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'It's time consuming, demanding, but worth it'

Business plans plot success for hospitalist groups

At first glance the new hospitalist group at 283-bed Comanche County Memorial Hospital in Lawton, OK, does not seem to have much in common with the regional program IPC-The Hospitalist Company maintains in Phoenix, AZ.

The Oklahoma group has two hospitalists working shifts five days a week with a physician's assistant. It only accepts unassigned patients, and it relies on a subsidy from the Comanche County Hospital Authority.

IPC/Phoenix has no hospital contracts, but its 36 physicians cover patients in multiple sub-units as well as general medicine at 23 hospitals. Focusing on contracts with managed care companies and referring physicians, the entrepreneurial operation just had six consecutive best ever months. Year-to-date revenues are up 30% compared to 2002, and turnover has been reduced 50%.

Yet both practices are proceeding according to plan. In Lawton and in Phoenix, administrators brought in consultants to help them identify realistic goals and develop a business plan for achieving them. (See "How much does it cost to hire a consultant.")

Executives are satisfied

Despite the contrast in size and profitability, administrators of the two programs are pleased with the outcomes.

"I think the value is there. It goes back to the number of unassigned patients, convenience to medical staff, and good medical care for patients who come without providers. I think the final results are going to be there," says **Randy Segler**, CEO of the Comanche County Hospital Authority, which put its first hospitalist to work in January 2003.

"If anyone has an existing practice in hospital medicine, it's worth their time and worth the

expense to go through a strategic planning process. It is time consuming. It's demanding, but it is worth it," says executive director **Saul Blair**, MBA, who started IPC/Phoenix in 1998. (See "Five-step business planning for hospitalist groups.")

Small and new Lawton

Segler's agency serves about 350,000 people spread across nine counties in southwestern Oklahoma. In addition to Memorial hospital, it leases a small 50-bed hospital in Frederick and operates 15 rural satellite clinics.

When primary care physicians asked the authority to start a hospitalist program, executives enlisted consultant **Roger Heroux**, MHA, PhD, CHE, a partner in Hospitalist Management Resources based in Colorado Springs, CO.

The process began with medical staff meetings and interviews of area physicians to establish needs and gauge support. "I wanted to be sure the medical staff as a whole bought into the concept," says Segler.

Overwhelmingly, they did. Almost all the physicians polled wanted a hospitalist program. Their first priority was an inpatient medical service to relieve community physicians of having to

How much does it cost to hire a consultant?

The cost of hiring a hospitalist consultant can vary greatly. **Roger Heroux** estimates \$30,000 to \$60,000 for development of a business plan and return on investment strategy. The process includes four to five days of interviews with medical staff.

Mark Oborn says he can help a small practice for \$5,000 to \$10,000. More typically, however, he estimates the cost of developing a sophisticated strategic plan at \$25,000 to \$50,000.

take unassigned patients on call. The unassigned volume is high, according to Segler, because many rural physicians do not have privileges and their patients are admitted as unassigned.

Other services are also in demand. Many physicians wanted to be able to refer their own patients as well, and eventually Segler would like to make hospitalists available to skilled nursing and geropsychiatric units.

Looking at everything on the list, the planners figured Memorial would need six or seven hospitalists to provide 24/7 coverage.

Anticipating volumes, costs, staffing

Next came numbers crunching. Heroux and CFO **David Blackmon** drew up a budget based on anticipated patient volumes, billables, the cost of setting up a new office, and a slow build-up of staff. In today's tight job market, hiring that many doc-

tors would take time.

From the outset, the Authority was prepared to subsidize the program. "We did not expect them to break even because of the payer mix and reimbursement on the payer mix," says Blackmon.

He explains the math this way: all told about 6% of the hospital's patients have no health coverage. Not all unassigned patients are uninsured, but as a group they include a higher percentage of people who do not have doctors because they do not have health insurance.

When local physicians on call took responsibility for unassigned patients, everyone shared the burden. Now unassigned patients are concentrated in the hospitalists' care. According to Blackmon, 30% of the hospitalists' patients cannot pay.

Measuring results

The hospital collects data monthly, comparing

Five-step business planning for hospitalist groups

Business planning can be done many ways.

Here are two simplified five-step approaches, as outlined, respectively, by the consultants who guided the Comanche County Hospital Authority in Lawton, OK, and IPC-The Hospitalist Company's regional office in Phoenix.

Notice that both consultants start with a fact-finding process, draw up a budget in the middle of the process, and include a system for monitoring progress. They also urge hospitalist groups to factor in administrative help up front, and not wait until non-medical tasks take physicians away from patient care and generation of revenues.

Prepare for growth

Roger Heroux has worked with approximately 100 hospitalist groups. He says the biggest problem all programs face is accommodating for growth. Sooner or later they need money to expand. About one-third of the programs he helped had been labeled dysfunctional, according to Heroux, MHA, PhD, CHE, partner, Hospitalist Management Resources, LLC, Colorado Springs, CO and Del Mar, CA.

The problems involved reimbursements, recruiting, retention, structural issues, or conflicts with the medical staff. Invariably, however, he found they were related to skipping one of the five basic steps in developing a business plan.

His advice: It's never too late to do your homework.

Step 1: Do a needs assessment. Before starting a program, always ask the hospital and the medical staff what it wants the hospitalists to do.

"The primary care physicians, internal medicine physicians, the surgeons, and the subspecialists all have different needs. The needs assessment drives the structure of the program, which drives the cost of the program, which drives the return on investment strategy, which drives what you are going to measure -- in fact, determining whether the program is successful or unsuccessful."

Step 2: Set up priorities for the program. Now that you know what the hospital and the medical staff want, decide what's most important to do. It could be taking unassigned

patients, referrals from primary care physicians, surgical consult and/or co-management, service on quality improvement committees, etc. Every hospital is different.

"Programs are driven by the priorities of the hospital and/or the medical group that agree to those objectives."

Step 3: Develop the business plan. Pick a program model that satisfies the priorities identified by the needs assessment. Heroux says his company favors a model in which physicians are "dedicated at one hospital and they are integrated within the total inpatient care continuum of the hospital."

Be sure to put all your costs as well as anticipated revenues in the budget. Will you need three hospitalists or five for primary care referrals -- or more for overnight coverage? Will you need physicians for a surgical co-management program? Staff for post-acute care planning? Hospitalists to take care of skilled nursing facility patients? Administrative staff?

If the costs exceed revenues, you can show the hospital what it will get for its money. Hospitals are willing to contribute if they can show a return on investment.

"Based on the budget, determine through analysis of the hospital payer mix what the program is going to generate in terms of gross and net revenues -- and if there is a shortfall, how the hospital is going to justify that shortfall by providing that subsidy."

Step 4: Decide on benchmarks. Identify measurable criteria for determining whether the program is meeting its goals as identified from the needs assessment and giving the hospital a return on its investment. Criteria could be length of stay, cost per discharge, denied days, readmission rates, available hospital beds, and so on.

"You create benchmarks both clinical and financial to measure the outcomes of the program."

Step 5: Evaluate your program monthly and meet frequently with hospital administrators to review the data. Discuss whether you are achieving agreed-upon goals or exceeding them. Don't wait until your program is growing and you need more money to hire more staff.

"You have to prove value. You can never take for granted

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the hospitalists' length of stay, their charges, and their cost per DRG to those of all the other physicians practicing in the hospital. So far Blackmon reports the hospitalist volumes -- about three admissions per day -- and costs are as projected in the business plan. One early adjustment, hiring a physician assistant, saved money and is believed to have turned out well.

At the three-month point, an analysis of the top 10 DRGs produced an intriguing finding, however. The hospitalists had shorter LOS and lower charges

for seven DRGs, but community physicians did better on three DRGs.

Are the numbers reliable? Relatively few cases were recorded for some DRGs. Can the hospitalists and the community physicians learn from each other?

"We are going to pull some charts and figure out what other physicians are doing that's different, and we're going to make some changes," Blackmon says, adding that eventually the hospital hopes the hospitalists can help it develop best practice models that will benefit everyone.

Five-step business planning for hospitalist groups (continued)

the issue of justifying your existence."

Patience is key for effective planning

IPC was **Mark Oborn's** first hospitalist group, though he has worked with many health care organizations. In his experience, business planning is a new experience for most physicians, and some want to take short cuts or lose the patience essential to going through a complete planning process.

The method can be sophisticated or simplified, depending on the size and the readiness of the group, he advises, but everyone should be prepared to work hard.

"There's a limitless number of different strategies you can do to generate revenues...what you don't want to have happen is physicians go to work and wait to see who shows up," says Oborn, MBA, Partner, Petrous, Inc., Bountiful, UT.

Step 1: Identify critical issues in areas that you will follow throughout the process: The practice (financials), customers, clinical processes and outcomes, and people.

A practice issue could be aggressive competition and flat or declining growth, whereas a customer issue might be poor relations with referring physicians. A reputation for long average length of stay or substandard outcomes could be a clinical process problem. If something is disrupting the physicians' work-life balance and creating burnout, that's a people problem.

"It's kind of a discovery step," Oborn says. "When a group of physicians becomes unified around what the problems and issues are, this is really the first point of unity."

Step 2: Develop a vision of the future in each of the areas. Identify every-

one's aspirations for the hospitalist group. Some members may want to be world-class physicians. Others may desire financial independence.

"You don't want to be tethered by reality. Let your imaginations go and practice the art of the possible."

Step 3: Identify the goals that are actionable. These could be work-life balance; better relations with customers, or medical outcomes. You want to end up with a handful of goals; any more

and they'll never get done. The goals drive your plan and your behaviors. This is the step where you crunch numbers and draw up a budget.

"A lot of hospitalists will have goals with numbers of encounters and revenues per encounter. What I discovered is the best goal to drive all those behaviors is to have a salary goal -- how much money do you want to make? If everyone wants to make \$200,000 a year, then that goal drives all sort of great behavior."

Step 4: Create a scorecard so that everybody can get feedback to know they are on track or not. (See **Figure 1.**) You want to measure no more than 10 to 15 metrics. Depending on your goals, these can range from revenues and income to patient encounters per day and weekends on call per month.

Publish the scorecard monthly, so that everyone in the practice can monitor whether it is on plan or not -- and figure out what to do next.

"If it's off track, that's a big motivator. Physicians are very bright. They'll come up with ideas; it doesn't take long," Oborn says.

Step 5: Create accountability by assigning roles to different people. Invite them to take responsibility by reporting back on their assignments on a monthly basis.

"People in practice usually like each other. They're friends. They're interested in each other's success and the success of their practices," he concludes.

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Figure 1: Scorecard

Goal	Measure	POD Total			Doctor 1			Doctor 2		
		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Be Number 1	-\$200,000 per year income/physician									
Be Customers First Choice	-Customer Satisfaction									
	-PCP									
	-Hospital administration & staff									
	-Participate on committee each physician									
Life Balance	Number of new phiciayl									
	-0 turnover for dissatisfaction									
	-Encounters/days									
	Number of weekends per month									
	Number of nights per week									
Exceptional Medical Outcomes	-Reduce avoidable night pages due to standing orders not written									
	-Medical outcomes (discharge sum)									
	-Average length of stay									
	-Readmits									
	-Pateint satisfaction									

Source: Mark Oborn, Petrous, Inc., Bountiful, Utah. Reprinted with permission.

Big and growing

In Phoenix, Blair says he had a business plan when he started IPC's regional operation. The plan just wasn't on paper -- it was in his mind, and it was based on his previous experience as a hospital and practice administrator. As the IPC program grew larger, he felt he needed a more sophisticated plan.

"I was missing goals," he says. "I wasn't losing money -- we were getting bigger. But the attrition rate was higher than it should have been. I wasn't bringing in enough physicians to meet demand or to take strain off the existing work force."

Enter consultant **Mark Oborn**, of Petrous, Inc. in Bountiful, Utah. Oborn took the IPC administrative staff and its medical director to the mountains for a two and half retreat. The goal was to come up with a strategic plan.

Now the focus was on what the executives wanted for themselves and for their company. The concept was simple: A practice needs to know its destination before it can plot out a road map to get there.

"What did we want to do? What are the obstacles to getting there?" Blair asks. A group might decide it wants to increase market share by 20% and profitability by 15% in two years. How can it do that?

Information gathering

Information gathering was another part of the process. Blair says his group:

- studied the community to determine what proportion of patients was likely to be senior citizens carrying Medicare cards and how many would be blue collar workers with better paying health insurance plans;
- surveyed staff about their capabilities and desires; and
- asked their customers -- the primary care physicians and specialists referring patients to the group -- what kinds of programs they needed.

Each piece of information went in to projecting income, the market for new programs, what the individual physicians wanted to accomplish -- and what they would be able to do.

Drawing up a budget

Inevitably, pencils and calculators came out.

"The key part is sitting down with your accountant and learning how to put a budget together. The budget is part of the business plan," Blair says, enumerating a long list of numbers that have to be crunched.

The administrators have to understand reim-

bursement, he says. They must know their payer mix (what each component is expected to pay), and the group's expenses -- everything from salaries and malpractice insurance to pagers and telephone service.

The biggest problem many groups face, Blair says, is that they don't know how much they need. They can't assume that a line of credit will carry them, or that any bookkeeper can navigate all the complexities.

Get an accountant who has medical experience, he advises: "Healthcare is not like it used to be," he says. "It's so complicated."

Blair knows just how he is doing because he watches his "dashboard." That's his term for a one-page document that tells him whether he is meeting his monthly goals. It lists, for example, target revenues, actual revenue, year-to-date revenue, and revenue a year ago.

Learning to say no

Another thing Blair and Segler have in common is they each have maintained the integrity of their plan by turning down opportunities that did not fit. "It's very important to have a business plan and follow it -- not just start a program," Segler says.

His biggest challenge has been limiting the new group to unassigned patients until more hospitalists are hired. At times he has had to disappoint physicians who wanted to refer patients.

"Our business plan was very clear, and we were very clear to the medical staff," Segler says. "Until we get enough physicians, the group would only take unassigned patients."

For Blair, the strategic planning process led to the conclusion that one of his biggest obstacles was staff turnover. When the regional office took on more business than it could handle, it burned out the physicians it had. Therefore, a key component of its strategic plan is not to grow until it has enough staff to take on new business.

"You never move into an expansion mode, until you've got present conditions stabilized," says Blair.

He had to learn to say no, he admits. Turning down business is hard. Every opportunity to increase revenue is tempting.

The danger is that the revenues won't cover expenses or that the group will perform poorly and lose the contract. Then, Blair warns, its reputation is damaged, and it may never get another chance with the client.

"It's better to say no and walk away with your head high vs. saying yes and failing," he says.

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