Cutting costs to help your practice thrive

By Janet Kidd Stewart
On November 22, 2015

No one wants to be the person nitpicking how much money is being spent on paper clips. And yet, with payers willing to deny claims for the slightest deviance from billing protocol, you could hardly be blamed for turning the heat down and shutting the lights off early.

How to cut costs without coming off like a substandard practice to patients or a Scrooge to employees, both of whom need to be cared for properly? It's a balance, practitioners say.

Carl Olden, MD, a family physician in Yakima, Washington with Pacific Crest Family Medicine, recalls going to see a colleague about 20 years ago for a consult on a neurosurgery procedure.

The secrets to financial flexibility

“The space he carved out for his office retreat was three times larger than mine and fitted with stuff he did not need,” Olden says. “I realized the money was going to accoutrements, not care.”

Of course, there is a fine line between projecting a professional image through office décor and simply wasting money.

On the one hand, a practice that replaces aging institutional décor with warm, comfortable furnishings and colors is considered not only patient-friendly but additive to healing. And presenting a warehouse-store image can be unsettling for patients and employees alike. On the other, cutting practice expenses increasingly is viewed as being helpful to patients, given their increasing financial burden.

Setting priorities

“We have to do a better job of spending our healthcare dollars. The leading cause of bankruptcy in the U.S. is unpaid medical bills,” Olden says.
He says his seven-physician primary care practice “takes a minimalist approach,” meaning providers share office space.

“The physician office with walnut furniture and art work is non-productive space, so we were intentional in making physician space a low priority, while the workspace for staff and patients is larger,” he says.

Right-sizing staff

A much bigger challenge, providers say, is getting and keeping the right mix of staff. Generally, staffing costs have declined slightly since 2010, according to the latest Medical Group Management Association (MGMA) cost and revenue survey. Costs in specific specialties vary, however. Physician-owned cardiology practices, for example, saw an uptick in support staff costs of about 2.3% over the period, according to a subset of MGMA data run for Medical Economics.

The fact that staffing costs were basically flat while overall operating costs grew by 12% through the end of 2014 suggests that practices have scrutinized this category, says Laura Palmer FACMPE, a senior fellow with MGMA. Practices are spending more on electronic health records (EHRs) and other technology and on non-physician providers, while holding down increases or spending less on support staff, she says.

How to turn skilled physicians into strong leaders

Don’t celebrate too quickly on the staffing cost savings, however, providers and practice managers warn.

“Everybody looks at staff costs as the big challenge,” Olden says. “If you control them to the extreme and reduce staffing to a minimum and offer skeleton benefits, you’re going to have turnover, and turnover kills you.”

Susanne Tetzlaff, JD, an attorney who manages Austin Cardiac Clinic for her husband, solo practitioner Eric Tiblier, MD, says investing in a generous retirement and health insurance plan for employees has helped keep turnover costs to a bare minimum.
Hiring an insurance coordinator dedicated to the practice also has translated into savings because of more accurate coding, she says. “You really need someone who understands” the nuances of how various types of cardiology pain complaints need to be documented, she says.

Olden’s general practice is part of an integrated delivery system with centralized coding and staffing and group rates on standardized supplies.

And while some practices are staffing up in nursing rather than hiring more providers, his practice is doing the opposite, proving that practices need to customize their budgets and set their own priorities. The practice employs medical assistants (MAs), but no nurses, he says.

“There are some tradeoffs, some things RNs can do that MAs can’t, and so it’s physicians that have to triage, but overall it has worked well,” he says.

The value of a pension: 3 considerations
In fact, the practice is now experimenting with adding MAs, which raises labor costs but more than pays for itself, he says.

“We’re looking at doubling up. We’ve had a 1-to-1 MA/physician ratio for the last 10 years and are now experimenting with 2-to-1. One of my partners is piloting this and with two doing the non-physician functions like documentation and quality measurement, he can see five more patients a day and actually be done at the end of the day,” Olden says.

Re-thinking service menus

Because of the no-nurse structure, his practice also made the decision not to offer annual Medicare wellness visits, which are reimbursed in such a way that typically requires a nurse to perform them, he says. The practice also does a daily huddle, a three-to-five-minute meeting for everyone in the practice, he says.

“We figure out what the day looks like, where there is increased capacity in the schedule, what issues came up from the previous day,” he says. Such on-the-fly scheduling reduces costly down time and re-scheduling patients.
Another scrimp: His office stopped seeing pharmaceutical reps, which means the practice doesn’t get free samples.

“We don’t have people coming in just to get the free samples now,” he says. “It was also a lot of work for staff to document, so it’s a cost savings for us in time spent with the reps and in documenting where the samples ended up.”

He says the change has dramatically cut the number of prior authorization calls he has to deal with (because time saved is money saved) and it helps patients stick to generics instead of getting started on pricier brand-name medications.

Shopping smarter

Meanwhile, Tetzlaff spends a fair amount of time hunting for bargains where she can.

“I shop around and am very cost-conscious,” she says. “A lot of times the medical supply companies won’t have pricing in their catalogs because everybody gets a different price depending on how much you’re ordering,” she says, creating a situation where a time-crunched MA might not press for better deals. “So I work with vendors, pitting them against each other on price, and I’m able to get the better prices that bigger cardiology groups tend to get,” she says.

Shopping around for the best deal on laser services is another area where she has realized substantial savings. “There’s a big variation in the hard costs as well as the total costs” associated with ancillary services, she says. In addition, she negotiated about six months’ free rent and a substantial upgrade allowance in their Austin offices, despite the rapid rent increases taking place in that city now.

“But being in a nice building with a central location and plenty of parking is part of the reason behind having a successful practice,” she says. “Some physicians have downsized, and patients notice. But landlords don’t want turnover in the building and there is a new place near us that is huge, so they knew we’d have other options,” which provided some leverage to get the perks, she says.

Another saving strategy has been to forego an automated telephone system for making appointments.
“We really try to focus on providing personalized care, and patients hate those automated systems,” she says. “We’ve actually had patients call us when they have a question for another one of their providers, but they tell us they couldn’t reach that doctor so they called us.”

And when it gets down to the nitty gritty on items such as toilet paper and office supplies, Tetzlaff goes to the big-box consumer warehouses instead of ordering through business suppliers.

“You can get postage stamps for 75 cents less at Costco than you pay at the post office,” she says. “It’s a loss leader for them. I buy everything there from Clorox wipes to Post-Its and highlighters.”

She even buys white towels at the warehouse in bulk and washes them herself. “They’re actually really soft and nice for patients having echo procedures,” she says. “I don’t leave many stones unturned.”

Inspiring passion

Other providers and office managers echoed that sentiment.

“This is a way of life for us, what we live and breathe,” says Debbie Emmons, office manager for Glenn Womack, MD, a family practitioner in Flemingsburg, Kentucky. Getting staff buy-in for practice cost cuts is easier when put in context with declining reimbursements, says Womack.

“I’m a country boy that started with nothing, so I try to do some things to save money,” he says, adopting a philosophy that comes down to, “If you don’t do windows, don’t live in a house full of windows.” By that he means trying to hold down expenses he can control. For example, his practice hired an engineering company to study the optimal energy-use plan across its four offices.

Small changes add up

Simple steps such as turning off the lights and putting locks on air conditioning and heating controls, as well as spreading certain costs over a 24-hour period to take advantage of off-peak rates have made a difference, he says. Recently, Emmons dissected the 15-page phone bill the practice typically receives and found charges for modem lines it no longer uses. She cut out unused features in the service
package, reducing the bill substantially, she says. She also quit paying hundreds of dollars per year on maintenance packages for equipment like printers and scanners and now buys them on eBay.

With its income declining, Womack says, his practice did have to make some cuts that were more painful. Last year the practice reduced its nursing staff uniform allowance and stopped giving employees eight extra paid hours for their birthdays. The cost cuts, when taken together with other savings strategies, have helped the practice avoid layoffs.

“We’re not extreme cheapskates but we do evaluate new equipment by doing a budget analysis that tells us how long or how many procedures it will take to recover our investment costs,” Emmons says. And Womack makes a point of evaluating detailed bookkeeping reports and meeting regularly with staff about expenses, which keeps costs at the top of other staffers’ minds, she says.

“You can’t just talk about this once a year,” Emmons says. “We meet frequently to see where we are and where we’re going. If we see there’s a need to add a service line like allergy testing or imaging, we make sure it pays for itself and is medically necessary.”

And speaking of reminders, those Costco Post-It notes are another low-budget way of implementing cost savings right away in your practice, says James Welters, MD, with Northwest Family Physicians in Plymouth, Minnesota. The practice was identified by researchers at Stanford’s Clinical Excellence Research Center and Peterson Center on Healthcare as one of 11 high-performing primary care practices that delivered high-quality care at lower-than-average cost.

As his practice looked for ways to trim costs, it found a substantial savings by maximizing the services it provides to patients in a single visit.

“If they come in for a cold and are due for immunizations or a screening test, we try to take care of it right there so we avoid a lot of repeat visits,” he says. “We also wrote some standing orders where we could so staff would be empowered to order certain tests.”

By performing more services in-house, such as colonoscopies and stress tests, Northwest gets the income and keeps patients from paying the typically higher facility fees at a hospital, he says.
“Lab panels, follow-up high blood pressure tests, smaller test panels for specific issues that don’t have to be as large as some hospitals use,” can all save money for patients and keep services inside the practice, he says.

And with long-standing patients he feels less pressure to practice defensive medicine to avoid lawsuits, he says.

“As an independent primary care clinic, we know our patients well and so we focus on ordering what is appropriate,” he says.

As with many practices, EHRs have reduced the number of staff required to deal with paper charts, and centralized triage for nursing and patient scheduling saves on labor costs as well, he says.

The practice has also found little, low-tech ways to save, such as putting handwritten reminders on the soda machine to do BMI checks on every patient, which is another way to maximize services done in a single visit.

“One time we printed up a piece of paper with a big ‘stop’ sign and handed it to the patient as a reminder to get their blood pressure re-checked if it was initially elevated when he walked in,” Welters says.

SureCare Medical Center in Springboro, Ohio, is another facility Stanford identified as a leader in lowering costs while maintaining care quality. A big reason was SureCare’s emphasis on widening its hours to reduce patient trips to the emergency room and urgent care, says Joe Garland, MD, a primary care physician with SureCare.

Jerome Yount, practice manager for SureCare, says the facility also uses its size to leverage the best possible pricing on a variety of services.

Emmons echoed the sentiment. “Getting all these costs out of the system has to rank right up there with providing good medical care,” she says. “It has to be a way of life.”