DELTA HEALTH CARE
The Business of Physician Practice
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VIEWPOINT
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Diddling the Overhead

by Randy Bauman

Sometimes I think physicians must have watched the cartoon series *Southpark* where school counselor Mr. Mackey tells the children about the evils of drugs by endlessly repeating the mantra: “Drugs are bad, OK.” Physicians repeat the mantra as: “Overhead is bad, overhead is bad.” Since overhead is “bad,” it must be reduced. If it can’t be reduced, it must be allocated to someone else.

Dr. Smith (not his real name) wanted the latest version of Microsoft Word®. This handy software counts not only the number of words in a document, but also the number of lines and characters. In fact, it counts the number of characters both with and without spaces. Dr. Smith, you see, was in charge of his group’s overhead allocation calculation – a task so complicated he set aside two days each quarter to tend to it.

When I started working with Dr. Smith’s group, I reviewed the minutes of their partner meetings for the previous year. What I found was truly amazing. One month the minutes recounted a discussion about how transcription costs were allocated among physicians which, at the time, was by the page. It was noted that the pages weren’t always full. In fact, sometimes they only contained one or two lines. So they decided it wasn’t “fair” to charge that physician for an entire page. The decision was made to allocate transcription costs based on lines instead of pages.

The next month it was decided that since some lines weren’t full that they should allocate by the word. The following month they went to characters. I’m not sure if they counted spaces or not. As Pogo said, “We have met the enemy and it is us.”

Overhead isn’t the enemy

A good deal of disagreeable behavior exhibited within medical groups can be traced back to money – and overhead is an easy target because everyone understands it (and it’s always “too high”). Fanatical focus on how overhead is divided is usually a harbinger of the inability or unwillingness to address other issues in the Practice.

Last year we did an assessment of a group where the overhead was “too high” and found a majority of the physicians producing below the 30th percentile compared to national surveys. Blaming it on the overhead is a typical way of distracting the discussion.

Groups with higher overhead generally report higher physician incomes. To paraphrase management guru Tom Peters: Your ability to cut costs is limited, but your ability to increase revenue is unlimited.

Almost any practice in financial trouble can trace it’s problems back not to overhead, but rather to problems on the revenue side. Focus on negotiating better contracts with payers. Focus on improving collections. Focus on learning to code better. Focus on being more efficient with your time. Don’t fret so much about the overhead.

I regularly ask physicians if they would invest in a new ancillary service that would produce a guaranteed $1 million in revenue with 80% overhead and always find several who say no -- the overhead is too high.

Delta Tapped for Sokolov Projects

SSB Solutions, a nationally renowned consulting firm founded by **Jacque J. Sokolov, M.D.**, has tapped Delta as a resource on several projects. When SSB develops complete heart/cardiac care programs for large hospital systems, Delta's expertise is used for cardiology and CV surgery group assessments and reorganization.

"Delta has in-depth expertise in physician practice business and relationship issues," said SSB president and senior partner **Michael Treacy, J.D.**, "And those can be critical components of major system reorganization or when creating an entirely new program."

We are extremely proud of our working relationship with SSB because of the visionary, quality results they deliver.

Bauman to Present Audio Conference

Randy Bauman will conduct a live audio conference titled “Disruptive Physicians and How to Deal with Them.”

The audio conference will be presented by *The Journal of Medical Practice Management* and Greenbranch Publishing. It is scheduled for Thursday, June 29, at 1 p.m. EDT. Registration information is available at: www.mpmnetwork.com.

Recent Projects

SC Development and implementation of a hospital strategy for physician acquisitions

WI Assessment of a large cardiology group

MO Management / Board mentoring for internal medicine group

AL Assessment and restructuring of a geriatric practice

PA Valuation of a large primary care practice

TX Assessment and restructuring of a hospital / physician private practice partnership

AR Valuation of a sleep lab

OH Ongoing management / board mentoring for general surgery group

NC Assessment and restructuring of an OB-GYN group

ID Restructure governance, buy-in and compensation for a cardiology practice

Many large, successful enterprises in this country provide a nice return to shareholders by eeking out a pretty modest profit margin. Physicians need to remember this concept. If a service is revenue-positive, it's revenue-positive. Twenty cents on the dollar is better than zero cents on the dollar.

Faux Indicators

Overhead percentage is the most overrated and overused tool for evaluating medical practices. Overhead percentage doesn't reflect overhead, it reflects the *ratio* of overhead to revenue. Without looking at both revenue and overhead you get a very distorted view.

I'll never forget the surgeons and internists we were merging a few years ago. "We can't merge with you," the surgeons said, "your overhead is 60% and ours is only 40%. You're too inefficient." The surgeons got real quiet when I pointed out that, in terms of real dollars, the overhead of the two groups was virtually identical – it was the revenue that was different.

You would expect the procedural nature of a surgical practice to have higher revenue than internists. That's the distortion in looking only at overhead percent – when your revenue goes up, your overhead percent magically goes down even though the overhead didn't change.

Allocate it to someone else?

Another issue that regularly comes up, often under the guise of income distribution, is how overhead is allocated. Many groups say they "Eat what you kill." While this may be true on the revenue-side, it ignores how they divide the overhead.

The mantra seems to be that if the overhead can't be cut, it must be allocated to someone else – anybody. I see groups allocate overhead to newly hired associate physicians and even mid-level providers. Then they complain they are "losing money" on their employed providers. I've seen amazingly complex schemes created to justify this allocation method or that one, all in an attempt to keep the focus on the overhead.

The reality in a medical practice is that most overhead is fixed and adding or subtracting a provider doesn't appreciably alter the overhead. So allocating it to someone else creates only the *illusion* of overhead reduction.

Ultimately, all overhead is paid by the owners. Adding a provider should be done to increase revenue, not to decrease overhead.

An obvious solution

Do you think Dr. Smith, our friend who spends two days each quarter figuring out how to allocate costs, might be better off seeing patients with that time? Of course he would. The incremental cost of seeing an additional patient is almost nil and that revenue goes straight to the bottom line.

Or maybe he should spend some of that time reviewing what his group is being paid by some of the payers and thinking about renegotiating or terminating some of the marginal contracts.

Or maybe he should investigate new ancillary services, disease management clinics, joint ventures, practice expansion – anything but focusing on overhead.

When you pay attention to profit instead of overhead you are looking at the glass half-full, instead of half-empty.

The bottom line for physicians who want to see a better bottom line is to work on the bottom line by negotiating better contracts, improving coding and collection rates, and developing services that will generate additional revenue. The overhead will take care of itself.

Time for an Outside Board Member?

by Daryl Demonbreun

There is often a stark difference between larger and smaller groups in how productive their Board meetings are. Board meetings in larger medical groups generally benefit from experience and depth of management. Board meetings tend to focus on "big picture" issues – expansion, new services, new providers, etc. The management team has the depth to deal with most of the day-to-day issues outside the forum of a Board meeting and the expertise to complete the analysis necessary to facilitate timely decisions on strategic initiatives.

On the other hand, Board meetings in smaller groups tend to focus on day-to-day operational issues. The meetings tend to go on for hours discussing rather mundane issues, with little time (or expertise) for detailed analysis and discussion of more strategic issues. Sometimes they seem to raise more questions than answers.

The guiding hand of a trusted and experienced outside advisor can serve many purposes, from mentoring existing management on how to approach and analyze new projects to providing a broader view of what other groups are doing and what works and what doesn't.

Delta Health Care regularly serves as that "outside voice" for physician groups. Our experience and perspective provide valuable input on strategic issues, as well as insight in making Board meetings more efficient and effective (and shorter too).

QUESTIONS, ISSUES OR COMMENTS?

Contact Delta's highly experienced consultants at 800-467-3310 or email:

Daryl Demonbreun, dd@deltahealthcare.com

Randy Bauman, rb@deltahealthcare.com

Leif Beck, leifbeck@deltahealthcare

Angela Herron, aherron@deltahealthcare.com

Since 1991, highly experienced consultants improving physician practice performance for physicians and hospitals.