



Greenwich Hospital

Surviving in a Competitive Marketplace:
Opportunities for Physician Practices

November 9, 2005





Introduction

Integrated HealthCare

- Established in CT in 1996
 - IHC has served over 100 academic and private physician practices in NY, CT & NJ
- Ronald Dreskin, Managing Partner
 - Over 25 years of leadership experience in the health care industry
 - Former executive for NYC academic teaching hospital
 - Columbia University School of Public Health Faculty Member
 - Chairman, Nathaniel Witherell Nursing Home in Greenwich

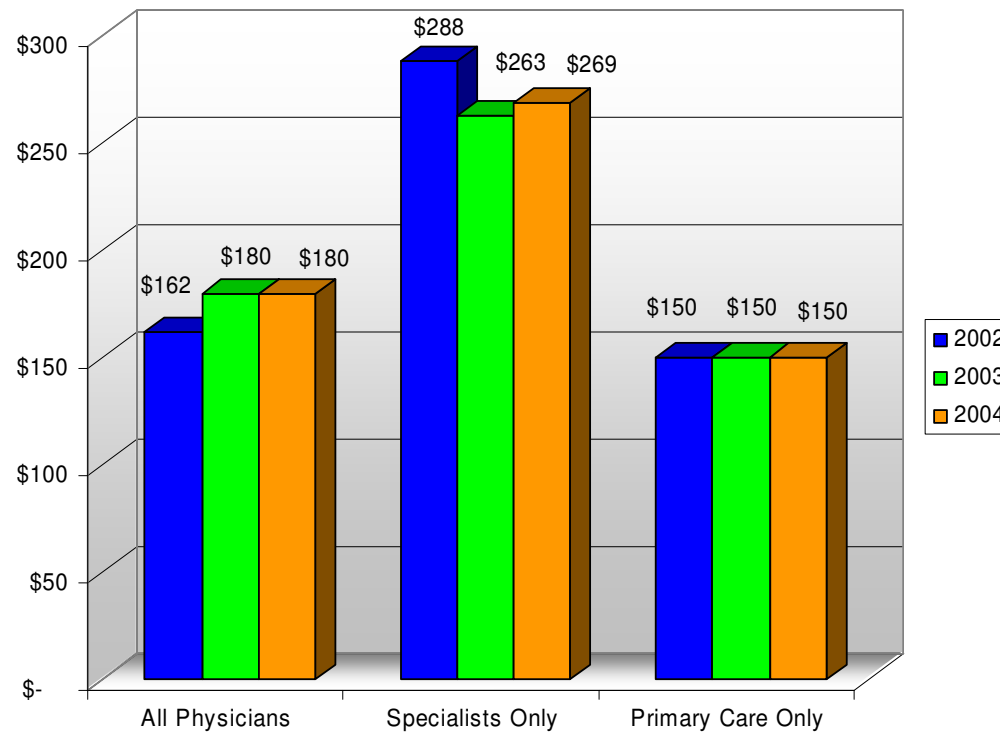


Agenda

- National Trends
- How to Improve Your Practice
 - Mission Statement
 - Benchmarking Defined
 - Sample Self-Assessment Tools
- Competition
 - Strategic Responses
- Next Steps

National Trends-Compensation

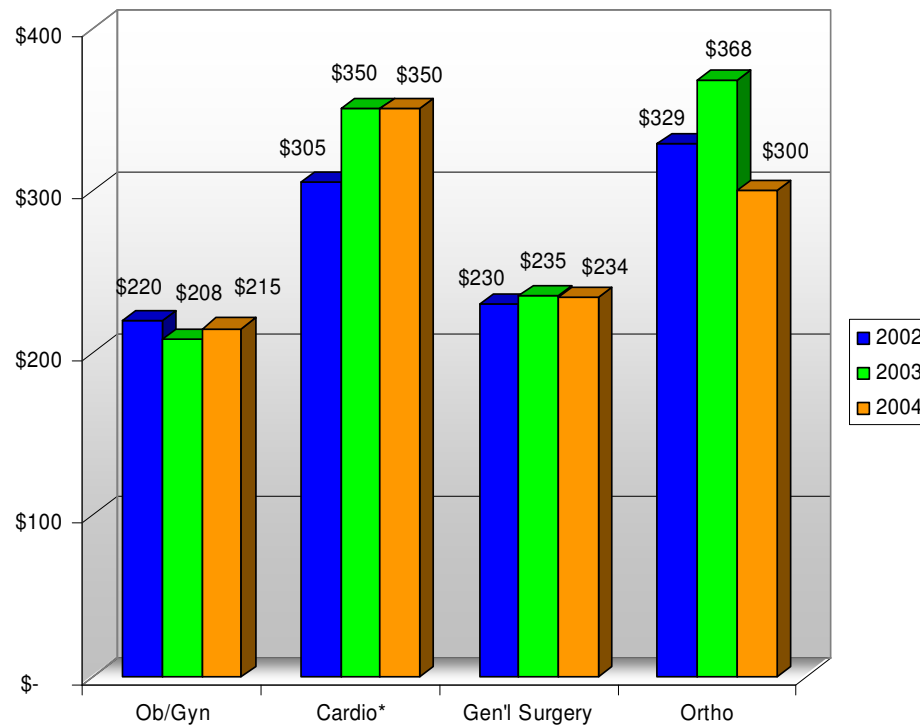
Median Physician Compensation
2003 vs. 2004
in 1,000s



Source: Medical Economics Compensation Survey published 9/14/05;
Compensation excludes fringe benefits

National Trends: Specialty Compensation

Median Compensation, Selected Specialties
2003 vs. 2004
in 1,000s

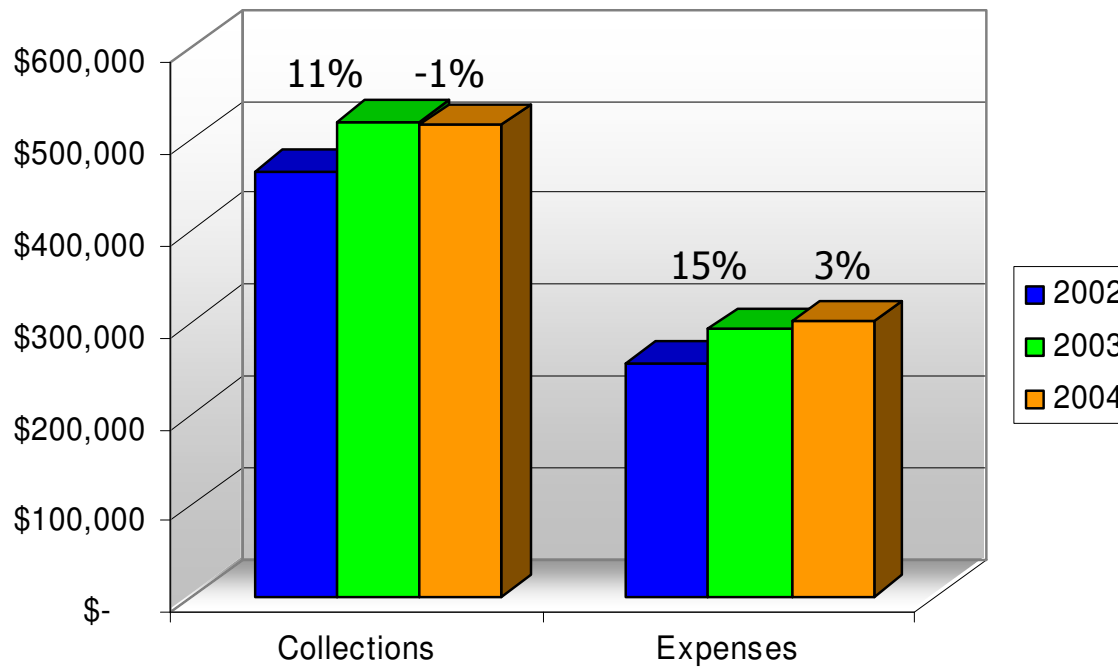


Source: Medical Economics Compensation Survey published 9/14/05

*Cardio numbers represent an average of invasive and non-invasive cardiologist compensation

National Trends: Expenses

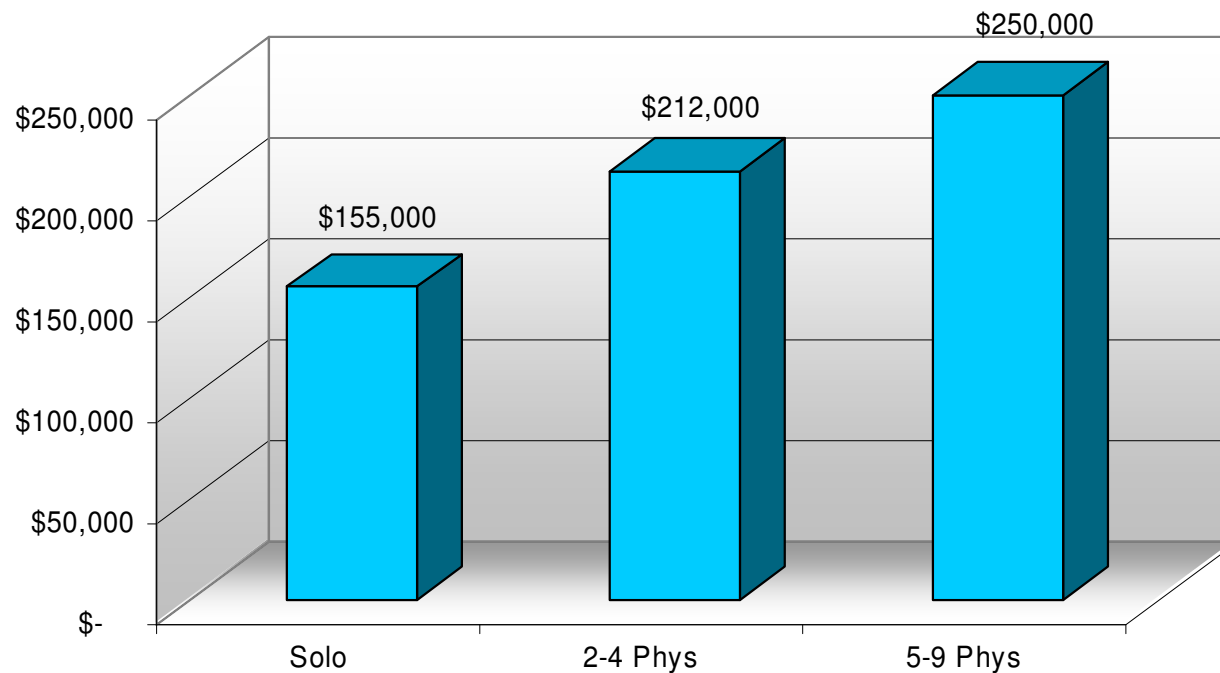
**Internal Medicine Collection and Expenses
2002, '03 and '04**



Source: MGMA Cost Survey 2003, 2004 and 2005

National Trends: Compensation and Group Size

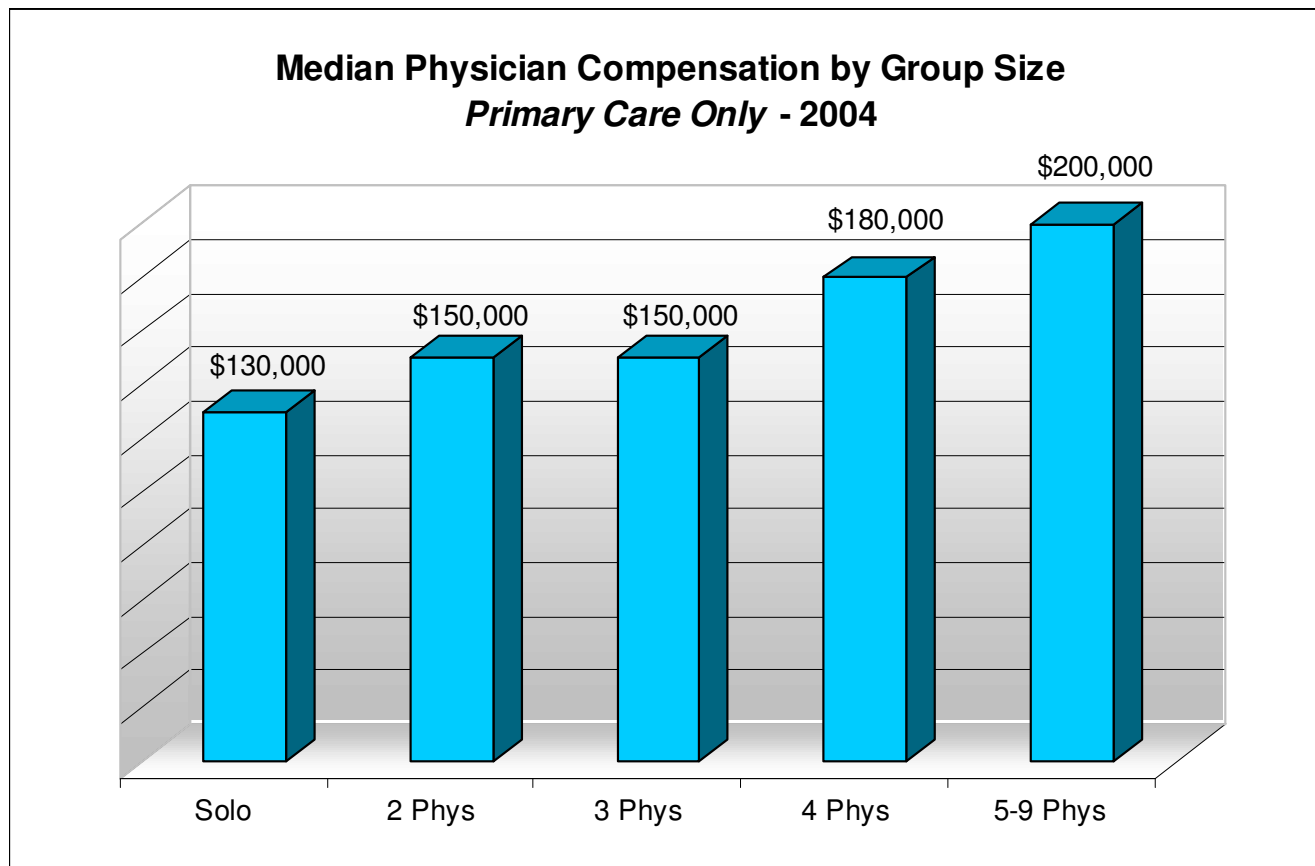
Median Physician Compensation by Group Size
2004



Source: Medical Economics Compensation Survey published 9/2005

Compensation and Group Size

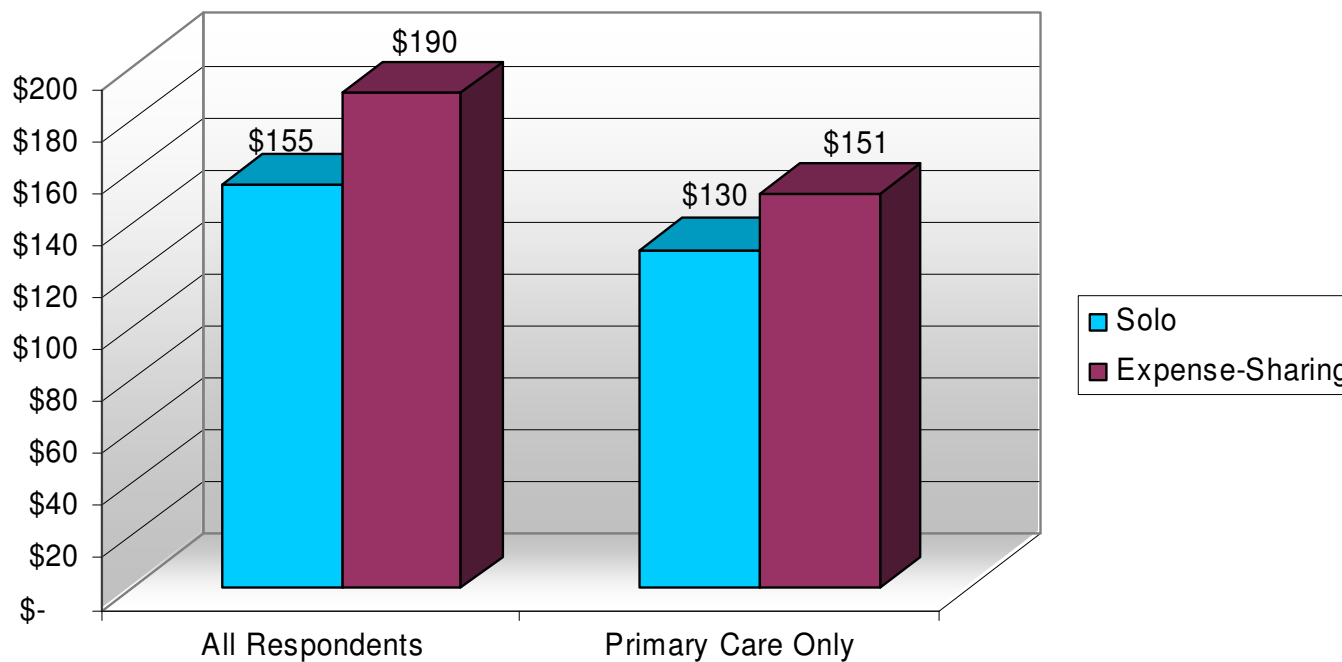
Primary Care Only



Source: Medical Economics Compensation Survey published 9/2005

Compensation: Cost-Sharing

Median Compensation 2004
Solo vs. Expense-Sharing
in 1,000s



Source: Medical Economics Compensation Survey published 9/2005



How to Improve Your Practice

- Identify Mission
- Assess your Practice Performance
 - Self-Assessment tools
 - Benchmark key indicators
- Consider Collaborating to Leverage Resources
- Quantify Opportunities and Implement



Mission Statement - Definition

A Mission Statement is a self-imposed obligation which reflects the values of the organization and which drives the organization's objectives.



Sample Mission Statement

"The mission of our Practice is to provide **superior care** to our patients and the community, to run a **profitable** organization and to ensure the **long-term continuity** of the Practice."



Benchmarking Defined

"A continuous process of measuring

- *Productivity*
- *Revenue*
- *Costs*
- *Quality*

using standard, objective measures."



Benchmarking 101

- Benchmark key indicators
 - Benchmark practice against industry
 - Benchmark internally
 - Benchmark yourself over time
- Share data among practice providers
- Show what can/should be achieved
- Set targets

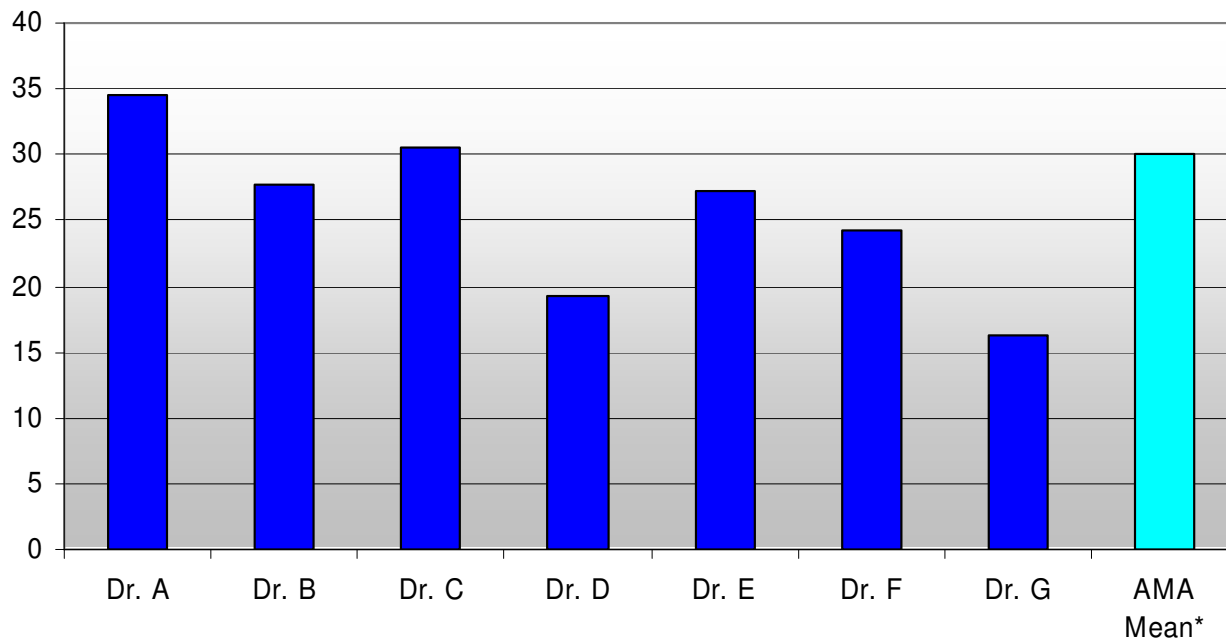


Keys to Profitability

- **Productivity Indicators**
 - Hours per wk - *example provided*
 - Visits per hr
 - Revenue (collections) per physician - *example provided*
 - Surgeries per week - *example provided*
- **Account Receivable Indicators**
 - A/R by Aging - *example provided*
 - Charges vs. Collections - *example provided*
 - A/R by Physician
- **Expense Indicators**
 - Staffing levels - *example provided*
 - Overhead as a percentage of revenue
- **Governance** - Qualitative Indicator
 - How effective is your decision-making process?
 - Hiring a new MD - *example provided*

Productivity Indicator 1: Hours per Week

Office Hours per Week:
Case Study



Annual Revenue Opportunity: \$241,500

Case Study: 7-physician ob/gyn group in CT
*AMA Mean based upon a 4-day work week

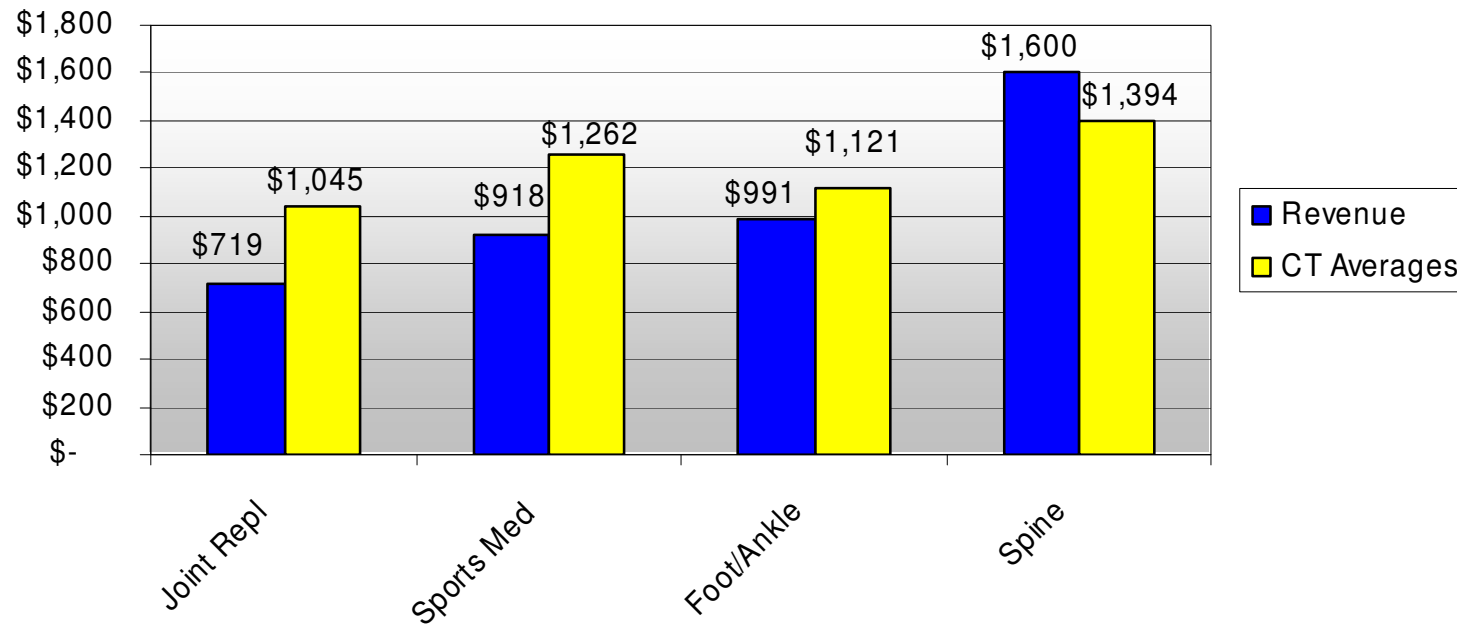
Worksheet to Calculate Revenue Opportunity

1. AMA mean hours per week (30) * 7 physicians =	210
2. Less total actual practice hours worked per week =	<u>180</u>
3. Difference in hours per week worked =	30
4. 30 hours per week * 3.5 ¹ visits/hr equals visits per week of =	105
5. At collection rate of \$50 per visit, lost revenue per week =	\$ 5,250
6. At 46 weeks per year, lost revenue per year =	<u>\$241,500</u>

1. Actual AMA mean visits per hour is 4.0

Productivity Indicator 2: Collections by Sub-Specialty

Annual Collections by Sub-Specialty: Case Study
in 1,000s

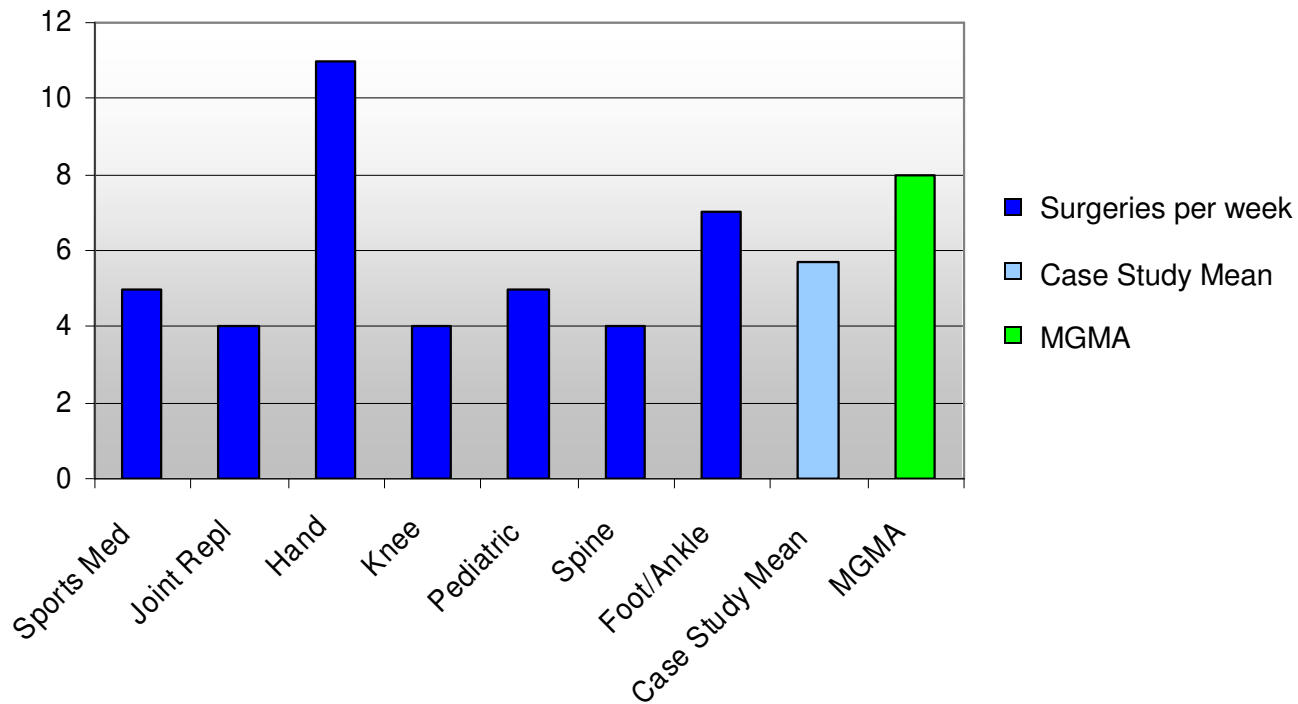


Potential Revenue Opportunity: \$594,000

Case Study: 11-physician orthopedic group in CT

Productivity Indicator 3: Surgeries per Week

Surgeries per Week: Case Study



Case Study: 11-physician orthopedic group in CT

Accounts Receivable Indicator 1: A/R by Aging

A/R by Aging: Case Study

1.	<u>AGING</u>	<u>AMOUNT</u>	<u>%</u>	<u>MGMA</u> <u>AMOUNT</u>	<u>MGMA %</u>
	0-30	\$ 158,866	32%	\$ 151,667	54%
	31-60	\$ 57,794	12%	\$ 44,636	16%
	61-90	\$ 20,536	4%	\$ 24,534	9%
	91-120	\$ 19,094	4%	\$ 17,118	6%
	>120	\$ 243,710	49%	\$ 39,645	14%
	TOTAL	\$ 500,000	100%	\$ 278,800	100%

Case Study: 4-physician family medicine practice in CT
Source Data: MGMA Cost Survey 2005

Accounts Receivable Indicator 1: A/R by Aging - *continued*

A/R by Aging: Case Study

2. How long does it take to collect a patient bill?

Actual A/R	\$ 500,000
Daily Charges*	/ \$7,400
	<hr/>
	68 days

MGMA Ave 40 days

Days over MGMA **29 days**

3. How much A/R should each physician have?

Actual A/R	\$500,000 / 4 phys =	\$ 125,000
MGMA Ave		<hr/>
		\$ 70,000
A/R Above MGMA		\$ 55,000

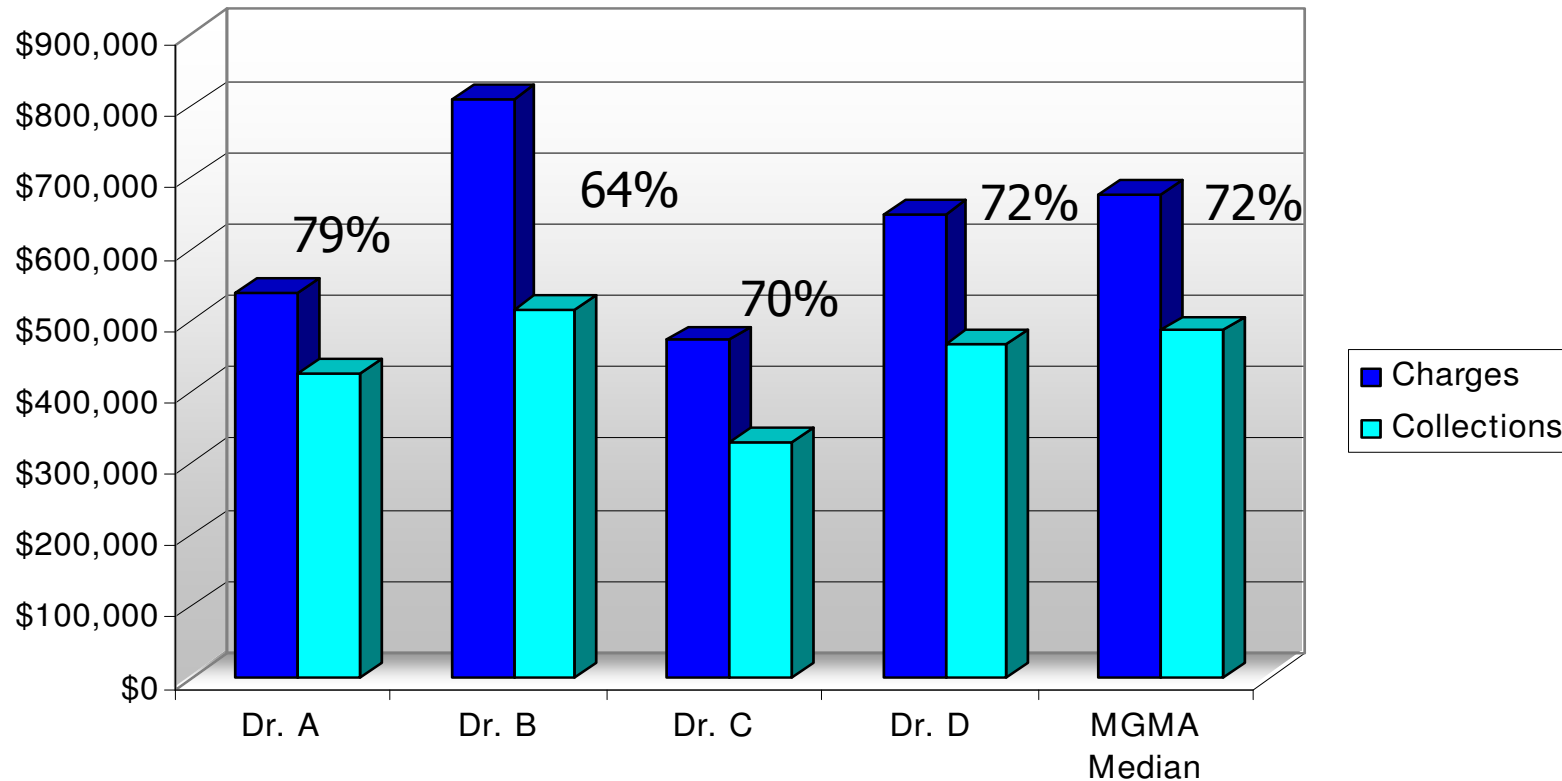
Case Study: 4-physician family medicine practice in CT

Source Data: MGMA Cost Survey 2005

*MGMA Ave Charges per day = \$675,000 / 365 days = \$7,400

Accounts Receivable Indicator 2: Charges vs. Collections

Charges vs. Collections: Case Study



Case Study: 4-physician family medicine practice in CT



Expense Indicator: Staffing Levels (a)

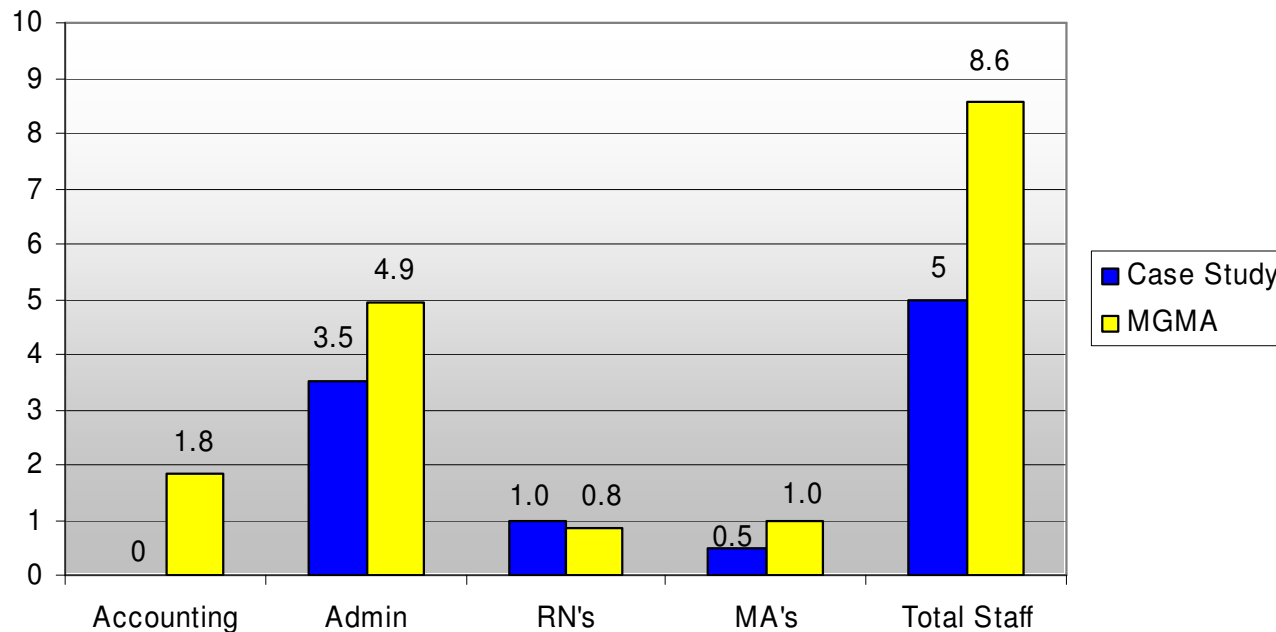
Staffing Levels vs. Benchmark: Case Study Example of Over-Staffing

	Case Study	MGMA	Variance
Medical Reception	5.4	3.4	2.0
Nursing	3.6	4.3	(0.7)
Medical Records	1.3	1.2	0.1
Total Staff	10.3	8.9	1.4

Case Study: 2.5 FTE internal medicine physicians within a multi-specialty group in CT

Expense Indicator: Staffing Levels (b)

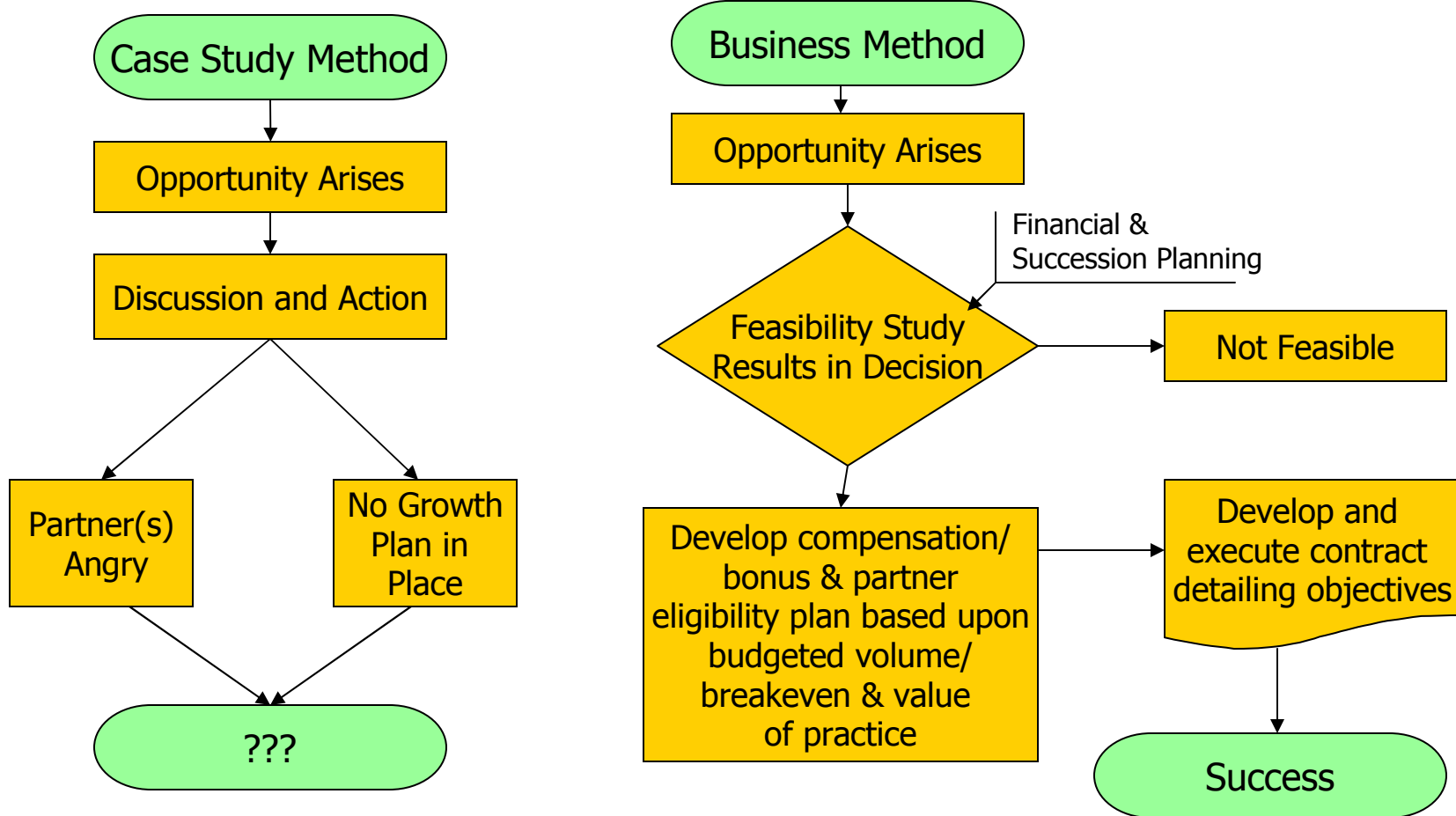
Staffing Levels vs. Benchmark: Case Study
Example of Under-Staffing



Case Study: 3-physican general surgery group in CT

Group Governance and Decision-Making

Decision-Making Case Study: Recruitment of New MD





Competition: Local Greenwich Market

- Competition in Fairfield County is exploiting opportunities developed by consolidation
 - Pooling resources has enhanced technology
 - Centralized scheduling has improved patient access, throughput and utilization of physician time
 - Centralized Billing Offices have enabled advanced technology and standardization of best practices
- These improvements have increased profitability and recruitment opportunities



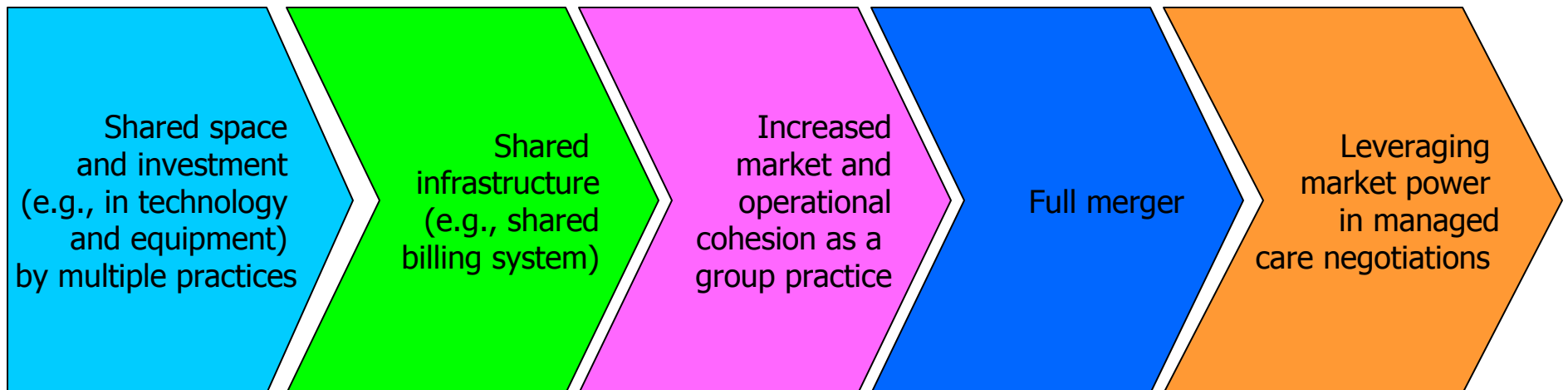
Potential Strategic MD Responses

- Improve Individual Practice Performance
 - Organizational Effectiveness
 - Revenue Enhancement
 - Operational Efficiency/Cost Reduction
- Collaborate Among MDs to Gain:
 - More resources to improve technology, both office and clinical
 - Economies of scale in overhead, e.g. staffing
 - Improved hiring opportunities
- Collaborate Among MDs to avoid:
 - Competition in recruiting that leads to MD over-population in specialty
 - Squabbling that leads to out-migration to other area providers



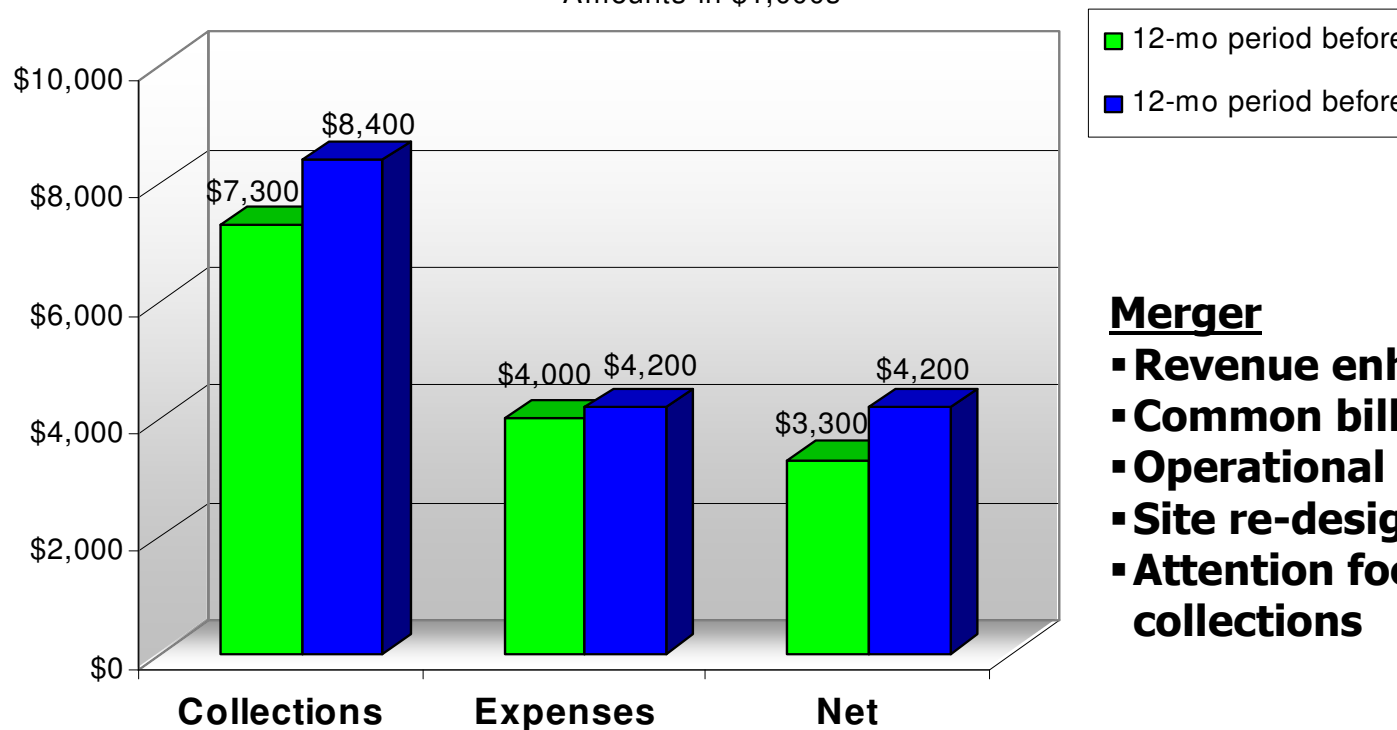
MD-MD Collaborative Efforts

Array of Collaborative Strategies



MD-MD Collaborative Efforts: Merger Case Study

Tale of a Merger: Before and After
Amounts in \$1,000s



Merger

- Revenue enhancement
- Common billing & collections
- Operational consolidation
- Site re-design
- Attention focused on collections



For More Information

- A Copy of this Presentation is available at www.ihchealth.com
- Any Questions/Comments may be addressed to:
 - Ron Dreskin
 - Tel: (203) 487-0880
 - rdreskin@ihchealth.com