Directions

Tools and ideas to improve the profession of health care management

MGMA Health Care Consulting Group

Defining Your Profession™

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Physician recruitment:
How to ensure a successful site visit — and how to hang on to that new doctor

Recruiting a physician to your medical practice is not an easy task. Increased competition for candidates and a shrinking applicant pool, changing lifestyle values of old and young physicians and financial constraints all conspire against a practice seeking to attract a new associate. Physician recruitment is one of the most important tasks a medical group practice leader faces in developing and ensuring the future of a medical group — and one of the most complex, as well.

Two areas of the process rarely receive enough attention: the candidate's visit to the practice and efforts to retain the physician once he/she has been recruited.

The site visit

This is the practice's opportunity to display its attributes. You and your physicians must present your organization, the community and affiliated hospitals in the best possible light. It's also your chance to see how the candidate interacts with physicians, administrators and members of the community.

Typically, the site visit is woefully under-choreographed and its importance underestimated. For example, a three-physician cardiology group I recently worked with brought in a candidate and his wife for an interview. They had arranged to stay with family who lived in the area, but the practice had purchased their airline tickets. Beyond that, practice leaders intended to leave everything else to chance. "We'll see what they want to do when they get here," they said.

I asked a few questions. Will they meet the hospital administrators? Who will give them a tour of the other facilities? Will each doctor in the group meet with them? Are they going to meet other physicians in town? Do you have social events planned during the visit? What has been planned for the wife? Have you contacted a realtor?

I got stunned looks in return. Practice leaders had not developed an agenda; no one had considered how to showcase the organization and make the best of the opportunity.

Don't let that happen to your group. Prior to the site visit:

- Know what you want to accomplish;
- Know what the candidate and his/her spouse want out of the site visit;
- Make sure that the candidate or spouse speaks with a realtor prior to the site visit regarding housing needs and wants;
- Develop an itinerary — in writing — that includes flight arrangements, car rental arrangements, hotel and contact information, meetings with members of the practice, and contact

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Kenneth T. Hertz, CMPE, senior consultant, MGMA Health Care Consulting Group

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information for at least the administrator and one physician in the group. The itinerary should include:

- A tour of the community;
- Meeting with hospital executives;
- Meeting with all physicians in the practice;
- Social events for physicians and spouses;
- Social events with other physicians from the community;
- Free time;
- A real-estate tour;
- Meeting with religious or school leaders, if appropriate;
- A hospital tour, with time in the operating rooms, catheterization lab, etc., as appropriate to the medical specialty; and
- Time for a recap of the site visit and possible contract discussions.

E-mail the itinerary to the candidate in advance. In addition:

- Consider having a fruit/welcome basket at the hotel for the candidate's arrival;
- Send a package promoting the community and hospitals (generally available from the chamber of commerce, realtors, hospitals); and
- Provide the candidate a statement of how expenses will be handled.

But wait — there's more

Wow, that's a lot to deal with. Recruiting can be a full-time job, and depending on the number of associates your practice seeks, it can consume a significant amount of the administrator's and the physicians' time. Leave the logistical planning and arrangements to administrative staff, but it's critical that physicians participate in the recruitment process well in advance of the site visit through phone conversations, reviews of curricula vitae and reference checks.

An important word here about reference checks. I believe that physicians, rather than the administrator, should call to check references. Doctor-to-doctor communication works far better than sticking a civilian in the middle. Assist your physicians by creating a form to use during reference-check calls to guide the questioning and record the comments. The information can then be shared with the group.

A few final thoughts about the site visit. Consider it showtime for your practice. Make every performance a top-notch event. If the candidate meets muster and the group is interested, tell the candidate so; if not, tell him/her that, as well, in a respectful way. If you're using a recruiter, involve him/her in this step. And if the group is truly interested, a phone call from the president and one or two other physicians goes a long way toward sealing the deal.

Hanging on to that new hire

Once you get a new associate in the practice, you want to protect your investment of time and money, as well as new physician's investment, for he and his family have taken a risk by joining your organization. How do you protect those outlays? How do you retain the new associate?

To improve your chances of retention, return to the start of the recruitment process. Ask yourself whether:

- Your group has a clear vision, values and mission statement;
- Your physicians have a clear, shared vision;
- Your group has a defined need for a new associate, and all physicians agree with it;
- You know current market trends in physician compensation and benefits;
- Your group has a clearly articulated compensation and buy-in plan for a new associate;
- Your group has a clearly articulated and viable overhead allocation method and income distribution method;
- You, the physicians and the candidate believe a cultural match exists with the practice;
- Your area offers a familial support network for the candidate;
- Your group has a plan for introducing the new associate to the community and developing his/her practice;
- You have a plan to provide ongoing mentoring and coaching to the new associate;
- You have a plan to provide performance measurement and feedback to the new associate; and
- You have detailed the group's needs, processes and communication channels for the new associate.

How many times did you answer "no" and how many times did you answer "yes"? The more times you answered yes, the greater your chances of retaining a new physician. The more you answered no, the greater the chance the new associate will leave your practice sooner rather than later.

Recruit for the right reasons

Too many practices jump into recruiting for the wrong reason. For example, a cardiology practice I worked with wanted to recruit a new physician just to cover call. Why?

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Physician recruitment

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Two of the senior members of the group were going off call, and slowing down their practices over a two-year period. A third cardiologist planned to do so within the next two to three years. Add to the mix a declining patient base in the group's once-busiest location, low levels of production for the other physicians, declining compensation trends over the last two years, and conflict in the group over whether to recruit another physician "just to cover call."

After extensive discussion and consideration of expanding to a more populated location, the administrator and physicians saw a rationale to hire a new doctor.

Look at the bigger picture

How do you retain your new associates? By answering yes to those questions. By establishing solid policies for physician compensation, overhead allocation and buy-in/buy-out policies. By running a practice that emphasizes open communication among physicians and staff.

One more story: I recently worked with an OB/GYN practice that recruited a new associate — who left after one year. This seemed surprising, given that he was from the area, knew several of the partners and had expressed a commitment to the community.

But his spouse had ideas about her future that never surfaced during the interviews. More importantly, I believe, the group had no plan to work with the new physician — to coach him or to provide feedback on his performance. Shortly before his departure, I asked, "Tom, did you have any idea how you were doing in the practice?" He answered, "No, actually, nobody ever said anything to me. I had no idea if I was doing well or not."

Obviously, this practice's approach is not a model for physician retention. You need a plan that has the support of physicians, the administration and the staff. A successful recruitment and retention effort takes a thoughtfully executed site-visit strategy, good communication between the practice and the candidate, organization-wide commitment to integrating a new associate into the practice, and protocols for ongoing support of the new hire.

The unexpected shutdown

Does your practice have data safeguards in place?

Rosemarie Nelson, MS, principal,
MGMA Health Care Consulting Group,
rosemarienelson@alum.syracuse.edu

It won't happen to you, will it? You may live in a region free from tornados or hurricanes, but even a heavy snowfall can put your business at risk if the building's roof leaks or caves in.

Is your organization adequately protected? Are your data secure?

Data security takes testing, vigilance

You may feel safe because you back up your data every day. But before you get too comfortable, ask yourself where original software CDs are stored. How readily can you restore your system if it goes down? Have you tested your backup data? Have you tried restoring a file from the backup tape? Do you follow that procedure every quarter?

What is your backup and disaster recovery (DR) plan? Many medical practices use a tape backup procedure that runs against the practice management system during off hours. But many medical practice professionals give little thought to network servers and the documents they store, or to the workstations attached to the network. Do you back up payroll and accounts payable files? What other files are at risk? Does the network house your transcription files, monthly financial statements, business spreadsheets or clinical databases?

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The unexpected shutdown

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Do you have an inventory of your software applications and a network map? Disaster recovery is a component of business continuity. A business continuity plan identifies your risks and establishes protocols to safeguard your organization. The first step is determining how much downtime your organization can tolerate: one hour, one day, one week?

Disaster recovery involves costs, benefits

You must figure the amount of downtime — the cost of stopped functions per minute/hour/day — your practice can endure. For example, consider the economic toll in time spent locating a patient chart. Ask clinicians how patient care would be affected if they couldn't access the electronic medical record for 30 minutes. Then consider the effect of downtime stretching several hours or a full day. Estimate:

- Employee costs: Hourly wages consumed during downtime — For example, if the average employee makes $20 per hour and you have 100 employees, one hour of downtime will cost your organization $2,000;
- Unexpected expenses from backup methods (e.g., prescription pads, paper forms);
- Time it takes employees to catch up from the downtime; may include overtime or temporary workers;
- Information technology (IT) recovery costs — time and expenses for parts/repair;
- Loss of income due to interrupted patient care; and
- Perception value — patients developing a negative view of the organization.

Backup plans must include more than IT

Remember that business continuity plans include personnel, facilities and communications, as well as IT. If a natural disaster strikes, are key employees going to come to work to ensure data are safe? What if the building was quarantined because someone received a package containing white powder, or because of a structural fault? How would users access data?

Cover such bases in your IT DR plan. It might be cost-effective to store data remotely. However, in the event of a communitywide disaster, your data would most likely be unprotected and unretrievable. You might want to consider remote storage in another city. A number of vendors specialize in business continuity and/or DR planning.

Finally, DR procedures must be tested. Documented processes should be easily accessible to everyone on the team — in electronic and paper format. Other team members should test the recovery procedure regularly.

IT checklist for loss-prevention planning and recovery

- Maintain at least one phone line (phone, fax, modem) separate from your main phone system (i.e., PBX) as a "back door" in or out of the practice in case your core phone system is disrupted.
- Separate communications equipment. Don't allow a single point of failure by housing phone lines and equipment in the same closet as data systems.
- Use remote call-forwarding to redirect phone calls to an alternate site (e.g., second office, home, cell phone) in case of emergency.
- Invest in an uninterruptible power supply for phone systems and network components (routers, etc.).
- Use two carriers for cell phone coverage to ensure service.
- Ensure that employees have e-mail and Internet service on home computers so they can work offsite if your facility is compromised. Calls could be forwarded to employees' homes and staff may be able to access your information system to contact patients for rescheduling.
- Install virus-scanning utilities. Establish procedures to scan your network (servers and workstations) routinely.
- Have a maintenance agreement to cover corrupted file(s) recovery, application failures, hard-drive crashes.
- Establish a procedure for loss/theft of computers. Maintain an inventory of all equipment, and applications and data maintained on each workstation.

Consultants in the news

MGMA Health Care Consulting Group consultants are frequent sources for the health care media. You can find them quoted in trade and popular publications, demonstrating their knowledge of group practice governance, marketing and more.

A Feb. 11 article in the *Orlando (Fla.) Sentinel*, "Double-check your medical bills for errors," quoted Kenneth Hertz, CMPE:

"'The biggest part of the problem is that people think the hospital or medical practice will take care of that,' said Kenneth Hertz, senior consultant with the Medical Group Management Association in Colorado. 'If the contract exists between the consumer and the insurance company, it's really [the consumer's] . . . responsibility to make sure the bill is correct.'"

A recent article in *Physicians Practice,* "Strategy: Adding Ancillaries — Cash cow or money pit?" quoted Nick Fabrizio, PhD, FACMPE:

"But MGMA Senior Consultant Nick Fabrizio cautions that ancillaries are not always the monetary cure-all they're made out to be. 'Physician groups only hear the success stories at conferences and through networking groups, and that's very dangerous because all practices are different,' he says. 'For every group I have seen [offer ancillary services] successfully, I've seen an equal number not be successful.'"

The article, "PAs and NPs — How they boost practice earnings," in the Feb. 16 issue of *Medical Economics* quoted Cynthia Dunn, RN, FACMPE:

"'If you find that you have to book patients further and further out and turn away new patients, or that your established patients need more care than you can comfortably provide, it's time to think about adding a new physician or a nonphysician provider,' says Cynthia L. Dunn, a Cocoa Beach, Fla., consultant with the Medical Group Management Association Health Care Consulting Group."