Solo-to-Group Transition Checklist

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A working checklist for solo therapists scaling to a group practice. Print it, tick the boxes, and use it to decide whether you are actually ready — and what to put in place before your first hire.

1 Are You Ready to Scale? — Demand Signals

If **three or more** of these are true, you are likely past due for the move, not just considering it.

- [ ] Your waitlist is consistently **four or more weeks** (a sustained waitlist, not a seasonal spike).
- [ ] You **turn away right-fit clients** in your specialty — revenue and clinical need walking out the door.
- [ ] Your solo practice nets **1.3–1.5×** what you'd earn employed (margin to absorb year-one hiring costs).
- [ ] You **decline referral relationships** because you can't take the volume.
- [ ] You've done admin work nights and weekends for **6+ months**.
- [ ] You want **more than two weeks off** a year without losing income.
- [ ] You're starting to **dislike client work** because of everything around it (operational, not clinical, burnout).

2 Operational Readiness — Before You Hire Anyone

A long waitlist proves demand. It does not prove readiness. Build the systems **before** you hire, not after.

- [ ] **Documented processes** — intake, scheduling, billing, documentation standards, client-communication norms all written down so a new hire can follow them without constant check-ins.
- [ ] **Six months of personal runway saved** — year one often reduces your take-home before it grows.
- [ ] **Professional support lined up** — employment attorney, mental-health-savvy accountant, group-capable malpractice carrier.
- [ ] **A tech stack that scales** — multi-user EHR, group-capable AI documentation, multi-clinician billing.

3 Business-Model Decisions — Decide These First

LEGAL STRUCTURE

- [ ] **LLC / PLLC** — most common starting point; separates personal assets.
- [ ] **S-Corp election** — revisit once net profit clears ~**$80k**.
- [ ] **PC / PA** — required in some states (CA, TX, NY) for clinical practices.

W-2 VS 1099

- [ ] If you set schedules, fees & require your EHR → they're a **W-2 employee**.
- [ ] Misclassifying clinicians as 1099 is a top audit trigger — confirm with an attorney.

REVENUE SPLIT — PICK YOUR MODEL

Model	Typical use
60 / 40	Fully-licensed associates (clinician / practice).
50 / 50	Associates needing referrals, supervision or heavy admin support.
70 / 30	Clinician brings own referrals, minimal practice resources.
40–50%	Pre-licensed clinicians (practice supplies required supervision).

~70% of group practices use a fee-split model; 60/40 and 70/30 are most common. There is no industry standard — model your own loaded costs first.

Don't skip credentialing math

If you accept insurance: plan **6–24 weeks per panel** and apply **3–6 months before** you start billing under the group. You'll need an **NPI Type 2**, an **EIN**, and a fresh contract with every payer — even panels you already joined individually.

Hiring Framework & Tooling Checklist

Your first hire is the highest-stakes decision in the transition. Diagnose what's actually broken before you advertise, then choose tools that scale with the team rather than against it.

4 Your First Hire — Diagnose Before You Advertise

The common mistake: assuming the first hire must be a clinician. If you can't reach your inbox, another clinician makes the admin problem **worse**.

If the bottleneck is…	Hire first
Clinical demand / waitlist of handoff-ready clients	A licensed clinician "mini-me"
Administrative time (scheduling, billing, intake)	Admin or virtual assistant
Systems & process gaps	OBM / part-time operations lead

BEFORE YOU POST THE ROLE

- [ ] Define the **population** and **training level** required (licensed / pre-licensed / supervised).
- [ ] Name the **specialized training** that matches your niche (EMDR, IFS, DBT, couples).
- [ ] Calculate **true loaded cost** — an $80k salary really costs **$95k–$105k** (payroll tax, workers' comp, PTO, supervision time, software, onboarding).
- [ ] Confirm what the clinician must bill monthly to cover loaded cost **plus** practice margin.
- [ ] Build a competitive package: market rate **+5–15%**, benefits or stipend, CE budget, sane caseload cap (**20–25 hrs/wk**), documentation support.

30–60% of therapists leave their org annually; the leading reason is financial strain (Adams et al., 2019). Compensation and support retain — high-stress, unsupported environments don't.

5 Supervision — The Load-Bearing Element

- [ ] Confirm you hold the required **supervisor credential** for each license type you'll oversee.
- [ ] Schedule **≥1 hour face-to-face supervision weekly** per pre-licensed clinician, with a consistent agenda.
- [ ] **Document every supervision session** — it's a clinical record boards may request.
- [ ] Set **measurable competency goals**, reviewed quarterly.

6 Tooling Checklist — What Must Scale

EHR / PRACTICE MANAGEMENT

- [ ] Multi-clinician scheduling & calendar visibility.
- [ ] Role-based access (admin / clinician / supervisor).
- [ ] Centralized billing & group insurance claims.
- [ ] Clinician- and practice-level reporting.

AI DOCUMENTATION FOR TEAMS

- [ ] **Unlimited notes** — note caps die fast on a team.
- [ ] Centralized admin controls (add/remove seats).
- [ ] **Supervisor visibility** — review drafts before finalization.
- [ ] Consistent templates across the whole team.
- [ ] One-click EHR autofill (not copy-paste).

DON'T LET THESE KILL GROWTH

- [ ] **Hiring too fast** — add clinicians one at a time, ~3 months apart, while you build systems.
- [ ] **Under-charging** — splits that don't cover overhead, supervision & management margin.
- [ ] **Avoiding hard conversations** — address performance/documentation issues in the first 30 days.
- [ ] **Solo-first tooling** — choosing tools you'll have to rebuild at five clinicians.