

PRIVATE PRACTICE SUCCESS

Independent advice for building and running a top-performing private medical practice.

► PERSONNEL

Non-financial incentives may be all you can afford in tough times

They're no substitute for money, but...

With many practices struggling financially, advice to pay incentive bonuses to employees can sound suspiciously like a voice from an ivory tower.

While you can't completely discuss employee incentives without including money, non-financial incentives absolutely have a useful

place. Some can motivate staff and improve morale — and you can still implement many of them if revenue and profitability are down. Think about these perks as a program separate from any financial incentives you might offer.

Recognition. Most people love recognition, including many who profess that they don't. Make the effort to acknowledge your people for the good work they do. It may feel a little contrived at first, but planning and then doing these little things develops the habit. Here are

some simple ideas for recognizing employees.

- Thank employees for their efforts in front of their peers.
- Have one of the physicians send a personal handwritten note to a deserving worker's home.
- Refer to staff as associates instead of employees.
- Name an Employee of the Month; include the special parking spot, too.

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► HIRING A PHYSICIAN

Physician starting salaries generally climbing

Some groups reduce salary guarantee and add incentive comp

Starting salaries for new physicians generally climbed higher in 2002, according to the recently released *Physician Starting Salary Survey: Year 2002*. The survey, produced by The Health Care Group,¹ includes detailed salary and benefit information on hires in 55 specialties and subspecialties from around the country. It offers practices a tool for setting base salary and benefits for their 2003 new hires. Table 1 on page 3 shows the average

¹ Contact The Health Care Group at (610) 828-3888, or e-mail to service@healthcaregroup.com for more information about *The Physician Starting Salary Survey: Year 2002*.

first-year salary for 11 selected specialties.

Finding specific details like incentive compensation in your specialty and locale is the major potential benefit of the *Physician Starting Salary Survey* — if it contains information matching your situation. The survey's details can help you structure the offer you'll make to a candidate.

Salary or incentives?

Ten of the 11 specialties listed in Table 1 reported larger starting salaries than in 2001. Only cardiology reported a decline. Looking at the details of the specific cardiology hires, the smaller average start-

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Non-financial incentives

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- Let employees know you're documenting their exceptional performance.
- Send flowers/fruit baskets for exceptional events.

Freebies. People like free stuff. With a little creativity, you can come up with a low-cost treat your staff will love. Consider these ideas:

- Keep the lunch room refrigerator stocked with free soft drinks.
- Provide free microwave popcorn.
- Offer employees free flu shots.
- Give away movie tickets. Theatre chains offer discounted pre-paid tickets. Occasionally handing out a pair of \$5 movie passes is a low-cost, well-received treat.

Awards/Rewards. These can be a little or a lot more costly than the freebies, but they're still

clearly a reward gift. One problem with some monetary bonus arrangements is that what starts as a bonus becomes perceived as an entitlement. Gift rewards make it easier to cut back when times are truly tough.

Keeping such rewards as gifts makes it easier to cut back on them when times are truly tough.

When considering this option, come up with ideas that people will value, remember and otherwise wouldn't do for themselves. Here

are some examples:

- Award a gift certificate to a day spa.
- Give a gift certificate at a high-quality restaurant.
- Hire a professional cleaning service to clean an employee's house.
- Give good seats to a professional sporting event or the theatre.
- Pay to have an employee's income taxes done by a tax service.

Camaraderie. Making your office a "fun place to work" shouldn't be your primary objective, but camaraderie-building events — especially when they become traditions — mean more than you might think to many employees. Here are some examples:

- Provide the ingredients for a make-your-own sundae event in your lunch room.
- Hold a staff appreciation outing or lunch.
- Have an office picnic with a volleyball match between teams of employees. Divide the staff between clinical and office staff and doctors, or whatever works for your practice. "Bragging rights" can be great morale builders.

Though it may be difficult to close the office for such events, it's a good idea if you can. Many busy working parents truly appreciate an event they can attend while the kids are in school or day care — or one they don't have to skip because they're driving between soccer games and dance practice on weekends.

Incentives for growth. Giving people the opportunity to expand responsibilities motivates them and

helps you develop loyal long-term employees. Fostering that growth appeals to the type of employee you really hope will stick around. Here are some simple ways you can help that process:

- Invite an employee to lead a staff meeting.
- Provide business cards for employees who wouldn't normally have them.
- Involve current staff in your hiring process.
- Solicit employees' ideas on procedures/policy development for their respective departments.

In good times, these small perks shouldn't be a substitute for financial incentives. But in a difficult period, some of these very low-cost items may be all you can afford.

Next month, we'll report on an approach to building a sound financial incentive plan that rewards staff based on excellent practice results. You can't build an effective long-term bonus plan unless it's tied to the operation's overall success. ■

Sources: The Coker Group. (800) 345-5829, or online at www.cokergroup.com.

Staff Management Strategies for Medical Offices. For a free sample issue, e-mail customerservice@advisorypub.com.

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Starting salaries

— continued from page 1

ing salary usually was offset by adding incentive compensation.

All of the cardiology hires reported for 2002 included some bonus pay in the first year. But a year earlier, 60% of the cardiology hires reported straight salary and no bonus. The 10 specialties reporting salary increases in 2002 did not show an increase in the frequency of first-year incentives from 2001.

In both years, the Survey's cardiology sample size was too small to attribute statistical significance to the differences between straight salary and incentive-laden contracts. Still, the details of various hires show that some cardiology practices were able to reduce starting salary guarantees in exchange for incentive compensation. Depending on your specialty and specific situation, you may or may not be able to achieve that in your new-doctor negotiations. But it's certainly an idea worth remembering as you contemplate your hiring strategy.

Split strategy

There's a nearly even split between groups paying straight salary and those offering salary plus production incentives. Among the survey's respondents, 49.1% of physicians were paid a combination of salary and production incentive; 48% were paid salary only. The remaining 2.8% were compensated purely on production.

The malpractice insurance crunch has pushed more providers — 70.5% — toward claims-made liability insurance, compared to 29.5% buying more expensive occurrence type coverage. The employer pays for the basic liability coverage in 94.5% of the contracts. When tail coverage is required to

cover claims arising after the employee leaves the practice, 48.7% of the deals call for the employee to pay for it. The practice pays in 45.6% of the deals; the parties share the cost in 5.7% of reported hires.

Tail coverage

Until the malpractice insurance issue cycles back toward affordability, more practices will face this tail issue. Generally, we recommend that the practice make sure the tail coverage is paid to ensure coverage and protect the practice. If you decide that the physician who leaves will ultimately bear the cost, be sure to provide in the contract that the practice can deduct the tail premium from the final paychecks or any pay-out.

Table 1

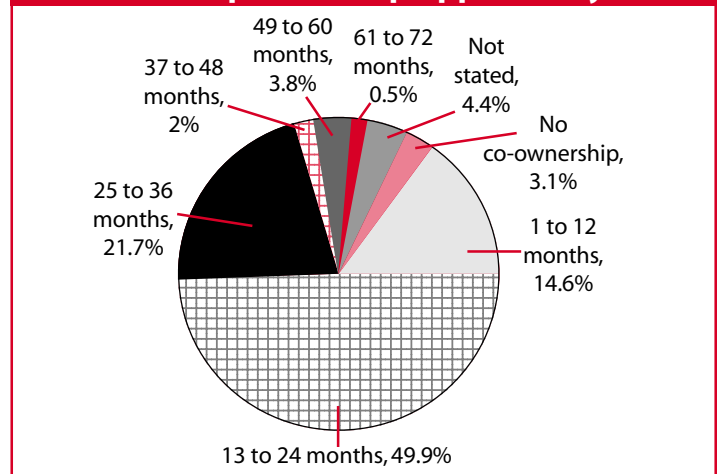
Average 1st-year salary: 2002 hires

Specialty	2002 Mean 1st-year salary	% change from 2001
Anesthesiology	\$230,000	23.5%
Cardiology	\$183,333	-18.5%
Family Practice	\$124,364	2.0%
General Internal Medicine	\$124,353	5.7%
General Surgery	\$176,000	16.7%
OB/GYN	\$157,538	9.5%
Ophthalmology	\$155,000	11.0%
Orthopedic Surgery	\$182,850	10.5%
Pediatrics	\$109,027	10.9%
Radiology	\$231,700	18.8%
Urology	\$188,857	47.2%

Source: The Health Care Group

Table 2

Average months before partnership opportunity



Source: The Health Care Group

Partnership timing

Survey respondents reported that 13 to 24 months is the most common length of time an associate must work for a practice before being considered for partner/shareholder status. Table 2 shows the breakdown. ■

Use surprise payables report as a financial spot check

The best accounting software packages today can generate a list of unpaid bills to date at any time.

Use that capability as a financial control. Occasionally have your manager generate an "instant" to-date payables report and review it with him/her. If you suspect manipulation, ask your accountant to run the report for you after hours and compare it with the manager's to-date account.

The little bit of time it takes you, the physician, to perform this random spot check acts as a prod that keeps your manager or bookkeeper on the ball.

Also require staffers to post invoices as they arrive or, at the very least, on a particular day each week.

► GROUP PRACTICE

Decide your group's definition of 'part-time' practice

It's easier before you face a request to cut back

What does "part-time" practice mean in your group? And what about part-time *partnership*?

Define "part-time" and decide how you will handle it — or whether you'll accept part-time partners at all — before you face the situation. Doing so gives you a sensible starting point to structure arrangements.

Although part-time doctors comprise only a modest percentage of total physicians, 40% of group practices have at least one, according to the most recent Medical Group Management Association's *Physician Compensation and Production Survey*.¹ This means that roughly 60% of groups still have time to lay the groundwork on handling a part-time request in advance.

What is part-time?

Start by making sure your group defines full- and part-time participation. For example, the MGMA survey defines "part-time" as 0.4 to 0.6 of full-time equivalency. Exactly what definition the group chooses isn't nearly as important as the fact that it clearly establishes one.

For example, one group that defines 0.8 FTE as full-time, doesn't allow part-time partners. The group's expectation is that if a physician wants to work less than 80% of full-time, he or she must do it as an employee.

A doctor working 80% of full-time probably has very similar goals and objectives as a 100% partner. At some level, however,

cutting back hours will probably change how a doctor views practice decisions. For example, a senior physician scaling back his or her practice to two days a week may have a different view — and vote — on investing practice funds for future growth.

Voting participation

A production-based compensation formula can usually take care of the pay issues involved with part-time work, but you still need to decide how much participation your group requires to merit a partner's voting rights (and full voting rights should come with a full share of fixed overhead charges). Looking at how part-time practice affects overhead costs, revenue and compensation are keys to setting the parameters within your group.

Healthcare attorney and consultant Robert Landau² says he can't imagine allowing a physician working less than half-time to maintain partnership status, "except maybe for a senior doctor phasing down his or her career."

Again, your group must decide what level of participation you require to maintain partnership status — a decision that's much less sensitive if made when no partner is seeking to cut back.

Giving a half-time physician half a vote usually doesn't provide a solution. In, say, a five-partner group with four full partners and one partner with half a vote, the half-time partner essentially has a

full vote when the group's bylaws require only a simple majority to pass a measure. And many practices rarely vote anyway, instead only acting by consensus. In that case, the part-time partner effectively has a full vote.

Framework & flexibility

While it's good to establish a framework, detailing every scenario simply won't work. Different part-time situations create different needs. A senior doctor phasing down, a young physician wanting to work four days a week and a colleague facing a permanent health or disability problem each present different challenges to the group.

Don't create a policy that excessively narrows your options.

When developing your policy, avoid lumping close-ended periods of reduced activity into it. Treat leaves-of-absence, sabbaticals, maternity leave and other de-

Exactly what definition the group chooses isn't nearly as important as the fact that it clearly establishes one.

defined, short terms differently than indefinite part-time participation. A promising young partner who wants to work fewer hours for several years until his/her children reach school age represents a different situation than a doctor who just doesn't want to pursue medicine full-time. ■

¹ The 2002 report is available directly from the MGMA at (303) 799-1111 or online at www.mgma.com. The cost is \$260 for members, higher for others.

² Contact Landau at Wade, Goldstein, Landau & Abruzzo, P.C. in Philadelphia at (610) 296-100, or e-mail to rlandau@wadegold.com.

► **CODING****Take our physician extender coding quiz****Get paid properly;
reduce denied claims**

How are your skills at coding for non-physician practitioners? Take this little quiz developed by consultant Jeannie Cagle, RN, CPC.¹ Are the following situations “fair” or “foul?” The answers² and explanations are printed in the box below. Play ball!

Question 1. A nurse practitioner (NP) employed by a physician has her own UPIN number. An established patient comes into the office for follow-up care. The physician is seeing patients in the office. The NP sees the patient and bills under the physician’s UPIN for 100% of the allowable charge.

Fair Foul

Question 2. An NP employed by a physician sees a Medicare patient in the hospital and bills Medicare under his own UPIN?

Fair Foul

Question 3. An NP employed by a physician specializes in working with hyperlipidemic patients and has a higher-than-average compliance success rate. A family practitioner across town sends a patient to the NP for recommendations on improving compliance. The NP sees the patient and bills a consult under his own UPIN.

Fair Foul

Question 4. A hospital-owned Ob/Gyn practice employs physicians and a nurse midwife. The nurse midwife sees routine patients and refers complicated or complex cases to a physician. The physician then charges for a consultation.

Fair Foul

Question 5. A managed care patient calls a physician’s office for the first time, complaining of severe back pain. The physician’s schedule is full that day. The patient sees a PA, who bills the managed care plan with the physician’s UPIN.

Fair Foul

Question 6. An NP employed by a physician has her own UPIN. An established patient comes to the office for follow-up care. The physician is seeing patients in the office. The NP sees the patient and bills under her own UPIN to receive 85% of the allowable charge.

Fair Foul

Question 7. A nurse practitioner sees a new patient with commercial insurance, while the physician is in the office. The NP bills a 99204 under his own provider number.

Fair Foul

Question 8. Physician employs nurse practitioner to see patients in a “sick clinic” on Saturday mornings. The NP sees established patients for follow-up care and bills under the physician’s UPIN.

Fair Foul

¹ Cagle is a consultant with The Coker Group, based in suburban Atlanta. Contact her at (800) 345-5829, or e-mail to jcagle@cokergroup.com.

² Answers in this quiz do not reflect special rules for Rural Health Clinics, as defined by federal regulations.

Answers

Question 1. *Fair.* NPs and PAs may bill under a physician’s UPIN even when they have their own UPIN.

Question 2. *Fair.* NPs (with the appropriate hospital privileges) can provide services in a hospital setting as long as they’re billed under their own UPIN.

Question 3. *Fair or foul,* depending on Medicare carrier directive. There’s no national policy on whether mid-level providers can perform consultations for Medicare.

Question 4. *Foul.* A certified nurse midwife is considering being in the same specialty as an Ob/Gyn. It’s not appropriate for the physician to bill a consult.

Question 5. *Fair,* unless it’s prohibited by the plan’s rules, because Medicare/Medicaid do not apply.

Question 6. *Fair.* But, as described in this case, the NP could bill “incident to” under the physician’s UPIN and expect 100% of allowable charge.

Question 7. *Fair or foul.* Once again, this becomes a matter of carrier directive. There’s no national policy on what level visit a mid-level provider can bill when working under physician supervision. Carriers set their own rules.

Question 8. *Foul.* Cannot bill “incident to” unless NP provides care under the physician’s direct supervision in the suite. ■

► TECHNOLOGY

Control sales demos to learn what you want to know

Dog and pony shows belong in the circus

The problem with sales demonstrations is that what you seek from the experience differs from the sales team's goals. You want to learn everything you need to compare candidates and select the best system for your practice. The company wants to show what will sell you its product.

Structure the experience to meet your objectives, says consultant Jeff Daigrepoint,¹ who spoke on selecting information technology systems at the American Academy of Medical Management.²

Set the rules

Whether you're looking for new billing software, an EMR system, or clinical equipment, limit the number of demos you permit. Use your request for proposal (RFP) to select the two or three best candidates. (Last month we wrote about developing an RFP and using it to guide your search.) Focus on two or three systems, no more than five, Daigrepoint recommends. If those demos don't identify at least one that clearly meets your needs, you can always add more.

In setting up appointments, Daigrepoint suggest these guidelines:

- Limit demos to three or four hours. Time constraints keep vendors focused.
- Have a cross-section of likely

users sit in on the demos.

- The same people should participate in all the demos.
- Ask vendors to use a projector so everyone can see well.
- Don't allow vendor reps to outnumber your selection team. You want to interact with your team members during the demo, not a fleet of sales reps.
- Inform vendors they'll be evaluated on all items in the RFP.
- Never demo a product that is not currently available.

Use your RFP

Let your RFP help you plan for the demos. Use the RFP itself or develop an outline or script based on it. This approach helps you ask the same questions to each prospect.

The salesperson or team has probably done hundreds of sales demos and developed an effective presentation for their product. Don't let the company trot out its usual dogs and ponies. Stick to your RFP or outline and make vendors show you what you want to learn about their system, not just what they want to show you.

Make sure the vendor demonstrates the exact version you are interested in purchasing — including any add-ons you'll need. Some companies regularly demonstrate a system with upgrades and add-ons while quoting you prices for only the basic system. Others demo the upcoming version, which may or may not be available. Beware of vaporware!

Show me

Don't take the vendor's word that the system does something; make him/her show you. For ex-

ample, EMR systems can frequently identify potentially dangerous drug interactions. Test that feature by coming up with two medications that you know shouldn't be used together. During the presentation, ask the vendor to demo this feature using those two. The system should flag it. Such tests prevent salespeople from showing you cherry-picked examples that they know the system can handle properly.

Ask plenty of questions throughout the presentation. Then keep your ears open for contradictions. The more questions you ask, the more likely you'll expose inconsistencies.

Pay attention to how the presenter navigates through the software. How many screens must you select through to go between routine tasks? Is the vendor primarily navigating using a mouse, or by keyboard shortcuts? In almost all software, keyboards are the fastest way — presuming you know the commands — but most people use a mouse to find their way around a program, even if it takes a little longer.

Hands-on

Schedule time for hands-on evaluation of the features explained in the demo. Include it in the three-hour time allotment. After seeing a salesperson — who is obviously well trained in using the system — skillfully use its features, make sure you see how it functions in your hands.

Immediately after the demonstration, dismiss the vendors and have each member of the selection committee complete a quick, one-page evaluation of the demo, ranking key features on a scale of 1 to 5. Doing this immediately keeps the pluses and minuses of each system clear.

— see **Sales demos** on page 7

¹ Daigrepoint is a senior consultant with The Coker Group, a medical practice consulting firm based near Atlanta. Contact him at (800) 345-5829, or e-mail to jdaigrepoint@cokergroup.com.

² The American Academy of Medical Management offers a wide range of excellent practice management instruction, certification and CME programs for physicians and managers. Contact the Academy at (770) 649-7150, or online at www.epracticemanagement.org.

► **PERSONNEL**

Script your efforts to improve OTC collection

Make a tough task easier

Asking patients for payment creates some awkward situations for your staffers who handle the chore. Your uninsured patients, non-covered services and managed care co-pays represent revenue you can no longer afford to pursue casually. Giving your front desk workers tools to collect from patients makes your staffers more comfortable and improves your over-the-counter (OTC) collections.

Preparation produces

Good OTC collection requires teaching staffers appropriate collection skills and creating an environment where your patients *expect* to pay at the time of service. Using the sample scripts in this article as templates, develop your own scripts that your staff can use when asking patients to pay. These three sample

¹ The Coker Group is a healthcare consulting firm based near Atlanta. You can reach the organization at (800) 345-5829, or online at www.cokergroup.com.

Sales demos

— continued from page 6

Don't rely on memory to separate the impressions and details of three demos scattered over several weeks.

Working from a framework gives you the best chance to learn what you need to know about each finalist product and to keep all that information straight. Combined with the RFP, well-run demos should help you identify the system that will best serve your practice.

Next issue, we'll address reference checking and negotiating the purchase of a system. ■

scripts, based on ones developed by The Coker Group,¹ cover the appointment phone call, the sign-in discussion and the check-out process. You might not follow these samples exactly, but they'll help your staff develop their own appropriate approach to pursuing OTC payment. These scripts are written in a fairly formal style; you may wish to modify them to make them more conversational as suits your style.

◆ **Sample script:** *When a patient calls for an appointment*

Phone staffer: Mrs. Smith, since we see that you don't have any insurance coverage, you'll be responsible to pay in full at the end of your visit. (If the patient is enrolled in a managed care plan, tell them their co-pay is expected at the time of service.)

Patient: *I never pay anything at my visit. You can bill me.*

Phone staffer: Mrs. Smith, if you have insurance, we'll be happy to bill your insurance company. If not, we must ask for full payment at the time of service. If you'd like to talk to someone about your account, please arrive 30 minutes early and tell us that you'd like to speak with our patient account representative.

Rationale: This exchange reinforces the idea of payment at the time of service when the patient first makes an appointment. It eliminates the excuse that the patient didn't know about their obligation when she arrived at the practice.

The reference to the patient account representative encourages up-front payment, but also tells people you're willing to be reason-

ably flexible in appropriate circumstances. People simply trying to duck payment at the time of service may be discouraged by the subtle threat of meeting with the billing department.

If you're implementing new, stronger point-of-service payment procedures, mention the "change in practice policy" during the initial appointment call. It introduces the expectation of up-front payment, which may take some time to build among your patients.

◆ **Sample script:** *When an uninsured patient arrives for an appointment*

Desk staffer: Mrs. Smith, since we won't be filing an insurance claim for today's visit, we expect full payment at the time of service. For your convenience, we'd be happy to accept cash, check or a major credit card. (For managed care patients, adapt the script to something like, "the co-pay for your plan is \$10. How would you like to pay that? For your convenience...")

Patient: *I can't pay anything today; can you send me a bill?*

Desk staffer: I'm sorry, but we're reducing our patient billing. If you'd like, at the end of your visit, you can talk to our patient account representative and discuss payment options.

Rationale: The sign-in desk is your last chance to reinforce up-front payment before a doctor sees the patient. Don't let the opportunity pass. The reference to the patient account representative shows your flexibility and reduces the number of wallets and purses that patients "forgot" or "left in the car."

◆ **Sample script:** *Immediately after the visit*

Desk staffer: Mrs. Smith, your charge for today's visit is \$100. For your convenience, we accept cash, check, or a major credit card. How will you be paying today?

Patient: *Can you send me a bill?*

Desk staff: I'm sorry, we're reducing our patient billing. Our policy calls for collecting patient balances at the time of the visit. We accept all major credit cards for your convenience.

Patient: *You usually bill me. I didn't bring any money, so I can't pay today.*

Desk staff: If you can't pay for today's visit, you'll have to make arrangements with our

patient account representative. If you'll take a seat, I'll get/call her now.

Rationale: The staffers immediately informs the patient of your flexibility in forms of payment and that you expect payment. Note that the script doesn't ask the softer question, "Would you like to pay today?" It asks how will you pay, today?

When the patient raises the billing option, the staffer responds by apologetically referring to a policy, not stating that the "Dr. expects immediate payment." Don't let your staff transfer the blame for OTC payment to you.

If the patient still resists, once again refer to an immediate meeting with the ominous-sounding patient account representative.

Give it time

Develop your own scripts from these samples. A less formal patient-friendly style may better suit your practice's style. While the format can vary, instructing your staff to handle in-office collection with scripts like these steadily builds and reinforces the notion of payment at the time of service.

You'll still have problems with some patients who deliberately dodge paying, perhaps even losing a few who move on to practices less rigorous about asking them to pay. You'll also see a drop in the number of basically responsible patients "forgetting" wallets. It's among that group, where you can most improve your OTC collections. ■

► CLINICAL MATTERS

Tracking clinical research on CAM

Keep up with real science on this expanding, sometimes controversial, field

More than one hundred complementary and alternative medicine treatments are being tested in clinical research sponsored by the NIH's National Center for Complementary and Alternative Medicine (NCCAM). Scientists are rigorously evaluating treatments and therapies ranging from yoga as an insomnia treatment to clinical trials of mistletoe extract used in combination with traditional oncology drugs.

Well-controlled studies

With many of your patients utilizing CAM, it just makes sense to stay informed on controlled clinical research attempting to evaluate these treatments. While many CAM treatments have long histories, physicians rightly contend that

little of that history comes from controlled clinical trials. That's changing as NCCAM sponsors three-phase studies conducted under FDA protocols:

- Phase I (20 to 80 patients): Researchers test a new drug or treatment in a small group of people for the first time to evaluate its safety, determine a safe dosage range and identify side effects.
- Phase II (100 to 300 patients): The study drug or treatment is given to a larger group of people to see if it is effective and to further evaluate its safety.
- Phase III (1,000 to 3,000 patients): The study drug or treatment is given to large groups of people to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and

collect information that will allow the drug or treatment to be used safely.

More than 90 conditions

The table on page 9 lists all diseases and conditions for which NCCAM sponsors clinical trials and a link to the Web page containing detailed information about the studies. In some cases, several studies are underway for certain conditions. You can start from the general link to NCCAM clinical trials at www.nccam.nih.gov/clinicaltrials/.

Look for the diseases and conditions you commonly treat and follow the link to the related trial. Many of the studies investigate treatments already popular among patients. Keeping up with the research on what your patients might be using or considering can help you plan your treatment. ■

Current NIH-sponsored CAM clinical trials

Links to summaries of NIH-sponsored research

— A —

Abdominal Pain www.clinicaltrials.gov/show/NCT00010933
 AIDS www.nccam.nih.gov/clinicaltrials/hiv.htm
 Alcoholism www.clinicaltrials.gov/show/NCT00010907
 Alzheimer's Disease www.clinicaltrials.gov/show/NCT00010803
 Anxiety Disorders www.nccam.nih.gov/clinicaltrials/anxiety.htm
 Arthritis www.nccam.nih.gov/clinicaltrials/arthritis.htm
 Asthma www.nccam.nih.gov/clinicaltrials/asthma.htm

— B —

Binge Eating Disorder www.clinicaltrials.gov/show/NCT00032760
 Bipolar Disorder www.clinicaltrials.gov/show/NCT00010868
 Benign Prostatic Hyperplasia (BPH) www.clinicaltrials.gov/show/NCT00037154
 Brain Tumors www.clinicaltrials.gov/show/NCT00029783
 Bronchitis www.clinicaltrials.gov/show/NCT00051792
 Bone Marrow Transplantation www.clinicaltrials.gov/show/NCT00032409

— C —

Cancer www.nccam.nih.gov/clinicaltrials/cancer.htm
 Breast Cancer www.nccam.nih.gov/clinicaltrials/breastcancer.htm
 Cancer Side Effects www.nccam.nih.gov/clinicaltrials/cancer.htm
 Colorectal Cancer www.nccam.nih.gov/clinicaltrials/colorectalcaner.htm
 Endometrial Cancer www.clinicaltrials.gov/ct/gui/c/w2r/show/NCT00010829
 Laryngeal Cancer www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00026975
 Lung Cancer www.nccam.nih.gov/clinicaltrials/lungcancer.htm
 Ovarian Cancer www.clinicaltrials.gov/ct/gui/show/NCT00039793
 Pancreatic Cancer www.nccam.nih.gov/clinicaltrials/pancreaticcancer.htm
 Prostate Cancer www.nccam.nih.gov/clinicaltrials/prostatecancer.htm
 Cardiac Diseases www.nccam.nih.gov/clinicaltrials/cardiac.htm
 Cardiovascular Disease www.nccam.nih.gov/clinicaltrials/cardiovascular.htm
 Carpal Tunnel Syndrome www.clinicaltrials.gov/ct/gui/c/w1b/show/NCT00029497
 Cerebral Palsy www.clinicaltrials.gov/ct/gui/c/w2r/show/NCT00011024
 Common Cold www.nccam.nih.gov/clinicaltrials/commoncold.htm
 Contraceptive Effectiveness www.clinicaltrials.gov/ct/gui/c/w1b/show/NCT00026013
 Congestive Heart Failure www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00032422
 Coronary Disease www.nccam.nih.gov/clinicaltrials/coronary.htm
 Cumulative Trauma Disorder www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00029497

— D —

Dementia www.nccam.nih.gov/clinicaltrials/dementia.htm
 Depressive Disorders www.nccam.nih.gov/clinicaltrials/depressive.htm
 Diabetes www.nccam.nih.gov/clinicaltrials/diabetes.htm
 Drug Interactions www.nccam.nih.gov/clinicaltrials/interactions.htm

— E —

Ear Infections www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00010465
 Emphysema www.nccam.nih.gov/clinicaltrials/emphysema.htm
 Endometriosis www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00034047

— F —

Fibromyalgia www.nccam.nih.gov/clinicaltrials/fibromyalgia.htm

— G —

Glioblastoma www.clinicaltrials.gov/ct/gui/c/w1b/show/NCT00029783
 Gum Disease www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00010634

— H —

Hepatitis www.nccam.nih.gov/clinicaltrials/hepatitis.htm
 HIV Infections www.nccam.nih.gov/clinicaltrials/hiv.htm
 Hot Flashes www.clinicaltrials.gov/ct/gui/c/w2r/show/NCT00010712

Huntington's Disease www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00026988
 Hypercholesterolemia www.nccam.nih.gov/clinicaltrials/hypercholesterolemia.htm
 Hyperglycemia www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029250
 Hyperlipidemia www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00029250
 Hypertension www.nccam.nih.gov/clinicaltrials/hypertension.htm
 Hypertriglyceridemia www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029250

— I —

Insomnia www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00033865

— K —

Kidney Failure (Chronic) www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029796

— L —

Low Back Pain www.nccam.nih.gov/clinicaltrials/backpain.htm
 Lung Disease www.clinicaltrials.gov/show/NCT00051792

— M —

Memory Disorders www.nccam.nih.gov/clinicaltrials/memorydisorder.htm
 Menopause www.nccam.nih.gov/clinicaltrials/menopause.htm
 Multiple Sclerosis www.nccam.nih.gov/clinicaltrials/multiplesclerosis.htm

— N —

Nausea www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00034996
 Neck Pain www.nccam.nih.gov/clinicaltrials/neckpain.htm
 Neurological Disorders www.nccam.nih.gov/clinicaltrials/neurological.htm

— O —

Obesity www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00032760
 Obsessive Compulsive Disorder www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00035438
 Osteoarthritis www.nccam.nih.gov/clinicaltrials/osteoarthritis.htm
 Osteoporosis www.nccam.nih.gov/clinicaltrials/osteoporosis.htm
 Otitis Media www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00010465

— P —

Pain www.nccam.nih.gov/clinicaltrials/pain.htm
 Parkinson's Disease www.nccam.nih.gov/clinicaltrials/parkinsons.htm
 Periodontitis www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00010634
 Phobic Disorders www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00035412
 Postmenopause www.nccam.nih.gov/clinicaltrials/postmenopause.htm
 Post-Traumatic Stress Disorder (PTSD) www.clinicaltrials.gov/show/NCT00055354
 Premature Birth www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029198
 Prostate Disease www.clinicaltrials.gov/ct/gui/c/w1b/show/NCT00037154
 Pulmonary Disease www.clinicaltrials.gov/show/NCT00051792

— R —

Repetitive Strain Injury www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029497
 Respiratory Diseases www.clinicaltrials.gov/show/NCT00051792
 Retinitis Pigmentosa www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00029289

— S —

Sexual Disorders www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00034021
 Stress www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00034008
 Stem Cell Transplantation www.clinicaltrials.gov/ct/gui/c/a2b/show/NCT00032409

— T —

Temporomandibular Joint Disorder (TMD) www.nccam.nih.gov/clinicaltrials/tmd.htm
 Tooth, Impacted www.clinicaltrials.gov/ct/gui/c/a1b/show/NCT00010972

— V —

Varicella www.clinicaltrials.gov/show/NCT00029484
 Vascular Disease www.clinicaltrials.gov/show/NCT00029991
 Vestibulopathy www.clinicaltrials.gov/show/NCT00032383
 Vomiting www.clinicaltrials.gov/show/NCT00034996

Source: Compiled from the NCCAM Web site

► TECHNOLOGY

A look at online computer backup services

An automatic process may make sense for 'technophobes'

Backing up your computer system data via the Internet may be an excellent solution for smaller practices with little or no computer expertise. It can also be a hard-to-justify expense for practices that already have effective backup systems and procedures in place.

Many companies offer such backup services. Most of these Application Service Providers (ASPs) operate the same basic way: For a monthly fee, the backup company provides you software that you install on your network. The software copies the data on your system, encrypts it, compresses and then uploads it to the company's secure facility through a Internet connection. You control what information and how often you wish to back up.

Do you need it?

Once installed, the backup process happens automatically. Uploading an encrypted file to a company's secure Web site is an easy, effective way to protect your data off site in case disaster strikes your computer system or facility. But does using such an ASP service make sense for a medical practice? That answer depends on your staff's computer ability and how reliably they follow backup procedures.

Almost all practice management and EMR systems come with backup systems — usually a tape drive or CD burner. These create regular backups, which you or someone in your practice can take off-site each day.

Quality system vendors understand the importance of backing up your system. They handle the phone calls when a system goes

down — regardless of fault. That's why they push for adequate backup capability when installing their systems, even if it's not an inherent part of their product. If you've heeded their advice, you likely have the hardware and software in place.

If your staff diligently monitors and confirms the daily backups, understands how the system works, keeps the tapes/disks and tests the system periodically, you probably don't need to add the extra expense of an ASP to back up your files. Spending around one hundred dollars each month (possibly more, depending on how much data you need to protect) for a *secondary* backup is hard to justify, especially if you're fighting to cut expenses.

Yes, but...

The bigger problem is that many medical offices have haphazard backup practices.¹ If yours is among them, seriously think about contracting for automatic backup. Once the system is set up, it automatically creates the backup and transfers the data off-site via the Internet.

Don't trivialize backup procedures. An unprotected system crash could cripple your practice finances. Before deciding to skip the expense, look at how reliably backups happen — or don't happen — in your practice.

Properly implemented, an automatic process fulfills the data security and privacy requirements established by HIPAA. Jennifer Walzer, President of Backupmyinfo.com,¹ explained how her company's service handles the HIPAA issues. Only encrypted data is transmitted by *Backupmyinfo.com*, Walzer said. The software creates the backup, encrypts it (up

to 256-bit data encryption if you desire) and compresses the file before uploading to the company's secure servers. Only you and your authorized staff have the password that will unlock encrypted files. The service doesn't have access to your data; it merely stores it.

Password protection

When you restore data from the company's servers, you download the encrypted file and use your password to unlock it and re-write the file to your system.

The software allows multiple passwords so you can identify who accesses backed-up data. User authentication gives you better control over access than if everyone logs in under the same name.

Many companies sell Web-based data protection. You can find plenty of candidates by typing "Internet backup" or a similar search string into your search engine. ■

¹ Contact Walzer at (212) 987-0066, or online at jwalzer@backupmyinfo.com. You can visit the company's Web site at www.backupmyinfo.com.

Watch your money

continued from page 11

ing to cover costs as indicators of financial trouble.

Spot checks

These regular steps should strengthen your control over payables — at least your understanding and confidence in their accuracy. To better protect yourself from embezzlement, occasionally break from your pattern. Every now and then examine the source documents your manager uses to prepare the monthly reports. Make these random checks an "irregular standard practice." ■

FOUNDATIONS FOR A STRONG PRACTICE

Back-to-basics reminders for *veterans* and management fundamentals for *novices*

Watch where your money goes, doctor

Sound steps for reviewing accounts payable

Tight financial times require exercising firm control over your accounts payable. How cash flows out of your business is just as important as how it flows in.

Follow these time-honored steps to manage your payables. After all, nobody takes ownership like an owner.

Build a procedure

A physician partner should always scrutinize vendor statements before signing the accompanying checks; you shouldn't just receive and sign a stack of checks. Facilitate that process by having your bookkeeper make a list of all the checks to be signed.

Is the check for full or partial payment? Is the account past due? By how much? Are you being charged for late payments? If any of these apply, get an explanation from your manager or the appropriate staffer before you sign. Find out the "why's."

Carefully reviewing bills takes time; structure that time efficiently by paying your bills once a month. Doing so helps make you a better cash-flow manager.

Monthly payment

Decide on a date each month to pay all practice bills. (The 25th may be an excellent choice since bills sent the first of the month still won't be overdue.) Regular payment on the same date will almost surely prevent any bills from becoming overdue and subject to finance charges. You rarely

see bills marked "net due 10 days" anymore, but if you get any, pay that lower price anyway — even if your monthly date falls later. We doubt you'll be billed for the difference very often.

Third-party payors already demonstrate this basic business principle when they delay reimbursement for your services. Use the same concept to hang on to your cash as long as possible.

Added efficiency

Writing checks once a month also leads to better review. Before signing the checks, you can audit the month's expenditures as a whole — rather than looking at isolated checks every few days.

Your bookkeeper won't be interrupted so often for small check-writing tasks either, freeing more time for full attention to other duties. S/he can more effectively handle delinquent account collection follow-up, special financial reviews and other useful jobs.

If once a month creates too large a burden, consider a semi-monthly routine. Link it with payroll check-writing to maximize efficiency.

Between bill-paying sessions, you can hold the necessary funds in your bank or money market account. The interest earned on this monetary "play" isn't great these days, but it's still money received at no cost.

Regular reviews

In addition to paying close attention when you sign checks, create a procedure for reviewing your payables — and other finances — monthly. Instruct your manager to provide these reports *weekly*:

- Accounts payable on hand
- Total accounts receivable
- Checking account balance
- Savings account balance

Review the weekly reports quickly, but keep them handy for comparison to the full monthly profit-and-loss statement.

In reviewing your monthly statement, don't start at the bottom line. First, check that gross receipts are stable, reflecting neither a sudden nor a creeping decline. If the receipts look normal, problems at the bottom line must reflect how money is being spent.

As a general rule, accounts payable on hand should represent no more than 25% of your average monthly expenses — presuming your bills are up to date. The exceptions: bills for large quarterly or annual expenses (such as insurance premiums) and for major purchases.

A poor collection month or large expense such as a malpractice insurance payment could cause profits to drop and maybe even a cash flow crunch, but make sure your manager isn't trying to disguise financial trouble. Also, look for both rising accounts payable and increasing transfers from savings to check-

— see **Watch your money** on page 10

If your bills are up to date, accounts payable on hand should normally represent no more than 25% of your average monthly expenses.

► **PRODUCTIVITY**

Customized stamps speed documenting of patient lab results

Improving efficiency in paper charts

Even without investing heavily in an EMR system, you can improve your efficiency using paper charts.

You can, for instance, efficiently document lab results with a low-tech solution like the customized self-inking stampers Lisa McTavish, MD,¹ uses. We saw Dr. McTavish's idea when she described using stampers in the April issue of *Family Practice Management*.²

Low-tech efficiency

Unwilling to take on the expense of an EMR system, Dr. McTavish wondered how she could better handle processing routine lab results. She chose customized self-inking stamps to document that she has reviewed lab results and issued necessary instructions to her patients.

"In my practice, my staff is responsible for contacting patients with their results or with further instructions after I have reviewed their reports and communicated my findings in the chart," Dr. McTavish wrote. "...I found myself repeating the same messages to my staff."

Common tests

To speed the process, Dr. McTavish created and then ordered customized stamps. The stamps' text was based on her typical chart notes for reviewing test results and

issuing appropriate follow-up instructions. The text of Dr. McTavish's cholesterol test results stamp is shown to the right. It contains boilerplate information; a spot for the doctor to fill in the test result; basic follow-up instructions; and a way to note that staff must communicate additional instructions to the patient.

When the test result comes back from the lab, Dr. McTavish reviews the result, uses the appropriate stamp to make a chart note, then adds the test result plus any specific instructions before signing-off on the entry.

Self-inking stampers saved about two minutes per test result recorded — an hour a week in McTavish's case. The idea also makes good sense because it promotes standardized, legible medical records.

Dr. McTavish has appropriate stamps for colonoscopy, Pap tests, mammograms, gastroscopy and other routine tests she orders for her patients, according to the article. You can view several more of her stamp samples online at the *Family Practice Management* Web site at www.aafp.org/fpm/20030400/51maki.html.

Online design

She said the stampers cost about \$30 each and save about two minutes per test result recorded — an hour a week in McTavish's case. Using them also makes good sense because they promote standardized, legible medical records.

Many vendors — including all the major office supply chains — offer customized self-inking stamps

Sample stamp for cholesterol test

Inform: Your good cholesterol (HDL) is too low _____/normal.

Your bad cholesterol (LDL) is too high _____/normal.

Book follow-up / Other

online. Shopping online for these stamps works well because you can sit at your computer, design your stamps and proof your work. Once you've worked out the text and format, simply submit your order via the Web.

The self-inking stampers come in various sizes from different manufacturers and resellers. One model, the Ideal 300, is sold by many vendors and creates a 1-1/2 x 3-inch stamp, containing up to 10 lines of text. Many vendors offer the Ideal stamps. One Web site, www.carolinastamp.com, offered a customized Ideal 300 stamp for \$21.95.

Risk management

Customized stamps complement a formal lab log — a running log-in sheet recording all tests ordered so your staff can confirm that you actually received the results. This forms a sound risk management strategy for managing test results.

Self-inking stamps are no substitute for EMR, which we've advocated for years. If you're sticking with paper charts, though, this idea helps makes them as efficient and legible as possible. ■

¹ Contact Doctor McTavish in Rossville, IN at (765) 379-3311.

² You can visit the *Family Practice Management* Web site at www.aafp.org/fpm.

New Physician Starting Salaries

1. What is your practice specialty: _____
2. How many physicians are in your practice: _____
3. What state is your practice located in: _____
4. Is your practice location:
 Urban Suburban Rural
5. Did you hire one or more new physicians to start with your practice this year (presumably 7/1/03):
 No
 Yes (If more than one, how many: _____)

(Note: If you answered "No" to Question 5, please skip to Question 12.)

(If you hired more than one physician, please photocopy this form and complete the following items on separate copies for each hire. If more convenient, fax each copy to us at (610) 941-4499. If any physician is hired in a different specialty than you answered in Question 2, please note it on the page you are giving answers for.)

6. What is the agreed annual base starting (first-year) salary:
\$ _____
7. Did you agree also to pay:
 - a. an up-front signing bonus (a sum to be paid before his/her arrival for work):
 No Yes, in the amount of: \$ _____
 - b. a moving allowance (a sum to help pay for moving to your area):
 No
 Yes, maximum amount to be: \$ _____
8. Does the contract provide for an agreed
 - a. second year annual salary:
 No Yes, and it is: \$ _____
 - b. third year annual salary:
 No Yes, and it is: \$ _____

9. a. Does the contract provide incentive pay above straight salary?
 No Yes, based on:
 His/her own production
 The practice's overall profitability
 A specific evaluation process
 A combination of the above
 Other: _____
- b. If "Yes," what is the specific incentive:
Year #1: \$ _____
Year #2: \$ _____
Year #3: \$ _____
10. Does the contract say when the new doctor will be considered for "partnership" (co-owner status):
 No Yes, and it is after _____ years as an employee
11. Does the contract include a Restrictive Covenant limiting the new doctor's freedom to practice in your service area if his/her employment with you ends:
 No Yes

(If you answered "No" to Question 5, please resume this survey here.)

12. Are you considering hiring a new physician within the next two years (2004 and 2005)?
 I did **NOT** this year and
 - am considering doing so.
 - am not
- I did this year and
 - am considering doing so again.
 - am not

THANK YOU. Just fold this survey in thirds with the address portion facing out, tape and drop in the mail postage-free or fax it to (610) 941-4499.

••• Please return this survey by August 15, 2003 •••

New Physician Starting Salaries

We want to keep you posted annually on trends in private practice starting salaries, so this survey asks you about your 2003 hirings, which should be completed by now (July 2003). We will publish the results as soon as possible, so you will have them available for your recruiting efforts for July 2004 hiring.

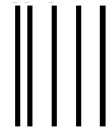
We hope this undertaking will give you the best available information to help you judge the market

factors for recruiting and hiring new physicians. You need it to have a feel for competitive salaries if you are either recruiting or contemplating an additional physician for your practice.

We'll publish results of this reader survey in an upcoming issue. We hope it will help your practice and be another benefit of your subscription.

Please return this survey by August 15, 2003.

RS703

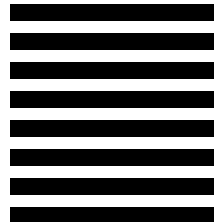


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Medical Office Financial Management: A Practical Primer

Improve the financial management of your practice with this book's practical, straightforward information and advice. It will help you get a better grasp of these vital financial concepts and it will show you how to apply them successfully to your practice:

- **Using Data:** What financial data do you need to grow your business? Learn how to analyze it and how to benchmark your practice's performance effectively.
- **Budgeting:** Learn how to include short and long term plans, accurately project revenue and expenses and determine whether physician pay should be a budgeted expense.
- **Financial Reporting:** What reports should you review weekly and monthly to manage your practice more efficiently? And should your reports reflect cash or accrual-based accounting.
- **Cost Accounting:** More important than ever! Learn how to determine the cost of each procedure and how switching from revenue to cost emphasis identify areas for improvement.
- **Managed Care Performance:** Use your data to manage managed care. Organize this information to strengthen your position in payor contract negotiations.
- **Cost-Containment Strategies:** Learn which small cost-cutting steps can lead to big savings. Discover the keys to controlling employee-related costs and to reducing overhead.

This comprehensive book will help you better understand and control all the financial aspects of your practice — and add to your bottom line. [\$99]

Scheduling Strategies: Making Physicians More Productive

Seeing just one additional patient per hour can create upwards of \$50,000 more per doctor per year — without sacrificing quality care or your ability to get home at a decent hour. Some of the proven tools you'll learn:

- The how-to of wave/modified wave/open access and other modern scheduling approaches

- How to calculate each physician's "patient per hour rate"
- Ways to handle work-ins and no-shows without hurting your timing
- 12 rules of thumb to optimize physician time
- When and how best to use support staff
- When to add exam rooms
- How office "clinics" can improve staff efficiency and patient care

With this complete, practical guide to improving your schedule, you're guaranteed to improve productivity and boost your bottom line. [\$79]

Solving Partner-Level Challenges

This is a complete guide to addressing and resolving the major issues in group medical practice. Learn the 9 rules for group success as well as the 6 misconceptions of group practice. Also covered:

On promoting to partnership:

- Not every associate is partner material
- Guidelines for partner buy-ins
- Why "in-exact" buy-ins make sense

For group governance:

- How to assess practice goals and missions (where does "balance" fit in?)
- Standards for interpersonal behavior
- Evaluate performance in partners and yourself, using our sample form

Dealing with problem partners:

- How to avoid "locked-in" partners
- Dealing with inappropriate behavior
- How to sanction, fine, and even fire a partner

Fair methods of partner compensation:

- 5 principles of income division formulas
- Why a three-tiered approach works
- Compensating a partner who wants to cut back or take on more responsibility

How Stark II affects group compensation:

- Defining Designated Health Services (DHS) and a "group"

- How to legally distribute DHS profits
- Clarifying "physician services" and "in-office ancillary services"

All this and more to help you build your group practice and run it profitably. [\$99]

Improve Your Productivity: See More Patients, Earn More Profit and Make It Home for Dinner

Optimizing the doctor's productivity in seeing and caring for patients is key to conducting a successful and profitable practice. Have you heard for instance, that "Things go to the doctor, the doctor doesn't go to things," or "Do all you can to help the physician work efficiently, even if it disrupts the staffers?" You're probably aware that one doctor seeing one more patient per hour can add \$50,000 per year to the bottom line, without extending the work day. Working smarter pays off, and this book tells how to do that. As a sampling, this book includes:

- ✓ The four S's of physician productivity
- ✓ Plus a T for Technology
- ✓ How to delegate to non-physician staff so you can concentrate on clinical care needing your training and expertise
- ✓ A fresh look at how to design — or redesign — your office systems to serve the productivity goal

Finishing the day feeling good about what you did, not being exhausted from the hassle, and joining your family for dinner shouldn't be impossible. This book is packed full of practical ideas focused directly on physician productivity — helping you achieve those purposes. [\$99]

Paying Partners: Buy-In, Pay-Out & Income Division Strategies

This book covers the three parts of a physician's career as a private medical practice co-owner/partner. We start with the details of an associate's buying into the group, including how long before being offered partnership; how to value the tangible and intangible values; approaches for accomplishing either an "exact" or an "inexact" buy-in method; and ways to make the buy-in protect the parties from tax problems.

Then, we take you through the vagaries of finding the income division formula that will reasonably satisfy each partner so the group will hang together and thrive. Read, for example, the “golden rules” of designing a physician compensation plan; see why a three-tier formula can boost practice success; and learn equitable ways to compensate physicians for taking on extra call duty, administrative work and group leadership.

Lastly, we address pay-out issues like what the departing partner should receive upon leaving the group; ways to make it fair to both the outgoing partner and the ongoing group; and how to bring goodwill value benchmarks into the formula. This down-to-earth reference book will help you understand and apply all the factors involved in partnership arrangements. [*\$99*]

Medical Office Staff Development Series

- a. *The Receptionist Manual*
- b. *The Billing Clerk Manual*
- c. *The Medical Assistant Manual*

A first of its kind, this series of manuals guides you through all aspects of overseeing a job position. Each manual (one per position) is a comprehensive guide to making each position as effective and productive as possible. Included are answers to the following:

- What are your practice’s needs for the specific position
- How to structure the position for your practice, with suggested special instructions and procedure descriptions
- How to recruit for the specific position, with sample job descriptions and help wanted ads
- How to hire the right person, including interview tips
- What you need to do to train your new hire for success and incorporate him/her into your existing environment
- How to evaluate the worker’s actual job performance as applied to the position, both during an initial probationary period and then as a regular employee

An accompanying diskette for each manual enables you to download, adapt and print out a myriad of valuable forms for each position — so you can use them hands-on in your practice.

[Buy any one for \$125, two for \$225 or all three for \$300]

How to Build Your Practice’s Best Staff

Your staff is your practice’s largest investment, so it’s vital that you develop it into a smoothly operating, profitable office team.

We show you proven techniques to recruit, hire, train, motivate and retain superior staff, plus how to use your staff to increase productivity and profitability. Among the many topics covered are:

- Assessing how many staff you really need
- The hiring process for new staff: placing the ad, top 10 questions to ask every candidate, best approaches to skills testing and reference checking
- Setting fair salaries — you’ll know if your offer is in line with your peers
- How to evaluate if your benefit package measures up: setting up 401(k), cafeteria plans, profit-sharing programs and more
- 5 steps to successful job skills training
- The importance of a complete personnel policy manual and how to create, revise and review your existing manual
- Equitable performance evaluations and raises
- Conventional and creative ways to motivate employees
- Advice on disciplining or dismissing
- Compliant termination pay
- Job-sharing and flex-time

Packed full of practical ideas and approaches, this book will help you develop the team you need to increase your practice’s spirit, efficiency and profitability. [*\$99*]

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Thank you!

Special Reports Collection

We've carefully reviewed articles from our practice management newsletters and pulled them together to create what we call special reports. These reports focus on individual areas that are key to succeeding in today's challenging private practice environment. We hope you find them valuable.

Financial Oversight for Doctors Who Hate It

Digging into the hard-core finances of your practice does not merit high priority for many doctors. But you must manage your finances effectively to maintain or improve your practice's profitability.

This practical report, packed full of valuable tools and techniques, helps you:

- Interpret, with understanding, your balance sheet, income statement and cash flow statement
- Learn which key ratios you should watch *every* month
- See which financial reports top-performing practices monitor on a regular basis *and why*
- Watch for the 5 early warning signs of financial problems

Do you currently break out direct, indirect and physician expense? If not, you may be ignoring some insightful data. Also included are tips for monitoring your receivables and payables and much more — all to help you improve your practice's financial management. [*\$44*]

Dealing with Claims Denials

An estimated half of submitted claims are denied or downgraded for no apparent reason. And too many medical practices accept the lower reimbursement or slow turn-around with no argument.

Arm yourself with proven tactics to handle your claims more effectively and receive more of the money that is rightfully yours! This report will help you:

- Set up a detailed payor mapping system to identify problem payors even as you receive the EOBs
- Apply the 5 principles that help you *win* insurance appeals
- Get an insurance payor's strict attention
- Streamline your appeals process with our sample form letter

- Learn how to file a state insurance department complaint
- And that's just a sampling of the invaluable tips included. [*\$44*]

Using Physician Extenders Effectively

The average extender often produces twice as much *collected* revenue as their salary! This report shows how to recruit, hire, train and use physician extenders to boost your practice's success.

- Learn proven techniques for building a strong team
- How to educate your patients that extenders *improve* your quality of service
- Why you can bill confidently for extender services, often at your full fee
- Sample contract and employment agreement
- Guidelines for the clinical management of your extender

Separate Report for Selected Specialties

All the content of our basic report above is included *plus* extra articles specifically applying the concept to these specialties:

- For Cardiology
- For Orthopedics
- For Ob/Gyn

[*Standard version, \$44; Specialty version, \$49*]

Convert to Paperless Charting

Electronic Medical Records (EMR) are here. They are necessary. They are reliable. They are efficient. They save you time and money. If you haven't converted your practice, do it now — but do it carefully.

Although success stories and testimonials about the benefits of EMR are included, we go beyond that validation to give you practical tools to implement the conversion, such as:

- The 2 critical questions to ask when evaluating a system
- 5 elements of a successful implementation strategy
- How to decide what charts to convert
- Strengths and weaknesses of various input devices
- Who should be on your "action team" and a broader "evaluation team"
- Why a "non-techie" physician is an ideal candidate to get the process going
- How to develop office acceptance and enthusiasm for the change

Also included is a worksheet to measure your return on investment by moving to EMR. [*\$44*]

Accommodating Senior Physicians' Unique Requests

Now here's a topic we're sure you've encountered and quite possibly struggled over. Can a senior partner drop call duty, and, if so, at what price? What about a senior who seeks to curb his or her workload? Can/should a senior be able to continue as a partner — and at what pay — if s/he opts to semi-retire? And how can you help set up a plan for someone who is partially retiring so it works for all concerned? [*\$44*]

Measuring Practice Success: Benchmarking Basics

Since you can't manage what you can't measure, this report gives you important tools to accurately compare your practice's performance with industry standards.

Included is actual benchmark data on key medical practice financial information such as gross/net charges, collection ratios, expense ratios, overhead and profit. Also see national data by specialty for accounts receivable, physician compensation and liability insurance costs. Plus, this report gives you:

Measuring Practice Success, continued

- Techniques and advice for comparing your data against actual benchmark data in a number of areas
- Which benchmarks really matter and how to apply them — plus the limitations most benchmarks pose
- An explanation of the 12 common management ratios that should make up your practice's "report card"
- Tips on right-sizing your staff to achieve your financial goals

With sound information for any medical practice, this report provides a solid foundation for financial benchmarking and analysis. [S44]

How to Identify and Introduce New Practice Services

It's time to widen your revenue stream by finding new activities and services — especially given the absolute limits on maintaining or increasing income through normal strategies.

Thinking "outside the box" can keep your practice both dynamic and profitable, and this report, packed full of creative yet practical ideas, can help. Recent studies of so-called "Best Practices" show that many

of them attribute their continuing financial success to providing new services.

- Learn how to find new revenue opportunities and integrate them into your practice
- Learn how to test a new revenue generator that fits your specialty and how to plan it out to minimize the new venture's risk
- Consider "value-added" marketing to generate new opportunities
- 3 important steps to follow *before* launching a new venture
- Take a close look at Stark II
- Once started, evaluate your new service's profit level and its success in serving your patients

Separate Report for Selected Specialties

All the content of our basic report above is included *plus* between 10 and 20 extra pages specifically applying the concepts to these specialties:

- a. For Cardiology
- b. For Orthopedics
- c. For Ophthalmology
- d. For Ob/Gyn
- e. For Pediatrics

[Standard version, \$44; Specialty version \$49]

Malpractice & Liability Issues: Protect Your Practice and Personal Assets

The malpractice insurance crisis continues to hit hard. Regardless of your outlook on the premium-pricing crunch, there really are things you can do to protect both your practice and yourself. This report addresses both approaches head-on. Part I deals with your practice:

- Ways to protect your practice's finances, such as hunting for still-available discounts, fairly allocating premiums among partners, dealing with "tail" coverage and possibly self-insuring.
- Ways of "malpractice-proofing" your practice, like how to train staff in risk management and whether to introduce patient-level arbitration agreements.

Part II addresses the liability concern from a *personal* level. A number of available asset protection strategies can help shield your wealth, such as:

- Simply shifting ownership
- Deflecting more to retirement plans
- Creating more complex family limited partnerships and asset protection trusts.

Far more than an issue only for the high-income practice or the wealthy doctor, every physician should understand these options. [S44]

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