Best Practices Physician Services
Organization Development

October 11, 2011

John Boland - Vice President
MedSynergies, Inc.
Agenda

- Introductions
- The Hospital-Physician Relationship
- Best Practices Physician Organization Development
- Case Study
Introductions

John Boland
Vice President
MedSynergies, Inc.

John Boland is a vice president leading initiatives for hospital-physician alignment solutions nationwide. Prior to joining MedSynergies in 2006, Mr. Boland held regional and national leadership roles focused on installation, support, product and service launches, client relationships, and strategic planning for IDX Systems Corporation. During that timeframe he also served as a member of the IDX Groupcast® Executive team. Previously he has served with IBM Corporation in their healthcare marketing division.

John received his bachelor of arts in economics from the University of Chicago.
Overview

About MedSynergies, Inc.

MedSynergies partners with health care organizations and physicians to align their operations by providing revenue cycle management, practice management, consulting services, business process analysis and software integration solutions. Leveraging its knowledge and experience in hospital-physician alignment, MedSynergies improves processes, optimizes technology and builds on trusted patient relationships, enabling hospitals and physician practices to offer quality health care.

Founded in 1996, MedSynergies is privately held and headquartered in Irving, Texas. MedSynergies currently partners with hospitals and health networks and serves more than 7,400 providers across the United States.
The Hospital-Physician Relationship
The Hospital-Physician Relationship

• It has always been in the best interest of health care delivery organizations to have tighter integration between hospitals and the physicians who serve patients in their facilities.

• There have been numerous attempts at streamlining relationships in the past with examples of both success and failure.

• Intense current market drivers.
2011 Drivers for Integration

- Macro Economic Drivers – Cost of U.S. Healthcare
- Reductions in fee schedules for Medicare combined with the ailing economy were motivating factors driving physicians to seek safe havens even before health care reform
- Physicians seek more work-life balance
- The Affordable Care Act increases the complexity (and therefore the cost) of operating a physician practice
- Due to proposed changes in reimbursement, hospitals may become major aggregators and distributors of payments for health care services
- Hospital drivers are focused on lower cost and better health care delivery; reduced re-admissions
  - Accountable Care Organizations (ACO)
  - Medical Home
  - Meaningful use
Challenges to Physician Alignment

- Lack of hospital commitment to physician relationship vision
- Poorly designed vision, plan and execution
- Lack of speed (Bureaucracy)
- Partial MSO integration (Silo Impact)
- Driving hospital admissions
- Absorption of the practice goodwill into a hospital organization
- Lack of consistent physician relationship models
Physician Concerns about Health System Integration

“Physicians lack trust that the hospital system will deliver services that fit practices; to enable consistent delivery that will be required over the long haul.”

“We need to do a better job of integrating individuals with practice management backgrounds as opposed to hospital backgrounds.”

“Expects the organization to provide better navigation tools through the hospital bureaucracy and more efficient issues management.”

“The system does not understand what it means to involve physicians.”

“Expect the physician organization will fail because it is attempting to meld too many disparate groups into one without first gaining buy-in on the centralization.”

“Would like for services to be attractive enough for physicians to want to be in the employed practice as opposed to forcing participation.”

“Expects the service org. to provide successful, transparent, cost effective services in a drama-free environment allowing the physician to focus on medicine.”

“Physician comp model was not well thought out; compensation graduated based on productivity without key components from the physicians perspective”
Characteristics of a Good Physician-Hospital Alignment Model

- Overall mission oriented
- The overall objective is patient market share
- Physician compensation is the same or higher than an independent practice with much less risk to the physician
- Managed care contracts are a health system contract
- Physicians are accountable for the overall financial performance of the practice
- Solid physician growth
- Subsidies or practice losses are identified in a systematic method with an overall view of the health system
- Workflow and clinic operating processes are the same from practice to practice
- Financial platform plus clinic platform equals quality healthcare
Best Practices Physician Services
Organization Development
Vision and Engagement

- Fully engage the physicians; agree on strategy
Organize for Successful Integration

• Provide world-class physician services
Provide Dedicated Physician Services

The Process Model Blueprint displays the 14 business processes and their relationship to the six major delivery categories. There are seventy-four sub-processes associated with the model...
The Physician Organization Blueprint
Requirements/Challenges

• Trust relationship
• Responsiveness
• The HR difference
• Sheer volume
• Client service

• Systematic approach of managed care contracting
• 20 projects at once versus 20 projects one at a time
## Develop Stakeholder Matrix

<table>
<thead>
<tr>
<th>Stakeholder Organization</th>
<th>Stakeholder Name</th>
<th>Expectations of MSO</th>
<th>Individual KPIs</th>
<th>Critical Success Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and Insert</td>
<td>Insert individual and title</td>
<td>Identify components the individual expects out of the MSO or the MSO to fulfill</td>
<td>Identify KPIs by which the individual will be measured, are there conflicts?</td>
<td>Indentify the components by which the success of the MSO will be judged either by individual and/or organization</td>
</tr>
<tr>
<td>Academic</td>
<td>Russell Crowe, Ph.D.</td>
<td>1. Capture data to manage key program 2. Transparency of information 3. Quantify cost /ROI for key program</td>
<td>1. Supervising physicians to improve data capture rates by 5%</td>
<td>1. Train staff and implement incentive plan</td>
</tr>
</tbody>
</table>
Stakeholder Matrix Benefits

• Proactively gather critical and timely input from individuals and organizations that are beneficiaries of the MSO solutions and services.

• Reveals what is deeply important to the stakeholder and facilitates the opportunity for a win/win result.

• An inclusive approach that enables key stakeholders to influence the MSO; resulting in new synergies that would not otherwise be achieved.

• Enables discovery and clarification of the stakeholder view of the interdependencies, as well as the strengths and weakness of the system, leading to opportunities for the MSO to positively contribute to improved outcomes.

• Results in strategies and tactics that are responsive to stakeholder needs; mitigating risk of the MSO being perceived negatively.

• Provides the foundation for ongoing, incremental success of the MSO.

• Promotes a collaborative, open and transparent relationship with stakeholders.
Lead the Physician Relationship

- Lead physicians; don’t manage them
Benchmarking is the strategic process in which organizations evaluate financial and operational performance and compare to best practices within their own industry.

**Where are we now?**
- Review current operations
- Gather current statistics

**Where do we want to be?**
- Review current performance metrics
- Identify accountability for the benchmarks
- Ensure benchmarks are in alignment with the objectives

**How do we get there?**
- Implement new and improved process
- Align people and incentives
- Develop on-going performance management
- Identify supporting technology

**Establish a baseline**

**Compare to industry best practices**

**Identify opportunities to improve performance**
Business Process Optimization

- Focused on the patient experience resulting in increased patient satisfaction and improved collections.

<table>
<thead>
<tr>
<th>Components</th>
<th>Definition</th>
<th>Services and Activities</th>
</tr>
</thead>
</table>
| Pre Point-of Service (Pre-POS) | First point of contact with the patient during which the appointment is scheduled and continues through pre-registration and benefits verification. Critical to set expectations for collecting co-pay, deposits, outstanding balances. | ▪ Call Routing  
▪ Scheduling  
▪ Pre-Registration  
▪ Financial Screening  
▪ Insurance Verification  
▪ Referral Management  
▪ Pre-Authorization  
▪ Education/Patient Preps  
▪ Logistics  
▪ Appointment Reminders |
| Point-of-Service (POS) | Activities begin with the check-in process prior to the patient seeing the physician and after they have received care with patient check-out. | ▪ Patient Check-in  
▪ Registration Verification  
▪ Patient Tracking  
▪ Financial Counseling  
▪ Collect and Post Payments  
▪ Patient Check-out  
▪ Schedule Follow-up Appointment  
▪ Patient Satisfaction Survey |
| Post Point-of-Service (Post-POS) | Administrative and financial activities associated with collecting payment for services rendered. | ▪ Reconciliation  
▪ Electronic Claims Submission  
▪ EOB Imaging and Indexing  
▪ A/R Management  
▪ Self-Pay Management  
▪ Denial Management  
▪ Account Resolution  
▪ Contract Management |
Develop Practice Game Plan

• A transparent, consistent leadership model for each physician practice to identify practice trends, benchmark performance and determine priorities in practice economic initiatives

• A basis in financial and operational process design and measurement

• Accountability within “1,000 points of failure”

• Ability to leverage data conversion to information at the financial side and ultimately the quality side of the practice

• The basis for a client service delivery model of leadership financed by MedSynergies’ Five Key Metrics™ and reduction in MSO cost efficiencies
Establish Best Practices

MedSynergies Five Key Metrics™

- **Pass Through Rates:** 3% or less
- **1st Pass Denial Rates:** 10% or less
- **Pre-Bill Reject Rates:** 4% or less
- **Unreconciled Visits:** 0.5% or less
- **DOS:DOCE:** 2 days or less
Deploy Performance Measures

- **Financial** – Measures focus on revenue, productivity, A/R, payer mix, payment per CPT, denials, fee schedule, margin and collections.

- **Operations** – Measures efficiency (cycle times, volumes/FTE) and quality (rework and accuracy) of internal processes and measure the cost side of the business.

- **Customer Satisfaction** – Measures patient and referring physician satisfaction related to access, communication and quality of care.

- **Employee Satisfaction** – Measures staffing levels, retention, and employee knowledge (skills assessments and ongoing training).

*Performance measures are focused on four categories*
Publish Clinic Performance Measures

- Clinic performance as compared to industry best practice

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Procedures / Physician FTE</th>
<th>Revenues / Physician FTE</th>
<th>Total RVUs / Physician</th>
<th>Work RVUs / Physician</th>
<th>Patient Visits / Physician FTE / Day</th>
<th>DOS:DOCE</th>
<th>Pass-thru Rates (self-pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice 1</td>
<td>1,720</td>
<td>$144,269</td>
<td>4,220</td>
<td>1,966</td>
<td>5</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Practice 2</td>
<td>1,933</td>
<td>$79,715</td>
<td>2,871</td>
<td>1,573</td>
<td>18</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Practice 3</td>
<td>6,106</td>
<td>$410,030</td>
<td>10,592</td>
<td>7,745</td>
<td>22</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Practice 4</td>
<td>1,385</td>
<td>$88,510</td>
<td>2,831</td>
<td>1,501</td>
<td>3</td>
<td>12</td>
<td>15%</td>
</tr>
<tr>
<td>Practice 5</td>
<td>2,904</td>
<td>$134,557</td>
<td>5,681</td>
<td>3,231</td>
<td>11</td>
<td>12</td>
<td>4%</td>
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<tr>
<td>Practice 6</td>
<td>5,463</td>
<td>$229,242</td>
<td>9,628</td>
<td>3,168</td>
<td>13</td>
<td>20</td>
<td>5%</td>
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<tr>
<td>Practice 7</td>
<td>7,602</td>
<td>$346,764</td>
<td>6,577</td>
<td>3,526</td>
<td>15</td>
<td>2</td>
<td>8%</td>
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<tr>
<td>Practice 8</td>
<td>1,725</td>
<td>$251,717</td>
<td>7,472</td>
<td>4,338</td>
<td>8</td>
<td>2</td>
<td>5%</td>
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<td>Practice 9</td>
<td>2,640</td>
<td>$202,699</td>
<td>6,868</td>
<td>7,173</td>
<td>12</td>
<td>7</td>
<td>6%</td>
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<tr>
<td>Practice 10</td>
<td>12,705</td>
<td>$642,008</td>
<td>16,005</td>
<td>8,142</td>
<td>33</td>
<td>1</td>
<td>5%</td>
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<tr>
<td>Practice 11</td>
<td>5,648</td>
<td>$651,983</td>
<td>18,171</td>
<td>7,232</td>
<td>21</td>
<td>4</td>
<td>6%</td>
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<tr>
<td>Practice 12</td>
<td>7,346</td>
<td>$696,220</td>
<td>17,115</td>
<td>8,802</td>
<td>20</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Practice 13</td>
<td>9,515</td>
<td>$452,318</td>
<td>10,700</td>
<td>5,748</td>
<td>25</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Practice 14</td>
<td>3,300</td>
<td>$189,124</td>
<td>7,238</td>
<td>5,273</td>
<td>15</td>
<td>18</td>
<td>5%</td>
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<tr>
<td>Practice 15</td>
<td>1,918</td>
<td>$236,914</td>
<td>8,139</td>
<td>4,131</td>
<td>8</td>
<td>14</td>
<td>4%</td>
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<tr>
<td>Practice 16</td>
<td>7,986</td>
<td>$379,826</td>
<td>10,998</td>
<td>5,631</td>
<td>25</td>
<td>6</td>
<td>13%</td>
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<tr>
<td>Practice 17</td>
<td>1302</td>
<td>$74,083</td>
<td>2,268</td>
<td>1,379</td>
<td>4</td>
<td>7</td>
<td>8%</td>
</tr>
<tr>
<td>Practice 18</td>
<td>1,679</td>
<td>$99,910</td>
<td>3,597</td>
<td>2,456</td>
<td>7</td>
<td>18</td>
<td>8%</td>
</tr>
</tbody>
</table>

Region #1

Region #2

Region #3

Region #4

Exceeds Industry Standards
Meets Industry Standards
Below Industry Standards
Deliver Physician Productivity Performance Measures

- The table illustrates the potential for increased revenue based on:
  - Incremental increase in patient volume
  - Increase in CPTs per visit to the MGMA standard
- Calculations based on 60 FTE Physicians

### Visit and CPT Volume Sensitivity

<table>
<thead>
<tr>
<th></th>
<th>ACTUAL</th>
<th>Increase Patient Volume</th>
<th>MGMA* Patient Volume</th>
<th>MGMA* Patient and CPT Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Visits/Physician/Day</td>
<td>13.00</td>
<td>18.00</td>
<td>20.00</td>
<td>20.00</td>
</tr>
<tr>
<td>CPTs per Visit</td>
<td>1.56</td>
<td>1.56</td>
<td>1.56</td>
<td>2.60</td>
</tr>
<tr>
<td>Annual Visits per Physician</td>
<td>2,860</td>
<td>3,960</td>
<td>4,400</td>
<td>4,361</td>
</tr>
<tr>
<td>Annual CPTs per Physician</td>
<td>4,462</td>
<td>6,178</td>
<td>6,864</td>
<td>8,876</td>
</tr>
<tr>
<td>Avg Collections per Visit</td>
<td>102.82</td>
<td>102.82</td>
<td>102.82</td>
<td>171.37</td>
</tr>
<tr>
<td>Collections</td>
<td>$294,064</td>
<td>$407,166</td>
<td>$452,406</td>
<td>$747,327</td>
</tr>
<tr>
<td>Growth in Collections</td>
<td>$   -</td>
<td>$113,102</td>
<td>$158,342</td>
<td>$453,263</td>
</tr>
<tr>
<td>% Growth in Collections</td>
<td>0.0%</td>
<td>38.5%</td>
<td>53.8%</td>
<td>154.1%</td>
</tr>
</tbody>
</table>

I. FTE assumes full time physician for previous 12 months
II. Physicians seeing patients less than 12 months considered a partial FTE (e.g. 4 months would be .33 FTE)
III. Physicians not seeing a full schedule of patients were considered a full FTE
IV. A full year was considered 220 days (excludes weekends, vacations, sick days, holidays, continuing education, etc.)
V. Physicians seeing patients less than 12 months have a reduced Days in Operation (e.g. 4 months = 73 days)
VI. Source: MGMA Performance and Practices of Successful Medical Groups, 2007 Report Based on 2006 Data*
VII. MGMA Benchmark based on Multi-specialty, hospital-owned, greater than 50 percent primary care, 4361 encounters per FTE physician; 8876 visits per year; 2.6 CPTs per visit
VIII. Collections calculations is constant $65.91 = average collections per charge
Early Warning Signs of Trouble

- Ever increasing practice losses
- Focus upon a technology solution as a lead
- Inability to meet with physician practices on a monthly basis
- Inability to terminate non-compliant physicians
- Inconsistency in the physician alignment model
- Lack of a commitment to developing a relationship with the physician
- Inability to review system-wide economics approach
- Lack of centralization of process and standards
Case Study
About Health System

- One of the largest faith-based, nonprofit health care delivery systems in the United States, and the region's largest in terms of patients served

- Primary service area consists of 16 counties in home to more than 6.2 million people

- Includes three anchor hospitals, a large physician group, outpatient facilities, and home health, preventive and fitness services

- More than 20,500 employees
About Health System

- 24 acute care and short-stay hospitals are owned, operated, joint-ventured or affiliated with Health System
- More than 4,100 licensed hospital beds (more than 3,500 staffed beds)
- More than 5,500 physicians with active staff privileges
- $2.9 billion in total operating revenue (FY 2009)
- $3.9 billion in total assets (FY 2009)
Physician Organization: Growth Timeline

- December 2008 – 66 providers in 6 organizations with 7 operating systems

- January 2009 – formed and capitalized a new for-profit management services organization (MSO) that consolidated all physicians under one organization, one operating system, new hospital-independent HR and accounting systems

- December 2009 – 120 providers

- December 2010 – 236 providers

- January 2011 – growth through acquisition of MedicalEdge Healthcare Group; over 620 providers under one organization along with ambulatory services under one operating MSO

- Today – 750 providers
Reasons for Success

• Clear vision, detailed plan, quick and effective execution

• Non-hospital leadership; strong governance model

• Comprehensive practice management solution
  – Benchmarking
  – Standard processes, policies, job descriptions and workflows

• Trust in vision, implementation and execution

• Communication channels with physicians at multiple levels

• Relationships are being built within the hospital facility over time
**Model | Physician Services Organization**

- **Consulting Services**
  - Work flows and benchmarks
  - Road map to best practices
  - Gap analysis
  - Job descriptions
  - Quality and performance measures
  - Policies and procedures
  - Financial and operational assessment

- **Pre Point-of-Service**
  - Call routing
  - Scheduling
  - Pre-registration
  - Financial screening
  - Verification of benefits
  - Referral management
  - Pre-authorization
  - Education/patient preps

- **Point-of-Service**
  - Patient check-in
  - Registration verification
  - Financial counseling
  - Collect and post payments
  - Patient check-out
  - Post charges
  - Schedule follow-up
  - Patient satisfaction survey

- **Financial Management**
  - General accounting
  - Financial decision support
  - Accounts receivable
  - Accounts payable
  - Cash management
  - Reporting
  - Client services

- **Data Management**
  - Maintain financial systems
  - Monitor and manage IT system resources and requirements
  - Reporting and management analysis
  - Practice management system
  - System training
  - Compliance with health system security standards

- **Marketing**
  - Practice and Physician group marketing
  - Corporate communication
  - Branding

- **Human Resources**
  - Recruiting
  - Clinic staff compensation
  - Benefits administration
  - Staff training/development
  - Payroll
  - Employee policies

- **IT Support**
  - Provider data center management
  - Application support for practice management system
  - Help desk triage
  - Interfaces
  - Clearing house

- **Practice Management**
  - Manage and monitor compliance
  - Business development
  - Financial reporting standards

- **Payer Enrollment**
  - Payer credentialing application process
  - Payer network contracting process
  - Provider demographic database

- **Central Business Office (CBO)**
  - Reconciliation and audits
  - Electronic claims submission
  - EOB imaging and indexing
  - A/R management
  - Self-pay management
  - Denial management
  - Account resolution
  - Payment processing
• **Contract Management**
  - Payer contract negotiation
  - Contract tracking
  - Fee schedule maintenance
  - Contract compliance & analysis

• **Regulatory and Compliance**
  - Monitor OIG, HIPAA, OSHA regulations
  - Conduct internal monitoring and audit
  - Maintain standard policies and procedures
  - Implement and manage compliance plan
  - Conduct training
  - Communication plan
  - Enforce disciplinary action

• **Business Development**
  - Physician recruitment and contracting
  - Practice acquisition/affiliation
  - Facilities credentialing
  - Market analysis

• **Data Management**
  - EMR
  - Lab and radiology systems
  - Interfaces
  - Data integrity
  - Security

• **IT Support**
  - Desktop support
  - Communications network
  - Hardware

• **Facilities Management**
  - Materials management
  - Building maintenance
  - Vendor selection management
  - Contract compliance
  - Reporting and analysis

• **Marketing**
  - Service line marketing
  - Hospital entity marketing
  - Intranet
  - Branding
  - Physician portal

• **Clinical Services**
  - Clinical quality
  - Coding
Model | Physicians Group

- Physician Relations
  - Physician compensation & benefits
  - Physician education
  - Provider productivity/performance

- Physician Network Development
  - Physician recruitment and contracting
  - Practice acquisition/affiliation
  - Credentialing

- Clinical Services
  - Clinical quality
  - Coding