ADVISORY PUBLICATIONS,
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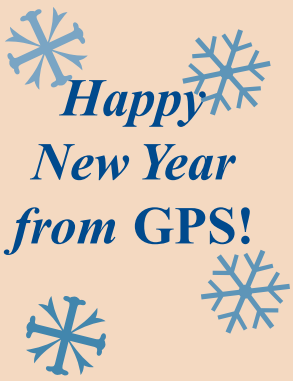
Practical ideas and strategies to improve group relationships, productivity, and performance.

Group PRACTICE SOLUTIONS

What's Inside GPS

January 2005



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■ Group strategies

Recruitment: Guide your group safely across the physician generation gap

We recently received this request from an oncologist in Missouri: *Help me understand the psyche of "new millennium" doctors (out of residency in the past four to five years). We find many have rather unrealistic expectations—signing bonuses, immediate partnerships, and reduced workload so they have more time to spend with their families.*

This is neither a one-sided story nor a matter of determining who's right or wrong, says consultant Leif C. Beck.[1] Senior doctors pride themselves on their dedication to their practices—it's their badge of honor, Beck says. Meanwhile, younger-generation docs maintain that there is more to life than work, and that they can have a full family life and still be good physicians.

Some older physicians make that concession, but they are still put off by an "I am the prize" attitude among residents. "Most of this generation was raised by parents who made [their children] the center of everything," says consultant Rosemarie Nelson.[2] Many were also self-reliant, latchkey kids who witnessed their parents' downsizing at work, she says. So it makes sense for them to be confident enough to demand the security they fear losing.

To recruit today's new physicians, you must bridge this generation gap. Understand that residents' expectations are not necessarily unrealistic—huge physician shortages in some specialties tilt the law of supply and demand in the younger generation's favor. However, it's important to know when to give in and when to walk away.

Get to the facts

Residents often complain that their classmates got better deals (e.g., have higher incomes, work only from 9 a.m. to 5 p.m.). The Internet has contributed to these claims, allowing physicians seeking practices (as well as groups seeking physicians) easier access to current salary surveys, discussion boards, etc., says physician recruiter Frank Vigil.[3] "When one candidate gets a great deal and brags about it on the Internet, the bar is raised."

To separate fact from rumor, determine where your practice truly stands in the marketplace, says consultant Randy Bauman.[4] "It was a different world 20 years ago." Talk to your noncompetitor colleagues (e.g., out-of-area physicians in your specialty, local physicians in different specialties) to get a handle on what types of deals young

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1 Beck advises on top-level group practice matters and is the author of **GPS**' "Consultant's perspective" column. Contact him at Leif C. Beck Consulting at 610/355-0797 or via e-mail at *leifcbeck@comcast.net.*
2 Contact Nelson at 315/391-2695 or via e-mail at *RosemarieNelson@alum.syracuse.edu.*
3 Contact Vigil at 800/378-0207 or via e-mail at *fvigil@earthlink.net.*
4 Contact Bauman at 800/467-3310 or via e-mail at *rb@deltahealthcare.com.*

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doctors actually receive, Beck adds.

Determine what your practice has to offer, what you have to sell, and what you are up against, Bauman says. To do so, assess your practice from the following standpoints:

- **Location.** Consider your state's weather, outdoor activities (e.g., skiing, beaches), cultural amenities (e.g., theaters, sports arenas), and income and sales taxes.
- **Income level.** Do your doctors make more or less than the national average? If less, you may have to be more flexible in other areas to appeal to candidates.
- **Ancillary services.** Do you have a CT scanner or other revenue-enhancing service? Do the neighboring practices?
- **Hospitals.** Can the local hospital assist with your recruiting efforts, either financially or with practice-establishment assistance?
- **Hospitalists.** In major cities with established hospitalist programs, you may be able to offer a minimal call schedule. Competition for "no-call" positions is greater in cities than in rural communities.

If you find you are not attractive from a recruiting standpoint, develop a three- to five-year plan to increase the appeal of your practice, Bauman says. The best time to do this is when your senior doctors are in their 50s—before they begin to cut back on their hours or consider retirement.

In the meantime, with a clear picture of the marketplace, offer recruits a reasonable contract and maybe even give in to some new-generation requests. And you have to set your ego aside, Bauman says. "Know when to fight and when to give; know what's important and what isn't. The most important unimportant thing is what the deal was when you bought in." If the market calls for a two-year buy-in and you waited five years, you have to let it go, he says.

Don't be mysterious

Be up-front with residents. Develop a one- to two-page recruitment handout, Bauman says. In a question-and-answer format, outline your compensation formula, bonus system, call schedule, and, most importantly, requirements to be a partner.

Explain that partnership is not a privilege—it's earned—and offer a simple explanation of your requirements, as in the following example: Partnership can be earned after two years, subject to satisfactory evaluations and a vote of the partners. Buy-in is typically the net-worth value of the hard assets and an earn-in of accounts receivable over three to five years.

Although this statement is negotiable, it keeps residents aware of protocol and shows them that your group is organized, Bauman says.

Don't go it alone

Teach residents the business side of medicine. Bauman recommends assigning new doctors to mentors who can teach them business fundamentals, the nuances of the practice, and the meaning of being part of a group. (For a related article on mentoring, see the October 2004 **GPS**.)

Assign each new doc two mentors: one who's fairly established and another who is more in the middle, Nelson says. All three physicians will stand to gain from discussing the experiences of the others, she adds.

Further, physicians who believe they want to one day become partners should always complete at least a few courses in healthcare/practice-specific business management, says Vigil.

Generational conflicts may not become obvious or problematic until a new doctor asks to become a partner sooner than the older doctor thinks is appropriate. If you haven't already communicated your practice's path to partnership (via a written document, orientation, or mentorship), invite the recruit to dinner, listen to his or her case, and then explain your feelings on the matter.

If necessary, find a facilitator to help, Nelson says. Consider bringing in a consultant or psychologist to work with your group on team building and understanding intergenerational differences.

Require mutual respect

Despite their inexperience, some residents assert that they are of more value to a practice because of their many productive years ahead. And although potential doesn't necessarily equal value, Bauman suspects a bit of an inferiority complex on the part of older doctors. After all, someone fresh out of training in an ever-advancing field such as medicine may in fact know more about new techniques than established doctors.

However, you can embrace recruits' knowledge without giving up authority. Establish an employer-employee relationship from the beginning, Bauman says. Don't shy away from evaluating new doctors or lose sight

of the fact that they are employees, not peers, he adds.

If you can't get the respect you deserve, say something along the lines of, "You may know how to do X better than me, but it's my practice and I'm going to help you along. You show me what you know and I'll show you what I know."

Fools rush in

If all else fails, walk away from the resident. "Early resentments are not going to be the building blocks of a trustful [potential] partnership," Nelson says. This can be difficult, especially if you are in an unattractive area or specialty suffering a physician shortage, Bauman admits. In those circumstances, it's easy to fall in love with a candidate.

If you find the perfect candidate and agree to give a bit more in the contract, don't keep dredging up your kindness later, Bauman says. To avoid later resentment, give yourself options. "Negotiating is setting deadlines and knowing when to walk away," Bauman says, adding that sometimes groups agree to generous contracts because they think they don't have a choice. "Maybe they don't—but if they do, it will be because they planned ahead."

Practice management

Audit your policies to verify compliance and efficiency

Audits help determine whether you are achieving your practice's goals and objectives. An audit or general practice review can verify actual compliance with your policies and procedures, evaluate the adequacy and value of your internal-controls system, and verify effective use of your resources.

A timely audit can also prevent conflict. In a group practice, it's not unusual for different physicians and staff to have their own practice or work styles, but sometimes differences foster resentment. An audit is "a good time to let the sun shine in on what you're doing," says consultant Daniel M. Bernick,[1] JD, MBA.

Therefore, call in a consultant or conduct the audit in-house. Remember, you may be too connected to problems to recognize them, Bernick says.

The more topics you cover in one audit, the less detailed data you will gather. A general management survey will address just your major concerns, Bernick says. From there, you can prioritize which areas you may want to audit more comprehensively.

For example, if your general review reveals deficiencies in both scheduling and billing, you may decide the billing problem is more pressing and you will tackle that first.

According to Anthony Almeda,[2] CPA, you should cover these major areas in your audit:

Appointments

1. Evaluate the adequacy of policies and procedures for scheduling patients. Look at your follow-up procedures for patients who fail to keep their appointments.

2. Determine whether patient appointment times permit coverage of walk-in patients and completion of scheduled patients. Try not to schedule patients too close to the end of the day so you have time for unexpected delays.

3. Analyze the adequacy of the registration procedures. Verify that you capture all appropriate information accurately and timely and that you employ appropriate procedures to ensure that demographic and insurance information are updated when changes occur.

4. Evaluate the adequacy of the system used to communicate registration errors (e.g., incorrect insurance information) to the clinic from the billing and accounts receivable departments.

5. Create a narrative of patient encounters from sign-in to checkout. Determine the effectiveness of your internal control policies and procedures during this process. Make sure to print a "missing encounter form" report at the end of each day.

Charge capture and recording

1. Review charge-posting procedures for appropriateness. Be sure correct charges are posted to correct patients' accounts.

2. Assess how you account for all visits and charges at your practice. Verify that no one except > p. 4

1 Contact Bernick at the Health Care Group at 610/828-3888 or via e-mail at *dbernick@healthcaregroup.com.*
2 Almeda is a senior internal auditor for Community Health Systems, Inc., in Brentwood, TN.

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the practice manager can delete an encounter form from the system.

3. Select 20 days at random from two to three months ago and 10 days from the previous month (sample size of 30). Include varying days of the week.

Next, obtain sign-in sheets for the selected days and match the number of patients per day per sign-in sheet to the number of encounter forms for that day. Trace back any discrepancies and obtain any reconciliations performed by office staff.

4. Randomly select one patient from each randomly selected day. Record the visit date, patient name, and service(s) rendered. From the patient's medical and financial records, obtain the detailed account history, medical record (chart), and encounter forms.

Trace items posted in the detailed account history to the patient's medical record. Verify that all charges are supported, that all procedures and chargeable supply items were charged, and that there is documentation to support that the billing was appropriate.

If a charge is missing, review the encounter form to identify the part of the encounter in which it was missed.

5. Obtain a list of patients discharged from the hospital within the past three months whose attending physicians belong to your practice. Randomly select 10 admissions and perform the same steps as those listed above.

6. Identify whether your physicians provided services in any other locations (e.g., nursing homes, patient homes). Then identify the procedures used to ensure that all charges are accounted for and properly billed. Obtain a sample of 10 of these cases and perform the same steps as in step four.

7. Analyze cash management, follow-up, and collection activities based on the information gathered in the above steps.

Cash and cash-handling procedures

1. Document the cash-handling process. Review cash-handling policies and procedures for their appropriateness.

2. Obtain and count the petty cash fund (if applicable) in the presence of the fund's custodian and determine the total cash on hand and in the receipts. If these two combined do not equal the fund's balance, resolve the discrepancy with the fund's custodian.

Finally, return the petty cash fund to the custodian and obtain his or her signature confirming that you returned the fund intact.

3. Gather end-of-day daily cash processing reports for days selected in step three under "charge capture and recording" and match the total encounter form charges plus the total money collected (including copayments) to the transaction postings journal. Then match

- the insurance company payments to remittance advices (if the practice receives these payments)
- patient mail payments to remittance advices

Obtain explanations for any out-of-balance conditions.

Look at validated deposit slips corresponding to days selected above and match total money collected by category (e.g., cash, check, credit card) per the transaction postings journal to deposit slip information.

Next, verify that the bank validation date and amount are consistent with the deposit slip information and that the deposit was made in a timely fashion.

If you find discrepancies, follow up to ensure that staff correct them in the system on a timely basis.

4. Verify cash deposits by doing the following:

- Compare the deposit slip to the bank statement
- Determine whether the day's cash receipts were posted to the cash receipts journal
- Review the bank reconciliations to determine whether your practice properly segregates reconciliation duties and performs reconciliations on a timely basis. Follow up on discrepancies with management personnel not involved in handling the deposit.
- Determine by reviewing the bank statement whether cash deposits are made daily.

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Recruitment

Do's and don'ts of physician background checks

In today's malpractice-leery environment, physician background checks are fairly standard procedure. To make the most of your efforts, follow this practical advice from recruitment expert and consultant Allison McCarthy.[1]

Do's	Don'ts
Do conduct a "wide-open" Internet search for potential candidates on a search engine such as *www.google.com*. Put the doctors' names in quotes and look for any articles written about them. Cross-reference the community listed in the article with the physicians' curricula vitae.	**Don't** ask physicians for their Social Security numbers or other personal information unless they are serious candidates.
Do coordinate background-checking efforts with your local hospital.	**Don't** duplicate investigations conducted by the hospital for its credentialing process.
Do verify board certification and licensure before interviews. You can obtain this information for free through Web sites from organizations such as the American Board of Medical Specialties (*www.abms.org*). Some state licensing boards provide this information online. License verification will also reveal the physicians' malpractice histories.	**Don't** wait until you have already invested significant time and effort in recruiting a physician to verify board certification and licensure. Screen out unqualified individuals immediately, especially if your practice or hospital bylaws require board certification.
Do send serious candidates letters of intent or offers stating that your official offers depend on a background check and full verification of the candidates' credentials and references.	**Don't** waste time or money conducting full background checks on all applicants. Only do so for the few you're serious about hiring.
Do explain the background-check process to candidates before you begin a formal investigation. Give candidates a chance to disclose anything they think you should know before you discover it on your own, and give them a chance to explain any unusual situations.	**Don't** make decisions based solely on finding problems or inconsistencies in candidates' backgrounds. Approach candidates with the information and allow them to explain. A one-time mistake may not be reason enough to lose an otherwise excellent physician.
Do check candidates' • credit history • criminal/civil background • professional and personal references • driver's license record Consider checking • workers' compensation history • drug screening • National Sex Offender Registry	**Don't** delegate professional reference checking to the practice manager or office manager. Physicians should contact these professionals themselves because they have a better understanding of various practice experiences than administrative staff. In other words, physicians should communicate directly with each other because they speak the same language.
Do recognize a red flag if candidates balk at a standard background check. If necessary, ask the physician to imagine themselves in your shoes—responsible for hiring qualified physicians while protecting the safety of the community.	**Don't** forget that smart candidates will also conduct their own background investigations on your practice. Be prepared to answer any questions candidates may have regarding your group's history.

1 McCarthy is a managing consultant for Corporate Health Group's northeast office. Contact her at 508/394-8098 or via e-mail at *amccarthy@corporatehealthgroup.com*.

■ Technology

How to write an effective request for proposal—and where to go from there

Put EMR vendors to the test with a carefully crafted checklist

Second in a three-part series.

Last month, we outlined the basic steps your electronic medical record (EMR) selection committee must take to choose the best vendor for your group's needs. Here, we delve more deeply into two of the most crucial tasks in this process: developing and analyzing your request for proposal (RFP).

Remember, before you begin writing your RFP, thoroughly define—and document—your needs. Otherwise, you could wind up with an RFP too generic for your practice.

"The leading cause of disappointment [with an EMR] is not defining your needs beforehand," says consultant Jeffery Daigrepont.[1]

Your RFP is basically a checklist of needs that you send to a number of vendors as you begin your EMR selection process.

This document should be extremely detailed, listing all the features your practice must have, along with items on your wish list (e.g., keyboard, mouse, trackball, pen, voice interface options). The vendor checks yes or no for most of your questions regarding its features and services, but fills in answers to certain open-ended questions, such as those about the vendor's company history.

Keep your priorities in mind. Determine ahead of time what items with a negative response will indicate a deal breaker.

For example, you might rule out vendors that cannot provide an interface allowing you to connect to the lab, hospital, etc. You'll also want to know right off the bat whether monthly payments will include upgrades or will cost extra.

Tip: Before sending out your RFP, select all items you consider to be mandatory or must-have features and mark them with an M or other symbol to make it easier to analyze completed RFPs.

Cover the what-ifs

Address all the what-ifs, Daigrepont says. As a group, brainstorm all possible changes in your practice or environment that could affect your agreement with an EMR vendor.

For example,

- what if the vendor goes out of business?
- what if the government changes the EMR functions required for reimbursement?
- what if you add future providers after the sale? (If you don't agree on the price now, the vendor can hold you over the barrel down the line.)
- what if you reduce number of users? Will the vendor reduce your support cost accordingly?

It is easier to negotiate these terms with vendors before hiring them than after the fact.

Gather a full understanding of what kind of technical support the vendor will supply and what it will cost. Your support needs likely will be greatest in the beginning, so plan for that. For example, consider requesting that for the first 50 hours, the vendor doesn't charge for special requests such as customizations, and that for the first full year of service, the vendor offers discounted special requests.

In addition, ask the vendor whether it will provide reinforcement training, either in-person or online. Remember to find out whether your contract includes the assistance or whether you will have to pay extra for it.

Beware of crafty vendors

Recognize that vendors filling out your RFP are essentially completing a job application—and will attempt to appear as capable and qualified as possible. For example, some may check yes to having features that are really still in the works or coming soon.

An entire section of your RFP should provide vendors with explicit instructions on how to respond. Although checkboxes for yes and no seem self-explanatory, not all features of their products may be

Questions? Comments? Ideas?

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1 Daigrepont is a manager with the Coker Group in Roswell, GA. Contact him at 800/345-5829 or via e-mail at *jdaigrepont@cokergroup.com* for a free sample RFP or script to use with vendors.

available yet.

Even if you include a third "under development" box in your RFP, specify in your instructions that vendors must not check yes regarding features that don't exist at the time and that items coming soon will be addressed in a separate section.

Some of your questions will require a specific write-in response. Make sure you're clear on how vendors must respond to those as well. Vendors often supply a less-than-specific answer by referring you to another section of the document and then never really answer your question. For example, your RFP may ask, "How many systems have you installed in Texas?" If no number appears in the blank provided, you'll probably receive an answer such as "We have installed 2,000 systems nationwide," with no figures for Texas.

Daigrepont has also seen vendors modify questions in an RFP to fit their answers, skip questions, or delete questions altogether.

The final analysis

Once you receive all of your RFPs back from vendors, you have careful decisions to make. "The main thing is you don't want to trade quality for discounts," Daigrepont says. But you don't want to leave yourself vulnerable to unexpected expenses, either.

He likens hiring an EMR vendor to hiring a contractor to build a house. Amidst the chaos of planning and construction, you may notice too late that the builder plans to install only one phone jack in the house—and you definitely need three. Assumptions may lead you to paying extra for fundamental features not included in your contract. (Next month, we'll provide sample language not covered in the RFP to include in your contract once you select a vendor.)

After examining your returned RFPs, narrow the field to vendors you want to invite to your practice to demonstrate their products. Remember that the vendor's demonstration will be a well-scripted, well-rehearsed presentation.

To ascertain how the EMR will work in a real, unscripted day at the office, prepare a script of your own to challenge the product with scenarios typical of your practice. Embed subchallenges or conflicts in your scenarios. For example, give a male patient a female diagnosis or try upcoding or downcoding a procedure and notice whether the software generates an error or alert.

Make sure all members of your selection committee have copies of your original documents in front of them during the vendor presentation. Throughout the presentation, members should interrupt the vendor, refer to specific items or claims in the RFP, and ask the vendor to demonstrate how the software performs those functions.

After further eliminations, arrange site visits to practices to see the finalists' products in action. Make sure that the practices you visit don't have inducement arrangements with the vendor. Although it is reasonable for the vendor to compensate the practice a small sum for its time, avoid practices that stand to receive a percentage of the vendor's sales.

Send three or four key members of your selection committee on site visits. Upon arrival, spread out. Talk to as many nonleadership personnel as possible to get the most honest answers about the system. The manager usually chooses the vendor, so by human nature, he or she will defend that decision, Daigrepont says. On the other hand, "the medical records clerk or front-desk receptionist will lay it on the line for you."

Consultant's perspective

Value A/R fairly when buying out a partner

Use a six-month activity test as the base

By Leif C. Beck,[1] JD, CHBC

Of the three types of assets making up a group's value for partner buyout purposes—tangible assets (e.g., cash, equipment, furniture), accounts receivable (A/R), and goodwill—A/R should be the simplest. It is expressed in hard dollars and, except for a few items such as workers' compensation and litigation bills, will likely become either actual cash or uncollectible write-offs within three to six months. Still, it's important to value the A/R fairly to avoid shortchanging the departing partner or the practice.

Receivables (less the practice's payables) are logically functions of practice income. Therefore, in your employment agreements, call for continued (deferred) compensation, rather than keeping the compensation part of the corporate stock price. If your group is an LLC, LLP, or pure partnership and not a corporation, you'll have different documents, but the suggested capital v. income differences remain the same.

Pay-over as received

Groups have a natural tendency to distribute to departing physicians shares of their receivables "as collected." I see this approach most often in groups whose compensation formulas base individual partners' pay on their patient services. They assume that the receivables belong to the doctors and that paying the receivables out to departing doctors will not hurt the remaining ones.

However, this system may severely interfere with the group's finances. Those receivables normally cover the practice's overhead expenses as well as the doctors' income, so deflecting them as collected will reduce the income available to the continuing members. In other words, even if the partners receive payment based on their production, the actual A/R is group property.

A better buy-out format spreads out the A/R payments to departing physicians over a period much longer than it likely took to collect that amount. For instance, a full year helps the group cover overhead during a possible period of hardship following physicians' departures.

Plus, you're better served by a formula capable of an exact calculation of A/R on a specific date. The latter approach produces an approximate number as of the departure date. This puts the ex-partner in a position to look over the group's shoulder to make sure it collects and reports accurately.

Activity test

Some agreements call for your accountant to value the A/R "based on [the accountant's] uniformly applied estimate of collectability as of the valuation date." This approach leaves the issue up to a supposedly independent professional not beholden to either the ex-partner or the ongoing members. I've seen conscientious CPA efforts, as well as some sloppy ones, so I don't favor this approach. Besides, it's best to avoid giving discretion to anyone with an ongoing business interest in the group.

I prefer payout language referring to "all open accounts receivable having any activity within six months before the valuation date." This means you total up the accounts of all patients for whom you have provided a service or who have made a payment within that time period. It arbitrarily rejects all of the older inactive accounts, even if they continue to show balances.

The six-month activity test has the advantage of being mechanical. It requires no estimates and disregards what happens after the departure date. Such certainty is important because the parties, although formerly partners, have differing economic interests upon buy-out.

Consider the nature of the group's receivables. Some practices estimate a realistic, fair value by taking 100% of the six-months-open figure and disregarding the old accounts. Others multiply the open-accounts figure by an agreed collection percentage dependent on the practice's circumstances.

Good, one-time advice and spreadsheet work by your accountant or an independent consultant should help you arrive at a figure that you can rely on for the foreseeable future (at least until your next review of the entire payout format).

Remember, though, that two classes of assets relate to income, the second one being goodwill. Once you agree on a method of valuing A/R, combine it with a method of valuing goodwill (if any) to create a single income payout figure. I'll take up goodwill valuation and the tax-preferred way to combine it with the A/R value next month. ▲

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