

CRAFTING A MEDICAL PRACTICE BUSINESS PLAN



COMMENCE

Good Afternoon. My Name is Dr. David Edward Marcinko from the *Institute of Medical Business Advisors*, in Atlanta, Georgia.

I am the Editor of the 400 page text book: *Hospitals and Healthcare Organizations*. [Management Strategies, Operational Techniques, Tools, Templates and Case Studies] It's available from most book sellers, Amazon, Barnes and Noble, or directly from Productivity Press - the publisher.

I am also a financial advisor and health economist to physicians, healthcare organizations and medical professionals of all stripes. And, for the last seven years I've been the Publisher of the online education forum known as the: **MedicalExecutivePost.com**

Now, as we begin this presentation on business planning, I can recall when I began my own medical practice more than two decades ago. At that time, obtaining start-up capital was easy. Although new in town, I simply took my medical degree to the local bank, and received a loan. No business plan, or collateral, was needed.

Today however, in a time when almost half of all doctors are employees – and despite interest rates being at all time lows – obtaining a bank loan is a daunting task. And, more banks and lenders than ever before are requiring a cogent business plan just to get a foot in the loan officer's door.

WHY the SeaChange? Because long recognized as a quintessential tool in the business community - the formal structure and mental rigor of a classic business plan is only now being recognized by physician-executives, as competition increases in the healthcare industrial complex.

And so, as we continue - FEAR NOT - This discussion is excerpted from my *Audio-Educator* white paper of the same name.

Just sit back, listen and learn!

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Currently, there are many reasons to write a medical practice business plan. The process of gathering, compiling and analyzing information is an invaluable experience to the beginning practitioner or experienced veteran physician – and all those in-between.

Some specific reasons for writing a business plan include:

-) Determining the feasibility of a new practice start-up.
-) Raising money for that new practice and create a budget, time line or business direction for the practice.
-) Expanding an existing practice or turning-around a declining satellite office.
-) Offering a new service or product line - like an outpatient radiology facility, cosmetic health spa, or retail clinic.
-) Focus on existing or new or market opportunities by determining revenue centers or cost drivers.
-) Persuade Third Party Payers, networks and insurance carriers that your practice has a future and represents a viable synergistic partner for their organization
-) And many others

Of course, before we even begin crafting a business plan, we need to name our new practice.

Most experts recommend against using your own name because it limits future growth and you may lose the benefits that a more descriptive name would bring. Your business name will likely be incorporated using your practice's name, although larger (multi-specialty group) practices may use a more general name for the entire enterprise; and then having multiple "Doing Business As" for the individual practices under the umbrella. It is important to discuss these options with an attorney if you believe this arrangement has advantage; others find it confusing.

Usually, your medical specialty can be used as a base-name, and then some descriptor to differentiate it from local competing practices. Selecting a name like "The Allegiance Partners" does not indicate that medicine is your service.

On the other hand, naming your practice "Orthopedic Associates of Your Town" won't be helpful to patients looking for you in the yellow pages, or internet search engines, and finding your practice listed just before "Your Town Orthopedic Partners".

It is therefore good to be cognizant of your competitors' names when choosing your own. And, you should select a name that will hopefully grow with you into a larger enterprise.

For example, are you a solo doctor, but are pretty sure you'll take on one or more partners in the future? Then besides not naming your practice after yourself, you may choose to add "Group" or "Partners" to your name initially even if you're the only doctor.

Is there any possibility you'll open a second office in another town? ... Naming your medical practice something like the "Apple Street Internal Medicine Group" may not make sense when your second office is opened on Main Street in a nearby city, in a few years.

The Next-Pre Business Plan Consideration is to UNDERSTAND THE PHYSICIAN-EXECUTIVE'S PERSONALITY

OR- Should you write a Business Plan

There is no way to eliminate all the risks associated with starting a private medical practice, or launching any innovative concept in the health 2.0 ecosystem.

However, entrepreneurial focused doctors can improve their chance of success with good planning and preparation. So, prior to starting your practice, merging, franchising or purchasing an existing one, ask yourself the following sobering questions. Hopefully, such reflection will enhance success, or at least prevent an unmitigated catastrophe.

Is medical practice ownership right for you?

It will be up to you, and your consultants; not someone else telling you to develop projects, organize your time or follow through on details. You must be self motivated.

Do you like people and get along with different personality types?

Practice owners need to develop working relationships with a variety of people including patients, customers, vendors, staff, other physicians, and professionals like lawyers, accountants, consultants and bankers. Can you deal with a demanding patient, an unreliable vendor or cranky staff person in the best interest of your practice?

Can you make decisions and live with ambiguity?

Practice owners are required to make independent decisions constantly; often quickly, under pressure and without all the facts. Ambiguity is a constant.

Do you have the physical and emotional stamina?

Practice ownership can be challenging, fun and exciting. But it's also a lot of work. As a physician-owner, can you face twelve hour work days? As a doctor, can you offer advice, service, care and moral support 24/7?

How long can you live on your current savings?

Most small medical practice startups have a declining bank balance in the early going. So, it's wise to look at your expenses and determine how long you can live on your savings, and what personal costs you can temporarily eliminate.

Emotionally, it's easier to tighten expenses when you're contemplating a new practice, than it is to cut back after you've started. Financial consultants and accountants that perform financial statement preparation and analysis are vital in this regard. A two to five year margin of safety is not unusual and may be needed.

How deeply in debt can you go?

Medical practice business debt can be good. It can fund expansion, improve profit ratios and cash flow. But, for physician entrepreneurs, business debt is often personal debt. Many start a practice by deferring payments for their own labor. Although lenders may make loans to a practice, the physician-owner will often be required to personally guarantee the loan.

So, although the debt is on the business's books, it is ultimately the doctors' debt should the practice fail.

What about your own health insurance?

If your current residency, fellowship or job offers health insurance, and is subject to COBRA, you might be able to keep your coverage by paying the premiums, plus another 2% for administrative costs. You may keep your coverage under COBRA for up to 18 months and is a useful stopgap.

Can you line up credit in advance?

Some new practice owners may set up a home equity line of credit that will let them borrow money at 1-2 percentage points over the prime rate or less. Lenders are more willing to make loans to someone who has a steady paycheck than to a new practice entrepreneur. If you have an excellent credit rating, you can probably get a home equity or other secured loan, but with more paperwork than in the recent past.

Once you are self-employed, you'll probably have to provide your most recent tax returns before getting approval.

But, today, the biggest obstacle to a practice loan is a home mortgage and auto loan. Domestic credit has been very tight since 2008, even for physicians.

What if you can't manage the practice?

Disability insurance, unlike health insurance, usually cannot be transferred to an individual policy when you leave your job to start a new venture. So, get your own disability policy while you are still employed. Once you have the policy and are paying the premiums, you should be able to keep the policy when you go out on your own.

Remember, benefits received on a policy paid by you are free of federal income tax. But, benefits on a policy paid for by a previous employer are taxable.

How well do you plan and organize?

Research indicates that many medical practice failures could have been avoided through better planning. Good organization of finances, inventory, work schedules, information technology, medical services and human resources can help avoid many pitfalls.

Is your determination and drive strong enough to maintain your motivation?

Running a practice can wear you down. Some doctor-owners feel burned out by having to carry all the responsibility on their shoulders. Strong motivation can make the practice succeed and will help you survive slowdowns as well as periods of burnout.

How will the practice affect your family?

The first few years of practice startup can be hard on family life. The strain of an unsupportive spouse may be hard to balance against the demands of starting a medical business. There also may be financial difficulties until the business becomes profitable, which could take years. You may have to adjust to a lower standard of living or put family assets at risk.

OUR NEXT PRE-Business Plan Consideration is the Medical Practice MISSION STATEMENT.

There are no firm rules about what a mission statement should contain or how long it should be. For some doctors, a succinct statement is appropriate; for others, it may take one or two pages to capture the mission.

However, the critical element in every mission statement is the physician-executive's belief that he or she can uphold every principal in the statement.

So; here are some important elements of any medical practice mission statement:

- J The MS should include both a local vision with global beliefs, because this view helps keep things in perspective when patients get caught-up in their day-to-day business and personal lives; and healthcare needs.
- J It should include steps that support the doctor's vision. These steps can be written in either a list form or incorporated in paragraph form. It is important to commit to specific facts, figures, or goals in your mission statement. Mission statements are designed to communicate principal beliefs and ideals, but a statement of specific goals and outcomes should be included to suit the doctor's purpose and patient's needs.

- J It must be stable, yet flexible. Because a mission statement is about who the doctor is and what he or she believes, the core elements should remain relatively stable.
- J A mission statement should inspire and motivate potential patients. This is the most important element, so have sample patients look at the document and see if it inspires to the practice.
- J Finally, a mission statement should include a vision of what the doctor's practice wants to become. A mission statement should state practice ideals, not current reality. This is a statement about who the doctor wants his patient to become too—and not necessarily what the patient's health is today.

Remember, a mission statement serves as a guide only if the doctor commits to making it a part of his or her medical practice.

FINALLY ... and most contemporaneously ... the last pre-BP consideration is

How do you feel about the Patient Protection and Affordable Care Act of 2010? And ... its' implementations and effects on you thru 2020 and beyond? OR M-4-A?

CRAFTING or Writing YOUR BUSINESS PLAN

Now, that you've decided to go into independent medical practice, and we haven't di-suaded you thus far, exactly how do we craft a business plan that will raise the necessary money for your dream?

Well - Did you know that a BP has a STANDARD Academic FORMAT?

It sure does. The rest of this discussion will not only review that format; but it also represents the exact model I have personally used in my own practice, when starting my Ambulatory Surgery Center, and presenting plans to venture capitalists and angel investors in various industries like healthcare, technology and telecommunications.

IOW: It is a tried and proven format.

The First component a BP is known as the Executive Summary

The Executive Summary is a brief synopsis of the entire plan. Its appearance, grammar and style should be sharp and crisp - as it represents an enticement for the reader to maintain interest and contribute intelligent input into the new venture.

The Executive Summary should contain information about the practice, advertising and marketing opportunities, physician management, proposed financing with *Pro Forma* financial statements, business operations and exit strategy. This last point, while unpleasant is often overlooked by naive practitioners. Business experts however, look favorably upon an escape plan and view it as the mark of a mature professional that realizes the possibility of success, as well as failure.

Ultimately, the plan must explain to potential investors how you will make the practice profitable and produce the required *Return on Investment (ROI)* for them.

It must describe medical services, patient acceptance and benefits, provider qualifications and accomplishments, the amount of capital required, market size, potential practice growth, and market niche; etc.

Additional information may include office location, proximity to labor sources, transportation, license requirements, business status, proprietary technology if any, and potential working agreements with various insurance companies, managed care companies and HMO plans.

Now – remember that if you do not have the money - or can't borrow the funds to begin a private practice - you will just have to become an employed practitioner until you do.

It is therefore imperative to start off on the right foot with a sound business plan, as you begin your medical career.

The SECOND component of a Business Plan is Marketing Analysis

Marketing generally describes your strategic competitive advantage and/or professional synergy that's' unique to your embryonic practice and not necessarily a significant cost driver.

Generally, this may be evaluated through the classic business school technique of SWOT analysis. SWOT. That is to say, the [(S)trengths, (W)eaknesses, (O)pportunities and (T)hreats)] to the practice and Business plan.

The science of such modern marketing analysis is based on competition largely derived from the interplay of five forces.

In the early 1980s, Professor *Michael F. Porter* of the Harvard Business School codified these competitive forces that are often used in business plans today. Consequently, they must be addressed and demonstrated to benefit you, in this section of the business plan.

First Force - Power of Buyers - Patients – or – Insurance companies, etc.

IOW: The payers – private patients – the government and/or other third parties.

And, corporate buyers of employee health insurance today are demanding increased quality that has affected competition within the entire healthcare industry.

To the extent to which these conduits succeed in their bargaining efforts - depend on several factors:

) **Concentration Factor:** Insurance companies represent those buyers that can account for a large portion of a practice's revenue, thereby bringing about certain concessions.

These are typically CPT fees, global payments, fixed rate or capitation-like pay reductions. But, they may also include service restrictions such as precluding certain surgical procedures, mandating venue or excluding certain practitioners in favor of others.

Service fulfillment is an important part of practice success so all proposed or current third party insurance contracts should be listed here. A danger sign is when any entity encompasses more than 20% of a practice's revenues.

) **Switching Cost Factor:** Notable emotional switching costs include the turmoil caused by uprooting a trusted medical provider relationship, and resulting monetary constraints of fees, deductibles and co-payments. These switching costs serve to either retain patients already in the practice - or retard new patients from entering in it.

But, there are also emotional costs, as well. For example, a woman may not want to change her gynecologist, or, an established cancer patient may not want to change his care plan.

) **Integration Level Factor:** The practitioner must decide early on whether or not his or her practice will be *vertically* or *horizontally* integrated. For example, a provider may horizontally integrate as a solo practitioner, while a larger group practice may prefer vertical integration in a bigger medical healthcare complex.

) **Profitability Factor:** When a Third Party Administrator earns a low profit, for example, and a specific medical specialty is an important part of its' costs - more aggressive bargaining is likely to take place with an individual doctor or his associated networks. Explanations must be made for such unpleasant contingencies in this portion of the business plan.

) **Service Importance Factor:** Remember the adage: *Perception is reality*. Increasingly, HMOs do not often strive to delight their clients and may be responsible for the backlash these entities experience. AND, as the affects of the Affordable Care Act are yet to be discerned.

In medicine, as in any business, the power is in the marketplace. Thus, always do your best.

Second Force - Threat of New Entrants:

In the historic past, some authorities argued that medical schools produced more graduates than needed - especially geographically - inducing an over supply and provider shock. With today's uninsured population and the ACA however, the opposite is of course true; especially for primary care physicians.

Therefore, astute medical practitioners realize that this dilemma must be mitigated, either in the macro-economic long term through national organizations, or micro-economically in the short run by individual choice; the latter being a practical, albeit slow way for most doctors.

This may be accomplished by practicing in rural or remote locations, away from medical schools, managed care entities, or in areas with under-served populations!

Third Force - Current or Existing Competition:

In addition to intra-professional competition, heightened inter-professional competition within the entire industry has induced allopathic, osteopathic and podiatric medical physicians to increase the intensity and volume of certain services Therefore referrals may be with-held.

Rivalry occurs because a competitor acts to improve his standing within the marketplace; or to protect position by reacting to moves made by other specialists. Thus, physicians are mutually dependent, and what one practices does - impacts on other practices, and *vice-versa*.

Therefore, increased existing competition from non-physicians, para-professionals, and alternate healers must be considered in any well-executed business plan.

Fourth Force - Substitutions:

Professional substitutes are alternate non-professionals that are not branded and perform essentially the same function as doctors and other medical professionals.

Examples include: nurse practitioners for physicians, surgical technicians for operating room nurses, hygienists for dentists, physical therapists for physiatrists, and foot care extenders for podiatrists.

Aggregate competition will be particularly acute for generalists, while specialty competition will be increased for sub-specialists.

Any strategy to neutralize these conditions will augment the successful business plan.

Fifth Force Power of suppliers:

The bargaining power of physician suppliers has weakened markedly in the last decade. Reasons include demographics, technology and a lack of business acumen.

However, physicians may again assume their role as leaders of healthcare, if they acquire and update the business skills needed to compete in today's marketplace.

Business and technical education just produces more potential – and innovation - for the private medical practice arena.

THIRD Component - Advertising Channels

Advertising is often a gut activity that generally describes those methods of practice promotion that can be done by anyone. However, a well-defined advertising plan should include several more rational considerations – now to be discussed.

-) Considering Goals and Objectives:** The goals and objectives of any advertising plan should be reasonable and quantifiable. For example, a new advertising plan will not likely generate 250 new patients a month, but it may add an additional weekly patient, or some incremental revenue increase; for the first 1-2 years.

-) Considering Communication and Media Channels:** Typical channels of advertising include: print: (coupons, office brochures, newsletters, bill stuffers, billboards, signs and the like), audio, radio and telecommunications, etc.

- If you believe that video (television) advertising is important but feel you can't afford it, then look into your local public broadcasting station.

- Sometimes, even the media becomes the message, as is the case of the Internet and social media today..

- **Considering Message Credibility:** Your advertising message must be delivered in such a way as to build, change or reinforce patient and payer attitudes. Studies have shown that the more honest, fair and unbiased the audience perceives the source to be, the more credible the message-and the more likely that attitudes will shift towards the source's position.

- **Considering Reinforcement and Repetition:** An advertisement must be repeated for several reasons: to emphasize the message, keep the audience from forgetting the message and save the costs of producing more messages. For example (print 3-5 times and TV 8-12 times). Exposure time must also be considered to reduce fatigue.
- **Considering Feedback and Evaluations:** Any advertising campaign must be continuously monitored for results. In fact, many experts feel that no advertising campaign is better than a poorly monitored one, merely because it is economically unwise.

Finally - Have A Defined Budget: Advertising is an expense that should be controlled. Typically, it is a variable cost that is increasingly becoming a greater portion of medical practice expenses.

So, I suggest that start-up practices devote 5 to 7 or even 10 % of gross revenues toward advertising. More mature practices devote about 3-5% to marketing and practice branding advertising endeavors.

NOW - A NOTE ON Public Relations:

Public Relations is not advertising.

Let me say it again - public relations is not advertising; It is a FORTUITIOS EVENT.

Generally - public relations is much more credible than any marketing or advertising endeavor. *Media coverage* is probably most synonymous with the concept of public relations since reporters will cover your story if it seems newsworthy, timely or important to their constituency.

So REMEMBER THE ADDAGE: We *Pay* for Advertising *BUT* we *pray* for Public Relations.

THE NEXT COMPONENT OF THE BUSINESS PLAN IS OPERATING PHILOSOPHY

Some pundits believe that a general medical, or even broad specialty practice, will have limited appeal to patients and buyers in the future.

In its place, the doctor must philosophically decide if she or he is to become either a discount, service or value provider, and then pursue this operational strategy. And, generally, the real world operating ratio of these three ideals is about 60-30-10%; respectively.

The decision on which philosophy to pursue can be presented as an expansion of the practice mission statement, or declaration of practice culture, and then outlined in this section of the business plan.

And now – let’s review the three types

1. The First Operational Type is the Discount Medical Provider:

A discount provider is one who has made a conscious effort to practice low cost, but high volume medicine. Unfortunately, this is easier said than done, and this section of the plan must persuade the reader of the doctor’s commitment to this moral and business philosophy through estimated cost-volume-profit-analysis mathematical projections.

For example, discount providers must depend on economics of scale to purchase bulk supplies, since this model is ideal for multi-doctor practices. Otherwise, several practitioners must establish a network, or synergy, to create a virtual organization to do so. In this manner, malpractice insurance, major equipment and other recurring purchases can be negotiated for the best price.

Another major commitment must be made to *Management Information Systems (MIS)*, Electric Medical Records, and computerized office automation devices. By necessity, such offices are small, neatly but sparsely furnished with functional and utilitarian assets. Most all managed care contracts are aggressively sought since patient flow and volume is the key to success in this organizational type.

THINK WAL MART

Make no mistake about it - a low cost philosophy is not evil as it satisfies a real niche in the medical marketplace for basic care. It should not however, be the operational plan of default because low fees, high patient volume and high office overhead costs may be a formula for top-line *grossing the practice revenues to death*.

In other words, low fees are often thought by physicians to be an advantage in attracting new patients. And for the short term, they often are.

However, the long term reality is that regardless of how low your fees get, there will always be a more deeply discounted competitor willing to do what you do, for a lower fee.

2. The Second Operational Type is the Service Provider

The medical provider committed to a service philosophy must be willing to do *whatever it takes* to satisfy the patient.

For example, this may mean providing weekend, weeknight, or holiday office hours, instead of a routine 9-5 schedule. House calls, hospital visits, prison calls and nursing home rounds would be included in this model. Children, elderly patients or those with mental, physical or chemically induced challenges are all fertile niches of a core service philosophy.

Be sure to charge for what you do - based on your time, expertise and venue. It makes no sense to provide *service excellence* and charge for *service mediocrity*.

THINK NIEMAN MARCUS

3. The Third Operational Type is the Value-Added Provider:

A value-added provider is committed to practicing at the highest and riskiest levels of medical and surgical care and has the credentials and personality to do so.

Value differentiation is based on such factors as board certification, hospital privileges, subspecialty identification or other unique attributes such as fluency in a second language or acceptance into an ethnocentric locale.

Now, make no mistake about this philosophy - because a certain amount of self-aggrandizement is needed to develop a brand image; and charge for it.

In other words, it is just not enough to be an orthodontist or expert cosmetic dentist - or a high class spa dermatologist - you must also develop the gravitational pull of a singular public image.

This brand identification must be enunciated in your business plan ... as you answer the very specific question: *What medical service can I offer ... that no one else can offer?*

Put less delicately: you have to have a unique practice proposition. Shy personality types might wish to avoid this operational archetype.

NOW - A word to reduce complaints about fees in this model is *transparency*;

IOW: inform your patients about your fees.

More medical providers are harmed by fees that are too low ---- than hurt --- by fees that are too high.

Remember, if you never get complaints about fees, it either means that you are providing first rate care and your patients think you are worth every penny - or you are undercharging them.

THE NEXT PORTION OF OUR BUSINESS PLAN FORMAT is ... The CONSOLIDATED FINANCIAL STATEMENTS

Since a start-up medical practice has no historical financial information - simplified *Pro Forma* production logs are forecasted for 3-5 years, along with a projected *Break-Even Analysis*.

Pro Formas are simply estimates of like -or- similar practice types.

They demonstrate the *best case, worst case, and most likely* financial scenarios. Computerized spreadsheets are ideal for this task. And, there are generally three types.

The First Financial Statement is the Net Income -OR- Profit & Loss) Statement

By allocating a practice's profit or loss into operating groups, the physician-executive and potential investor can isolate revenue centers and costs drivers.

In some managed care contracts, an analysis to identify per patient unit, or per dollar revenues, gross profit and/or gross margin, is vital.

Certain non-cash expenses, like depreciation, amortization and deferred taxes, are then deducted from revenues to determine overall net income.

The Second Pro-Forma is the Statement of Cash Flows

Cash Flow is the lifeblood of any medical practice. And, The *Statement of Cash Flow* projects estimated cash by month, quarter and year, along with the anticipated timing of cash receipts and disbursements.

Recall - The medical office bills and obligations are paid out of cash flow, not net income. It is very important for *accrual* based accounting practices and aged accounts receivable.

In the end - Cash flow reflects the internal generation of funds available to re-pay investors It is VITAL.

3- The Third Financial Statement is the Balance Sheet

The *Balance Sheet* forecasts the financial condition of an office at a singular point in time. It projects the ability to meet financial obligations and the capacity to absorb financial setbacks without becoming insolvent.

So - Now-the question becomes *How do we Estimate Solvency?*

Actually this was a difficult task in traditional fee for service reimbursement paradigm during the golden age of medicine. A time when ... *the doctor never was sure when, if, or how much she was going to be paid for medical services rendered.*

Today, the task is much easier with fixed payment reimbursement schedules, capitation payments, bundled fees, Accountable Care Organizations, and the like.

So, how do we start? Well, a solid method of estimating practice solvency is BEA.

So, what is Break Even Analysis?

Break-Even Analysis is a method of assessing practice profit potential and down side risk. It represents the minimum percentage of productive capacity the office must utilize, the minimum patient volume it must generate, and the minimum market share it must obtain to break even.

At this production volume, the doctor experiences neither a profit nor a loss.

For example, if the new office projects 300 new patients during the first year, but only requires the revenue of 150 patients to break

even, then the office has only to attain fifty percent of its projected volume to Break-Even.

To perform this analysis, the practice expenses should be divided into fixed and variable costs.

Fixed costs do not fluctuate with volume and remain constant as volume increases. These fixed costs include rent, insurance, interest and minimal doctor living expenses.

Variable costs, on the other hand, are uniform per unit of output. For example labor, Human Resources, materials, utilities and equipment fluctuate in direct proportion to volume.

The Break-Even Point In *Patient Units* **and** *Dollars* is then calculated with the following formulas:

Break-Even Point In *Patient Units* is:

Fixed Costs / (Revenue Price Per Patient - Variable Cost Per Patient)

Break-Even Point in Dollars

BEP in Patient X Revenue Price Per Patient

FINALLY - CRISIS MANAGEMENT is the newest component of the modern medical practice business plan. Like an exit strategy, it alerts the reader of your awareness of potential adverse financial events.

So, why is this needed?

-) If you remain in practice long enough, something adverse is sure to happen that will negatively affect your business. For example,
-) A patient may die, your hospital may close, the surgery center you frequent may lose accreditation, a trusted employee may be caught embezzling, or a patient may *go ballistic* and injure your staff or yourself.
-) **When, not if,** this scenario occurs, you must have a *crisis management plan* in place to deal swiftly and successfully with the matter. And, most management experts suggest the following course of action when tragedy strikes:
 1. Stay calm and relaxed but act immediately.
 2. Release detrimental, but accurate information as soon as possible. Stay neutral.
 3. Educate your staff about the crisis, and then your local community.
 4. Find a solution to minimize recurrence and routine disruption.
 5. Monitor and report the results of your strategy to all affected or people, patients, insurance plans, and the community.
 6. Finally, thank everyone for their support and turn a negative story into a positive one through good public relations.

You will grow personally and professionally from the experience.

IN CONCLUSION

I hope all our listeners now realize that writing a medical practice business plan is an effort ---- that is not nearly as difficult as starting or expanding a practice without one.

It is time-consuming and emotionally challenging. But, more often than not, leads to the raising of needed capital.

You may even learn something about yourself and whether or not you wish to be a employed-physician OR an employer-physician.

It is a decidedly positive endeavor and well worth the conscientious industry it requires.

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And now, allow me to wish you good luck.

Please feel free to opine or submit questions to me.

**I'm Dr. David Edward Marcinko, signing off – FOR NOW - by
WISHING YOU:**

Good medicine.
Good business, AND.
Good day.



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