LUGPA 2022 Annual Meeting:

Independent Urology Powered by Innovation

Practice Administrators Workshop

Chair: Alan D. Winkler, MHSA, FACMPE

November 10-12, 2022

Chicago Marriott Downtown Magnificent Mile Hotel | 540 N Michigan Ave | Chicago

LUGPA
Integrated Practices
Comprehensive Care

875 N. Michigan Avenue | Suite 3100
Chicago, IL 60611
www.lugpa.org

VERITY™

PHARMACEUTICALS

Special Thanks to
Verity Pharmaceuticals
for Their Commitment
to LUGPA in 2022

Welcome to the Practice Administrators Workshop!

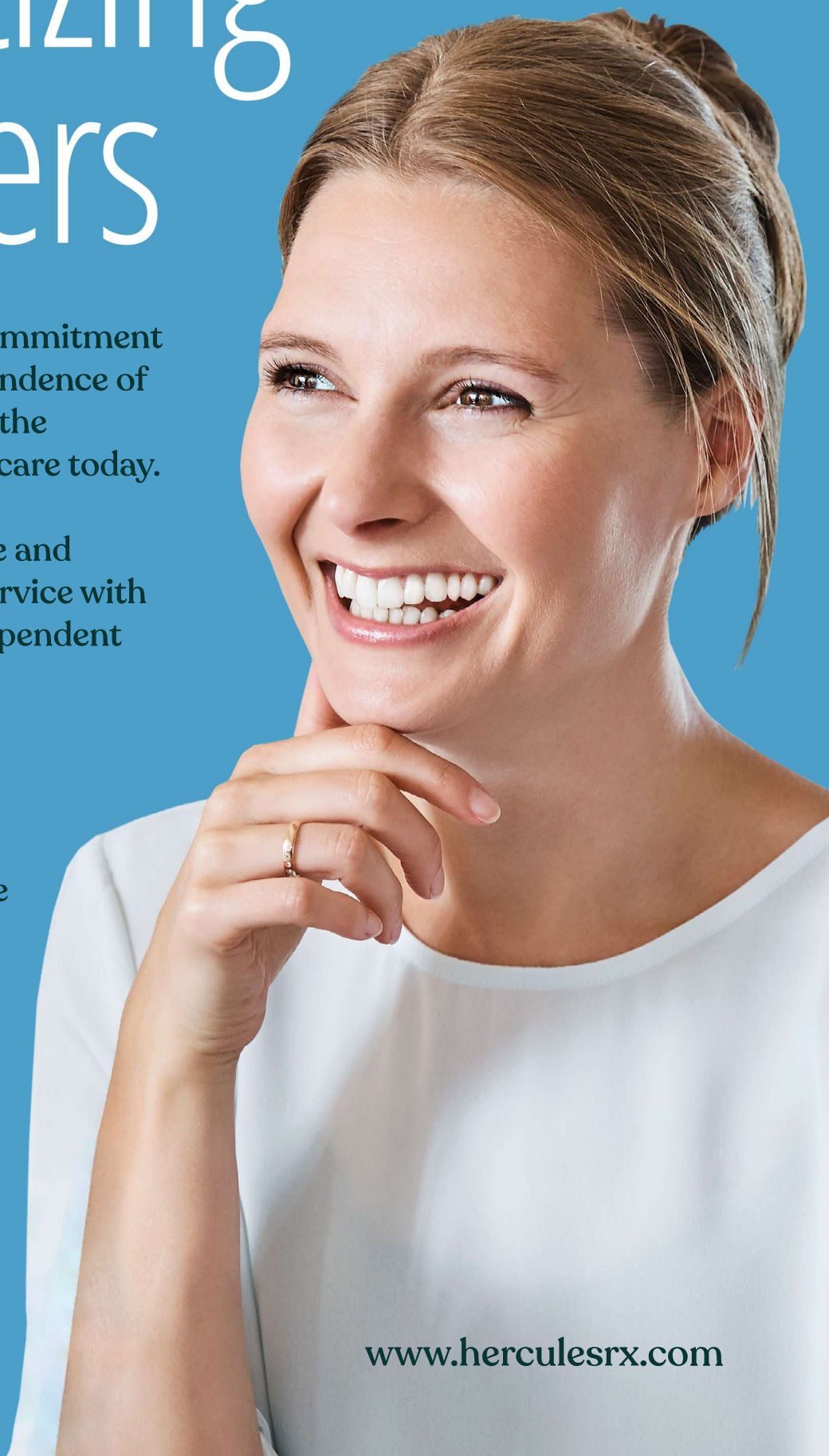
Table of Contents

Prioritizing Partners

We stand by LUGPA's commitment to preserving the independence of Urology and addressing the challenges facing healthcare today.

Discover enhanced value and exceptional customer service with Hercules, your fully independent wholesale distributor.

Network at our cocktail reception and learn how Hercules can generate significant and immediate savings on your practice's drug spend.



Hercules
your ethical wholesaler

www.herculesrx.com

Welcome

Dear Colleagues:

Welcome to the LUGPA 2022 Annual Meeting Practice Administrators Workshop. We are delighted to have an opportunity to network and have made several enhancements this year to encourage more networking. We encourage you to change tables throughout the day so you can meet new people and gain new insights.

The sessions are structured to encourage active participation. This is your opportunity to not only learn something new but also to walk away with tangible resources to implement in your own practice and with new professional friends with whom to interact throughout the coming year.

The day begins with the energetic enthusiasm of Cameron (Cam) Cox, an experienced practice administrator and receivables management business owner known as the "MacGyver of Healthcare". Cam compares the key stakeholders in healthcare to various types of sharks in the humorous but poignant **Sharknado: Healthcare Under Attack.**

We then move to the interactive **"Three 'R's of Staff Compensation: Recruitment, Retention, Rewards."** Each table will be asked to answer one specific question about one of the "R's". Our facilitators will share their own experience, then the tables will provide additional ideas/insight. All input is being captured by our Flipchart Recorders and will be shared following today's meeting.

Dave Carpenter then closes out the morning with **"When to Hold; When to Fold: Dealing with Disruptive Behavior: Preventing the Behavior, Protecting the Practice."** We may have the greatest physicians anywhere, but one disruptive physician can derail even the best strategic plan. Dave provides specific insight about structuring a policy, enforcing expectations, and ensuring EEOC compliance.

The lunch buffet will be available in the Halsted Room with seating in the adjacent Avenue Room. While there is no lunch time speaker, tables will be labeled with different topics in case you wish to network with others from similarly sized groups or individuals interested in specific initiatives.

Immediately following lunch, we'll dive into some current challenges many of us are facing in our groups in our "What's Keeping You Up at Night?" session. Handouts have been prepared, and flipchart recorders will capture salient points to share after the meeting. Topics include **"The Importance of a Strong Operating Agreement/ Bylaws, " "PCR Implementation," and "No Surprise Billing."**

A panel discussion follows which compares CCM/PCM and whether it should be outsourced or kept in-house.

Addressing the needs of retiring physicians and backfilling their positions is a constant challenge for administrators, often requiring modifications in business policies and processes. A group of administrators shares their experiences in an interactive session entitled, **"Retiring Physicians: Lessons Learned."**

The day closes out with four break-out sessions: **"Negotiating Paid Physician Service Agreements with Community Hospitals," "New to LUGPA"** designed for administrators who joined a Urology practice within the past few years, **"Shortcuts to Efficiency,"** and deciding where a new procedure should be performed in **"Optimizing Patient Place of Service."**

We strongly encourage you to visit with our exhibitors at each break. Without them, none of this is possible.

Thanks again for joining us. Let's get started!

Sincerely,

Alan D. Winkler

Alan D. Winkler, MHSA, FACMPE
Chair, LUGPA Practice Administrators Committee

Practice Administrators Committee

Program Chair

Alan D. Winkler, MHSA, FACMPE
Board of Directors, LUGPA Chair,
Practice Administrators Committee
Executive Director, Urology San Antonio, P.A.
San Antonio, TX

COMMITTEE MEMBERS

Sara Betancourt
Director of Finance
Golden Gate Urology
San Francisco, CA

Carla Blue, MBA, MSP, FACMPE
Chief Executive Officer
Urological Associates of Western Colorado
Grand Junction, CO

Terry FitzPatrick
Chief Executive Officer
Oregon Urology Institute/Oregon SurgiCenter
Springfield, OR

Angela Gilfillan, CMPE, CASC
Executive Director
Wisconsin Institute of Urology
Neenah, WI

Allison Griffin
Administrator
Urological Associates of Savannah, PC
And Urology Surgery Center, LLLP
Savannah, GA

Whitt Holder, MBA
Chief Executive Officer
Amarillo Urology Associates
Amarillo, TX

LeeAnn Shea
CEO
Urologic Specialists of Northwest Indiana
Merrillville, IN

Agenda

Thursday, November 10, 2022

TIME	SESSION TITLE	LOCATION
7:30am – 8:30am	**Breakfast**	Halsted (4th Floor)
8:45am – 9:00am	**Welcome and Introductions** Alan D. Winkler, MHSA, FACMPE	Marriott Ballroom (4th Floor)
9:00am – 9:45am	**Sharknado: Healthcare Under Attack** Presenter: Cameron Cox, MHA, FACMPE	Marriott Ballroom (4th Floor)
9:45am – 10:00am	**Break**	
10:00am – 11:15am	**The Three "R's" of Staff Compensation: Recruitment, Retention, Rewards** Moderator: Alan D. Winkler, MHSA, FACMPE Panelists: Twila Puritty Claudio Zanin Jason Biddy	Marriott Ballroom (4th Floor)
11:15am – 12:00pm	**When to Hold; When to Fold: Addressing Disruptive Physician Behavior** Presenter: Dave Carpenter	Marriott Ballroom (4th Floor)
12:00pm – 1:00pm	**Lunch**	Avenue Ballroom (4th Floor)
1:00pm – 2:00pm	**What's Keeping You Up at Night?** 1:00pm – 1:15pm Topic: PCR Implementation/Operation Facilitator: Dan Fellner, JD 1:15pm – 1:30pm Topic: No Surprise Billing Act/ Implementation Challenges Facilitator: Sara Betancourt	Marriott Ballroom (4th Floor)

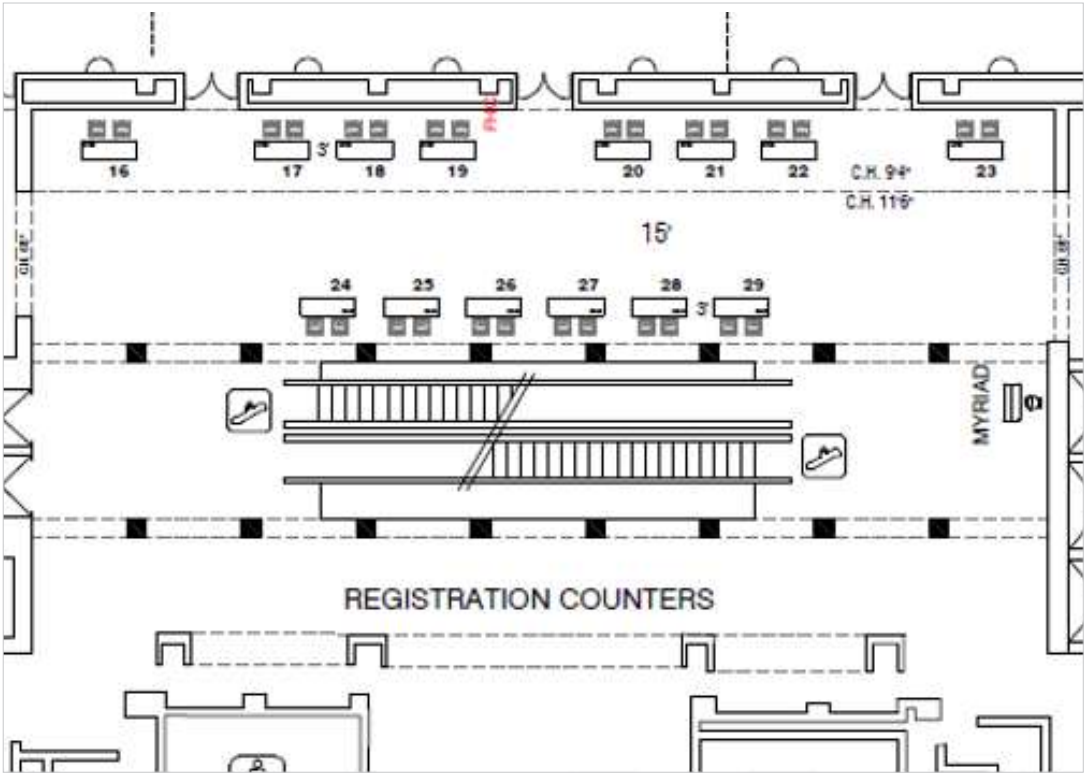
**Topics and Speakers Subject to Change*

Agenda: Thursday, November 10, 2022

TIME	SESSION TITLE	LOCATION
	1:30pm – 2:00pm Topic: The Importance of a Strong Operating Agreement Facilitators: Carla Blue, FACMPE Whitt Holder Terry FitzPatrick	
2:00pm – 2:30pm	**CCM/PCM – In-House vs. Outsourced: Medicare Requirements, Time Tracking, Billing and Staffing** Panelists: Kirsten Anderson Lisa Baker Stephen Gabelich, MBA, FACHE, CMPE Kimberly Ramsey	Marriott Ballroom (4th Floor)
2:30pm – 2:50pm	**Break in the Exhibit Hall**	Grand Ballroom Foyer (7th Floor)
3:05pm – 3:30pm	**Retiring Physicians: Lessons Learned** Facilitators: E. Scot Davis Dave Carpenter Michael Shannon	Marriott Ballroom (4th Floor)
CONCURRANT BREAKOUT SESSIONS		
3:30pm – 4:30pm	**Negotiating Paid Physician Service Agreements with Community Hospitals** Presenters: Angela Gilfillan LeeAnn Shea	Belmont (4th Floor)
	New to LUGPA Presenter: Terry FitzPatrick	Sheffield (4th Floor)
	Shortcuts to Efficiency: Managing the Administrators' Growing Workload Presenter: John O'Connor	Armitage (4th Floor)
	Optimizing Patient Place of Service Navigation: Clinic, ASC or Inpatient Presenters: Chris Setzler, MBA Mark Painter, CPMA, MBS	Marriott Ballroom (4th Floor)

**Topics and Speakers Subject to Change*

Exhibit Hall Floor Plan



INDUSTRY PARTNER	Table #
Athena Surgical	28
Axonics, Inc.	21
BioProtect Ltd.	26
Boston Scientific	18
Bristol Myers Squibb	27
Lantheus	25
LUMEA	22
Millennia	29
Molecular Testing Labs	17
Myovant Sciences, Inc. & Pfizer Oncology, Inc.	23
PathNet, Inc.	24
Prostate Centers USA	19
rater8	20
Zero – The End of Prostate Cancer	16

Sponsors

THANK YOU TO OUR LUGPA 2022 CME PROGRAM & PRACTICE ADMINISTRATORS WORKSHOP SPONSORS AND EXHIBITORS

Featured Partners

MYOVANT SCIENCES | Pfizer Oncology

PROSTATE CENTERS
COMPREHENSIVE MEN'S HEALTH CARE

Collaborating Partners

MOLECULAR TESTING LABS

Contributing Partners

ATHENA SURGICAL

Axonics

BIO PROTECT

Boston Scientific
Advancing science for life™

LANTHEUS

LUMEA

MILLENNIA
NOW EVERYTHING'S COMPLETE.

PathNet

rater8
Reputation Management
Practice Improvement

Exhibitor

Bristol Myers Squibb

Special Guest

ZERO – The End of Prostate Cancer

Biographies

Alan D. Winkler, MHSA, FACMPE

Board of Directors, LUGPA Chair,
Practice Administrators Committee
Executive Director,
Urology San Antonio, P.A.
San Antonio, TX

With forty years of experience in healthcare, Alan D. Winkler has served as the Executive Director of Urology San Antonio, P.A. since October 2012. Alan holds a Master's degree in Health Services from the University of Arkansas for Medical Sciences and has worked in private and corporate settings with physicians of many specialties. Alan is a Fellow in the American College of Medical Practice Executives and served on its board of directors for nine years, concluding as its chair. Alan currently serves on the LUGPA Board of Directors.

Kirsten Anderson, CMPE, CPC, CASC

Head of Medical Oncology,
Urology and Surgical Oncology
GenesisCare

Kirsten Anderson has a 20+ year record of achievement and demonstrated success leading physician practice and healthcare organizations as a results driven forward thinking operations executive. Her areas of expertise include medical facility operations, strategic partnerships, electronic medical records implementations and business office operations. Her previous roles include Urology Practice Administrator, Director of Operations for a Hospital owned Physician Practice Organization and Ambulatory Surgery Center Administrator. She is the US Head of Medical Oncology, Urology and Surgical Oncology for GenesisCare.

Kirsten received her Bachelor's of Science Degree from Virginia Tech and her Master's Degree in Health Administration from the Medical University of South Carolina. She is certified as a Medical Practice Executive (CMPE) by MGMA, a Certified Professional Coder (CPC) through AAPC, and a Certified Ambulatory Surgery Center Administrator (CASC) by ASCA and has served on several boards for Professional organizations. Born in Washington, DC, Kirsten currently calls North Myrtle Beach, South Carolina home. In her free time, she enjoys playing tennis, cooking, traveling, and spending time with family.

Lisa Baker

CEO
Urology Partners of North Texas

Ms. Baker is responsible for overseeing the day-to-day operations of multiple clinic locations, a radiation center, a pharmacy, a centralized call center and a clinical laboratory. In addition to organizational strategy & efficiencies, Lisa is responsible for all human resource management, marketing and compliance for the organization.

With a passion for engaging and motivating the staff, Lisa ensures her team members provide compassionate and high-quality patient care. She is process-oriented and applies focus to continual learning to advance efficiencies and manage expenses in the overall operations of the practice.

Lisa studied accounting at The University of North Texas and healthcare administration at Columbia Southern University. She has enjoyed a rewarding career of 30+ years in urologic healthcare administration.

Sara Betancourt

Vice President,
Finance & Administration

Sara Betancourt is the Director of Finance of Golden Gate Urology, the largest free-standing urology practice in the San Francisco Bay Area. Sara recently joined LUGPA's Practice Administrators Committee.

Sara earned a Bachelor of Science in Accounting and continued building her career by cultivating more than 20 years of experience in health care providing consulting, finance and regulatory services to not-for-profit and for-profit health care organizations including hospitals and health systems, payers, physician practices, and long-term care facilities. Sara also holds an active CPA in Indiana – a legacy from her Big Four public accounting and consulting days – and earned certifications, including Lean Level 1 and UC Systemwide People Management Series. In addition to her devotion to continual learning, her professional passions include the integration of finance and operations, understanding the invaluable talent each person brings to their work to collaborate and implement improvements, and helping teams maximize their potential.

On a personal note, Sara's toddler keeps her extremely busy, sleep deprived and thankful outside of her professional career.

Jason Biddy, MBA, CMPE

CEO
Urology of Alabama

Jason began working in healthcare in 1997 and joined Urology Centers of Alabama in 2016. Prior to joining UCA, Jason has worked with several other groups in the Birmingham area including Alabama Allergy and Asthma Center, MedHelp Family Practice and Urgent Care, and Orthopaedic Specialists of Alabama. He attended Birmingham Southern College graduating with a Bachelor's degree in Biology/Psychology. He went on to earn his Master of Business Administration from the Executive MBA program at the University of Alabama. Jason continues to work with Auburn, Birmingham Southern, Samford, and UAB to mentor college students interested in pursuing a career in healthcare. Jason is actively involved in the local and state Medical Group Management Association (MGMA) and is currently serving as Executive Director for Birmingham MGMA and President for Alabama MGMA. In 2018, he earned the Certified Medical Practice Executive (CMPE) designation from the American College of Medical Practice Executives and in 2019 was named one of Birmingham's Top 40 under 40 by the Birmingham Business Journal. Jason and his wife Brooke currently reside in Trussville with their 5 children and are actively involved at North Valley Church.

Carla Blue, MBA, MSP, FACMPE

CEO
Colorado Surgical Affliates

Carla Blue has more than 20 years of healthcare management experience in both hospital-owned medical group practice and private practice. Currently, she serves as the CEO of Colorado Surgical Affiliates. CSA has 44 providers (24 doctors) who focus on quality, cost-effective, local care by independent physicians advocating for their patients. Carla led the merger of this multi-surgical specialty group comprised of Urologists, Urogynecologists, Gynecologists, Radiation Oncologists, General Surgeons, Trauma Surgeons, Bariatric Surgeons and Critical Care. Urological Associates of Western Colorado is a Division of Colorado Surgical Affiliates.

Carla earned her master's degree in business administration and physics from The University for Foreigners in Perugia, Italy and is a Fellow in the American College of Medical Practice Executives. She serves on the boards of Urological Associates of Western Colorado, General Surgeons of Western Colorado, Western Therapeutics and Canyon View Wellness and Spa. Carla and her husband also volunteer at HopeWest Hospice with their service dog.

David M. Carpenter

CEO
Minnesota Urology

As the Chief Executive Officer of Minnesota Urology, the largest independent urology medical group in the upper mid-west, Dave is privileged to offer his experience as a medical group administrator and business leader.

Prior to arriving at Minnesota Urology, Dave spent 9 years as Chief Executive Officer of Physicians Neck and Back Clinics (PNBC), a Minnesota-based medical practice specializing in the non-operative treatment of chronic spinal disorders.

Prior to PNBC, Dave was a company co-founder and Vice President of Prevention First, Inc., a healthcare solutions company offering programs to reduce workers' compensation costs associated with back and upper extremity injuries.

Before arriving in Minnesota, Dave served eight years as a faculty member within the University of Florida College of Medicine. During his tenure at UF, Dave worked closely with the late Dr. Michael Pollock, Ph.D., and Arthur Jones, founder of Nautilus and MedX exercise/rehabilitation equipment, to develop international programs for the prevention and rehabilitation of chronic spinal disease. He has lectured and taught throughout the world in the area of resistance training and active spinal exercise rehabilitation and has authored and co-authored more than 50 scientific articles. Dave holds a master's degree in Exercise Science from the University of Florida and is a certified facilitator of The 7 Habits of Highly Effective People. He and his wife Jenifer have a twin daughter (Chloe), and son (Hudson). Dave enjoys golf, woodworking, leathercraft, relaxing in his hand-built tree house overlooking the St. Croix River, and caddying for his son.

CHECK OUT THE PRACTICE ADMINISTRATORS' ALLEY
5th Floor Alcove near the Chicago Ballroom

A place to network and meet with colleagues. A place to relax.

Cameron M. Cox, III

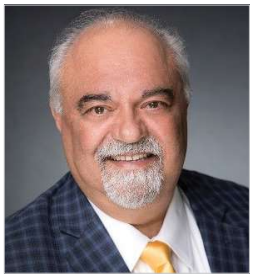
(C3) Founder & CEO

Cameron Cox is the MacGyver of healthcare business management, and he's a man with a mission: to help medical practices thrive.

With a history of being a practice administrator and founding a successful medical billing and consulting firm, Cam brings unique views and perspectives on today's practice management. Over the course of the last 25 plus years, Cam has worked with more than 500 medical practices and health systems across virtually every medical specialty in the spectrum.

Cam is a Fellow of the American College of Medical Practice Executives, which is the most prestigious designation you can earn in the medical practice management profession. He also has undergraduate and graduate degrees in Healthcare Administration from the University of North Carolina at Chapel Hill.

Never settling for the status quo, Cam has participated passionately in numerous capacities advocating for physician practices in both the legislative arena and within the scope of educating administrators and providers. He regularly speaks to national and regional organizations on a broad range of issues – including strategic planning, organizational behavior, customer service, effective practice management, proper technology deployment and a wealth of other subjects that present challenges and opportunities for today's medical practitioners.



E. Scot Davis

CEO
Arkansas Urology

As its CEO, E. Scot Davis has played an instrumental role in the development and evolution of Arkansas Urology, located in Little Rock. Davis joined the practice as its CEO in May of 2013. Davis' extensive contributions to healthcare prior to Arkansas Urology include service as the CFO of Baptist Medical Group and CFO of Northeast Arkansas Clinic in Jonesboro. Davis is also a member of the Arkansas Medical Group Management Association and the American Medical Group Association.

Davis received a Bachelor of Arts in Political Science and a Master of Public Administration from Memphis State University. He also earned a Master of Business Administration from Christian Brothers University. Davis has over 25 years of physician practice management experience with expertise in operational efficiency, physician recruitment, joint venture arrangements and compensation modeling.

Dan Fellner

CEO
Georgia Urology

Fellner brings nearly 25 years of law practice and human resources experience to the table. He recently put his people-centered approach to use as part of Georgia Urology's Coronavirus Task Force by supporting the retention of every Georgia Urology employee during the pandemic.

Terry FitzPatrick, MPA

CEO
Oregon Urology Institute

Oregon Urology Institute, a 16-physician, 27-provider medical group in Springfield, Oregon. Oregon Urology Institute is the result of the integration of two independent urology practices that has evolved into the most comprehensive urology group in the Pacific Northwest. Terry has over 35 years of experience managing medical practices - multispecialty and single specialty, in both physician-owned and hospital-owned environments. He has served as the President of the Oregon Medical Group Management Association and is currently on the Board of the Oregon Ambulatory Surgery Center Association. Terry has an undergraduate degree in Recreation Administration from Fresno State and a Masters in Health Care Administration from the University of Southern California.

Stephen Gabelich, MBA, FACHE, CMPE

CEO
Urology Nevada

Stephen Gabelich is CEO of Urology Nevada, Reno's largest Urology Group. Prior to this role he was CEO of Placerville's largest multi-specialty group, CEO of Sacramento Valleys', largest Ophthalmology group and COO of two business application and development companies.

With professional and family support he contributes back to the communities he serves by managing associations, sponsoring events, sitting on committees and boards. He holds a B.S. from Cal Poly, San Luis Obispo, CA and an M.B.A. from U.C. Davis.

Angela Gilfillan, CMPE

Executive Director
Wisconsin Institute of Urology

Angela Gilfillan has been involved in practice administration for many years. Her responsibilities include preparing annual budgets and working directly with physicians to meet their financial goals. She understands accreditation and meeting AAAHC requirements from her involvement in opening surgery centers and building projects.

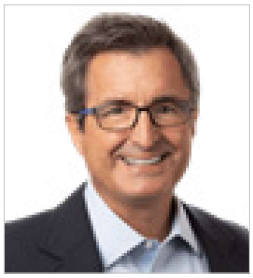
Angela leads a team of 80 employees with 9 physicians and 3 mid-levels. She has a passion to keep independent physicians independent and she plays a strategic role in planning for the "office of tomorrow." Angela regularly works with accountants, lawyers and key stake holders to keep communications with the local health systems open and productive.

Angela has a passion for education and has participated in speaking events at conferences over the last several years. Angela has taken on volunteer leadership positions with the MGMA, AUA and LUGPA. She is currently on the advisory board for CPOMP (Congress of Physician Owned Medical Properties).

Whitt Holder

CEO
Amarillo Urology and
AUA Surgical Center

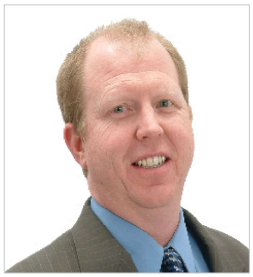
He has more than 30 years of experience in various industries in accounting, operations, and management. In addition to a B.S. in Accounting and an MBA in Healthcare Management, he also is a certified Lean Six Sigma Black Belt and Master Black Belt.



John O'Connor, FACMPE

CEO
Five Valleys Urology, PLLC

Mr. O'Connor joined Drs. Guth, Westenfelder, and Simmons in 2002. He led the formation of Five Valleys Urology in 2003 and currently serves as the CEO. John is a Fellow in the American College of Medical Practice Executives and holds certifications in Human Resource Management and Practice Management. An experienced medical practice executive, John has worked in healthcare administration, operations, and governance for over three decades. He is a 1985 graduate of Purdue University with a degree in Organizational Communications. He completed graduate courses in organizational leadership and business development.



Mark Painter, CPMA, MBS

CEO and Vice President of Coding and Reimbursement Information
PRS Managed Services, LLC

Since co-founding PRS in 1989, Mr. Painter has served as the primary coding resource for the PR products including Hotlines, Coding Manuals and quick reference tools, the Internet based application codingtoday.com and seminars. He has lectured to a variety of groups concerned with healthcare reimbursement. Mr. Painter's extensive knowledge of physician reimbursement issues has allowed him to assist insurance companies, physicians and their staff members, legal counsel, actuaries, specialty societies and consultants on a daily basis. He serves as an expert to legal counsel, bio device companies and pharmaceuticals. He was a co-chair of the Colorado Clean Claims Task Force, a committee of nationally known industry experts charged with the development of single payment edit database for the state. He received his B.A. From Grinnell College in Grinnell Iowa.

Twila Puritty, MBA

CEO
Wichita Urology

Twila Puritty serves as Chief Executive Officer of Wichita Urology, a 10 physician, 5 APP, and 130+ employee comprehensive urology practice in Wichita, KS. Mrs. Puritty has over 30 years of experience in healthcare leadership. Prior to joining Wichita Urology, Mrs. Puritty served as the lead non-physician executive for radiology groups in Florida, California, Oklahoma, Nebraska, and Kansas.

In her ten years with Wichita Urology, the practice has grown by building a free-standing radiation oncology facility, adding a successful clinical trial program, establishing an advanced prostate cancer clinic, and by developing catheter and in-office dispensing programs. The group recently completed construction on a 26,000 sq. ft. expansion of their primary clinic location which included a 14,000 sq. ft. ambulatory surgery center addition. Mrs. Puritty and the Wichita Urology physicians have also developed successful equipment and building leasing LLCs.

Twila's professional passions include facilitating growth initiatives, increasing clinical productivity, and enhancing collection efforts through microanalysis resulting in the maximization of shareholder wealth.

Twila's enthusiasm to help others succeed is evidenced by her active participation in various LUGPA and UroGPO committees. She has presented at regional and national meetings on a variety of urology related topics. Local healthcare facilities enjoy working with Twila one on one thru her consulting activities.

Kimberly Ramsey

Director of Clinical Operations,
Urology of Virginia

Kim Ramsey has worked at Urology of Virginia for over 15 years. Her operational responsibilities include oversight of clinical staff and clinical processes and procedures. She also oversees the in-office dispensary and MIPS programs for the practice.

Chris Setzler, MBA

Principal, Chris Setzler Consulting

Mr. Setzler comes with over 25 years of private and academic healthcare experience across multiple specialties. Chris is skilled in organizational development, revenue growth, ancillary and service line expansion, integrated clinical delivery, economic and clinical analytics, and revenue cycle management. Chris is considered an expert in developing and enhancing Ambulatory Surgical Centers in the Urology space from conceptual to first patient. Chris is currently focused on expanding Ambulatory Surgical Centers, Infusion centers, PET Scan and imaging capabilities, urology/oncology clinical and economic analytics, and practice optimization.

Previously, Chris served as Chief Operation Officer at UroPartners where he oversaw 35 practice locations, two cancer treatment centers, in-office dispensary, and pathology lab. He developed UroPartners' first Ambulatory Surgical Center and data analytics platform. Chris also served as President of UroMSO a Specialty Networks company that focused on business operations such as revenue cycle management, ancillary development, supply chain management and analytics for independent urology practices across the country.

Chris has a Bachelor of Arts from Villanova University and a Master of Business Administration in Healthcare Administration from the University of Phoenix. Chris served as a Program Co-chair for LUGPA Practice Administrators Workshop and wrote articles in the Practice Management for Urology Groups Guidebook.

Michael Shannon

CEO
First Urology

Mike is a native of Jacksonville Beach, Florida, and earned his Bachelor of Science in commerce degree from the University of Louisville. He then completed his postgraduate studies at Harvard Business School, commerce degree from the University of Louisville. He then completed his postgraduate studies at Harvard Business School.

Mike has been in primary and specialty healthcare management for over 20 years and joined Metropolitan Urology in 2001. As Chief Executive Officer of Metro, he was an integral part of the 2011 merger with Allied Urology. Mike has guided First Urology to become the largest privately owned medical practice in the state of Kentucky.

Mike and his wife, Theresa, have been married for 34 years and enjoy spending time with their three grown children and two granddaughters.

LeeAnn Shea

CEO
Urologic Specialists of Northwest Indiana

With over 20 years of healthcare experience in various capacities, LeeAnn is currently the Chief Operating Officer for Urologic Specialists of Northwest Indiana, a growing, 11-physician group. LeeAnn holds a Bachelor's Degree in Organization Communication from the University of Wisconsin and a Master's degree in Business Administration with an emphasis in Technology from Walton University. Prior to joining Urologic Specialists, LeeAnn worked primarily in non-profit healthcare.

LeeAnn brings a passion for developing staff to their highest potential and approaches management with a people-centered approach. She also finds excitement in new technologies and revolutions in the healthcare industry. Enhancing the patient experience for patients is her ultimate goal.

Claudio Zanin

CEO
The Urology Center of Colorado

Claudio Zanin is the recently appointed Chief Executive Officer of The Urology Center of Colorado (TUCC). TUCC is a 26 provider Urology practice that services Denver, Colorado Springs and the Rocky Mountain region. Prior to moving to Denver, he served as the Chief Executive Officer of SouthWest Urology LLC., in Cleveland, Ohio. Mr. Zanin has demonstrated success in the health care field as an administrator, director, manager and financial professional for over 34 years. In addition, he is has been an adjunct professor at Baldwin Wallace University for 15 years, teaching classes in both the healthcare graduate & undergraduate programs. Although he has been in practice management for the last 11 years, Mr. Zanin has spent the balance of his time in health care working in the hospital sector. His initial introduction to health care began as a hospital accountant and where he ultimately ended in a hospital administrative role that included developing and implementing strategic physician alignment plans. Consequently, this led him to the role he has today in leading a large independent urology practice. He holds a BA in Accounting from the University of Toledo and earned his Health Care Master's degree from Baldwin Wallace University.

LUGPA
Integrated Practices
Comprehensive Care

Practice Administrators Workshop

Presentations

2022 LUGPA ANNUAL MEETING

LUGPA Integrated Practices Comprehensive Care

Independent Urology

Chicago Marriott Downtown Magnificent Mile Hotel

NOVEMBER 10–12, 2022

Powered by Innovation

Practice Administrators' Workshop

November 10, 2022

REMINDERS

- You are encouraged to move to different tables throughout the day to maximize your ability to network with your peers and meet new professional friends.
- We will be capturing ideas throughout the day on flipcharts and sharing them after the meeting. The sessions are not recorded, but the content will be shared with all Workshop attendees.
- Information discussed in this session should be treated as confidential, so we will capture ideas not the names of practices or participants making the comments.
- Industry is welcome to sit at the back of the room and listen. They may join any table at lunch but are asked not to approach any participant about their product or services during the Workshop.

2

SINCE WE LAST MET … NEW NETWORKING RESOURCES

- LUGPA Practice Administrators ListServ
- To participate, simply send an e-mail to ListServ@lugpa.memberclicks.net
  - Your comment or question will be sent to all LUGPA Practice Administrators
  - Rules of Engagement appear at www.lugpa.org/listserv-rules
- Valuable topics, resources and information from the listserv will be archived in the Practice Management Library section of the LUGPA website: www.lugpa.org/practice-management , so that they will be readily available without having to search your work e-mail inbox.
- Be sure to bookmark the LUGPA website for ease of use.
- ListServs are now available for Administrators, Advanced Practice Providers, Research Directors / Coordinators, and Radiation Oncologists.

3

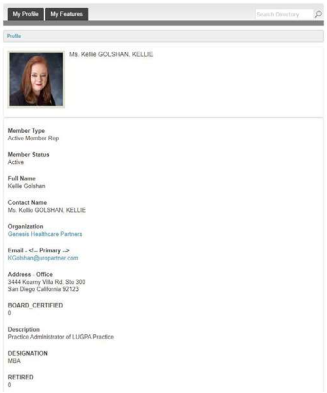
EXPLORE THE PRACTICE MANAGEMENT LIBRARY

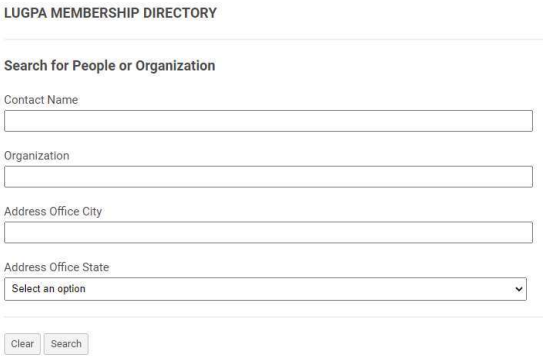
Human Resources	Active Shooter Resources, Benefit Eligibility, Managing Workflows in MS Teams, Call/PTO Management Software, Using Medical Assistants as Navigators, Outsourcing H/R Services
Urology Equipment and Vendors	Bladder Scanners, PCR Lab, Linear Accelerator Leases, EMRs
Strategy and Growth	Strategic Planning Toolkit,
Recruitment	Physician Recruitment Toolkit, Contracts
Operations	Bone Density, Health Information Technology, Patient Flow and Efficiency, OAB Questionnaire, Referral Scoreboard, IODs, Pelvic Floor PT, SpaceOAR and Fiducials, Nitrous, First Assists
Compliance	Confidentiality Agreement, ICD-10 Updates
Financial Management	Dashboard Reports, Reporting Tools, Payer Contract Analyzer, Denial Management, PCR Denials, Payor Contract Negotiations
Patient Communication	Authorization to Disclose Health Info, Patient Balance Letter, Termination Letter

4

ON-LINE MEMBER DIRECTORY

- www.LUGPA.org
  - Resources
    - Practice Management Library
      - Member Directory





5

A SPECIAL "THANKS" TO THE PRACTICE ADMINISTRATORS' COMMITTEE

- **Allison Griffin**, Urology Savannah
- **Angela Gilfillan**, Wisconsin Institute of Urology
- **Carla Blue**, Urological Associates of Western Colorado
- **Sara Betancourt**, Golden Gate Urology, Inc.
- **LeeAnn M. Shea**, Urologic Specialists of Northwest Indiana
- **Terry Fitzpatrick**, Oregon Urology Institute
- **Whitt Holder**, Amarillo Urology Associates

Our LUGPA "Superheroes"

- **Celeste Kirschner**
- **Katherine (Kathy) Stack**
- **Sommer Thornton**

6


LUGPA
Integrated Practices
Comprehensive Care

SHARKNADO: HEALTHCARE UNDER ATTACK

Cameron Cox, III, MHA, FACMPE

e3c3 consulting

SHARK ATTACK….

HTTP://WWW.NBC.COM/SATURDAY-NIGHT-LIVE/VIDEO/LANDSHARK/2832305

FIRST QUESTION….

- **Who's the shark…?**

THE BULL SHARK…A.K.A. THE GOVERNMENT SHARK

- **…this shark is also known as one of the top 3 sharks most likely to attack humans…**

CIRCLING THE PREY…

PLANKS OF PRESIDENT BIDEN'S PLAN

- Lowering the Medicare age to 60
- End Surprise Billing
- Reforming Prescription Drugs
- Lowering ACA Costs

HEALTH INSURANCE EXCHANGE

- Primarily the health insurance exchange will bring together private health insurance companies along with a government health insurance option to compete for business among individuals and small businesses. To be in the health insurance exchange the health insurance, policies offered cannot exclude someone for pre-existing conditions.

  - *Source: http://personalinsure.about.com/od/insurancetermsglossary/g/insuranceexchange.htm

ANOTHER ACRONYM…

- **Accountable**
- **Care**
- **Organization**
- **Another**
- **Cryptic**
- **Oligarchy**

BLOOD IN THE WATER???

- https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-math-of-acos

On the whole, ACOs in the Medicare Shared Savings Program (MSSP) have delivered high-quality care, with an average composite score of 93.4 percent for quality metrics. However, cost savings achieved by the program have been limited: ACOs that entered MSSP during the period from January 1, 2012 to December 31, 2014, were estimated to have reduced cumulative Medicare FFS spending by $704M by 2015; after bonuses were accounted for, net savings to the Medicare program were estimated to be $144M.[3] Put another way, in aggregate, savings from Medicare ACOs in 2015 represented only 0.02 percent of total Medicare spending. The savings achieved were largely concentrated among physician-led ACOs (rather than hospital-led ACOs). In fact, after accounting for bonuses, hospital-led ACOs actually had *higher* total Medicare spending by $112M on average over three years.[4]

THE TIGER SHARK…A.K.A. THE EMPLOYER SHARK

- **…they blend very well with darker seas because of their color. This makes them almost invisible to their prey and once the prey is in catching distance, the shark can muster great speeds to catch it.…**

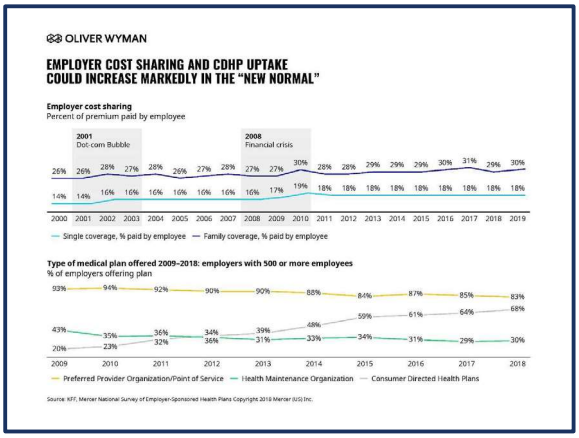
HUNT FOR THEMSELVES…

Consultancy PwC also projects a 6 percent medical cost trend in 2020, a slight uptick over the past two years, with revised estimated cost growth for 2018 and 2019 coming in at 5.7 percent for both years. After figuring in health plan changes, such as increased employee cost sharing and network and benefit changes, PwC projects a net growth rate of 5 percent in 2020, which again dovetails with the NBGH forecast.

"Employers are taking a more active role in managing health care costs," PwC reported. "For example, they're negotiating contract prices themselves, setting up provider networks and even building a parallel health system to take care of employees at more manageable costs."

The PwC survey, conducted from February through June, asked health industry executives, health benefits experts and health plan actuaries whose companies cover more than 95 million employer-sponsored large group members about their estimates for 2020 and the factors driving those trends.

EMPLOYER SPONSORED INSURANCE IS CHANGING …



- Source: https://health.oliverwyman.com/2020/04/The-Potential-New-Normal.html

THE HYBRID SHARK…A.K.A. THE "PAYVIDER" SHARK

- **…the term "hybrid shark" might sound like something out of a second-rate horror movie, there's nothing to fear in this case….yet… The new species lives in both types of water. The close resemblance between the two species makes interspecies mating much more likely than more diverse species of sharks.….**

NEW TERMS FAMILIAR CONCEPTS (WE CALLED THIS CAPITATION IN THE 90'S ☺)

Source: https://www.fiercehealthcare.com/payer/these-markets-are-ripe-for-payviders-report-finds?mkt_tok=Mjk0LUJRRi0wNTYAAAF9hYSBkXuNV3qDPIdKD6ofNorAUnu4KbSVl6Mi0-v2hpfQtrFC6sI18kPtyrBwLawCe5MH2JGS2yIBs0lKC2lqnJ2ZsjV_CFlBr5on81QLp8uZI&mrkid=957259

- "Providers and payers must be prepared to both share risk and understand where market opportunities for risk-sharing exist so that they can compete for members," said Aimee Sziklai, Guidehouse partner and Commercial Payer leader, in a **statement**. "When done right, payvider models can turn organizations into growth engines that support sustainable margins and better health for all."

- Payers and providers should be investing in these relationships now for a number of reasons, according to the report. For one, Medicaid managed care continues to grow and is now deployed in 40 states.

  In addition, Medicare Advantage is the fastest-growing segment of health insurance. Both types of coverage center on risk-based arrangements that offer opportunity for "payviders" to get aggressive about value-based care, according to the report.

THINKING INSIDE THE BIG BOX

- "UnitedHealth means to capitalize on the fact that retail is a "significant portion of individuals' lives" by creating new retail partnerships to make it easier for the consumer to access all aspects of the insurance industry."

- "Insurers could, say, team up with grocery stores to help increase health awareness and wellness purchasing among their consumers. Or they could partner with technology companies to help inform consumers' wellness goals, including walking, weight management and diet."

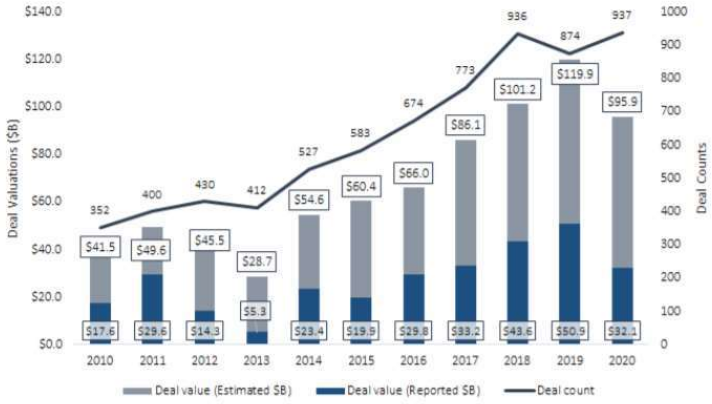
Source: June 19, 2013, http://www.fiercehealthpayer.com/story/unitedhealth-retail-partnerships-bring-more-holistic-experience-consumers/2013-06-19?utm_medium=nl&utm_source=internal

Well, this is from 2013….does this sound at all like today?

THE SPINNER SHARK…A.K.A. THE PRIVATE EQUITY SHARK

- **…they are swift and gregarious predators that feed on a wide variety. This species employs an unusual tactic when feeding on schools of small prey; the shark charges vertically through the school, spinning on its axis with its mouth open and snapping all around it. The shark's momentum at the end of these spiraling runs often carries it into the air, giving it its common name.….**

Figure 1. Total PE Deals in Healthcare* — Reported Deal Value, Estimated Deal Value, and Reported Deal Count, 2010-2020



Petris Center/AAI analysis of PitchBook data.
SOURCE: PitchBook Data, Inc. Data has not been reviewed by PitchBook analysts.
NOTE: Data as of 3/30/2021. Valuations are reported in current dollars. Analysis conducted by PitchBook Data, Inc. and provided courtesy of Eileen Appelbaum and Rosemary Batt. The PitchBook database is dynamic and deal counts produced by the same search may vary as underlying data change over time. Deals defined according to Pitchbook's "standard PE methodology," including LBOs, add-ons, growth investments and secondary buyouts. Estimated total deal value in current dollars, 2010-2020 = $749.5 billion, estimated total deal value in Jan. 2020 CPI-adjusted dollars, 2010-2020 = $805.9

GROWTH OF PE ACTIVITY IN HEALTHCARE OVER LAST DECADE

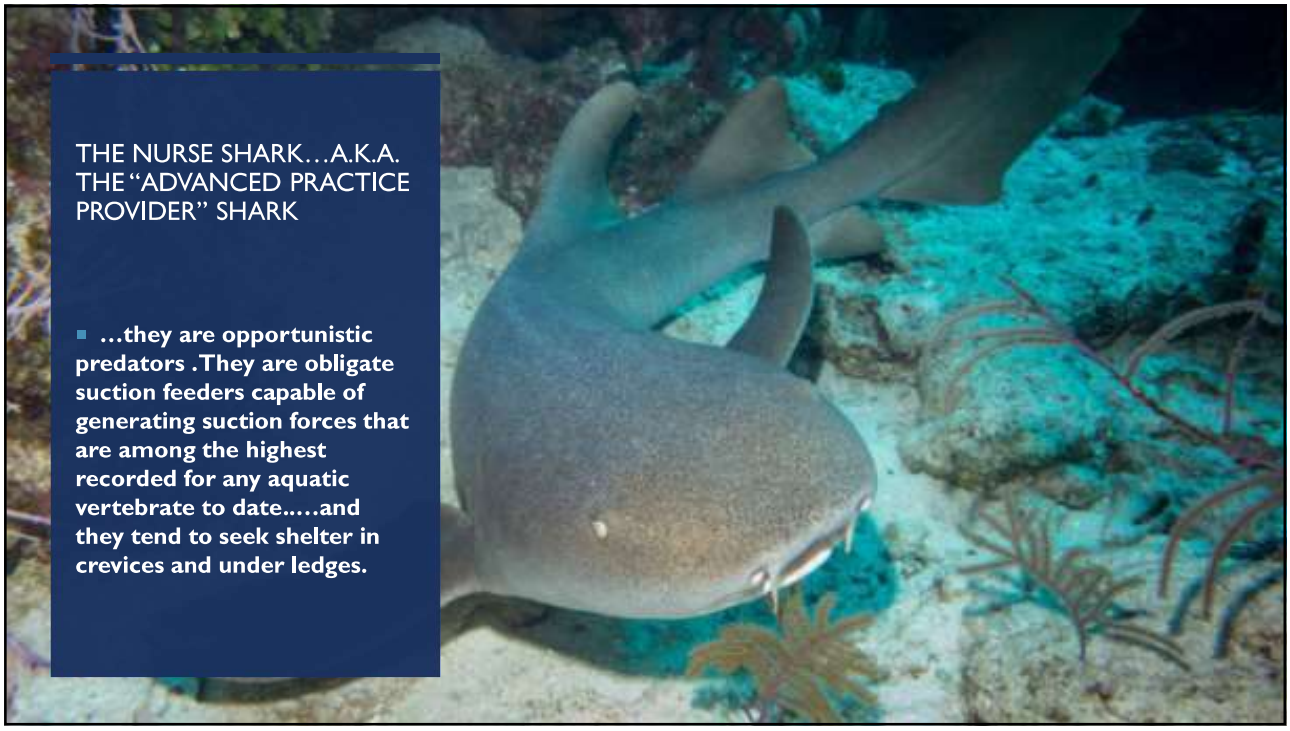
GOOD OR BAD FOR HEALTHCARE?

PROS

- Access to capital
- Better business management
- Maintain level of independence
- Potential future financial upside

CONS

- Loss of control
- Less immediate compensation for potential future financial upside
- Focus on money
- Accelerated consolidation



Historical and Projected Numbers of Physicians, Nurse Practitioners, and Physician Assistants.*

Provider Group	No. of Full-Time Equivalents				Average Annual Growth (%)		
	2001	2010	2016	2030 (projected)	2001–2010	2010–2016	2016–2030 (projected)
Physicians	711,357	862,698	920,397	1,076,360	2.2	1.1	1.1
Nurse practitioners	64,800	91,697	157,025	396,546	3.9	9.4	6.8
Physician assistants	44,282	88,047	102,084	183,991	7.9	2.5	4.3

* Based on data from the American Community Survey (ACS) and the National Sample Survey of Registered Nurses. Estimates for NPs in 2001 are interpolated on the basis of data from the 2000 and 2004 surveys. Full-time equivalents are defined on the basis of reported usual weekly hours worked and a 40-hour workweek for NPs and PAs and a 50-hour workweek for physicians. NPs include a small number of certified nurse midwives who were not separately identified in the ACS because of their small

GROWTH IN ADVANCED PRACTITIONERS OVER THE LAST 20+ YEARS

WHY, YOU ASK?

- Shorter training times
- Fewer institutional educational constraints to expand capacity
- Rapidly aging population
- Profitability sector for healthcare systems and physician practices

https://www.fiercehealthcare.com/practices/growth-advanced-practice-clinicians-will-outpace-physicians-projections-predict

DON'T FORGET ABOUT MONEY AND QUALITY…

- "the role physicians assistants and nurse practitioners can play in the nation's future should be at the forefront of their discussions. Not only do PAs and NPs provide quality care, they do so at a reduced cost, which is going to be pivotal over the next two decades, as Baby Boomers increasingly need more services, and costs associated with Medicare and Medicaid continue to rise."

https://www.forbes.com/sites/realspin/2017/03/16/advanced-practice-providers-are-key-to-americas-healthcare-future/?sh=1a8ced745998

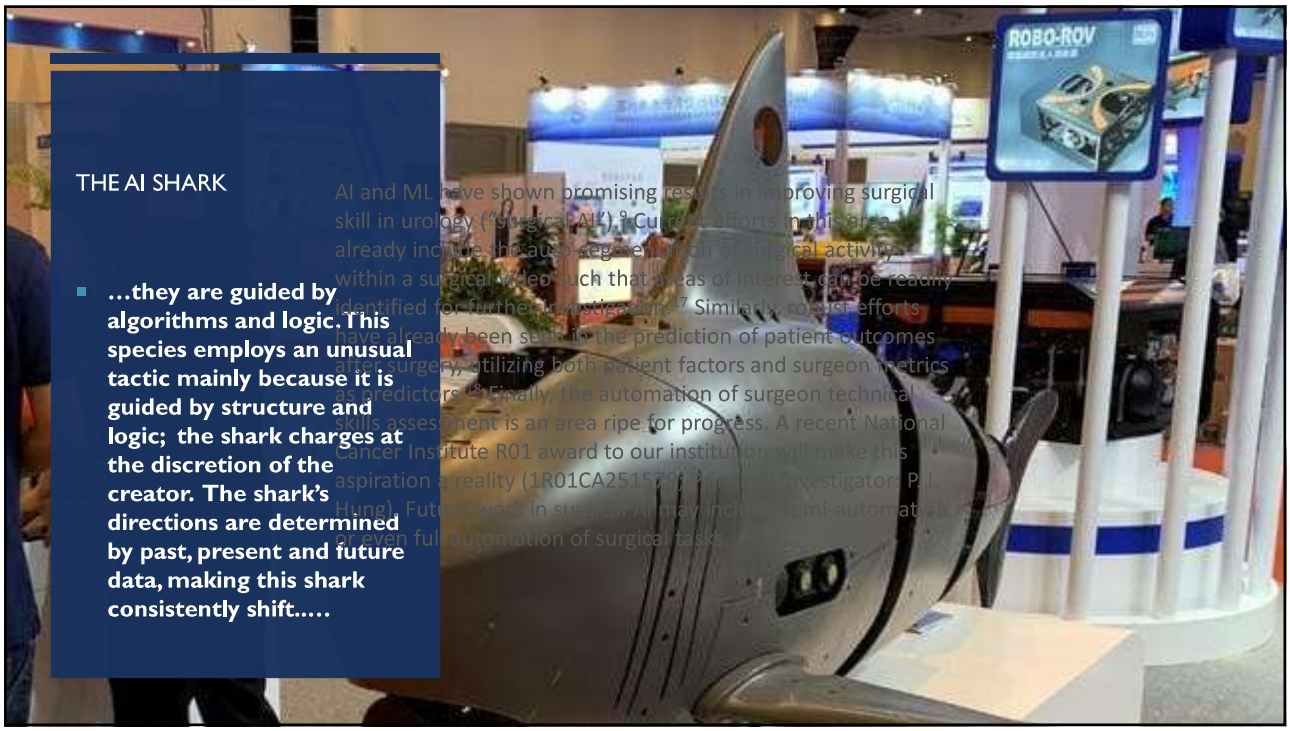
Shark Fight!

https://www.hpnonline.com/patient-satisfaction/population-health-care-continuum/article/21225880/ama-remarks-on-aapa-physician-assistant-title-change

AMA remarks on AAPA 'physician assistant' title change

Jun 8th, 2021

Dr. Bailey stated:
"AAPA's recent move to change the title 'physician assistant' to 'physician associate' will only serve to further confuse patients about who is providing their care, especially since AAPA sought a different title change in recent years, preferring to only use the term 'PA'. Given the existing difficulty many patients experience in identifying who is or is not a physician, it is important to provide patients with more transparency and clarity in who is providing their care, not more confusion.



THE AI SHARK

- **…they are guided by algorithms and logic. This species employs an unusual tactic mainly because it is guided by structure and logic; the shark charges at the discretion of the creator. The shark's directions are determined by past, present and future data, making this shark consistently shift…..**

AI and ML have shown promising results in improving surgical skill in urology ("surgical AI"). Current efforts in this area already include the auto-segmentation of surgical activity within a surgical video such that areas of interest can be readily identified for further investigation.[17] Similarly, robust efforts have already been seen in the prediction of patient outcomes after surgery, utilizing both patient factors and surgeon metrics as predictors.[18] Finally, the automation of surgeon technical skills assessment is an area ripe for progress. A recent National Cancer Institute R01 award to our institution will make this aspiration a reality (1R01CA251579, Principal Investigator: P. Hung). Future work in surgical AI may include semi-automation or even full automation of surgical tasks.

IT'S COMING…OR IT'S HERE AND GAINING SPEED?

- AI and ML have shown promising results in improving surgical skill in urology ("surgical AI").[9] Current efforts in this area already include the auto-segmentation of surgical activity within a surgical video such that areas of interest can be readily identified for further investigation.[17] Similarly, robust efforts have already been seen in the prediction of patient outcomes after surgery, utilizing both patient factors and surgeon metrics as predictors.[18] Finally, the automation of surgeon technical skills assessment is an area ripe for progress. A recent National Cancer Institute R01 award to our institution will make this aspiration a reality (1R01CA251579; Principal Investigator: P. I. Hung). Future work in surgical AI may include semi-automation or even full automation of surgical tasks.

https://www.auanet.org/membership/publications-overview/auanews/all-articles/2021/july-2021/artificial-intelligence-applications-in-urology

LAST BUT NOT LEAST…

Not the deadliest shark in the waters but…still a bit scary…

THE HAMMERHEAD SHARK…A.K.A. THE PATIENT SHARK

- **…Unfortunately, this eye placement causes a huge blind spot directly in front of their nose! This fish is well known for its ability to make very sudden and sharp turns…..**

Hammerhead Shark

IT'S COMING…

Arielle Trzcinski, principal analyst at Forrester, told *Insider*, "The healthcare market is finally shifting to become more consumer-centric. These retail giants have both hit on the need to bring care to the consumer and are capitalizing on the seismic shift we see happening across the healthcare industry."

CON·SUM·ER *N.*

- One that consumes, especially one that acquires goods or services for direct use or ownership rather than for resale or use in production and manufacturing

DEFINITION OF A CUSTOMER

cus·tom·er *noun* \'kəs-tə-mər\

Definition of *CUSTOMER*

- **1:** one that purchases a *commodity* or service
- **2:** an individual usually having some specified distinctive trait <a real tough *customer*>

Examples of *CUSTOMER*

- She is one of our best *customers*.
- She's a pretty cool *customer*.

Origin of *CUSTOMER*

- Middle English *custumer*, from *custume* First Known Use: 15th century

*http://www.merriam-webster.com/dictionary/customer

WHAT IS A CUSTOMER?

- Advocate
- Apathetic
- Assassin

*Satisfaction: How Every Great Company Listens to the Voice of the Customer, 2006, Chris Denove and James D. Power IV

WHY ARE CUSTOMERS IMPORTANT?

It costs 5 times as much to attract a new customer than to keep an existing one.

- (Source: seohosting.com)

68% leave because they are upset with the treatment they've received.

- (Source: U.S. Small Business Administration)

On average, loyal customers are worth up to 10 times as much as their first purchase.

- (Source: White House Office of Consumer Affairs)

48% of customers who had a negative experience told 10 or more others.

- (Source: Harvard Business Review)

WHY ARE CUSTOMERS IMPORTANT?

64% of customers cited shared values as the primary reason for a strong brand relationship.

- Source: Corporate Executive Board

68% quit because of the attitude of indifference toward the customer by the owner, manager or some employee.

- Source: Michael LeBoeuf, "*How to Win Customers and Keep them for Life*"

3 in 5 Americans (59%) would try a new brand or company for a better service experience.

- Source: American Express

89% of consumers began doing business with a competitor following a poor customer experience.

- Source: RightNow

WHAT DO CUSTOMERS WANT?

- A novel question asked by other industries … does healthcare ask that question?

And yet, healthcare is lagging.

Patients are demanding more convenient access to care…and the market is complying

Urgent Care Providers	Retail Health Clinics	Telehealth Care Providers
9,600 urgent care centers (6,000 in 2013)	2,800 retail health clinics (1,200 in 2010)	>260 telehealth care companies (>20 in 2016)

2015:

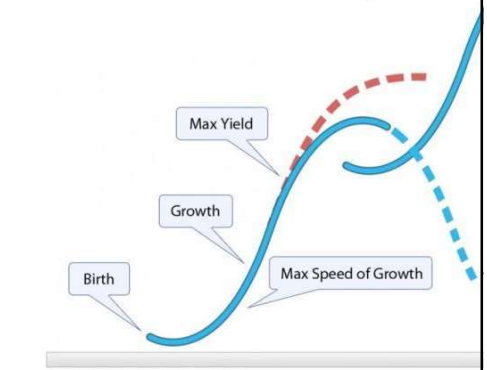
UBER
the world's largest taxi company owns no vehicles

facebook
the world's most popular media owner creates no content

阿里巴巴 Alibaba.com
the most valuable retailer has no inventory

airbnb
the world's largest accommodation provider owns no real estate.

JUMPING THE CURVE …



Growth follows a predictable pattern:

Exploration ▸ Execution ▸ Extinction

Acceleration ▸ Stabilization ▸ Deceleration

Creating sustainable growth means:

Delay extinction: stretch the curve

Avoid extinction: change the curve


ENOUGH
SAID!


Healthcare
Branding
& Sales Basics
digg
You
Tube
minute clinic
medicare
High deductible plans

Survival yes…

…but Growth Preferred

DISRUPTION…

"Uber's message for healthcare is clear. Providers have three choices: ignore innovators and hope for the best; call for increasing regulation to make it harder for innovators to enter the market; or compete on quality and efficiency, disruptive though that might be,"

http://www.nejm.org/doi/full/10.1056/NEJMp1512206?utm_medium=nl&utm_source=internal&mkt_tok=eyJpIjoiTkdJeE16T mhORGt6WXpabSIsInQiOiI5ODVHa0N2Mk16OFFqeVdpMXlxVjFQSVJKdTdoaTdvbkhpemdUeINVWem5UYnJ6V0tQWmd DUEhRVWdKbHFxenc4UGVZbzRQWnNBSVRITUExUTQxOEc4eHdXXC90cVJFY01qYkZBSlNId0x0Y1E9In0%3D& (New England Journal of Medicine)


THANK YOU
e3c3 consulting
200 Timberhill Pl Ste 223
Chapel Hill, NC 27516
cam@e3c3consulting.com
919-368-0741

WHEN TO HOLD, WHEN TO FOLD: ADDRESSING DISRUPTIVE PHYSICIAN BEHAVIOR

Dave Carpenter, CEO
Minnesota Urology
dcarpenter@mnurology.com

Review of Disruptive Physician Behavior

1) DPB defined
2) Prevalence of DPB
3) Impact of DPB in the workplace
4) Characteristics of physicians who engage in DPB
5) The look and sound of real world DPB
6) Effectively managing DPB
7) Land mines to avoid
8) Discussion

Have you experienced disruptive physician behavior within your organization in the last year?

a) Yes
b) No
c) Not sure

slido

Have you experienced disruptive physician behavior within your organization in the last year?

ⓘ Start presenting to display the poll results on this slide.

What Does Disruptive Physician Behavior Look Like?

Blatantly aggressive behaviors:

- Yelling
- Foul and abusive language
- Threatening gestures
- Public criticism of coworkers
- Insults and shaming others
- Intimidation
- Invading one's space
- Slamming down objects
- Physically aggressive or assaultive behavior

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

What Does Disruptive Physician Behavior Look Like?

Passive-aggressive behaviors:

- Hostile avoidance or "cold shoulder" treatment
- Intentional miscommunication; malicious gossip
- Unavailability for professional matters, e.g., not answering pages or delays in doing so
- Condescending/belittling language or tone
- Impatience with questions
- Racial, gender, sexual, or religious slurs or "jokes"
- "Jokes" about a person's personal appearance, e.g., fat, skinny, short, ugly
- Spiteful sarcasm
- Implied threats, esp. retribution for lodging complaints

Re-do: Have you experienced disruptive physician behavior within your organization in the last year?

a) Yes
b) No
c) Not sure

slido

Have you experienced disruptive physician behavior within your organization in the last year?

ⓘ Start presenting to display the poll results on this slide.

Prevalence of Disruptive Physician Behavior

2004 survey of physician executives:

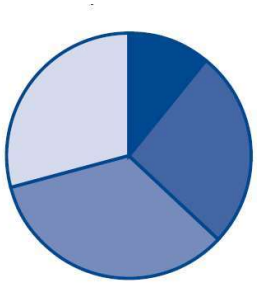
- More than 95% reported regularly encountering DPB
- 70% reported that DPB nearly always involved the same physicians
- 80% said that DPB is under-reported due to victim fear of reprisal

Weber DO. For safety's sake disruptive behavior must be tamed. *Physician Executive*. 2004; 17.

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

American College of Physician Executives 2011 Survey:



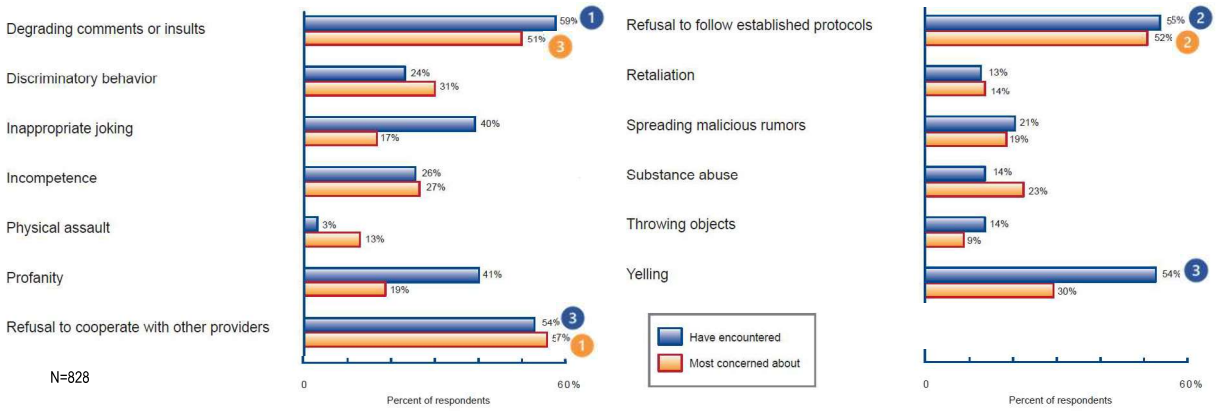
11%	Daily
26%	One incident per week
34%	One incident per month
29%	One incident per year or less

70% of physicians report DPB occurs at least 1x/mo

N = 842

MacDonald, Owen. Disruptive Physician Behavior. Whitepaper collaboration of American College of Physician Executives and QuantiaMD, May 15, 2011.

Which of the following disruptive physician behaviors have you encountered and are most concerned about?



MacDonald, Owen. Disruptive Physician Behavior. Whitepaper collaboration of American College of Physician Executives and QuantiaMD, May 15, 2011.

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

What do you think is the root cause of most DPB (choose one)?

a) Policy or procedure related
b) Other members of the health care team
c) Patient compliance
d) Workload
e) Compensation related
f) Learned behavior (e.g. medical school)
g) Non-work related causes
h) Other root causes

slido

What do you think is the root cause of most DPB (choose one)?

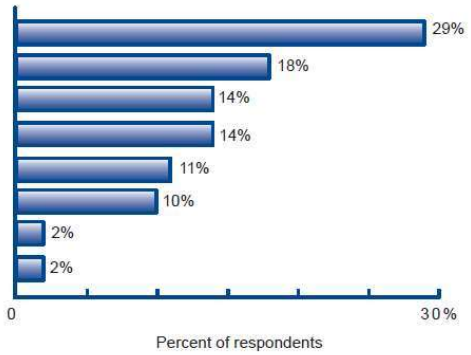
ⓘ Start presenting to display the poll results on this slide.

2022 LUGPA ANNUAL MEETING

Independent Urology Powered by Innovation

What do you feel was the root cause of the DPB?

Workload
Learned behavior (e.g., medical school)
Other members of the health care team
Other root causes
Non-work related causes
Policy or procedure related
Compensation related
Patient compliance



N = 214

MacDonald, Owen. Disruptive Physician Behavior. Whitepaper collaboration of American College of Physician Executives and QuantiaMD, May 15, 2011.

Impact of DPB in the workplace

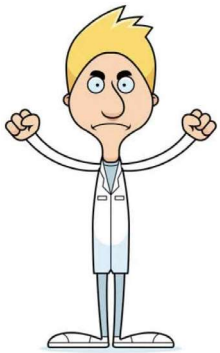
- Lowered staff morale
- Increased turnover of staff
- Damaged work environment and culture
- Negative reputation of the health care organization
- Erosion of staff trust and confidence in leadership
- Undermined team effectiveness
- Poor patient satisfaction
- Increased cost of care
- Lawsuits
- Diminished patient care: medical errors, adverse elements

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Has your organization experienced any of the following related to DPB (check all that apply)?

a) Patient or family written complaints
b) Patients changing physicians or leaving the practice
c) A deteriorated culture
d) Disciplinary action against a disruptive physician
e) Verbal or physical confrontations with other physicians
f) Nurse or other staff resigning or requesting a transfer
g) Adverse clinical events attributable to a disruptive physician



slido

Has your organization experienced any of the following related to DPB? (check all that apply)

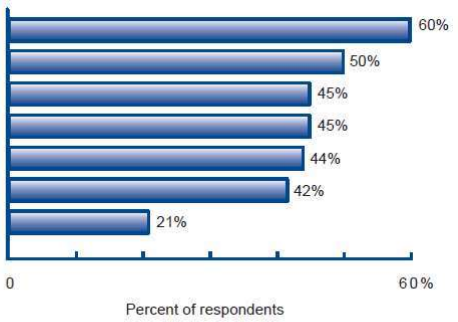
ⓘ Start presenting to display the poll results on this slide.

2022 LUGPA ANNUAL MEETING

Independent Urology Powered by Innovation

Has your organization experienced any of the following related to DPB?

Patient or family written complaints
Patients changing physicians or leaving the practice
A deteriorated culture
Disciplinary action against a disruptive physician
Verbal or physical confrontations with other physicians
Nurse or other staff resigning or requesting a transfer
Adverse clinical events attributable to a disruptive physician



N = 828

MacDonald, Owen. Disruptive Physician Behavior. Whitepaper collaboration of American College of Physician Executives and QuantiaMD, May 15, 2011.

DPB is a threat to patient safety because it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices.

Leape, Lucian et al. A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. Academic Medicine, Vol. 87, No. 7, July, 2012.

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

To what extent do you believe that DPB affects patient care?

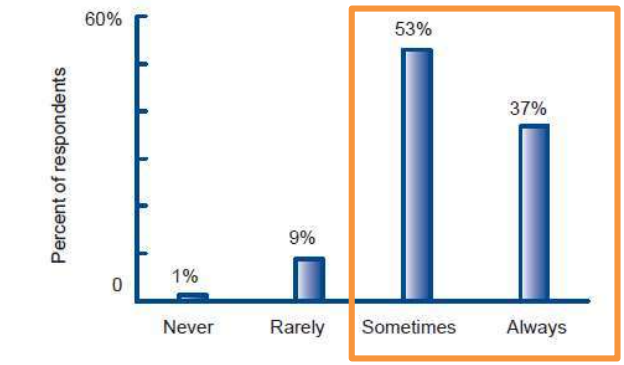
a) Never
b) Rarely
c) Sometimes
d) Always

slido

To what extent do you believe that DPB affects patient care?

ⓘ Start presenting to display the poll results on this slide.

To what extent do you believe that DPB affects patient care?



N = 832

90% of physicians report DPB affects patient care

MacDonald, Owen. Disruptive Physician Behavior. Whitepaper collaboration of American College of Physician Executives and QuantiaMD, May 15, 2011.

Anyone can have a bad day. The disruptive label should not be applied to a physician who has a one-time or occasional disruptive episode that is otherwise out of character for the physician. Pure disruptive behavior is rooted in personality; it is deep-seated and pervasive.

Reynolds, Norman. Disruptive Physician Behavior: Use and Misuse of the Label. Journal of Medical Regulation, Vol. 98, No. 1,

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Snapshot of the offenders

- Arrogant and intimidating
- Controlling; insistence of having things their way
- Inflexible, uncompromising
- Self-centered; exaggerated sense of self-importance
- Strong sense of entitlement
- Lack of empathy; incapable of genuine apologies
- Rationalizing to justify their behavior
- Blame others
- Creates distress in others; viewed as difficult
- Lack of self-awareness, insight, remorse
- Vindictive, litigious

AMA defines “Workplace Bullying” as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target.

AMA Workplace Bullying Policy, Bullying in the Practice of Medicine H-515.951, American Medical Association, 2022.

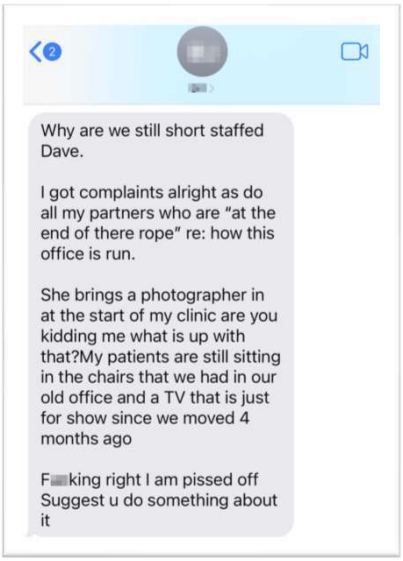
2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

What does real-word DPB *look* like?

(Minnesota not-so-nice)

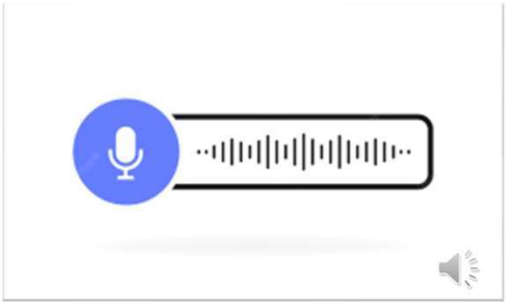
…Real-world DPB



2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

What does real-word DPB *sound* like?



Voice recording intentionally distorted to protect anonymity

MASSIVE Key Point:

DPB should be managed via a *structured, written* approach

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Create a board-approved DPB policy that:

1) Establishes standards of professional behavior
2) Defines DPB and its effects (*DPB includes any form of retaliation*)
3) Describes process and procedures for addressing DPB
4) Delineates consequences of DPB, including disciplinary action up to and including suspension and/or termination of employment
5) Is reviewed by legal counsel
6) Is distributed to all providers

Minnesota Urology P.A.	
Policy Title	Policy Regarding Disruptive Physician/APP Behavior
Department	Administration
Departments/Individuals Affected	All Physicians and Practitioners
Original Effective Date	May 1, 2018
Revision Date	October 12, 2022
Approved by	Minnesota Urology Board of Directors
Version Number	v.10.12.2022

Rationale/Purpose: The Board of Directors establishes as a foundational principle and expectation that all individuals, patients, and others at Minnesota Urology (the "Practice") should be treated with courtesy, respect, and dignity. This requires that all physicians and advanced practice providers ("Providers") conduct themselves in a consistently professional, respectful, and ethical manner at all times at work, whether in our facilities, other clinics or hospitals, or any other setting in which they are representing the organization.

The purpose of this Policy is to: 1) define disruptive Provider behavior and its effects, and 2) outline the process for addressing and resolving issues related to disruptive Provider behavior at Minnesota Urology.

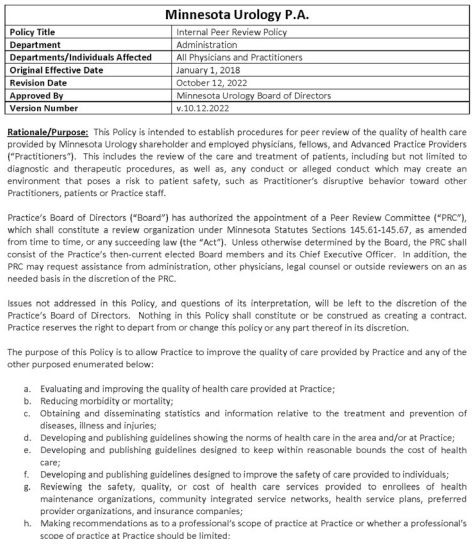
Scope: This policy applies to all Minnesota Urology shareholder and employed physicians, fellows, and Advanced Practice Providers.

Policy and Procedures:

1) **Standards of Professional Behavior:** The public, and the Practice, hold Providers to high standards of behavior. It is imperative that Providers of the Practice live up to these standards and exhibit professional and respectful behavior in the performance of their job and when interacting with others. Appropriate conduct expected of our Providers includes, but is not limited to:
   a. Treating patients, staff, Providers, or others in a professional, courteous, and respectful manner.
   b. Expressing disagreement directly, respectfully, and professionally with others, or through appropriate channels.
   c. Addressing concerns about another Provider's or staff member's behavior or performance

Establish the governing body that will address DPB:

1) Bylaws generally not strong enough
2) Best practice is Peer Review Committee
   - can be same members as board/exec committee
   - protected from legal discovery in many states
   - addresses variety of issues including quality of care, physician competency and performance, DPB
3) Separate meetings and minutes, confidentially maintained



Minnesota Urology P.A.	
Policy Title	Internal Peer Review Policy
Department	Administration
Departments/Individuals Affected	All Physicians and Practitioners
Original Effective Date	January 1, 2018
Revision Date	October 12, 2022
Approved By	Minnesota Urology Board of Directors
Version Number	v.10.12.2022

Rationale/Purpose: This Policy is intended to establish procedures for peer review of the quality of health care provided by Minnesota Urology shareholder and employed physicians, fellows, and Advanced Practice Providers ("Practitioners"). This includes the review of the care and treatment of patients, including but not limited to diagnostic and therapeutic procedures, as well as, any conduct or alleged conduct which may create an environment that poses a risk to patient safety, such as Practitioner's disruptive behavior toward other Practitioners, patients or Practice staff.

Practice's Board of Directors ("Board") has authorized the appointment of a Peer Review Committee ("PRC"), which shall constitute a review organization under Minnesota Statutes Sections 145.61-145.67, as amended from time to time, or any succeeding law (the "Act"). Unless otherwise determined by the Board, the PRC shall consist of the Practice's then-current elected Board members and its Chief Executive Officer. In addition, the PRC may request assistance from administration, other physicians, legal counsel or outside reviewers on an as needed basis in the discretion of the PRC.

Issues not addressed in this Policy, and questions of its interpretation, will be left to the discretion of the Practice's Board of Directors. Nothing in this Policy shall constitute or be construed as creating a contract. Practice reserves the right to depart from or change this policy or any part thereof in its discretion.

The purpose of this Policy is to allow Practice to improve the quality of care provided by Practice and any of the other purposed enumerated below:

a. Evaluating and improving the quality of health care provided at Practice;
b. Reducing morbidity or mortality;
c. Obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;
d. Developing and publishing guidelines showing the norms of health care in the area and/or at Practice;
e. Developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;
f. Developing and publishing guidelines designed to improve the safety of care provided to individuals;
g. Reviewing the safety, quality, or cost of health care services provided to enrollees of health maintenance organizations, community integrated service networks, health service plans, preferred provider organizations, and insurance companies;
h. Making recommendations as to a professional's scope of practice at Practice or whether a professional's scope of practice at Practice should be limited:

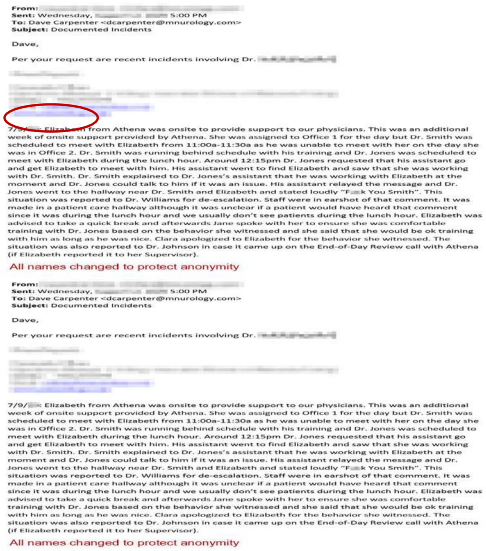
2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Document <u>all</u> instances of reported DPB:

1) Maintain record of all e-mails, texts, voice mails
2) "Per the request" of the President, CEO, etc., summarize DPB encounters
3) Documented by management (supervisor or above)
4) Who, what, where, when…facts only
5) Timely…within a few days of occurrence
6) Depending on situation, involve senior HR professional to assist with validity investigation

Confidentiality and zero-tolerance for retaliation must be assured by President/CEO!



From:
Sent: Wednesday, [redacted] 5:00 PM
To: Dave Carpenter <dcarpenter@mnurology.com>
Subject: Documented Incidents

Dave,

Per your request are recent incidents involving Dr. [redacted]

[redacted]

7/9/[redacted] Elizabeth from Athena was onsite to provide support to our physicians. This was an additional week of onsite support provided by Athena. She was assigned to Office 1 for the day but Dr. Smith was scheduled to meet with Elizabeth from 11:00a-11:30a as he was unable to meet with her on the day she was in Office 2. Dr. Smith was running behind schedule with his training and Dr. Jones was scheduled to meet with Elizabeth during the lunch hour. Around 12:15pm Dr. Jones requested that his assistant go and get Elizabeth to meet with him. His assistant went to find Elizabeth and saw that she was working with Dr. Smith. Dr. Smith explained to Dr. Jones's assistant that he was working with Elizabeth at the moment and Dr. Jones could talk to him if it was an issue. His assistant relayed the message and Dr. Jones went to the hallway near Dr. Smith and Elizabeth and stated loudly "F**k You Smith". This situation was reported to Dr. Williams for de-escalation. Staff were in earshot of that comment. It was made in a patient care hallway although it was unclear if a patient would have heard that comment since it was during the lunch hour and we usually don't see patients during the lunch hour. Elizabeth was advised to take a quick break and afterwards Jane spoke with her to ensure she was comfortable training with Dr. Jones based on the behavior she witnessed and she said that she would be ok training with him as long as he was nice. Clara apologized to Elizabeth for the behavior she witnessed. The situation was also reported to Dr. Johnson in case it came up on the End-of-Day Review call with Athena (if Elizabeth reported it to her Supervisor).

All names changed to protect anonymity

From:
Sent: Wednesday, [redacted] 5:00 PM
To: Dave Carpenter <dcarpenter@mnurology.com>
Subject: Documented Incidents

Dave,

Per your request are recent incidents involving Dr. [redacted]

[redacted]

7/9/[redacted] Elizabeth from Athena was onsite to provide support to our physicians. This was an additional week of onsite support provided by Athena. She was assigned to Office 1 for the day but Dr. Smith was scheduled to meet with Elizabeth from 11:00a-11:30a as he was unable to meet with her on the day she was in Office 2. Dr. Smith was running behind schedule with his training and Dr. Jones was scheduled to meet with Elizabeth during the lunch hour. Around 12:15pm Dr. Jones requested that his assistant go and get Elizabeth to meet with him. His assistant went to find Elizabeth and saw that she was working with Dr. Smith. Dr. Smith explained to Dr. Jones's assistant that he was working with Elizabeth at the moment and Dr. Jones could talk to him if it was an issue. His assistant relayed the message and Dr. Jones went to the hallway near Dr. Smith and Elizabeth and stated loudly "F**k You Smith". This situation was reported to Dr. Williams for de-escalation. Staff were in earshot of that comment. It was made in a patient care hallway although it was unclear if a patient would have heard that comment since it was during the lunch hour and we usually don't see patients during the lunch hour. Elizabeth was advised to take a quick break and afterwards Jane spoke with her to ensure she was comfortable training with Dr. Jones based on the behavior she witnessed and she said that she would be ok training with him as long as he was nice. Clara apologized to Elizabeth for the behavior she witnessed. The situation was also reported to Dr. Johnson in case it came up on the End-of-Day Review call with Athena (if Elizabeth reported it to her Supervisor).

All names changed to protect anonymity

Discuss reported incidents with involved physician:

1) Explain what was reported; share documentation
2) Seek to understand physician's perspective
3) Determine whether further investigation or escalation is warranted
4) Emphasize confidentiality and zero-tolerance for retaliation policy
5) Document and share outcome of discussion

Documentation does not become part of physician's personnel file!

From: Dave Carpenter <dcarpenter@mnurology.com>
Sent: Friday, [redacted]
To: [redacted]
Cc: [redacted]
Subject: Employee concern

Dr. [redacted]

Thank you for the conversation yesterday. To follow up, attached is the summary of the employee's concerns that we spoke about. The employee discussed these concerns with [redacted] in HR, who documented the conversation/concerns as a standard practice and forwarded to me.

During our discussion yesterday, I understood you to say that the first two concerns were valid in that you have discussed your views re: immigration with patients and employees. I also understand that you emphatically deny having made the statement "I don't think a Mexican should have won this."

As conveyed yesterday, my suggestion is to avoid expressing your personal views regarding immigration with patients and employees. It would not be uncommon for such remarks to be misconstrued or taken out of context (as may be the case with those in the attached summary), which from a reputation and liability standpoint could have an adverse impact on you and/or the company.

At this point I do **not** think you should address these concerns with the employee. Rather, my suggestion is to gain an understanding and appreciation for the sensitivity others may have to such divisive issues, and refrain from discussing them publicly at work.

As a matter of protocol with the Disruptive Physician Behavior policy recently adopted by the MNU board (attached), I am including Drs. [redacted] and [redacted] on this note. In my view, this matter has been resolved and requires no further escalation.

Any further comments you may have regarding this matter are welcomed.

Thank you for your understanding and cooperation. -dave

Dave Carpenter
Chief Executive Officer

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Once a documented pattern of DPB is established:

1) Bring to governing body/Peer Review Committee
2) DPB now becomes a matter of record, forcing policy action
3) Governing body enacts DPB policy/procedures

Minnesota Urology Peer Review Committee in Session

Dr. XXXXXX – Behavioral Concerns

January 30, 2018

CONFIDENTIAL

Behavioral Concern	Impact	Remedy
There is a perception that you can be arrogant and condescending with staff, especially when you are approached with questions. You are perceived at times as having a short fuse and easily upset.	Staff avoids coming to you because they fear you will become angry. Thus, they seek help and advice from other providers. This places a burden on your partners. Also, this behavior is inconsistent with the company's values, and gives the impression that physicians are immune to the behavioral expectations we have of staff. This is damaging to our culture.	You must work on becoming more approachable with staff. You must bear in mind you are working with a care team, and as a physician you are the leader of the team. As a physician leader, you have the responsibility to demonstrate the values of the organization, which include compassion and respect for patients and coworkers. Specifically, when approached by staff with questions, concerns, or advice, you should: 1. Listen. Seek to fully understand the question/concern. If you do not have adequate time to give at that moment, state this in a respectful manner, and set aside another time that works. 2. Assume positive intent. You should assume the staff member's intent in approaching you is to gain information or help with solving a problem that will result in better patient care or improved operational efficiency. 3. Respond in a thoughtful and considerate manner. Offer helpful information or viable options. Utilize the situation as an opportunity to develop staff ("Have you thought of this..."; "What if you approached the problem a different way..." etc.). Do not make judgmental comments. Demonstrate leadership. 4. Follow up. Approach the staff at a later time, and ask if the question/concern was adequately addressed or resolved. Ask if there is anything you can do to help further. This demonstrates that you care.
You become angry, stressed and inflexible with staff regarding scheduling issues, especially with unexpected additions.	Same as above. Also, patients may be added to other provider schedules because of your perceived inflexibility. This negatively impacts your production.	Use the same approach outlined above with scheduling issues. Also, given your relatively low production within the group, you should work to become more accommodating and inclusive with requests to add patients to your schedule.
You have been overheard by coworkers swearing in clinic, and offsite by personnel in hospital ORs and lounges.	This behavior makes others feel uncomfortable around you. It also reflects poorly on your professionalism. Most importantly, this behavior is damaging to the group's reputation, and adversely impacts your colleagues who work hard to build and protect our image.	Zero tolerance on this issue. You must stop this behavior immediately.

Formal PRC meeting with involved physician:

- Review behavioral concerns
- Explain impact of DPB
- Clarify remedial expectations…be specific
- Encourage physician response, but allow documented evidence to guide discussion and action
- Review DPB policy, progressive discipline, consequences
- Document everything
- Follow up within explicit time-frame
- Emphasize confidentiality/no retaliation

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

A collegial approach is best for the physician and the organization:

- Professional coaching – funded by practice
- Physician mentorship (esp. for younger physicians)
- Anger management resources
- Professionally led assistance groups for physicians
- Professional training (conflict resolution, negotiation, sensitivity, team building)

If situation does not improve and/or becomes contentious:

1) Involve organization's legal (employment) counsel
2) Double-down on documentation…esp. physician's ongoing DPB
3) Follow DPB policy *explicitly*
4) Act under the assumption that a lawsuit is imminent, and all communications (written and verbal) could be deposed

2022 LUGPA
ANNUAL MEETING

Independent Urology
Powered by Innovation

Land mines to avoid:

- Meeting with involved physician or discuss matter informally or 'off the record'
- Suggesting that it's time for the physician to retire, or worse…
- Threatening to bring matter to PRC if physician does not retire or 'step down'
- Engaging in hallway or informal discussions with other physicians (all related conversations must take place within the confines of PRC!)

Discussion

LUGPA
Integrated Practices
Comprehensive Care

LUGPA 2022 Annual Meeting
Practice Administrators Workshop

Session Type: What Keeps You Up at Night
Session Time: 1:00 - 2:15 pm CST
The Importance of a Strong Operating Agreement
Facilitators: Carla Blue, FACMPE, Whitt Holder, Terry Fitzpatrick

The Importance of a Strong Operating Agreement or Bylaws

Introduction

- How many of you have operating agreements or bylaws?
- If you don't have one, how do you get one?
- How many times have you referred back to it?

What Is an LLC Operating Agreement or Bylaws?

An LLC operating agreement, or Corporation Bylaws is a document that customizes the terms of a company according to the specific needs of its members or shareholders. It also outlines the financial and functional decision-making in a structured manner.

Although writing an operating agreement or bylaws is not a mandatory requirement for most states, it is nonetheless considered a crucial document that should be included when setting up a company. The document, once signed by each member (owner) or shareholder, acts as a binding set of rules for them to adhere to.

The agreement is drafted to allow owners to govern the internal operations according to their own rules and specifications. The absence of an operating agreement or bylaws means that your business must be run according to the default rules of your state.

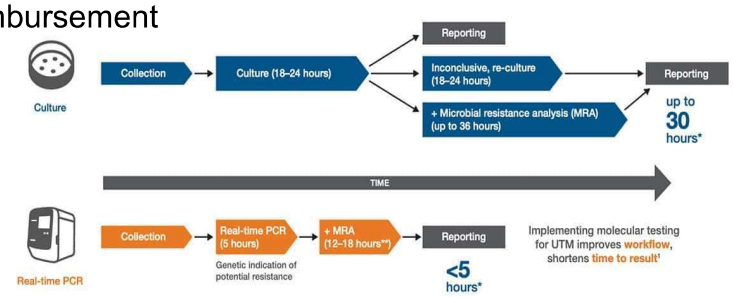
1. Why do we need an operating agreement?
2. Can you tell me about a time it came in handy for your practice or in what situations have you needed an operating agreement?
3. How do we practically use an operating agreement?
4. What should be contained in an operating agreement and what should not?
5. When should we change an operating agreement?
6. Have you had any conflicts that a good operating agreement could have settled?

PCR Implementation & Operations

Kidney Stones | Vasectomy & Vasectomy Reversal | Overactive Bladder | BPH
Pediatrics | Prostate Cancer | Laparoscopic & Robotic Surgery

PCR Testing for UTI

- When compared to urine culture, PCR offers:
  - Faster results
  - Arguably more precise diagnosis, leads to arguably more precise care
  - More expensive test
  - Higher reimbursement



Credit: ThermoFisher Scientific

Implementation and Operation

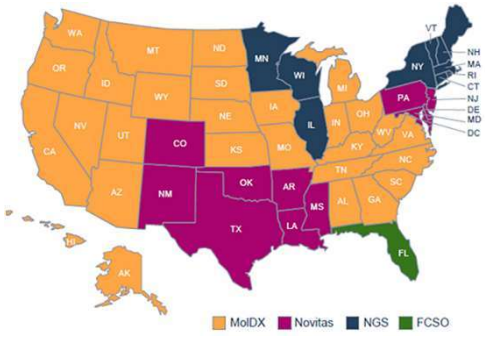
- Requirements:
  - PCR System
  - Nucleic Acid Purifier
  - Pipettes & Pipette heads
  - Absorbance Microplate Reader
  - Technology (computers, etc.)
  - Staffing
  - Lab space
- Order-to-result processing




GEORGIA UROLOGY 50 YEARS

MolDX & PCR

- June 2022 – MolDX LCD set criteria for PCR for infectious disease including UTI
- UTI panels covered for patients who are:
  - Symptomatic AND at higher risk for UTI complications (i.e., elderly, patients with recurrent symptomatic UTIs and/or complicated urinary tract anatomy) AND/OR
  - Seen in urogynecology or urology specialty care settings.
- Steps to get coverage
  - Obtain DEX Z-Code
  - Submit and get approval
    - Technical Assessment
    - Analytical Validity and Clinical Validation
    - Lab Validation Report
    - PDF copy of peer reviewed studies demonstrating clinical validity and utility for the intended use
- Oct 6 – Novitas preparing to follow MolDX LCD



GEORGIA UROLOGY 50 YEARS

No Surprises Act: A Quick Reference Guide

CMS' Frequently Asked Questions

1. What is the No Surprises Act?

- As of January 1, 2022, consumers have new billing protections when accessing
  - Emergency care,
  - Non-emergency care from out-of-network providers at in-network facilities, and
  - Air ambulance services from out-of-network providers.

Through new rules aimed to protect consumers,

- Excessive out-of-pocket costs are restricted
- Emergency services must continue to be covered without any prior authorization, and regardless of whether or not a provider or facility is in-network.

Source: Ending Surprise Medical Bills | CMS

2. What are Surprise Medical Bills?

- Surprise billing sometimes occurs when patients unintentionally receive emergency or non-emergency services from providers who do not participate in their health plan's network. Patients often bear the financial burden of such out-of-network care. While some states have enacted laws addressing this issue in varying ways to protect patients from surprise bills, not all states have, and even those states with existing law on the books are generally unable to regulate many patient encounters, including those encounters with patients who have health coverage under self-funded health benefits plans regulated by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). The NSA addresses this problem on a federal level to "fill the gaps" where states have not enacted (or are unable to enact) laws regulating encounters with patients who have commercial health coverage.
- Medical bills sent to a patient who has accessed services from a non-contracted provider or facility in which the patient is billed for the full charge less any insurance payment (or for full charges if the insurance pays nothing).

3. Who is an uninsured or self-pay individual?

- You are generally considered an uninsured or self-pay individual if you do not have health insurance, or do not plan to use your insurance to pay for a medical item or service. If you are an uninsured or self-pay individual, a provider or facility must give you

a “good faith estimate” detailing what you may be charged before you receive the item or service.

4. What is Good Faith Estimate?

- Good Faith Estimate shows the costs of items and services that are reasonably expected for the patient’s health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.
- The patient could be charged more if complications or special circumstances occur. If this happens, federal law allows the patient to dispute(appeal) the bill.
- The patient may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. The patient can ask that the bill be updated to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.
- The patient may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If the patient chooses to use the dispute resolution process, the patient must start the dispute process within 120 calendar days (about 4months) of the date on the original bill.
- There is a $25 fee to use the dispute process. If the agency reviewing the dispute agrees with the patient, the patient must pay the price on this Good Faith Estimate. If the agency disagrees and agrees with the health care provider or facility, the patient will have to pay the higher amount.

Source: Good Faith Estimate Example (cms.gov)

5. Who is a convening provider or convening facility?

- It is the provider or facility who schedules an item or service or who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual. A convening provider must provide a good faith estimate to the uninsured individuals, including any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service by another provider or facility.

6. Who is a co-provider or co-facility?

- Co-provider or co-facility is a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service. For instance, if a patient schedules a surgery, the convening provider or facility might include in the good faith estimate the cost of the surgery, and the co-provider or co-facility might include the costs of any labs, tests, or anesthesia that might be used during the operation.

7. Which providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals?

- Generally, all providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a GFE from an uninsured (or self-pay) individual must provide such individual with a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement.
- The terms "health care provider (provider)" and "health care facility (facility)" are defined in regulations for purposes of the GFE requirements for uninsured (or self-pay) individuals as:
    - "Health care provider (provider)" means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services;
    - "Health care facility (facility)" means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.
- There may be variations in practice patterns, such as whether a specific provider or facility furnishes services to uninsured (or self-pay) individuals, along with the types of items or services provided. There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.
- For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services, for which coverage is often not provided by a plan or issuer and thus even individuals with coverage must self-pay.

Source: Good Faith Estimates FAQs 12.21.2021 FINAL (cms.gov)

8. What happens if more than one provider or facility is involved in providing a primary item or service to an uninsured (or self-pay) individual?

- In instances where multiple providers might be responsible for furnishing care in conjunction with a primary item or service, the "convening provider or facility" must provide a GFE to the uninsured (or self-pay) individual, which includes items or services

reasonably expected to be furnished by the convening provider or facility, and items or services reasonably expected to be furnished by co-providers or co-facilities.

- The convening provider or facility is the provider or facility that is responsible for scheduling the primary items or services. Other providers or facilities that furnish items or services in conjunction with the primary item or service furnished by the convening provider or facility are considered "co-providers" and "co-facilities."
- No later than one business day after scheduling the primary item or service or receiving a request for a GFE, the convening provider or facility must contact all co-providers and/or co-facilities that will provide items or services in conjunction with the primary items or services and request GFE information including the expected charges for these items or services expected to be provided by the co-provider or co-facility.
- Therefore, for GFEs provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.
- We note that nothing prohibits a co-provider or co-facility from furnishing the GFE information to the convening provider or facility before December 31, 2022, and nothing would prevent the uninsured (or self-pay) individual from separately requesting a GFE directly from the co-provider or co-facility, in which case the co-provider or co-facility would be required to provide the GFE for such items or services. Otherwise, during this period (January 1, 2022 through December 31, 2022), we encourage convening providers and facilities to include a range of expected changes for items or services expected to be provided and billed by co-providers and co-facilities.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

9. Do providers or facilities need to provide GFEs to all individuals, for instance, patients with Medicare or Medicaid?

- Effective January 1, 2022, providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals who schedule items or services or request an estimate. An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan. A self-pay individual is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested.
- Under the No Surprises Act statute, providers and facilities are generally not required to provide GFEs to individuals insured under Medicare, Medicaid, or other federal health care programs. Know here more no surprises act FAQs here with best answers.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

10. Do providers or facilities need to provide GFEs to individuals who have insurance but do not seek to have a claim for such item or service submitted to such plan or coverage?

- An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a federal health care program, or a FEHB program health benefits plan. A self-pay individual is one who is enrolled in but is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a GFE is requested. Providers and facilities are required to provide GFEs to uninsured (or self-pay) individuals. When inquiring about whether an individual is enrolled in a plan or coverage, providers and facilities may wish to consider discussing with the individual whether there are situations where the individual expects that the plan or coverage may not provide coverage for certain items or services.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

11. Do providers or facilities need to provide GFEs to individuals who have insurance and are seeking to have a claim submitted to their insurance?

- HHS has not yet issued rulemaking related to the provision of GFEs for individuals who are enrolled in a plan or coverage and are seeking to have a claim submitted to their plan or coverage. Until rulemaking to fully implement this requirement to provide such GFE to a plan or coverage is adopted and applicable, HHS will defer enforcement of the requirement that providers and facilities provide GFE information for individuals enrolled in a plan or coverage and who are seeking to submit a claim for scheduled items or services to their plan or coverage.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

12. In what forms must the GFE be provided?

- The GFE must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery. GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual. If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

13. Why must a GFE be provided in writing to an uninsured (or self-pay) individual?

- A paper or printable electronic copy of the GFE is integral as it is a required input for the patient-provider dispute resolution (PPDR) process that the uninsured (or self-pay) individual can use if the actual billed charges exceed the GFE by at least $400. When initiating the PPDR, the uninsured (or self-pay) individual must submit a copy of the GFE.

Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

14. Do providers or facilities need to factor in financial assistance an uninsured (or self-pay) individual may receive when calculating the expected charges for items or services included in the GFE?

- Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges.

  Source: Good Faith Estimates FAQ 12.21.2021 FINAL (cms.gov)

15. Do providers or facilities need to provide a GFE to uninsured (or self-pay) individuals who have zero financial responsibility? – No Surprises Act FAQs

- Yes. All uninsured (or self-pay) individuals who schedule items or services or request an estimate must be provided a GFE. A GFE is required even if the uninsured (or self-pay) individual has no estimated financial responsibility because the actual billed charges for the items or services is not guaranteed to be $0 and a GFE is required to initiate the patient provider dispute resolution process if actual billed charges are at least $400 greater than the estimate.

WHAT DO YOU NEED TO DO RIGHT NOW ?

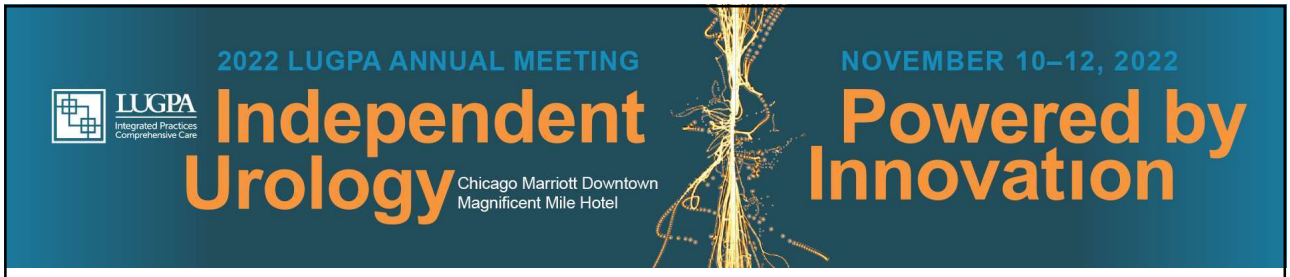
(IF YOU HAVE NOT ALREADY DONE SO)

- **No Surprises Act Disclosures.** Certain providers and facilities must notify patients of their rights under the NSA on a public website, and by providing to patients in a one-page written document, disclosures that include: (1) the requirements and prohibitions applicable to the provider or facility under the NSA and its implementing regulations; (2) information regarding any state balance billing laws and (3) information about how to contact state and federal agencies if the patient believes the provider or facility has violated the NSA.[vi]
- **Implement the Notice and Consent Process**. The NSA does not apply to some out-of-network services when the patient is given notice and consents to the out of network care. Providers should develop systems to identify those encounters eligible for the notice and consent process and implement a procedure for giving notice and obtaining consent. [vii]
- **Prepare to Engage in the Independent Dispute Resolution ("IDR") Process for Reimbursement Disputes.** Health plans and issuers must reimburse providers and facilities directly for out-of-network services subject to the NSA at an undefined amount the NSA calls the "initial payment." This "initial payment" must be made within 30 days after claim submission. The provider or facility may accept that amount as payment in full or dispute the amount through a statutory IDR process. The IDR process begins within a 30-day open negotiation period. The open negotiation period is followed by submission of the dispute to a third-party arbiter when the parties cannot settle. If the dispute is submitted to an arbiter, the parties must submit a final offer and the arbiter must select one of the two offers submitted as the prevailing award.
- **Understand What Factors Are Considered at the IDR Process.** When a dispute involves providers (excluding air ambulance providers)x or facilities, the arbiter of the IDR process must consider seven general factors in reimbursement disputes involving providers and facilities: (1) median in network rates (as calculated by the plan or issuer); (2) the provider's training and experience, quality, and outcomes; (3) the market share of either party; (4) patient acuity or complexity of the service; (5) in the case of a hospital, its teaching status, case mix, and scope of services; (6) good faith efforts (or lack thereof) of either party to agree to a network contract and any contracted rates during the prior four years; and (7) any additional information submitted, so long as it is credible and reliable and does not relate to the provider's billed charges, UCR charges, or governmental reimbursement rates.
- **Understand the Burden of Proof at the IDR Process.** The Departments imposed a mandatory presumption through regulation that the health plan or issuer's median contracted rate is the appropriate reimbursement rate. This presumption may be

rebutted only by "credible" and "relevant" information that the median contracted rate is "materially different" than the appropriate rate.

- **Implement Good Faith Estimates for Uninsured (or Self-Pay) Patients.** At the time of scheduling or upon request, providers and facilities must inquire about the patient's health insurance status or whether the patient wants to submit a claim to their health plan or issuer for the care sought. If the patient is uninsured (or self-pay), the provider or facility must give a good faith estimate of expected charges for services reasonably expected to be provided, including services that may be furnished by other providers or facilities.
- **Prepare to Engage in Reimbursement Disputes for Uninsured (or Self-Pay) Patients.** An uninsured or self-pay patient may institute a patient-provider dispute resolution process when the provider's final bill is $400 or greater than the original good faith estimate (discussed above). In this dispute process, the provider or facility must demonstrate that the difference between the amount billed, and the good faith estimate is based on unforeseen circumstances not anticipated when the estimate was provided.
- **Take Note of Uncertainty in Washington Over Existing NSA Rules.** Industry associations and lawmakers have publicly denounced the presumption that the health plan or issuer's median contracted rate should be presumed an appropriate level of reimbursement via letters to the Departments and lawsuits [xiv] against the federal government. It is unclear whether regulators will amend the regulations in response, but this uncertainty is worth the industry's continued attention.

Source: The National Law Review, October 31, 2022, Volume XII, Number 304



CHRONIC CARE MANAGEMENT (CCM) & PRINCIPAL CARE MANAGEMENT (PCM)

CCM/PCM - In-House vs. Outsourced, Medicare Requirements, Time Tracking, Billing, Staffing

Steve Gabelich, CEO Urology Nevada
Kirsten Anderson, Head of Medical Oncology/Urology and Surgical Oncology, GenesisCare

CHRONIC CARE MANAGEMENT (CCM) & PRINCIPAL CARE MANAGEMENT (PCM)

- ✓ What is CCM / PCM
- ✓ Medicare Requirements
- ✓ In-House vs. Outsourced
- ✓ Staffing
- ✓ Time Tracking
- ✓ Billing

2

WHAT IS CCM / PCM ?

What is it?

- **Non-face-to-face care navigation and coordination performed by staff** (navigators, MAs, nurses, pharm tech, etc.)
  - Appt scheduling, lab follow-ups, benefits verification, and prior authorization
- Medicare reimbursement for these services though CPT codes

54% Increase in reimbursements in 2022

What does it help solve?

- **Improves patient outcomes**
  - Standardizes clinical protocols and care
  - Fewer gaps in care
  - Progresses patients through care pathways
- **Improves business outcomes**
  - Direct revenue & ancillary service revenue (new treatment identification)

$155 Average hourly reimbursement for staff

3

MEDICARE REQUIREMENTS – CCM & PCM

	CCM (2+)	PCM (1+)
Number of Chronic Dx's	2+	1+
Minimum Expected Dx Duration	12+ months	3+ months
Advanced Consent	Written or verbal • For verbal, patient must have been seen in-office within past 12 months	Written or verbal • For verbal, patient must have been seen in-office within past 12 months
Time Tracking	• 20-minute intervals for 1st hour • 30-minute intervals thereafter	30-minute intervals throughout
Care Plan	Comprehensive: for all health issues with focus on chronic conditions	Disease-specific
Allowable Time per Month	**Max 6 hours** billed using CCM Codes: 99490, 99439, 99487, 99489	**Max 1.50** hours billed using PCM Codes: 99426, 99427
Billing Rule	1 provider per patient, regardless of TIN	More than 1 provider per patient, if providers are billing from different TIN
Billing Rule	Cannot be billed in the same month as Telehealth audio only code	Can be billed in the same month as Telehealth audio code

4

CHRONIC CARE MANAGEMENT REQUIREMENTS

Initiating Visit	Patient Consent	CCM Service Elements
Requires face-to-face visit with billing practitioner for patients not seen within one (1) year. This initiating visit is not part of CCM service and separately billed.	Obtaining advance consent for CCM services ensures patient is engaged and aware of applicable cost sharing and opt out option. Only one provider can bill for CCM during a calendar month. This is one provider per patient (PCP, specialist, etc.)	Five service elements must be met and applies to both complex and non-complex CCM. CCM services are typically provided outside of face-to-face visits.

Note: Many Medicare Advantage Plans now require preauthorization for CCM services.

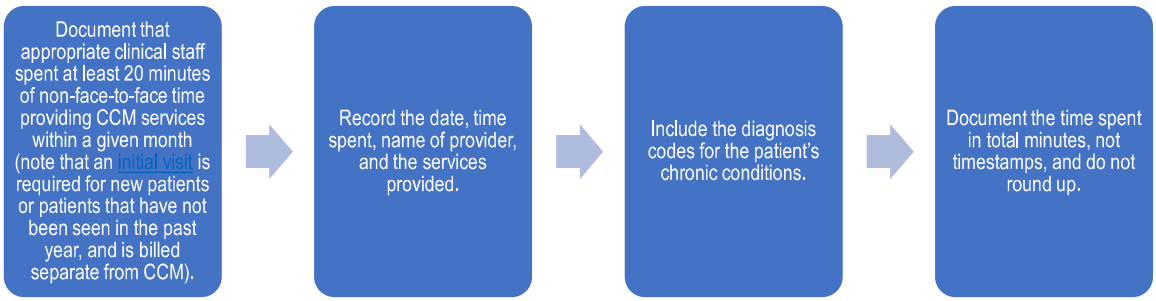
5

Five Required CCM/PCM Service Elements

1. **EHR is Certified Technology-** Patient Demographics, problems, medications, and medication allergies must be recorded using certified EHR.
2. **Comprehensive Care Plan-** a person centered, electronic care plan based on patient assessment and inventory of resources
3. **Access to Care-** provide 24 hour-a-day, 7-day-a-week access to physicians or other qualified healthcare professionals
4. **Facilitate Transitional Care Management-** facilitate transitions of care, follow up with patients after ED visits, coordinate referrals to other clinicians, share information digitally with other clinicians
5. **Coordinate Care-** coordinate with home and community-based providers- home health, hospice, outpatient therapies, DME, transportation, nutritional services to meet patient's needs.

- Chronic Care Management Services (cms.gov)

DOCUMENTATION REQUIREMENTS



7

MEDICARE REQUIREMENTS – ADDITIONAL CALLOUTS

What counts as a chronic condition?

60 minutes

Is the Outsourced CCM cap

DEFINITION BY CMS

Chronic conditions are expected to last at least 12 months or until the patient's death and place them at significant risk of death, acute exacerbation and or decompensation, or functional decline.

8

CCM / PCM Reimbursement Changes in 2022
Reimbursement Changes in 2022

CPT	Category	Description	2021 CMS Payment	2022 CMS Payment	$ Difference	% Difference
99490	CCM	Initial 20 minutes, clinical staff	$ 41.17	$ 62.16	$ 20.99	51%
99439	CCM	Subsequent 20 minutes, clinical staff	$ 37.69	$ 47.04	$ 9.35	25%
99491	CCM	Initial 30 minutes, MD or NPP	$ 82.53	$ 83.66	$ 1.13	1%
99437	CCM	Subsequent 30 minutes, MD or NPP	-	$ 59.47	-	
99487	Complex CCM	Initial 60 minutes, clinical staff	$ 91.77	$130.37	$ 38.60	42%
99489	Complex CCM	Subsequent 30 minutes, clinical staff	$ 43.97	$ 68.51	$ 24.54	56%
99426	Principal CM	Initial 30 minutes, clinical staff (previously G2065)	$ 38.73	$ 61.49	$ 22.76	59%
99427	Principal CM	Subsequent 30 minutes, clinical staff	-	$ 47.04	-	
99424	Principal CM	Initial 30 minutes, physician or NPP (previously G2064)	$ 90.37	$ 80.98	$ (9.39)	-10%
99425	Principal CM	Subsequent 30 minutes, physician or NPP	-	$ 58.46	-	

STAFFING

Outsourced Staffing

- Employees of the outsourced company
- Requires oversight from someone internally at the practice
  - Identify patients
  - Coordination with providers

In-House Staffing

- Employees of the practice with a direct connection to providers for prompt, medical decisions
- Captures time your existing clinical staff is spending on non-face-to-face patient care
- Best practices on staffing care navigation efforts
  - **Time maximization exercise**
  - **Remote staffing -** possible with software

10

TIME TRACKING

CCM and PCM is aggregate time spent on patient navigation throughout the month across all clinical staff at the practice

Top 5
"Misses" on Time Capture
(But They're Eligible to be Counted)

1. Benefits review and prior authorizations
2. Chart review
3. Labs & scans follow-up
4. Discussions with providers on behalf of patient
5. In office dispensary – financial review, refills

11

BILLING

Outsourced

- Care plans are not signed-off by providers
- Care plans take a few months to complete for new patients

In-House

- Provides a holistic view of all patient care to ensure optimal patient outcomes
  - CCM / PCM care plans generated by navigators and signed-off on by providers in the EHR at month-end
- Software automation of qualified CPT codes based on time spent and medical decisions make for faster claims filing

12

CCM / PCM IN-HOUSE VS OUTSOURCED

Outsourced

Benefits

- Generates direct CCM/PCM revenue
- Staff provided by vendor
- Minimal set-up time required (1.5 – 2 months)

Considerations

- CCM reimbursement capped at 1 hour/month/patient
- Audit risk: E.g., Billing for deceased patients, patients expressing they did not consent
- Patient attrition

In-House

Benefits

- Reimburses up to 6 hours/month/patient ($700)
- Self-funds care navigation efforts and increases ancillary services
- Makes sure patients aren't falling through the cracks
- Cleans/improves data and analytics

Considerations

- Must provide own staffing resources
- Requires time to set up (3 – 4 months)
- Needs software

13

CCM / PCM IN-HOUSE VS OUTSOURCED – A NOTE

These two are not necessarily mutually exclusive!

Example: Low-risk patients to outsourced CCM firm; clinically complex/high-risk patients navigated internally

14

CASE STUDY – OUTSOURCED CCM/PCM AT UROLOGY NEVADA

Outsourced Structure

- 3 Month Period
- Conditions Navigated: Prostate Cancer, BPH
- Team: 4
- 417 patients navigated

Business Outcomes

- Provider Feedback
  - Patients seemed confused
  - Data inconsistent

Patient Outcomes

- Patient feedback
  - Love the calls
  - I did not consent
  - Different navigator monthly
- How it benefited patients
  - Meds and appt verification
- Patient Attrition 5%

$15,000	CCM Revenue
$10,000	Overhead
$5,000	Net Profit $
33%	Net Profit %

15

CASE STUDY – IN HOUSE CCM/PCM AT UROLOGY NEVADA

In-House Structure

- June - August 2022
- Conditions Navigated: PCa
- Team: 1 FT PCa CCM navigator; 2 additional PCa team members
- 322 patients navigated

Business Outcomes

- Automated IOD refill process
- Customized Pathways
- Patient Attrition
  - .01< %
- Provider Feedback – how it's benefited Urology Nevada (UN) providers
  - Know navigators
  - Clinic employed

$15,000	CCM Revenue
$TBD	Ancillary Service Revenue
$5,000	Overhead
$10,000	Net Profit $
%66	Net Profit %

16

CASE STUDY – IN HOUSE CCM/PCM AT UROLOGY NEVADA

Patient Outcomes

- Patient feedback
  - Looking forward to the call
  - Personal touch
  - Being heard
  - Spouses love it
  - Quicker resolutions

PATIENT OUTCOMES TOTAL

Type	Outcomes
Cancer or cancer progression detected	30
Depression/mood improved	11
Illness resolved	2
Medication discontinued because no longer needed	3
Missing lab/scan/test discovered	141
New treatment(s) identified	24
Other	1
Outcome Pending - Further Coordination/Navigation Required	192
Patient satisfaction score increased	72
Side effect(s) reduced/removed	9
Symptom(s) improved	24
Total	**509**

17

GenesisCare US- In-House Considerations

- Have had Urology practices implement CCM during and prior to COVID pandemic with limited success, business case for in-house pilot completed in 2022 (project on hold)
- **Pros:**
- Integrated part of practice to support Patient Navigation for Advanced GU Cancer patients leading to better patient communication, increased patient satisfaction, better patient outcomes
- Reimbursement provides way to support business case for CCM/PCM through reimbursement

- **Cons:**
- Limited Staffing resources for RNs/LPNs/LVNs/CMAs, staff constantly pulled to assist with direct patient care as top priority
- Staff Training requirements
- EMR Documentation requirements, lack of CCM Module, longer implementation process
- Monthly Charge Capture
- Patient Consent/Co-payment, non-coverage for CCM/PCM by Payors other than Medicare/MA plans
- Unable to monitor staff productivity

GenesisCare US- Outsourcing Considerations

- Currently reviewing Proposals to Outsource CCM/PCM
- **Pros:**
- Assists with staffing/allows for remote staffing with productivity KPIs and monitoring
- Augments practice ancillary services and improved patient outcomes through communication
- Hybrid models for outsourcing/in-house available, more complex disease states could be managed by practices
- Turnkey solutions/Documentation/Billing with technology and resources with minimal cost to practices

- **Cons:**
- Integration with EMRs
- Cost of Outsourcing per patient per month fee
- Physician Supervision requirements of outsourced staff
- Coordination/Communication process back to provider
- Patient population under 65 yo, could lead to these patients not being managed (some payors have coverage)

SOURCES

- MLN Booklet – Chronic Care Management Services from cms.gov
- Care Navigation App Reporting for UN In-House Case Study
- Practice Management Reporting for UN In-House Case Study

20


LUGPA
Integrated Practices
Comprehensive Care

RETIRING PHYSICIANS: LESSONS LEARNED

Dave Carpenter, CEO – Minnesota Urology
E. Scot Davis, CEO – Arkansas Urology
Mike Shannon, CEO – First Urology

RETIRING PHYSICIANS: LESSONS LEARNED

- Advice from older administrators about older doctors
  - Evaluation of Language in Buy Out Agreements
  - Taking Care of Existing Patients
  - Distribution of Cash for Retiring Physicians
  - Managing Call Schedules with Retiring Physicians
  - Doctors who Don't Want To Retire / Competency Testing
  - Transitioning to Retirement
  - Emotional Change in Purpose

3

LUGPA
Integrated Practices
Comprehensive Care

LUGPA 2022 Annual Meeting
Practice Administrators Workshop

Breakout A: Negotiating Paid Physician Service Agreements with Community Hospitals
Location: Belmont
Presenters: Angela Gilfillan, LeeAnn Shea
Dismissal: Angela Gilfillan

Negotiating Paid Physician Service Agreements (PSA) with Community Hospitals

Introduction: Having a PSA with a local hospital is a great way to form a partnership that is mutually beneficial to both the practice and the hospital. There are various forms and set-ups for a PSA. During this session, we will discuss some of these factors, pros and cons to consider, and things to be aware of before entering into your first PSA discussion.

Talking points:

Why would you want to do a PSA?

- Allows you to expand your office footprint without adding to your buildings or rent. You can use the space one or multiple days/week by one or several physicians, giving them space for clinic you may otherwise not have. You are also not responsible for staffing, supplies, maintenance, etc.
- Can lead to a great set of referrals – hospitals often encourage their employed physicians to keep referrals internal. Additionally, "hanging a shingle" in the building allows for regular visibility.
- It's a great opportunity when bringing on new physicians for them to have visibility but also a consistent income while they are ramping up their own practice. It can help to offset the initial cost of this employed physician.

Why would the Hospital want to do a PSA?

- They are able to expand the services they offer to the patient without the cost of a full-time urologist on their team.
- Typically, testing, procedures, administered medications, etc would stay within the hospital. This is a great internal referral for them. If the patient were to see the physician in their own office, the patient may go to other sources for these items, especially diagnostics.
- It is a great way for hospitals to secure service lines to under-serviced or poverty-designated facilities without risk.

Types of PSA's

- There are numerous ways that a PSA could be set up, but the two typical methods are to be paid either by day/time worked or by volume (RVU, charges, collections, etc are all various measurements that could be utilized).

- Could be done by a physician or APP. The hospital would likely prefer a physician due to the billing considerations, however if an APP is placed in the space, then the expected PSA payment would be lower.
- This may be a great way to transition a retiring/relocating physician – if the office has a newer physician who is in need of volume, the already-established patient base will allow for an immediately full schedule.
- Some are structured as "floors". For example, your office may bill services but the hospital will reimburse the practice for any difference between collected monies and the agreed-upon floor.

Considerations

- Is the PSA focused on clinic time or does it cover surgical time as well? If it covers both, and the same provider does procedures at that hospital for patients from their own office, it will be important to discuss this with the hospital and also identify how these will be tracked/billed so both entities are not trying to bill the same patient.
- What is the goal of the PSA? Do you want this to be a longer-term plan or something shorter in duration? Is it to supplement space within your facilities, help to expand your referrals/patient base, something else? Having these concepts thought out in advance will aid the conversation.
- Will call be included in the PSA or does it fall outside of this? You may already be covering call for this same facility within your group (either through an agreement or just due to staffing at the hospital), so the PSA may not change this, but it should be discussed to ensure all are on the same page with this expectation.

Other Things to Think About/Discuss

- How long do you want the initial contract to be?
- What are the communication expectations with the hospital management and the office? Will this occur primarily with the physician and the hospital or will office management also be involved?
- How frequently will you meet to discuss the current success of the PSA and/or changes that may need to be considered?
- At what intervals will metrics/RVU information be provided to the physician?
- If problems arise within the hospital practice, who should this be communicated with?
- Who is the day-to-day contact for the flow of the hospital office?
- Who will communicate to other physicians about this endeavor?
- If there is an existing practice that is being supplemented with this PSA, how is this being communicated out to the patients?
- How will staff be trained on specific processes/procedures? If there is a need for them to come to your office to learn, are you open to this?
- How will payments be made? Will the practice need to provide some sort of invoicing or is there another routine that would be followed?
- How will this money be designated/divided once paid to the Practice?

It's Time to Renew…

- Are there any changes or adjustments that would be worthwhile to make at this time? Perhaps the initial contract was more exploratory and has proven to be successful – this is the time to look for potential pay increases. Is the time spent at the PSA comparable to the profits generated by that same provider in your office? The hospital has the benefit of an on-site provider at the fraction of the cost of a full-time provider, so make sure that you aren't short changing yourself.
- Are there limitations at the hospital office that you can remedy by having those patients come to your own offices? If so this is a great time to discuss those situations.

Our Experience:

- PSA's for time designated to the facility work best in settings where the hospital is not particularly organized or the patient population is less reliable. This leaves the staffing and scheduling headaches in the hands of the other organization.
- Offer "days" of staffing that include both clinic and OR time. This is particularly useful if the other facility is far away from an efficiency standpoint. This tends to be more valuable to the partnering hospital in the long run.
- Separating call money from the PSA has been lucrative. Try to keep these separate.
- If there is a way to offer "full coverage", the hospitals will pay more. We have used transfer arrangements to help with this. Everybody wins in this scenario also as it allows hospitals to contract with the practice as the practice can translate this into how many FTE's of a urologist this would require.

LUGPA 2022 Annual Meeting
Practice Administrators Workshop

Breakout B: New to LUGPA – What LUGPA Can Do for You
Location: Sheffield
Presenter: Terry FitzPatrick
Dismissal: Terry FitzPatrick

New to LUGPA – What LUGPA Can Do for You

Introduction: Coming to your first LUGPA Meeting can be overwhelming. This session is to help you understand what LUGPA affords each member

Components of the session include:

- Introductions
- Creating your network
- Where/ how to participate
- Roundtable Q&A

LUGPA 2022 Annual Meeting Practice Administrators Workshop

Breakout C: Shortcuts to Efficiency: Managing the Administrators' Growing Workload
Location: Armitage
Facilitator: John O'Connor; Dismissal: Allison Griffin

Shortcuts to Efficiency: Managing the Administrators' Growing Workload

Introduction: Stressors from the pandemic continue to change both the way people work and the availability of the workforce itself. Pressures on practice bottom lines are translating into longer days and more work for administrators. The reality of our positions today requires us to be more efficient to counter and overcome obstacles.
This interactive session is intended to provide insights, tips & tricks being utilized to maintain and improve our effectiveness. Please join us to learn and share.

Areas of focus

Operations

- Collaborate on progress reporting [Teams, Slack, OneDrive, Drive]
- Reduce meetings
- Introduce project management tools
- Digital ways to celebrate [Nectar, Kazoo, Fond]
- Instant messaging
- Upgrading your reporting/dashboard and analytics capabilities [PowerBI, InfoDive, PPS Analytics]

Human Resources

- Leverage HR platforms
- Consider virtual staff
- Consider outsourcing

Risk & Compliance Management

- Online compliance & education platforms [for tracking/training/reminding/reporting]
- Online staff training [BPH bootcamp, difficult cath placement, Urocuff, etc]

Organizational Governance

- Improving the administrator-physician leadership dyad
- Annual planning processes

Individual focus

Better Managing the Workload

- Set aside time for planning and organizing your day
  - Wake up earlier

  - Exercise your brain
  - Exercise your body
  - Utilize planning tools [Franklin Planner, Bullet journal, Moleskin, Clever Fox) *See resource page
- Eat the elephant one bite at a time (breaking down tasks and projects)
- Properly delegate
- Free yourself by saying NO more often and by holding others to accountable timelines
- Manage digital & physical clutter [Meeting/webinar invites, Intranet, Foxit vs. Adobe]
- Use meeting and other productivity templates for prep, agendas, and minutes [Monday.com, Any.do, Microsoft PowerPoint, Microsoft Notes]
- Organize important meetings & inspections dates on a shared drive
- Put your phone on silent
- Utilize digital organization tools [Any.do, Evernote, Microsoft To-Do]
- Set aside professional development time [Examples: Webinars, meetings, newsletters]
  - MGMA
  - The Assist Newsletter (www.theassist.com)
  - SnackNation Newsletter
  - LUGPA [https://lugpa.memberclicks.net/practice-management]

Pre-Meeting Resources
Digital organizing tools:
Any.do
officeotter.com
todo.microsoft.com/tasks

Meeting & Agenda templates:
https://youexec.com/presentation-templates/meeting-and-agenda-part-4

Physical planners:
https://nymag.com/strategist/article/best-planners-according-to-productivity-experts.html?utm_source=sem&utm_medium=p2&gclid=CjwKCAjwkaSaBhA4EiwALBgQaFeVbny1VtW2BGFTnU7Isxsb_KF5DZi27gMrqoLxkLqLg2CGI5R1SRoCRIUQAvD_BwE
https://shop.franklinplanner.com/store/

(Post-meeting resources will be sent as a follow up to the session)

LUGPA 2022 Annual Meeting
Practice Administrators Workshop

Breakout D: Optimizing Patient Place of Service Navigation: Clinic, ASC, or Inpatient
Location: Marriott Ballroom (Addison/Clark)
Presenters: Mark Painter, Chris Setzler
Dismissal: Carla Blue

Optimizing Patient Place of Service Navigation-Clinic, ASC or Inpatient

Overview of the Urology ASC Landscape

a. ASC Statistics in the Urology Space
b. Good, Bad and Ugly for ASCs
    i. Hospitals, CONs and goal alignment in diverse groups
c. Balancing Short-, Medium- and Long-term goals
d. Assumptions for Office vs. ASC for specific Procedures

Urology Patient Place of Service Navigation Study

a. Financial benefits of ASC vs. Office vs. Hospital
    i. Spotlight on Cystos, Interstim, PnBx, TURBT, Stones and new procedures

Next steps in Study

a. ASC Physical structure considerations
b. Navigation

Big Picture considerations

a. No Surprise Act
    ii. Functional impact
    iii. Patient Impact/Sales
b. The ASC role in next generation Payment structures

Notes

Notes

875 N. Michigan Avenue | Suite 3100 | Chicago, IL 60611 | www.lugpa.org