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Commentary and Perspective

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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.

Keywords: Finance; General hospital; Administration

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-

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lection. Productivity in the teaching and research area would also become defined as grant or specific stipend support. General expectations to see patients, teach, attend conferences, and so forth, are being replaced with more specific position descriptions defining allocation of time and effort. Revenue/productivity expectations are commonly part of the formula. There are some inherent tensions associated with compensation based on an individual productivity basis. There may be concerns about the shifting of difficult patients, the avoidance of lower paying patients in the case mix, or the unwillingness to participate in noncompensated activities such as management conferences, or even teaching conferences. However, without specific productivity targets, it may be difficult to get clinicians to comply with the complex regulations required by managed care to obtain reimbursement (e.g., authorization processes, coding for billing, and so forth).

Another common problem in productivity-based compensation is how to manage shortfalls in productivity targets. 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 models are best managed as an evolutionary process. It may not be possible to shift a system in a single step from one in which expectations are loosely defined and salary is guaranteed to one in which salary depends on revenue collections. 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 overhead refers to staff expenses associated with practice management, including secretaries, transcriptionists, billers, filing clerks, receptionists, and so forth). Problems should not automatically be solved by adding more staff. Cultivation of a collaborative problem solving value system which includes 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 dimensions 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, social work therapists, and nurse clinical therapists. The collaborative relationships and contiguity of these clinicians may facilitate coordination of care, and enhance learning across disciplines. In many programs, however, the reimbursement 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 service 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 program, 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 important 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 operations or endowment) to reward research productivity based proportionally on outside dollars brought to the institution 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 investigators 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.