nashville. Contact him at 615/620-5158 or via e-mail at jdeane@southwindhp.com.

2 Contact Milburn at 719/538-2911 or via e-mail at jmilburn@cshp.net.
Managed care says. From the beginning, keep in mind that the contract may eventually become undesirable, so develop your contingency plan before you sign.

“That’s when you’re laying the foundation for the [termination] process,” he says.

Step three: Express your intent to terminate.

Don’t threaten to terminate the contract unless and until you’re prepared to follow through with that threat. Although Deane has seen many health plans cede to a practice’s demands (or a significant portion of them) at the 11th hour when they believe the group is serious, he cautions against bluffing.

Instead, give the payer a strong warning, Milburn says. He recommends sending the payer a certified notice of your intent to terminate the contract if the plan does not meet your demands within a certain time frame (e.g., 30 days) (see sample letter below).

“A lot of times, that [letter] will smoke them out,” he says. “They’ll come back to the table.”

Step four: Influence other stakeholders.

While your practice awaits the plan’s response to your written warning, gather other community stakeholders to fight for your cause, Milburn says. For example, if you’re a specialty group, go to the primary care physicians who routinely refer their patients to you and explain that you may lose the contract. If many of their patients carry that plan and they often refer to you, they may try to influence the payer to comply with your requests.

Also approach local independent health insurance brokers who sell that payer’s product. Once the brokers learn that they may lose several doctors from the plan’s panel, they may alert the payer’s marketing department. The marketing department, in turn, may pressure the contracting department to find a way to not lose your business, Milburn explains. However, resort to this strategy sparingly, he adds, because it’s not likely to elicit this chain reaction more than once.

Your community’s major employers may be among the most important stakeholders who come to your aid. Inform their human resources departments that you may

Sample intent-to-terminate letter

[Insert date]

[Insert name of payer]
[Insert name of payer representative]
[Insert payer address]

Dear [insert name of payer representative]:

The purpose of this letter is to advise you that the [insert name of group] board of directors will consider termination of our contractual relationship during its next meeting. Unfortunately, we and [insert name of payer] have apparently reached an impasse in our efforts to [insert cause].

We consider contract termination a serious event and regret having to take this action. Specifically, we are looking for [insert request].

Our intent is to follow the terms of the contract and applicable government regulations relating to the termination. We also intend to notify our patients, local independent insurance brokers, and major employers of our decision. Our objective is to minimize the potential adverse effect on our patients by providing ample time to find alternate physician or health insurance coverage.

The board meeting will be held on [insert date], and I will advise you of the board’s decision. I would be happy to meet with you prior to our board meeting to discuss ways to avoid contract cancellation.

[Insert signature]

Source: Jeff Milburn, Colorado Springs Health Partners, PC. Adapted with permission.
no longer be on the payer’s panel, Milburn says. If the employers consider your group of doctors critical to providing care to their employees, they may also call the payer’s marketing department.

**Step five: Proceed with termination.**

Despite your efforts, sometimes you have no alternative but to end a relationship with a payer. When you must take this final step, “make an objective to mitigate the adverse impact to the patients and your organization,” Milburn says. “Finding ways to retain/recover those patients is critical to the process.”

Timing is key to losing the fewest patients. Provide at least three months between when you notify the payer and patients of termination and the actual termination date, Milburn says. This window both allows some time for follow-up negotiations (and possible reconciliation) between you and the payer and gives patients plenty of time to make alternate provider/insurance arrangements.

You will likely retain a larger percentage of your patients by having the termination take effect during community employers’ open enrollment periods, Deane says. “In every health plan termination I’ve been associated with, we’ve retained 80% of our patients from the get-go by timing it with the enrollment process and following through with a strong patient and employer communications campaign.”

In addition, don’t forget to check your contract for pre-and posttermination requirements. For example, some contracts require you to give payers 60, 90, or 120 days’ notice prior to the annual renewal date of evergreen contracts, Milburn says.

Posttermination provisions may require you to continue treating patients until their annual benefit renewal period—another reason to have termination coincide with open enrollment. “That could keep you married to the payer a lot longer than you want,” he says.

But if it’s July and most of your patients’ open enrollment begins January 1, don’t despair. You can sometimes influence employers to hold an open enrollment period (for an alternative health plan) at another time by explaining the situation, Deane says.

**Tip:** Upon contract termination, make sure the payer takes you off its provider list, Milburn says. “Don’t let [the payer] continue to use you for marketing purposes.”

**Step six: Communicate continually with patients.**

If the termination process affects a large percentage of your patients, consider running an open letter in the local newspaper (and maybe post it in your waiting room) explaining that your group could not successfully reach an agreement with the plan and that you will no longer be part of its network, Deane says.

Describe the consequences that may occur if a patient visits your office on an out-of-network basis (e.g., a higher copay/deductible or a bill for the balance the insurer doesn’t pay), and list the health plans you will continue to accept. Avoid any negative language that may elicit a response from the payer, Milburn warns. “The payer can probably afford to buy a lot more newspaper space than the group can.”

Notify patients individually, Deane says. Identify affected patients via your practice-management system and send them tailored letters signed by their physician—not the administrator—with the above information. Keep in mind that some patients, especially those who visit infrequently, may not pay attention to your notices, Milburn says, so you need to continue the communication process. When patients carrying that insurance call your office, remind them that the visit will be out of network, and explain what that means before booking the appointment.

Finally, stay in touch with the patients who switch healthcare providers. For example, mail out gentle reminders that list the health plans you do accept and that state that you’d be happy to have these patients back should they change insurers, Deane says. △
Recruitment

Five ideas for attracting docs to the heartland

Twenty percent of Americans (approximately 60 million people) live in areas of the country classified as “rural,” yet only 10% of doctors live and practice in those areas. Couple those numbers with a demonstrated difficulty in winning new converts to the mission of rural medicine, and the risk is high for a healthcare emergency in the heartland.

“Rural areas are very fragile,” says Howard Rabinowitz, MD, head of the Physician Shortage Area Program (PSAP) at Jefferson Medical College in Philadelphia. “If you lose just one or two doctors in a small town, it has a devastating impact.”

Robert Bowman, MD, a family practitioner and member of the rural faculty at the University of Nebraska Medical Center in Omaha, has been an advocate for rural healthcare since 1983. He and Rabinowitz have seen firsthand the need for greater physician presence in small towns, and they offer the following suggestions for recruiting the right doctor for a rural practice or community:

1. Find future associates by looking to your past. Bring new partners into your practices by returning to your roots. Recruit physicians who grew up in similar areas as the one in which you currently practice, or look for graduating doctors originally from the area.

2. Understand physician motivation. All doctors are not created equal and, as such, their priorities differ, Rabinowitz says. “The traditional view of rural practice is that it’s less attractive than urban practice because of fewer amenities, lower reimbursement, less support services, relative isolation, and so on,” he says.

To sell the rural life, remind a prospective associate that the life of a city doc isn’t all peaches and cream, Rabinowitz says. “The rural practitioners who succeed generally enjoy many of the things that their urban counterparts wish for—specifically, greater autonomy, more time to spend with patients, and better opportunities to establish relationships,” he says. It’s a chance for the best of both worlds.

“I remind [physicians] that this is an opportunity to live that Norman Rockwell kind of life,” says Marc Bowles, CPC-PRC, vice president of physician search for Delta Medical Consulting. “You get a better quality of life—you’ll know what’s happening with your kids at school, you’ll know your neighbors, you can go home for lunch and not sit in traffic. There’s a greater concept of community.”

3. Talk dollars and cents. Money has never been and probably never will be the allure to being a country doctor, Rabinowitz says. But when recruiting new physicians, tell them that the economic bottom line may be closer to their urban counterparts than they think ($204,000 vs. $218,000, respectively).

And remember to factor in the cost of living when discussing salary. After adjusting the numbers for the rural cost of living, the real income shows that rural providers earn $225,000 vs. $199,000 for urban docs and, on average, have 13% more purchasing power than their urban counterparts (see “Mean urban and rural physician incomes by specialty, 2003” on p. 7).

4. Target maturity. The most successful rural doctors share a common characteristic—maturity, says Bowman.

“These are people who select a practice community because they’re thinking about where they want to raise a family,” he says. “They set down roots. So when you pick a physician based on maturity, you’re not only improving your quality of physician, but also your rate of retention.”

5. Seek assistance. Your state’s Office of Rural Health can be a tremendous resource, Bowman says. It can help you determine whether your region qualifies for government assistance or resources, help track students or residents from your area who will soon need jobs, and act as a point of contact for new and established physicians.

Questions? Comments? Ideas?

Contact Managing Editor Debra Beaulieu

Telephone: 781/639-1872, Ext. 3721
E-mail: dbbeaulieu@hcpro.com

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### Mean urban and rural physician incomes by specialty, 2003

<table>
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<th>Specialty</th>
<th>Urban</th>
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- \(a\) Difference with mean for urban physicians significant at \(p < 0.05\).
- \(b\) Difference with mean for urban physicians significant at \(p < 0.10\).
- \(c\) Less than 50 unweighted observations in cell.
- \(d\) Mean in adjacent and nonadjacent rural counties is significantly different at \(p < 0.10\).

Plan how you’ll handle requests to drop call

By Leif C. Beck, JD, CHBC

As physicians enter their early 50s, many begin to think of either retiring or slowing down their ultra-busy work pace. For doctors who seek to cut back without quitting, the first step is often to reduce or eliminate their night and weekend call obligations.

For some specialty groups, a senior member’s request to drop or reduce call presents one of the toughest of all interpartner challenges. Even if night and weekend coverage only occasionally interferes with personal life, virtually all physicians, regardless of specialty, would like to be relieved of it.

The problem, of course, is that unless a group has a unique arrangement with the hospital, it must cover the practice every night and weekend, allocating the duty among its physician-members. Usually, a member’s coverage time decreases as a group adds doctors. Conversely, when a member drops out of the rotation, the load on his or her colleagues increases.

Prospective rules

For these reasons, plan how you will handle requests for reduced call. Some groups implement prospective rules. One approach requires full duty until a partner has attained a stated age/length of group service (e.g., age 55 and 15 years as a member), entitling members to drop or reduce call after that.

The trouble with prospective rules, however, is that it’s difficult to predict the circumstances at which a member reaches that stage. Suppose, for example, that a five-doctor group adopts the rule, but only four doctors are on hand when one of them elects out. This pullout then reduces coverage to three doctors, which means that one of them must be on call two nights each week.

Other groups adopt a simpler position: If you’re part of the group, you share call—period. Such an extreme attitude may lead seniors to fully retire sooner than they would like.

If you don’t have a policy allowing some way to drop call, you may eventually face embarrassing, disruptive confrontations. Suppose, for example, that a valuable partner becomes physically unable to take call or else must fully retire. You may have to back off on an absolute call requirement because the partner’s case—and your conscience—merits it.

The value of call

Reducing call also raises the sticky question of its economic importance. In almost all specialties, a partner’s share of income depends on sharing all group responsibilities, including coverage. Even if the partners’ pay is wholly productivity-based, they will likely insist upon a colleague relinquishing some income if he or she requests uninterrupted nights and weekends.

The only occasional exception is when night and weekend duty give rise to heavy fee production, and groups allow relatively new members to take more call so they can earn much-needed extra pay and further develop their practice presence.

Call’s dollar value is one of the most difficult questions that groups face. No single figure fits all practices—or even all of those within a specialty—because the value of call depends purely on the group’s particular circumstances. Those circumstances include

• a group’s interpartner chemistry
• a group’s members’ attitudes toward their work and even toward senior partners
• the more obvious issues of time and energy actually expended when on call

I have seen pay reductions of as much as 25% for dropping call, although the more common charge is in the 5%–10% range. The number usually differs with the toughness of the duty, the specialty, and the number of doctors involved.

Some large groups allow their members to buy or sell call among themselves. In effect, the “market” determines the price. But often, a senior wants to give it up for far less than his or her partners will take. And in many specialties, no one will take on more duty regardless of the price, creating a dilemma for the aging partner.

I advise groups to seriously discuss their coverage policy up-front before a request to reduce or drop crops up. Allowing a partner to apply anywhere from six to 12 months in advance for permission to drop or reduce coverage after reaching a stated age and tenure (but at a specified income reduction) would be a good result of such discussion.