CHAPTER 7

Operational Chaos Phase

Anything you build on a large scale
or with intense passion invites chaos.

—Francis Ford Coppola

In the Operational Chaos phase (exhibit 7.1), the employed physician network has outgrown the capabilities or capacity of the infrastructure initially established to manage it. This healthcare organization–based infrastructure includes the following:

- Director-level manager whom the organizational CEO assigned to oversee the network
- Billing system
- Electronic medical record (EMR)
- Support functions (e.g., finance department)
- Informal organizational structure, with no clear lines of communication or network chain of command

In addition, during the Operational Chaos phase, physician practices in the network experience the following:

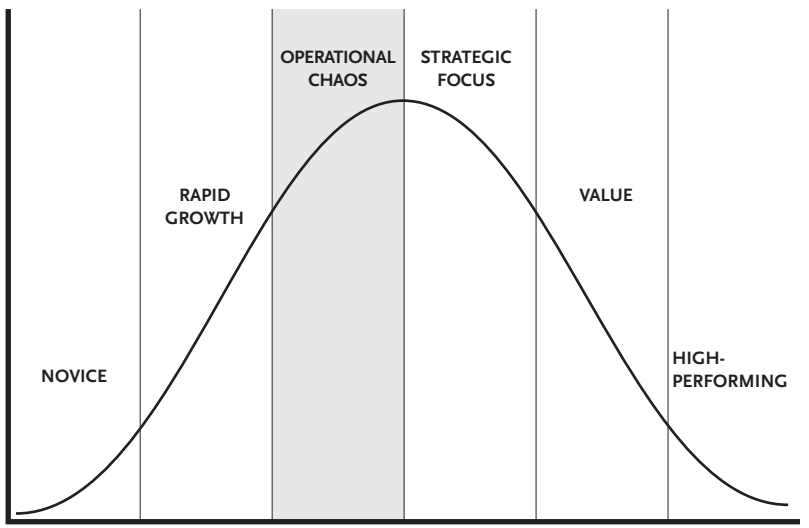
- Rapidly escalating practice costs while reimbursement stays flat

- Dwindling generous deals (deals that are typical during the Rapid Growth phase, in which organizations focus on "getting" the provider and not on managing the losses)
- Layering of organizational benefit structures and overhead onto the practices
- Skyrocketing subsidies

These and other operational issues may cause organizational leadership and/or the board to question the viability of physician employment as a strategy, pull back on employment deals ("We can't afford to employ more providers"), cut network staff or fail to resource management appropriately, and ask already busy executives or managers to take on more responsibility within the network (leading to other problems within the healthcare organization).

Because of these dynamics, Operational Chaos is a dangerous phase. When practice-level financial losses start affecting the organization-level bottom line, the board starts getting curious,

Exhibit 7.1: Operational Chaos Phase on the Growth Curve



and leadership teams start getting frustrated and anxious. Providers start feeling the pressure, especially when they weren't losing money before.

The core characteristics of a network amid the Operational Chaos phase are summarized as follows:

- The network has grown exponentially from the flurry of deal making, recruitment, negotiations, or acquisitions happening in the Rapid Growth phase.
- The management capabilities of the network have not scaled in the same manner, however, resulting in a mismatch between group size and management resources.
- Current network managers feel the need for day-to-day firefighting as operational challenges seem to spark every day.
- Financial losses are rapid and cause much anxiety, which drives the pullback from the employment strategy and investment in building the management infrastructure.

Networks evolve from Rapid Growth to Operational Chaos when they start to mature and when the organization switches its focus from growing the network to "stop losing so much money on the network." This phase does not have a natural end point. The network will remain here until the organization makes a conscious decision to fundamentally change the way it manages the network. This includes building the right infrastructure, engaging the providers, creating an integrated network, standardizing practice operations, and standardizing compensation arrangements. To leave this phase, the organization must work toward leveraging the group as a strategic asset.

THE EIGHT ELEMENTS IN THE OPERATIONAL CHAOS PHASE

A network in the Operational Chaos phase handles these eight elements of an employed network as follows:

1. *Strategy.* Strategy shifts from growth to management—that is, how do we strategically move every aspect of the network's operation (essentially, all of the eight key elements) forward?
2. *Culture.* Culture development tends to lag behind, partially as a result of management's operational focus, which doesn't allow the time for activities related to vision or culture development.
3. *Quality.* Quality is usually not a focus, either. In most cases, the development of a robust quality program and integration of performance measurement into compensation is a Strategic Focus phase initiative.
4. *Physician leadership.* Engaging providers in the work of network leadership begins in the Operational Chaos phase. To truly address operational and financial performance issues, provider input and buy-in are heavily needed. However, most networks find that physician engagement entails more than inviting doctors to the table. Major cultural barriers must be broken down, and the right type of forum must be developed to solicit appropriate provider input.
5. *Management infrastructure.* The network must build the infrastructure to support the current size of the network. That infrastructure must be optimized to help make the network financially sustainable.
6. *Aligned compensation.* Compensation is ideally standardized. Networks that have gone through the Rapid Growth phase invariably end up with a variety of provider agreements or contracts. Many of these agreements are geared toward what providers want, rather than what the organization needs.
7. *Brand.* Brand is still not a major focus. But at this point, some thought should be given to letting the public know that the organization and practices or physicians are now on the same team. True brand development, however, still takes a backseat to getting the operations right.

8. *Financial sustainability.* Along with establishing an infrastructure, financial sustainability is another core focus in the Operational Chaos phase. The hard work directed at employing providers has resulted in an unsustainable financial position, which may continue without significant intervention.

KEY AREAS OF MANAGEMENT FOCUS

Actions in the Operational Chaos phase should focus on one overall goal: Get the network to a point of sustainability—of financial performance, provider satisfaction and retention, and management satisfaction and retention. Achieving this goal requires developing and executing a plan that will take the network to the next phase—Strategic Focus. The seven key areas of management focus in the Operational Chaos phase are discussed in this section.

Key Area 1: Reorganizing and Rightsizing the Management Infrastructure

To define the appropriate management infrastructure, we ask the organization the following seven questions:

1. Do you have the right organizational structure to effectively manage practices in the network?
2. Are you in the optimal legal structure to maximize revenue and operating efficiencies?
3. Does the practice executive have the skills and capabilities required to implement your vision for the network?
4. Do you have distinct functions and dedicated resources—such as information technology (IT), finance, and revenue cycle—that support the group's day-to-day operations?
5. Do your management capabilities and skill sets reflect the size of the network?

6. Does your IT infrastructure provide your clinicians the clinical data they require to deliver high-quality care?
7. Does your IT infrastructure provide the financial reports and data required to effectively and efficiently manage the practices?

Put in place the organizational structure

The first focus should be on the organizational chart (see exhibit 7.2 for a sample). If you haven't done so, now is the time to appoint dedicated full-time administrative and clinical leadership for the network. The intensity of these roles will vary by network size and other factors. Adequate physician leadership for smaller networks may be 0.2 full-time equivalents (FTEs), although networks with 30 to 40 providers often require full-time medical leadership.

The central billing office (CBO; discussed in key area 4) also needs to have full-time leadership. If practice billing is done through the CBO, dedicated resources are needed to ensure that collections for the practices are accurate, timely, and in accordance with a standardized process.

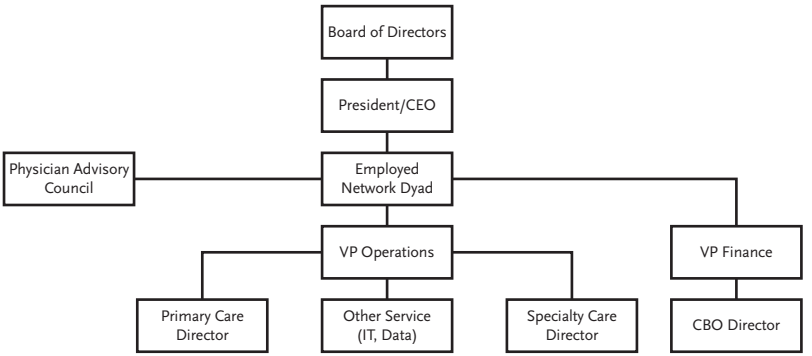
IT resources need to be brought into the network. At some point, the network will begin consolidating EMR platforms or moving en masse to a new platform. Either way, resources need to be in place to enable or assist with this transition, train providers and staff as quickly as possible, and actively optimize IT use in daily practice.

Review the network's legal structure

During the Novice and Rapid Growth phases, the network is treated as just another department under the organization's tax-ID number. However, this comes with a handful of downsides, most notable of which is that the practices take on the benefit structure of the typically richer hospital or health system that employs them.

With the need to consolidate the many tax IDs under the network, the organization must now evaluate whether moving the network into its own tax ID, either as a for-profit or a nonprofit, makes sense. The financial advantages of switching benefit structures

Exhibit 7.2: Sample Organizational Chart for a Network Moving Through Operational Chaos



Note: CBO = central billing office; IT = information technology; VP = vice president.

are huge. The core challenge to changing the legal structure is that staffers who perform the same functions (general administration, for example) for the organization and the network will end up with different benefit structures depending on where they work.

Key Area 2: Installing the Right Administrative and Clinical Leaders

Building the right infrastructure starts with getting the right leader in place. This leader is rarely the person who has been in charge of the network through the Novice and/or Rapid Growth phases. Whether your network has gone from 5 to 45 FTEs, or 50 to 500, it needs a skill set now that was likely not present when you started.

Identify the right administrative leadership

To identify whether the current practice administrator in the network is suitable, ask the following distinguishing question first: Do the physicians work through operational challenges with the administrator, or

do they reach out to the organizational executive team to intervene? Engagement of the executives indicates weakness at the practice level.

Next, establish a formal leadership title for the role. Depending on your network's setup, this title may be *executive director*, *president*, or *vice president* of the network. Some organizations use *president*, to create equal status with the hospital presidents. Regardless of title, this leader can be brought into your network if you treat this search with the same care and importance you give to the recruitment of an organizational executive:

- *Take the time.* Conduct a national search of experienced executives. Done correctly, this search could take 80 to 100 days to complete.
- *Spend the money.* Experienced network leaders typically have advanced degrees and/or certifications. Be willing to offer executive-level salaries and benefit plans to attract and sign the best candidates; this talent pool is narrow.
- *Use the right eyes.* People who have run large networks know inherently what to look for in a candidate. An in-house recruiter or staff from the human resources department may lack the knowledge to evaluate candidate resumes or ask the right screening and interview questions.

Identify the right clinical leadership

Develop a clinical leadership position that functions as part of a management dyad with the administrative executive. For most networks, this role is ideally filled internally, rather than through an outside search. During the Operational Chaos phase, this position is usually part-time, with a goal to introduce aspects of dyad management to the network.

Institute the dyad management approach

Dyad management consists of one clinical member (typically a physician) and one administrative member who co-lead the network. It is a team-based approach in which the physician leader leverages her

strengths and expertise to oversee clinical functions and the administrator brings his strengths and expertise to manage the business operations. Each dyad leader directly contributes to organizational performance through well-defined, mutually supportive individual and shared responsibilities. The exact roles and responsibilities of each leader vary according to the size and complexity of the network, the organization, or the assigned subunit. See exhibit 7.3 for an example of these roles and responsibilities.

Exhibit 7.3: Dyad Management Roles and Responsibilities

Shared	Physician Leader	Administrative Leader
• Developing or implementing strategy and associated action plans	• Providing provider supervision – Performance review – Discipline – Recruiting, onboarding	• Developing operational goals, priorities, and responsibilities
• Fostering group culture	• Creating, implementing, and monitoring clinical practice guidelines	• Monitoring group financial functions—budgeting, accounting, and reporting
• Promoting, monitoring, and reporting group and individual performances – Quality of care – Patient safety – Patient experience – Operational efficiency – Operation budget	• Driving population health management initiatives	• Managing and developing human resources consistent with organizational guidelines, established contracts, and legal requirements
• Developing internal and external organizational relationships	• Evaluating clinical outcomes (effectiveness and efficiency)	• Coordinating necessary support functions—marketing, IT, and financial
• Optimizing clinical informatics and data analytics systems	• Supporting administrative leader	• Supporting physician leader

The development of dyad management usually occurs after the Operational Chaos phase, but this should not preclude the network from beginning to build the approach into its culture.

Key Area 3: Standardizing and Streamlining Operational Performance

Operational consistency—use of standardized measures and approaches to minimize practice variation—is essential, especially during this phase, and should be assessed for the following practice components:

- *Financial performance.* In general, how close to established benchmarks are the losses on each practice? What is the target for losses?
- *Revenue cycle performance.* Whether managed by a CBO or the practice billing function, is the revenue cycle performance in line with or above benchmarks?
- *Staffing levels.* Are staffing levels consistent with production levels?
- *Provider production.* Are physicians producing at the levels expected?
- *Advanced practice professional use.* Do the practices employ nurse practitioners, physician assistants, and other advanced practice professionals? Are these providers, including the physicians, performing at the "top of their license" (Moawad 2017)?
- *Provider compensation.* How does compensation compare with production levels? Are there compliance issues with any contracts due to compensation?
- *Overhead costs.* Are the nonlabor or administrative costs within the practices appropriate?

As you perform this assessment, look at both the individual practices and the trends across the network as a whole.

In general, operationally chaotic networks tend to be operationally inconsistent and are characterized as follows:

- Higher-than-benchmark practice losses
- Poor revenue cycle performance, particularly in charge capture and documentation
- Wildly variable staffing levels
- Wildly variable provider utilization, with some practitioners functioning as nursing staff and some carrying their own patient loads
- Variable productivity, and compensation levels that are not consistent with production levels
- Initially lean overhead costs that balloon as the network progresses along the growth curve (In the Operational Chaos phase, organizations rarely fully allocate to the practices the costs of the management structure. Therefore, as cost accounting systems for the practices improve, overhead costs tend to increase.)

Key Area 4: Formalizing the Revenue Cycle Process

Revenue cycle management is complex and involves a long list of activities (exhibit 7.4). It is affected by stagnant or declining reimbursements, the implementation of electronic health records, evolving local-carrier determinations, and payer credentialing. The emphasis on healthcare fraud and abuse and on compliance has elevated the importance of accurate data reporting and claims filing. The efficiency of a practice's billing operations has a direct effect on the practice's financial performance.

During the Novice and Rapid Growth phases, networks often outsource the practices' billing function under the rationale that it is too important to not do correctly but requires much attention while the practices are amid acquisition. The Operational Chaos phase is the time to bring revenue cycle management back into the network as part of the expanded management infrastructure.

Develop a CBO

The exact setup of a CBO varies from network to network. We recommend evaluating a CBO on the following eight key factors:

1. *Leadership.* Does the CBO have a dedicated, full-time leader?
2. *Roles and responsibilities.* Do the CBO staff members have clear day to-day responsibilities?
3. *Dashboard.* Is a dashboard report generated for key performance indicators? The ability to measure allows network management to make timely and appropriate interventions.
4. *Fee schedule.* Are the fee schedules updated yearly, when the Medicare fee schedule is released? The schedule should be set as a percentage of Medicare reimbursement that ensures the maximum allowable capture from commercial payers (200 to 250 percent). Otherwise, the network is missing revenue opportunities.
5. *Policies and procedures.* Are policies and procedures in place for fee schedule updates, reconciliations, write-offs, insurance follow-ups, denial management, and other functions?
6. *Net revenue collections.* Does the network calculate this metric to get an accurate picture of the CBO's performance?
7. *Appropriate workflows.* Are workflows, such as payer checks and balances as well as coding audits, in place and well defined? Are accountabilities assigned for these workflows?
8. *Staffing.* Is the CBO's staffing level appropriate for the network's size and productivity? Do not try to save FTEs in this area.

Key Area 5: Engaging Providers in Network Operations and Performance

Formally engaging providers in the network's performance represents a shift from past approaches whereby the physicians were engaged

Exhibit 7.4: 21 Daily Activities in Revenue Cycle Management of an Employed Physician Network

1. Patient pre-visit or call for appointment
2. Patient record entry in the EMR
3. Patient check-in
4. Visit documentation
5. Potential charges recorded on a superbill
6. Visit coding
7. Patient checkout and copay collection
8. Posting of the charge
9. Preparation of the day's batch, and checking for missing tickets, hospital reports, etc.
10. Billing office verification of the charge and information
11. Scrubbing of the bill
12. Electronic and paper transmission of the bill to the patient
13. Preparation of the documentation, if necessary
14. Preparation of the explanation of benefits for appropriate posting of the payment
15. Preparation of the patient check for deposit
16. Posting of the payment to the correct patient
17. Review and preparation of any denials
18. Getting additional information for denials from the billing office
19. Resubmission of the claim
20. Working the aged accounts receivable
21. Sending the patient statements

in practice or individual performance. Engagement should focus on developing and building out the network's Physician Advisory Council (PAC). Following are tactics for forming and operating a PAC.

Articulate the purpose

PACs take on many names (e.g., governance councils, leadership councils, boards [informal]), but their purpose is the same: to create a core group of physician leaders who assist network administration with problem solving and strategic direction. Management's message should be as follows:

- We want our physicians to take ownership of the performance and success of the network.
- We need physicians' help and leadership in (1) discovering operational challenges, (2) developing the solutions, and (3) supporting the implementation of those solutions.

Determine the PAC composition

Ideal PAC composition varies according to the network's size and complexity. Provider membership should be relatively inclusive to do the following:

- Achieve the broadest input during PAC deliberations
- Effect the greatest buy-in for the PAC's decisions
- Be representative of the network's specialty mix; geographic locations; provider age or generation, experience level, and gender; and advanced practice professionals mix

In addition, the council should include a member from a newly acquired practice.

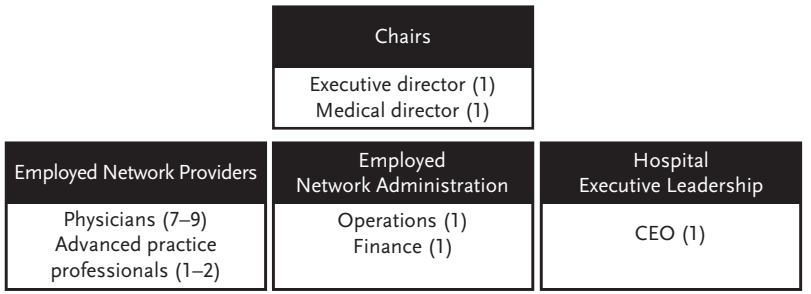
The PAC's size must balance inclusiveness with a workable decision-making process. Most councils are led by dyad management (an administrator and a medical director). Other administrative team members are involved on an ad hoc basis, whereas certain ex officio leaders hold positions as standing members; exhibit 7.5 provides a sample PAC composition.

Define the duties

The PAC should be assigned the following responsibilities:

- *Soliciting strategic and tactical input from direct care providers.* Early, ongoing physician involvement in the strategic planning process drives more positive results. Engage your PAC in strategic initiatives related to the network and the organization.

Exhibit 7.5: Sample Physician Advisory Council



- *Reviewing practice performance.* Performance and metrics should be reviewed through a dashboard format on a regular basis. This review provides the council with the opportunity to replicate positive practices and identify potential areas for improvement.
- *Presenting potential new initiatives.* The PAC is an excellent place to vet proposed initiatives arising from management or the practices.
- *Promoting physician ownership of practice functions and initiatives.* Abdicating this important responsibility will result in subpar performance.
- *Educating and grooming future physician leaders.* Council membership introduces prospective physician leaders to the organizational perspective and strategic objectives. It promotes a collective rather than an individual focus.

Set expectations

All PAC members should be informed of and should embrace membership expectations and ground rules. Consider adopting the following guidelines:

- Assume a fiduciary duty to the system and to peers. Membership does not represent an opportunity to advocate or pursue private agendas.

- Exhibit respect for all those involved in the council.
- Attend meetings faithfully.
- Actively prepare for and participate in meetings.
- Serve as an information conduit between peers.
- Champion PAC-approved projects and initiatives.
- Openly discuss opinions during meetings, but rally behind the final decision.
- Leave what is said in the meeting at the meeting.
- Share PAC discussion feedback with practice members.

Key Area 6: Standardizing and Optimizing Compensation Methodologies

In the Operational Chaos phase, provider compensation is a typical concern for organizational executives and managers. Varying levels of compensation are the direct result of the multitude of deals made during the Rapid Growth phase. When viewed in the aggregate, these deals had different compensation methodologies, incentives, term lengths, agreements for oversight of or working with advanced practice professionals, and compliance complications; lacked alignment with organizational strategic goals; and disregarded other organizational arrangements signed with network physicians (e.g., professional services agreements, call coverage agreements, medical directorships). Building the right compensation plan is imperative at this point.

Get a handle on physician agreements

After Rapid Growth, network providers likely have multiple contracts with one organization, some of which may no longer be relevant. The Operational Chaos phase is the time to make sense of these contracts. Review the contracts or agreements for the following:

- The terms are aligned with the network's strategic goals and objectives.

- Total compensation is within the bounds the organization is willing to pay.
- The fair market value and commercial reasonableness of total compensation from all sources are in compliance with Stark and Anti-Kickback laws.

We recommend these steps: First, conduct a comprehensive inventory of these contracts. Second, compare the total compensation against benchmark to identify concerns about fair market value. Third, compare the terms with organizational objectives. Last, build a plan of action that addresses the following: What changes need to be made? When do contracts expire? How will we educate providers on the needed changes, and how will we get their buy-in?

Strive to align compensation and productivity levels

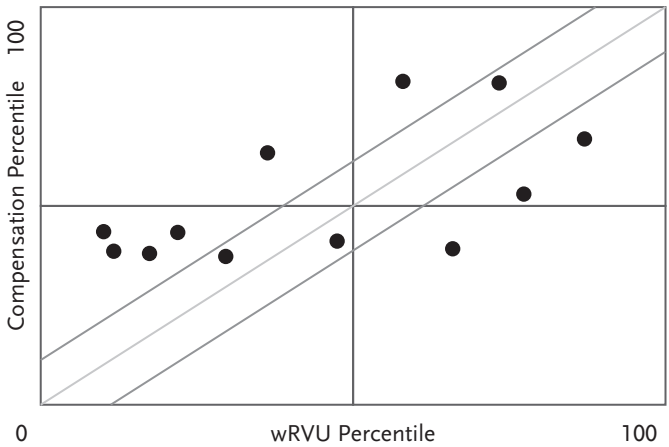
Financial challenges will drive you to align compensation levels and work relative value units (wRVUs). To start this process, run a comparison of percentile compensation and percentile production. It is reasonable for compensation and production to vary within a +/–10 percentile point range. Consider the scatter diagram in exhibit 7.6; you may use such a diagram to plot your providers' levels or data. Exhibit 7.7 shows the details of this diagram. As exhibit 7.7 shows, the northwest corner of the plot is your biggest concern. These physicians are being paid more than their production can justify. Using such a tool, you can identify what is at risk and what intervention to take for your network.

Start educating physicians

Inform physicians now that compensation changes will be coming, and begin their education on the new methodology. In most markets, this education is focused on transition to value-based reimbursement and includes

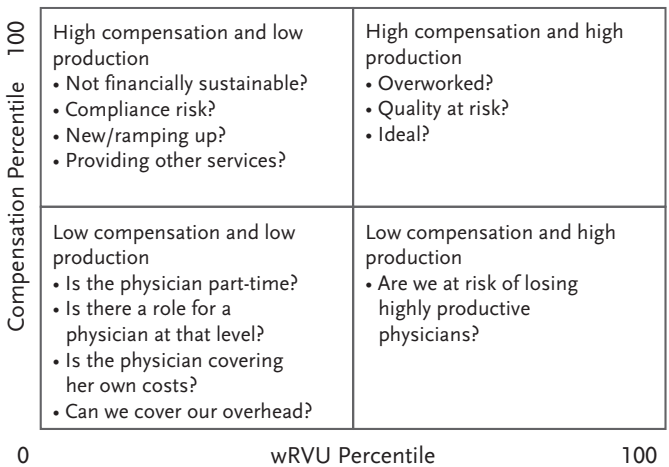
- the Merit-Based Incentive Payment System as part of the Medicare sustainable growth rate fix;

Exhibit 7.6: Scatter Diagram: Production vs. Compensation



Note: wRVU = work relative value unit.

Exhibit 7.7: Scatter Diagram Data: Production vs. Compensation



Note: wRVU = work relative value unit.

- hospital-based programs, such as value-based purchasing and penalties for readmissions and hospital-acquired conditions;
- voluntary alternative payment models, such as value-based accountable care organizations and Medicare shared savings programs; and
- bundled payments.

Your overall message to physicians should be simple: In the near future, our compensation framework will

- gain physician buy-in and ownership;
- support the development of a cohesive culture within the group;
- offer incentives for improvements in productivity, quality, patient satisfaction, citizenship, clinical processes, and teamwork;
- maintain correlation between individual physician compensation and performance;
- be competitive in the national marketplace while considering unique challenges within the market;
- be financially sustainable; and
- provide a consistent foundation that will enable the network to adjust revenue streams as value-based reimbursement models become more prevalent.

Key Area 7: Managing the Relationship with Organizational Stakeholders

Take a step back to (1) look at the impact of the growth in employment on the rest of the organization and then (2) determine where this critically important structure of the employed network fits within the organization's long-established management hierarchy.

Vestiges of how the organization managed provider relationships before physician employment tend to linger. Executives, service line leaders, and other management team members may take offense when key providers begin reporting to the new management structure. Joint planning and focusing on how the group supports the organizational strategy will help address many of these challenges.

CONCLUSION

Following are the key learning points of this chapter:

1. *Force yourself through Operational Chaos.* It's a phase that doesn't go away on its own. Organizations move beyond it when they commit to building the capabilities to manage the network they enlarged during the Rapid Growth phase.
2. *Find the right leaders.* Networks cannot move out of the Operational Chaos phase with only part-time organizational executives or unqualified practice managers. Likewise, a dearth of physician leaders will slow progress.
3. *Do a formal assessment of each practice within the network.* What is working, and what is not? What's the plan for fixing it? What is driving the issues across multiple practices?
4. *Build revenue cycle capabilities.* Make sure this function meets the network's needs, and make sure the network gets paid for what it does.
5. *Start engaging providers.* Lay the groundwork for the expansion of provider leadership, and ask physicians to start thinking about how the network gets out of the Operational Chaos phase.
6. *Start the conversation about compensation.* Deals that were created during the Rapid Growth phase may not serve the network's long-term needs.
7. *Bring your organization's stakeholders along as you work on the network.* Everyone needs to understand why the network requires so much attention and resources.

REFERENCE

Moawad, H. 2017. "Practicing at the Top of Your License." *MD Magazine*. Published May 3. www.mdmag.com/physicians-money-digest/contributor/heidi-moawad-md/2017/05/practicing-at-the-top-of-your-license.

ADDITIONAL RESOURCE

Barker, N. D. 2018. "From Operational Chaos to High-Performing: The Right Path for Your Physician Network." HSG. http://hsgadvisors.com/flipbooks/operational-chaos-high-performing-right-path-physician-network/.

CASES

The following cases illustrate the concepts discussed in the chapter. The healthcare organizations featured in this section have had a long-term relationship with our consulting practice, HSG, and have given us permission to discuss their employed physician network journey.

Health System in the Northeast

After a multiyear effort of growing its employed physician network, this health system had a collection of employed physicians, but the network did not function like a group in any sense of the word. When the system retained HSG, the network had

continued

- primary care, specialist, and hospital-based physicians under different tax identification numbers;
- practices with dissimilar names and branding;
- on-site managers reporting to different hospital vice presidents;
- billing done by system staff or by a separate physician billing department on two different systems;
- different compensation models and structures; and
- no group culture or no feeling among physicians that they were a part of a larger unified network.

The system wanted to form a subsidiary organization for the employed physicians that would function under the system's influence but would be managed separately by physician practice administrators rather than system executives.

Approach

For two years, the system added new practices and transitioned existing employed practices into the new entity. During that time, a central billing office (CBO) was established specifically for physician practice professionals and technical services. An electronic medical record, integrated with the practice management system, was implemented in practices. Directors of primary care and specialty practices were hired to oversee practice operations. The entity installed its own chief administrative officer, billing manager, credentialing coordinator, and director of finance and accounting. The practices have been branded similarly and are clearly identifiable as a part of the system's employed physician group. Physician compensation models have been implemented with similar values and structure.

Result

Today, the system's employed physician network is advancing toward being a multispecialty group. The network has an

infrastructure, trustworthy data and information, and more provider cohesion and direction. More work is being done to create a shared purpose, vision, and culture.

Apex Medical Group

Apex Medical Group is a not-for-profit healthcare system with facilities in six counties in the Southeast. It employs 140 providers in 19 specialties. Apex sought to optimize its revenue cycle operations to address internal structural factors that were financially affecting the organization. The leadership also was determined to standardize its processes and establish financial accountability and consistency of metrics across its clinics.

Approach

Apex engaged HSG to guide and execute a comprehensive revenue cycle redesign. This redesign involved evaluating historical data, consistently following revenue cycle indicators, implementing a daily budgeted volumes report, creating a dashboard, reorganizing the CBO structure, resolving an insurance denials backlog issue, standardizing a fee schedule, and developing a staffing tool.

Key focus areas of the project included increasing accountability and visibility of metrics across the revenue cycle; therefore, HSG initially provided full-time managerial support to streamline communication and transparency between the CBO and the different practices. The team collaborated to reestablish communication lines between the various points of contact.

Apex's leadership developed a list of key financial indicators that required monthly analysis, established priority when

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analyzing these indicators, implemented a revenue cycle meeting structure, and allowed staff to work toward financial goals. In addition, Apex identified revenue leakage to improve the annual net revenue, aided by a CBO now organized around the revenue cycle process (including insurance verification, coding and charge posting, claims processing and payment posting, insurance follow-up, and self-pay collections). The insurance denials were streamlined, and all coding and charge entry staff members changed their work location to the CBO and started reporting to the coding and charge entry lead.

Process documentation, fee standardization, and staffing and productivity benchmarks were all addressed.

Results

Exhibit CS7.1 shows performance improvement, from the third to the fourth quarter of 2016, in all major measures. These results were produced with the addition of eight FTEs and the reassignment of 14 individuals within the network. Annual collections improved by more than $7 million.

Exhibit CS7.1: Third-Quarter vs. Fourth-Quarter Performance

	Q3	Q4
Quarterly collections	$15.84 m	$17.58 m
Net collection rate	90.2%	99.1%[1]
Days in AR	45	40
Denial percentage	3.33%	2.3%

[1] This rate reflects some "catch-up"; expect 2017 to be 96.5%.
Note: AR = accounts receivable; m = million.

Compensation Planning for a Tertiary Hospital

A tertiary hospital on the Atlantic Seaboard with more than 1,000 beds, a children's hospital, a level-I trauma center, and one of the nation's largest transplant centers employs a broad range of specialists—from primary care physicians to transplant surgeons. The compensation methodology for these employed physicians was not consistent across specialties or even within a specialty, and it largely used a base salary model that did not incorporate bonuses for productivity or quality. The hospital was experiencing unnecessary practice losses because of lack of productivity, and it was dealing with an administrative nightmare of reconciling the different types of physician contracts each month and each quarter.

Approach

With HSG's guidance, the hospital formed a steering committee composed of the executive team, board members, and physician leadership. This committee received education regarding industry trends in compensation planning, economic incentive alignment, and financial stability and compliance considerations. Group discussions led to the identification of four key issues that the new compensation plan must address:

1. Program sustainability
2. Quality and productivity incentives
3. Flexibility to expand quality incentives as reimbursement environment changes
4. Fair market value–compliant total compensation package

Next, term sheets were developed that incorporated these components in the structure of the compensation agreement.

continued

These term sheets were reviewed and approved by the employed physician group.

Results

By using a process that incorporated key stakeholder education and direct physician involvement in the creation of a compensation methodology, the hospital achieved a greater level of buy-in from the employed network as a whole. Today, this compensation methodology is applied to both new provider contracts and existing contracts as they expire.