THE 12-STEP WAY TO REDUCE PRACTICE EXPENSES:

Part 1, Staffing Efficiencies

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KEITH NEGLEY

Staff-related expenses consume the largest portion of your overhead, so that's where this 12-month plan begins.

With the overhead of the typical family medicine practice around 60 percent of revenues, working to control practice expenses has to be a high priority for family physicians. Of course, overhead can be reduced by increasing productivity and revenue, reducing expenses or both. This article will focus on reducing expenses. To modernize the old saying a bit, a dollar saved in practice expenses is a dollar earned, while a dollar earned by seeing more patients is less than a dollar earned since some of it is eaten up by practice expenses.

While you may think your practice is so lean that you couldn't possibly cut another dollar out of your expenses, chances are it's not. Chances are you have several opportunities to capture money that is currently being wasted. If you can stop that waste, you'll have more money for physician salaries or for reinvesting in the practice, and you'll be able to practice more cost-effectively.

Working to reduce practice expenses can seem daunting, in part because it's hard to know where to begin. That's where this article and the one in the next issue of *FPM* can help. We'll break down your expenses into sections you can tackle individually, one a month, starting with the ones most likely to repay your effort.

Weighing in

Since you're about to put your practice expenses on a 12-month reduction plan, it makes sense to start by getting baseline measurements. Your accountant should be able to tell you your overhead percentage and what you're spending in several expense categories, such as staff salaries, supplies, and building and occupancy costs. The result might look something like the table to the right, which shows that overhead expenses typically consume 59.74 percent of practice revenue, according to survey data from the Medical Group Management Association (MGMA).[1] So, if a physician brings in $50,000 in revenue each month (which is roughly $76,000 in charges minus adjustments and write-offs), his or her monthly overhead should be about $30,000, according to the benchmarks.

If your overhead percentage is below average as a whole or in certain categories, don't let that stop you from trying to do better. You may still have opportunities for savings. If your overhead percentage is above average, you too have opportunities for savings, but don't assume that you'll be able to reduce it significantly; your situation or practice style may somehow make practice particularly expensive. In fact, MGMA statistics suggest that physicians with the highest incomes often have more staff and higher overhead, which allows them to be more productive. So be careful that you do not reduce your expenses in a way that actually hurts your productivity and thereby increases your overhead percentage.

Month 1: Staffing needs

Staff costs are the largest expense in any family medicine practice, which makes this a good place to start. Any savings related to staff costs are likely to result from difficult, emotionally wrenching decisions about staff cutbacks, demotions and other measures that may hurt someone, leave you with an unsettling feeling of disloyalty to your staff, and threaten morale. Why not get the hardest part of the task over with first?

In my work with family medicine practices, I have found that payroll costs (not including benefits) generally run approximately 22 percent to 26 percent of practice revenues. If your payroll runs higher than that or if you have other reason to believe you are paying more than you should in salaries, perform a personnel needs assessment. Essentially, this involves figuring out whether the tasks that occupy your staff are worth doing, whether

MEDIAN OPERATING EXPENSES FOR FAMILY MEDICINE PRACTICES

Operating expenses	Percentage of total revenue
Support staff salaries	26.28
Support staff benefits	5.52
Information technology	1.85
Laboratory	3.26
Drug supply	3.42
Imaging	0.91
Medical/surgical supplies	1.70
Building and occupancy	6.81
Furniture and equipment	0.29
Furniture and equipment depreciation	0.77
Administrative supplies and services	1.71
Professional liability insurance	1.52
Other insurance premiums	0.23
Outside professional fees (legal, accounting, etc.)	0.86
Promotion and marketing	0.40
Other operating expenses	1.74
Total	**59.74***

Data shown is for family medicine practices not owned by a hospital or integrated delivery system. Data does not include nonphysician provider salaries and benefits, which total 3.81 percent of total revenue.

*Note that, because not all groups surveyed supplied information for every line in this table, the total differs from the sum of the percentages.

Source: *Cost Survey for Single-Specialty Practices: 2009 Report Based on 2008 Data*. Englewood, Colo: Medical Group Management Association; 2009.

>> Be careful that you do not reduce your expenses in a way that actually hurts your productivity.

>> Your employees may need to pay part of their premiums – perhaps up to 50 percent.

In the typical family medicine practice, overhead accounts for 60 percent of revenue, with staffing being the largest expense.

To assess your personnel needs, identify the essential tasks in your office and the ideal staff for those tasks.

Make sure your staff salaries are competitive but not excessive, especially for long-term employees.

each responsibility is assigned to the best possible person and whether the whole operation is as efficient as possible. In other words, you need to know that the right things are being done by the right people in the right way. One approach is to list all the tasks carried out by your staff, eliminate or modify any that you consider unnecessary or inefficient, and then imagine the ideal staff for the remaining tasks: How many people, with what kinds of background and training, *should* you need? Now compare that personnel listing with your actual staff. Do you have two staff doing the job of one? Are certain jobs being done by staff who are overqualified for them – and probably overpaid and underchallenged? Could those individuals take on additional work?

Look at your current staff from as many perspectives as possible. Try to think outside your day-to-day acceptance of the way things are done in the office. Are all your employees essential to the practice? Do you have anyone working full time at a job that could be redesigned to be handled by a part-timer? Are there ways of combining tasks that would save time or staff members?

Are there places where *adding* staff might help? For instance, is patient flow so backed up that the practice's lack of productivity is hurting the overhead percentage? Maybe you need more clinical staff. (Of course, you may just need more efficient procedures, so go carefully before you spend money to save money.) Similarly, if your billing and collections are running sluggishly, you may need to add more collections personnel – or hire *better* collections personnel – or you may need to consider outsourcing some billing, collections and administrative work.

Data from the MGMA show that practices employ 0.28 nonphysician providers and 5.15 support staff per full-time physician on average.[1] The numbers are even higher for high-performing practices. In deciding how many staff you should maintain, consult the published benchmarks, but remember that what is good for one practice may not be good for another. (See "Resources on practice expenses," page 41, for a listing of organizations that offer survey information on staffing, salary and other expenses.)

Action steps: Assess personnel needs. Adjust staffing. Look for functions that could be outsourced.

THE 12-MONTH PLAN AT A GLANCE

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Month 1:	Review staffing needs and adjust staff size if necessary.
Month 2:	Assess and systematize staff compensation.
Month 3:	Look for savings in health insurance.
Month 4:	Review your retirement plan for potential savings.
Month 5:	Develop or refine your sick leave, vacation and overtime policy.
Month 6:	Review your office lease and other lease agreements.
Month 7:	Optimize the ordering and handling of supplies.
Month 8:	Scrutinize the cost-effectiveness of outside services.
Month 9:	Look for ways to economize on postage and telephone costs.
Month 10:	Review your practice advertising for waste and ineffectiveness.
Month 11:	Track down and eliminate causes of refunds to patients.
Month 12:	Tighten controls on petty cash and eliminate problems that incur bank charges.

Month 2: Employee salaries

The first question to answer is whether you are paying your staff more than the norm for your area. Examine your payroll carefully. For each position, find out as best you can what other local physicians pay. Ask personnel recruiters, hospital physician-relations personnel, hospital human resources staff or your local medical society. Your local newspaper's classified advertising section may even yield this information. The average salaries shown on page 42, or salary data obtained from the resources listed above-right, can be helpful, but don't take them as gospel.

If your salaries are generally in line with your local market, you may still be paying a couple of employees excessively, such as long-term employees who have been receiving annual pay raises for many years. An office manager who started out at $30,000 annually 15 years ago might now be making more than $60,000. Consider whether the employee's contributions to the practice justify a higher-than-market salary. Even though you value your long-term employees, you are not obligated to grant sizable salary increases each year – and you may not be able to afford to.

Instead of awarding annual raises haphazardly or automatically, try to give no more than the prevailing average, which generally ranges from 2 percent to 4 percent annually. To provide flexibility, consider giving yourself an overall, staff-wide budget for increases. If that budget is, say, three percent of your current salaries, you can assign more or less of it to individual staff to reward performance while keeping within your salary maximum.

RESOURCES ON PRACTICE EXPENSES

Cost Survey for Single-Specialty Practices: 2009 Report Based on 2008 Data, published by the Medical Group Management Association; 877-275-6462; cost: $300 for MGMA members, $350 for affiliate members and $515 for nonmembers. http://www.mgma.com/article.aspx?id=29008

PAHCOM 2009 Medical Office Salary Survey, published by the Professional Association of Health Care Office Managers; 800-967-7790; cost: $15 for PAHCOM members and $59 for nonmembers. http://www.practicesupport.com (click on "Benchmarks/Surveys" in the left-hand column)

Staff Salary Survey, published by The Health Care Group; 800-473-0032; cost: $245. http://www.thehealthcaregroup.com/p-18-staff-salary-survey.aspx

If needed, call in an objective third party – a consultant or accountant – for help in making sure that your salary decisions are fair to the practice as well as to your staff.

Have you set salary ranges for your staff positions? By all means do so. One approach is to start with the local average for a given position and establish a minimum salary 20 percent below that figure and a maximum 20 percent above it. Inform employees that their salary increases will slow down as their salaries approach the maximum.

Although you may decide that the pay increases you've been giving are just too big, don't do away with them altogether – except, perhaps, as a one-time emergency measure if the practice is clearly in trouble. The negative effect on morale would outweigh whatever savings you might realize. (Of course, withholding an individual staff member's raise because of poor job performance is another story.) You might also find it effective to use incentive bonuses as an alternative to hefty raises. Incentives can range from giving movie passes to giving $500 for outstanding performance on occasion, and they can make everyone involved feel good without committing you to years of maintaining a higher salary.

Although raises and salaries depend on employee performance, length of service and inflation, the bottom-line determinant is your generosity. Too much generosity has a price.

Action steps: Assess salaries in your area and

For annual raises for your staff, it's wise to stay within the 2 percent to 4 percent range.

Set salary ranges for each position in your practice, and give smaller increases as employees approach their maximum.

Don't do away with salary increases altogether; the negative effect on staff morale would offset any savings.

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Article Web Address: http://www.aafp.org/fpm/2010/0300/p38

compare them with what your practice pays. Set salary ceilings and incorporate some mechanism to control the amount of annual increases. Develop inexpensive employee incentives.

Month 3: Health insurance

In my experience, staff health insurance and retirement plans combined typically range from 3 percent to 6 percent of practice revenues. Your real challenge will be containing health insurance costs. Some family medicine practices have experienced annual premium increases of as much as 50 percent.

To control the costs of health insurance, consider providing your staff with some free care.

As a first step in containing health insurance costs, review your current insurance coverage. Is it too generous for what you can afford? A policy with a $250 deductible generally costs more than one with a $500 deductible. A policy that has dental coverage costs more than one that does not. In an era of skyrocketing premium rates, it may not make economic sense to provide expansive health insurance coverage to employees. To offset the effect of a high deductible, your office could offer your staff some medical care for free or at substantially reduced rates. That way your employees would get a price break on outpatient services just as they would if they were covered by insurance with a smaller deductible. Naturally, there are some supervisor-employee boundary and privacy issues to consider if you choose this option.

Staff health insurance and retirement plans combined typically cost between 3 percent and 6 percent of practice revenues.

Have you solicited competitive bids for your health insurance coverage lately? It may be time to do so, especially if your practice has used the same health care insurer for a number of years. For assistance with bids, enlist the help of an independent insurance agent. If you switch plans, lock in the premium rate for as long as possible. Generally, this can be done for at least one year after the new policy is purchased. Each year, though, monitor health insurance premium costs and increases, and be prepared to switch plans.

If your retirement plan is costing you too much, switch to another plan.

Don't neglect the possibility of negotiating your way out of premium increases demanded by your current insurer. Were your staff members' health care expenses lower this year than last year? If so, you might have some bargaining chips. Talk with your agent.

If your rates continue to increase over time despite all cost-cutting efforts, you may need to take more extreme measures. Your employees may need to pay part of their premiums – perhaps up to 50 percent. Check your state's employment laws first, though, to make sure there are no limitations on employer-subsidized premiums. If your back is to the wall, you may have to impose coverage limitations or eliminate the benefit altogether. Explore all possible alternatives to outright cancellation of employee health insurance. Without offering it, you may have trouble attracting and keeping good employees.

Action steps: Review policy specifications. Bid out health insurance. Change insurers and reduce benefit levels, if necessary.

Month 4: Retirement plan

Is your retirement plan as cost-efficient as possible? Is it the right one for your practice? For example, you may not be well-served by a money-purchase (or defined-contribution) pension plan because of the mandatory annual contribution requirements. A profit-sharing

SUPPORT STAFF SALARIES

The following mean salary estimates were gathered from the Bureau of Labor Statistics' May 2008 National Industry-Specific Occupational Employment and Wage Estimates. Means for your local area may vary. For more detailed information, visit http://www.bls.gov/oes/2008/may/naics4_621100.htm, or consult the resources listed on page 41.

Billing clerk	$32,360
Insurance clerk	$31,810
Lab technician	$36,000
LPN	$35,940
Medical assistant	$29,330
Medical secretary	$29,960
Office manager*	$47,060
Physician assistant	$81,650
Practice administrator**	$86,190
Receptionist	$25,830
Registered nurse	$65,070
Transcriptionist	$32,050

*Identified in the data as "first-line supervisors/managers of office and administrative support workers."

**Identified in the data as "medical and health services managers."

>> Do you pay employees for unused sick leave? You may not have to.

plan would provide you much more flexibility.

Pay particular attention to the length of the plan's vesting schedule. If your practice has high turnover, structure the plan to reallocate any unvested accounts to remaining participants based on the ratio of their account balances. And remember that staff retirement plans combined with health insurance typically run from 3 percent to 6 percent of revenues, so consider this range as you determine how much you want to spend.

Action steps: Assess your current retirement plan in the context of other plans available. Switch to the most advantageous one.

Month 5: Sick leave and overtime payment

Another employee issue to examine is your leave policy. Remember that anything you put into writing for your employees has the force of law behind it, so think carefully about what your written leave policies say, and check with your attorney about any state laws that might govern sick and vacation leave.

The industry standard for sick leave is five days a year for each employee. Do you pay employees for unused sick leave at the end of the year or upon termination? Do you treat sick leave as a compensated benefit? You may not have to. After all, sick leave is a contingency benefit for the employee in case of illness. If you remove the cash payment, though, your healthier employees might balk at the idea because they would feel penalized for never using sick leave. As a compromise, carry over unused sick leave to future years, or convert a portion of unused sick leave to vacation. This allows the employee to bank at least part of the unused sick leave in case of an illness, especially a serious one, but frees you from the costly position of paying your resigning employees for unused sick leave.

For vacation, two weeks a year for each employee is the industry standard. You may want to set a limit on the number of days you will allow your staff to carry forward each year. One of your long-time employees could conceivably accumulate a year's worth of vacation days. Could you afford to have that employee take a full year's vacation at once? Probably not. This kind of limit is particularly crucial if you have a written policy that pays employees upon termination for accrued vacation. Moreover, it's important for everyone to take vacations regularly, and limiting the carryover of vacation days can encourage the workaholics on your staff to take time off.

And don't forget an overtime policy. Do you hold a tight rein on overtime? Are employees made accountable for their overtime hours? How is this time documented? Is overtime approved beforehand? Is overtime being paid to exempt employees when in fact it should not be? Establish a reasonable, practice-wide policy, and stick to it.

Action steps: Stop offering cash payments for unused sick leave. Initiate a sick-leave carryover plan. Establish a vacation policy. Establish an overtime policy.

When you have completed these staff-related action steps, you will have tackled most of your overhead problems, but there are seven months to go. In the next issue of *FPM*, we'll look at operational efficiencies. FPM

Send comments to **fpmedit@aafp.org.**

Editor's note: FPM *was published for several years before going online. In an effort to capture the best of the "pre-web"* FPM *for the online archive, we are publishing updated versions of some particularly useful early articles. The original version of this article appeared in 1997. A follow-up article in the May/June issue will provide advice on making the day-to-day operation of your practice as cost-effective as possible.*

1. *Cost Survey for Single-Specialty Practices: 2009 Report Based on 2008 Data.* Englewood, Colo: Medical Group Management Association; 2009.

When trying to cut overhead costs, don't forget to examine your leave policy.

The industry standard is five days a year for sick leave and two weeks for vacation.

Make sure you have a policy in place to limit the number of vacation and sick days employees can accumulate.