Financial management challenges for general hospital psychiatry 2001

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Abstract

Psychiatry programs are facing significant business and financial challenges. This paper provides an overview of these management challenges in five areas: departmental, hospital, payment system, general finance, and policy. Psychiatric leaders will require skills in a variety of business management areas to ensure their program success. Many programs will need to develop new compensation models with more of an emphasis on revenue collection and overhead management. Programs which cannot master these areas are likely to go out of business. For academic programs, incentive systems must address not only clinical productivity, but academic and teaching output as well. General hospital programs will need to develop increased sophistication in differential cost accounting in order to be able to advocate for their patients and program in the current management climate. Clinical leaders will need the skills (ranging from actuarial to negotiations) to be at the table with contract development, since those decisions are inseparable from clinical care issues. Strategic planning needs to consider the value of improving integration with primary care, along with the ability to understand the advantages and disadvantages of risk-sharing models. Psychiatry leaders need to define and develop useful reports shared with clinical division leadership to track progress and identify problems and opportunities. Leaders should be responsible for a strategy for developing appropriate information system architecture and infrastructure. Finally, it is hoped that some leaders will emerge who can further our needs to address inequities in mental health fee schedules and parity issues which affect our program viability. © 2001 Elsevier Science Inc. All rights reserved.

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1. Introduction

The primary mission of psychiatry programs is to provide clinical care, and if the program is academic, to teach our next generation and generate new knowledge. It has also been said “no margin...no mission.” For better or worse, psychiatry programs face significant challenges to develop themselves in a business and financial context [1]. Programs are competing for limited resources, and, while maintaining a focus on their primary mission, cannot escape the struggle to manage expenses and generate revenues. Therefore, program leaders in psychiatry increasingly need to develop financial expertise [2]. This paper provides an overview of financial management challenges facing general hospital psychiatry program leadership. Financial challenges can be categorized on five levels: departmental [3–5], hospital (or health care system) [6], insurance (reimbursement) [7–9], finance [10], and national policy [11]. Because there is such a variation of program structures, not all issues may pertain to every program, and some programs may have unique issues not included here. The review is not intended to provide the answers to these challenges, but to articulate areas of financial concerns and skills needed to assure future program success.

2. Department level challenges

2.1. Evolving compensation models

Increasingly, psychiatrist salaries are based on defined productivity models, where productivity may be narrowly defined as providing services which result in revenue col-
sions of outpatient divisions in general hospitals are less inpatient services in general hospitals. The financial dimen-

2.3. Keeping outpatient divisions viable

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Another common problem in productivity-based compensa-
tion is how to manage shortfalls in productivity tar-
gests. For example, in the first year of a new productivity
based system, shortfalls may need to be written off because of
start-up issues in business management and collections.
Eventually, however, clinicians need to carry over their own
deficits or have their salaries lowered. Compensation mod-
els are best managed as an evolutionary process. It may not
be possible to shift a system in a simple step from one in which
expectations are loosely defined and salary is guar-
tanteed to one in which salary depends on revenue collec-
tions. Support may need to be redefined in stages in order
not to lose too many staff. Different systems have different
needs during their development. Optimally there will be
some type of clinician “finance committee” with appropriate
representation to work with management to define and
evolve the system.

2.2. Managing overhead

Despite the need to manage practices, there must be
some discipline in the overhead structure (in this case over-
head refers to staff expenses associated with practice man-
agement, including secretaries, transcriptionists, billers, fil-
ing clerks, receptionists, and so forth). Problems should not
automatically be solved by adding more staff. Cultivation of
a collaborative problem solving value system which in-
cludes clinicians and managers is necessary to avoid the
“We-they” conflicts which can occur when the frustration of
clinicians with managed care is confronted by the lack of
resources of their managers.

2.3. Keeping outpatient divisions viable

A significant amount has been written about maintaining
the viability of consultation-liaison and medical-psychiatry
inpatient services in general hospitals. The financial dimen-
sions of outpatient divisions in general hospitals are less
often addressed. Outpatient programs usually provide care
through an integrated, multidisciplinary approach which
coordinates the services of psychiatrists, psychologists, so-
cial work therapists, and nurse clinical therapists. The col-
laborative relationships and contiguity of these clinicians
may facilitate coordination of care, and enhance learning
across disciplines. In many programs, however, the reim-
bursement and salary structure actually creates problems for
the practice as a result of the ratio of overhead to income for
the therapists. The overhead costs for a clinician include
secretarial salary, office rent, computer and answering ser-
dvice expense, as well as payroll taxes and benefits. The net
loss to the program after paying for overhead and benefits
can be in the range of $5000/year for a master’s level
clinician paid in the range of $38,000/year. If psychiatrists
were to spend their time providing low reimbursed services,
they would run into a comparable overhead problem.
Programs may be forced to decide to either accept this
loss, to not employ lower salaried professions in their pro-
gram, to try to pay them less (which may not be a viable
market strategy), or to offset the loss through the earnings of
others or from some other source. Systems need to articulate
the value of these therapists and determine the value of the
offset. For example, if the presence of employed therapists
makes it easier to discharge patients from the inpatient unit,
then the gain from a shorter length of stay (for non per-diem
contracts) can translate into financial benefit which can
offset the direct salary shortfall.

2.4. Protecting academic support

Academic departments are experiencing erosions of base
academic support which can lead to the disappearance of
academic productivity in favor of clinical work. It is impor-
tant to review how academic dollars are being spent to
ensure their investment in staff likely to leverage them into
outside funding support. In addition, it is important to find
ways to create incentives for successful academics who
bring in significant indirect support. Although a hospital
cannot transfer income from indirect research support to
provide incentive payments, it can establish or utilize the
research budget it creates from other sources (such as op-
erations or endowment) to reward research productivity
based proportionally on outside dollars brought to the insti-
tution by an investigator. This approach would only work in
hospitals with some established research support budget.
Hospitals who do create such a system, would enable in-
vestigators to utilize their accrued revenues to create a pool
for start up dollars to fund new investigators who are judged
to be virtually assured of outside funding success based on
their track record. The incentive payments made to these
new investigators could go back to the funding group to pay
back their investment while growing their research critical
mass.
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