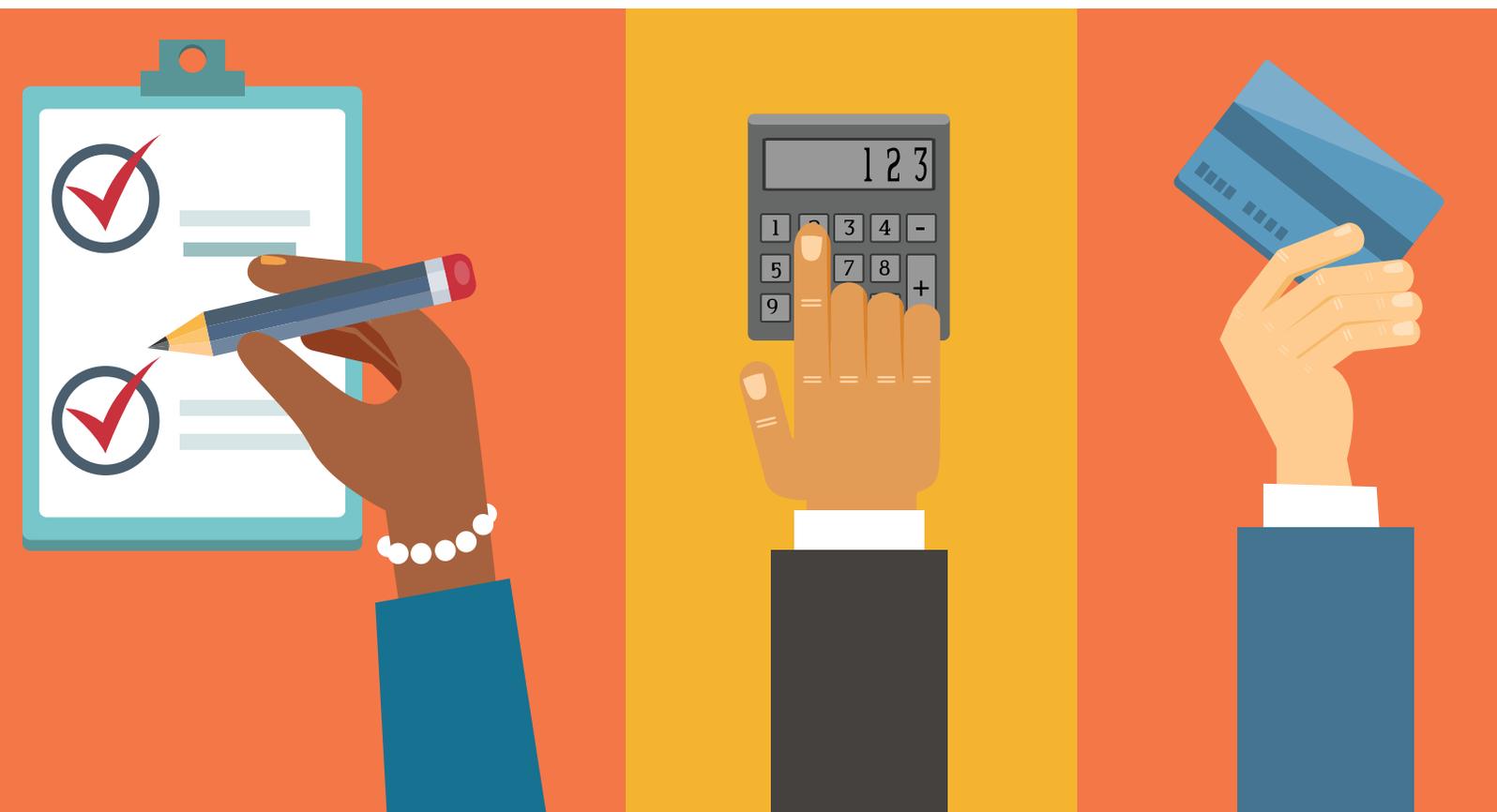




# 2015 Health Care Transactions Resource Guide





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# Employed Physician Turnarounds: A Roadmap to Financial Success

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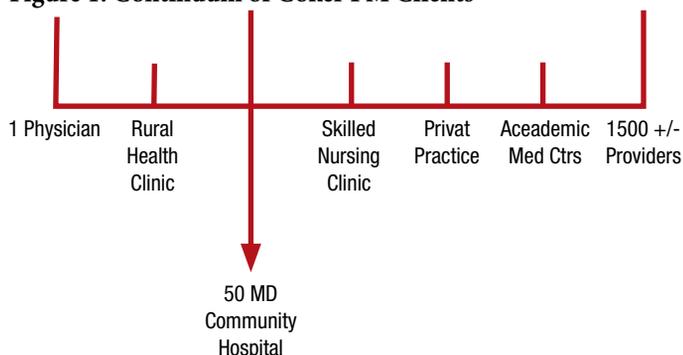


Are health systems experiencing a 1990s redux? Perhaps. While Employed Provider Networks (EPNs) are not necessarily in a dire position, many have failed to heed the hard lessons learned from the physician employment ventures that adversely impacted them in the '90s. Many hospitals continue to struggle financially through their EPNs. Steadily shrinking profit margins can be an all-consuming issue for hospital executives, likely prompting them to focus disproportionately on immediate losses rather than giving more of their attention to revamping the EPN's structural integrity. Even in seemingly dire circumstances, however, not all is lost. The marriage of hospital and provider, whether an employed model or a clinically integrated network (CIN) can work to strengthen their combined mission and grow their employed models. History need not repeat itself.

## Nothing is Vanilla

Coker Group's Practice Management service line (Coker) includes a variety of different clients and operational services, ranging from a 50-provider employed network for community hospitals that have rural health certifications for their employed model to a 1,500+ physician academic medical center (see Figure 1).

Figure 1. Continuum of Coker PM Clients



While EPNs may share similar themes and issues, the commonalities usually end there. Each EPN is too unique and too complex to be plain vanilla. Each network and each situation is a function of its clinical staff: physicians and advanced practice professionals (APPs), location, geography, client/patient needs and demands, and many other factors that make one network uniquely different from another. As health care management advisors, it is incumbent upon us to listen carefully to the client and marry subjective aspects with objective components to create the right fit for the client.

## Start Before the Beginning

An honest look at an organization's profit and losses will provide an accurate picture of the organization's overall health (see Figure 2). Occasionally, shortcomings will be evident to management and staff and yet, an outsider will need to validate what they already know to be true. Other times, however, the issues validate what the system knows to be true. Every now and then, our analyses will point to issues that a hospital system had not previously contemplated.

Figure 2. Where are Your Client's Margins?



Issues often begin forming when the EPN is built. In some cases, the problems are hard-wired into the system via acquisition. As EPNs grow, private practices are often acquired "as-is" and added to the system, resulting in oversized staff; staff with questionable skill sets; and outdated, inefficient processes and procedures. The

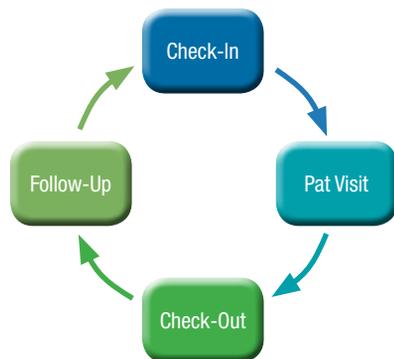
net result can be an EPN that has several individual practices functioning under the one system's umbrella while deploying their own unique processes.

How did this happen? Historically, private medical practices have underinvested in staff, training, resources, and compliance. These shortcomings would often emerge during acquisition because, for example, chief executives are reluctant to push back on a doctor who insists on keeping a certain staff member, despite that staff person's skills and abilities. Worse, many hospital systems did not understand the practices they were folding into their "families," which resulted in a patchwork network of physician practices, all of which continued operating in their own ways.

### The Process-In General

The EPN and its associated processes should be assessed and reviewed from the moment a patient opens the front door to the moment he or she checks out. Changes should be deployed that allow the "cycle" to function optimally and, when it deviates, allow for inputs and adjustments (see Figure 3).

Figure 3. Review Lifecycle



Understanding "where" the EPN is—its baseline or starting point – is essential. A sound and thorough quantitative endeavor coupled with qualitative analyses will point to the right answer. A well-balanced approach that factors both subjective and objective considerations will help identify the real issues undergirding or eating away at the construct of an EPN.

No process within an EPN functions in a vacuum. The various physician practices in an EPN are multi-variant and interrelated systems that blend together or work dynamically with the push-and-pull of a complex ecosystem. For instance, physician compensation plans are often minimally tied to some component of the work relative value unit (wRVU). When providers are incentivized to produce, an EPN normally sees higher patient volumes and more revenue throughout the enterprise. Conversely, providers on fixed compensation plans typically experience smaller patient volume, are not nearly as productive as their incentivized peers, and incur costs to the system.

### The Client

The board of directors and senior leadership of a certain health system was in financial disrepair and approached Coker for help. Like many health systems across the country, this client was 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 of one physician practice blossomed into a full-blown assessment of the entire EPN.

In many systems, the senior executive level tends to look at the "big picture" of EPN troubles when, practically speaking, the issue may originate from only one (or a few) simple processes that have not been measured, managed, or treated as the critical processes that they really are. Coker believes that a thorough review must assess an EPN's issues at both the macro and micro levels and blend both subjective with objective components so that the root causes can be identified.

### The Task

In the first quarter of 2014, a mid-sized community hospital asked Coker to assess the processes and operations of its orthopedic practice, which was part of the hospital's larger multi-specialty EPN. The employed orthopedic model was struggling financially and trying to function in a culture that was not conducive to running an efficient, patient-centered practice. The orthopedists essentially practiced under their own set of rules, akin to being an unaffiliated private practice. Clinics were canceled without notice, patients were moved, and call was avoided. We thought we were performing the typical "physical exam" on one component of a client's EPN, but we were essentially gearing up to assess an orthopedic model that needed more than the basic physical.

Coker was charged with reviewing the practice's operational continuum, starting with patient check-in through check-out and everything in between. While Coker assessed the practice's operational stability, Coker's Financial Service line analyzed provider contracts and contemplated possible strategic points for the hospital's orthopedic service line, including outreach, alternative alignment models, and employment of more physicians. After completing the assessment and following review by the hospital's CEO and board of directors, Coker was charged with implementing change to improve the practice's operations.

In the midst of reviewing the orthopedic practice, Coker was asked by the hospital's senior leadership to review and assess the functionality of the EPN's *entire* operational structure. It seemed the EPN was losing approximately \$400,000 *per provider*. During this time of assessment and impending changes pursuant Coker's assessment of the employed orthopedic model, the EPN's Vice President of Physician Services resigned. Coker deployed a seasoned interim Vice President who was already familiar with the system and who became the point person during the evaluation and assessment process of the EPN.

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

### The Subjective Process

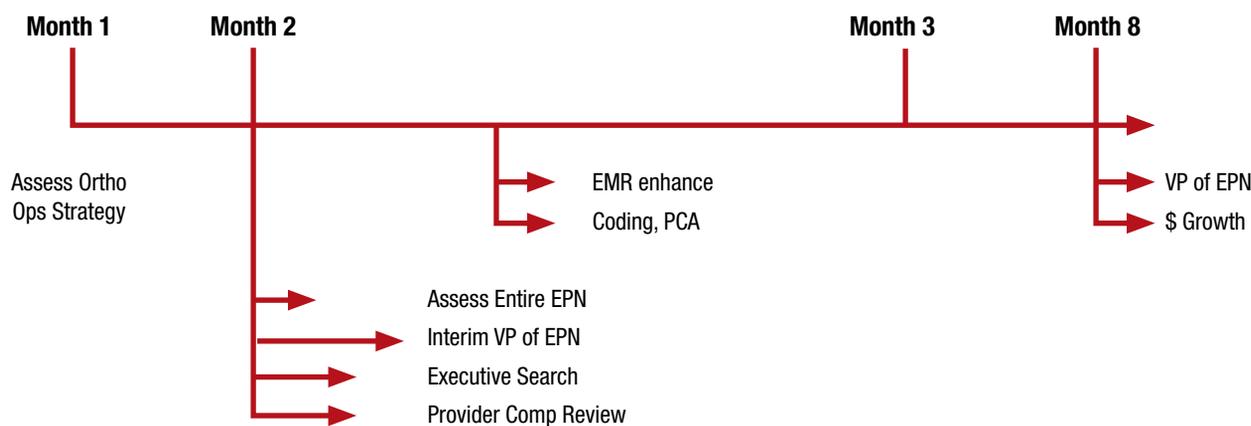
The hospital’s EPN consisted of multiple specialties housed in 21 practices, both on and off campus. Coker commenced work by deploying a team to review each of the individual practice’s operational functions. Concurrently, Coker requested from each practice data for the twelve months prior to obtain an accurate picture of each practice’s financial and operational standing. Operational assessments are generally more valuable and successful when the structure of the entire practice is reviewed. For instance, Coker has been asked in the past by other clients to review only a practice’s revenue cycle, scheduling or patient access components. These are legitimate requests, but at some point, each of those components will interact and/or act in concert with other pieces in the larger “ecosystem.” For example, when front desk operations are compromised, the clinical flow or check-out process will eventually feel the impact.

Coker established interviews with key leaders and stakeholders in each of the practice locations. The number of

participants interviewed varies depending on the size of the organization. For instance, in a small medical practice, Coker may only need to interview the lead physician and practice manager. In this engagement, however, and in like-sized situations, Coker often interviews the onsite practice administrator, a lead clinician or two (provider and/or APP lead), and identified C-suite executives. Participants’ interview results are kept confidential so that the most candid information can be obtained. Anonymity provides a strong subjective component that combines with objective data to paint a clearer picture of the issues. When multiple parties interviewed in isolation broach or corroborate similar thoughts, an issue or pattern usually exists that requires attention. These interviews are semi-structured, allowing participants to free-associate their thoughts within loosely constructed parameters. While we allow for open discussion, we navigate the discussion to obtain the information needed.

Included in the subjective component of an assessment is a thorough review of how the practice functions, including a review of patient data and patient demand; the check-in process; collection of copays and deductibles; patient workup and throughput (the care team); use of exam lanes and equipment (e.g., hard asset limiting factors/physical plant parameters); deployment of extenders; the checkout process; and follow-up for procedures and visits.

Figure 4. Timeframe for Adding Coker Resources



## The Objective Process

Coker typically requests 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 the practice or facility. An exhaustive list of data requested includes productivity by provider, revenue cycle, provider schedules, patient visits and Current Procedural Terminology (CPT) information, staffing, staff compensation, and collections. With multiple entities living under one umbrella, each practice can have disparate numbers and operations, specialty-specific differences notwithstanding. Each practice should therefore be reviewed as its own subsystem within the larger ecosystem. In the instant case, this was decidedly true. We found that each practice worked in a silo, having in common only the hospital system's name rather than the system's mission. Hours varied, policies were incongruent and inconsistent, and some problem providers were deemed "untouchable."

Coker reviewed data individually, by provider and practice, to a level of precision not often performed by individual practices due to lack of time, staffing constraints, inertia, or other factors. In this particular case, we continued assessing the operations for each of the multiple practices while the necessary data arrived as time was of the essence.

## The Results

With data, interviews, and subjective components in hand, we had all of the items necessary to perform our review and build a report that would help our client see more clearly the larger picture and the issues within. Coker's assessment revealed issues specific either to the medical specialty, the individual provider(s), or both, as well as underlying structural issues endemic throughout the EPN, including multiple processes within the EPN that were in disarray. Addressing misaligned physician expectations and demands were key to tackling the system's financial shortcomings. In addition, patient volumes were inconsistent and politics played a role in limiting patient access. In the current fee-for-service environment (vs. bundled patient payment/value-based reimbursement), improved patient access—i.e., getting patients in the door and meeting local demand—is critical to an EPN's financial viability.

Figure 5. Misaligned Organizational Structure



A laissez-faire management approach by an EPN often results in giving physicians too much autonomy and insufficient guidance. This hands-off style likely trickled down to the individual practices and may have been one of several factors that contributed to the former VP's inertia and subsequent departure; in other words, the now-departed VP had not been empowered or supported sufficiently enough to correct the wrongs that were occurring. The employed model lacked physician input and yet, physicians were enabled, culturally, to do essentially whatever they wanted. One of our primary tasks was, therefore, to empower the interim VP to accomplish her mission, deploy plans, and engage physicians in a meaningful way. Coker identified key subjective and objective components and measured them by their return and time lapse for turn around. We prioritized to obtain "quick wins," such as deploying front-end collections protocols. We also developed plans for other structural components that were politically dicey and which required time and buy-in from others.

Coker helped the system further by constructing a physician advisory committee (PAC) for the purpose of prompting and valuing physician input about the EPN's operations. While the PAC did not have final authority to act on the physicians' input, the PAC deployed "advise/consent" powers on behalf of its constituents, which gave the physicians a voice and offered them a vested interest in how the EPN moved forward. For example, Figure 5 shows a system that is structurally sound but one that is constructed with misaligned priorities.

Figure 6, however, 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. The operations must be readily scalable for whatever the strategy dictates for the organization.

Too often, strategies are created at the macro level without contemplating the ramifications of cost and work imposed on the EPN. Employed models often lack the solid operational foundation needed to build and grow the model. In fact, it is not uncommon for clients to adopt the strategy of merely acquiring more providers to grow their provider networks; however, this type of strategy would often lead to the system's operations being unable to handle the stresses of newly added physicians and their

practices. A system’s vision for its EPN must be well defined, have buy-in, receive input from physician partners, and be supported by sound strategy to move forward. In this instant case, Coker’s careful review and understanding of the client’s goals and the client’s perceptions of what was broken identified eight areas that needed attention to remedy the system’s financial standing:

- » Increased patient access
- » Improved revenue cycle management
- » Standardized policies and procedures
- » Optimized staffing model and staff/resource utilization
- » Procedural coding audit and education
- » Collaborative leadership (providers coupled with the C-suite)
- » Compensation alignment
- » Electronic Medical Records template standardization development and deployment

*Increased Patient Access*

Prior to Coker’s engagement, providers were free to manage their schedules as they saw fit due to the system’s hands-off style of management. This resulted in screening patients, blocking schedules, canceling clinics, and limiting available patient slots. This approach bred inefficiency and waste throughout the system and created consternation among staff members; limited internal and external referrals; and reduced patient satisfaction. Limiting referrals and quashing access meant that patients and referring providers were choosing to receive their health care elsewhere. Coker immediately established set operational standards to deploy throughout the individual practices which 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); and standard operational aspects related to check-in procedures, such as insurance-due collection and scheduling patients.

*Improved Revenue Cycle Management*

The system had recently deployed a solid integrated practice management/electronic health record (PM/EHR) system throughout the EPN, but even installs that are considered 100% experience foibles. Prior to and during transition to the new PM/EHR system, there was little standardization and little

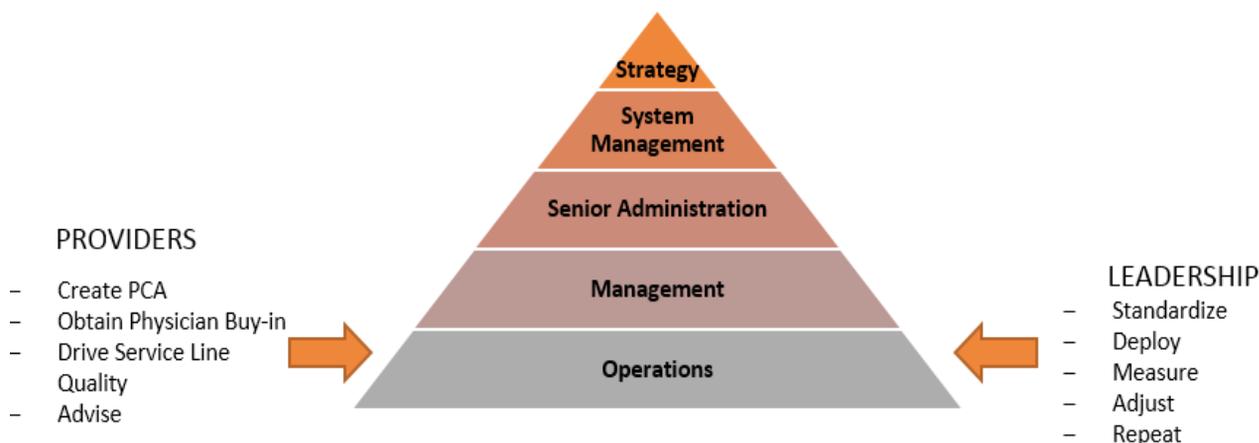
consideration for the accounts receivable (AR) process, AR management, and the revenue cycle. As a result, outstanding balances in the “old” system aged quickly as bugs and glitches were addressed during the new system roll out. To address the situation, Coker reviewed balances, identified low-hanging fruit, targeted the largest balances, and deployed a plan to work the old AR and recoup monies due to 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 addition, Coker built an AR management team, deployed revenue cycle standardization throughout the EPN, and ensured seamless synchronization between the billing team and the front desk teams in each of the practices. As noted earlier, nothing happens in a vacuum, meaning that even if a practice’s staff did not bill the insurance companies per se (billing management was located in another building), the staff was still integral in the EPN’s revenue cycle. Standardization and synchronization occurred by ensuring accurate registration of patients and their insurance information; completion and collection of required forms (e.g., Advanced Beneficiary Notice [ABN], Medicare Secondary Payer [MSP] paperwork, any Provider Based Billing [PBB] notification, etc.); and collection of appropriate copays, coinsurance, and deductibles. Coker instituted collection targets for each of the practice locations based on the practice’s specialty and history. The collection targets ensured that staff collected the monies due to the practice prior to the patient’s next visit. This simple act improved cash collections dramatically and gave the practices a goal to pursue while engaging in friendly internecine competition with the other practices.

*Standardized Policies and Procedures*

In Coker’s work with this client, only operational flow and patient throughputs were standardized, not clinical protocols; however, it was still important that non-clinical staff have a clear understanding of what was expected from them throughout the EPN, regardless of which practice they worked. Coker therefore developed and deployed standardized policies for each practice’s management team that empowered staff to perform their jobs in different practices throughout the system. For example, an employee should be able to work the front desk at Practice 1 as

**Figure 6. Sound Organizational Structure**



efficiently as the front desk for Practice 21. Contrary to what one might surmise, standardization does not stifle the practice. Instead, repeatable and standardized actions produce efficiency, savings, and consistency.

Coker further equipped the management team with better tools with which to manage and measure staff's work for the purpose of annual performance evaluations. With standardized policies and procedures in place, each person's job, responsibilities, and expectations were clearly delineated and could be measured throughout the year to guide performance.

#### *Optimized Staffing Model & Staff/Resource Utilization*

Our assessment and review revealed that certain practices were overstaffed while others were understaffed. Coker therefore assisted the system in "right sizing" staff throughout the EPN by developing a mentorship program for current leaders and staff members who showed good aptitude and interest in expanding and growing as managers. In other words, we optimized the "in-house" assets already employed.

As with any organization, health care or not, skill sets also differed from manager to manager, which meant that opportunities existed to consolidate and "flatten" the management structure, grow current leaders who had aptitude and desire, and rebuild a scalable structure that offered the hospital system future opportunities to build upon a dynamic organization. Included in this rebuilding were certain key performance indicators (KPIs) by which directors and managers could manage their practices and keep an eye on their financial health, including other key volumes such as collections targets and new and established patient visits. The final numbers would then be benchmarked against each other – current month vs. prior year's month and current year to date vs. prior year to date – to show change in volume.

Reductions in force (RIFs) cannot always be avoided; my general business philosophy is to manage current staff and carefully add staff as demand requires so that overstaffing – which could conceivably lead to RIFs if demand wanes – is not built into the system. In this situation with this particular client, only a small number of staff members lost their jobs during the implementation while consolidation yielded savings through attrition. When attrition did occur, the slots were not automatically filled. Rather, standardized policies and procedures gave the system flexibility to fill positions internally and manage supply and demand based on schedules and practice patient loads. While RIFs may make sense in some circumstances, re-apportioning staff and growing strong, tenured managers is preferred. In this case, the strategy saved the system hundreds of thousands of dollars.

#### *Procedural Coding Audit and Education (PCA)*

Coker reviewed the coding for all of the EPN's providers. Coding is a balanced endeavor and there are always areas for improvement. As we reviewed CPT usage and volumes, we noted many instances of over coding (billing for a level of service that was not

supported by the provider's documentation) and under coding (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 and explained 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 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 began the process of educating the providers to use more accurate coding. Within six months of our initial visits, audit, and education, Coker reviewed the providers to gauge improvement, many of whom experienced significant coding improvement that directly enhanced the bottom line.

#### *Collaborative Leadership Between Providers and Chief Executives*

The EPN's providers felt they had no voice at the senior management level. They viewed the executive offices as a place where decisions were rendered without input from the providers who would be impacted. The system did not devalue its physicians, but it did not value them enough and treat them as partners in a give-take relationship that should have fostered trust and empower them in their decision-making. Concurrent with the delivery of system "fixes" delineated above, Coker set out to aid in the construction of a robust and scalable PAC. The PAC's main objectives were:

- » Enhanced bi-directional 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); and
- » 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 *pro rata* by specialty. A physician leader was then appointed to speak on behalf of the providers and inform them about the results from chief executive meetings. This structure included:

- » Established tenure and term;
- » Established roles and responsibilities;
- » Established authority, e.g., the ability to spend up to a certain dollar amount without Board approval, etc.; and
- » Established voting protocol and regimen (Robert's Rules of Order).

It is important to note that this position was not a board seat and votes did not carry final rule. Items voted on that exceeded

the spend threshold were submitted to the board with accompanying financials, pro formas, etc., so that the board could rule on implementation. In addition, monthly meetings were held with the following components:

- » Minutes were taken and recorded; final version shared with employed providers; and
- » Meetings were agenda-driven and included the date, attendees, old business, new business, financials, and physician reports (feedback, input, subcommittee report out, etc.).

While some providers were indifferent to the PAC, the PAC's initial accompaniment of members included strong, invested physician players and partners who were eager for the opportunity to help grow the system and improve the quality of care delivered to the community. The PAC gave providers a "say" in the EPN's operations. They also bore some responsibility for managing themselves, which can be helpful to leadership when dealing with a physician who poses problems. In this case, within four months of inception, the PAC had already worked to manage a difficult provider. Almost immediately, the PAC also began reviewing productivity numbers and assumptions to ensure that all providers in the EPN were contributing to its betterment and fiscal health.

#### *Compensation Alignment*

As noted earlier, the EPN is a dynamic ecosystem. Tension exists between all components where some, more than others, positively or negatively impact the greater peace of the system. The unintended consequence of one action can send ripples throughout the organization. Many of the providers within this ecosystem had employment contracts with guaranteed base compensation and incentives based on gross charges instead of wRVUs, quality, or both components. Figure 7 shows the folly in that type of arrangement.

Coker's client had compensation models that, while well-intentioned, did not incentivize providers to increase productivity. Essentially, they were paid strong base packages and incentives were based on gross charges, regardless of production. That is not to suggest the providers were clinically unsound or unwilling to see patients; they simply had no financial incentive to innovate, see more patients, and help the system. This misaligned compensation model directly impacted patient access, which consequently impacted the system's top line, downstream, and bottom-line financial standing. Key themes emerged from this type of arrangement:

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 that negated any desire/incentive to be productive; and
3. The "gross charges incentive model" is outdated and inconsistent with market norms.

**Figure 7. Compensation Based on Gross Charges**

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

Coker therefore proposed a model that better aligned key compensation components to increase productivity, improve access, and enhance the system's overall revenues. Provider buy-in was essential, so we suggested gradually easing providers into a change in compensation to avoid pushback. The gradual change in compensation meant leaving providers at current compensation levels with minor tweaks to pay for the first twelve months and incorporating a wRVU model component that included a wRVU threshold/baseline.

#### *Base Compensation*

- » In the plan design, providers were offered a base compensation as a pure production model would not have been acceptable.

#### *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 (incent 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)

This process involved designing, vetting with senior leadership, and testing for a defined period of time to determine how real data worked 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

#### *EHR Template Standardization, Development, and Deployment*

While our client's PM/EHR system was at 100% install, no install, especially of that scale, is ever perfect. Deployment requires teams of focused specialists who will train staff and provide input about various factors and intricacies that should be contemplated or considered *prior* to PM/EHR development and deployment. Care must be taken in setting up the practice management system as it relates to insurance tables, fee schedules, etc., as well as the clinical side to ensure consistency, stability, and accuracy (scheduling templates, etc.).

The client in this case was not an outlier. Most health systems underinvest when it comes to the development and deployment of their PM/EHR systems, relying instead on the vendor and assuming the vendor will understand the numerous aspects that make a particular health system unique. In this case, Coker found that its client's use of templates in the clinical realm was sporadic. We identified many inaccurate builds that exacerbated structural issues, thereby negatively impacting patient volume and the prospect of optimizing provider time in the practices. This shortfall was not necessarily a vendor-specific issue but rather, a failure to understand the nuances that should have been key considerations in developing the usability of the PM/EHR in light of the health system's unique needs and parameters. The lesson: Investing on the front end is never a bad decision and engaging those who will actually perform the work and who will be directly impacted by the new PM/EHR is essential. Coker's information technology team has members with skill sets specific to many of the leading and lesser known PM/EHR systems. This bandwidth enables Coker to deploy quality resources that understand the PM/EHR dynamic and can have a meaningful impact from the start, resulting in better, higher quality results and cost savings to our clients.

Coker tasked a registered nurse (RN) who was knowledgeable about the system's PM/EHR to construct clinical documentation templates. Coker assisted in reviewing and editing all templates for each specialty so as to limit template options during an exam; ensure correct documentation for Meaningful Use purposes; and validate 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 vendor to develop a report outlining our system-build findings and shortcomings relative to the install. We 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;
- » Editing encounter reasons to avoid duplicates;
- » Reviewing Past Medical History Questions, Social History, Surgical History, and Family History per office to build their templates specifically to the specialty's needs as performed during the Intake portion of each patient encounter; and

- » Retraining staff on clinical forms and office utilization in order to phase out paper forms and move towards total EHR utilization.

#### **Good Things Come to Those Who Wait**

Our charge as health care advisors is to understand the problems throughout the system and manage both client expectations and deliverables so that a deliverable is not overcommitted and the work comports to the accuracy and quality required. When we partner with our clients, it is incumbent upon us to set expectation levels about the project. Essential elements of the arrangement include the following:

*Have a clear understanding of the project's scope.* While the project should be defined prior to project commencement, project scope may ebb, flow, and change as the project moves forward. A clear understanding ensures that the client and project manager keep on target and safeguard against project creep and cost overruns. A touchstone for the project should be defined for both the client and the advisor to ensure smooth and consistent flow of information.

*Convey what will happen when.* Delineate for the client the timeline to accomplish the work. This sets the expectation levels for all involved and ensures that the client is not surprised by the duration of the project. Understand the constituents involved, remain sensitive to their perceptions and to the impact the data (especially poor performance data) will have on those reading such a report.

*Quantify but Qualify.* Projects require baselining, quantification, measurement, and management. Understanding the data from the project's outset is crucial to measuring and monitoring successes and setbacks. Targets must be established and shared throughout the EPN. Transparency is crucial to the success of a turnaround and data must be solid and unimpeachable. The analytics are only as good as the data presented by the system to the management advisory team. Even in this day and age, fractured reporting from multiple systems or a simple lack of attention to the "value" of data may result in "suspect" data. The assessment process entails a review of the data, data scrubbing, and normalizing data to benchmark against nationally accepted standards and Coker's proprietary data. No two systems are the same, so some aspects must be carefully qualified to obtain buy-in and ensure understanding by the EPN.

*Report Frequently and Consistently.* Reporting is essential to the success of the project. Clients do not want to be surprised. Coker uses quick-report formats and structures so we can apprise clients of our findings, vet data, and convey messages that are tailored to system politics and peculiarities. Reporting consistently (e.g., using same metrics, structure) also offers a semblance of normalcy where expectations have been established and are now realized.

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%
Operating Expenses (Q2 vs. Q2 prior year)	Plummeted 60%
Point of service collections (never before measured)	Quickly approached six figures per month

### The Win

This project was not without its minor issues. System restructuring, process redesign, and provider compensation adjustments can be tenuous and prickly issues. This project required a cultural shift that is seldom accomplished quickly or without some angst. Coker built rapport with the client and weighed suggestions against the realities and exigencies of the community: could we adjust provider compensation without causing a mass exodus of physicians? Would patients, who until now were not asked to pay up front, take to paying their obligations at the time of service? Several questions needed to be asked with each change made to the EPN.

Personality conflicts, whether real or imagined, and the departure of a senior manager or executive can be difficult on the system. Changes in management can, however, breathe new life into the system; build allies, strong employees, and a solid

management staff; rebuild and restructure the organization; deploy teams; equip staff with the appropriate tools; and consolidate the reporting structure.

As the search for a new Vice President continued, Coker and its client deployed operational fixes and cut (annualized) losses for the EPN from nearly \$400,000/provider to \$100,000/provider within six months following deployment of its strategies. Coker gave flight to a fledgling, yet functioning, physician advisory committee and 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 handoff from the interim vice president to the incoming appointment. 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. ♦