Employed Physician Networks: Keys to a Successful Turnaround

A Roadmap to Financial Success

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AGENDA

I. Overview of EPNs (Past and Present)
II. EPN Assessment/Turnaround Process
III. Case Study
IV. Key Takeaways
V. Q&A
GOALS AND OBJECTIVES

• Review an actual employed physician model turnaround example
• Understand the items that create havoc for the employed physician network (EPN) - historically and the here/now
• Understand components of the employed model requiring urgent focus during a turnaround
• Understand the value of objectively measuring and monitoring employed models both in the turnaround stage, and as they move forward in their repaired stage
• Understand the absolute requirement of maintaining newly established standards
I. Overview of EPNs (Past and Present)
INTRODUCTION - HISTORY

• Many health systems have had “Napoleon” moments with their EPNs
• Many systems are experiencing the 1990s redux
• C-suite tends to be too engaged in applying Band-Aids to shrinking margins and fails to consider the bigger picture that EPN requires
• Same old, same old: actions may include revamping the structural integrity of the EPN
  o Impending changes in payment methodologies will require efficient, streamlined ambulatory outpatient clinics
• Some hospitals are running negative margins
  o Myopic; “here and now” focus on their shrinking margins
  o Focus on the losses that continually nibble at their P&Ls, but failure to see, and take, the long view
  o What is an acceptable “subsidy”?
• Some employed provider networks (EPNs) are not necessarily in dire positions
  o Why?
  o Under the radar?
• No attention to these multi-million dollar relationships, whether employed models or clinically integrated networks (CIN)
Hospitals and providers can work together to not only solidify their combined mission but to grow their employed models as they migrate toward\(^1\):

- Integrated care delivery
- Management
- Population health management
- **PARTNERSHIP!**

\(^1\) By definition, employed models *may* also entail Professional Services Agreements (PSAs) where physicians are contracted for services
II. EPN Assessment/Turnaround Process
THE OPTIMAL APPROACH – NOTHING IS “VANILLA”

• Reviewing an EPN involves nuance and finesse; one size never fits all
• Each network, each situation, is a function of:
  o Clinical staff
  o Physicians and advanced practice professionals (APPs)
  o Location
  o Payer mix
  o Geography
  o Client/patient needs and demands, etc.
• It’s incumbent upon experts to listen carefully to what clients say; sometimes the “actual” is different than the “perception”
• Marry subjective aspects to objective components to arrive at the right conclusion--the right fit for the system and its “individual” needs
• Message: One size never fits all and/or if you’ve seen one EPN, you’ve seen one EPN
START BEFORE THE BEGINNING

• Consider: what is an “acceptable loss” (subsidy)?
  o $100,000 per FTE? $50,000? $200,000?
• What are the system’s/EPN’s goals?
  o Regardless of the business, there’s always room for improvement
• A cursory look at the P&L of an organization offers a pretty good picture of the organization’s financial status
• Baselining “here/now” and reviewing future results relative to the baseline is essential
• Some shortcomings are evident to management/staff but require an outsider to validate
• Other times, issues are not glaring:
  o They percolate under the surface

Exhibit I - Where Are Your Margins?

1 See slide 26 where we supply an example of such a summary
## The Numbers

Can you get a 6.5-1 return in the stock market in 8 months??
e.g. If you invested $1MM today, would you receive $6.5MM in 8 months?

<table>
<thead>
<tr>
<th>Client ROI</th>
<th>Approximately 6.5 – 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss per provider (annualized)</td>
<td>$400k/provider reduced to $100k/provider</td>
</tr>
<tr>
<td>Patient visits (measured vs. same period, prior year)</td>
<td>9% growth</td>
</tr>
<tr>
<td>Gross charges and receipts (measured vs. same period, prior year)</td>
<td>Increased 34%</td>
</tr>
<tr>
<td>Operating Expenses (Q2 vs. Q2 prior year)</td>
<td>Plummetsed 60%</td>
</tr>
<tr>
<td>Point of service collections (never before measured)</td>
<td>Quickly approached six figures per month</td>
</tr>
</tbody>
</table>
BUILD A NETWORK, BUILD IN ISSUES!

- Many EPNs were “built” for potential issues
  - Problems are hard-coded into the system via acquisition
- Why? As EPNs grew, practices acquired/added “as-is”
  - Acquisition essentially brought over “bad habits”
  - Bloated staffing?
  - Staff with questionable skill sets?
  - Stale, or no, processes/procedures (P&P)
  - Historically, private medical practices have underinvested in staff, training, resources, and compliance. This shortchanging arrives at the EPN during acquisition because the C-suite is reluctant to push back on the issue of Dr. X bringing his favorite manager along in the deal regardless of the manager’s skills and abilities
- Many systems still don’t “understand” the ambulatory model/practices they fold in
- Net result:
  - Patchwork of practices
  - Systems with a cadre of individual practices functioning under the system’s umbrella (name only)
THE PROCESS – IN GENERAL

• Understand the baseline, the starting point:
  o Understand “where” the EPN is
  o Sound, quantitative endeavor coupled with qualitative analyses leads toward the right answer
  o In a vacuum, neither subjective nor objective suffice
  o Amalgamated, each component weaves an undeniable story about issues undergirding or eating away at the EPN
  o Benchmark

  Subjective Analysis (on-site) + Objective Data (on and off-site) = Complete Picture

• Ambulatory practices are multi-variant, interrelated systems that mesh together or work dynamically and push/pull like complex ecosystems
THE PROCESS — IN GENERAL (CONT’D)

- No process within the EPN functions in a vacuum:
  - When providers are incentivized to produce, an EPN typically sees higher patient volumes and more revenue throughout the enterprise; yet as reimbursement moves to “value based,” few EPNs have structures built to handle this change
    - Conversely, providers on a fixed compensation plan do not necessarily see as much patient volume, are not nearly as productive as their peers, and incur costs to the system

![Diagram of a process cycle with steps: Check-In, Follow-Up, Pat Visit, Check-Out, with corresponding dollar signs and hashtags]
There are five main stages in a successful EPN turnaround:

- **Assess**: Assess current situation and define problem areas.
- **Develop**: Develop a plan for corrected action.
- **Implement**: Implement new policies and procedures.
- **Stabilize**: Stabilize and monitor new processes.
- **Monitor**: Continuously reassess and reevaluate based on new standards.
III. Case Study: EPN Turnaround
CASE STUDY: THE CLIENT

- A non-profit, mid-sized community medical center ("Organization A") located in the Southwest
- Approximately 123 licensed beds and nearly 30 employed physicians
- Consists of multiple specialties housed in 21 practices, both on and off campus
CASE STUDY: THE IMPETUS

- Organization A had an employed physician network that was in need of significant operational, financial, and strategic improvement
- Board and senior leadership of Organization A were concerned about the EPN’s finances
- Subsidies to network were unsustainable
- Bondholders grew increasingly troubled by the financial outlook
- Physician compensation was misaligned; patient access was limited
CASE STUDY: WHAT TOOK PLACE?

• Particular need existed for focused action on orthopedic component of medical center
• Physician leadership engaged third-party consultants to assess/implement change in orthopedic practice
• System anecdotally sensed that economically/politically employed orthopedic model was struggling:
  o Providers essentially practiced under own rules, akin to being an unaffiliated private practice
  o Clinics were canceled on a whim, patients were moved, call avoided
• Though experts thought they were performing a routine analysis on a component in the EPN, they were gearing up for review of an EPN in need of a significant overhaul
CASE STUDY: WHAT TOOK PLACE? (CONT’D)

• Advisors reviewed the production of the orthopedic model by performing an operational assessment:
  o From check-in to care process to check-out
  o Considered the operational stability of the practice
  o Financially analyzed the provider (physician and APP) contracts contemplating comp alterations

• Organization A was considering possible strategic points for the hospital’s orthopedic service line including outreach, alternative alignment models, and further employment of physicians

• After completion of the assessment report and review by the CEO and Board, the outside consultant was authorized to implement recommended changes
CASE STUDY: WHAT TOOK PLACE? (CONT’D)

• While reviewing the orthopedic practice, advisors stepped into something a bit....deeper

• Experts were asked by senior leadership to review and assess the functionality of the entire operational structure of the EPN:
  o The EPN was losing approximately $300,000 per provider!

• During the process, the vice president of the EPN resigned to take a VP role in an adjacent state

• Given the unsteady position of Organization A, leadership was concerned the departure could create more large-scale issues
  o A seasoned practice management expert was placed on-site to serve as the interim vice president and oversee the turnaround process

• The project morphed from a simple assessment of one practice to a system-wide review with an interim vice president and an executive search in place
• The experts deployed a seasoned individual to:
  o Serve as the interim VP of physician services
  o Become the point person in the evaluation and assessment of the EPN
• Organization A required the arrival of an interim VP due to the departure of the former executive; however, an interim executive is not essential to moving the assessment project forward
  o Can additionally add a level of continuity/structure for the EPN
CASE STUDY: STEP-BY-STEP APPROACH

• Deploy team to review practices’ operational functions
• Review functionality of entire clinic:
  o E.g. Organization A was asked by other clients to review revenue cycle, scheduling, or patient access
  o Doable; however, each acts in concert with other pieces of the ecosystem
• Concurrently request data for the prior 12 months for each practice to obtain “freshest” data and recent “feel” for the practices’ financial/operational standing
• Interview key leaders and stakeholders in each location

Deploy team to review practice’s operational functions
Request current data to ascertain current financial/operational standing
Interview key leaders and stakeholders in each location
Analyze data received
CASE STUDY: STEP-BY-STEP APPROACH (CONT’D)

• Interviewees vary with the size/complexity of the organization:
  o E.g., in a small medical practice the lead physician and practice manager might be interviewed
  o In Organization A’s case, and like-sized situations, experts may interview site practice administrator(s), a lead clinician or two (provider and/or APP lead), and the C-suite

• The interview results should be kept confidential; enabling “good,” candid information from participants

• When multiple parties are interviewed in isolation and broach/corroborate similar thoughts, something usually exists that requires attention

• Interviews are semi-structured – allowing participants to freely associate within loosely constructed parameters

• While open discussion is encouraged, experts are advised to navigate discussions to obtain the information needed
• This review coupled with patient data/demand, such as:
  o Check-in review
  o Collection of copays and deductibles
  o Patient workup and throughput (the care team)
  o Use of exam lanes and equipment (hard asset limiting factors/physical plant parameters)
  o Deployment of extenders
  o Provider schedules
  o The check-out and scheduling follow-up procedures and visits
CASE STUDY: STEP-BY-STEP APPROACH (CONT’D)

• Aforementioned data should be requested approximately three (3) weeks prior to site visit
• Invariable data points to areas of concern prior to entering a clinic
• An inexhaustive list of data potentially requested includes:
  o Productivity by provider (physician and APPs)
  o Revenue cycle
  o Provider schedules
  o Staffing
  o Staff compensation
  o Collections
• Note: with entities living under one corporate umbrella, each practice can have disparate numbers and operations, notwithstanding specialty specific differences
  o Each practice requires review as a subsystem within the larger ecosystem
  o Data should be reviewed individually, provider-by-practice, to a level of granularity not often performed by clinics, whether due to time and staffing constraints or inertia
CASE STUDY: RESULTS (CONT’D)

After careful review, understanding that no system is like another, and contemplating the client’s goals, experts determined what was in most dire need of improvement by focusing on eight areas that needed concurrent remedial action to quickly improve financial standing:

1. Increase patient access
2. Improve revenue cycle management
3. Standardize policies and procedures
4. Optimize staffing model and staff/resource utilization
5. Procedural coding audit and education
6. Collaborative leadership (providers coupled with the C-suite)
7. Compensation alignment
8. EMR template standardization development and deployment
CASE STUDY: RESULTS (CONT’D)

I. Increase Patient Access
• Pre-assessment, hands-off management nature, providers managed their schedules
• By its very nature, this approach bred inefficiency/waste throughout the system
• Limiting referrals/quashing access meant patients and referring providers would vote with their feet and select care elsewhere

Solution
• With client-partner, expert immediately:
  o Crafted set operational standards to deploy throughout the clinics including:
    ➢ Standard clinic hours (e.g., Monday-Friday, 8:00 am-5:00 pm)
    ➢ Standard patient contact hours (e.g., 36 hours per week),
    ➢ Standard operational aspects related to check-in procedures, such as insurance-due collections prior to care, scheduling of patients, etc.

Result
Nine (9) percent increase in patient visits for the same measured period vs. PYTD
II. Improve Revenue Cycle Management

• The health system had recently deployed a sound integrated PM/EHR system throughout the EPN
• During/prior to the system transition, little standardization and effort regarding the accounts receivable (AR) process/managing the AR and revenue cycle
• As the new system rolled out, associated bugs addressed, aging of outstanding balances in the “old” system exacerbated
• Plan included a scheduled drop dead date to “turn off” the old system, write off, and/or turn over outstanding balances to a collection agency

Solution

• Expert built an AR management team
• Deployed RCM standardization throughout EPN, and
• Ensured synchronization between the billing team and the front desk teams in the practices
• Clinic staff is part of the RCM
• Expert instituted collections targets
• Billing and collections standardized policies

Result

RCM worked aggressively and POS collections were tracked for first time. Six-figure point of service revenue pickup followed
CASE STUDY: RESULTS (CONT’D)

III. Standardize Policies and Procedures

• Disparate policies and procedures (does NOT include clinical protocols)
• DOES include operational flow and patient throughput
• Non-clinical staff required clear understanding of expectations from clinic-to-clinic, regardless of which shop they worked
• Practices were, for all intents, separately functioning entities under the protective blanket of the greater system
• Aside from a shared common name of health system, little bound the practices to the system, and vice versa
• Development of P&P not relegated to RCM and clinic office hours
• Standardization does not stifle the practice; it lends to efficiency, savings, and consistent, repeatable actions.
• Standard policies and procedures ensure that staff understand their jobs and responsibilities

Solution

• With client’s approval, expert developed and deployed standardized policies
• Empowered staff to perform their jobs in different practices across the system continuum
• Offered better tools with which to manage staff work and measure work

Result

Consistent staff production and effort; better use of staffing and “normalizing” of FTEs (since staff can be moved across the spectrum)
IV. Optimize Staffing Model/Staff & Resource Utilization

• It was determined that certain practices were overstaffed while others were understaffed
• Junior management required practice management training and education
• Assessment displayed supply/demand anomalies vis-à-vis staffing and patient demand

Solution

• Expert assisted in “right sizing” clinical staff throughout the EPN; share/reassigned team members, as needed
• Developed a mentorship program for current leaders/staff members who displayed aptitude/interest in expanding and growing as managers:
  o Optimized “in-house” staff assets already employed
• The staff review also entailed management span of control/skill set assessment:
  o Management structure in place fostered imbalance of personnel under specialties that were managed and the skills of the managers
  o As with any organization (healthcare or not), skills differed from manager-to-manager
  o Opportunities existed to consolidate/flatten the management structure, grow current leaders, and build a scalable organizational structure that offered the system future opportunity to add on to a breathing organizational structure

Result

Savings via not filling after attrition, right-sizing staff utilization, netted six-figures in annualized savings
V. Procedural Coding Analysis and Education (PCA)

- Expert reviewed the coding of all of the providers in the EPN
- Coding is a balanced endeavor; there are always areas for improvement
- As expert studied CPT distribution, witnessed instances of either over coding and under coding

Solution

- Quantified results, by provider, delineating revenue left on the table or revenue requiring repayment
- Educated providers & staff providing reason/logic substantiating coding review results
- The EPN was leaving hundreds of thousands of dollars on the table by not documenting and/or not billing for all of the services provided
- Comparison of all providers to their specialty peers using Medicare data for E&M CPT codes (office and hospital visits) showed that the providers were under coding across the spectrum
- Presented the results to senior leadership; began process of ongoing education to assist providers in deploying more accurate coding:
  - As a sidebar, expert did not encourage providers to rely solely on the coding components built within EHRs

Results

Within six months of initial visits, audit, and education, PCA team reviewed the providers to gauge improvement. Many of the providers had significant coding improvement, which would lead directly to an enhanced bottom line
VI. Collaborative Leadership (Providers/C-suite)

• Physicians in EPN perceived they had no voice at the senior management level
• Physicians viewed the executive offices as a place where decisions occurred without input from the providers who would be impacted
• Providers saw themselves as cogs vs. as valued partners in the delivery of high-quality care
• Providers had no voice; when they did, it was in passing
  – The system didn’t devalue the physicians; it didn’t value them enough
• A strong relationship/partnership fosters trust, empowers physicians to assist in decision-making (with oversight and teamwork from the C-suite), and empowers them to drive/work toward clinical outcomes

Solution
• Expert assisted in the construction of a robust/scalable Physician Advisory Committee (PAC)

Results
• PAC’s initial accompaniment of members was that of strong, invested physician players and partners. They were eager for the opportunity to grow the system and improve the quality of care delivered in the community
• Physicians became engaged and those who wanted to improve the system stepped up
VII. Compensation Alignment

- Physicians had employment contracts with guaranteed base comp/incentives based on gross charges vs. wRVUs, quality, or both components
- Comp models, while well-intentioned, created disincentives to work and impacted the overall finances; contracts were unnecessarily rich based on old constructs
- Contracts did not incentivize providers to see patients and be productive (e.g., they were paid substantial base packages regardless of production)
- Misaligned compensation models directly impacted patient access, which consequently directly affected the system’s top line, downstream, and ultimately bottom-line financial standing
  - All things impact the eco-system

Solution

- Expert proposed a model that better-aligned key compensation components to help drive productivity, access, and enhance revenues
- Deployment contemplated leaving providers at current compensation levels with minor tweaks to pay for the first 12 months and incorporating a wRVU model component that included a wRVU threshold/baseline
VII. Compensation Alignment (cont’d)

Results

The system would:

• Develop and deploy a working group, comprised of physicians and system management (PAC), to review comp plan recommendations and work toward a final revised model
• Facilitate 2 to 3 on-site meetings to collaborate with providers and to build consensus
• Final decision-making still resides with the client
CASE STUDY: RESULTS (CONT’D)

VIII. EHR Template Standardization, Development, and Deployment

• The health system made the right choice re: their PM/EHR system
• The devil is truly in the details; “perfect” installations are never flawless
• Care must be taken in the practice management system set up relative to insurance tables, fee schedules, etc., and in the clinical side to ensure consistency, stability, and accuracy (visit templates, etc.)
• The client, like most systems, underinvested in the development/deployment of their PM systems
• Use of templates in the clinical realm was sporadic
• Inaccurate builds in the PM and EHR systems exacerbated structural issues; had adverse impact on patient volumes and the prospect of optimizing provider time in the clinics
Case Study: Results (cont’d)

VIII. EHR Template Standardization, Development, and Deployment

Solution

- A registered nurse (RN) on expert’s team, with skills in the client’s EHR, was tasked with constructing clinical documentation templates
- Assisted in review/editing of all templates for each specialty to limit choices of templates in the exam portion for the physician, ensure correct documentation gathered for Meaningful Use and validated charge entry in the claims process
  - This process occurred with provider input
- Coker worked with vendor, served as intermediary between client/vendor to:
  - Develop a report outlining our system build findings and shortcomings relative to the install
  - Developed recommendations/next steps to address these in order to remedy problems
- Other clinical adjuncts included:
  - Procedure code and order mapping builds to ensure accurate charge entry
  - Edit encounter reasons to avoid duplicates
  - Reviewed Past Medical History Questions, Social History, Surgical History and Family History per office to build their templates specifically to the specialties needs as performed in the Intake portion of each patient encounter
  - Suggested retraining of staff on clinical forms and office utilization to wean the clinics off of paper and steer them towards total use of the EHR

Results

More operational efficiency and ease of use for providers enabling them to increase patient volumes
CASE STUDY: RESULTS (CONT’D)

- The intent of the following gap analysis was to ascertain the projected level of improvement for the EPN should all recommended initiatives continue to progress as expected over an 18-24 month timeframe.
- Additionally, the figure shows the state of operations a year into the project.

<table>
<thead>
<tr>
<th>Financial Opportunities Identified</th>
<th>Mar-14 (Start of Turnaround Engagement) ($264,000)</th>
<th>Mar-15 (End of On-Site Expert Assistance; Hand-Off to Client with Periodic Check-Ins) ($264,000)</th>
<th>Mar-16 (Projected Future State after Full Two Years of Improvements) ($264,000)</th>
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</thead>
<tbody>
<tr>
<td>CPT Coding</td>
<td></td>
<td>$4,601</td>
<td>$6,860</td>
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<tr>
<td>Accuracy/Improvement</td>
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<td>$45,400</td>
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<td>Improved Patient Access</td>
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<td>$14,300</td>
<td>$16,600</td>
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<tr>
<td>Ortho scheduling</td>
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<td>$6,800</td>
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<td>Improved Credentialing</td>
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<td>Improved Collections</td>
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<td>Staff Adjustments/Alignment</td>
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<tr>
<td>(via attrition)</td>
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<td>$22,850</td>
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<tr>
<td>Revenue from PBB</td>
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<tr>
<td>Savings from dropping Cerner</td>
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<td>MU Attestation</td>
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<td>Collection of Elective Surgery</td>
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<td>Payments</td>
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<td>Growth of Allergy Clinics</td>
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<td>Totals</td>
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<td>($113,549)</td>
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<td>Adjusted Operating Loss</td>
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<td>($264,000)</td>
<td>($61,290)</td>
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Case Study: Results (Cont’d)

• Based upon data furnished by Organization A’s management, the actual loss per physician being realized by the EPN at the beginning of the turnaround was approximately $264,000.

• The experts projected a loss of nearly 77% over an 18-24 month timeframe should the client invoke all improvement initiatives as recommended → this translates to a loss of nearly $60,000 per physician.

• Following eight months of collaborative efforts between the experts and Organization A’s staff and management, the operational fixes resulted in a reduced cost structure from nearly $300,000/physician to $115,000 per physician.

<table>
<thead>
<tr>
<th>FY 2014/FY 2015/Projected Change</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Prior YTD</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Total Revenue Gains and Other Support</td>
</tr>
<tr>
<td>Total Expenses</td>
</tr>
<tr>
<td>Revenue less Expenses – gain/(loss)</td>
</tr>
<tr>
<td>Avg Gain/(Loss) per Provider (26 providers)</td>
</tr>
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</table>
CASE STUDY: SUMMARY

• Combining both subjective information and objective data builds a complete picture and resultant report
  o Both should be identified and measured by both return and the timeline for turn-around
  o Prioritize changes to obtain quick wins; e.g. deploy front-end collections protocols; build plans for other structural components that are politically dicey and require time and allies to manage into place
  o Massage puzzle pieces together crafting a picture that makes sense to both the experts and the client; vetted in development

• Leaders need to be empowered to accomplish mission, deploy plans, and engage physicians in a meaningful way

• Construct a physician advisory committee (PAC) to:
  o Promote and value physician input
  o The PAC should not have final “yes/no” authority; only “advise/consent”; initiative offers MDs “say” in the operations of the EPN and offers them a vested interest in how the EPN moves forward

• Sometimes a change in management, as with a head coach change on a sports team, can bring a breath of fresh air
CASE STUDY: SUMMARY (CONT’D)

- Below is an example of a more structurally sound model of an EPN construct
- Operations, from P&P to management and financials, must be established and in place before adding providers to an EPN
- Operations must be readily scalable for whatever the strategy dictates for the organization
Case Study: Next Steps

• Continue to measure and monitor changes in all clinics; remediate any deviations from established plans
  o Continue to update providers on their performance, including production and overhead
• Transition from any intermediate leadership to permanent leaders
• Final implementation of established guidelines and plans established for moving forward without presence of outsiders
  o Experts should be available to provide ongoing assistance, as necessary
• Institutionalize changes, creating resistance towards falling into old patterns
Case Study: Update

• Due in part to the EPN’s financial turnaround, the consolidated entity (the hospital and the EPN) realized a 10-Figure PROFIT.
IV. Key Takeaways
KEY TAKEAWAYS

• Collaborative efforts resulted in the level of success realized in the Case Study Example
• The project will likely not be without its issues (minor or major)
• Nothing is ever perfect but with good communications, issues should be mitigated
• System restructuring, process redesign, and provider compensation adjustments can be tenuous and prickly things
• What is often found is a collateral reason for systemic problems; that is, what senior leadership identifies as problematic may not be the issue at all
• This project will assuredly require a cultural shift, which is seldom accomplished quickly or without some angst:
  o Might provider compensation be adjusted without a mass physician exodus?
  o Would patients, until now not asked to pay up front, pay their obligations at the time of service?
  o These questions and others must be weighed with each change in the makeup of the EPN
• The challenges faced by Organization A are not uncommon; however, efforts to address them should be considered immediately in order to effectively respond to the Accountable Care Era
Q & A
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