



Prescriptions

Medical Alert

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The production-based compensation method rewards physicians for better performance and more cost-conscious behavior.

The Pros and Cons of Productivity-Based Compensation Plans

The “eat what you kill” approach to compensation can feel foreign to physicians accustomed to sharing resources, overhead costs, and revenues with their colleagues in a group practice. But some practices may find equal share compensation provides too few incentives for efficiency and hard work. This method can even lead to friction between physicians as more productive doctors come to resent colleagues who bring in less income or put in fewer hours.

In sharp contrast to the equal share concept, the production-based compensation method rewards physicians for better performance and more cost-conscious behavior. Under a strict form of the productivity model, a physician’s compensation is based solely on the revenues he or she produces individually; expenses beyond fixed overhead costs are billed to the physician incurring them, rather than to the group. Because each physician has the receipts to justify his or her income under this method, conflicts over income distribution can be more easily resolved.

There are, however, some potential drawbacks to paying doctors based purely on their productivity. General practitioners (GPs) in multi-specialty practices may not perceive a production-based model to be equitable because GPs often earn less than specialists, even if they are seeing the same number of patients. Some doctors may also generate less income than other group members for the same amount of work because their payer mix is skewed toward lower-paying plans.

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Continued from Page 1 The Pros and Cons of Productivity-Based Compensation Plans

Critics of the “eat what you kill” compensation model have pointed out that paying doctors solely on the basis on their quantifiable productivity fails to take into account the value of certain kinds of nonproductive work and unpaid cooperation between colleagues. If, for example, a doctor agrees to examine test results for an absent colleague’s anxious patient, how will the doctor be compensated? What happens when a GP refers a patient to a specialist—a service that is of potential value to the specialist but does not produce income for the GP? How would a physician be paid for proactively calling patients to discuss care options? Would informal mentoring of younger physicians by more experienced members of the group break down in the absence of financial incentives? Moreover, while many of the administrative tasks involved in the daily operations of a practice can be delegated to an office manager, physician owners can hardly avoid committing some time to dealing with group financial, legal, and human resource matters.

Even the principle of equal allocation of overhead expenses can be a source of conflict in practices with a production-based income distribution model if certain physicians, because of the type of medicine they practice, necessarily contribute more to overhead costs than their colleagues. Conflicts can arise between group members over which types of expenses should be considered part of the practice’s fixed overhead costs and, therefore, shared equally; and which costs should be classified as discretionary expenses that should be billed to individual physicians.

Planning for the Future with a Business Plan

Sound financial management is essential to the success of any business, including a medical practice. Even when revenues are stagnant, businesses can find ways to grow by efficiently managing their existing resources. Yet many physician groups lack even a basic business plan to guide the practice in maintaining fiscal discipline, increasing profitability, and preparing for expansion.

A business plan is often drafted with the sole purpose of obtaining a loan or other forms of financ-

While no compensation model will satisfy all physicians all of the time, some practices have attempted to minimize the problems associated with both the production-based and the equal share income distribution formulas by adopting a hybrid form of these compensation models that retains some of each method’s benefits. Practices may opt to restrict the productivity component of their compensation formula to a certain percentage of income. For example, a practice may credit half of the practice’s total distributable income in proportion to individual performance, while dividing the remainder equally among colleagues. Proponents of these mixed models contend that they provide incentives for hard work, but still promote cooperation and commitment to the best interests of the group as a whole.

A physician group may want to further adapt these models to fit the unique requirements of the practice. Compensation for certain non-income-producing tasks may be included in the formula, or bonuses may be awarded to physicians who meet performance targets. Ideally, groups should strive to adopt a compensation model that engenders a healthy degree of competition and drive to generate profits among individual physicians, while still promoting teamwork and high levels of patient service. By sharing openly with each other their views on what constitutes an equitable distribution of income, practice owners can develop a compensation plan that fits their goals and values both as individual physicians and as a group. *P*

ing. But writing and regularly updating a formal business plan also encourages physician owners to establish medium- to long-term strategic initiatives and put down on paper how they intend to achieve their objectives. Composing a business plan involves much more than simply preparing a budget; it provides an opportunity for owners and managers to take stock of their existing business practices and contemplate



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what steps they may wish to take to boost productivity and improve the bottom line.

Having a business plan in place is especially important for practices that intend to grow. Whether the goal is to purchase expensive equipment, hire additional employees, expand office facilities, or add partners, physician owners should consider well in advance how best to achieve growth without sacrificing profitability.

The starting point for any business planning session involves a review of cash flow statements. Analyzing inflow resources will help physicians and practice managers better understand the ways in which accounts receivable and credit may affect the practice's cash flow. The plan should include measures ensuring the practice's financial capacity to provide credit is not over-extended and establish policies to collect what is owed on time. Operational overhead costs should be carefully scrutinized to identify any wasteful expenditures that can be trimmed or eliminated. The plan may reveal the need to increase fees, renegotiate contractual arrangements with insurance companies and vendors, or adjust the payer mix to better cover the cost of operations.

A business plan can also help a practice make the most of changes in tax laws. If expecting to acquire or replace equipment, you may wish to plan ahead to take advantage of a tax break, known as the Section 179 deduction, which is due to expire in 2007. In 2003, Congress quadrupled the amount a business owner could deduct for the acquisition of

qualifying property from \$25,000 to \$100,000, an amount that has been adjusted for inflation in 2006 to \$108,000. The deduction applies to much of the office and medical equipment that a practice would normally depreciate over a longer period of time, including computer software.

In the course of drafting a business plan, practices should look at whether the current business form is appropriate given its longer-term objectives. While many physician groups are structured as C corporations, moving to a "pass-through" entity, such as an LLC or S corporation, can make sense in certain cases, particularly if the plan calls for changes that could impact tax liabilities.

Before considering any major acquisitions or growth initiatives, practices should conduct market research to ensure the services the group intends to provide are in demand. Business plans typically include information about market demographics and potential competition. An investigation of the local market may reveal, for example, that a certain service a practice intended to add is already available in the area and is under-utilized.

In a rapidly evolving medical marketplace and regulatory landscape, physicians cannot afford to leave the growth and continued success of their practices to chance. A business plan for your practice, reviewed and adjusted annually, can help you improve the way you run your business and maximize your net profit. *P*

Making Medical Offices Safer for Staff and Patients

Promoting the health and welfare of patients is, of course, the foremost concern of all medical practices. But how does office safety factor into the practice's ultimate goal of providing quality care and service to patients? Attention to health and safety not only protects a practice from liability, but it also prevents illness and injury—and may even save lives.

The first step in any office safety review is to identify obvious hazards that may be easily remedied. Some practices undermine their own efforts, making improvements, such as ramps and automatic doors to help the elderly and disabled, but overlook-

ing basic measures, such as clearing ice and snow from sidewalks and parking lots.

Among the most serious health and safety risks are the potential for the spread of disease and the possibility that an already sick patient may require life-saving medical attention. Even small practices should consider investing in a crash cart equipped with the



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tools most likely to be needed in life-threatening situations.

Being well-equipped to deal with emergencies and other hazards is, however, no substitute for training staff in how to handle a crisis. Medical and administrative staff should take part in regular cardiopulmonary resuscitation and safety training sessions. If the risk of a cardiac arrest occurring in the office is high, physicians or nurses may want to receive additional training in cardiac life support.

Infection control requires constant vigilance on the part of all staff members. The Occupational Safety and Health Administration (OSHA) has established safety standards that apply to all medical offices, regardless of size. The appropriate use and disposal of needles and sharps waste is of particular importance in preventing the spread of HIV/AIDS, hepatitis, and other blood-borne pathogens. To minimize risks, OSHA requires practices to use labels and color coding for items such as sharps disposal boxes and for other contaminated waste containers.

The agency also mandates the use of appropriate protective gear by staff, certain vaccinations for medical personnel likely to be exposed to communicable diseases, and employee training in safety procedures. In addition, practices must have a plan in place for dealing with any “exposure incidents.”

If a practice has laboratory or X-ray facilities, all staff members should be made aware of the safety issues associated with radiation and chemicals, as well as how to deal with any contact with hazardous substances that might occur. Oftentimes, technicians who routinely face these potential dangers as part of their jobs are less vulnerable to exposure than other staff members who may be unaware of the hazards.

At a minimum, practices should draw up a written health and safety plan, post it in the office, distribute it to employees in the form of a safety manual, and update it annually. Making your premises safe for both staff and patients can avert legal problems and contribute to the more efficient operation of your practice. *P*

Bill Promoting Electronic Health Records Introduced in Congress

In what would become the nation’s largest health information technology (HIT) project, Congressman Jon C. Porter (R-NV) has proposed legislation that would provide more than eight million federal employees with electronic health care records (EHRs). Porter said he hopes the implementation of an EHR system in the federal employee health benefits program (FEHBP) would lead to a nationwide adoption of electronic medical records.

The legislation, the “Federal Family Health Information Technology Act of 2006,” would require insurance carriers within FEHBP to create individual EHRs for all participants; however, insurance providers could use a small portion of the FEHBP’s reserves to offset the cost of setting up the electronic health records. Participants would be encouraged to access their records online to add relevant health information, such as dietary restrictions or allergies. Under the proposal, physicians would receive incentives to invest in the technology necessary to implement HIT in their practices. The bill calls for the establishment of a trust fund financed by private donations that would issue grants to physicians to set up their systems.

“With tens of thousands of patients dying every year from preventable medical errors, it is imperative that we embrace available technologies and drastically improve the way medical records are handled and processed,” said Porter. *P*