Practice Excellence

Success Stories from Outstanding Orthopedic Practices

Jerry A. Harvey, Maj, USAF, MSC, CAMA
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Table of contents

Foreword ................................................................................................................................... 5
  Optimal orthopedic practices share ideas ......................................................................... 5
Introduction ............................................................................................................................... 6
Past performance trends ............................................................................................................6
The makings of a “better performer” .....................................................................................10
Research methodology ..........................................................................................................12
Shared characteristics of top-performing orthopedic surgery practices .................................13
  A. Business and strategic planning ................................................................................. 13
    Proactive vs. reactive and the business planning process ........................................... 13
    Tools for business/strategic planning ......................................................................... 14
    Future plans for growth ............................................................................................ 15
  B. Billing processes ........................................................................................................ 16
  C. Physician assistants and nurse practitioners ............................................................. 18
  D. Ancillary services ..................................................................................................... 19
    Ambulatory surgery centers .................................................................................... 19
    Physical therapy ..................................................................................................... 20
  E. Physicians and practice culture .................................................................................. 21
  F. Technology ............................................................................................................... 22
    Future plans for electronic health records (EHRs) ................................................... 23
  G. Process improvement ............................................................................................... 24
Conclusion.................................................................................................................................26
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About the partner

In the business of health care, reputation is everything. That’s why we have worked hard to live up to the high calling our name inspires: ETHOS is a Greek word relating to foundational or supporting expertise, knowledge, and competence – with the implication of honest conviction and integrity. It is also the reason our services are conducted in a manner that aligns our outcomes with results. It is also why we believe that it is more important to equip your practice with knowledge, not just information.

EthosPartners Healthcare Management Group works in partnership with physician groups to return the joy of practicing medicine to them by:

- Assisting physician groups (at the practical level) in improving shareholder compensation through enhancing practice operations, market position, and operations; and
- Providing practice management data tools to provide essential information that guides practice leadership in key decision-making and reduces the cost of doing business.

In the end, EthosPartners Healthcare Management Group offers a reputation of excellence and a history of shared risk that can increase your group’s efficiency and profitability.
Foreword

Optimal orthopedic practices share ideas

What makes a better-performing practice? Better yet, what makes an optimal orthopedic surgery practice out-perform other orthopedic surgery practices? Each year, MGMA publishes the Performance and Practices of Successful Medical Groups report, which provides data and insight to this question. However, we wanted to know even more.

MGMA and EthosPartners Healthcare Management Group, a health care consulting firm, dug deeper and conducted a study of 20 better-performing orthopedic surgery practices to learn what they do differently and what lessons they learned along the way.

In this unique booklet, you will find data on past performance trends and open discussion on how these specific practices survived and surpassed the changes in health care, regulations, and limitations on their daily operations.

The following materials are a unique compilation of ideas and perspectives of colleagues across the country, whose insight can be used to assist you in making improvements or even provide reinforcement in areas where you already succeed. We feel we have outlined some of the key indicators within practices that have a proven track record and can easily be implemented.

Practice executives are in a complex industry that will likely continue to increase in complexity. This is our opportunity to prepare for the future, embrace change, and make a commitment to keep our practices moving forward.

Robin L. Kretchmar, FACMPE
MGMA Orthopaedic Practice Assembly President
Introduction

In a world of decreasing reimbursement and increasing practice expenses, physicians, and practice executives often disagree on what constitutes a successful practice. Physicians struggle with expectations of increased compensation while balancing their workload with an enjoyable lifestyle. These same physicians expect their practice executives to optimize the practice’s performance, put more money in their bank account, and ensure they’re home for dinner at a reasonable hour. While not all practice executives excel at this juggling act, we can learn from those who do.

The findings and lessons learned in this paper are drawn from the Optimal Orthopedic Surgery Practice Study, a joint study of the Medical Group Management Association (MGMA) Center for Research and EthosPartners Healthcare Management Group, a health care consulting firm located in Atlanta, Ga. The lessons learned were drawn from practice executives from 20 better-performing orthopedic surgery practices.

Many group practice consultants will say that the group practice executive’s primary role is to maximize physician compensation. Based on this perception, this exploratory study seeks to identify the factors that enable practice executives in physician-owned orthopedic surgery groups to maximize the financial return paid to physicians as equity owners.

This paper reviews past performance trends, defines the characteristics of a better-performing orthopedic surgery practice, examines the strategies of better performers, and draws conclusions on how the practices optimized their performance.

Past performance trends

To plot the course of a trip, you must know where the trip begins and where it ends. Do you want to take the shortest route, or the fastest route? The same is true when measuring group practice performance. This section analyzes the past performance trends of orthopedic surgery practices, then defines the selection criteria for better performers in orthopedic surgery practices as determined in MGMA’s Performance and Practices of Successful Medical Groups: 2006 Report Based on 2005 Data.

The study focused on the three Cs — cash, costs, and collections — when analyzing orthopedic surgery practices’ past performance. For our purposes, “cash” is defined as practice revenue, while “cost” is the practices’ operating expenses. Lastly, “collections” refer to the practices’ accounts receivable (A/R) and collections. These measures serve as the foundation for measuring financial performance and later define the criteria of a “better performer.”

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First, let’s examine cash and costs. The phrase “cash is king” may have come from medieval times when a king was measured by how much gold was in his coffers. This view can be applied to how an orthopedic surgeon views his or her practice at the end of the day. Each physician hopes to see an equitable amount of cash relative to the level of effort exerted each day.

Figure 1 reflects the revenue generated by orthopedic practices from 1985 through 2005, based on MGMA’s cost survey reports. It is interesting to note the moderate increases in revenue and costs from 1985 through 1995. After 1995, we begin to see the impact of the Balanced Budget Act of 1997, which paved the way for managed care entities and capitation plans. The Act also significantly impacted how practice executives altered practice operations to ensure continued profitability. These changes will be discussed later.

Figure 2 represents median operating expenses as a percent of total medical revenue, which reflects a different perspective of the relationship between cash and costs over the same time frame. It is easy to see the impact of the Balanced Budget Act of 1997 on cost as a percentage of total medical revenue between 1995 and 2000. The Stark law against physician self-referral is another regulatory change that significantly impacted revenue and physician compensation. This was an effort by the U.S. government to reduce Medicare fraud and abuse. The legislation restricted physicians from referring patients to medical entities in which physicians or their family members had a financial interest.
Figure 2

Orthopedic surgery groups
Median operating expense as a percent of total medical revenue
MGMA Cost Survey Reports

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<td>Expense (%)</td>
<td>42.20</td>
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<td>41.81</td>
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Figure 3

Mean FTE support staff per FTE physician
Orthopedic surgery groups
MGMA Cost Survey Reports

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<tr>
<td>FTE Support Staff</td>
<td>4.00</td>
<td>4.59</td>
<td>4.72</td>
<td>4.97</td>
<td>5.64</td>
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</table>
So, how did orthopedic surgeons survive and strive from the 1990s into the new millennium? The answer lies within their cost structure. Surgeons focused on what they do best — surgeries and patient care — and hired support staff to handle minor and non-revenue-generating duties. Figure 3 reflects this new cost-management methodology. To offset the decreased reimbursement resulting from the Balanced Budget Act of 1997 and the Stark law, physicians and practice executives added support staff to increase physician productivity and medical revenue. Figure 3 reflects the accelerated increase in operational cost, largely due to increased staffing, as compared to the gradual increase in total revenue. Without the added support staffing to boost physician productivity, physicians may have faced decreased compensation based on reduced reimbursement rates at the same productivity level.

The last of the three Cs is collections. Having caused negative outcomes, such as decreased reimbursement and the need to increase cost and productivity to generate revenue, how did the Balanced Budget Act of 1997 impact collections? Figure 4 reflects one of the positive impacts of the managed care environment. Built using data from multiple MGMA cost survey reports, Figure 4 illustrates a dramatic decrease in the mean number of days of gross charges in A/R from 1985 through 2005.

Figure 4

Although this decrease has occurred for numerous reasons, two stand out with the introduction of managed care — capitation and contractual agreements with third-party

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payers. Both streamlined the billing process and expected dates of reimbursement. In many cases, an orthopedic practice could expect to be paid within 45 days of submitting a clean claim to a third-party payer. Contractual write-offs contribute the second piece of this equation: With an agreed-upon fees structure, practices write off the difference between what they normally bill and the agreed-upon reimbursement stated in the contract with the third-party payer.

The makings of a “better performer”

What makes a better-performing practice? MGMA’s *Performance and Practices of Successful Medical Groups: 2006 Report Based on 2005 Data* uses three functional areas as the selection criteria for these practices: Profitability and cost management; productivity, capacity, and staffing; and A/R and collections.

To be identified as a better performer in the functional area of profitability and cost management, the medical practice must meet the following criteria:

- Greater than the median for total medical revenue after operating costs per full-time-equivalent (FTE) physician; and
- Less than the median for operating costs per medical procedure.

After profitability and cost management, the next logical functional area to consider is how well a medical group manages productivity, capacity, and staffing. Two criteria apply here:

- Greater than the median for procedures per FTE physician; and
- Greater than the median for gross charges per FTE.

The last functional area that MGMA considers crucial to being a better performer is proper management of A/R and collections. Not only must a medical practice generate revenue and manage costs, it must also have in place processes to bill and collect money owed. Collection efforts must generate enough cash flow to pay creditors and staff salaries, as well as compensate the practice’s physicians. The selection criteria in this functional area are:

- Less than the median for percent of total A/R over 120 days;
- Greater than the median for adjusted fee-for-service collection percentage; and
- Less than the median for months gross fee-for-service charges in A/R.

If an orthopedic surgery practice was rated as a better performer in all three functional areas, what would it look like? The spreadsheet in Figure 5 extracts data from MGMA’s *Performance and Practices of Successful Medical Groups: 2006 Report Based on 2005 Data*. The spreadsheet compares the performance of better-performing orthopedic surgery practices to that of other orthopedic surgery practices in the survey.
Looking at profitability and operating costs, the better performers generated $761,720 in total medical revenue after operating costs per FTE physician vs. $534,114 for all other orthopedic surgery practices that participated in the survey. That’s a difference of 42 percent! Also, notice that in the criteria of productivity, capacity, and staffing, better performers complete 10,660 procedures per FTE physician as compared to 7,297 procedures in the other practices. The better performers are 46 percent more productive than their peers.

This increased productivity generates almost an additional million dollars in charges per FTE physician. And, the better performers collect what is owed to them more efficiently, as indicated in the total percent of A/R over 120 days, which is 4 percent less than their peers.

In theory, a better performer can generate more procedures, which accomplishes two things. First, it generates higher medical revenue. Secondly, it spreads the facility overhead over a greater number of procedures, which lowers the cost per procedure. And, a better performer collects the cash quicker.
Research methodology

The facts and figures discussed previously were based on a literature search to trend the performance of orthopedic surgery practices over a span of time and to identify what a better-performing orthopedic practice would look like today.

With this background knowledge, let’s look at the results of focus group discussions with practice executives from 20 optimal-performing orthopedic practices (see Figure 6). These practice executives shared their experiences on what it takes to be a better performer and maximize physician compensation.

Figure 6

<table>
<thead>
<tr>
<th>Name</th>
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<th>State</th>
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Practice executives associated with optimal-performing practices were selected from the pool of orthopedic surgery groups that participated in the 2005 MGMA Cost Survey. They were selected as better-performing practices in the *Performance and Practices of Successful Medical Groups: 2005 Report Based on 2004 Data*.

Thirty-three orthopedic surgery medical groups were identified as meeting the better-performer criteria in at least two of the report’s three performance areas (profitability and cost management; productivity, capacity, and staffing; and A/R and collections). Invitation letters were sent to these practices in June 2006; 16 orthopedic surgery groups were willing to participate in the study. Four additional medical groups were added to the participant list on the recommendation of EthosPartners Healthcare Management Group and MGMA’s Practice Management Research department.

We analyzed the data that the practices submitted to the MGMA Cost Survey and the MGMA Physician Compensation and Production Survey to document the relative performance of each medical group. Additionally, we used qualitative research methods, including telephone conference calls, a focus group at the 2006 MGMA Annual Conference, and e-mail communications to examine the strategies, processes, and organizational structures that enabled them to attain a higher level of practice performance and physician income than their peers.

**Shared characteristics of top-performing orthopedic surgery practices**

**A. Business and strategic planning**

Just as a global positioning system (GPS) is a great tool for getting you from destination A to destination B, business and strategic planning is a practice executive’s roadmap to success. So, do better performers have a secret master plan that ensures success? This section examines how better performers approach business planning and the future growth of their practices. Do they proactively plan ahead, or do they simply react to problems as they arise? Simply put, better performers discuss their visions for their practices’ future growth, such as adding physicians, expanding services, purchasing equipment, starting new construction, procuring real estate, and securing capital or financing.

**Proactive vs. reactive and the business planning process**

Overall, the practice executives realized that they are more reactive than proactive with their business and strategic planning processes. They stated there are numerous external and internal variables that are beyond their control, such as physician retirement, insurance fee schedules, and regulator changes that constrain their ability to plan for their practices’ future growth.
Most of the practice executives interviewed agreed that they use a two- to three-year strategic planning cycle. Given the changes in the health care environment, they find it difficult to forecast beyond that time frame. Most start with a review of the prior year’s financial data and a reassessment of the previous strategic plan before progressing into new development or responding to upcoming changes, such as a retiring physician. Many found that a retreat away from the office was beneficial, while others stated it was a challenge to get their physician partners to attend and participate in a strategic planning meeting.

Chris Greenman, MBA, MHA, uses a five-year strategic plan, which he revisits at each year’s end.

“We have an open agenda,” Greenman says. “We begin with a review of the prior year’s success. Then we discuss new programs and goals to update our strategic plan. We also make sure we discuss upcoming issues that will impact the practice’s operations, such as physician disability, regulatory changes, and retirements.”

When asked if they use an outside consultant to facilitate the strategic planning sessions, the group stated that although they believe it would be beneficial, the partners would not agree to the added expense. The practice executives facilitate their own strategic planning meetings and push for consensus among the physician partners.

**Tools for business/strategic planning**

The primary strategic planning tool used by most optimal performers is an analysis of strengths, weaknesses, opportunities, and threats – commonly known as a SWOT analysis. The majority use a one- or two-year SWOT analysis. Practice executives solicit the practice’s strengths, weaknesses, opportunities, and threats from their physicians. Then, they decide how best to get from point A to point B. Getting physicians’ input helps move the meeting in a particular direction and prevents the participants from changing the topic during the strategic-planning meetings.

Barbara Sack, MHSA, CMPE, has a slightly different approach.

“We use a questionnaire to solicit input from our physicians,” Sack says. “The questionnaire enables me to gain the physicians’ perspective and perceptions. For example, if a physician has a misconception about the cost of adding a piece of equipment or service, I can do my homework prior to the meeting and obtain the information to dispel the misconceptions. This makes for a more productive meeting and helps keep the physicians focused.”

Greenman has a unique team approach to strategic planning.

“I give my employees the opportunity to have input into the strategic planning process,” he says. “The employees’ concerns vary from health benefits to working late at night past their scheduled shift. Although I may not be able to correct all issues, I can at least keep the physicians aware of the impact their decisions have on the staff. Even though the physicians
may not change their behavior, at least the employees feel they have a voice and that it’s being heard.”

**Future plans for growth**

When the practice executives addressed their practices’ plans for future growth, the majority planned to add a specialist to their practice. The biggest obstacle was finding a qualified physician. Most orthopedic surgeons would like to choose their specialist from fellowship programs. The problem is that the candidates who show promise already have a job waiting for them when they complete their fellowship.

The majority of the group would like to use a head hunter or recruitment agency to recruit a qualified specialist. However, the physician partners are reluctant to pay for this service.

“The difficulty with recruitment varies with the specialty,” John Nosek, MPA, CMPE, says. “I have had great success in negotiating recruitment rates. Recruiting services are a competitive market, and there are numerous reputable agencies vying for your business. I have been successful in negotiating a flat fee in the $20,000 range, as opposed to paying a percentage of the specialist’s salary, which can be costly. The smaller fee has been an easier pill for my physician partners to swallow.”

The practice executives were asked how long it takes to recruit a specialist and for the newly hired specialist to cover his or her expenses. The group agreed that the hiring process, from recruitment through hiring, typically takes 12-18 months. Of course, this does not include time spent by the practice partners making the decision to recruit a new specialist. Once hired, there is increased pressure from the partners for the new specialist to generate revenue to offset his or her salary and operating expenses. The pressure is usually in the form of a partnership in the practice. It usually takes a new specialist six months to become oriented and fully cover his or her salary and expenses. One of the most significant hurdles is credentialing the new specialist with various payers, which is crucial to the practice’s revenue generation and cash flow.

Greenman changed the topic and discussed his construction plan for an Ambulatory Surgery Center (ASC).

“The construction project has grown since we started it,” Greenman says. “The original idea was to build a spine center. It has grown into the current plan for an ASC and has run into a number of issues. My practice is located in an area of the country that is experiencing phenomenal growth, which has fueled construction costs well beyond the original forecast. On top of that, my practice resides in a certificate-of-need state, and that has slowed progress. Barring any unforeseen obstacles, the project should be complete soon.”

Gene Austin is in the process of building a new ASC and procuring new equipment.

“The physician partners discussed this for a number of years and purchased real estate a couple of years ago,” Austin says. “They are discussing options, such as moving the existing
MRI or purchasing a new one to incorporate digital technology. I will be decreasing staff because I will gain efficiencies from the new workflow design, digital radiography (DR), and a new electronic medical record (EMR) system. I obtained financing through a local bank for a construction loan and I’m working on securing more permanent financing. We are leaning toward purchasing and financing our equipment needs instead of leasing.”

Alan E. Okun, FACMPE, is building a 40,000 square-foot building, half of which his practice plans to occupy. The other 50 percent will be leased to other specialties, such as musculoskeletal, physical therapy, and phlebotomy.

“I am trying to minimize non-revenue-generating space,” Okun says. “My physicians have agreed to give up their offices in exchange for two large rooms with cubicle spaces, a dictation area, and a small lounge to have meetings or complete their administrative tasks.”

When asked about physicians’ level of involvement during the construction/planning phase, most practice executives agreed that once the implementation decision is made, the physicians’ involvement is almost nil. They are lucky to get physicians to attend planning and project update meetings. One practice executive scheduled a facility tour so physicians could see the progress and address any of their concerns; only one practice physician attended.

However, one practice executive experienced a great deal of physician involvement. The physician had previous real estate development experience, and was interested and engaged. Most practice executives in the group would have liked more input from their physicians, which would have alleviated problems during the planning and construction phases. Physician preferences for workflow design could have been accommodated had the practice executives known their physicians’ needs during the development phase.

Many members of the group voiced concern over the increased overhead cost associated with new construction. They do their best to keep their physicians informed of the impact of increased overhead that comes with construction. Then they need to keep reminding them, so the physicians don’t forget. The practice executives estimated it took two to three years to digest the debt structure associated with new construction. The overhead eventually tapers off over time and is absorbed by normal practice operation. It is best if a practice can increase its monthly revenue stream to offset any increase in overhead cost, thereby avoiding the challenge of managing a timeline to justify decreased physician compensation.

B. Billing processes

Billing processes and cash flow can significantly impact a group practice. Practices survive by generating revenue and collecting debt. Steady A/R is a result of appropriate collection processes performed by trained personnel. Better performers understand the impact of cash flow on their ability to meet payroll and pay outstanding debt. To meet their obligations to staff, vendors, and creditors, better performers have spent a great deal of time assessing and evaluating their billing processes to ensure their financial success.
The following billing process was based on the shared experiences of the better-performing practice executives from a December 2006 teleconference.

The process begins with verifying benefits before the patient visit. The better performers initiate contact with the new patient approximately two days before the scheduled appointment to complete the pre-registration packet. In addition to the patient’s demographic information, the packet includes insurance verification and guarantor information. If staff cannot obtain all the required information at this time, they make every effort to do so with a follow-up telephone call. As a last resort, staff can obtain the required information when the patient comes to the office for the visit.

A completed pre-registration packet is so crucial to the billing process that some better performers use e-mail to communicate and obtain information from their patients. One practice developed a Web site for the practice where patients access and complete the pre-registration packet at their leisure.

Other successful tactics used by the group to improve their billing process and cash flow include collecting copayments up front.

“I collect a 50-percent deposit prior to all elective procedures,” Nosek says.

Edward Gulko, MBA, FACMPE, FACHE, LHNA, collects the portion for which the patient is responsible at the end of the appointment.

“There is a $25 fee if the patient cannot pay the bill or wishes to be billed.” Gulko says.

“Be sure to verify your state regulatory requirements before implementing such a measure, because some payers, such as Medicaid, may not allow you to collect copayments before providing services if the patient cannot pay,” Angela Gamber, RN, BSN, MBA, says.

Even the best-laid plans can go awry. So how do these better performers handle collections? Overall, the practice executives we interviewed handle their accounts on a case-by-case basis. No one had a concrete policy on how or when to send an account to collections. Most believed payment was a patient’s responsibility, and they were willing to work with patients who made an effort to pay. As a rule of thumb, payment was expected within 30 days.

Most of the practice executives set a $50 minimum before sending an account to collections. Prior to sending an account to a collections agency, their billing staff would initiate telephone calls when an account was between 60 and 90 days overdue. As a general rule, all patient accounts were handled case by case. There were not any concrete rules on the number of calls the billing staff had to attempt prior to sending an account to collections. Generally, at 120 days past due, a letter was mailed informing the patient of the overdue bill and that failure to pay could result in the account being sent to a collections agency. A majority of the group added a collection fee to the account at the time the account was turned over to the collections agency.
No one in the group charged interest on past-due accounts. They all agreed that the regulatory requirements associated with the notification and consent for charging interest on past-due accounts was not worth the effort. They felt their time was better spent improving up-front billing processes and collecting on the easy-to-collect accounts. They were better off paying a collections agency a percentage on the difficult-to-collect accounts or accounts older than 120 days.

Jeanetta Lawrence, CMPE, takes a unique approach to collections.

“I created an internal collections representative,” Lawrence says. “After the initial attempt to collect, the billing staff turns the account over to the internal collections representative. A letter is sent to the patient stating that the account has been turned over to internal collections.”

This simple letter enticed patients to fulfill their payment obligations, which has improved the practice’s collections rate. The internal collection representative makes four attempts or two phone calls on each account before turning the account over to an external collections agency.

C. Physician assistants and nurse practitioners

Physician assistants (PAs) and nurse practitioners (NPs) represent another opportunity to help generate revenue. The practice executives found that employing PAs in the practice was an area in which they had a great deal of influence.

“I approached the topic of adding a PA at my practice’s strategic planning session,” Sack says. “I discussed the benefits of adding a PA instead of adding a physician. At the end of the session, the physician partners decided to hire a PA. The PA was recruited in August 2005, and we experienced improved productivity by the end of the year. The PA spent half the time in surgery and the other half seeing patients for post-surgical visits.”

The PA also served as the first assist in surgery for total hip replacement and other procedures, which improved the practice’s productivity and revenue. Taking full advantage of billing for the PA’s service required extensive research. Sack interviewed other orthopedic practices billing processes to become familiar and comfortable with acceptable billing processes.

“After learning all I could from other practices, I tweaked our billing system to accommodate billing for the PA services,” Sack says.

One of the practice executives found that nonphysician providers improved productivity and relative value units (RVUs) per encounter. In addition to increasing the RVUs associated with the first assist in surgery, the PA handled almost all follow-up visits, which may not have been billable by the physician. This freed up the physician to see more complex cases and generate a higher RVU-per-encounter ratio than would have occurred without the PA on staff.
Moreover, the practice executives indicated that it didn’t matter if the skill sets of the nonphysician providers were specialized or general. All agreed that the greater benefit came from the individual than from his or her formal training. However, the amount of ramp-up time to get the individual incorporated into the practice’s operations was critical.

The biggest challenge of employing PAs or NPs in an orthopedic practice is overcoming the practice’s culture of physicians wanting to see their own patients. Physicians eventually realized the benefit that a PA or NP brought to the practice, and valued his or her role in performing Coumadin checks, pharmacy refills, patient training, and other functions. Some of the billable services they can perform include patient histories, physicals, first assist in surgery, and castings.

D. Ancillary services

According to the group, ancillary services provide the most revenue opportunities for their practices. So, what’s included in ancillary services for an orthopedic surgery practice? An ancillary service is any service a physician practice provides over and above its basic offerings and general professional fees.¹ For an orthopedic surgery practice, this includes but is not limited to, diagnostic radiology and imaging, physical therapy, and ASCs.

Ambulatory surgery centers

Of the 20 group members, 11 responded to an e-mail posting that asked if their practice had an ASC. Eight stated that their physicians participated in an ASC, the majority of which were joint ventures with other physicians or organizations. Of the three whose practices did not have an ASC, they were considering a joint venture with a local hospital or physician and planned to build an ASC within the next two years.

So, why build or participate in an ASC? The answer is one word: productivity. It is important to note, however, that the degree of increased productivity relates directly to the practice’s proximity to the ASC.

One practice executive shared his experience building an ASC. The best decision the practice made was to hire a consultant to assist them with the certificate of need. They were fortunate to expedite the process because the state now has a moratorium on ASCs. At first, the practice considered a joint venture with the local hospital, but the hospital wanted control of the operation and more than 50 percent of the revenue generated. This offer was unacceptable, so the practice built a three-surgical-room ASC next to its existing building. The proximity of the ASC to the practice enabled the physicians to increase their productivity without much travel to other locations or disruption to practice operations. On average, the practice’s physicians can perform 15 procedures a day in the ASC, then walk to the practice office and see another 15 patients.

Since most of the practice executives had joint ventures with other groups, they were not involved with the financial decisions. Some from the group shared their ASC profitability
experiences, with one stating that his physicians generated $800-$850 per procedure, with a profit margin of 10 to 15 percent. In his opinion, this was a good – but not great – revenue generator. The biggest hurdle to a higher profit margin is the cost associated with implants and other expensive medical supplies or devices. Another practice executive indicated that he experienced greater profitability based on the types of procedures performed. For example, his physicians could charge $8,000 to $9,000 for an epidermal.

All group participants who had experience with ASCs boasted about their increased physician productivity.

“ASCs increased our physicians’ satisfaction,” Lawrence says. “The physicians were routinely bumped by emergency physicians when performing procedures at the local hospital. This created a huge domino effect, because the delay of the procedure at the hospital impacted the schedule of the rest of the patients who were to be seen later in the day. The ASC alleviated the problem.”

“We use the ASC as a recruitment tool for new physicians,” Gamber says. “Not having to travel and increased productivity are great selling points to new physicians.”

While increased productivity, augmented revenue, and physician convenience are all positive aspects of having an ASC, there must be a downside. The biggest drawback was third-party insurers not recognizing the ASC as credentialed; as a result, procedures performed at the ASC were considered out of network. The key was to verify benefits, limit the number of high-deductible plans, and negotiate with the payers in an effort to minimize the patients’ financial burden.

**Physical therapy**

Although DR and imaging can be considered a major component of ancillary services, many of the practice executives had to find new ancillary revenue streams to offset decreased reimbursement from payers. Many use digital technology in radiology and make up for any losses through volume, while others have diversified their services to include physical therapy services.

The practice executives identified several benefits to having one or more physical therapists on staff, such as enhancing the quality of patient care by improving operational efficiencies. In other words, the physician oversees the care provided by the physical therapist. The proximity, communication, and working relationship between the physician and physical therapist promotes quality of care and fosters immediate medical intervention should the patient not be progressing under the current care plan. Another benefit is that patients love it. Patient satisfaction increased because patients stayed with the practice instead of being referred to another practice to continue care.

The group was asked if their practices accept outside referrals for physical therapy. All said that their own physicians generate enough business to keep their physical therapists fully...
employed. They are far more likely to have to refer one or two patients outside the practice
for physical therapy than to solicit business to keep the therapists busy.

The physical therapists more than pay for themselves based on the demand for physical
therapy generated by the orthopedic surgeons. So, how are the physical therapists employed?
All members of the group stated that their therapists were hired as salaried employees, with
the majority offering productivity bonuses to their physical therapists.

E. Physicians and practice culture

Many of the practice executives financially benefit from having a salaried physician on staff.
This can be a great funding stream for the physician partners when the staff physician is
integrated into the practice and his or her charges far exceed his or her cost and overhead. So,
how can this level of productivity be guaranteed? These practice executives offer productivity
bonuses – and more importantly, the promise of partnership – to the salaried physicians.

How does a salaried physician become a partner and contribute to the practice’s growth and
financial stability? First, the salaried physician must meet or exceed the partners’ productivity
expectations, which include time and service. For these practices, the average time a
physician must be on staff prior to becoming partner is between 18 months and three years.
The trend over the past few years has been for the orthopedic practices to reduce this time
commitment. The majority of the interview group requires that a salaried physician be on
staff for at least two years before becoming a partner.

A salaried physician must also make a commitment to generate at least enough revenue to
cover his or her expenses and facility overhead. It is not uncommon for one of the senior
partners or the practice executives to set productivity measures for the salaried physician.
Administrators trend the staff physician’s productivity on a monthly basis and benchmark
performance against the partner’s performance. The information is shared with the staff
physician to motivate productivity and assist him or her in making partner.

Secondly, the new partner must pass his or her board certification within a specified time
period. The preference among these practice executives was to give the new partner two to
three years to become board certified in the specialty.

So, what are the physicians’ expectations for maintaining partners’ productivity standards?
Most practices in the group use physician compensation plans to drive productivity. For
example, one practice executive changed the physician compensation plan from
approximately 30 percent productivity based to 60 percent. This drove one low-producing
physician out of the practice and changed the work ethic of the practice’s other low-
producing physician. Better-performing administrators agreed that a physician compensation
plan based on productivity more fairly distributes the wealth and expenses of the practice and
fosters the practice’s growth.
F. Technology

In a January 2007 teleconference, the practice executives discussed how they integrate technology into their operations. They discussed two approaches:

- Look at technology that already has been procured and implemented in the organization with an emphasis on return on investment (ROI) and outcome measures; and
- Examine future plans for technology implementation with an emphasis on vision or rationale for implementation and the anticipated break-even point.

The discussion began with their computer radiography (CR) experiences and DR implementation within their orthopedic practices. One member of the group said that his orthopedic practice implemented CR approximately two years ago. He thought the cost to implement CR and a picture archiving and communication system (PACS) was approximately $250,000. There was no variance between the estimated and implementation costs because the vendor delivered on the agreement as promised. This orthopedic practice used vendor financing, which was a three-year capital lease that helped the organization minimize costs, and included the option of adding on to their current imaging system as part of the lease.

He stated that he couldn’t see an immediate ROI for this implementation. However, the benefits associated with the implementation were numerous. The lease payment of CR was offset by the savings of no longer having to procure film, chemicals, and other supplies associated with film processing. Additionally, the increased processing speed allowed his 2.5 FTE technicians to increase their imaging productivity by 25 percent. This practice also experienced a reduction in storage space. As patients come in for CR, the practice scans in the patients’ old films into the PACS. Then, it provides the patient with the films to free up storage space. The physician within the group agreed that converting film to CR retained the quality expected in the practice.

Training for the staff to use CR was minimal in this example. CR uses the existing X-ray equipment, which decreased the amount of training required. He found that the learning curve was approximately two weeks. At three weeks, the physicians and technicians were very comfortable with the equipment and familiar with the process.

The technicians at this practice embraced the technology. Using knee and hip templates improved productivity and image retrieval is far easier than going into records storage to file or retrieve film. Most of all, the technicians enjoy not being exposed to the film chemicals. Overall, the experience has been positive for the staff.

The other practice executives shared similar experiences. Vendors delivered as promised, and imaging productivity increased when the CR process was implemented.

“I capitalize on the new technology as a marketing tool,” Lawrence says. “To combat competition, we marketed the practice as state of the art because we had implemented the
new digital technology. This was an indirect benefit on top of the many tangible benefits, including physicians’ ability to view images with a patient or with another physician. Other indirect benefits include increased patient satisfaction and decreased complaints associated with the lower cost of creating additional images for patients to take with them.”

William R. Pupkis, CMPE, implemented DR approximately three years ago. He installed a dual GE unit with multi-plate readers.

“The estimated cost of the PACS software was $250,000, and the entire installation, including hardware and staff training, was around $500,000,” Pupkis says. “I estimate that it took our technicians approximately 10 minutes to develop film, seven minutes to process the images with CR, and three minutes to process the images with DR. Prior to this, I had six FTE technicians struggling to meet the demand generated by 16 physicians. It was not uncommon for the technicians to be running 30 to 40 minutes behind schedule.”

After DR implementation, the practice added eight physicians and reduced technicians to four FTEs. These four technicians generate approximately 55,000 studies per year. Based on these outcomes, the estimated ROI on DR is five to six years. The life expectancy of the DR/PACS is 10 to 12 years.

Pupkis found that the staff training for DR was easier.

“It took approximately two weeks for the staff to be fully trained,” he says. “And despite the increased overhead expense related to financing, the decreased supply cost along with other benefits made the venture worthwhile. The strongest benefit of DR was the processing speed and the ability to manipulate the image with density and contrast.”

One practice executive had a different perspective on converting film to CR or DR. His orthopedic practice decided not to scan films because the insurance carrier and physicians were concerned about the quality of the image after scanning. They believed that film provided higher quality and would stand up better in litigation.

All practice executives agreed that the benefit of CR and DR far outweighed their prior experiences with film. One critical factor related to storage was based on the amount of memory required to store digital imaging. Although it was more expensive to purchase the memory needed to store digital images and add a larger memory storage device to their PACS, installation was easy and it required little additional physical space.

**Future plans for electronic health records (EHRs)**

What role do EHRs play in the success of better-performing practices? Ed Gulko is working on an EHR implementation, a decision that all the physicians in his practice supported.

“This idea came from the physicians,” Gulko says. “I would not pursue an EHR implementation unless all the physicians were in agreement. Many of the physicians have experienced issues with dictation, and they see an EHR as the answer to complete and
accurate charting. In addition to a complete and accurate patient record, the physicians also see a variety of practical applications, such as greater flexibility and the choice to point and click, dictate, or create their own templates.”

Because many of the benefits of EHR are non-economic, Gulko finds it difficult to assess the ROI. However, the benefits include a paperless system, saving record storage space, and possibly eliminating the transcription contract.

“We have one transcriber in-house, and one transcription contract to handle the overflow,” Gulko says. “With the efficiency of the EHR, we hope that the in-house transcriber will handle the volume. This would allow us to cancel the transcription contract and to see an ROI in three years.”

The practice has 10 providers who will use EHR; Gulko estimates that he will meet 60 percent of the hardware requirements with the existing equipment in the practice, thereby reducing the overall system cost. The estimated system cost is approximately $25,000 to $30,000 per provider.

“I considered reducing the cost by partnering with the local hospital; however, I found this would reduce the amount of flexibility and control I have over the selection and implementation process,” Gulko says.

To minimize the impact of FTE downtime and loss of provider productivity during implementation, Gulko will operate two medical record systems concurrently. The providers’ training and use of the new system will be phased in over time. Once they are trained, they will use the new system for a couple of procedures a day. They will gradually add procedures to the new system as they become proficient.

“The providers will not alter their schedules or reduce their patient volume,” Gulko says. “Most of them see 30 patients per day.”

At the time of the interview, the other practice executives did not plan to implement an EHR or any other major medical equipment in the near future, and all agreed that the impetus would have to come from the physicians. The risks associated with an EHR implementation were far greater than the benefits. This could be a career-altering decision for any practice executive.

G. Process improvement

How do better-performing orthopedic practices handle process improvement? No one jumped to answer the question. However, one outspoken participant stated that he deals with issues as they come. Are better performance and process improvement a fluke or a matter of luck? When the group was asked how they benchmark or measure the practice’s performance, all of the practice executives raced to answer, saying that they used benchmarks and consultants as their process-improvement tools.
Although the topic of conversation focused on A/R, the discussion was very revealing. The practice executives hire consultants to benchmark specific measures, such as accounts more than 120 days old. Then, the consultant works with the practice executive and the staff to break down processes and identify opportunities for improvement. At the end of the consultation the practice executive receives a report with recommendations and assists staff in implementing the recommendations. Lastly, the consultant returns at a later date to trend and measure the progress and make further recommendations. All of the practice executives agreed that their consultants are well worth the consultation fee.

Moreover, these practice executives vary on how often they benchmark and on the indicators they measure. Some measure physician productivity RVUs monthly, while others measure RVUs quarterly. Some benchmark their A/R monthly; some quarterly. The common denominator was consistency. Once they committed time and resources to benchmarking, they continued it regularly to prevent breaking the process improvement cycle. The benchmarks became process-improvement tools to verify progress or alert them to problems.

This all sounds so simple. So, what stimulates and what stifles process improvement? It depends on the practice’s culture. For example, increased physician compensation piques physicians’ interest but may do little to motivate staff. Handling change and how it is assimilated into the practice’s culture can be the biggest hurdle.

One practice executive said that there are three types of individuals of whom you should be aware when change happens within the practice: Some will want the change to fail and will push you off the cliff, some will watch you being pushed off the cliff, and some will want the change to succeed and pull you back before you fall off the cliff. It is imperative that you know your organization’s culture and implement change in a manner that will succeed and elicit the help of those who want it to succeed.

Staff buy-in can be difficult to come by. Better-performing practice executives understand resistance to change, because they experience it every day. However, they realize that with change comes growth and potential. To combat resistance and promote the growth of the practice they take multiple steps when implementing change.

The first step in the process is good communication. People fear the unknown. The more they know about the change the less likely they are to be concerned about it. Next, empower individuals within the practice who will be impacted by the change. Build your alliances, for it will be difficult for them to resist or chastise the change that they helped implement. Given the size of the change, consider finding a champion — someone in the practice who has a vested interest in the change and is well respected by others. When people identify with the project or want to see their champion succeed, they are more likely to make the necessary commitment.

Another approach is to identify a staff leader who empathizes with the struggle to implement change. In this case, the leader may show compassion for the staff; however, he or she must communicate the reasons for change and the consequences associated with failure. Most of the practice executives believe it is best to implement change in small steps. Encourage staff
to try the change for 30 days. Many behavioral psychologists believe that 30 days is the time frame to change an attitude into a habit. Practice executives who use this method praise its success. Generally, after 30 days the staff has embraced the change and rarely is there a need to revert to the previous process.

**Conclusion**

The main objective of this study is to identify the factors that enable practice executives in physician-owned orthopedic surgery groups to maximize the financial return paid to their physicians as equity owners.

To establish a baseline for performance, MGMA analyzed historical performance trends of orthopedic practices and built a model of better-performing practices based on performance areas outlined in the MGMA cost surveys: profitability and cost management; productivity, capacity, and staffing; and A/R and collections. It’s amazing to see that these three criteria have been MGMA’s gold standard for benchmarking better performers for almost a decade. Also, 20 better-performing orthopedic surgery practices, based on the selection criteria of better-performing practices established in the MGMA *Performance and Practices of Successful Medical Groups: 2006 Report Based on 2005 Data*, were selected. Their experiences and lessons learned were based on qualitative research methods compiled from focus-group discussions, teleconferences, and e-mail communications.

Most important, the optimal goal is for readers to walk away with one or two tools to improve their practice’s performance. The research identifies seven operational factors that could positively impact a practice’s bottom line: business and strategic planning, billing processes, PAs/NPs, ancillary services, physicians and the practice’s culture, technology, and process improvement.

Although not addressed in the paper, the group was asked about quality-of-care issues, such as patient satisfaction, tracking clinical outcomes using the Health Care Effectiveness Data and Information Set (HEDIS). Amazingly, the practice executives were not performing routine patient satisfaction questionnaires or trending and benchmarking clinical outcomes. They agreed that these areas have value; however, incentives do not exist for the practice to perform these tasks, so they cannot afford to dedicate staff to these quality-of-care issues.

The prevalent perception among the practice executives was that their physicians expect their efforts to be directed toward the practice’s profitability, and ultimately improving their physicians’ compensation and quality of life. Therefore, efforts in gauging patient satisfaction and tracking clinical outcomes were more reactive than proactive. Rather than having a solid system that benchmarked and responded to patient satisfaction needs, the practice executives assumed the role of handling patient issues with a solid grievance process. Most practice executives agreed the patients need an outlet to vent their frustrations and be heard. However, the practice executives followed up with the patients to correct the issue as appropriate.
In the final analysis, a common thread among these better-performing practice executives is that they are all leaders with high morals and integrity. As leaders, they share three common attributes: They provide their practice with a vision and a plan; they vote with their time; and they are who they are. In other words, they all had a vision of what it would take to improve and ensure the continued operation of their practices. They communicated their vision in a formal plan that could be understood by both physicians and staff. Then they focused their time and resources on executing the plan. Lastly, they were true to themselves and genuine, the perfect complement to competence and character.
Endnotes


2 Kolenda, Christopher. Leadership: The Warrior’s Art. (Carlisle, PA, The Army War College Foundation Press, 2001), 278.

References


How did orthopedic surgeons survive the rules and regulations of the 1990s and begin to thrive in the new millennium? Why would a successful practice incorporate process improvement initiatives? And, where do orthopedic groups get the data to prove ROI before they add on ancillary services?

In this booklet, you’ll hear your peers’ success stories, as they are drawn from the Optimal Orthopedic Surgery Practice Study — a joint study from the Medical Group Management Association’s (MGMA) Center for Research and Ethos Partners, a health care consulting firm in Atlanta. The study focused on facts and real-life experiences of 20 better-performing orthopedic surgical practices across the United States.

Among the various areas covered for better performers are:
- Strategic planning
- Billing
- Physician assistants and nurse practitioners
- Ancillary services
- Technology and process improvement

Using data and examples from MGMA’s Performance and Practices of Successful Medical Groups reports, orthopedic practice administrators openly discuss past performance trends and then define the characteristics of a better-performing orthopedic surgical practice, examine the strategies and traits of better performers, and draw conclusions on how to optimize the performance of orthopedic surgical practices.