Employed Physicians Turnaround

Case Study

Coker GROUP
Business Advisors for the Healthcare Industry

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CASE STUDY

A health system in financial disrepair approached Coker. As with many health systems across the country, the Board and senior leadership of our client were concerned about the EPN's finances. Subsidies to the network were unsustainable and growing while bond holders grew increasingly troubled at the financial outlook. What began as a simple assessment blossomed into a full-blown project.

At the senior executive level, many systems contemplate the macro, the broader picture of EPN troubles. Practically speaking, the variable for the trouble may spawn from one (or a few) simple processes that are not measured, managed, nor contemplated as if they are critical. A thorough review must examine both the macro and micro aspects of the EPN blending subjective with objective components. Coker assesses the macro and the micro combining both subjective and objective measurements at a level of granularity that drives to the root causes of the trouble. What we often find is a collateral reason for systemic problems; that is, what senior leadership identifies as problematic may not be the issue at all.

THE TASK

In the first quarter of 2014, Coker Group's Practice Management service line was called in to assess and implement change in an orthopedic practice that was part of a larger multi-specialty EPN in a mid-sized community hospital. The hospital, rightly so and anecdotally, sensed that economically and politically their employed orthopedic model was struggling. The providers essentially practiced under their own set of rules, akin to being an unaffiliated private practice. Clinics were canceled on a whim, patients were moved, call was, well, avoided. Though we thought we were performing a "physical" on a component in the EPN, we were gearing up for review of a model actually in Stage 2.

Coker's charge was to review the production of the orthopedic model performing an operational assessment that ranged from check-in, to the care process, to check-out. While PM considered the operational stability of the practice, Coker's Financial Advisory (FAAS) service line was busy analyzing the provider (physician and APP) contracts and contemplating possible strategic points for the hospital's orthopedic service line including ideas such as outreach, alternative alignment models, and further employment of physicians. After completion of the assessment report and review by

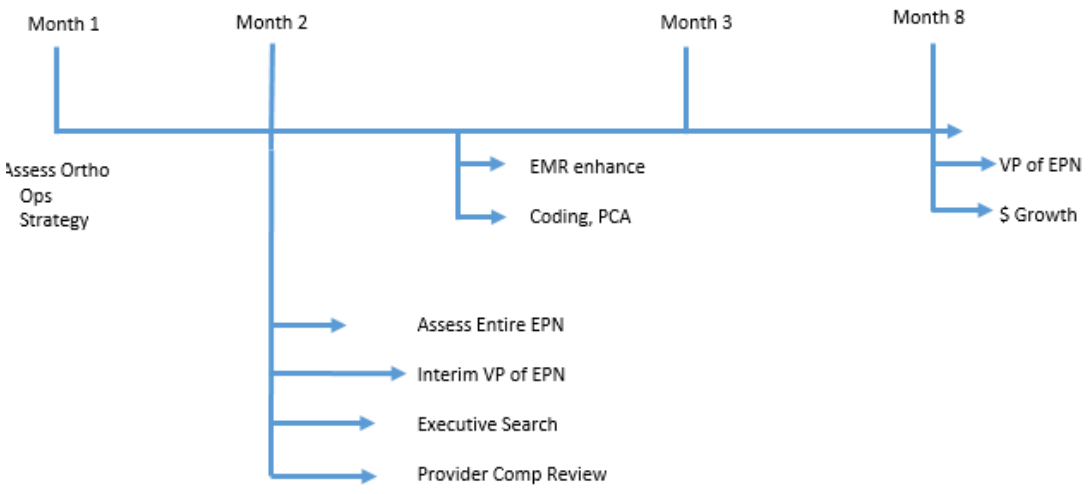
the CEO and Board, Coker was charged with implementing change to improve the practice.

In the midst of reviewing the orthopedic practice, we stepped into something a bit….deeper. Coker's PM team was subsequently asked by senior leadership to review and assess the functionality of the *entire* operational structure of the EPN. It seemed that the EPN was losing approximately $400,000 *per provider*.

Subsequent to, or because of, Coker's engagement, the Vice President of the EPN resigned to take a VP role in an adjacent state. While Coker prides itself on working collaboratively with client senior leadership as partners, we were surprised by the sudden departure of the VP of the EPN. We would later come to understand the reasons for his departure. The vacuum spawned by a senior executive's departure could have fomented disaster for the struggling system. Instead, the system asked Coker to place a seasoned interim Vice President on site to fill the void while they recruited a new VP for the EPN.

Our project had morphed from a simple assessment of one practice to a system-wide review with an interim vice president in place and an executive search underway. Figure 4 illustrates the project timeline and the subsequent use of Coker resources.

Figure 4. Timeframe for Adding Coker Resources



We deployed a seasoned individual who not only filled in as the interim VP of Physician Services, but who became our point person in the evaluation and assessment of the EPN. Having an interim executive on the ground was helpful, but not essential, to moving our assessment project forward.

PROCESS – SUBJECTIVE

The EPN consisted of multiple specialties housed in 21 practices, both on and off campus. We commenced work by deploying a team to review each of the individual practice's operational functions. Concurrently we requested data for the prior 12 months for each practice so we could get the "freshest" data and the most recent "feel" for the practices' financial and operational standing. Operational assessments are normally more valuable and successful when the entire clinic structure undergoes a review. For instance, we've been asked by other clients to review revenue cycle or scheduling or patient access. All of these are doable; however, each, at some point, acts in concert with other pieces of the ecosystem. Thus, when you squeeze the front desk portion of the balloon, the clinical flow or check out receive the "extra air." You get the metaphor.

As this transpired, we established interviews with key leaders and stakeholders in each location. The participants vary with the size of the organization. For instance, in a small medical practice we might interview the lead physician and practice manager. However, in this engagement, and in like-sized situations, we often interview the onsite practice administrator, a lead clinician or two (provider and/or APP lead), and the C-suite. The interview results are confidential so that we obtain the best and most candid information possible from the participants. Anonymity provides a strong subjective tool that meshes with the data and paints a clear picture of the issues. When multiple parties interviewed in isolation broach or corroborate similar thoughts, something usually exists that requires attention. These interviews are semi-structured allowing participants to associate their views freely within loosely constructed parameters. While we allow for open discussion, Coker navigates the discussion to obtain the information needed.

Included in the subjective component is a walk through to perceive how the clinic functions. This review couples with patient data/demand. We review check-in, collection of copays and deductibles, patient workup and throughput (the care team), use of exam lanes and equipment (hard asset limiting factors/physical plant

parameters), deployment of extenders, and the checkout and scheduling follow-up procedures and visits.

Process – Objective

Usually, we ask for data three weeks before arriving on site. This lead time affords us the opportunity to see where the data leads and points invariably to areas of concern prior to entering a clinic. An exhaustive list of data requested includes productivity by provider (physician and APPs), revenue cycle, provider schedules, patient visits and Current Procedural Terminology (CPT®) information, staffing, staff compensation, and collections. With entities living under one umbrella, each practice can have disparate numbers and operations, notwithstanding specialty specific differences. Each practice requires review as its subsystem within the larger ecosystem. In the instant case, this was decidedly true. We found that each practice worked in a black hole, sharing the commonality of the system name more than its mission. Hours were variable, policies were incongruent and inconsistent, and some problem providers were deemed "untouchable."

We reviewed data individually, by provider by practice, to a level of granularity not often performed by clinics, whether due to time and staffing constraints or inertia. In the current case, we assessed the operations of the clinics while needed data arrived. Time was of the essence.

Result

With the data in hand and the interviews and subjective components in our portfolio, we had all of the items necessary to perform our review and build our resulting report. We began to massage the puzzle pieces together to craft a picture that made sense to us and the client.

Coker learned that multiple processes in the EPN were in disarray. A couple of the keys to the system's financial shortcomings were the misalignment of physician expectations and demand. Additionally, patient volumes were inconsistent, and politics played a role in limiting patient access to clinics. In the current fee-for-service environment (vs. bundled patient payment/value-based reimbursement), a key to moving toward financial nirvana is improved patient access. Coker would need to focus on getting patients in the door and meeting local demand.

There were underlying structural issues endemic in nature and throughout the EPN. Then there were, of course, issues specific either to the medical specialty, the individual provider(s), or both.

Historically, management engaged in a laissez-faire approach to the clinics and providers offering the physicians too much autonomy and insufficient guidance. This hands-off style trickled down to the clinics and may have been one of several contributing factors to the former VP's inertia and subsequent departure. He simply wasn't empowered or supported to right the wrongs he had seen.

The employed model lacked physician input yet physicians were enabled, culturally, to do what they wanted. One of the primary tasks would be empowering our interim VP to accomplish their mission, deploy plans, and engage physicians in a meaningful way. We identified key subjective and objective components and measured them by both their return and the time lapse for turn around. Specifically, we prioritized to obtain quick wins, such as deploying front-end collections protocols. Plans were built for other structural components that were politically dicey and required time and allies to manage into place.

To offer providers input, Coker assisted the system in constructing a physician advisory committee (PAC) with the design of promoting and valuing physician input in the operation of the EPN. While the PAC did not have final authority to act on their contributions, they deployed "advise/consent" powers on behalf of their constituents. This initiative gave them a "say" in the operations of the EPN and offered them a vested interest in how the EPN moved forward; they now had skin in the game.

Structurally, the system was relatively sound. However, Figure 5 shows an organizational pyramid constructed with misaligned priorities.

Figure 5. Misaligned Organizational Structure

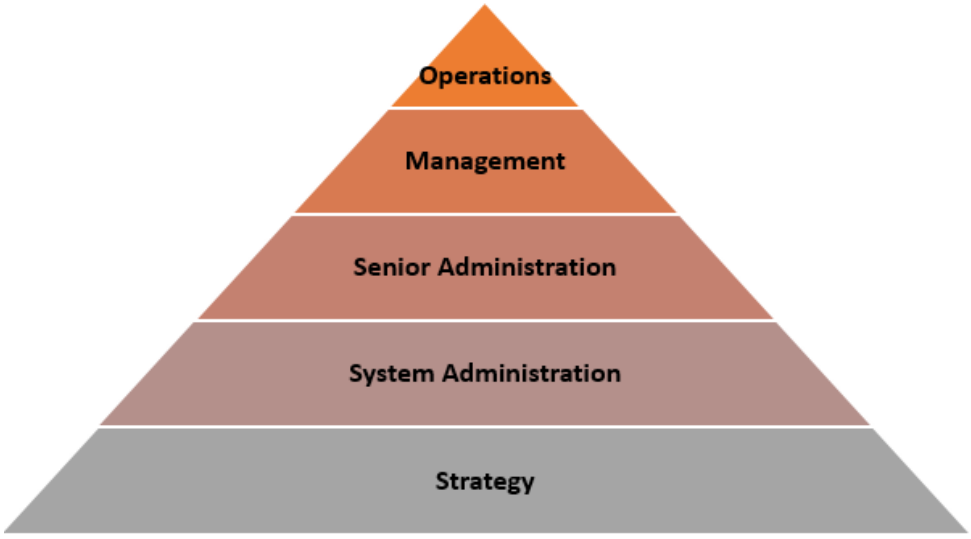
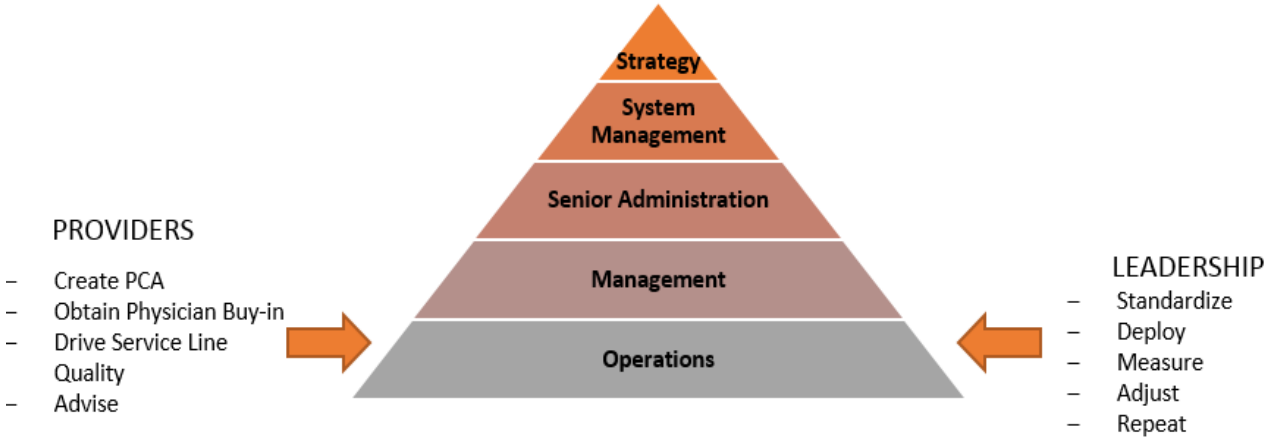


Figure 6 shows a more structurally sound model of an EPN construct. Operations, from policies and procedures to management and financials, must be established and in place before adding providers to an EPN. That is the operations must be readily scalable for whatever the strategy dictates for the organization.

Figure 6. Sound Organizational Structure



The operations (inset pyramid) provide a sound base structure on which to build and grow an EPN. Too often, strategies are fomented that have a macro approach without contemplating the ramifications of cost and work imposed on the EPN. Specifically, often employed models don't have good foundational structure in the model. I had a client whose strategy for growing their provider network was to acquire providers: "…if we don't do it, System X down the road will." To expound on a sub-optimal idea, they had Figure 5 in place, so operations were unable

to handle the stresses of adding new physicians and practices to the system. Their approach did not seem to be a well-thought-out strategy for growth, but until the point they needed a healthcare advisor, it seemed to work for them. The vision of the system needs to be defined, given life, and supported by a sound strategy. It requires buy-in from physician partners and input to move forward. After careful review, knowing that no system is like any other, and understanding the client's goals and perceptions of what was broken, we determined eight areas that needed concurrent action to remedy financial standing:

1. Increased patient access
2. Improved revenue cycle management
3. Standardized policies and procedures
4. Optimized 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

1. Increased Patient Access

Prior to the engagement, and owing to the hands-off management nature, providers were free to manage their schedules as they saw fit. This freedom meant screening patients, blocking schedules, canceling clinics, and limiting available visit slots. By its very nature, this approach breeds inefficiency and waste throughout the system. It creates consternation among staff members, limits internal, and external, referrals, and reduces patient satisfaction. Limiting referrals and quashing access means that patients and referring providers will vote with their feet and select care elsewhere.

With the client-partner, Coker immediately crafted set operational standards to deploy throughout the clinics. Those included, but were not limited to, standard clinic hours (e.g., Monday-Friday, 8:00 am-5:00 pm), standard patient contact hours (e.g., 36 hours per week), in addition to standard operational aspects related to check-in procedures, such as insurance-due collections prior to care, scheduling of patients, etc.

2. Improved Revenue Cycle Management

The health system had recently deployed a solid integrated practice management/electronic health record (PM/EHR) system throughout the EPN. All PM/EHR installs, even those that are 100% solid, still experience foibles. For example, a 100% install is still probably only a 90% victory. However, during and in fact prior to the transition to the new system, there was little standardization and little effort regarding the accounts receivable (AR) process

and managing the AR and revenue cycle. As the new system rolled out, and its associated bugs addressed, the specter of aging of outstanding balances in the "old" system was exacerbated.

Coker reviewed balances, identified low-hanging fruit, targeted the largest balances, and deployed a plan to work the old AR and recoup monies due the system. This plan included a scheduled drop dead date for when to turn off the old system and write off and/or turn over outstanding balances to a collection agency.

In the meantime, Coker built the AR management team, deployed revenue cycle standardization throughout the EPN, and ensured seamless synchronization between the billing team and the front desk teams in the practices. As noted, nothing happens in a vacuum. Even if the clinic staff does not bill the insurance companies per se (the billing management was located in another building), they are integral players in the "revenue cycle" of the EPN. This occurs by ensuring that patients are registered in the practice management system accurately; insurance information on file in the PM system is accurate; required forms are offered to the patients, completed, and collected (e.g., Advanced Beneficiary Notice [ABN], Medicare Secondary Payer [MSP] paperwork, any Provider Based Billing [PBB] notification, etc.); and appropriate copays, coinsurance, and deductibles are collected. Additionally, Coker instituted collections targets for each of the clinic locations based on the clinic's specialty and history. Prior to the collections targets, there were few aggressive front-end collection actions. While those efforts can be touchy and difficult for staff to address (uncomfortable discussions with patients), copays and deductibles are part of the patient's contract with their insurance company and thus their obligation. These targets ensured that staff were collecting the monies due the practice prior to the patient's visit with the provider. This simple act improved cash collections dramatically while allowing practices a target to hit and a little friendly internecine competition.

Included in these efforts were billing and collections standardized policies, both at the billing/collection point and within the practices. This standardization ensured efficiency, standardization, and revenue (by ensuring balances were not written off without proper follow-up, etc.).

3. **Standardized Policies and Procedures**

Standardization did not include clinical protocols but instead operational flow and patient throughput. This exercise was not charged with altering the clinical care delivery model. But non-clinical staff needed a clear

understanding, throughout the EPN and from clinic to clinic, of what was expected of them, regardless of which shop they worked.

As noted, Coker learned that the practices were, for all intents, separately functioning entities under the protective blanket of the greater system. Aside from the common name of the health system and the relative protection that it offered, there was little binding the practices to the system, and vice versa. Development of policies and procedures was not just relegated to the revenue cycle and clinic office hours.

Contrary to what one might surmise, standardization does not stifle the practice. Instead, it lends toward efficiency, savings, and consistent, repeatable actions. With the client's management team, Coker developed and deployed standardized policies that empowered staff to perform their jobs in different practices across the system continuum. (For example, the same employee can work the front desk at Practice 1 or Practice 21.) Also, they were offered better tools with which to manage staff work and measure that work when it comes time for their annual performance evaluations. In many cases, staff annual performance evaluations boil down to their performance during the last two to four weeks leading up to the actual evaluation. With standardized policies and procedures, expectations are clearly delineated to staff members and can be measured during the year to guide performance.

Standard policies and procedures ensure that staff understands their jobs and responsibilities.

4. **Optimized Staffing Model/Staff and Resource Utilization**

As part of our assessment and review, it was determined that certain practices were overstaffed while others were understaffed. The assessment showed certain supply and demand anomalies apropos of the staffing and patient demand. Coker assisted the system in "right sizing" its clinical staffing throughout the EPN.

We developed a mentorship program for the current leaders and staff members who had good aptitude and an interest in expanding and growing as managers. We optimized those "in-house" assets already employed.

The staff review also entailed management span of control and skill set assessment. The management structure in place fostered an imbalance of personnel under specialties that were managed and the skills of the managers. As with any organization (healthcare or not), skills differed from manager-to-manager. Thus, opportunities existed to consolidate and flatten the management structure, grow current leaders who had aptitude and desire, and

rebuild a scalable organizational structure that offered the system future opportunity to add on to a breathing organizational structure.

Included in the structure were certain key performance indicators (KPIs) by which directors and managers could "manage" the practices and keep an eye on the financial health and other key volumes in the practices, including collections targets and new and established patient visits. After deployed, these counts would be benchmarked against a current month vs. prior year's month and then current year to date vs. prior year to date. The logic to this exercise is showing change in volumes.

It would be more comfortable to say that there was no staff downsizing during this process. That is not the case. Philosophically, it is best to avoid reductions in force (RIFs) whenever possible. Instead, it is preferable to manage the staff, carefully adding people as the demands require. This way oversupply of staff is not built into the system; i.e., staff that will, conceivably, be released if demand wanes. A *few* staff members lost their jobs during this implementation while much of the consolidation yielded savings via attrition. In the instant case, as we moved pieces on the board, we simply did not backfill slots as staff attrition occurred.

While RIFs can make sense to some, the preference regarding personnel and management infrastructure's delicate balance is to reapportion staff and grow powerful, capable, tenured managers. This careful nurturing of the structure and use of employees saved the system hundreds of thousands of dollars.

Lastly, with the standardized policies and procedures in place, the system can flex to fill positions internally, managing supply and demand based on schedules and practice patient loads.

5. **Procedural Coding Audit and Education (PCA)**

Coker reviewed the coding of all of the providers in the EPN. Coding is a balanced endeavor, and there are always areas for improvement. As we studied the CPT use and volumes, we noted many instances of either over coding (e.g., billing for a level of service that was not supported by the provider's documentation) and instances of under coding (e.g., where documentation substantiated a higher level of service than what was billed). We quantified the results, by provider, delineating revenue left on the table or revenue requiring repayment. We also educated providers and staff commenting on the reasoning and logic behind our coding audit results.

On the whole, the EPN was leaving hundreds of thousands of dollars on the table by either not documenting and/or not billing for all of the services provided. Comparison of all providers to their specialty peers using Medicare data for Evaluation and Management CPT codes (office and hospital visits) showed that the providers were under coding across the spectrum.

Coker presented the results to senior leadership and then began a process of education to assist the providers in employing more accurate coding. (As a sidebar, we do not encourage providers to rely solely on the coding components built within EHRs.)

Within six months of our initial visits, audit, and education, our 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.

6. **Collaborative Leadership (Providers/C-suite)**

Physicians in the EPN perceived that they had no voice at the senior management level. They viewed the executive offices as a place where decisions occurred without input from the providers who would be impacted.

Providers saw themselves more like cogs in the machine than valued partners in the delivery of high-quality care. They had no voice, and when they did, it was more in passing. That's not to say that the system devalued the physicians; it is to say that they didn't value them enough. Note that embracing physicians does not imply coddling, acquiescing, or otherwise going against your better judgment regarding the latitude they are offered. It also does not mean that when hospitals employ physicians the providers are indentured servants. Instead, it suggests a relationship of partnership and give/take that fosters trust, empowers physicians to help make their decisions (with oversight and teamwork from the C-suite), and gets them to drive and work toward clinical outcomes so that physicians' work to balance must be gained and each party respected. (Note: For instance, during recent revenue cycle work performed for a hospital system with an EPN, we learned that the physicians loved the health system and the relationship they had. Physicians were nominally engaged and had a functioning physician advisory committee (PAC). However, as we looked at the detail, we divined the root of physician joy: practices were acquired, lock, stock, and barrel, and physicians were not asked to integrate but were instead essentially allowed to continue with their old ways, pre-merger. That strategy, in and of itself, begs for problems, structural and other. Recall, one of the benefits of the acquisition of practices can include

economies of scale and standardization that enables health systems to deliver better quality care at lower cost.)

Concurrent with the delivery of system "fixes" delineated, Coker set out to aid in the construction of a robust and scalable PAC. The PAC's primary objectives were:

- Enhanced bidirectional communications (providers and system executives)
- Physician buy-in and intellectual investment into the system
- An avenue for clinical guidance and input (counsel on new modalities and service line growth)
- Valued partners in the delivery of care

The construct included a majority membership of senior hospital leadership (e.g., CEO, CMO, Vice President of Physician Services, etc.) and a representative body of the employed providers (with chairs appointed as *pro rata* share by specialty). A physician leader was deployed as a "touchstone" to speak on behalf of the providers and to funnel ongoing information from C-suite [CEO and CMO], results of meetings, etc., to providers. Structure included:

- Established tenure and term
- Established roles, responsibilities
- Established authority, e.g., able to spend up to $X0,000 without Board approval, etc.
- Established voting protocol and regimen (Robert's Rules of Order) NOTE: This is NOT a Board seat nor do votes carry final rule. Items voted on that exceed the spend threshold, noted above, are submitted to the Board, with accompanying financials, pro formas, etc., so that Board can rule on implementation.

Meetings are held monthly with the following components:

- Minutes are taken and recorded; final version shared with employed providers
- Agenda driven including date, attendees, old business, new business, financials, and Physician reports (feedback, input, subcommittee report out, etc.)

While some physicians were indifferent to the PAC, the PAC's initial accompaniment of members was that of strong, invested physician players and

partners. They were eager for the opportunity to help grow the system and improve the quality of care delivered in the community.

In addition, a benefit to the PAC is that physicians have a say in the operation of the EPN. They also bear some responsibility for managing of physicians and, to that end, can assist leadership in dealing with physicians who pose problems. Within four months of inception, the PAC had already worked in managing a difficult provider.

Additionally, right out of the gate, the PAC began reviewing productivity numbers and assumptions to ensure that all providers in the EPN were contributing to its betterment and fiscal health.

7. Compensation Alignment

As noted, the EPN is a breathing ecosystem. A dynamic tension exists between all of the components with some, more than others, positively or negatively impacting the greater peace of the system. Generally speaking, the unintended consequence of one action sends ripples throughout the organization. On the provider side, many of the providers had employment contracts with guaranteed base compensation and incentives based on *gross charges* (see Figure 7) instead of wRVUs, quality, or both components. There exists inherent folly baked into that approach.

Figure 7. Compensation Based on Gross Charges

Provider Compensation	Patient Volume	Reimbursement	Revenue
$100	10	$20	$200
$100	20	$20	$400

The client had compensation models deployed for providers that, while well-intentioned, created disincentives to work and impacted the overall finances. First, the contracts were unnecessarily rich based on old constructs. Next, those contracts did not incentivize providers to see patients and be productive (e.g., they were paid substantial base packages regardless of production). That is not to suggest that the providers were neither clinically unsound nor unwilling to practice; they simply had no financial incentive to innovate, to see patients, and to help in their partnership with the system. So the misaligned compensation models directly impacted patient access, which

consequently directly affected the system's top line, downstream, and ultimately bottom-line financial standing.

Coker found that the EPN providers' current compensation levels were elevated, and subsequent physician productivity was down, relative to specialty peer groups and available metrics. Providers were compensated with strong base pay and incentives based on gross charges. A few key themes included:

1. Overall, compensation outpaced productivity of the physicians, with substantial room to enhance production.
2. For many physicians, guaranteed base compensation was set at levels such that negated any desire/incentive to be productive.
3. The "gross charges incentive model" is outdated and inconsistent with market norms.

Coker proposed a model that better-aligned key compensation components that would help drive productivity, access, and enhance the revenues of the system. Obviously, provider buy-in was essential. Coker suggested easing providers into a change in compensation to avoid a shock to the system that drives negative behavior and pushback by the providers.

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.

Base Compensation

In the plan design, the providers were offered a base compensation. It would be imprudent and unaccepted by the providers to rip/replace their compensation with a pure production model.

Productivity Incentive

- wRVUs used as a productivity measurement tool
- Tiered levels to further incentivize (e.g., $x for 1,000 wRVUs, $y 1,001-2,000 wRVUs, etc.)

Non-Production Incentive

- Patient satisfaction scores
- Quality of care targets (as defined and agreed upon between the system and the providers)

Other

- Call coverage incentives
- Administrative payments for meaningful and documented work within the system (incents partnership). This payment could be compensation

for working as a service line leader, etc., paid at a fair market value [FMV] rate.)

Compensation Ceiling

- Ceiling compensation (total) delimited by nationally accepted benchmarks, variance FMV allowed for location/geography (e.g., underserved areas)

The process involves the design, vetting with senior leadership, and then testing for a defined period to determine how real data works within the model.

The system would:

- Develop and deploy a working group, comprised of Physicians and Hospital management (PAC), to review compensation 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

8. EHR Template Standardization, Development, and Deployment

While the health system had made the right choice (in Coker's opinion) on their PM/EHR system, as with any endeavor of that nature, the devil is truly in the details. "Perfect" installations are never flawless, and attention must be paid to every facet of the PM/EHR deployment. Deployment calls for roping in teams of focused specialists to both train on the system and to provide input on intricacies throughout the healthcare system that should be contemplated prior to PM/EHR development and deployment. 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 was not an outlier in this instance. Most health systems, we find, underinvest in the development and deployment of their PM systems. They rely on their vendor to simply do what the system wants presuming, wrongly, that the vendor clearly understand what it is that makes the system tick. Remember, no health system is like another.

In this case, Coker found that the use of templates in the clinical realm was sporadic. Coker determined that there were many inaccurate builds in the PM and EHR systems that exacerbated structural issues and had an adverse impact on patient volumes and the prospect of optimizing provider time in the

clinics. This shortfall is not necessarily a vendor-specific issue, rather a failure to communicate nuances that should craft the usability of the PM/EHR within the health system's needs and parameters. The lesson: Investing on the front end is *never* a bad thing and engaging those who will perform the work and who will be affected by the new PM/EHR is essential.

Coker's information technology shop has team members with skill sets specific to many of the leading (and lesser known) PM/EHR systems. This bandwidth enables Coker to deploy quality human resources who understand the PM/EHR dynamic and can have a meaningful impact from the start, which delivers better, higher quality results and saves cost for our clients.

At the client turnaround, Coker tasked a registered nurse (RN) with skills in the client's EHR to construct clinical documentation templates. Coker assisted in the review and editing of all templates for each specialty to limit choices of templates in the exam portion for the physician and to ensure that the correct documentation was gathered for Meaningful Use and validated charge entry in the claims process. This process occurred with provider input.

Coker worked with the vendor and served as the intermediary between the client and the vendor developing a report outlining our system build findings and shortcomings relative to the install. Coker 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

SUMMARY--THE WIN

The project didn't go off without its minor issues. Nothing is ever perfect. System restructuring, process redesign, and certainly provider compensation adjustments can be tenuous and prickly things. After all, this project required a *cultural shift,* which is

seldom accomplished quickly or without some angst. Coker found its rapport with the client and suggestions were brought to bear and weighed against the realities and exigencies of the community. Could we adjust provider compensation without a mass physician exodus? Would patients, until now not asked to pay up front, take to paying their obligations at the time of service? These questions and others needed to be weighed with each change in the makeup of the EPN.

It seems that the past VP of the EPN had smacked heads on numerous occasions with the system CEO, and the personality conflict, whether real or imagined, was palpable. For the last two years of his tenure, the VP was essentially biding his time, nodding his head, and pursuing another opportunity. His departure, while difficult on the system, may have offered a glimmer of hope. Sometimes a change in management, as with a head coach change on a sports team, can bring a breath of fresh air. The interim VP quickly found allies and strong employees. She set about to rebuild and restructure the organization, deployed teams, placed sound management staff, provided tools, and consolidated (flattened) the reporting structure.

The three-month interim VP engagement turned into an eight-month assignment as search for the right candidate for the VP role bogged down. However, in that time Coker and its client partner deployed operational fixes, cut (annualized) losses from nearly $400,000/provider to $100,000 per provider. That is, within six months the EPN was down to $100,000 loss per provider.

Compensation plans were redesigned to align client goals with their providers. The PM/EHR was adjusted and amended to empower clinicians to see and document patient visits more efficiently.

Coker gave flight to a fledgling, yet functioning, physician advisory committee, and perhaps, most importantly, Coker delivered results that delighted bondholders as the system improved its financial standing and remained within its bond covenants. Figure 8 shows the numerical results from the inception of the project to the handoff from the interim vice president to the incoming appointment.

Figure 8. Numerical Results from Project Inception to Interim VP Handoff

Client ROI	Approximately 6.5 – 1
Loss per provider (annualized)	$400k/provider reduced to $100k/provider
Patient visits (measured vs. same period, prior year)	9% growth
Gross charges and receipts (measured vs. same period, prior year)	Increased 34%
Net revenue (Q2 vs. Q2 prior year)	Plummeted 60%
Point of service collections (never before measured)	Quickly approached six figures per month

All in all, the project was a resounding success. Our client was a willing, and collaborative partner, and that symbiosis set the path for a sound structural and financial turnaround.