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employed physician groups plugging the facilities cost drain

A rational approach to group practice facilities will curtail building and occupancy costs over the long run.

AT A GLANCE

- > Building and occupancy costs related to employed group practices are a formidable challenge for hospitals and health systems.
- > To improve this income statement line item, healthcare organizations can establish an accurate diagnosis (and acknowledgment) of the problem.
- > They also can develop a rational and consistent organizationwide approach to group practice facilities.

A hospital-employed primary care group has 36 providers (28 physicians and eight midlevel practitioners) in approximately 16 practice locations (about 2.3 providers per location). Ten of the 16 practice locations are located within a single zip code, with the result that the physicians end up facing stiff competition from each other.

A community hospital designs and builds a 5,000-square-foot building for a hospital-employed primary care group. The building is designed for a maximum of two providers and does not include space for significant ancillary services, preventing any opportunity for future expansion of the practice.

A 140-provider multispecialty group practice with 57 practice locations designs and builds nine new practice sites for 32 providers. Number of locations using a common footprint approach = zero, resulting in a lack of brand identification among the practices and the hospital owner.

Hospital-employed group practice facilities and their locations are often a function of decisions that were set in motion years earlier and involve past commitments and sunk costs. Even in best-case scenarios in which groups are starting with a blank slate from a facilities perspective, getting to the right facilities answer (size? location? cost?) can be difficult without the correct set of initial criteria. Can groups that are stuck with past decisions find a logical way out of their current facilities box (given the very real financial constraints of the current healthcare environment)? How can groups that are lucky enough to have a blank slate minimize the odds of going down the same unsuccessful path taken by others?

How Did We Get to This Point?

Although each hospital-employed group's history is different, many share at least a few common evolutionary themes in terms of how they were put together. These themes often contribute to the development of an employed physician group with a less-than-optimal facilities solution.

An employed group is the sum of its original parts. If an employed group has been built, to a significant degree, through the purchase of existing physician practices, there is a good chance that physician-owned real estate was also part of the original practice acquisition. In many instances, the purchase of physician-owned real estate was a necessary requirement for an independent physician group to join an employed model. From a physician perspective, it was logical to get out of a significant investment in real estate at the same time that the practice was being purchased. However, the result was the development of large employed physician groups with too many distinct practice locations and too few providers (one or two) per location. Although it may be necessary to have primary care practices placed close to where patients live, having multiple, small practice sites in close proximity to each other (sometimes within several hundred feet of each other) is a difficult model to effectively manage.

Physicians no longer foot the bills. In an independent setting, physician shareholders' take-home compensation is directly related to practice costs. Therefore, the benefits of increased building and occupancy costs are weighed against the costs and impact on physician take-home pay. This natural relationship is lost within most hospital-employed groups. Employed physicians with no financial responsibility will often participate in the planning of new clinic facilities, contributing to the construction of space/locations in which the square footage per provider FTE is significantly above the industry norm for independent physician groups. Employed physicians who were previously in independent practice will see the benefits of more and larger exam rooms, break rooms, and conference and meeting rooms. (Meetings previously may have taken place in the waiting room after hours.)

Clinics are planned and designed by hospital (rather than clinic) operators. In many cases, sites built for employed physician groups end up being quite similar in design/cost structure to other hospital/health system facilities. As a result, the cost structure of these sites is also similar to hospital space, which may cost 50 percent to 100 percent more on a per-square-foot basis than space used by independent physician groups, which are financially responsible for all costs related to their clinic. Put another way, hospitals and health systems are operating a "\$100 per square foot business in \$200 per square foot space." Why the difference? Factors that can contribute to more expensive outpatient facilities include everything from interior/exterior design decisions to the actual materials used on the project.

Groups get caught up in the "arms race." Competitive factors within individual markets can lead to the design and construction not only of more clinic locations but also in space that is designed to "keep up with the Joneses" from an appearance standpoint. Although this approach may be attractive from a patient point of view, it again layers additional costs into an employed physician practice that would not exist if the practices were independent and therefore had to fund the added facility costs out of their own take-home pay.

Performance and strategy sometimes collide. Ultimately, employed physician groups are developed to support the overall strategic objectives of hospitals and health systems. Therefore, facility decisions are also driven by hospital strategy rather than what the clinic would pursue independently. A health system with a strategic goal to significantly increase the number of employed physician FTEs over the next several years will need to build future clinic/outpatient facilities with the excess capacity necessary to absorb future providers. In the interim, the existing physician group typically absorbs the excess cost burden related to the hospital's provider growth strategy.

Is There a Simple Solution?

Probably not. The potential solution can be complex and multifactorial. However, getting to a

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more rational facilities approach can be simplified by following some basic principles.

Develop (and implement) a long-term strategic approach to outpatient service delivery. The truth, in many cases, is that hospitals and health systems do not have a strategy-driven approach to delivering outpatient services, including both physician and diagnostic services. A strategy-driven approach that attempts to answer key service and facility questions (where? what services? what specialties? financial implications?) will, in many instances, result in hospitals/systems pursuing fewer but larger outpatient sites or "footprints." Not only will larger footprints allow for the development of more efficient physician services, they also allow for the provision of a more robust offering of outpatient/diagnostic services, such as lab, X-ray, computed tomography, magnetic resonance imaging, and therapies. If a full cadre of ancillary testing/diagnostic services are offered in close proximity to physicians, will the utilization of system-owned ancillary services increase (assuming utilization is appropriate)? If utilization rates stay flat but testing previously referred to independent physician group ancillary services stays in house, the system will realize a net gain and patients will have access to more services in a single location.

Identify the correct footprint and stick to it. While many employed groups are locked into their current sites in the short term, the reality is that over a five-year to 10-year period, the organization will have an opportunity to rethink many of its locations/sites. In these instances, the group should develop a common approach to its ideal group practice footprint and consistently use it. Too often, new site designs within employed groups are driven by the practice styles of current providers, which may differ significantly from other subgroups within the organization. When this occurs, the opportunity to build more similar practice sites and develop a groupwide culture is lost.

Disconnect strategic costs from operating costs. The reality is that many hospital-employed groups are developed as part of larger strategic goals driven

by the overall health system. If the health system strategy is the right strategy and results in facility costs that cannot be supported by an employed physician group, the costs of these strategic decisions need to be disconnected from the performance of the group. Examples can include breaking "strategic" practice locations into a separate profit and loss statement, e.g., new practice start-ups on the periphery. Another option could include allocating adjusted building and occupancy expenses to the group that only reflect what costs would be in a typical independent practice environment.

Stick to the basics. In reality, practice leadership can continually circle back and ask some basic questions regarding practice facilities/locations, such as the following:

- > Number and size of practice locations? With the exception of strategically driven locations (e.g., defensive practice locations), a consistent focus on fewer sites with a larger number of providers will allow for improved practice performance.
- > Specific target provider FTEs per site? The easy answer is the more the better. In reality, the answer will differ by specialty. For primary care providers, a goal of a minimum of four to six FTE providers (or greater) may allow for increased efficiency while still allowing the group to locate sites in necessary geographies. However, sites on the periphery of a service area will support fewer providers and need to anticipate the ability to allow for "circuit riding" specialists who provide services on a part-time basis (which only increases the inefficiency of these strategic sites).
- > Square feet per provider? Again, the answer to this question differs by specialty. For primary care providers, a hospital may target an ideal ratio of 1,500-2,000 square feet per provider. If square footage per provider is significantly above the target range and the site is not designed for additional provider growth, the group is being locked into space that will not work well from a profit and loss perspective. In addition, square footage will be affected by how and where key physician group functions (e.g., administration, billing/collections, scheduling) are provided. To the extent that functions are

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provided at a centralized location, total square feet per provider targets for clinic sites should be adjusted accordingly.

What's Next?

The bad news: There is no quick fix to the facility/building and occupancy issues currently faced by many hospital-employed group practices. What can be accomplished in the short term is the creation of a more accurate profit and loss snapshot of the group's performance through a more rational methodology for allocating realistic (versus strategic) expenses to the group. The good news: There probably is a more effective (and less painful) long-term solution.

In the long run, organizations can get to better, more effective facility strategies for their employed group practices if they move to more consistent models that not only support the

efficient and effective utilization of physician services but also the appropriate build-up of supporting ancillary and diagnostic services. Short-term pain will be realized in pursuing a common, more rational facilities approach. But over the long run, the long-term benefits of a more rational facilities/building and occupancy approach should far outweigh the costs of getting there (and the frustration of explaining ongoing physician group losses to the board of directors). ●

About the author

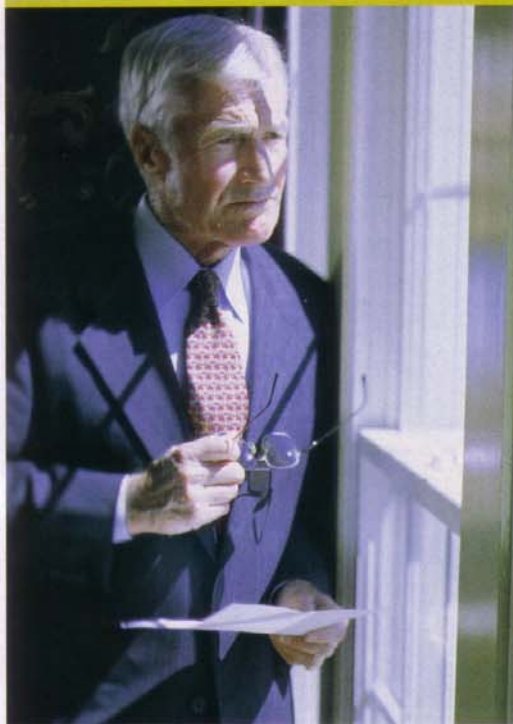


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