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SPECIAL TOPIC

Business

Budgets: How They Are Planned, Prepared, and Managed

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Background: Budget planning and execution is as difficult as it is vital to any practice, whether academic, private, or group. Well-planned and executed budgets are a source of revenue and growth that fuels the practice for the next cycle. Conversely, poorly planned budget is disastrous, and a badly executed one invariably leads to unrecoverable losses. Many clinicians, especially those in academic centers, are not involved in budget-planning preparation and yet are held accountable for their yearly performance in relation to the budget.

Methods: Key processes for budget planning and their significance are identified. Integrating these steps with the needs of a clinical practice, a stepwise method is described for both clinicians and administrators to work together to plan, prepare, and manage budgets.

Results: Relevant examples of how budgets affect clinical workflow and common pitfalls of budget planning and mitigation methods are identified. A simplified systematic approach allows for a streamlined, smooth budget-planning process that involves faculty and staff, which holds them accountable for the year-long performance of the entire clinical team.

Conclusions: A systematic proactive approach to budget-planning, preparation, and management provides a financial direction to the department; tracks performance; allows growth; and provides the flexibility to stay on track, change course, or reassign resources. *(Plast Reconstr Surg Glob Open 2024; 12:e5755; doi: 10.1097/GOX.0000000000005755; Published online 2 July 2024.)*

INTRODUCTION

Less than 3% of academic chairs have formal training in business management.[1] Consequently, budget planning, preparation, and management (BPPM), a crucial task of any chair, becomes burdensome. Importantly, the degree of department-chair involvement in budget preparation varies among institutions (from a simple sign-off to active engagement). In the current environment where departments are increasingly held accountable for financial performance as much as clinical productivity, this level of involvement is changing. Chairs do find themselves, more now than ever, actually involved in budget preparation and management. Clinical and administrative responsibilities leave little time to learn nuances of BPPM, which is inherently difficult. Increasing administrative pressure from the top to "do more with less," growing faculty demands and dissatisfaction, and the uncertainty of reimbursements makes financial forecasting even harder. In most cases, chairs delegate this task to nonphysician administrators and sign off. Alternatively, some chairs create an "incremental budget," which blindly tacks a small increase across the board to the past-year's budget, and call it done.[2] Either way, inattention to BPPM harms the performance and growth of the entire department, with far-reaching consequences.

Here, we present a systematic approach to budget planning and management for clinicians, be they chairs, chairs-to-be, faculty, or private practitioners who want to optimize their financial performance. Basic budgeting principles and a stepwise method of creating a right-size budget using examples are explained, including common errors and their mitigation methods.

ROLE OF AN ACADEMIC CHAIR

Historically, our misconceptions toward budgeting include:

- It is a pain—best finished quickly.
- Budgets are barriers to progress.
- It's an administrator's job, not a physician's.
- Budgets are handed "top-down," by administration. Our input is pointless.
- Demonstrating need is enough. Administration figures out the rest.

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The best way to address these misconceptions is to understand and broadcast the following facts:

- *Academic Chairs are de facto CEOs/CFOs of their team,*[3] *not purely academic leaders.*
- *BPPM is a leadership opportunity, not a burden.* BPPM considers the context of the academic center and tracks performance closely through the year. Through appropriate resource allocation, chairs can achieve their vision for the department and improve productivity, patient care, and profitability.
- *Budgets are not barriers—they are guides.* Budget tracking provides a financial direction to the department, via dynamic real-time monthly performance charts of revenues and expenses. Teams can stay on track, change course, or reassign resources.
- *Budgets unite.* Teams that build budgets together focus sharply on staying on-target year-round.[4] This enhances stability and morale. Hospital leadership also appreciates commitment to financial responsibility and responsiveness.
- *BPPM is not just a one-time task.*[5] Continual budget monitoring is just as critical. Comparing actual performance to budget every month guides future budget modifications.
- *Data sharing with clinicians is crucial.* The simple availability of financial and clinical performance data enables faculty and chairs to accurately understand costs, revenue, and growth. This facilitates their input and suggestions, which can then be used to craft a better, more realistic budget. Without data transparency, all stakeholders (including the medical center) suffer.

Takeaways

Question: What role do budgets play in a clinical practice?

Findings: (1)Budget preparation is a long process and must start early in the financial year; (2) engaging the faculty and staff creates the buy-in not only for planning but for its subsequent execution and review; (3) monthly assessments of the variances between actual and budgeted performance allows early intervention; and (4) diligent budgeting aligns the department with the administration.

Meaning: A systematic stepwise process, faculty-involvement, a sharp timeline, and a robust methodology can create and manage a strong departmental budget that provides stability and fosters growth.

GENERAL DEFINITIONS

Budget Cycle

A budget applies to a finite period (calendar year, January 1–December 31, or financial year, July 1–June 30). Although budgets are posted at the beginning of the fiscal year, with several subsequent updates,[6] budget planning starts much earlier, in quarter 3 (Q3) of the previous year (Fig. 1).

Types of Budgets

Capital Budget

This comprises long-term investments by the medical center into the department (eg, building/remodeling a med-spa, new facilities, high-cost equipment purchase). Planning meetings between department chairs and hospital administrators occurs around Q2 to negotiate these

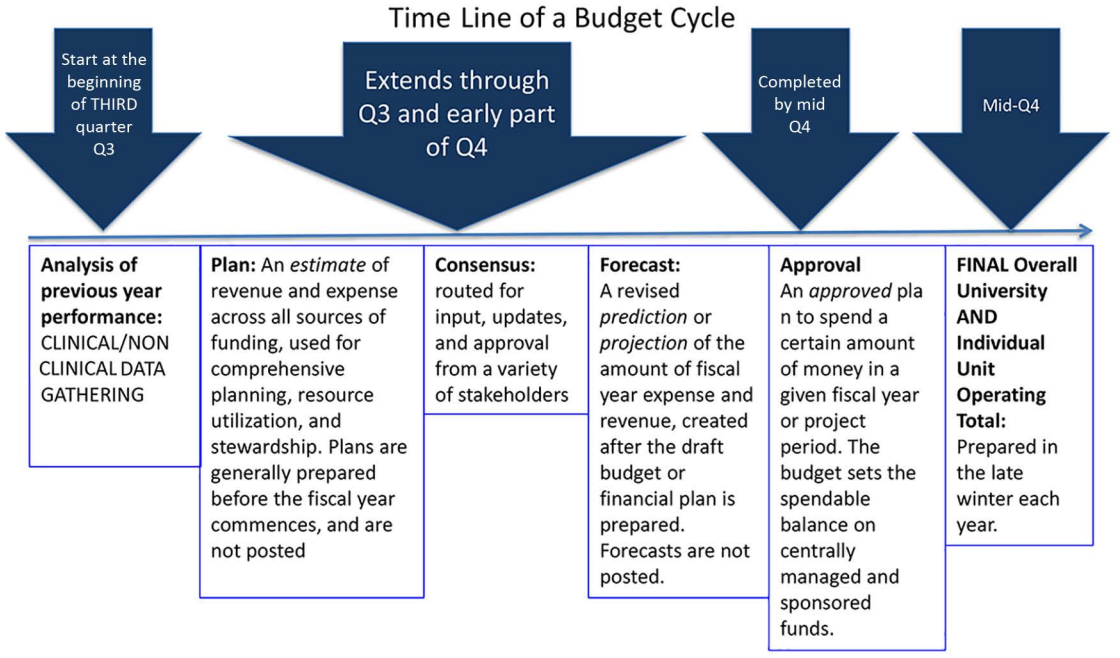

Fig. 1. Timeline of budget cycle.

purchases, shared services/equipment, short-term leases, or a trial of a new service/equipment (eg, lease laser equipment or surgery suite).

Operating Budget

This estimates departmental expenses/revenues, including salaries, supplies, and rented medical equipment and other variable costs.[7]

Capital budget (CB) impacts operating budget (OB) as follows[8]:

- After a center builds new facilities, departments using these facilities are expected to increase revenues.
- The continued resources required to maintain CB investments become part of the OB, not the CB. By anticipating recurring costs, chairs ensure that the CB is profitable.

FUNDING SOURCES FOR THE OB

Centrally Managed Funds (50%)

- Managed by practice-group or surgery department (if plastic surgery is its division).
- Chairs must engage hospital leadership on long-range planning for proper resource allocation.
- Centrally managed funds (CMFs) offset management-financing costs.
- They limit the chair's executive authority on staff performance and efficiency, especially when services are inefficient.
- CMFs are a buffer against unforeseen circumstances.
- Year-end balances do not roll forward to next fiscal year.

Departmentally Managed Funds (~40%)

- Managed by department chair.
- Covers variable costs (eg, supplies, incidental expenses, discretionary spending).
- Separate authorization levels based on rank and focus of work to avoid runaway spending (eg, a nurse manager can give out annual bonus payments to deserving staff; an office manager can purchase a new office equipment or fund the Christmas party).
- Year-end balances do roll forward.

General Fund (~10%)

Supports teaching, training, and research activities.

Sponsored Project Funds (Highly Variable)

Need updating periodically: for example, a research grant award or expiration changes the faculty-clinical productivity in the budget.

STEPS OF BUDGET PLANNING (FIG. 2)

1. Look Back to Plan Forward

Financial and operational data identify the team's strengths and opportunities and help forecast need for additional faculty, staff, and resources. Such data help incorporate strategic goals (departmental/institutional) into the budget plan.[9] Because retrospective data-gathering requires time and effort, one must start early (around Q1). Data points must include faculty productivity, resource utilization, patient volumes, and clinic appointment and surgery wait times.

When data become available, calculate last year's net income (=revenue minus expenses): negative net income is ominous. Long-term goals are unattainable when treading water: revenue/service expansion and/or cost-cutting measures are mandated.

2. Participatory Budgeting

Common faculty concerns are that department budgets are "shoved down their throats" without soliciting

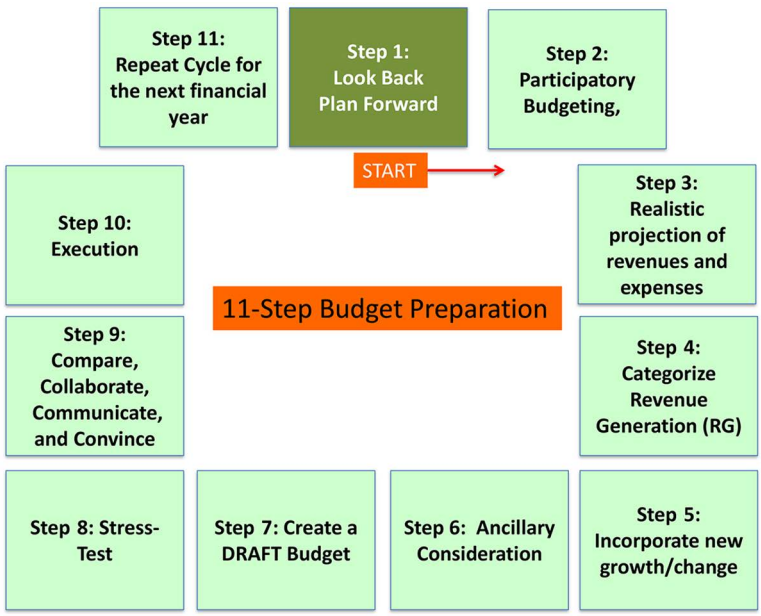

Fig. 2. Steps of budget preparation.

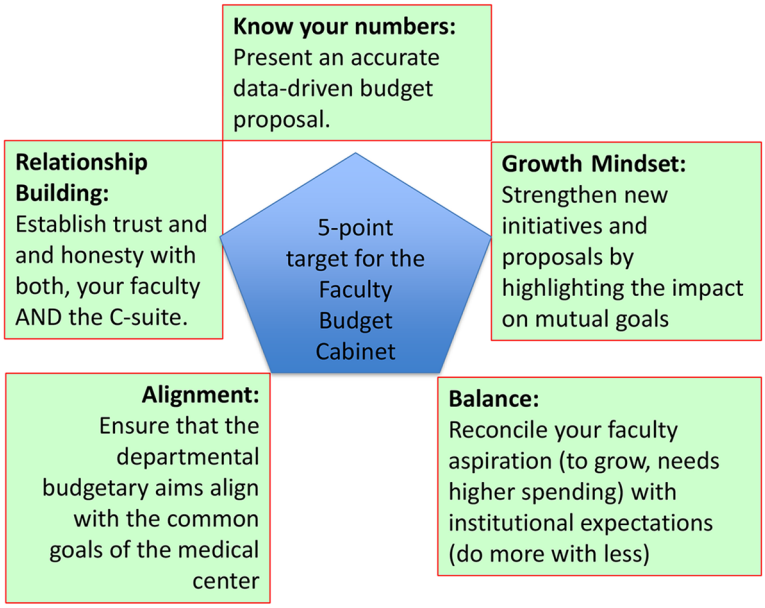

Fig. 3. Five-point target for the FBC.

their opinions. Setting up a faculty budget cabinet (FBC) tasked with a five-point budget plan circumvents possible dissatisfaction (Fig. 3). Termed "participatory budgeting," it seeks inputs from providers closest to point of care.[10–12] The FBC must generate a draft budget plan that forecasts annual operating costs, new hires and capital equipment, and funding via volume growth/loss, leaving realistic room for practice changes.

Because plastic surgery provides varied services, participatory budgeting brings diverse service-providers together to describe their needs. This promotes resource-sharing, consensus, and a right-sized budget that identifies common services and transparent resource allocation. For example, cancer reconstruction, hand, and trauma are discrete services that could share resources such as microscopes but will differ in their on-call staffing and emergent-care needs.

Data: Monthly variance analysis (defined as "actual minus planned") of expenses/revenue and patient volumes are presented as easy-to-read basic reports. The revenue-cycle team provides reimbursement profiles and correlates charges with payments, helping the team identify the best/worst-paid services and payors. This helps forecast operating profits.

Timeline: A budget calendar with deliverable deadlines, assigned tasks, and a meeting structure ensures that the FBC is on track.[13]

3. Realistic Projection of Revenues and Expenses

Revenues

Typically, revenues include professional fees (office and surgical services), direct cash-paying patients, copays, lease income, and financial support from the academic center (eg, medical directorships and program director cost from graduate medical education).

Factors affecting revenue include provider productivity, contract changes, insurance-coverage plans, number and value of insurance denials, and billing timelines. Forecasts are dependent on the key revenue drivers, for example:

- *Internal drivers*: surgical volume, efficiency, productivity
- *External drivers*: reimbursement rate, inflation, negotiation with insurers/institutions.

Current resource crunch will negatively impact future planned increase.

Expenses

Salaries

Staff salaries/benefits, hiring costs, overtime pay, and professional development costs are the biggest expenses. However, trying to run lean, keeping salaries low and noncompetitive, is a mistake that leads to attrition and higher burnout with exorbitant rehiring costs that wreck the originally "lean" budget. Ways to offset salary costs include having administration pick a percentage. For example:

- Co-hire administrative clinical staff with the administration.
- Get the hospital to appoint a faculty as medical director/education director and offset a percentage (up to 50%) salary and benefits cost.
- Have the hospital fund a faculty's salary via a quality project or a grant, again offsetting a percentage of their salary. However, be aware that if a faculty loses the funding, the salary cost-burden falls back on the department's budget.

Equipment

Leased or bought equipment and medical/office supplies are expense budget-line items. Equipment budgeting avoids supply shortages at critical times and restocking with rush shipping. Further, if the price of any item

increases, these data identify the uptrend early, providing us time to identify less-expensive alternatives.

Monthly review of expenses identifies resource utilization and depreciation and helps control runaway costs. For example, biologics for wound care, a high-cost medical supply, can increase monthly expense dramatically. If unreimbursed/denied, these costs can disrupt a budget.

Negotiables

These comprise tax (facility, dean), office rent, insurance, and marketing, which can add up to 20% of expenses. Understandably, negotiation with the administration requires care.

4. Categorize Revenue Generation of Each Service into Revenue Generation-positive, Revenue Generation-negative, and Revenue Generation-neutral (Fig. 4)

Since most plastic surgery departments comprise many services (trauma, hand, cancer reconstruction, cosmetic etc.), this step identifies patterns of fund flow and profit and loss of each service.

- For revenue generation (RG)-positive services, identify ways to increase profitability, resources needed for market expansion (more clinic space and facility acquisitions), and need for new hires. Also consider limiting factors. Thus, higher patient numbers require more appointments, increasing flow-through service costs, and more operating room efficiency. All these may or may not be possible within the hospital system.
- For RG-negative services, determine their *survivability versus growth*. If expenses exceed revenue despite various salvage attempts, the service should be closed (eg, cost of a money-losing med-spa or unused laser equipment). When a service is closed, both associated revenue and expenses are eliminated.

If an RG-negative service is to be retained, the plan must specify clear expectations of cost versus revenue, as well as strategies for close scrutiny via monthly variance reports.

- RG-neutral services need the same scrutiny as RG-negative services to determine if investment in their profitable components could improve revenues.
- Loss leaders: Defined as services/products that attract new customers via low prices (eg, Botox and fillers at break-even prices) but increase overall revenue by enticing consumers to seek services with higher profit margins (eg, skin products, surgery, office procedures). These must be identified and supported in the budget plan.

5. Incorporate New Growth/Change (Fig. 4)

The department chair and the FBC (from step 2) incorporate strategic goals for the year and map out required funds, estimated expenses, and expected revenues. Their chances of being funded increase when they align with institutional goals, potentially increasing cost-sharing and fund flow to your department.

For example, a goal to build a bariatric recontouring service will succeed when costs (new hires/resources/infrastructure staff-support and marketing) can be managed either incrementally or shared with the general surgery bariatric service. Further, a feasibility business-plan identifying revenues, insurance coverage, billing/codes, reimbursement contracts, and so on improves the budgeting process.

Assumptions for new growth are based on variables such as competitive market, new service offerings or new equipment, increased supply costs, or increased demand.[14] Involving the hospital's strategy or business teams ensures definition of realistic goals and improves the accuracy of predicted cost and revenue.

6. Incorporate Ancillary Fiscal Sources (Fig. 4)

Research grants generate significant revenue as shared facility and administrative and salary savings.

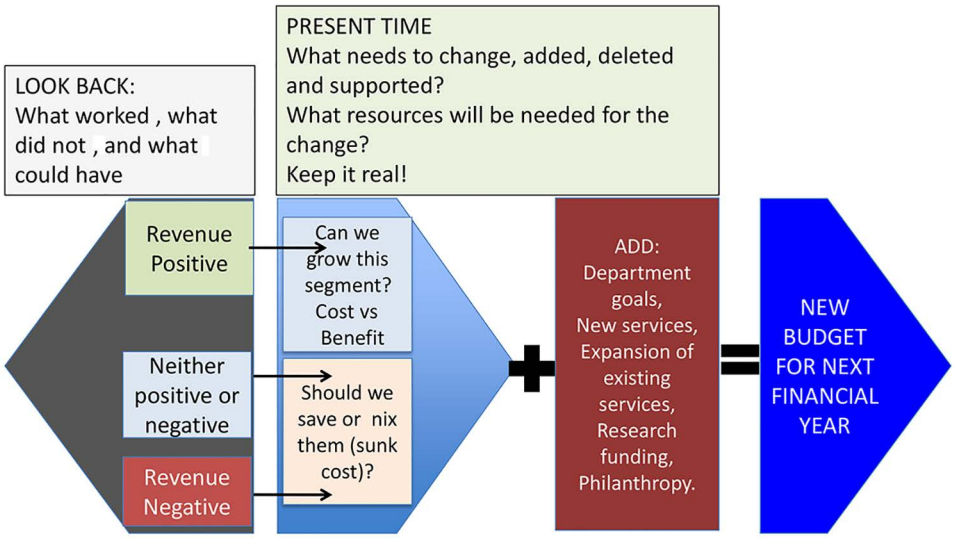

Fig. 4. Diagrammatic representation of steps 4–7 of budget preparation.

The budget plan created using input from the principal investigator(s) and research oversight teams must reflect astute management and accountability of these funds, to promote fiscal responsibility and prevent cost overruns.

Philanthropy: Donations to the department, designated by donors for specific activities, are typically held in a foundation account that is managed by the chair. These, along with endowments and industry gifts (especially for equipment purchases), can free up cash that can be repurposed.

7. Create a Draft Budget (Fig. 4)

The draft budget is based on, and simplified by, the groundwork laid by the previous steps.

8. Stress Test the Draft Budget to Identify Blind Spots

Stress testing (also called *sensitivity analysis* in other business domains) is a means of testing the assumptions of predicted revenue or expenses if the underlying variables change. For example, changes in OR availability, office staff support, and ancillary external variables affect demand or supply. The financial strain COVID-19 imposed on healthcare budgets is a stark reminder of why stress testing a budget is critical.[15,16]

Sensitivity analysis allows an objective approach toward risk quantification and contingency mitigation. It is typically performed using the "what-if" capability of spreadsheet software: it requires some fluency in advanced spreadsheet software use. Use of spreadsheets is complemented with the "if this then that" principle: for example, if the budgeted new med-spa patient volume increase by 20% does not happen, then, you will reassign the resources to another service (cancer reconstruction) with higher patient flows. Redeploying extra staff to higher patient-volume services may help defray some costs: boosting marketing to ensure new patient volumes do not drop is another potential solution.

If there is going to be an unplanned overspending or underspending of the budget, then the time to know about it is now. A small overspend on, say, simulation equipment in Q1 may turn into a massive overspend by fiscal year's end. The earlier corrective action is taken, the more likely it will be beneficial.

Underspending and saving money may be attractive, but beware that if you underspend in one year, your budget is likely to be cut by the variance in the next year. ("No good deed goes unpunished.")

9. Compare, Collaborate, Communicate, and Convince

Compare your draft budget with similar departments,[17] either in the same medical center, or same-size/range plastic surgery departments in other institutions. This collaborative approach gives a panoramic view of the budgeting landscape and identifies national trends.

Once the draft is ready, ensure the backing of the C-suite. Well-defined objectives, demonstration of value, a realistic estimation of revenue/expenses, and negotiating skills[18] help the hospital administration understand and ratify the budget.

If the administrative team feels your budget is too high and wants to cut costs, then the following five negotiating tactics are essential:

- Reassess your process; test if costs are truly high.
- If not, explain how these elements benefit the department, and how cutting them would be shortsighted and hamper your team, which would affect the health system.
- Offer alternative areas where savings could occur without affecting healthcare delivery.
- When the pressure is "to do more for the same financial investment," identify new opportunities to increase efficiency, both by the administrators and by your team.
- Finally, communicate your budget plans with other chairpersons. Share common concerns and seek overlapping activities where cost-sharing or resource-sharing is feasible.

10. Finalize the Budget and Execute

Even after the budget has been finalized, expect surprises. To quote former heavyweight boxing champion Mike Tyson in a different context, "Everyone has a plan until they get punched in the mouth." Even the best-laid plans require on-the-fly revision. The following strategies help considerably in execution.

- Monthly assessments: variances (as described in step 1) must be monitored and explained, and corrective decisions made early.
- Resilience: focus on creating a cushion in the budget, to account for sudden changes (eg, price increases due to supply-chain disruptions, and shutdown due to COVID-19).[19]
- Variance-reconciliation[20]: this becomes the formative step for budget planning for the following year.

11. Repeat Cycle for the Next Year

Go to step 1.

COMMON PITFALLS AND MITIGATION MEASURES

Lack of Data Sharing

Transparent data sharing of performance with clinicians is critical to the success of any institution, and must be firmly advocated for. One suggestion is messaging: involve sessions at national meetings, where physician leaders share ideas on how this issue is handled at their institutions, and benefits of data availability are explained and (if possible) quantified. Another suggestion is to have department chairs convince the hospital leaders to run a pilot program for 1 year, wherein they will witness the benefits themselves.

Periodic Performance Assessment

Failure to do this creates a false sense of "all-is-well" with department finances right up to Q4, which would be too late for recovery. Monthly review by the FBC (from step 2)

and communicating variances early allows for a swift root-cause analysis and early corrective intervention. Focus on second-quarter forecast versus performance. It identifies deficiencies early, allows for quicker intervention, and helps shape the next year's budget more accurately.

Cost Overruns

Even small recurring increases in cost can disrupt the budget: for example, leasing a laser device at a higher interest rate could destroy the office-based services budget. Mitigation involves reviewing purchase order carefully and researching less-expensive alternatives.

Too Many Accounts

This makes financial performance harder to track. The temptation to shuffle funds between accounts to shore up failing ones leads to a false sense of security. Simple compartmentalized accounting and fewer accounts best avoid this logistic nightmare.

Nonmonthly Institutional Expenses

Expenses such as Dean's tax and escalating facility rents can be overlooked through the year—hitting the balance sheet in Q4, causing budget disruptions.

Both sides (hospital and your department) can face unexpected operational or CB challenges. Examples of contingencies:

Hospital-related

- Unpredictable economic events (eg, COVID-19 pandemic) render static budgets obsolete.
- Changes to reimbursement and payment models (eg, declines in Medicare/Medicaid reimbursement).
- Development and adoption of new technologies (eg, telehealth and home-based medicine).
- Labor shortages and increasing labor costs.
- Mergers, acquisitions, and increasing market competition from new care delivery models.
- Supply-chain issues and interruptions (eg, personal protective equipment or drug shortages).
- Hospital-wide patient-volume changes affect service line budgeting.
- Macroeconomic trends: rising interest rates, inflation, and higher capital-acquisition costs.

Department-related

- Unexpected physician loss, new hire underperforms.
- New procedures drive up per-case supply costs.
- Leases and contracts expire.
- Seasonality: school season, snowbird patients, physician vacations.
- Reset of deductibles.
- Wage increases.
- Survey mandates changes.
- Staffing projections.
- Reimbursement changes during the year.
- Budgeting large purchases.

Both leaders need to have the rapport and understanding to help mitigate these problems together and not individually. Here, open, frequent communication with your faculty and staff (eg, a simple question, "How is the practice shaping up?" or "How is the staffing going?") can yield insights into faculty/staff perceptions. Candid conversations, apart from ensuring that the faculty and staff feel heard and valued, lower unexpected attrition.

Reassess Contracts

Failure to periodically reevaluate equipment contracts, leases, rents, and payors for reimbursements can result in large deficits from unforeseen financial leakage.

Charity Care

Medical centers absorb a higher percentage of indigent patients, negatively impacting the budget.[21] Conversion of these "losses" into gains can be achieved by:

- Letting the community appreciate the social responsibility of these services.
- Creating a community outreach plan that gives credit for this work (intangible goodwill gains).
- Writing off the costs of these services against hospital contribution.

Academic Output

Publications and unfunded research offset clinical productivity, are ignored in a typical budget, and could potentially reduce clinical revenue. Mitigate this "cost" by creating an education/research fund within the operational budget that buffers the lost clinical revenue by enabling buy-down of clinical productivity requirements.

CONCLUSIONS

A systematic stepwise budgeting process, faculty involvement, a sharp timeline, and robust methodology yield a budget with the following characteristics:

- It aligns operational plans with financial planning targets.
- It balances capital spending, operating costs, and revenue.
- It carefully tracks resource allocation and utilization.
- It enhances accountability within the team and with the hospital administration.
- It tracks fund allotment to clinical services, projects, and initiatives.
- It ensures capital investment for stability and strategic growth.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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