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NUMBER 139
DECEMBER 1993

Managed care: Negotiate a contract you can LIVE with

There are people in this world who will tell you that "managed care" is a medical term. It isn't, it's a *business* term; it means: *managing money;* and drawing up contracts that determine how, and *to whom*, that money will be distributed. The people who draw up those contracts know a *lot* about money...and a lot about how to *manage* care in order to make money for their own company. Your job—as a *medical* practice—is to provide the "care" part of managed care. Your job—as a business—is to *wisely negotiate managed care contracts that will allow you to practice medicine honorably, professionally, and profitably.*

From a *business philosophy* standpoint, there are two basic types of managed care programs:

1. Those *which your hospital* participates in or manages. Hospitals *respect* physicians as business partners and as medical colleagues; and

2. Those managed by outside firms such as traditional insurance companies and other contractors.

This article deals *only* with outside, third-party managed care firms, and has one objective: to help you *negotiate better contracts with the "money-managers" of the rapidly expanding managed care industry.*

What to look for in a managed care business proposal

There are three basic elements to any managed care contract: patients; money; terms. All three can be called (by the managed care organization): "Great opportunities for you!"—and, in fact, they may be. They may also be long-term financial traps. Let's look at all three, and see how they can work for (or against) you.

Patients. One goal of every managed care firm is to *control patients' healthcare choices* and "offer" those patients to medical providers. So the first questions to ask when

you consider any managed care contract are: How many new patients will you gain by signing up? And how many active patients might you lose if you don't? A *competitive* practice *must* begin with those questions—because if you reject the contract, one of your *competitors* will get all the patients the managed care firm *controls*.

Once you've decided to compete for those *patients*, ask: What level of care has the managed care firm promised to provide? (To find out, read the firm's patient contracts, and make sure the ICD-9-CM and CPT codes they cover correspond to services you can provide cost-effectively.) Then ask yourselves: Is this the level of care we *want* to be responsible for? And what income level will *justify* taking on this responsibility?

What *profit potential* do these patients offer? Are they young, healthy, working people? Are they familiar with *preventive care*, or are they accustomed to living under a run-to-the-doc-and-rack-up-the-fees-for-every-sniffle mentality? These questions should be settled *before* you get to the "Money" part of the contract. Why talk about capitation or fee-for-service reimbursements until you know how much work you'll have to do to earn the money!

Money. Lovely word: Money! Doesn't it sound delightful when a big managed care firm says, "We're going to *pay you* all this *MONEY!*" Well...they're going to pay you as little as you let them under the contract. *That's business!* And *you've got to draw the line when it comes to money...* which means you've got to know *where* the money-lines should be drawn.

In preferred provider contracts the line should be drawn at 75 percent to 90 percent of your "UCR" fee schedule. Practices must learn the cost of providing services to your top 20 (in volume) CPT codes according to patient demographics (age, sex, career) and, based on that figure, determine how much you can afford to discount your UCR in relation to the demographic mix proposed by the managed care contractor you're negotiating with.

Once you draw the line, *take your stand.* Many managed care contracts have "fine print" clauses that allow *your* fees to be reduced if *their* membership falls below a certain level, or if *their* profits don't measure up to *their* expectations. If they won't guarantee fees for the terms of the contract at least require 30 days notice of reimbursement changes and an "early out" clause for your practice.

In capitation contracts: first, find out how many patients the managed care firm intends to "assign" to you; then find out how much their average patient is likely to cost (#of visits x the average cost of the services) and be sure your capitation fee plus the patient copayment is at least that amount or higher. Don't back down more than five percent or ten percent from that figure, or you'll wind up with a long-term, money-losing contract.

Here's the way it works. If your managed care patients are younger and healthier, they won't come to you nearly as often as your older and less healthy patients do. So if you

Legal Reviews: $50.00

Some state medical societies and specialty societies review general contracts of larger managed care contractors and send you a legal evaluation with red flags.

If your society doesn't do this, encourage them to offer this service. It might be worth an extra $50 in annual dues to have this type of help available.

don't calculate the costs or the demographics of the managed care group accurately, you could be contracted to a losing situation.

"Capitation" puts you in an entirely different business: the *insurance* business. *You* will be expected to carry some of the same kinds of risks that are normally carried by insurance companies with millions of dollars in assets and reserves. If you're going to accept those risks, at least collect a high-enough capitation "premium" to give yourself a fighting chance to cover them.

Terms. In business, it's Standard Operating Procedure to figure out the best terms for your*self*, put those terms into "contract" form, and get the other guy to sign on the dotted line. In other words, there's one thing you can be pretty sure of when any managed care representative puts a contract in front of you: There is *room* for negotiation, *but you have to ask for it and ask the right people. (Provider relations isn't the top of the line.)* Here are some things you should ask for:

- Unilateral responsibility—no hold-harmless clauses.
- Reimbursement within 30 days but no more than 60 days. You should be allowed to assess per-diem penalties against the managed care firm if payments are significantly delayed.
- A reasonable claims structure. You should be able to file claims within at least six months after service has been provided.
- A clause allowing you to terminate the contract *for any reason*, on 30 days' notice, with the managed care firm to notify *their* patients and employers that you are no longer one of *their* providers.
- Assurance that your practice will not be bound by changes made in contracts between the managed care firm and its patients and employers or, if you can't get this, a thirty-day "early out" agreement.
- Elimination of "rollover" clauses that renew the contract automatically *unless* you cancel it by a specific date.
- Insist on a "back door" or "hardship" clause that allows you to renegotiate fees and conditions after the contract is signed.
- A provision that frees you from any responsibility for treating managed care enrollees after a contract has been terminated.
- Permission to bill patients direct if the managed care plan should fail financially—assuming that your state law allows this.
- An *"Emergency Clause"* that guarantees you'll be paid for *all* services provided to plan enrollees in an emergency...even if you have to call in physicians who are not part of the plan, and even if you have to violate "normal" authorization procedures.
- Patient may be personally responsible for payment of services patient requests that are not covered by the plan.
- *A Stop-Loss Clause.* Be sure these are realistic with regard to how long you must treat a patient before transferring him or her to long term catastrophic care and what financial responsibility you must assume before the transfer occurs. You might want the contract to state that if treatment for one patient exceeds a specific amount, all future care for that patient should switch to a fee-for-service basis.
- Basic legality. For instance, every managed care contract should—must!—comply with your state's laws governing patient confidentiality.
- A civilized grievance procedure:

Participation is where it's at

Medicare participation leapfrogged ahead of nonparticipation status by 14.8 percent last year, with a record 63.5 percent of physicians participating in 1993, up from 55.3 percent the previous year. Only one specialty decreased its participation rate—Clinic/other group practice went from a 77 percent to a 75.5 percent rate.

Medicare assignment, which includes both participants and nonparticipants, rose to an all-time high in the first three months of 1993 to 93.2 percent of Medicare claims filed.

The most probable reason for the upswing is the ever-shrinking balance billing advantage nonparticipants once held. In 1993, balance billing was held to 115 percent of the allowable (which for nonparticipatings is 95 percent of a participating physician's allowable).

be sure that this is spelled out and that the contract doesn't preclude pursuing action through the court if necessary. Look especially to be sure that procedures are outlined for dealing with grievances in situations where unauthorized referral services are provided.

- *Peer Reviews* must be conducted by actual *medical* peers.

To negotiate the terms and conditions of managed care contracts, *read the contract carefully,* paying special attention to the "Referral/Outside Services" arrangements and risks to you. These describe the services you will be *legally bound* to refer to plan-approved providers outside your practice, whether or not you feel qualified to provide those services yourself.

Then cross out anything you don't like, write in what you do like, add what you'd really like to have, ask your attorney about anything you don't understand, and return the contract to the managed care firm for their approval. Some will sign a *reasonably revised* contract, rather than negotiate over minor issues. Others will insist your revisions are "unacceptable"—and that's where the *negotiating* begins.

They'll say, *"We have all these patients!"*

You can reply, *"We have documented cost efficiencies in our managed care history."*

They'll say, *"We're the dominant player in your market!"*

You answer, *"We're the only practice in our specialty that provides (service)."*

Sound like a lot of fun? Well it's not; it's business, and negotiating is one of the things businesspeople *do.*

Which brings us to another *business* principle: **Never sign a bad contract.** If you can't accept what they offer...if you can't negotiate a profitable deal...walk away. One bad managed care contract can ruin you; just think what a dozen can do! Once you sign a contract, you're stuck with it. You could lose money on it every month, from now until it expires. Or, the managed care firm could fail financially, leaving you with thousands of dollars in uncollectible claims. So, in addition to reviewing and negotiating every managed care contract with great care:

- Don't put all your eggs in one managed basket; never let any one payer account for more than fifteen percent of your total revenues.
- Don't sign contracts with unstable firms; select a few managed care firms that are financially stable, and have provided quality service to other physicians in your own or other medical markets.
- Find out if the managed care firm has any cost-containment strategies: sharing paperwork-reduction systems; purchasing supplies and business services at reduced prices; access to medical and financial data-bases, and subscriber education.

Congratulations: you're in business! You're ready to negotiate with the managed care Goliaths in a *businesslike* manner. They'll tell you, "Here's a wonderful opportunity for you to provide care for *all these patients*; just sign this little ol' contract." That's when you say, "Hey; a contract isn't wonderful unless it's wonderful for our practice and patients! Let's talk."

SPECIAL FOR SPECIALISTS

Collecting bills from "sight unseen" patients

Anesthesiologists...and some other specialists...have a major problem in common: How do you collect from patients who've never seen you, never understood you were called upon to provide billable services, perhaps never really understood the value of your services?

The answer to this problem lies in the catalogs. Penneys, for instance, has sold a bajillion dollars worth of merchandise to millions of customers who never saw the inside of their store; because, in their catalogue, they made all this merchandise look useful, valuable, even exciting! Now, thanks to the magic of inexpensive, readily-available printing, you can do the same thing.

- First, write a brief paragraph explaining the value of your services in general, the qualifications of your physicians and other staff, and the fact that you make your services available upon direct referral from highly-qualified family physicians and medical specialists.
- Second, make an exhaustive (not exhausting; exhaustive) list of your services; after each listing, take a few words to explain the major benefit of the service. (Ex: Interpretation of chest x-ray; 71010—26. Reading and interpretation of the x-ray for medical clearance before surgery.)
- Third, have your printer organize this information into a folder that includes your practice's name and address, and a brief note to the patient explaining, "For the convenience of all concerned, our services are billed separately from those provided by your physician." Print enough folders to supply all your referring physicians, managed care plans, and other business sources for at least 30 days.
- Fourth, distribute a 30-day supply of folders to all your business sources, along with a covering letter (or personal visit) explaining: "These folders describe the benefits of the services you ask us to provide to your patients. They also reinforce the value of your total medical service offer. Please give one folder to each patient you refer to us, so he or she will be more familiar with the medical services that you and we cooperate to provide for them." Or something along those lines.
- Fifth, when you bill those "unseen patients," enclose a copy of the same folder that the physician handed them. On the folder, check off the services you provided to that patient; this will give the patient an automatic "list of benefits" that he or she received from you. (You may also want to write a short explanation on the bill.) The patient, at that point, cannot help but conclude: "Ah! These are the people who promised they'd provide specific services for me. I see by this list that they've made good on their promise; I see by this statement that they've charged me a fair price for the promised services; and now there remains one logical thing to do: pay this bill today. Sheldon, do you have the checkbook? Sheldon! What do you mean, you wrote out our last check for a new set of golf clubs!?"

We believe the lessons in the above paragraphs are conclusive: [1] establish an identity with the patient before you provide ser-

vices; [2] remind the patient of who you are, and all the benefits you've provided, when you send the bill; and [3] never, never, never tolerate anything but a cash-only relationship with anyone who'd marry a golfer named Sheldon! (Just kidding, of course.)

Practice Evaluations

Knowing the problem—the first step to the solution

By James Saxton

When performing an office evaluation or audit, from a risk management standpoint, the first job is to collect information. One reason why offices often don't know where their potential problems lie is they do not have any information. For instance, how long do your patients sit in the waiting room? Do you have a rough breakdown of the type of telephone calls received? Is there a lack of understanding of post-operative instructions? Are there questions about billing? Are there questions about medications? Further, what about how patients feel about your practice?

There are fairly simple ways to collect this information. Having information about your practice is the first step to knowing where you need improvement. Further, the process of collecting the information has many positive aspects to it.

This article will discuss just three areas in which you need to gather information, some suggestions on how to obtain it, and then actions you could take in response to what you learn.

The waiting game

A constant and nagging problem in a physician's office is the amount of time a patient spends in the reception area. The days when patients were pleased or grateful that a physician was even available to see them are certainly long over. Remember, creating the right environment for patients is critical to good risk management and good patient care. There is no longer any doubt that malpractice claims are worth preventing and preventable, and creating the right environment has a substantial impact on preventing malpractice claims.

Creating the right environment has a substantial impact on preventing malpractice claims.

Accordingly, how long your patients wait to be seen is a very important piece of information. Patients want to feel that you care about them, listen to them, and respect them. Long waits in the reception area violate at least two of these wants. To get this information, a simple audit done by your receptionist perhaps twice each year, will let you know how you are doing. The receptionist can simply jot down on a self-made pre-printed form when a patient arrives and when the patient is brought to an examining room. This may sound cumbersome, and it may mean some backup on those particular days, but when you only do this two days each year, the informa-

tion you gain is well worth the hassle. This should then be recorded so that you can gauge whether you fall outside or within the norm for your particular specialty. Further, if the waiting is on the long side—over twenty to twenty-five minutes on a regular basis depending on the type of practice—attention needs to be directed to it.

A number of things can ease the strain caused by excessive waiting. First of all, if your physician is sometimes called out for emergencies, this should be explained to patients during their first visit. It can be set forth in your practice brochure or placed on your bulletin board. A practice brochure can also be used to explain that it is very difficult to gauge how long office visits are going to take, that some visits may take longer than anticipated, and that physicians do everything possible to stay on schedule, but that delays are sometimes unavoidable. This keeps patient expectations in check and also reminds them that there are legitimate reasons for tardiness.

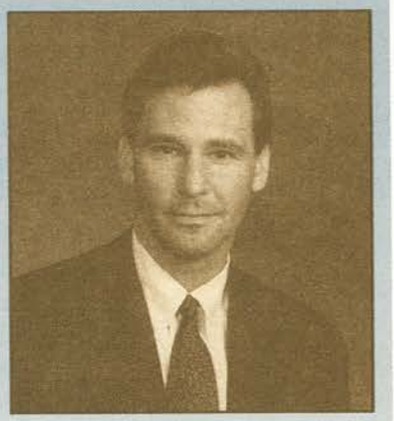
If the doctor is running very late, attempts should be made to let patients know and, in extreme cases, reschedule. Offering the telephone to them to change other appointments or a cup of coffee or beverage is appropriate. It actually does not take much to let them know that you care about them and that you care about their time and their schedule.

There are other more drastic steps that your practice may have to take. If you seem to be running chronically late, perhaps overbooking needs to be cut down by allowing planned work-in space, or a break in the mid-morning or mid-afternoon needs to be added to the schedule since it will serve as a buffer, although ultimately always be filled. Perhaps hours need to be expanded to either start earlier or run later. If your practice is reluctant to do this, you must realize that any economic gain from additional patients may eventually be eroded by loss of patients to other practices and even malpractice suits.

Tell me now or tell me later

The quantity of telephone calls and the type of information which is requested in those calls is important information for your office to be aware of.

Again, a simple audit by office personnel with pre-printed, self-made forms recording telephone requests during a specific period of time can provide valuable information. This can be accomplished easily by using a form with headings such as "questions about diagnosis," "questions about surgery," "questions about post-operative instructions," and "other" and having your staff check off the type of information that was requested. Of course this checklist will depend on the nature of your practice. An abundance of calls concerning diagnosis could lead to the conclusion that the quality of information provided to the patient in the office may need attention. Questions about post-operative instructions or pre-operative instructions leads one to the conclusion that additional



James W. Saxton is a partner with the law firm of Barley, Snyder, Senft & Cohen with offices in Harrisburg, Lancaster, and York, Pennsylvania. Mr. Saxton is Chairman of the firm's Healthcare Litigation Group. His entire practice has focused around the representation of healthcare providers and litigation and counseling them on healthcare related issues. Mr. Saxton acts as a consultant for physician offices and helps medical offices in their efforts to set up practices, protocols, and documentation to prevent malpractice claims. He has spoken and written extensively on the subject and co-authored a textbook about risk management which will be published by Plenum Publishing this Spring.

information needs to be given to patients and perhaps written instructions are needed by the office.

What is interesting is that an office which gathers this information and uses it to create forms and develops protocols for providing more and better information, can greatly reduce the number of phone calls received.

Telephone calls are a strain on the practice. The receptionist receives a call, which takes up time and distracts from receiving patients. Your receptionist perhaps misses the golden opportunities to connect with the patients entering the office. The best solution is to provide quality information in verbal and often written form initially. This is good practice, prevents malpractice law suits, and pleases patients. It also helps the office run in a more economic and efficient fashion.

Seek and thou shall find

For offices that are brave, yearly evaluations can yield great information. It can be a simple survey form given to patients as they leave or it can take on multiple formats. It can be developed as a self-mailer that patients can easily return or handed out along with self-addressed stamped envelopes. More sophisticated surveys can be mailed to patients' addresses to be sent back in or dropped off.

No matter what the format, the point is to get the survey into the hands of as many patients as possible with questions concerning your practice.

Questions may include rating your reception area on a scale of 1 to 5, the length of time spent in the reception area, the quality of information provided by the doctor, the information they received about their medical treatment, and of course an open ended question as to suggestions for making them more comfortable or how you can improve service to them.

Practices have gotten tremendous information and sincere, good suggestions out of such surveys. However, be forewarned that if you are going to ask, you need to follow through. Good suggestions need to be followed up on and problem areas need to be addressed. Patients need to see that problems once brought to your attention were dealt with in a positive fashion. This does not mean that every suggestion needs to be followed, since many will be impractical or unrealistic. However, a good faith effort must be made to follow through or the time you spent on the project will be wasted.

All of the above are easy ways a practice can find out how they are doing at creating the right environment for their patients. Further, just the fact that they take on any one of these projects says something to patients. It says that you care about them, respect them, and want to involve them in helping you create a better environment for them. Therefore, there are positive aspects to just embarking on the process. Once information is collected, it is important that steps be taken to resolve problems that are encountered. Often once your staff has gone through this process and has taken steps to resolve problems, they will find that patients are happier, the office is running more efficiently, and they may well experience a positive economic impact for their efforts.

How to get those records out of the doctor's attic!

Where do you put all those inactive, semi-active, and legally-required-thanks-to-consumer-activist *records,* when you run out of "extra" office space? You guessed it: up in the doctor's attic. Which is the worst possible place for them, because:

- They're definitely a fire hazard
- You can never find what you're looking for
- It's only a matter of time before they outgrow the attic and start coming down the stairs to get you
- They rob you of your heritage

Airline pilots, bricklayers, even traffic cops have atticsful of heirlooms, photo albums, and other family treasures; but what do doctors have up above their families' living space? Records!

Fed up with it?
Here's what to *do* about it!

- Call a professional records storage company. (Usually listed in the Yellow Pages under "Storage/Commercial" or "Archives"; but if you can't find one, ask your lawyer or banker.) They know how to take care of records. Then, separate the files you really need *now* from the ones you really don't; take the not-really-needed records *away* to where you'll never see them, dig through them, or trip over them again; set up a retrieval system; and deliver any document you may need, by FAX or messenger, at your beck and (telephone) call.
- Or, rent a self-storage shed. Divide your records into four categories (Patient; Business; Taxes; Misc.), and put them in boxes labeled by category and date. The shed has four corners; you have four categories of records; put the oldest-dated box of each category in a corner, and begin stacking outward until one of two things happens: [1] all records are neatly stacked; [2] you run out of space.
- Or, check the Yellow Pages for a business that can microfilm your records for easier storage.
- Or cull your files every year, throw away (or shred!) anything that doesn't *have* to be kept, and arrange the remainder of your office space (and your worklife) to accommodate your relentlessly-growing records. *How long* must you keep those records? Some—

under various federal and state laws—will be with you *forever.* Below, for your information, is a general "records retention schedule." Be sure to check with your state officials for more information on records retention requirements.

General Records Retention Schedule

- Adult patient records should usually be kept 10 years after the patient becomes (for whatever reason) inactive.
- Children's medical records should be kept for 10 years after the patient turns 21 (unless he or she continues as an active adult patient).

(Check with your state medical society for further information on these first two regulations.)

- If there is any indication of a malpractice suit being filed, the medical records of all patients involved must be kept until the suit is settled and the appeals process is exhausted.
- Date of discovery plus ten years
- Patient financial records (including insurance payments and bankruptcy-related papers) should be kept three years after the claim is satisfactorily settled or the debt is legally discharged.
- Employee tax and payroll records must be kept for seven years.
- Records relating to employees' work-related injuries/illnesses must be kept 30 years. Yep: thirty years!
- Insurance contracts, pension plan agreements (including IRAs and Keogh plans), and investment-related records should be kept for at least three years after the plan or agreement is terminated and all practice and/or personal funds are withdrawn.
- Records related to real estate and other property investments should be kept at least three years after the asset is liquidated.

This is only a partial list. For more specific information and advice, contact your state Professional Society, lawyer, CPA ...or a professional records storage company.

Sooner or later, you *will* need some type of professional records management service. Federal, state, and local laws—plus a herd of lawsuit-happy malpractice attorneys—are forcing U.S. physicians to *document/**document/DOCUMENT*** everything you do, every time you turn around...and it's only a matter of time before you turn around to find yourself buried in documents.

We suggest you contact a Records/Archives specialist sooner rather than later...find out what services they offer...and how much time/grief/money those services will save you in the long run.

Enter our First Class Mail contest and you could win $50.

Send your practice management ideas (no clinical subjects please) to:

First Class Mail
The Doctor's Office
P.O. BOX 10488
1861 Colonial Village Lane
Lancaster PA 17605-0488

Idea: Get "signature on file" when the patient is *able* to sign.

Our physicians see most of their patients in the hospital, usually in Critical Care, giving us little opportunity to get the "signature on file" required by Medicare and other carriers.

To solve this dilemma, we mail every patient a letter reintroducing our physicians, describing our specialty, and explaining why we were called in as consultants. We then recap all the insurance information given to us by the hospital, and ask the patient to make corrections and additions right on the letter. The letter also includes a Medicare-approved disclosure form for the patient to sign, date, and return to us in a postage-paid envelope. This gives us "signature on file"...a wealth of *confirmed* insurance information...plus closer relationships with our patients!

Mary Smith, Office Manager
Pulmonary Associates
Cherry Hill, New Jersey

Idea: Attract new patients...by helping current patients!

It amazes me how many people are in need of medical support services, community services, even basic transportation... and this problem seems to be getting worse as government programs are cut back.

To help out, we've dedicated part of our reception area as a Public Service Information Center. We have local bus schedules, along with forms for Senior and disabled citizens to fill out so they can qualify for reduced fares. We have phone numbers and information for support groups ranging from Recently Widowed Alzheimers to "Golden J 55." We have nutritional and dietary information—for patients who have various ailments and for those who want to stay well—plus facts about Food Banks and other ways to help our patients stretch their food dollars.

The cost of doing all this is nominal; the rewards—in word-of-mouth referrals and in personal fulfillment—are...amazing!

Carolyn B. Kerr, Office Manager
Podiatric Associates
Johnson City, Tennessee

The Doctor's Page

A monthly bulletin for the Physician from **The Doctor's Office**

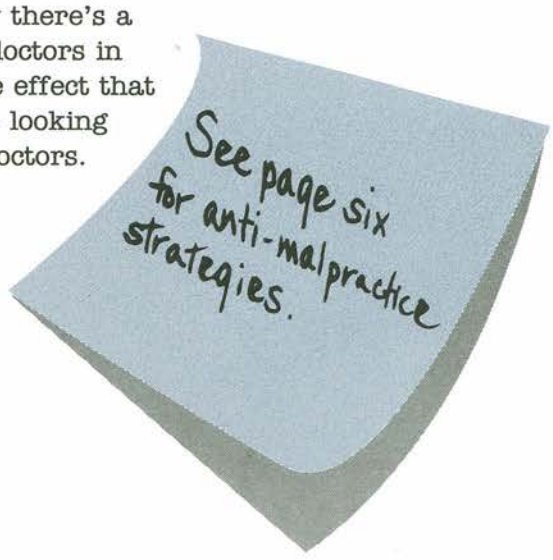
December 1993

Group Practice Without Walls: Handle With Care. It seems to be one of the hottest new trends—several small groups "merging" to increase their bargaining clout, without really moving any doctors from their present physical locations. But if you're looking to go this route, there are several legal hurdles you've got to make sure your lawyer has addressed. You've got to make sure you're not violating antitrust price-fixing rules. You've got to take a close look at self-referral laws. And you've got to be sure that you're complying with the complex rules related to tax-sheltered pension and profit-sharing plans.

Refer A Referral? According to a recent survey, 85 percent of primary care physicians want to be notified before a specialist further refers their patients to other specialists. It's probably one of the most striking examples of the need to keep in touch with referring physicians, and some experts suggest you could lose referral sources by violating this courtesy.

Banks Work On A Better Mousetrap. With some powerhouses like New York's Chase Manhattan Bank taking the lead, banks across the country are starting to offer life insurance. Although you'll still need to do comparison shopping, the costs are expected to be lower because there's no need for sales commissions or separate offices. But for busy doctors, the real appeal may be the speed of processing applications. Because approval is based on saliva tests rather than physicals, it's estimated that approval time is shaved from about a month to about a week.

The Future Of Practice Goodwill Values. When a young doctor buys into an existing medical practice, the value of the goodwill he or she is buying is frequently factored into the salary arrangement. This is risky to the new doctor from a tax point of view, because it seems like an attempt to circumvent complex rules on the deductibility of the cost of goodwill. And now there's a new risk from the point of view of the existing doctors in the practice. Since many doctors are wary of the effect that health reform will have on their income, they're looking for ways to guarantee more income to present doctors.



Create a community "Colleague Consulting Co-op"

"You can see a lot just by observing."
—Yogi Berra—

Very close to you—perhaps in your own office building, or across the street—is a practice that has a collection ratio 2.2 percent higher than yours...or a monthly electric bill 8.6 percent lower...or a waiting room where hardly anyone is ever kept waiting. You may wonder: "What are they doing *right* that we must be doing *wrong.*" And then comes the fatal thought: "Maybe we ought to bring in a high-powered (and high-priced!) *consultant* to 'fix' all our problems."

Save your money. You've already *got* a whole big bunchful of *expert* consultants... right in your own medical community!

Here's how to find the consultant(s) you need:

1. ***Identify*** your problems...anything from a low collection ratio, to patients complaining about busy signals when they call you, to people getting "lost" on the way to your office.

2. ***Target*** the most troublesome problem, and identify a practice that does *not* have it. (They may have other problems; lots of others; but not *that* one.)

3. Have your doctor or Office Manager ***ask*** their doctor or Office Manager if one of your staff can visit the practice, spend an hour or so hanging around the work-station where the problem is *not* happening, and see what they're doing *right.* And/or...invite one of their staff to visit your practice, hang around the place where the problem *is* happening, and suggest ways you can do the job *better.* Either way, take a few common-sense steps to make sure patient confidentiality is not violated, and no *individual patient financial information* or practice fee information is exchanged.

4. ***Solve the problem***—by applying everything you've learned from your own observations, plus any tips your colleagues may have offered—then go on to target (and solve!) your second-most-troublesome problem. Continue the process until you run out of problems.

5. To ***return the favors*** your colleagues have conferred on you, identify those office procedures you handle especially well, and invite practice staff from all over town to visit you and "see how it's done *right.*" This not only helps you and your colleagues improve operating efficiency, reduce workplace stress, and contain costs...it ***markets your practice to referring physicians all over your community.***

Finally...do you have an employee suggestion box? Oh, you should. You'd be *amazed* at the number of employees, in all kinds of companies, who have good money-saving/time-saving/grief-saving ideas, but never share them because "Nobody ever asked me." So ask! Put a box in the employees' lounge or lunchroom, and offer cash rewards or dinners-for-two or a reserved parking space for a month to anyone who puts in a great problem-solving idea (and be sure to acknowledge all the ideas you receive whether you can use them or not). Believe us, you'll *get* them! Do you ever wonder where all the great ideas in *The Doctor's Office* come from? A lot of them come from people who work in medical offices *just like yours!*