



WEALTH PLANNING FOR THE MODERN PHYSICIAN

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THRIVING IN A CHANGING HEALTHCARE LANDSCAPE WITH JERRY KELSHEIMER

David Mandell:

Hello. This is Dave Mandell, host of the program. Thanks for joining us. I've got a really interesting and knowledgeable guest today, Jerry Kelsheimer. Jerry actually is a repeated guest. He's been on here before. And so those of you who are listening, watching, and you find this interesting and you think, "Hey, this is someone I am learning from." If you want to go back, go to season one, episode 21. So now we're five years ago he's been on. God, time flies. Season one, episode 21, the last episode of season one, Jerry was on with a colleague of his and we went through some other topics. So let me tell you about Jerry and then we'll start up.

So, Jerry's the president of Medic Management Group. We're going to hear about that and what they do. He's been there since 2018 in his role. He's responsible for strategic planning, corporate growth and development, supporting clientele, achieving their business objectives. He leverages his expertise to increase his client's financial returns, enhance revenue cycle efficiency, mitigate manage risk, improved patient outcomes and satisfaction. Prior to this role, Jerry served as managing director and principal of Exodus Capital Partners, and he had roles at Fifth Third Bank and Huntington National Bank. He has his bachelor's in science and finance from Indiana University and is a graduate of the Huntington Executive Leadership Program at Fisher College of Business at the Ohio State University, which my partner Jason will be very happy about. And he's on the boards of the University Hospital's Health System, University Hospital's Cleveland Medical

Center, and a number of other healthcare institutions and will provide his full bio in the show notes. But that gives you a good picture of who he is and what his experienced. So, with that, Jerry, welcome back. Glad to have you.

Jerry Kelsheimer:

Well, I'm thrilled to be here and thank you for the invitation. It's amazing now how healthcare has changed in the last five years. The environment we're operating in has.

David Mandell:

Yeah, and that's what we're going to talk about today because you're on the front lines every day, understanding the business of health care. We're, at OJM group, obviously on the front lines of helping physicians and some practices on the financial piece and just like the wealth management piece, not revenues, not expenses, all that kind of stuff. So that's why I wanted you back because you can really give some insights to folks on the pulse of what's going on in the business of medicine. So, before we start to get into that, I gave a little bit of bio, but maybe you can fill that out a little bit about what are you guys doing for practices on the front lines every day? How are you helping docs?

Jerry Kelsheimer:

Sure, sure. Thanks for the question. So MMG is a professional service firm, not unlike your own. We've been delivering outsource administrative management solutions and advisory and consulting services to clinical practices all over the country now for more than 25 years. So simply stated, we're solving business problems for clinical entities. I'd like to say we're allowing our physician clients and practice leaders to focus on patient care and clinical activity, knowing that we're helping them maximize their cash flows and earnings and overall business performance.

So in some cases that involves us taking over critical elements of back office operations and execution, and others it may simply be our working with practices, med groups, hospitals to find performance opportunities and

essentially diagnose for opportunities and address issues, document past to revenue increase, cost reduction as you said, and overall performance improvement, finding unforeseen or previously unrealized opportunities. And my role with MMG, it's essentially to ensure that our team of now over 130 professionals remains highly qualified, adequately equipped and fully supported to help our valued clients reach their performance potential and their personal and professional goals.

David Mandell:

So, if I'm hearing it right, sometimes you get brought in by a medical practices management team to say, "We need some help, there's an opportunity, or we don't feel like we're being maximized or we feel like we could do better," and you're helping them improve, right? That's one piece of it. Right?

Jerry Kelsheimer:

Mm-hmm.

David Mandell:

The other thing I heard you say is sometimes you are actually outsourced. So maybe it's like, "Hey, we don't want to hire a bunch of people in our medical practice. We'd rather have you guys do it," and maybe that's more cost efficient or more headache efficient. You don't have to go build out a whole team or do the billing, coding. We could hire you guys to do that outside of our practice, sort of a back office. Is that right?

Jerry Kelsheimer:

That's correct, David.

David Mandell:

Yeah.

Jerry Kelsheimer:

In certain circumstances we may temporarily staff critical administrative roles. We may on an outsourced basis serve as a manager of certain back-

office functions and in other cases we're a full turnkey outsourced solution for various elements of administrative back-office services, revenue cycle included in that.

David Mandell:

And so, the temporary might be, "Hey, we lost a couple of people, we're kind of under the gun. We can't manage our practice without this. But again, we only have so much mental capacity. We could bring you guys in to steady the ship while we find other people, or you help us other people." That's also a piece of that?

Jerry Kelsheimer:

That'd be correct. We've had unanticipated attrition in a critical role. Office manager or a practice COO or executive. Could be that there's a major project that's underway. We simply don't have the competency or the capacity to address that with internal staffing. And it happens. There are those unfortunate circumstances or situations in our industry where somebody suspects a fraud or some other event that's forced removal of an individual from a key executive position or leadership position. And we're always available, anxious to help and ensure that we've got available capacity for those who need it when they do.

David Mandell:

Yeah. Okay. All right. And last question before we move on to sort of the state of where things are, but based on the number of professions you have, obviously you guys can go pretty high up the scale in terms of practices and administrative in hospitals even, et cetera. Do you have small practices? Meaning are there small groups or even solo that could use your help, could afford you, et cetera? Or what's your range of potential folks you could help?

Jerry Kelsheimer:

It's very broad. We've actually supported execution of several practice startups with sole practitioners in the first six months of this year. So, it could be one to two physicians in an office depending on the specialty to, some of

our largest clients would be well into the hundreds of physicians. But the vast majority of the number of our clients are going to be independently owned and operated medical groups and physician practice groups.

David Mandell:

Awesome. Okay, great. I wanted to set that stage so people watching or listening get a sense of where you're coming from, what your world is. So that's really helpful. So, you started off saying, "Hey, God, five years and some things have changed." But what are you seeing that's causing docs, midsize practice groups feeling that they're working harder without necessarily seeing a return on that extra effort? And I think that's an underlying reason that people even come to OJM Group because they need to be more financially efficient personally or in their retirement plan or what have you. But obviously you're seeing this on the front lines every day with just the business of healthcare. So, what's causing that, in your opinion, your expertise?

Jerry Kelsheimer:

We hear it often as well, and we see it. In the current healthcare business climate, it's going to be an aggregation of factors versus any one single challenge, I would say. And it tends to be an outcome of things that have evolved over time in terms of how maybe practices are positioned and how they're led, run and managed with that evolution exaggerated by current events. So, the environment's changed over the last eight to 10 years. You've seen it. Those who are listening have experienced it and we see it as well. Things like payer behaviors, declines in reimbursement, how the labor market has evolved and the expectations of our employees in a clinical environment. General compliance requirements and the implications of issues in compliance has changed. And one that we can't ignore, patient demands have become greater, the general influence of consumerism in healthcare and other cost structure pressures.

So if we're getting paid less and our employees are demanding more and our patients have increasingly greater leverage and choice and the rules of execution of our clinical businesses and operations are getting more

stringent, I would say we simply can't get away with running our businesses of medicine by accident, rather, we are going to need to be very intentional about tactical execution and discipline and oversight of our operations just to hold our ground, perhaps to be where we might've been from an earnings perspective some years ago.

David Mandell:

Yeah, well I think that's a very good point. And I think the young docs understand, I think all docs understand this. I mean, I think about my own family and my father would practice for 50 years before he passed away. It wasn't that they weren't efficient, but you could make a lot of mistakes. You could not have your eye on the ball as much and your income was growing every year and things were good. And I look at my brother who is more experienced in this stuff, and he's a solo cardiologist, so that's kind of a rare dinosaur to some degree, but he's had to do some reading for outside firms, echoes and things, whatever the entrepreneurship, the side hustle, the efficiency, renting some of his space to another doc, right?

Thinking and acting more intentionally to use your word about, "Hey, what am I going to do because I'm not getting paid anymore to see a patient." And like you said, my rent's going well, he owns his place, but my cost of employees going up, so I can't just continue to do what I do and expect my bottom line to improve or to your point, even hold steady.

Jerry Kelsheimer:

You maintain status quo. You're right.

David Mandell:

Just to maintain status quo, you've got to be thinking a step or two ahead. And I agree with that and I think that probably resonates with the people listening and watching to this. Do you think that is more pronounced in certain specialties? Sizes? Is this dynamic impacting everybody? I mean obviously there is a bit of a difference with aesthetics because they're not in the payer world, so there's a little bit different there. They also have some marketing

expense challenges and things like that. But what's your comments? What's your thoughts and experience on that?

Jerry Kelsheimer:

Yeah, I'd say generally speaking, there's a reality if you're feeling a bit tired, a bit challenged, feeling like you're working harder for less, you're all special, but you're not unique. I think the challenge is across broadband with the practice, specialties segments, geography, size, et cetera. Yes, depending on payer mix and some types of practices are more heavily weighted to patient pay, cash pay, you might be less affected, but nobody's off the hook and immune from the need to diagnose operating performance no differently than we might be diagnosing patients today. And the good news is though there are areas in any practice of any size, and they tend to be fairly common that we can get after to do something about it. Ultimately to find... Finding the inches, finding the basis points, the percentage points and margin that ultimately as physicians get us paid and allow us to take care of our professional and clinical staff.

David Mandell:

So, I think we don't want to be, and I know this isn't meant to be, and some people are probably listening or watching or saying, "God, yeah, tell me something I don't know," and, "What can we do about it?" So give us some nuggets or examples or a case study like, "Hey, this is the kind of thing we did for them, or these are the two or three things that often are the case." What's some of the good news when you're working with clients in terms of what can people do about it from a financial piece?

Jerry Kelsheimer:

Yeah. Well the good news is where we are getting involved and we're very active ongoing in multiple engagements. In fact, it's probably become the most pronounced area of our business. Those diagnostic assessments and executions where we're looking for business improvement, efficiency improvement, and it applies across broad range of types of practices, is our clients are getting traction, they're seeing a return on their investment of time,

energy and financial investment in business improvement diagnostics. And I could say that we tend to see solutions focused in any one of or perhaps an aggregation of five specific areas. One would be front desk execution, which includes scheduling and access as well as initiation of the revenue cycle. There's always room for lost transaction. From the time first call for scheduling is made and when we show up at our front desk, we're setting ourselves up for success across the continuum of how we make a dollar.

And secondly, I'd say administrative functional role definitions and accountability points perhaps have never been as important. Again, the things we have to do to run effectively and efficiently have changed. And yet many cases practices still run themselves and manage themselves in a way that's similar to time periods where there was a little bit more opportunity on the outside margins. Revenue cycle execution in general tends to be an opportunity area for most practices. And then fourthly and compensation practice, compensation modeling and alignment of comp structures to desired business outcomes could be a factor.

And then finally the fifth area would be market development and refinement. So knowing where our margin comes from in our clinical business, not clinical practice, but in our clinical business and being intentional about what we want to do for whom, and perhaps in some cases what we don't want to do. And then another area that's less controllable than that top five, but should be an area of focus for a practice that feels like we should be doing better for how hard we're working would be payer contracting and payer management. Again, less controllable than the other five, but something we don't want to go to sleep on.

David Mandell:

Jerry, what was number four? I want you to repeat that. I was taking a note and I want to make sure I understood that one.

Jerry Kelsheimer:

Sure. Number four would be market development and market assessment. So in our given practice, many times practices have evolved over the years to be what they are. We essentially deliver the services we deliver to the market we deliver it to because it's the way it's always been. I think in current times, understanding where we get our margin as we deliver healthcare, what specific services and for what specific population is not necessarily something that we can make broad changes in, but simply having an awareness of what we do for home can affect strategy, tactical execution, and where we want to focus our resources and our time in order to get highest and optimal amount of return.

David Mandell:

So I want to drill down on that one just so I have it here. And I want people who are listening, so they're the front desk, which makes sense. First opportunity. This is where you could be losing potential patients and revenue right from the get-go or you could be... Any marginal improvement there might pay off for a long time, right? Management of staff, that's kind of Business 101 right? MBA 101. You want each role to be doing better, that grows profitability, that can grow revenue, that can grow the organization, et cetera. And imagine that is something that is lacking in a lot of medical practices because whether it's a law firm or medical practice, et cetera, none of us were trained, even a wealth management firm, to be employers, to be managers. I mean, I have an MBA, it's not like I'm an HR expert. So there's that. Billing, coding. Obviously you want to get every last dollar you can and that makes sense.

But let's just talk about the marketing for a second because I think it's just interesting to understand where are your patients coming from? It would be interesting, and I bet a lot of docs don't really understand that if they have a pretty good, "Well, I get a fair amount of referrals from this doc because I know him and he will send me people." Et cetera, or patient referrals or people come into their health insurance website and say, "Who's covered in this specialty in my area?" But marketing is something I'm passionate about. And I think understanding where your patients come from because to your point, it

might be, "Hey, you're actually getting more patients from referrals than you think." So maybe spending one dinner a quarter to take out a couple of GPs that send you business is the best thing you could do to make some more money and not having to be just working harder to make that same dollar. So that's just one example I think that would probably fit into a lot of other options. But the first thing is you got to know where your patients are coming from, right?

Jerry Kelsheimer:

Yeah, I would add to that too. And this will vary by practice specialty and segment in type, but if I, as a physician provider, and especially in multi-provider offices, I look at the pie chart, so to speak, of how I spend my time. There are things that we do that we get paid more for than others. In rigorous discipline business models, we always work to push work to the lowest cost point of functional execution. So if I wake up in the morning or I start my... On Sunday night, I think I'm going to start my week on Monday relative to how I want to spend my time, in many practices, there can be opportunities to optimize the return on a physician provider's use of time financially or economically based on what work we choose to do and who we choose to do. And that doesn't mean we turn away patients necessarily. We may find other ways to serve our patients in certain circumstances.

David Mandell:

It makes total sense. That's why physicians don't answer the phone at their practice. I mean, that's the most extreme example. I use that all the time because everybody gets that. But that discipline all the way up and down the workflow in a business makes sense. I mean that's why extenders and PAs and all that have developed over time. In the investing world, there's something that we call the efficient frontier. It comes back to Finance 101, if anybody took finance. It comes from Nobel Prize winning financial theory, which is the concept of you want to get the most return out of any level of risk. And it's sort of a theoretical line there. And that's sort of what we're talking about is use your time as efficiently as possible. Probably everybody who's listening to this because they're motivated is probably better than the average doc, that's

why they're on this podcast, et cetera. But there's probably room for improvement all the way along.

Jerry Kelsheimer:

Right. And extend this conversation into administrative staffing. So as a business executive, I fully appreciate that I have many people in my organization that are more technically qualified to do their jobs than I am to be able to tell them how to do them. But it doesn't mean that I, as an effective executive, shouldn't create boundaries and KPIs and set clear expectations that those individuals would be held accountable to. It's always interesting to me, and this would be very, very typical. In fact, I don't say it's just ordinary. If we sat with a practice leader and we look to sync up what their administrative staff, let's say front desk or office manager or revenue cycle specialist, those that are handling billing and coding or credentialing, when we ask the physician leader what they think their team members are spending time on, and then we contrast that with the interviews and the observations that we've done and how their team is actually spending time, would it surprise you that there are often variances?

David Mandell:

No.

Jerry Kelsheimer:

I suspect not.

David Mandell:

No. No.

Jerry Kelsheimer:

And it's amazing at times the tens of thousands of dollars that can be found in reconciling those variances.

David Mandell:

Yeah, yeah, totally on board with that. I want to shift to a question more rather than on the number side, but on the what I would call sort of work-life, not work-life balance, but sort of let's just get to the word burnout. Okay? What are you seeing and what are some of the things that you're talking to physicians about outside of finance, outside of making it more efficient but making them so they don't feel like they want to quit or they want to just take a sabbatical. How are you dealing with that and helping practices deal with that issue?

Jerry Kelsheimer:

I think much of it comes down to relative level of self-awareness and willingness to motivate change and to be a part of change. So I often refer to the Four Seas, as many of our clients are doing well, let me start with this, but they feel stresses either personally or maybe they are sensing some stress and some fragility in their business models, and they do just want to do better and to get better. And so we talk about Four Seas, the first one being conscience, the second being competency, the third capacity and the fourth courage. So I always encourage our clients and our prospective clients to ask themselves these questions. Number one, am I really conscious of what is happening around me? Do I have this level of consciousness that tells me something needs to change? And sometimes that's the case, sometimes maybe less so. Secondly, do I have in and around me, in my office or in my infrastructure, in my organization, the competency to support where I am, where I want to be, where do I want to go?

And many times the answer to that question is, "Yes, I have competent people around me, and yet I may be tested with the level of capacity that I have in that competency." So that would be the third sea. And if I don't have that capacity, I have to be thoughtful and intentional, purposeful about how I'm going to address that gap. And then finally and fourth, and I think is probably the most relevant word on the list is courage. And if I've been doing what I've been doing the way I've done it for an extended period of time and I haven't gotten bad results, I have a good lifestyle generally speaking, and I realized

there's risk in doing things differently, am I willing to take mitigatable risks to get different outcomes? Do I have the courage to execute a bit differently?

Both as it relates to how I run my practice perhaps, as it relates to how I spend my time, as it relates to who am I delegate to and how I do that. And again, much of that comes down to what is my true threshold of pain and what's my relative awareness and consciousness about what's going to get me to where I want to go and be in terms of just general peace of mind and healthy life balance and life situation.

David Mandell:

I mean, there's that old expression, if it ain't broke, don't fix it. But I think that's a relative scale. So to your point, again, people who are watching this, listening to this probably don't have a dysfunctional practice in a big sense. They're not losing money, they're not going to bankruptcy, not they're not having patients who are totally dissatisfied, getting one star reviews. And there's another business book Good to Great, which is a great business book. So somewhere in between, if it ain't broke, don't fix it and Good to Great is where a lot of people are, right? Things are okay, they're pretty good I guess, but I know it could be better.

And when do those stress points say, I'm willing to do something that I haven't done before? Hire a firm, look at everything, sort of start fresh and everybody has a different answer to that question. And I would say there's not even a right answer. It's a right answer for that provider, for that group, et cetera. And to your point on courage, if you've already been doing it one way for a long time, it takes some fortitude to say, "I'm going to change," because there's going to be some pain involved, right?

Jerry Kelsheimer:

Yeah, always is. Change is part of it. The other thing that I see get in the way of practices reaching potential is the capacity perspective. I've got a full-time job. I'm seeing patients. The day I've got off, I'm taking care of administrative

things or I need that for the sake of my balance and my psychological well-being. I don't have the time to take something apart and put it back together just to make sure that the gears are well aligned and that we're positioned and to be successful facing the demands of today, not facing the demands of five years ago, which were different.

So we're increasingly seeing in the marketplace as physician leaders who are progressive thinkers who want to do better, who want to be better, realize that, "I'm likely going to need to get some third-party support to help me with this effort." And after they reflect and review, they accurately can conclude that getting third-party help or assistance going to actually have a high return on investment. Investment, not just of perhaps what you pay somebody to do it. And keep in mind if done right, we're paying somebody that's going to bring best practices, observations of what they've seen work for many other practices of similar type, size and scale, but also return on time that they'll invest because it does take something to drive change.

David Mandell:

For sure. I mean, when we get clients who engage our firm to do a review of all their personal finances, their personal insurance, their investments, their tax, their asset protection, their estate planning, all of that, it was going to take some time. Time to gather the documents, time to get with us on Zooms like this, to go through those, to listen to our recommendations and if they like some of them to implement them. There's a commitment there. But if people want to improve their financial situation, I tell them they either should do it with us or with another firm. I mean, there's no other way to get there. You got to put some work into it. We try to make it as minimal for them and as easy for them to do it and gather and do all the work and make it on their time, et cetera. But it's the same thing with the practice.

Jerry Kelsheimer:

But there's value. At the end of the process, one's in a better place than when they started. And likewise, when I look at the business environment that clinical operations execute in today, the winners I see are the ones that are

taking action. They're not waiting for things to change, which can be the tempting thing for a successful performing practice that is seeing margin dilution over time or the need to work harder just to hold ground. These are practices, physician leaders who are operating and managing their practices, clinical businesses with a much heightened degree of attention, rigor, and discipline perhaps then they would have.

And again, maybe they've come up with the models, the methodology, the rhythms on their own. If not, they've gotten somebody to help them with that. There are practice leaders that are adding definition and accountability to operational execution and what success looks like. They're becoming more KPI focused, knowing what to look at to identify one-offs or observations before they become trends that we just get numb to. They're ensuring that we're aligning execution with outcomes and paying attention to details that simply might not have mattered as much in the past.

David Mandell:

Yeah, that makes sense. One question left, and I need a shorter answer because I'm respectful of everybody's time. What do you see coming down the road next five years? I have you back on in season 11, and we'll probably have you on before then, but let's just say we want one to six. What do you think maybe one, two, three things that you think might be different in the next five years?

Jerry Kelsheimer:

Yeah, well, we could spend an hour on that topic for sure. I think a continuance of some of the trends that we see today around reimbursement competition, technology, et cetera, would be my answer to number one. What's happening is the general environment we're in isn't going to go away. As a broader point, I would say continued moves in the patient environment towards consumerism. And that's not just driven by the patient. That's also going to be influenced by payers and by employers who are looking to reduce healthcare costs. So access, efficiency and cost in that regard. And then also, one of the things that I do certainly see and since and then also see

changing is the economics of employment models in large hospitals are likely going to have the hospitals less aggressive, less interested in employing at scale and looking for alignment models, looser control models as they work with independent-

David Mandell:

Partnerships, you're saying?

Jerry Kelsheimer:

... practices versus large staff [inaudible 00 36 16].

David Mandell:

You're saying partnerships more than employment model? Is that what you're saying?

Jerry Kelsheimer:

Yeah. You see cycles and things across the world in general. We saw a period of time where hospitals were very aggressive in acquiring practice groups and looking to employ physicians in an aggressive way under aggressive compensation models. Touring environment hospitals are challenged no differently, in fact, in many cases, more so than what we see specialty practices and other independents in current environment. And as such are going, I believe, to be less apt to overpay for practices a from an M&A perspective, and to rationalize compensation models relative to productivity expectations in a way that becomes a less desirable, perhaps, model for physicians to want to migrate to. And so in order to maintain patient flow into hospitals, I think you'll continue to see creative ways for hospitals to reach into the independent landscape to seek alignment, both formal and informal alignments with independents to feed referral volume and likely some disposition of staffs within certain specialties out of the hospital market into the independent landscape.

David Mandell:

Interesting. Well, when we get you back on in five years, we'll see where we are with that. I think maybe that's a topic that we can't wait for five years, maybe in the next season or two, we'll dig in a whole topic on where things are going. But Jerry, really appreciate you being on. Very helpful, very insightful. We will put, obviously in the show notes, a link to Jerry's firm, his full bio, et cetera. So if this was something that as you're listening and watching you think, "Hey, I might want to have a conversation with them," we're going to make it easy for you to find. Obviously I mentioned season one, episode 21, you can hear more with us, and there was a partner of Jerry's on that one as well. So Jerry, thanks for being back. Really appreciate it.

Jerry Kelsheimer:

Oh, thank you for having me. And it's always a pleasure to be with you, and thanks for the great job that you do for your clients. I know they appreciate it, and we do as well.

David Mandell:

Excellent. All right, so for everybody watching and listening, number one, I'm always told by my mark and people to tell you, if you like what you're hearing, give us a five star review, leave us your comments, tell your friends and colleagues about us. And as always, there'll be another episode in two weeks. Thank you for tuning in.

Jerry Kelsheimer:

Thank you everybody.