Lessons for Financial Success
Lessons for Financial Success
Medical Group Management Association® (MGMA®) publications are intended to provide current and accurate information and are designed to assist readers in becoming more familiar with the subject matter covered. Such publications are distributed with the understanding that MGMA does not render any legal, accounting or other professional advice that may be construed as specifically applicable to individual situations. No representations or warranties are made concerning the application of legal or other principles discussed by the authors to any specific factual situation, nor is any prediction made concerning how any particular judge, government official, or other person will interpret or apply such principles. Specific factual situations should be discussed with professional advisors.

Production Credits
Executive Editor: David N. Gans, MHSA, FACMPE
Project Managers: Christopher Stokes, MD, MBA and Alyssa Lowell
Managing Editor: Ruth Gaulke
Page Design: Virginia Howe
Cover Design: Peggy Garrett
Proofreader: Kelli Davis

Lessons for financial success.

Summary: “Designed to assist physicians and office managers to reduce waste, improve practice efficiency and work flow, and pass the savings on to their practice's bottom line. Without either personal business acumen or the ability to hire a professional administrator, physicians in small practices need information on effective business procedures”--Provided by publisher.

ISBN 978-1-56829-310-3
   R729.5.G6L47 2009
   610.68'1--dc22
   2009035722

Copyright © 2009 Medical Group Management Association. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the copyright owner.

CPT codes copyright 2007 American Medical Association (AMA). All rights reserved. CPT is a trademark of the AMA.
Contents

Acknowledgments ................................................................. iv
Foreword ................................................................. v

Chapter 1 ■ Benchmarking Basics ........................................... 1
Chapter 2 ■ Patient Safety, Quality and Satisfaction ............... 17
Chapter 3 ■ Accounts Receivable and Collections ................... 39
Chapter 4 ■ Profitability and Cost Management ....................... 59
Chapter 5 ■ Productivity, Capacity and Staffing ....................... 89
Acknowledgments

Lessons for Financial Success available through a fully funded grant generously provided by
United Health Foundation www.UnitedHealthFoundation.org.

Special recognition goes to our advisory board members who reviewed and approved the content:

Alan J. Beason, MS, FACMPE, CEO / Administrator, Cardiovascular Consultants LLP, Shreveport, LA

Emily Callaway, CMPE, Executive Director, Morton Plant Mease Primary Care Inc., Clearwater, FL

Susan Gardner, Project Manager, Northwest Permanente PC, Portland, OR

Ina Roberts, Chief Operating Officer, Aurora Denver Cardiology Associates PC, Aurora, CO

Frederic Simmons, CPA, CMPE, Chief Executive Officer, Clearwater Cardiovascular & Intervention Consultants, Clearwater, FL

Lee Ann Webster, MA, CPA, FACMPE, Practice Administrator, Pathology Associates of Alabama PC, Birmingham, AL
Foreword

Today's medical practices face an uncertain future. As an industry, physicians are under intense scrutiny in the debate over healthcare reform while they have to contend with increased expenses and constrained reimbursement. Physicians are in the unenviable position of needing to improve productivity without increasing operating costs. At the same time, they must function in the administrative complexity of the U.S. healthcare system that drives up costs due to duplicated efforts, lack of standardization, rework and other forms of waste.

This seemingly daunting situation involves physicians who seldom have formal management training. These physicians, most often in solo and small practices, will be unable to hire a professional administrator and therefore have to assume the burden of seeking information on effective business procedures to run their practices.

In response to this need, the MGMA Center for Research, funded by a grant from the United Health Foundation, developed “Lessons for Financial Success” a five-chapter, print-on-demand resource packaged with online tools designed to assist physicians and office managers to reduce waste, improve practice efficiency and work flow, and pass the savings on to their practices’ bottom line. The information, data and real-life examples contained in this resource are based on the best practices demonstrated by MGMA better-performing medical groups. Lessons for Financial Success features numerous success stories, describing the experiences of medical groups selected for their superior productivity, cost efficiency, and business office operations. Additionally, this resource provides direction on assessing patient-safety risks and improving the quality of patient care.

The medical practice industry will continue to evolve, but the basic techniques for improving overall business operations will not change. Please use this resource as your guide to key business techniques and be sure to access Lessonsforfinancialsuccess.com for online tools designed to further help your practice provide quality care, at the most efficient cost.

David N. Gans, MSHA, FACMPE
Vice President Innovation and Research
Medical Group Management Association
Lessons for Financial Success

CHAPTER 1

Benchmarking Basics

WHAT YOU WILL LEARN

✓ What benchmarking means to a medical practice
✓ Reasons to benchmark
✓ Benchmarking methods
INTRODUCTION

Practices benchmark to gain a deeper understanding of where they are, where they want to go and how to get there. The current state of healthcare – constantly changing and growing in complexity – dictates more elaborate and accurate methods of measurement, analysis, comparison and improvement. And because long-term success relates to a practice’s ability to identify, predict and adjust for changes, properly used benchmarking can be the best tool for overcoming those challenges.

WHAT’S COVERED

This chapter defines benchmarking, provides reasons to do it and describes how to do it. You will also find benchmarking examples to help orient you to the most important concepts. Excerpts from success stories and best practices in the MGMA Performance and Practices of Successful Medical Groups Report describe real-life benchmarking examples of practices rated as better-performers.

Delve into this chapter to learn the nuances of benchmarking and see how adding this concept of measurement will broaden your knowledge and help create a path to furthering the success of your medical practice.

IN THIS CHAPTER

✔ Overview
✔ Benchmarking essentials
✔ Success stories
✔ Best practices
✔ Examples
✔ Summary
✔ Discussion topics
✔ Glossary
✔ Benchmarking data from MGMA survey reports
✔ Appendix

OVERVIEW

Benchmarking allows you to answer the question, “How are we doing?” The term can be defined as measurement and comparison for the purpose of improvement. Medical practices measure and compare internal and external performance areas such as number of patients, patient satisfaction, staffing, revenue, physician compensation, operating expenses, accounts receivable and productivity.
Most important, benchmarking consists of more than a simple comparison of two numbers. The true value of benchmarking lies in the numbers combined with an understanding of the current state of the practice, calculation of the difference between the current state and a new value or benchmark, knowing the context and background of the practice values when interpreting the results, deciding on a course of action and goal, and determining when the goal is achieved.

And by measuring and comparing work processes over time, benchmarking can help you determine best practices, which are proven processes that produce superior results. Your practice’s processes will benefit from measurement against industry standards. Those standards can be from the healthcare industry or another industry. For example, the Disney Corp. emphasizes standards for customer service, and Wal-Mart highlights standards for cost containment.

**BENCHMARKING ESSENTIALS**

**Why do it?**

Benchmarking your practice can be used to:

- Evaluate performance and to aid in understanding a practice’s strengths and weaknesses
- Observe where a practice has been and predict where it will go
- Analyze what others have done, and learn from their experiences
- Determine how the better-performing practices achieve their performance levels and what methods they use to implement their processes
- Convince physicians and staff of the need for change
- Identify areas for improving practice operations and the bottom line

**How do I benchmark?**

Initially, you need only to pick the measures most important to the practice and set a baseline (where you are today) for each measure as a starting point. This allows you to use that baseline value to compare that same performance at a point in the future. A baseline can be an internal benchmark (historical measure) or one taken from an MGMA survey report that contains a value from similar practices.

To calculate the difference (delta) between your baseline and a current value (benchmark), simply subtract the baseline value from the benchmark. To go one step further, you could determine the percentage change of the measurements. This helps you assess change over time or determine the proportion of one value in comparison to another.
You may hear the terms *mean* and *median* applied to benchmarking. *Mean* is just another term for *average*. It is the sum of all the numbers divided by the total count. For example, if 50 practices responded to the MGMA Cost Survey, you would divide the question responses by 50.

The median represents the true center of the dataset with an equal number of data points above and below it after the dataset values are placed from lowest to highest. However, if you have an even number of data points after arranging the dataset from lowest to highest, calculate the median by averaging the two data points in the center. And it’s important to note that the median is not affected by outliers (values in the data set that are very high or very low when compared to the rest of the dataset). So, if you are in doubt about which value to use (the mean or the median), choose the median because it gives you a truer picture by representing a value that is exactly in the middle.

**SUCCESS STORIES**

**ABCD Pediatrics**

A motivated and experienced staff working in a well-designed space helps ABCD Pediatrics stay on track with an ambitious growth plan. How ambitious? The seven-physician group wants to double — perhaps triple — its capacity in the next few years. The two physician partners who own the practice see expansion as the best way to combat stagnant payer reimbursement and rising expenses.

**Background**

ABCD Pediatrics was established in 1989 in the growing northern suburbs of San Antonio. Since then, the independent physician-owned group has seen its patient base boom in step with the surrounding area’s rapid growth. When the practice’s founding physician left in 2000, the two remaining partners initiated a 10-year growth plan. Today, ABCD Pediatrics offers the services of seven physicians and two certified pediatric nurse practitioners supported by a staff of more than 32 at two locations. The opening of a satellite office in October 2007 in a nearby community has helped to ease the space crunch – for now.

**Success factors**

The practice’s new physical plan and an electronic medical record (EMR) help improve patient flow and provider productivity while giving physicians more quality time with patients, says Victoria Waltemath, practice administrator. Waltemath says she keeps a close eye on expenses by “touching” every vendor services contract each year.

“We might stick with a vendor that’s more expensive because they offer better service, but they have to know that ABCD Pediatrics looks at the market every year, even on long-term contracts,” Waltemath says. “It helps build a better relationship.”
Benchmarking

Physicians and nonphysician providers at ABCD Pediatrics work on a base salary plus a productivity bonus arrangement. Each month, the practice’s owner-physicians review the monthly performance of all physicians and nonphysicians. The review includes checking patient volume and charges per physician and provider. Each month, Waltemath and the two owner-physicians review the practice’s balance sheet, income, expense, and cash-flow statements, and detailed productivity reports for each physician and nonphysician provider.

“I also choose one thing each month for them to focus on — something they don’t usually see — like our payer ratio or the percentage of patients by payer,” Waltemath says. “I want them to see where their collections come from.”

From time to time, Waltemath says she also looks at the number of patients per hour, phone calls per day, empty slots per clinic and other data.

“I don’t spend a lot of time on those numbers, but I like to see if any trends are developing,” she says.

ABCD Pediatrics participates in the annual surveys of staff salaries conducted by MGMA and by the San Antonio MGMA.

“I want to know what the range is in our market for positions so I can offer a competitive salary,” Waltemath says. “We will start someone at the middle to upper part of the range if they are experienced, and I don’t mind paying an experienced medical assistant like she’s an LPN if she’s going to be doing a lot of the same work.”

Final thoughts

Given its track record since 2000, ABCD Pediatrics can most likely double or triple in size, but Waltemath acknowledges that managing that growth may be the more difficult challenge. She adds that the practice has even tried to slow down growth, for example, by no longer accepting same-day appointments for patients who have not already registered with the practice.

“It’s clear that we are doing something right as far as the patients are concerned,” she says. “I also feel fortunate that the physicians have some business savvy — they aren’t trained in those areas, but they really do have a business sense.”

May Grant Associates

Founded in the 1960s, May Grant Associates, Lancaster, Pa., is named after its two founders — John May, MD, and Allistar Grant, MD, who built a reputation for patient service. Recruiting certified nurse midwives in the 1980s not only gave them a second pair of hands and eyes to cover labor and delivery but also pleased patients who sought the personal touch in healthcare. Today, the group features a 15,500-square-foot main office, which can support nine providers.
at one time, and five satellite offices. The group has 102 employees and nine physicians who are partners or on the partner track.

**Success factors**

Bryan L. Yingling, MD, managing partner of May Grant Associates, points to three factors in the group’s record of success for more than four decades: a reputation for quality; individual patient care; a variety of professional providers; and affiliation with Lancaster General Hospital, which has national recognition.

“Our greatest asset is our absolute commitment to providing an outstanding patient service experience,” Yingling says. “From the time the patient arrives at the front desk until they leave, that patient is our prime focus.”

**Benchmarking**

May Grant Associates lives by the data it pulls in from its practice management and accounting systems, including the numbers of:

- New patients
- Obstetrics patients
- Encounters per month by provider and by ancillary service
- Surgeries by physicians

Mona Engle, RN, practice administrator, says the group regularly keeps tabs on revenue and collections by payer, site and provider. In addition to tracking coding trends and the geographical distribution of new and current patients, she says she and the physicians also review the results of patient satisfaction and referring physician’s surveys. A new survey randomly selects scheduled patients just before their appointments and asks them to confidentially act as “mystery shoppers” and report their service experience. Engle says getting data is only the first step. The practice also makes sure to use information to answer questions such as:

- How can the group tighten up billing and collections? A year ago the practice started collecting copayments at check-in instead of check-out.
- What procedures or policies can enhance patient care? The practice is evaluating consent forms and ways to get better documentation into charts.
- How can the group improve employee service? The practice does monthly in-service education.

**Final thoughts**

Engle says she meets with Yingling at least once a day and that the constant contact with a physician who also is the practice’s president provides valuable new perspectives.

“There are aspects to the business that can only be seen through the administrator’s eyes, and there are others that can only be seen through the partner’s eyes,” Engle says. “Working together like this gives us the best of both worlds.”
BEST PRACTICES

Although several benchmarking methods exist, this simple 10-step benchmarking process will help you get started.

Ten-step benchmarking process

1. Determine what is critical to your organization’s success and understand current processes and information
2. Identify metrics that measure the critical factors
3. Identify a source for internal and external benchmarking data
4. Measure your practice’s performance
5. Compare your practice’s performance to the benchmark
6. Determine if action is necessary based on the comparison
7. If action is needed, identify the best practice and process used to implement it
8. Adapt the process used by others in the context of your practice
9. Implement a new process, reassess objectives, evaluate benchmarking standards and recalibrate measures
10. Do it again – benchmarking is an ongoing process, and tracking over time allows for continuous improvement

Benchmarking – an art and science

Some call benchmarking the art and science of comparison. The “art” takes place during the data-gathering and interpretation phases and requires a method with some common sense, whereas the “science” includes the systematic and logical process of analysis. After both of those phases take place, the data become information that can be used for comparison and decision-making. Exhibit 1.1 illustrates typical metrics and associated benchmarks. Definitions of the terms can be found in the glossary.

Exhibit 1.1 Examples of Benchmarks for Family Practice, Single-Specialty Groups

<table>
<thead>
<tr>
<th>Metric</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>25th Percentile</th>
<th>Median</th>
<th>75th Percentile</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters per FTE physician</td>
<td>6,569</td>
<td>2,188</td>
<td>4,945</td>
<td>6,250</td>
<td>7,444</td>
<td>10,762</td>
</tr>
<tr>
<td>Total procedures per FTE physician</td>
<td>10,760</td>
<td>4,734</td>
<td>7,181</td>
<td>10,142</td>
<td>15,274</td>
<td>16,773</td>
</tr>
<tr>
<td>Physician work RVUs* per FTE physician</td>
<td>6,266</td>
<td>2,178</td>
<td>5,743</td>
<td>6,255</td>
<td>8,272</td>
<td>8,996</td>
</tr>
<tr>
<td>Total RVUs per FTE physician</td>
<td>11,560</td>
<td>3,426</td>
<td>9,514</td>
<td>11,229</td>
<td>13,466</td>
<td>17,125</td>
</tr>
</tbody>
</table>

* Relative value units

Benchmarking – the future of healthcare

The process of benchmarking continues to evolve and expand to meet both present and future requirements. Take for example, the Physician Quality Reporting Initiative (PQRI) and the payers’ physician rating systems. By using either self-reporting data (PQRI) or claims data, these payers benchmark the performance of individual physicians and overall practices against expected standards of care as well as the overall costs of care. As with benchmarking specific managerial data against prior data from the practice to detect trends, or comparing the practice’s performance against peers, these efforts at comparing physician and provider performance against expected values (standards of care) allow the practice administrator and physicians to gauge their clinical performance and set the stage for investigating opportunities for improvement. For more information about PQRI, visit the MGMA Web site.

Life Moves Pretty Fast – Some Thoughts on Benchmarking

By W. David Holloway, MD, and Lisa Holloway, MS

This excerpt, taken from an article published in the Performance and Practices of Successful Medical Groups; 2002 Report Based on 2001 Data, provides a realistic view of benchmarking by two people in the field.

David Holloway writes:

My son created a screensaver with the movie line, “A man with priorities that are messed up does not deserve such a fine automobile as this.” My wife particularly likes the statement, “Life moves pretty fast. Sometimes you have to stop and look around or you might miss it.” And me, well, I just want to be like Ferris Bueller. You’re probably wondering, though, how Ferris Bueller relates to the topic of benchmarking and its role in organizational learning.

Ferris is an authentic learner who knows that school isn’t necessarily relevant to the core processes of life that he wants to learn. He’s got the adventurous, inventive, never-settle-for-mediocre kind of spirit that we need to deliver quality care. It’s doubtful that Ferris would be the MBA scholar waving his hand with the answer to the question, what is benchmarking? However, if called on, he’d probably say that benchmarking is the process of stopping and looking around. So, in the spirit of Ferris, as I offer some ideas on benchmarking, let me begin by admitting that I do not find the word “benchmarking” jazzy or sexy. In fact, it sounds like a dry, academic “ism.” However, words like curiosity, learning and exploration are definitely exciting to me, and these are the very things that make benchmarking a great idea when an organization wants to improve a key process or solve a vexing problem. What follows here is a works-for-me, practical approach to benchmarking as a method for process improvement.

Get the Question Right

“The question that you ask determines the results that you will get.” I don’t know who said this, but it is wisdom to remember in this first phase of
benchmarking. In trying to focus research topic questions, I’ve found it helpful to use an exercise called the Five Why’s. To enrich the perspective, gather together interested stakeholders, and begin with your preliminary problem or question. Then simply ask, “Why?” As you get an answer, ask, “Why?” again. Do this five times. You might find that an initial statement like, “We need to hire more nurses” will evolve into, “We need to free up nurses to spend more time with the patients.”

**Sketch Your Current Process**

Take a “before” snapshot of the process that you want to improve. Ask your stakeholders to help you sketch the general progression of actions that constitute the current process. Don’t get bogged down in every procedural detail at this point.

**Discover Who Does This Best and How Do They Do It**

Now it’s time to go exploring. Reviewing any measurement data you have related to the process you’re trying to improve is important. Otherwise, how can you determine if someone else’s process results are better than yours? A quick search on the Web will turn up some outstanding benchmarking software products and benchmarking companies and consultants. I must admit, though, that with the exception of MGMA, I’ve not used them. Lower-tech, less costly methods such as conferences and workshops, Web searches, networking, interviewing, business books and articles have met my needs for information and analysis so far.

In general, I explore three areas: our organization, other organizations within our industry and other kinds of businesses. And in all cases, I find out as much detail as possible through interviews, written material, site observation or whatever else the person or company being benchmarked is willing to share about the best practice being researched.

First, I look within. Often employees or departments have different approaches to accomplishing the same process. When people are free to accomplish the task in different ways, chances are that someone has found a best way of doing it. Does one workgroup or person consistently score better than others? If so, they may have discovered a best practice worth sharing with others in your organization. Here are two examples of benchmarking within:

1. There is always one physician in the group who is far busier than seems possible. We found that by making productivity reports available each month and by including names instead of disguises, physicians take note of the busiest. The physicians need no prompting to analyze the data and benchmark the best. For one physician, in addition to the numbers displayed in the productivity reports, surveys told us that his patients think he spends far more time in the exam room with them than he actually does. Many of our physicians, without prompting, have asked
for his secrets. He freely shares and allows others to shadow him. This is a simple and powerful form of internal benchmarking. Other doctors have changed their work flow and behaviors based on those observations.

2. Information, combined with a team, leads to even more powerful learning. We organized our physicians into teams, meeting once a week over breakfast or lunch, and reviewed each other’s utilization reports. We created the conditions for learning. During one meeting, a physician asked the five other doctors in her peer-learning team why they referred women with urinary incontinence to urologists. “Aren’t urologists surgeons? And isn’t incontinence usually a nonsurgical problem?” She sketched on a napkin how she handled this condition, and the others converted the napkin into a protocol they follow to this day. Five benchmarked the one.

Another way to benchmark is to look within the industry. When you need to improve the bottom line, we asked MGMA’s consulting area to work with us on staffing standards. They designed a staffing matrix that reflected various levels of productivity. The optimal level was so low that many doctors and staff were skeptical. We visited a clinic of similar size in Dallas running quite well with the new matrix and, in a matter of a few hours, learned several new processes and approaches for becoming more efficient.

The third area I explore is other kinds of businesses. Part of the key to innovation seems to be learning about fields outside of one’s expertise. When I want to make a major leap, my best success often comes from looking outside the medical field. Dell Computers, Amazon.com and my favorite local florist all do order, process and delivery pretty well. By researching these three diverse industries, I might discover similarities in their processes related to order, process and delivery that I could adapt for my organization’s use.

A process borrowed from Toyota was the key to the successful reorganization of our practice’s entire central business office. The goal was to create business processes with fewer errors. We studied various industries and saw that Toyota’s manufacturing approach of cross-trained small teams might make sense for us. The key to Toyota’s approach: teams, information and accountability. We converted our functionally organized (customer service, billing, posting, etc.) office into workgroups. A workgroup has three or four team members who handle all aspects of a business office for an assigned small group of physicians. The operation is now very modular, like an efficient manufacturer. As new physicians come on board, new workgroups can be created. The payoff: business office staff are more accountable for accuracy; communication between patients and business office staff has improved; and the system redesign has created better working relationships among physicians, clinical and business office staff.
**Adapt and Adopt**

At some time the exciting exploration period ends, and the last, most important step arrives. It may be tempting to grab onto a benchmarked process and implement it by saying, “OK, here’s how Best Company A does it, and they get magnificent results, so that’s how we’re going to do it, too.” Resist the urge because that would be missing the point of benchmarking. Take the time to evaluate if and how someone else’s best practice can be adapted into your organization in order to make it your best practice. Perhaps the most exciting thing about benchmarking is the learning that takes place about the process being studied. Here are just a few evaluation points to consider in the adapt/adopt phase:

- The cost of the new process;
- The effect on interaction with other processes and people in the organization;
- The implementation timetable; and
- Compatibility with the organization’s culture.

Life moves pretty fast. So does a group practice. By stopping to look around you can learn from others. The three steps:

1. Get the question right;
2. Sketch your current process, discover who does this best and how do they do it; and
3. Adapt and adopt to provide a workable approach to real-world benchmarking and process improvement.

**EXAMPLES**

**Mean vs. median**

*To calculate the mean:*

Average (Mean) = Sum of all data points / number of data points

*Example*

Data points = 101, 145, 167, 189, 192, 201

Number of data points = 6

\[
(101 + 145 + 167 + 189 + 192 + 201) / 6
\]

Average (Mean) = 995 / 6 = 165.8
To calculate the median:

If odd number of data points
Median = center data point
The data point located at the center position in the dataset when placed in ascending order; location of median = (number of data points + 1) / 2

Example
Data points = 101, 145, 167, 189, 192, 201, 213
Number of data points = 7
Location of median = (7 + 1) / 2 = 4th position
Median = 189

If even number of data points
Median = (two center data points) / 2
The two data points located at the center positions in the dataset when placed in ascending order; point 1 = (number of data points / 2) and point 2 = (number of data points / 2) + 1

Example
Data points = 101, 145, 167, 189, 192, 201
Number of data points = 6
Point 1 = (6 / 2) = 3rd position
Point 2 = (6 / 2) + 1 = 4th position
Median = (167 + 189) / 2 = 178

Formulas and ratios to measure practice and provider performance
Apply benchmarking formulas and ratios to:

Staffing
Support staff breakouts – areas where you can obtain counts of staff
- Total full-time-equivalent (FTE) Administrative Staff
- Total FTE Front Office Staff
- Total FTE Clinical Support Staff
- Total FTE Ancillary Staff

Use a formula to determine staff/expenses used in specific scenarios:
- Total FTE Support Staff per FTE Physician = FTE Support Staff / Total Physician FTE
- Total FTE Support Staff Expense per FTE Physician = FTE Support Staff Expense / Total Physician FTE
- Total FTE Support Staff Expense as a Percent of Total Medical Revenue = FTE Support Staff Expense / Total Medical Revenue
- Total FTE Support Staff Expense per Work Relative value Unit (RVU) = FTE Support Staff Expense / Physician Work RVUs
Accounts Receivable (A/R) & Collections

A/R can be the single largest balance sheet item. It’s worth spending time looking at different aspects of this asset.

- Total A/R per FTE Physician = Total A/R ÷ Total FTE Physicians
  Goal: Should be a low number
- Percent of Total A/R over 120 Days = (Total A/R over 120 days × 100) ÷ Total A/R
  Goal: Should be a low number
- Days in A/R = Outstanding A/R ÷ (Average Monthly Charges × 30)
  Goal: Should be a low number
- Gross Fee for Service (FFS) Collection Percentage = (Net FFS Revenue × 100) ÷ Gross FFS Charges
  Goal: Should be a high number
- Adjusted FFS Collection Percentage = (Net FFS Revenue × 100) ÷ Adjusted FFS Charges
  Goal: Should be a high number

Profitability & Operating Costs

Maximizing revenue and managing costs help practices reach their goals. Looking at a few key indicators will let you see how your practice currently performs.

- Total Gross Charges per FTE Physician = Total Gross Charges ÷ Total FTE Physicians
  Goal: Should be a high number
- Total Operating Cost as a Percent of Total Medical Revenue = (Total Operating Costs × 100) ÷ Total Medical Revenue
  Goal: Should be a low number
- Total Medical Revenue After Operating Cost per FTE Physician = (Total Medical Revenue − Operating Cost) ÷ Total FTE Physicians
  Goal: Should be a high number

Productivity

This area looks at physicians and how they perform, such as the number of patients they see, the number of encounters they perform and the amount of revenue they generate.

- Total Medical Revenue per FTE Physician = Total Medical Revenue ÷ Total FTE Physicians
  Goal: Should be a high number
- Patient Encounters per FTE Physician = Total number of patient encounter ÷ Total FTE Physicians
  Goal: Typically a high number (depends on the practice)
- Work RVUs per FTE Physician = Total Work RVUs ÷ Total FTE Physicians
  Goal: Should be a high number
SUMMARY

This chapter presented the nuances of benchmarking including how to do it, reasons to do it and why. You have the knowledge now to examine areas of your medical practice and determine its current status and future potential. You should be able to see how the practice is doing and compare the numbers with the practice’s numbers from a previous month or year (internal benchmark). Or compare the numbers with those of similar practices by using the MGMA Cost Survey Report (external benchmark). Either approach allows you to look inside your practice and have a better understanding of how it operates.

DISCUSSION TOPICS

Practice what you just learned with the discussion topics.

1. Focus on one area this month, such as number of patients by payer or the percentage of patients by payer and notice where the collections come from. Which payer brings the most dollars to the practice?
2. What’s critical to your practice’s success? For example, is the practice looking to add a physician or an electronic medical record system? Identify a few metrics that would help determine how to reach those goals.
3. Are you curious about the geographical distribution of patients because the practice may want to expand?

GLOSSARY

Baseline – a starting point in the measurement area
Benchmarking – the process of comparing performance to a pre-established standard or performance of another facility or group with the goal of determining best practices and achieving superior performance.
Best Practices – “Best practices” are defined as proven services, functions or processes that have been shown to produce superior outcomes or results in benchmarks that meet or set a new standard. However, there is no single best practice or “silver bullet.” Instead, “best” refers to what is optimal for a particular organization, given its patients, mission, community, culture and external environment.
Count – the number of responses.
Delta – mathematical result after subtracting a baseline value from the current value.
FTE – full-time-equivalent.
Mean – the average calculated by summing the data and dividing by the count (number of responses).
Median – the midpoint of all responses when lined up from lowest to highest.
Metric – appropriate method of measurement.

Standard Deviation – a measurement used to show the amount of variability (spread) within a set of numbers.

10th percentile – the value where one-tenth (10%) of the responses are lower.

25th percentile – the value where one-quarter (25%) of the responses are lower.

75th percentile – the value where three-quarters (75%) of the responses are lower.

90th percentile – the value where nine-tenths (90%) of the responses are lower.

BENCHMARKING DATA FROM MGMA SURVEY REPORTS

To illustrate some of the formulas presented earlier, this data table presents median, better-performing practices data and median MGMA Cost Survey Report data for a subset of specialties\(^1,2,3\).

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Family Practice*</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost Survey</td>
<td>BP**</td>
<td>Cost Survey</td>
<td>BP</td>
</tr>
<tr>
<td>Total FTE Support</td>
<td>4.75</td>
<td>5.43</td>
<td>4.73</td>
<td>5.65</td>
</tr>
<tr>
<td>Staff per FTE Physician</td>
<td>$209,922</td>
<td>$251,440</td>
<td>$185,231</td>
<td>$208,467</td>
</tr>
<tr>
<td>Total FTE Support</td>
<td>30.30%</td>
<td>27.58%</td>
<td>29.51%</td>
<td>—</td>
</tr>
<tr>
<td>Staff Expense per FTE Physician</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Total FTE Support</td>
<td>1.56</td>
<td>1.63</td>
<td>1.48</td>
<td>1.81</td>
</tr>
<tr>
<td>Front Office Staff per FTE Physician</td>
<td>$43,024</td>
<td>$42,581</td>
<td>$38,885</td>
<td>—</td>
</tr>
<tr>
<td>Expense per FTE</td>
<td>1.57</td>
<td>1.82</td>
<td>1.64</td>
<td>1.95</td>
</tr>
<tr>
<td>Physician</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

*Not hospital or IDS owned  **Better-performing practice  ***Relative Value Units

— Data not available


(Table continues on next page)
### Multispecialty

<table>
<thead>
<tr>
<th></th>
<th>Cost Survey</th>
<th>BP**</th>
<th>Cost Survey</th>
<th>BP</th>
<th>Cost Survey</th>
<th>BP</th>
<th>Cost Survey</th>
<th>BP</th>
<th>Cost Survey</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTE Clinical Support Staff Expense per FTE Physician</td>
<td>$54,404</td>
<td>$50,181</td>
<td>$54,304</td>
<td>—</td>
<td>$64,512</td>
<td>$64,151</td>
<td>$42,758</td>
<td>$41,951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FTE Ancillary Staff per FTE Physician</td>
<td>.67</td>
<td>.77</td>
<td>.65</td>
<td>.65</td>
<td>.92</td>
<td>1.18</td>
<td>.83</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FTE Ancillary Staff Expense per FTE Physician</td>
<td>$26,381</td>
<td>$28,683</td>
<td>$19,878</td>
<td>—</td>
<td>$52,072</td>
<td>$65,977</td>
<td>$35,357</td>
<td>$34,901</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total A/R per FTE Physician</td>
<td>$122,921</td>
<td>$93,350</td>
<td>$97,634</td>
<td>—</td>
<td>$253,761</td>
<td>$202,934</td>
<td>$315,190</td>
<td>$269,675</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of Total A/R over 120 days</td>
<td>16.84%</td>
<td>8.04%</td>
<td>13.15%</td>
<td>—</td>
<td>15.65%</td>
<td>8.66%</td>
<td>13.97%</td>
<td>9.62%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Fee for Service (FFS) Collection Percentage</td>
<td>57.68%</td>
<td>57.93%</td>
<td>69.05%</td>
<td>—</td>
<td>43.69%</td>
<td>43.97%</td>
<td>40.56%</td>
<td>48.04%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted FFS Collection Percentage</td>
<td>98.05%</td>
<td>100%</td>
<td>98.39%</td>
<td>—</td>
<td>98.56%</td>
<td>99.58%</td>
<td>97.41%</td>
<td>99.98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Gross Charges per FTE Physician</td>
<td>$1,076,662</td>
<td>$1,284,930</td>
<td>$849,172</td>
<td>—</td>
<td>$2,575,930</td>
<td>$3,114,200</td>
<td>$2,823,569</td>
<td>$3,241,664</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Cost as a Percent of Total Medical Revenue</td>
<td>61.19%</td>
<td>56.27%</td>
<td>59.74%</td>
<td>—</td>
<td>52.17%</td>
<td>47.44%</td>
<td>46.52%</td>
<td>44.19%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Medical Revenue After Operating Cost per FTE Physician</td>
<td>$272,460</td>
<td>$339,885</td>
<td>$239,118</td>
<td>—</td>
<td>$543,231</td>
<td>$752,850</td>
<td>$594,455</td>
<td>$742,484</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Medical Revenue per FTE Physician</td>
<td>$690,032</td>
<td>$864,137</td>
<td>$600,430</td>
<td>$635,094</td>
<td>$1,124,272</td>
<td>$1,304,574</td>
<td>$1,163,938</td>
<td>$1,515,639</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Encounters per FTE Physician</td>
<td>4,870</td>
<td>5,212</td>
<td>6,250</td>
<td>6,206</td>
<td>6,373</td>
<td>5,723</td>
<td>4,668</td>
<td>5,953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work RVUs*** per FTE Physician</td>
<td>6,024</td>
<td>6,088</td>
<td>6,255</td>
<td>8,272</td>
<td>10,588</td>
<td>11,767</td>
<td>10,893</td>
<td>18,028</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Not hospital or IDS owned  **Better-performing practice  ***Relative Value Units
— Data not available

### APPENDIX

Visit [mgma.com/lessons](http://mgma.com/lessons) for interactive tools that will help you practice the concepts presented in this chapter.
Lessons for Financial Success

CHAPTER 2

Patient Safety, Quality and Satisfaction

WHAT YOU WILL LEARN

✓ What patient safety and quality mean to a medical practice
✓ Three areas of patient safety and quality: teams, assessment and medication
✓ Ideas to measure patient satisfaction
✓ How patient satisfaction leads to overall practice quality
INTRODUCTION

Medical practices must keep patients safe and satisfied. This chapter provides methods and tools for medical practices that can be applied to the physician-practice setting. It’s important to mention that patient safety, quality and satisfaction mean more than just meeting basic patient needs. These terms, when applied in a practice, create employee awareness and an environment that puts the patient first. Your practice may already have many of these policies and ideas in place and may just need to revise them. You will also find ideas for implementing new policies and enhancing current work processes.

Delve into this chapter to learn the nuances of patient safety, satisfaction and quality of care, and see how understanding these concepts will broaden your knowledge and help further the success of your medical practice.

WHAT’S COVERED

This chapter introduces three concepts related to patient safety and quality: teams, assessment and medication safety. You will also read about methods to evaluate and improve patient satisfaction. Each concept provides ideas and tools to help you improve your practice and begin clarifying roles in achieving overall quality, patient safety and satisfaction. In addition, excerpts from success stories and best practices featured in the publication, MGMA Performance and Practices of Successful Medical Groups, describe real-life medical practice examples.

IN THIS CHAPTER

✓ Overview
✓ Patient safety, quality and satisfaction essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix

OVERVIEW

Creating a work environment that promotes teamwork and effective communication will allow you to take the first step toward ensuring patient safety in your medical practice. This first step includes providing employee communication training, allowing personnel to talk about safety errors and
suggest methods for improvement, and documenting and responding to patient complaints. When your practice works as a team, staff members’ attitudes, knowledge and skills improve, and your patients will notice the difference.

Step two of this journey addresses medical errors by assessing current processes to determine your practice’s strengths and weaknesses regarding safe patient care.

Finally, step three focuses on medication management, which plays an essential role in protecting patients from harm. This concept should be a regular item in all patient safety meetings and a key focus of your practice’s everyday protocols.

Even if these steps bring about improved patient satisfaction, be sure to measure and evaluate patients’ satisfaction regularly by polling both new and established patients. You will see observations from different points of view, as well as potential ideas for improvement.

**PATIENT SAFETY, QUALITY AND SATISFACTION ESSENTIALS**

**Teams**

Teamwork and communication skills may not come naturally – you must first learn, then practice them each day. The day-to-day medical practice realities — heavy workload patients with multiple caregivers and the complex steps involved in patient care — often get in the way of applying these skills. Applying teamwork principles to patient safety and quality begins by creating a sense of urgency around the need for improvement, as the practice may have experienced harmful incidents, poor marks on a patient satisfaction survey or staff concerns about quality and safety.

So, to start, understand that a team can be defined as two or more individuals who:

- Value and share a clear work vision;
- Have clearly defined roles and responsibilities;
- Exchange information, knowledge and skills;
- Coordinate activities necessary to complete tasks;
- Provide feedback without placing blame; and
- Trust other team members.

The makeup of a patient safety team varies by practice size and structure. While a smaller practice’s patient safety team may include all staff members, an average-sized practice (seven to 10 physicians) may only include key department representatives on its patient safety team. Larger practices may have a patient safety team organized by specialty. Practices with multiple locations should designate specific individuals at each site who are responsible
for the patient safety role. Regardless of team size or organization, each team should have a patient safety officer who has:

- The ability to see the big picture and understand how safety relates to healthcare;
- Superior interpersonal skills;
- Effective communication skills;
- Demonstrated integrity and trust among employees;
- Appropriate authority to ensure that all aspects of the practice's patient safety program are implemented; and
- Excellent follow-up skills.

Emphasizing open and direct communication is the next step to empowering your patient safety team. To achieve this, the team must:

- Use consistent terms to describe processes and procedures;
- Focus on delivering the message so that the person receiving the information understands it and can take the appropriate action; and
- Follow up to ensure that the information was delivered successfully.

Finally, the patient safety team must be an informed team. To accomplish this, short meetings should happen each day. Called daily huddles (see “Daily huddle agenda” in the Best Practices section), these meetings make all team members aware of issues such as staffing shortages, broken equipment or anything that may present a challenge to servicing patients that day.

Tools that show useful communication skills can be found in the Pathways for Patient Safety, Module 1. For example, the TeamSTEPPSTM technique called Situation, Background, Assessment, Recommendation (SBAR) helps team members share information by focusing on specific data related to a patient's condition and the required action. (See script in the Examples section.)

**Assessment**

Regularly assessing patient safety practices helps the staff do everything possible to ensure a safe practice for both patients and employees. However, it is difficult to create a plan for improving your practice's patient safety processes without knowing where you stand now. Patient safety includes many issues within a medical practice, which makes it difficult to know where to begin.

To help with this, The Physician Practice Patient Safety Assessment (PPPSA) was created to:

- Heighten awareness of the elements that make up a safe physician practice; and
- Establish a new baseline for efforts to enhance and sustain patient safety.
Designed by the Health Research and Educational Trust, the Institute for Safe Medication Practice and the MGMA Center for Research, with generous support from the Commonwealth Fund, the PPPSA will help you evaluate your practice's current safety practices and then measure your progress toward specific goals.

Use the PPPSA tool to:

- Gain specific ideas to improve patient safety;
- Compare practice data to summarized results from other practices;
- Enhance employee awareness of patient safety issues; and
- Prioritize results and define next steps in your patient safety improvement plan.

The PPPSA allows you to evaluate your practice in six categories:

- **Medications**: A number of patient safety risks relate to various aspects of medication use, such as asking patients to list all prescribed and over-the-counter medications.

- **Handoffs and transitions**: Patients often receive care from a number of different clinicians and facilities. Coordinating and tracking these clinical events can be challenging, and practices implement various manual and computerized systems to accomplish this task.

- **Surgery/anesthesia and sedation/invasive procedures**: Many physician practices perform surgery and invasive procedures that were once limited to hospitals. These activities create a variety of risks, including those associated with sedation and anesthesia.

- **Personnel/qualifications**: Physicians and staff must understand the elements of safe care and undergo continual education and skill evaluation.

- **Practice management/culture**: Practices should have in place consistent processes and procedures that create a culture of safety.

- **Patient education/communication**: Practices can take action to help patients follow their care plans, including taking prescribed medications and undergoing necessary tests.

Evaluating these areas allows you to create a culture of safety in your practice. This means that all aspects of your practice – policies, customs, training, communication, behavior, organizational structure and recognition – support a blame-free, patient-centered environment.

Three aspects of a practice’s culture must be in place to ensure that patient safety remains a priority:

1. Practice leaders identify patient safety as a top priority in all aspects of the practice;
2. Rewards and recognition reinforce safe behaviors; and
3. Open communication exists among all employees, who are not afraid to speak up when they witness an unsafe procedure.

Finally, implementing a patient safety plan will help your practice stick to its patient safety focus. This plan should be reviewed each year and changes made when necessary. Your patient safety team will help define this plan, which should include:

- Program goals and scope;
- Program management and specific safety-related functions;
- Communication processes;
- Staff education and training; and
- Safety improvement activities.

See the Best Practices section for a sample patient safety plan outline.

**Medication safety**

Managing medication plays an important role in keeping patients safe. With the goal of achieving the safest, most effective use of medication, the process should be team-based and include physicians, pharmacists, nurses and other healthcare professionals, as well as patients and other caregivers. Medication safety should be a regular item addressed in your practice’s patient safety team meetings and be a key part of its patient safety plan.

A September 2008 *MGMA Connexion* article, “Removing barriers so patients understand their care,” noted that patients can find medication use complicated and confusing. Medications present a number of risks, including overdose, allergic reactions and adverse drug interactions. Patients must understand these risks and be able to communicate their medication use to caregivers.

Two simple processes, which medical practices often overlook, can reduce patients’ medication-related risks. The first is providing written information to non-English-speaking patients. The second is providing patients with updated lists of all their medications (including the medication’s name, strength, dosage and frequency) before they leave the practice.

Clinical staff should also discuss with patients any over-the-counter medications they are taking, including vitamins, herbal treatments, cold medicine, pain medicine and others. Asking patients a few simple questions can provide the information you need. (See “Patient medication interview questions” in the Examples section).

Some practices implemented an electronic medical record (EMR) and added an e-prescribing process, allowing them to obtain a medication history, keep a current listing of patient medications, communicate the list to other caregivers and electronically receive changes.
Another aspect of medication safety includes high-alert medications, which may cause adverse drug events if taken improperly. Such medications include opiates, warfarin, anticonvulsants, anti-psychotics, antidepressants, insulin and immunomodulator medications. These medications can cause significant patient harm when used incorrectly. Your practice should have a list of these medications and the steps to administer them safely so that appropriate staff members have the important information at hand. For example, you could create a chart that organizes the medications by category and lists the safety procedures, storage and any other specific strategies for each category. (See “Medication chart for anticoagulants” in the Best Practices section.)

Once your team establishes this list, they must regularly update it, to ensure that the safety procedures are followed and share lessons learned with each other.

**Patient satisfaction**

A practice cannot exist without patients; this makes high levels of patient satisfaction essential. Many practices measure patient satisfaction and use the results to make improvements based on patients’ responses. Asking patients their opinion can be done in a variety of ways. You can ask patients to complete a short postcard-like survey after each visit, send patient satisfaction surveys to patients’ homes or provide a survey on your practice Web site. Many practices survey both established and new patients to gain different perspectives.

Patient satisfaction surveys ask questions about:

- Appointment availability;
- Practice cleanliness and comfort;
- Physician communication;
- Wait time;
- Check-in efficiency;
- Staff helpfulness;
- What patients like best about the practice;
- Suggestions for improvement;
- Quality of care; and
- How patients learned about the practice.

Some surveys do not ask patients for their name, while others make that optional. Some patient surveys ask if patients would like a response to any of their concerns. If the patient replies “yes” and provides contact information, the practice can follow up with the patient. These follow-up calls can be very helpful in identifying patient-satisfaction issues needing attention. In addition, patients appreciate a call from a medical practice in response to an issue. It is often an opportunity to identify a problem and satisfy a disappointed patient.
Getting this information is only half of the process. It's what you do with the results that makes a difference. Listening to patients, identifying areas that need improvement and creating new processes that address negative results allow your practice to become more patient focused and will potentially raise the “score” in future patient satisfaction surveys.

SUCCESS STORIES

Elizabeth Wende Breast Care, LLC
Dedicated to the spirit of the founder’s mother and to the spirit of all mothers who support, inspire and believe in their daughters, Elizabeth Wende Breast Care, LLC, Rochester, N.Y. devotes its mission to serving the women who visit the practice for that anxiety-driven test — a mammogram. Guided by a philosophy in which each patient is treated uniquely, paying close attention to any special needs, it is no surprise that this practice was deemed an MGMA “better performer” in the realm of patient satisfaction.

Background
Founded by Wende Logan-Young, MD, in 1976, the clinic became the nation’s first freestanding mammography and breast imaging center, devoted to breast disease detection. A pioneer in her day, Young saw the value of setting up a clinic specifically for mammography and breast health. Today, the clinic is ranked among the nation’s leading breast care facilities, seeing 340 to 350 patients per day and about 80,000 patients per year.

Success factors
Theresa Wade, administrator, attributes the practice’s success to the fact it treats each patient as a customer and hires employees who understand and apply this concept every day. Employees’ attitudes must match this philosophy, and they are encouraged to embrace the empowerment given them.

“Our patients are our calling card,” Wade says. “Employees must remember this when dealing with patients who may be frightened of the test or the results, and must try to make every patient’s experience as pleasant as it can be.”

Listening to patients and staff also contributes to the practice’s success, because the clinic values the opinions of those visiting and working there. This communication yields changes that make the practice more inviting to both new and established patients. For example, patients can complete an online patient satisfaction survey that uses a five-point scale to evaluate their visit.

“Oh on our patient satisfaction survey, patients have the option of including their name, and if they do, we follow up to let them know about any changes as a result of their comment,” Wade says.
The practice's online patient satisfaction survey evaluates the following:

- Ease in securing an appointment for a reasonable date and convenient time;
- Cleanliness of the reception and waiting areas;
- Whether the patient was encouraged to ask questions about the procedures;
- Satisfaction with the total duration of the appointment;
- Satisfaction with wait times before screening and while awaiting results;
- Satisfaction with staff;
- Whether the patient appreciated being able to wait for test results or leave without results; and
- Whether patients would recommend the practice to others.

Wade employs two patient advocates who help ensure patient satisfaction. In addition, an online time-tracking system designed specifically for the practice monitors patients for the entirety of their visit. Using this system, Wade and the patient advocates can track the time a patient waits to be taken into a room and when she leaves the office. For example, the practice has established that patients should wait no longer than 10 minutes at the front desk. If a patient waits longer, it appears on the screen and a patient advocate can address the situation.

“We can recreate the patient experience at any time,” Wade says. “So, if a complaint comes in, we can see what happened from a time perspective as well as who interacted with her.”

**Efficiencies and innovations**

The practice just converted to 100-percent digital mammography, which provides physicians with much more information but can slow the diagnostic reading time, and therefore extend patient wait times. To account for this, the practice allows the patient to choose if she would rather wait for results or receive the results via letter.

“We try to give the patients choices that hopefully make them happy,” Wade says. This emphasis on the patient experience extends to the clinic's design, which includes a tropical fish tank, fireplace, floor-to-ceiling windows and classical music, all intended to create a warm and relaxing environment. In addition, patients who are awaiting test results can access women’s magazines, cookbooks, wireless Internet connections, snacks and a large communication board filled with patient education information.

Wade’s innovative approach to working with payers includes relative value unit (RVU) cost analysis. After reading an article in the January 2003 *MGMA Connexion* entitled, “RVU cost accounting not just for the big dogs,” Wade applied this technique to the practice. She knows what it costs to generate
each procedure, so that when she negotiates with payers she does not accept a conversion factor that equals an amount lower than what it costs the practice.

Final thoughts
Wade sees moving to a paperless environment as one of the major goals for the practice, which will include eliminating the paper forms that patients fill out at check-in.

“We couldn't start this process until all our images were digital,” Wade says. “That process was achieved just a few weeks ago, so we are poised to move forward with the next steps.”

Morton Plant Mease Primary Care

Background
Florida-based Morton Plant Mease Primary Care (MPMPC) began in 1993. Although it is a large primary care organization, its individual practices benefited from taking the PPPSA in 2007 to assess their patient safety issues. This effort led to numerous changes, some deliberate and others resulting from a raised awareness of patient safety issues in its practices. MPMPC took the PPPSA again in 2008 to identify changes in the practices’ scores on specific dimensions. MPMPC found the PPPSA to be a valuable tool in its quest to improve quality and reduce patient harm.

Project initiation
Long-time MGMA member Emily Callaway, MPMPC executive director, responded to MGMA's call for practices to take the PPPSA, which she saw as an opportunity to support the philosophy of MPMPC's president, Stephen Jacobs, MD, FACP, a board-certified internal medicine physician who is very involved in patient quality and safety. He leads the organization with his philosophy, “If it doesn’t improve the care of the patient, why are you doing it?”

MPMPC's senior management team, saw the PPPSA as a no-cost tool that provided ideas to get people talking. After administering the survey at the practices, the team decided to benchmark the results against other practices in the PPPSA database.

Callaway encourages all medical practices to participate, as it brings out aspects of patient safety and quality that you might not consider.

“We found that we had opportunities for improvement and were somewhat surprised by that,” Callaway says. “We thought we were better than what we scored because we take pride in being a top-notch, quality group.”

Measures of success
After reviewing its PPPSA results, MPMPC focused on two specific areas: a tickler system and a solid protocol for immunizations. Most importantly,
the organization created a patient quality and safety committee to lead active discussions and create policies and procedures that further enhance its practices’ commitment to patient safety.

The committee challenged MPMPC’s individual practices to identify weaknesses, develop action plans to overcome those weaknesses and improve their PPPSA scores. It’s important to note that the practices didn’t focus only on the scores; they truly became competitive with one another in their efforts to serve patients more effectively. The PPPSA scores were a guideline, the patients were the focus.

**Lessons learned**

What began as a response to an MGMA request for PPPSA participants became an important aspect of MPMPC’s culture of continued self-improvement. The PPPSA experience allowed the organization to:

- Recognize that patient safety is an interaction of complex processes and systems within a medical practice;
- Understand that patient safety is not the responsibility of one committee or person – it happens through the collaboration of multi-department teams;
- Create voluntary and engaged teams and provide them with the tools to achieve patient safety goals;
- Develop procedures and standards for its practices;
- Communicate more effectively across the organization and with patients;
- Use competency assessments and training as opportunities for growth rather than criticism;
- Recognize the potential for harm from sedation and invasive procedures and standardize these procedures to minimize patient risk;
- Set “reach goals” such as national recognition for various programs;
- Realize that every patient safety milestone achieved motivates practice members to reach for higher goals;
- Identify weaknesses in its processes;
- Understand the importance for teams to talk – one person should not complete the survey alone.

**Final thoughts**

Callaway emphasizes that the process is never complete. The organization will continue to take the survey each year and develop action plans and processes to address any identified weaknesses.

“Patient safety and quality aren’t areas you can just check off,” Callaway says. “It’s an evolving process and we are including the PPPSA in our orientation
training and residency program so that new employees understand how important patient safety and quality are.”

According to Callaway, when a practice's physician leader encourages a culture of patient safety and quality, it helps others see how the importance of both aspects. Physicians must support the endeavor so that all other employees can buy into it.

“We’re excited, and Dr. Jacobs is proud of our success and commitment to this process,” Callaway says. “We are challenged to make our processes, documentation and data capture the same throughout all our practices. This continues to be a worthwhile and informative journey.”

**Elkhart Clinic LLC**

Elkhart Clinic, Elkhart, Ind., was founded in 1954 when four specialists partnered to provide multispecialty care to the community. The clinic prospered, and has become a major provider of cutting-edge primary and specialty care, as well as diagnostic, therapeutic and wellness services.

**Patient satisfaction measures**

Each day, executive administrator Darryl Busby receives informal feedback from patients about everything from their bills and treatment experience to how difficult it was to find a parking space.

“Patient feedback is ongoing,” Busby says. “But we also have a formal process to collect additional information.”

Elkhart Clinic uses MGMA Adminiserve® partner Sullivan/Luallin to administer its formal patient satisfaction survey and collect results. Using survey results, the practice found that patients were dissatisfied with the facility, the parking lot, the phone system, physician access and the specialties provided. After having addressed each of these issues, the practice is administering another survey to measure improvements in patient satisfaction.

**Motivating staff**

The practice is in its second year of a program called Essence of Caring, designed to help medical practices keep their patients and improve care. Staff has access to videos and other patient satisfaction resources. Internal facilitators regularly lead staff members through role playing and other exercises related to patient satisfaction.

“The exercises and information show staff how people are supposed to do things to keep patients happy,” Busby says. “We have incorporated these elements into our position descriptions and annual evaluations as well. We evaluate staff members not only on their task ability but on the manner in which they do their jobs.”
Guidelines center around the acronym RESPECT (See “Customer service standards” in the Best Practices section) aspire the staff to reach their professional goals. For example, staff members can increase their hourly wages by $2 if they become certified in the specialty in which they work.

“They have an incentive to pursue more knowledge, more experience and keep current with their continuing education units. We reimburse any expense associated with this pursuit,” Busby says.

Final thoughts
Elkhart Clinic will keep its current physicians whom it has worked hard to recruit, and will retain the level of service that the patients expect.

“It’s important to keep improving,” Busby says. “We want to be the practice choice of the patients and continue to provide a profit for the physicians.”

Pediatric practice
Background
Recently, Elizabeth M. Wertz Evans, RN, BSN, MPM, FACMPE was the chief executive officer of a large pediatric practice with 42 physicians and 14 locations. When MGMA asked for member practices to participate in the PPPSA, Evans took the opportunity to make a great practice's patient safety and quality even better.

Project initiation
One of Evans’ initiatives included evaluating patient safety measures using concrete measurements for the overall organization as well as the individual locations. She knew of instances in which errors occurred and wanted to see from a systems perspective how these errors happened and how to avoid them in the future.

“I recently read an article from the Institute for Healthcare Improvement that said a medical practice can destroy the confidence of a patient or patient’s family when errors occur, even if those errors are not fatal or do not cause direct harm,” Evans says. “Practices are busy places, and sometimes things get overlooked or are done in a hurry. That’s how errors occur.”

Evans needed an objective tool to measure the safety and quality of the practices so that employees could identify where improvement was needed. Using a small incentive as encouragement, Evans asked every employee to complete the PPPSA.

“Not everyone saw the value of the PPPSA tool but I wanted to make sure that everyone had input,” Evans says. “All departments were represented, including billing, clinical, administrative and physicians who filled out the survey individually.”
The practice’s Quality Improvement Committee supported the endeavor and encouraged employees to take the survey and be open to the results. Evans comments that, “Employees all thought they provided safe care, but I really needed to verify that theory. I wanted the offices and staff to recognize areas of improvement.”

**Measures of success**

The domains evaluated in the PPPSA included medications, handoffs and transitions, surgery/invasive procedures (not applicable to this practice), personnel competency, management and culture, patient education and communication. Practice leaders determined that implementing an electronic medical records system would address many of the items listed in the domains.

However, once the results were complete, the practice focused on medication safety by creating a safety quality improvement plan (based on the statements in the PPPSA) that included the following:

1. **All patients who are taking medications are asked at each office visit what medications they are currently taking and if they had side effects, and their responses are documented in their medical record.**

   **Quality improvement action:**

   This issue was reviewed with physicians. The medical record lists all patient medications, and physicians discuss with the patient all potential wanted and unwanted effects upon starting a new medication. Side effects are reviewed with a relatively new medication, but it is not clinically necessary to review all side effects each time for patients who are on a medication for an extended period of time. The medical record also documents allergic reactions. EMR implementation will also increase consistent medication documentation.

2. **All medications, reagents and other products that carry an expiration date are routinely checked (at least quarterly) by a designated staff member and discarded once they have expired.**

   **Quality improvement action:**

   A designated employee from each practice division checks all medications monthly to ensure that they are not expired or contaminated, discarding those that are. An expired drug log documents these activities.

3. **All multiple-dose vials of injectable medications used in the practice are labeled with the date opened and include a date on which the unused product should be discarded (as per manufacturer), no later than 30 days after opening.**

   **Quality improvement action:**

   All divisions currently have a designated employee who checks all medications monthly to ensure that they are not expired or contaminated. All multiple-dose...
vials of medications are dated and initialed when opened and medications that are expired or contaminated are disposed of appropriately. All single use vials or vials without preservatives are discarded at the time of use and not reserved for further use.

4. **Patients are routinely asked to repeat back what they hear when receiving critical information about prescribed drugs, treatment, diagnostic test, or laboratory result, both in person or by phone.**

**Quality improvement action:**

All clinicians use various means of patient education, including verbal, written and demonstration, to accommodate different learning styles. When providing clinical information, the clinician asks the patient questions to verify his or her understanding. This practice is utilized consistently to maximize patient education and understanding.

5. **A protocol to report potential threats to patient safety and near-misses is in place, is known to all staff, routinely followed and supported by a culture of safety that allows for open collection and sharing of data within the practice.**

**Quality improvement action:**

Office managers have been educated to instruct all clinical employees to complete a clinical incident report for all actual and potential patient-safety incidents. All incident reports will be reviewed by the clinical operations manager and chief executive officer and immediate action taken when indicated. Incident report data and trends shall be reviewed at Quality Improvement Committee meetings and organization-wide action plans developed when indicated.

“One of the most important aspects I tried to convey to employees is that the action plans were designed to help, not punish,” Evans says. “We needed to know where the system was breaking down and what aspects needed to improve to avoid those situations in the future.”

**Lessons learned**

In addition to the safety and quality improvement plan mentioned earlier, the practice gained some valuable knowledge that included:

1. **Ensuring buy-in from practice physician(s), who need to lead as safety champions;**

2. **Communicating the importance of safety and quality to management so that when they talk about the survey, they convey the right message and get employees excited about the tool. For example, say, “This is an exciting tool that will help us do our jobs better.” Don’t say, “I got this tool from management; it seems stupid, but you have to fill it out, otherwise I’ll get in trouble”;}
3. Providing time for employees to fill out the survey;
4. Understanding that the safety and quality improvement processes continually evolve; and
5. Focusing on patient safety improves practice credibility and ensures patient/family trust.

Final thoughts
“I would encourage practices to use the PPPSA at least once to validate their patient safety and quality situation,” Evans says. “You may have the impression that you provide safe care, but there are always areas for improvement.”

BEST PRACTICES

Daily huddle agenda
Using the agenda below, structure your daily huddles to give staff the best possible opportunities to address the day’s challenges. This will help prepare the team to do its best each day.

1. Check provider and staff schedules. Does anyone need to leave early or take a break for a phone call or meeting? Are there any staff shortages due to illness, vacations, family emergencies or other circumstances?
2. Are there any issues with broken equipment or unavailable labs?
3. Are lab results, test results and notes from other physicians ready in patients’ charts? What will be the most efficient path to patient flow?
4. Check for patients on the schedule who may require more time and assistance due to age, disability, personality or language barriers. Any suggestions on how to deal with this?
5. Check for back-to-back lengthy appointments such as physicals. How can they be worked around to prevent backlog?
6. Check for openings that can be filled or chronic no-shows that can be anticipated. Are there special instructions for the scheduler?
7. Are there any other expected issues that could disrupt the day’s workflow?

Patient safety plan outline
Program goals (consistent with organization mission)
Scope
- Activities and functions relating to patient safety
- Participating sites, settings and services
Structure

- Management (TIP: Regardless of the size of the practice, be sure to designate a patient safety officer.)
- Components (safety-related offices, committees, functions)
- Interdisciplinary participation (TIP: In larger practices, include representatives from all clinical and administrative disciplines in the practice. In smaller practices, include everyone. In all cases, include every member of the staff in various patient safety activities. Remember, safety is a team sport!)
- Oversight

Mechanisms for coordination

- Among components of the program
- Among the professional disciplines
- Across the organization

Communicating with patients about safety

- Patient education
- Patient care instructions

Staff education

- Safety-related orientation and training (TIP: Establish a training agenda each year and stick to it; update topic areas based on patient safety leaders’ monthly newsletters and other sources of patient safety news and innovations.)
- Team training
- Expectations for reporting (TIP: Establish monthly tracking of key patient safety statistics and post in a public space.)

Safety improvement activities

- Definition of terms
- Prioritization of improvement activities
- Routine safety-related data collection and analysis
  - Incident reporting
  - Medication error reporting
  - Infection surveillance
  - Facility safety surveillance
  - Staff perceptions of and suggestions for improving patient safety
  - Staff willingness to report errors
  - Patient/family perceptions of, and suggestions for improving, patient safety
- Identification, reporting and management of guarded events
- Proactive risk reduction
  - Identification of high-risk processes
  - Failure mode, effects and criticality analysis
- Reporting of results
  - To the practice’s patient safety program
  - To organization staff
  - To executive leadership and the governing body

**Medication chart for anticoagulants**

<table>
<thead>
<tr>
<th>Standardize</th>
<th>■ All warfarin and low molecular weight heparin (LMWH) orders are prescribed by generic name.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>■ All administration instructions will be written out, not abbreviated (e.g., use “daily” rather than “QD,” and “Monday-Wednesday-Friday” rather than “3 x week” or “MWF”).</td>
</tr>
<tr>
<td>Redundancies</td>
<td>■ All orders for LMWH include a verification of renal function.</td>
</tr>
<tr>
<td></td>
<td>■ All orders for warfarin include a verification of a recent international normalized ratio (INR) - the standard unit for reporting the clotting time of blood.</td>
</tr>
<tr>
<td>Patient education</td>
<td>■ All patients prescribed LMWH or warfarin receive written information and be asked to repeat back instructions, laboratory appointments and adverse effects.</td>
</tr>
<tr>
<td>Checklist</td>
<td>■ All patients prescribed warfarin will receive a checklist on important food interactions, side effects and laboratory appointments.</td>
</tr>
</tbody>
</table>

**Customer service standards**

**R-E-S-P-E-C-T**

<table>
<thead>
<tr>
<th>Service standard</th>
<th>Evaluation points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness</td>
<td>1. Actively listens to the patient and asks questions. (No repetitive questions)</td>
</tr>
<tr>
<td></td>
<td>2. Demonstrates positive body language, including eye contact, smile, etc.</td>
</tr>
<tr>
<td></td>
<td>3. Responds to customers’ requests, needs and expectations in a timely manner.</td>
</tr>
<tr>
<td>Excellence</td>
<td>1. Places a high value on quality of work. “Goes the extra mile.”</td>
</tr>
<tr>
<td></td>
<td>2. Strives to be knowledgeable and technically current.</td>
</tr>
<tr>
<td></td>
<td>3. Strives to exceed customer expectations.</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>1. Responds with empathy, courtesy and respect.</td>
</tr>
<tr>
<td></td>
<td>2. Generous with genuine and sincere compliments and has the ability to graciously accept compliments.</td>
</tr>
<tr>
<td></td>
<td>3. Ensures privacy and dignity of customers.</td>
</tr>
</tbody>
</table>
### Service standard | Evaluation points
--- | ---
Professionalism | 1. Maintains professional appearance and conduct while providing high levels of service competently and consistently.  
2. Independently handles stressful situations.  
3. Maintains a positive attitude and contributes to a positive perception of the team.
Empowerment | 1. Utilizes skills to effectively address customer requests, needs and expectations at the point of service.  
2. Follows through on promises.
Cultural Perception | 1. Recognizes and adapts to differences in cultures in all encounters.  
2. Demonstrates flexibility to respond to a wide variety of requests and needs.
Teamwork | 1. Recognizes and demonstrates the importance of partnership in teamwork.  
2. Actively contributes to the goals of the team, including customers.

### EXAMPLES

#### Using the SBAR technique in a conversation

**Situation:** What is going on with the patient?
*Mr. Jones called in saying he feels dizzy and his heart is racing.*

**Background:** What is the clinical background or context?
*Mr. Jones is a 72-year-old diabetic who has a history of hypertension.*

**Assessment:** What do I think the problem is?
*I think the problem is very likely related to Mr. Jones’ heart and cardiovascular system.*

**Recommendation:** What would I do to correct it?
*I think Mr. Jones should immediately come in for a cardiac examination and an electrocardiogram.*

#### Patient medication interview questions
Patients may not provide information on all prescription and non-prescription medications they use unless questioned specifically about certain products. One technique to use when obtaining a current list of medications is to follow a scripted list of questions, along with prompts for the information that you...
should obtain with each medication. The tool below provides a set of sample questions that your staff may find useful.

1. What medications are you currently taking that have been prescribed by one of your doctors?
2. Are you taking a new medication that has been prescribed to you or has a medication been changed by a provider from outside this office? 
   (Note: A trigger for this question would be if a patient has recently been to a referral appointment, hospital or rehabilitation center.)
3. Have you included any patches you may be wearing, inhalers you may use, birth control pills, injections you may take or receive, or any sample medications that were provided to you?
4. What over-the-counter medications are you currently taking or take when you need them? 
   (Note: Staff should ask the following questions and name specific medications in each category.)
   - Do you use any creams or ointments for itching, dry skin or irritation? (Examples: hydrocortisone, Benadryl®)
   - Do you take any medications for headache, arthritis, indigestion or constipation? (Examples: Acetaminophen, Ibuprofen)
   - Do you take any vitamins, herbal medications or supplements? (Examples: calcium, iron)
5. Where do you get your prescription medications? (Examples: Local pharmacy, mail order, Internet)

**SUMMARY**

This chapter presented the nuances of patient safety, quality and satisfaction by introducing methods for creating teams, assessing your practice, ensuring medication safety, measuring patients’ views of the practice and implementing improvements. The success stories featured in this chapter highlight some better-performing practices’ approaches to patient safety and satisfaction. You can incorporate and adapt these ideas to your practice to improve employees’ awareness of and commitment to patient safety, as well as create an environment that puts the patient first.

**DISCUSSION TOPICS**

Practice what you just learned with the discussion topics.

1. Practice some of the communication skills suggestions in your daily activities. Then begin to educate others in the practice.
2. Start a conversation with the staff about medications used in the practice and identify any high-alert medications and the safeguards that do or should occur.
3. Does your practice have a patient satisfaction survey? If not, try to create one. If you do, how are the results used today? How would you/the team improve that process?
GLOSSARY

**Daily Huddle** – A quick and informal gathering to become aware of what your staff will face each day.

**High-Alert Medications** – Medications that have a heightened risk of causing significant patient harm when used in error.

**Medication Reconciliation** – The process of identifying the most current, complete list of a patient's medications.

**Practice Culture** – Behaviors, processes, education and training that characterize a practice.

**Patient Centered** – Putting the welfare of the patient at the center of decision making.

**Patient Safety** – Creating employee awareness and an environment that puts the patient first.

BENCHMARKING DATA FROM MGMA SURVEY REPORTS


<table>
<thead>
<tr>
<th>Patient satisfaction – survey results</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How practices use survey results</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benchmark against other practices</td>
<td>18.62%</td>
<td>20.67%</td>
</tr>
<tr>
<td>Contracting purposes</td>
<td>11.72%</td>
<td>3.86%</td>
</tr>
<tr>
<td>Educate physicians about behavior</td>
<td>56.85%</td>
<td>52.88%</td>
</tr>
<tr>
<td>Educate staff about behavior</td>
<td>58.90%</td>
<td>53.85%</td>
</tr>
<tr>
<td>Educate and improve practice operations</td>
<td>60.27%</td>
<td>59.13%</td>
</tr>
<tr>
<td>Liability risk management</td>
<td>19.31%</td>
<td>16.83%</td>
</tr>
<tr>
<td>Marketing and promotional purposes</td>
<td>20.69%</td>
<td>16.35%</td>
</tr>
<tr>
<td>Part of physician compensation formula</td>
<td>2.07%</td>
<td>1.45%</td>
</tr>
<tr>
<td>Reward outstanding customer service</td>
<td>16.55%</td>
<td>14.49%</td>
</tr>
<tr>
<td>Staff incentives/bonus</td>
<td>13.79%</td>
<td>7.69%</td>
</tr>
<tr>
<td>Staff performance reviews</td>
<td>22.76%</td>
<td>16.35%</td>
</tr>
<tr>
<td>Other results of patient satisfaction</td>
<td>2.76%</td>
<td>1.93%</td>
</tr>
</tbody>
</table>
## Patient satisfaction – survey results

<table>
<thead>
<tr>
<th>Elements of patient satisfaction surveys</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment availability</td>
<td>58.22%</td>
<td>55.29%</td>
</tr>
<tr>
<td>Bedside manner</td>
<td>40.69%</td>
<td>42.58%</td>
</tr>
<tr>
<td>Cleanliness/comfort of facilities</td>
<td>52.41%</td>
<td>50.48%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>24.83%</td>
<td>22.60%</td>
</tr>
<tr>
<td>Overall experiences</td>
<td>60.96%</td>
<td>59.81%</td>
</tr>
<tr>
<td>Parking</td>
<td>27.59%</td>
<td>26.44%</td>
</tr>
<tr>
<td>Patient name</td>
<td>11.03%</td>
<td>8.65%</td>
</tr>
<tr>
<td>Physician communication style</td>
<td>40.00%</td>
<td>40.10%</td>
</tr>
<tr>
<td>Staff professionalism</td>
<td>61.38%</td>
<td>56.46%</td>
</tr>
<tr>
<td>Quality of care</td>
<td>52.05%</td>
<td>50.24%</td>
</tr>
<tr>
<td>Recommendation of practice to others</td>
<td>48.28%</td>
<td>44.02%</td>
</tr>
<tr>
<td>Unique appointment time code</td>
<td>2.07%</td>
<td>1.45%</td>
</tr>
<tr>
<td>Unique provider code</td>
<td>9.66%</td>
<td>8.21%</td>
</tr>
<tr>
<td>Unique service line</td>
<td>2.76%</td>
<td>3.38%</td>
</tr>
<tr>
<td>Wait time</td>
<td>53.10%</td>
<td>50.72%</td>
</tr>
<tr>
<td>Other elements</td>
<td>4.11%</td>
<td>2.42%</td>
</tr>
</tbody>
</table>

## APPENDIX

Visit [mgma.com/lessons](https://mgma.com/lessons) for interactive tools that will help you practice the concepts presented in this chapter.
Lessons for Financial Success

CHAPTER 3

Accounts Receivable and Collections

WHAT YOU WILL LEARN

✓ Effective billing procedures to maximize revenue
✓ Techniques to manage accounts receivable
✓ Ideas to avoid fraud in the practice
INTRODUCTION

Medical practices serve patients. Most (if not all) practices write this in their mission statement. However, medical practices are also businesses and have the same aspects and concerns of any business – getting paid for services, using effective billing processes, maximizing revenue, managing client payments and overdue accounts, and ensuring that office employees operate in a trustworthy manner.

Your practice exists today because it has in place processes that address all of these business practices. This chapter will help you improve those processes and perhaps introduce a few new concepts that will improve your medical practice’s efficiency and bottom line.

WHAT’S COVERED

This chapter covers incorporating billing procedures that fit your practice’s style, maximizing revenue, managing accounts receivable (A/R), strengthening internal controls and ensuring that your practice is free of employee theft. You will also find best practices and examples that you can use in your practice’s daily operations along with excerpts from success stories in the MGMA Performance and Practices of Successful Medical Groups Report that describe real-life medical practice examples.

IN THIS CHAPTER

✓ Overview
✓ Accounts receivable and collections essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix

OVERVIEW

A/R and collections relate to the business side of a practice. After patient care, practices consider maximizing revenue as an important aspect of running a successful business. This aspect includes more than just getting paid for services. You need to consider your billing cycle (which starts when a patient calls for an appointment), billing processes and technology.
Secondly, services rendered by medical practices must be paid by a third-party payer, such as an insurance plan and/or the patient. How quickly does your practice get paid? How can you accelerate collections? Managing this aspect of the practice ensures a better cash flow that can be invested back into the practice to improve processes and provide better services to patients.

And, finally, managing your revenue cycle processes and revenue will be of no use if someone steals from your practice. Theft can be a major barrier to a practice's success. Learning steps to prevent theft will help you maintain a trustworthy staff.

ACCOUNTS RECEIVABLE AND COLLECTIONS ESSENTIALS

Manage accounts receivable

Medical practice A/R equates to patients’ open accounts and the amounts due from insurance payers. To manage A/R (keep the amounts due you to a minimum) requires an effective billing process. This process includes more than sending out a bill, and it starts when a patient calls to schedule an appointment. Processes will vary among medical practices, but some key elements that should exist for all practices so that managing A/R can be done more effectively are:

- Gather all patient information at the time the patient calls in for an appointment;
- Obtain insurance information and verify it when the patient visits;
- Establish and communicate the expectations that patient balances are due at time of service;
- Collect all copayments and deductibles when the patient checks in;
- Work with the patient who owes past due amounts by setting up payment plans and explaining what their insurance covers and what it does not;
- Accept credit and debit cards as a method of payment;
- Educate the staff on collection techniques so that they understand the most effective methods of obtaining payment such as not arguing with a patient, not becoming emotional and sounding confident; and
- Implement a collection process that includes steps based on the time and amount past due.

During the patient visit, a physician will document what occurs in the patient record using diagnosis codes such as the International Classification of Disease (ICD-9) and procedure codes such as current procedural terminology® (CPT®) codes. Capturing this documentation becomes critical in obtaining payment for physician services from insurance payers. Why? Medical practices have contracts with payers that include fees associated with each CPT code billed.
So, it's important that the correct CPT code be documented so that correct payment can be obtained.

Further, much of your cash flow comes from these insurance payers, which affects your A/R balances. Handling this area of the business also requires a skillful process:

- Understand the individual payer contracts and the amounts negotiated for CPT codes billed;
- Encourage physicians to thoroughly document the patient encounter so that charges can be submitted accurately;
- Review payer claims for errors before submitting them;
- Submit claims on a timely basis;
- Create reports that classify past-due accounts and assign collection procedures to them; and
- Follow up on unpaid claims so that they do not go unnoticed and payment never occurs.

Today's economy has left many without medical insurance or insurance with very high deductibles (high-deductible health plans) that may include provisions for a Health Savings Account (HSA) to cover the patient's portion of the bill. Your practice needs to be aware of this and create processes to handle each situation. Accepting credit cards affords you the ability to obtain payment without incurring significant additional fees because the burden has been shifted to the patient who will pay potential finance charges to the credit card company. The practice will pay a percentage to the credit card company. However, you will still save money because you do not have to use a collection agency or maintain a past-due balance for the patient.

Some practices offer these self-pay patients a discount for paying in full with cash. This lowers your A/R and saves time and money because you receive payment up front and avoid sending patient statements. However, the charges can’t be less for these patients than you would charge Medicare or commercial payers. Beware of the language in your payer contracts. Practices should have in place a written policy on how self-pay discounts are handled.

HSAs may be more complicated because plans operate differently. For example, some plans manage the employee accounts and send the payments to the practices. Other plans require the medical practice to send a bill. Although this aspect sounds no different from what other payers currently do, patients may not fully understand this new plan, which could delay payments or create an additional burden on medical practice staff in answering questions.

Overall, the goal in managing A/R is to collect what is due you in a timely manner. The longer patient or payer accounts remain past due, the longer the practice waits for what it is owed. In some cases, you may never collect.

In chapter one of Lessons for Financial Success, we show you a few formulas and benchmarks to help you measure your progress in managing your A/R. These
benchmarks look at areas of your practice such as the percent of A/R over 120 days and your total A/R per full-time-equivalent (FTE) physician. Take a look back at chapter one for more formulas. Also, at the end of this chapter, we provide median A/R data from MGMA's Cost Survey Report and Performance and Practices of Successful Medical Groups Report. Both can give you an idea of what you can measure in your practice against other successful practices.

Monitoring cash flow and effective billing procedures

Effective management processes improve cash flow and generates income for future investments and operating revenue. Here are some ideas to improve your cash flow:

- Collect at the time of service – ask patients for payment before they leave the practice;
- Time vendor bills – work with vendors to set convenient payment dates for your supplies; and
- Don’t pay bills too early – make payments at the end of the discount period (net 30 – make the payment in 30 days) or at a time when you benefit from further discounts.

As mentioned before, insurance payers play a major role in your cash flow. To obtain payments from payers, you must have an effective billing system. This system must fit your practice’s needs but must be able to deliver a clean claim to all payers. Some practices outsource this function to outside companies because billing has become complicated and ever-changing. Outsourcing may be right for your practice if it is smaller and the cost of outsourcing is less than that of hiring one or two more employees.

Some practices keep all billing functions in-house and rely on electronic billing and claims processing to ensure that claims are submitted with limited errors. Submitting claims electronically provides advantages such as:

- Editing and correcting claims before submitting them to payers;
- Creating reports;
- Reducing the number of bills that must be resubmitted; and
- Reducing billing processing costs.

Whether or not you use electronic billing, you should track total billing amounts by payer. Tracking can be done daily as well as monthly and can help you determine payer trends (who pays, who doesn’t and how long you wait for payment). Using a tool such as a daily billing control sheet (see Examples section), helps you monitor the activity by payer.

Overall, your practice should serve patients to the best of its ability. However, situations arise where patients may not pay their bills. And it’s up to you to get the money owed without damaging the practice’s reputation. For ideas on
how to accomplish this, refer to the code of ethics (see Best Practices section) that will help guide you and staff in the appropriate aspects of collecting from patients while keeping a positive public image.

**Prevent employee theft**

Employees steal for many reasons. Patients may also attempt to steal services by using someone else’s identity and insurance information. Implementing steps to prevent theft and creating an environment that encourages trust are your best methods to keep your practice free of workplace crime.

Some ideas to help limit unethical employee conduct include:

- **Tighten the hiring process**: Conduct complete applicant interviews, contact previous employers to verify dates and positions, verify graduation records, interview personal references with detailed questions and conduct background checks.

- **Develop policies and procedures**: Create and distribute an employee handbook that details the expectations and accountabilities of each employee and the consequences associated with not adhering to them. Job descriptions should be well defined and list the specific aspects of the job.

- **Separate duties**: Specify which employees are responsible for handling cash, set up accounting records to be managed by employees not responsible for handling cash, create an auditing process, assign the monthly task of reconciling bank accounts to someone who does not handle cash and does not maintain the accounting records, and confirm patient identities.

- **Install and update computer security systems**: The computer has become a tool for employee theft. It’s important to use the latest electronic security tools and limit computer access to only those who need it. You can limit this access based on functional responsibilities, creating access passwords for employees and preventing/limiting Internet access.

(This information was reprinted with permission from the MGMA Center for Research, 104 Inverness Terrace East, Englewood, CO 80112. 877.ASK.MGMA.mgma.com. Copyright 2000.)

These ideas touch more than just the financial aspects of the practice. Creating a work environment that emphasizes fairness, strong controls, communication and honesty will go a long way in helping you prevent theft in your practice.

**SUCCESS STORIES**

**Cardiology Associates of New Brunswick**

Cardiology Associates of New Brunswick, N.J., was founded in 1938 by Norman Reitman, MD, a pioneer in the practice of medicine in the New Jersey area.
Success factors

This well-respected practice has excellent physicians who provide quality care that surpasses any other practice in the area. The physicians ensure that the practice stays on top of the newest technology because it is important to them to provide the best possible innovative care to their patients.

“Not only are the physicians good at what they do, they have good hearts and put patient satisfaction ahead of their own needs,” says Lana Gordover, MPA and practice administrator. “I am proud to work here.”

Adding nonphysician providers to the practice, who make hospital rounds, also contributes to the revenue of the practice. According to Gordover, a hard-working and dedicated staff makes this practice successful. The practice survived a few difficult years with respect to staffing in the billing area, and everyone pulled together to make it work. Cross training all employees helped the department survive this difficult time.

Most importantly, a monthly report card (see “Monthly productivity report” in the Best Practices section) distributed to the billing staff helps track A/R progress. The report card, broken up by payer, shows the employee who handles the payer, the payer type, the previous month’s A/R dollars and percentage, the current month’s A/R dollars and percentage, and receipts in dollars and percentage.

“The report card provides a pretty good indicator of how we are doing with A/R,” Gordover says. “I receive a summary version of the report card, which allows me to look at A/R from a summary perspective.”

Employee evaluations are based on this report card, with the goal for each employee to have zero in the column that lists the amount over 90 days. This benchmark is used specifically because there is more involved in managing employee productivity. The employees do not receive an incentive for reaching this goal; instead, they work as a team and understand the importance of managing their A/R accounts.

“Paying someone more is not necessarily an incentive,” Gordover says. “Having pride in your work and access to tools that make your job easier motivates employees to work harder and reach the goals that we established together.”

For example, the practice purchased new software that allows charges for a day to be posted in a couple of hours. As a result, employee time was freed up, which allowed them to learn and do other tasks to increase their efficiency.

Gordover includes the billing staff in decisions during their monthly meetings. Each month they explore new ideas and discuss new payer information and tasks that need to be done. Each employee has a voice, and is encouraged to suggest ideas and challenge current processes.
Most importantly, the billing staff attends conferences that allow them to stay up to date on changes in Medicare and other updates that affect their jobs and the practice.

“It’s important that the staff stay current on healthcare billing and collection issues just as it is for the clinicians to stay current on technology and innovative solutions,” Gordover says.

Collecting payment
Initially, the patient payment process was not efficient. Gordover implemented an approach in which the patient now pays the copayment at check-in. Then, to avoid any embarrassment, when the patient checks out (which is not in the waiting room full of people), staff addresses any outstanding balances and obtains payment for them at that time.

New processes and procedures also help the billing staff manage their accounts. Employees run A/R at the beginning of the month, review it and determine the amounts that are more than 90 days. These items gain their initial focus for the month, but employees still focus on the remainder of the A/R that is under their responsibility in these first two weeks.

“We work our A/R from right to left and use a method to determine the minimum number of pages an employee must work on each day,” Gordover says. “The A/R that needs to be addressed must be completed in the first two weeks. Then the staff reviews their A/R again in the second half of the month. Reviewing A/R twice in a month – that’s the secret recipe.”

Final thoughts
Reaching better-performer status makes Gordover proud, but she is not finished yet.

“It isn’t about getting there, it’s about staying there,” Gordover says. “We will continue to stay on top of our accounts and do better on all levels.”

Gordover is happy with her team and without them could never succeed. Each and every person is needed to make the practice a success — now and in the future.

Dublin Primary Care
Dublin Primary Care, Colorado Springs, Colo., started as a physician practice owned by an independent practice association (IPA) where the physicians worked as employees. In 1999, the physicians bought the practice, and it continues to operate as a physician-owned primary care practice for patients of all ages.

Success factors
“Several factors contribute to the success of Dublin Primary Care,” says Deborah D. Milburn, CMPE, practice administrator. “Our policies and
procedures are known and understood; physicians turn in their charges in a timely manner; and charges are sent to the payer the same day they are received all contribute to how well the practice functions.”

All staff, including the physicians, are accountable for their tasks and understands how their individual roles contribute to the success of the whole practice. The physicians are keenly aware of the importance of billing out their charges quickly. The process starts with the physicians – once their goals and deadlines are met, the staff can meet their goals. They are all encouraged to perform their tasks right the first time, as rework is expensive.

Further, open reporting (physician names appear on the report) on production, collections, overhead and salaries are reviewed each month. All information is shared. Physicians understand all reports and review them as a group twice a year. They look at key indicators such as days outstanding, and understand the components of collection percentage and how it may compare to other practices. They also receive payer reports each month that indicate the percentage of the patient base and how fluctuations in that payer could disrupt business.

**Communicating with patients**

It is vital to get the necessary billing information up front from the patients. Dublin Primary Care follows the policy of collecting copayments prior to service, checking patient demographics and verifying insurance information at each visit. If patients do not provide their insurance card, they are considered self-pay patients and will be billed as such until they present their insurance information to the practice. This is all explained to them before services are rendered.

“Self pay/patient pay takes on a different meaning today,” Milburn says.
“With payers shifting more of the payment burden to the patient, we see more patient responsibility as part of our A/R and collections."

Dublin Primary Care accepts credit/debit cards, but doesn’t track whether it is a Health Savings Account or a Visa debit card. The practice likes accepting credit/debit cards because it eliminates a billing factor and thus lowers costs.

**Technology, billing and collecting**

Information technology plays a large role in this practice. Just a few years ago, the physician and staff implemented electronic health records (EHR). They are more than happy with the results and realized benefits within a month of installing the system.

“A physician completes a note and codes it at the same time, just as if they were circling an entry on an old superbill,” Milburn says. “Now they point and click.”
Before loading a file into the practice management system, all charges are reviewed and accepted. A staff member reviews the patient report generated from the system and bills out the charges before noon that day.

“We used to have two full-time charge entry people; now we have one part-time person to complete charge entry,” Milburn says.

On the back end, the staff posts payments. However, the practice also implemented electronic remittance with three of the payers, which allows staff to review and verify the information. This reduced the billing staff as well, from eight people to three full-time A/R staff and one-half person on charges. All billing staff members pay attention to details, alert Milburn of any trends they see with payers and address any outstanding patient balances before they reach the 90-day window.

Final thoughts
As technology moves forward, Dublin Primary Care will add more payers to its electronic remittance function and continue to use its Web site to help market the practice.

In the ever-changing, difficult healthcare environment, many unknowns exist, and planning for them is difficult. Milburn will continue to watch the trends, pay their staff well and stay within their primary care niche.

Houston Allergy & Asthma Associates
Established in 1957 by two physicians, Houston Allergy & Asthma Associates has grown into the largest single-specialty allergy, asthma and clinical immunology group in the Houston area.

“We are still growing,” says David Reynolds, administrator. “Our goal is to locate clinics so that patients do not have to drive too far to be treated.”

Success factors
When asked, practice leaders attribute their success to a few areas, including hiring knowledgeable and appropriate staff who handle heavy workloads and enjoy their jobs, as well as creating a standard policies and procedures manual for all employees. However, the most important factor is the limited number of CPT codes the staff uses in this specialty. Allergy and asthma have 22 main CPT codes that account for 98 percent of the practice’s revenue. This limited number of codes not only makes billing easier, but it also aids in contract negotiations with the payers.

“We concentrate on just these specific codes when negotiating,” Reynolds says. “If the payer will give us the fee we want on these codes, we take the standard fee on all the others because we rarely use them.”

Growth spurred the practice to centralize its billing processes several years ago, and this has greatly improved collections. Clinics focus on real-time
patient charges and balances and collecting copayments while the billing office manages all aspects of A/R, daily claims filing, insurance follow-up and monitoring the accuracy of payer reimbursement according to clinic contracts.

The key to the practice's successful collection ratio stems from its proactive approach. Each day, the central billing office creates a daily audit for each clinic (see “Daily audit” in the Best Practices section), containing the following day's patient schedule. For each patient, the central billing office informs the clinic managers of any outstanding balances, copayments or coinsurance amounts that should be collected and reminded to gather and verify any privacy or benefit information.

“We educate the staff on the importance of keeping up with the expectations of the insurance providers and collect the copays at the time of service,” says Lori Smith, director of operations.

The practice offers an auto-credit card payment option, which allows all copayments and deductibles to be charged immediately for each visit. Today, about 20 percent of patients take advantage of this service.

**Benchmarking**

Monthly meetings with managers address A/R and collections for year-to-date and the current month, as well as the overall days in A/R. These measures are critical indicators when compared with outside data such as the MGMA Cost Survey Report, as the practice can see how it compares with other clinics.

“Collecting dollars is an important benchmark of overall efficiency,” Reynolds says. “We’ve never been above 20 days in A/R, which is stellar for any practice.”

Internally, Houston Allergy & Asthma Associates looks at its clinics as profit centers and compares the patient collections of each. The practice looks specifically at the number of accounts in patient collections. Each location strives to achieve a patient-receivable benchmark of less than 10 percent.

**Information technology and new ideas**

Houston Allergy & Asthma Associates considers technology a necessity when dealing with payers. Today, if a practice wants speed in reimbursement and quicker submissions, it must upgrade its software and hardware.

“Technology is a valuable tool we use to communicate with each of the clinics and billing office, as well as the payers,” Reynolds says.

**Final thoughts**

Each year Houston Allergy & Asthma Associates sets new challenges. In the years to come, the practice will strive to lower the collections rate of patient and insurance receivables and increase the number of patients paying with a credit card.
BVA Advanced Eye Care

The first statewide advanced eye care practice in Oklahoma, BVA Advanced Eye Care was founded in 1998 by an entrepreneurial physician who wanted to establish a world-class practice.

Efficiencies

Sandy Boles, executive director, says the offices are linked by a common management system and have local managers. Each office uses the same billing software for revenue cycle management and is monitored by a centralized A/R team. She reports that BVA’s A/R and collections approach features three circles:

- **First circle**: Each practice has its own front-office staff and a billing specialist. This staff generates the documentation needed for accurate claims and fast processing;
- **Second circle**: The centralized team sends electronic claims and statements to responsible parties, handles any denied claims, and solves any other claims-processing issues; and
- **Third circle**: Any unpaid claims go back to the local office for handling. The decision on whether to send the claim to collections is made locally.

Innovations

BVA uses electronic banking for payer reimbursement, with payments going directly into a lockbox at the bank. This eliminates cash handling, except for front-desk staff who collect patient payments. Managers use online banking services to retrieve explanation of benefits and check accounts.

Boles feels that “the secret of our success in A/R and collections is our A/R team and related internal controls. The team leader, one of the seven office administrators, and four assistants, manage the centralized A/R effort. The A/R manager analyzes ‘days outstanding’ reports and other data to spot any problems. Each local manager also watches the accounts and knows where more training may be needed.”

The goal is a 100-percent clean-claim result. When the managers review the weekly audit report, there is a friendly competition to see which office comes closest to hitting the target. The executive director reports that BVA averages a 35-day days-outstanding mark.

“If it is 37 to 39 days, we look for the reason, which might indicate a problem or not. Aging buckets can be affected by a physician who has been out for a week or the way the workdays fall in a given month.”

Billing

BVA educates all staff and its physicians about billing matters. The A/R team keeps everyone informed via reports and meetings. They all see the efficiency
level of the payment process, including copayments and deductibles not collected at the time of service. To stay on target with billing, BVA keeps a coding consultant on retainer. Boles reports that the consultant visits the practice every other year to conduct a chart audit, and is available by phone anytime. Every office has a go-to person to answer coding questions. Those who become certified as ophthalmic coding specialists get a $500 bonus. Everyone completed a recent course on coding new treatments. Boles says, “The managers also call each other about coding matters and learn from each other. We remind the physicians that staff helps with coding, but they are ultimately responsible for correct documentation and coding. There usually is one physician in each practice who really enjoys coding and helps the other physicians and staff.”

**Collections**

Each local administrator takes this approach to collections:

1. Send statements to patients for 90 days, supplemented by phone calls.
2. Check with patients’ physicians to determine whether to go to collections. They may be willing to write off the bill. If not,
3. Send a 10-day notice stating “We will be forced to go to an outside collection agency if the bill is not paid.”
4. Send to a collection agency. Result: Typically, BVA turns over less than 10 percent and, of that, collects about 20 percent. The old balances are written off as bad debt.

Boles states, “We’re lucky that most Oklahoma people pay their bills on time. Most still honor the values of farm people who would rather go without than leave a bill unpaid. So, collections, for us, are not a major problem.”

**BEST PRACTICES**

**Collection code of ethics**

1. Medical groups should fully explain the terms of any collection transaction to their patients.
2. Bills should be sent as soon as possible after the billing cycle ends – at least two weeks before the next payments is due.
3. Calls or correspondence from a patient claiming a billing error should be acknowledged promptly.
4. Collection practices should be based on the presumption that every debtor intends to pay or would pay if able.
5. Late charges should be assessed only to the extent necessary to recover overall expenses caused by the delinquency.
6. Patient complaints concerning collection practices should be investigated immediately.
7. Collectors should be instructed to attempt to determine the cause of a delinquency and to indicate willingness to arrange a mutually satisfactory repayment schedule when appropriate.

8. Patients who show a sincere desire to pay their debts should be offered, if necessary, extended payment schedules, financing arrangements or similar methods that would help re-establish solvency.

9. If the patient does not respond to an offer to help make alternative arrangements, the collector should explain the seriousness of continuing delinquency and advise the patient regarding courses of action.

10. While collectors have an obligation to disclose to debtors and endorse the remedies that may be invoked against them, legal action should not be cited unless it can and will be used.

11. Telephone calls must be placed between the hours of 8 a.m. and 9 p.m. in the patient’s time zone, unless other times are more convenient for the patient and have been previously noted by the patient.

12. Outside collection agencies, attorneys, process servers and other agents employed to collect delinquent accounts should be furnished with written instructions on how patients are to be approached and what practices are and are not sanctioned.

13. Medical groups should be particularly careful in handling delinquencies due to a patient’s dissatisfaction with services.

14. A patient’s medical complaint, as a reason for not paying, should be referred immediately to the patient’s physician for reconciliation.

---


---

### Monthly productivity report

**Month/year:**

**Employee name:** Beth

**Patient type:** Medicare

<table>
<thead>
<tr>
<th></th>
<th>Previous month A/R</th>
<th>% of previous A/R</th>
<th>Beginning month A/R</th>
<th>% of current A/R</th>
<th>Receipts</th>
<th>% of total receipts based on product</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–30</td>
<td>919,664.34</td>
<td>86%</td>
<td>1,318,985.02</td>
<td>92%</td>
<td>$57,871.37</td>
<td>16%</td>
</tr>
<tr>
<td>31–60</td>
<td>105,186.03</td>
<td>10%</td>
<td>99,182.12</td>
<td>7%</td>
<td>258,867.11</td>
<td>70%</td>
</tr>
<tr>
<td>61–90</td>
<td>42,062.03</td>
<td>4%</td>
<td>20,139.83</td>
<td>1%</td>
<td>34,605.04</td>
<td>9%</td>
</tr>
<tr>
<td>91–120</td>
<td>2,138.87</td>
<td>0%</td>
<td>4,046.18</td>
<td>0%</td>
<td>12,426.38</td>
<td>3%</td>
</tr>
<tr>
<td>120+</td>
<td>(1919.92)</td>
<td>0%</td>
<td>(3,543.40)</td>
<td>0%</td>
<td>6,777.29</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,067,131.35</strong></td>
<td><strong>100%</strong></td>
<td><strong>$1,438,809.75</strong></td>
<td><strong>100%</strong></td>
<td><strong>$370,547.19</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

© 2009 Medical Group Management Association. All rights reserved.
Daily audit

<table>
<thead>
<tr>
<th>Account #</th>
<th>Patient name</th>
<th>Benefits</th>
<th>Outstanding needed</th>
<th>Credit balance</th>
<th>Privacy due</th>
<th>Referral notice needed</th>
<th>Comments needed</th>
</tr>
</thead>
</table>

Manager signature: __________________________________________________________

Please make sure you write in the comment section what action was taken (e.g., collected, paid, insurance added, referral received, etc.)

**Note:** Each account must have action taken before being faxed back to the CBO and administration offices. If action was not taken at check-out it is the responsibility of the manager to resolve (e.g., get referral, enter benefits or call patient regarding balance and make payment arrangements).

Checklist for managing A/R

Specific behaviors instilled in many medical practices influence their decision-making capabilities and performance. These behaviors include establishing goals, monitoring performance and addressing A/R management problems early. Some things to consider when establishing these behaviors include the following:

**Management and culture**

☐ Provide staff training and continuing education as a job requirement.
☐ Provide physicians and staff members with updates on regulatory changes to ensure compliance and proper documentation of patient encounters.
☐ Involve the physicians in the billing process to ensure that staff members understand the importance of the process and the value of their roles.
☐ Create a policy handbook documenting all rules and procedures.

**Process**

☐ Set performance standards and expectations for billing staff.
☐ Cross-train staff on the A/R process.
☐ Define the elements of a clean claim and build training programs for billing staff.
☐ Establish a relationship with patients early to reduce patient stress caused by large payment obligations.
☐ Employ a certified coder or encourage appropriate staff members to learn more about coding.
☐ Manage payer relationships and contracts. Take action on any problems.
☐ Meet with payers regularly to form a relationship and understand their policies.
☐ Ensure that payer contracts explain what constitutes a clean claim, submission and payment requirements, the appeals process, and termination causes and methods.
Lessons for Financial Success

- Review patient account balances at scheduling time.
- Verify patient eligibility, copayments and deductibles prior to providing services.
- Confirm patient insurance status at each visit.
- Collect copayment or deductible at the time of service.
- Post charges for all office visits on the date of service.
- Follow up on outstanding claims early to reduce the need for more aggressive tactics later.
- Prioritize claims for follow up by amount and age.
- Establish structured payment in response to patient needs.


EXAMPLES

Daily billing control sheet

<table>
<thead>
<tr>
<th>Prepared by:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial class</td>
<td>Received</td>
</tr>
<tr>
<td>Medicare</td>
<td>Number</td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Private payer 1</td>
<td></td>
</tr>
<tr>
<td>Private payer 2</td>
<td></td>
</tr>
<tr>
<td>Self pay</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>


Tips for billing efficiency

The BVA (see practice success story above) staff uses these procedures to ensure billing efficiency:

- Update each patient’s payment information at the front desk at every visit;
- Educate new patients about the practice’s financial policies and their responsibilities;
- Check the patient’s insurance benefits before check-out;
- Let the patient know at check-out if he or she needs to pay any of the cost;

© 2009 Medical Group Management Association. All rights reserved.
• Ask, in a business-like manner, if the person would prefer to pay by check or credit card; and
• Send patients home with a payment envelope if they prefer not to pay that day. They can expect statements, messages and calls until they pay.

SUMMARY

This chapter featured many ideas and examples that help manage a medical practice as a business. It is clear that A/R and collections relate to the business side of a practice and that after patient care, practices share the same concerns of any business – getting paid for services, having effective billing processes, maximizing revenue, managing client payments and overdue accounts, and ensuring that employees operate in a trustworthy manner.

The success stories detailed a few approaches to managing A/R, billing and collections. You may already use some of these ideas or perhaps you can modify them to fit your practice operations. And the data tables provide a glimpse into the benchmarks you can use to measure your practice's success.

DISCUSSION TOPICS

Practice what you just learned with the discussion topics.

1. Analyze some of your practice's A/R data and see how the numbers compare against the MGMA benchmarks, which can be found in the MGMA Cost Survey Report.
2. What does your front-office process look like? Does it have any of the steps mentioned in the text? What can you suggest to make it more effective?
3. Do you outsource your billing or is it done in-house? What steps can you suggest that would make either method more beneficial to the practice?
4. Ethical employee behavior limits theft in a practice. Does your practice have an employee handbook? Does it have detailed job descriptions and expectations of employees? What can you do to create/improve these documents?

GLOSSARY

**Bad Debts Due to Fee-For-Service (FFS) Activity** – The difference between adjusted fee-for-service charges and the amount collected.

**Collections** – The sum of FFS collections, capitation payments and other medical activity revenues; also called total medical revenue.

**Current Procedural Terminology® (CPT®)** – A standard system of codes and descriptive terms, developed by the American Medical Association, for the reporting of medical procedures and services provided by physicians and other healthcare providers.
Health Savings Account (HSA) – Health insurance that combines a low-cost, high-deductible insurance policy with a tax-free savings account to pay for qualified medical expenses. An HSA is an individually funded plan that shifts more financial responsibility to individuals for healthcare management. Patients can withdraw or carry forward any funds in an HSA at the end of the year.

Payer – An insurance company that arranges for the delivery of healthcare services on behalf of insured beneficiaries.

Receivables – All money claims against individuals, organizations or other debtors.

Self Pay – Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients who pay the medical practice directly.

BENCHMARKING DATA FROM MGMA SURVEY REPORTS


<table>
<thead>
<tr>
<th>Business operations and financial management – survey results</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used dashboards to benchmark and track practice performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly financial reports</td>
<td>94.48%</td>
<td>85.10%</td>
</tr>
<tr>
<td>A/R summary reports</td>
<td>81.38%</td>
<td>65.87%</td>
</tr>
<tr>
<td>A/R detail reports that included data such as charges, collections and coding</td>
<td>64.14%</td>
<td>61.84%</td>
</tr>
<tr>
<td><strong>Percentage of copayments collected at time of service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 – 100%</td>
<td>47.15%</td>
<td>36.63%</td>
</tr>
<tr>
<td>75 – 89%</td>
<td>32.52%</td>
<td>29.07%</td>
</tr>
<tr>
<td>50 – 74%</td>
<td>9.76%</td>
<td>15.12%</td>
</tr>
<tr>
<td>0 – 49%</td>
<td>10.57%</td>
<td>19.19%</td>
</tr>
<tr>
<td><strong>Practice’s billing function structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralized – all claims are forwarded to a central location</td>
<td>73.33%</td>
<td>75.53%</td>
</tr>
<tr>
<td>Decentralized – each branch/office enters its own charges</td>
<td>6.67%</td>
<td>7.98%</td>
</tr>
<tr>
<td>Both/hybrid</td>
<td>13.33%</td>
<td>7.45%</td>
</tr>
<tr>
<td>Outsourced this function</td>
<td>6.67%</td>
<td>7.45%</td>
</tr>
</tbody>
</table>
Use the following financial measurements against those of your practice to help improve revenue and manage costs. The data table below presents median, better-performing practices data and median MGMA *Cost Survey Report* data for a subset of specialties\(^1,2,3\).

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost Survey</td>
<td>BP*</td>
</tr>
<tr>
<td>Percent of total A/R 120+ days</td>
<td>8.04%</td>
<td>16.84%</td>
<td>8.66%</td>
</tr>
<tr>
<td>Months gross FFS charges in A/R</td>
<td>1.05</td>
<td>1.38</td>
<td>.92</td>
</tr>
<tr>
<td>Adjusted FFS collection percentage</td>
<td>100%</td>
<td>98.05%</td>
<td>99.58%</td>
</tr>
<tr>
<td>Bad debts due to FFS activity per full-time-equivalent (FTE) physician</td>
<td>$7,647</td>
<td>$18,893</td>
<td>$33,174</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$725,814</td>
<td>$690,032</td>
<td>$1,082,890</td>
</tr>
<tr>
<td>Total medical revenue after operating cost per FTE physician</td>
<td>$273,425</td>
<td>$272,460</td>
<td>$553,079</td>
</tr>
<tr>
<td>Total medical revenue after operating and nonphysician provider cost per FTE physician</td>
<td>$262,706</td>
<td>$255,064</td>
<td>$512,602</td>
</tr>
</tbody>
</table>

*Better–performing practice

APPENDIX

Visit mgma.com/lessons for interactive tools that will help you practice the concepts presented in this chapter.
WHAT YOU WILL LEARN

✓ Basic terms and concepts in managing costs
✓ Techniques for operations planning and budgeting
✓ Strategies to improve payer contracting
✓ Ideas to market a medical practice
INTRODUCTION

Costs – in today’s economy everyone wants to manage them the best they can. But to do that, you need to understand the types of costs and how they affect medical practices’ day-to-day functions. Managing costs takes planning and innovation. This chapter points out the importance of both strategic and operational planning, as well as the financial side of planning, otherwise known as budgeting.

Politics brings the issue of revamping healthcare to the minds of many more Americans. The truth is that insurance payers – both private and governmental – have been around for years and continue to add complexity and confusion to the process. You must understand how to best work with insurance payers so that your practice gets paid for the services it delivers.

Patients remain the major focus of any medical practice, but you have to know how to attract patients to your practice and keep them coming back. You will gain a few tips on how to do this and see how other practices have succeeded in creating a sustainable patient base.

WHAT’S COVERED

This chapter covers planning, budgeting and marketing, while weaving in a focus on maximizing profitability and managing costs. You will also see strategies in managing both governmental and private payers that will encourage you to ask the right questions and get paid appropriately for the medical services provided. In best practices and examples, you will also find suggestions to improve your practice’s daily operations, along with excerpts from success stories in the MGMA Performance and Practices of Successful Medical Groups Report that describe real-life medical-practice examples.

IN THIS CHAPTER

✓ Overview
✓ Profitability and cost management essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix
OVERVIEW

Every function, item and service has an associated cost. Understanding the differences among the types of costs and how to manage them will give you better insight to your practice’s overall financial success.

Further, planning is critical to any business. Strategic planning establishes high-level goals and objectives for the practice, while operational planning supports these goals with specific task-oriented objectives that employees can follow.

Creating a positive relationship with each of your insurance payers, understanding your contracts and negotiating payment terms can help improve practice revenue.

Finally, a practice needs patients to survive. How do you attract new patients and keep the ones you have? You will learn a few tips and perhaps a new approach to marketing your practice’s services to your community.

PROFITABILITY AND COST MANAGEMENT ESSENTIALS

Cost concepts

Costs can be associated with many things, such as providing a service or product, running a department or marketing a practice. Two cost classifications are important to know:

- Direct costs – Costs that can be traced to or caused by a particular service, product or practice activity. For example, the direct costs of treating patients include the physician’s salary, medical personnel salaries and supplies.
- Indirect costs – Costs that cannot be traced to a particular service, product or practice activity and cannot be directly measured. Examples include business office salaries, rent, building and machine maintenance, utilities and insurance.

Managing costs may seem simple – don’t spend money the practice does not have. However, this process can be complicated because many factors affect a medical practice’s costs. To understand the basics, you must consider how costs respond to changes in the level of activity associated with them. Some call this cost behavior; two specific elements in this area are:

- Fixed costs – Costs that remain constant regardless of activity. Examples include rent, property taxes, insurance and administrative salaries. These costs may increase over time, but they are not related to changes in the level of activity within a period of time. One important fact about fixed costs is that although the total amount remains the same at different activity levels, the fixed cost per unit changes with the activity levels. (See Exhibit 4.1.)
Exhibit 4.1 Fixed-cost example

<table>
<thead>
<tr>
<th>Monthly rental cost</th>
<th>Number of patients treated</th>
<th>Average cost per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>10</td>
<td>$1,000</td>
</tr>
<tr>
<td>$10,000</td>
<td>100</td>
<td>$100</td>
</tr>
<tr>
<td>$10,000</td>
<td>1,000</td>
<td>$10</td>
</tr>
</tbody>
</table>


- Variable costs – Costs that vary as the volume or level of activity changes. Examples include hourly laborers whose total hours worked vary, and supplies costs that vary based on number of patients and types of procedures performed. In a medical practice, variable costs are tied to patients. Exhibit 4.2 shows an example in which a medical practice uses an outside laboratory. The costs vary with different volumes of tests performed.

Exhibit 4.2 Variable-cost example

<table>
<thead>
<tr>
<th>Number of tests</th>
<th>Cost per test</th>
<th>Total variable cost of testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>100</td>
<td>$20</td>
<td>$2,000</td>
</tr>
<tr>
<td>1,000</td>
<td>$20</td>
<td>$20,000</td>
</tr>
</tbody>
</table>


Understanding why specific costs change when operating conditions change will aid you in managing the costs of your practice and allow you to better estimate future costs. For example, if your practice wants to add an ancillary service, you need to know the costs associated with equipment, supplies, personnel and space allocation. Does this change impact current processes? Who needs to be trained or hired to perform the service? You need to determine these costs before adding the service.

Cost management

You can think of cost management as a continuous process of planning, monitoring and controlling operational costs to meet the strategic goals of the medical group. It’s an approach that focuses on profit improvement.

What areas should you first address when trying to manage costs? The first, and most likely the area with the greatest impact, is personnel costs, which
account for about 30 percent of the average practice’s annual revenue. You need to evaluate the number of staff that support each physician and, if necessary, determine if tasks can be changed to reduce the number of support staff. The MGMA Cost Survey Report contains staffing benchmarks that might be helpful in beginning this evaluation. Be cautious in cutting staff to a level too low to meet a benchmark. Each practice operates differently and you know what works best to support your physicians and processes.

Next, evaluate staff functions such as scheduling, front office and transcription to see if these areas can be centralized. Look at employees’ tasks to see if they match the skills required for their job. In some cases, overqualified (and expensive) staff are hired to do jobs that could be done by less expensive employees. Take a look at these steps to help reduce staff costs:

- Limit the number of registered nurses, using them only for tasks requiring their training and skills;
- Cross train the staff to fill in for temporary vacancies such as vacations or illnesses;
- Avoid overtime by keeping office hours on time and staggering staff work schedules;
- Move payroll to an outside payroll service, thereby reducing manager and accounting time; and
- Consider outsourcing functions such as billing.

Supplies also contribute to the costs of any business, including medical practices. If possible, one member of the practice staff should be in charge of ordering and monitoring supplies so that you have sufficient inventory and can take advantage of volume discounts.

Some other areas to consider when trying to reduce costs include:

- Telephones – Monitor bills, especially long-distance calls;
- Laboratory fees – Find volume discounts with outside laboratories;
- Legal and accounting functions – Negotiate reduced fees with an outside accountant and lawyer;
- Competitive bidding – Seek competitive bids for expenses such as medical supplies, office supplies, stationery, printing and insurance; and
- Group-purchasing organizations – These organizations may offer discounts on many expenses, including, but not limited to, medical supplies and office supplies.

In this uncertain economy, you can also consider adding new lines of service that will generate revenue and allow staff to function in a new capacity. Once the overhead (for example, new equipment and staff training) is in place, a new service will go a long way in increasing profitability. Instead of approaching cost management as merely reducing overhead, using your
existing capacity to drive new business will allow you to keep staff and possibly gain new patients.

**Planning and budgeting**

Medical practices that want to run efficiently plan. Treating a medical practice as a business requires that management look ahead and identify action steps that will meet the practice’s strategic goals. Planning includes deciding on services and procedures, the number of physicians and staff needed to provide the services, physical space and the effective design of that space to meet patients’ needs.

The planning process should involve developing goals and objectives. Goals are broad statements that indicate what the practice wants to achieve. Sometimes these goals become the practice’s mission statement. For example, providing efficient, timely healthcare for patients could be a goal for any medical practice.

Objectives help the practice achieve its goals. Objectives are specific, cover a short time period and include aspects of the practice such as hours of operations, physician compensation and collections.

How do you start the process of determining your practice’s goals and objectives? First answer these basic questions:

- What patient groups will be served?
- What types of services will be provided?
- What will the practice’s role and leadership position be in the medical community?
- What impact will changes in technology have on patient care?
- How large of a professional staff does the practice want in five or 10 years?
- What will be the impact of changes in the local healthcare market on the practice’s market share?
- Is the practice’s community growing or shrinking? Is the population getting older or younger?
- What does the future pool of physicians look like for your practice or specialty?


After answering these questions, you can start developing your strategic plan, a long-term, visionary and high-level plan, will set the course for the practice. This type of plan usually sets the stage for the practice’s next five to 10 years of operation. Some practices go offsite for a day or weekend with key personnel to focus on the plan.
To achieve the long-term goals set forth in the strategic plan, you should then create an operational plan that includes short-term goals that can be achieved within a week, month or longer as needed. All goals and objectives should be communicated to all staff so that everyone understands the direction of the practice and contributes to its success.

Exhibit 4.3 shows an example – providing superior quality medical care – and objectives for just some of the areas in the practice to achieve that goal.

**Exhibit 4.3  Example of objectives supporting a goal**

**Goal:** Provide superior quality medical care

**Professional services**
Objective 1 – Add three general practitioners within six months.
Objective 2 – Add all major specialties within five years.

**Financial resources**
Objective 1 – Negotiate a line of credit with a local bank for working capital within three months.
Objective 2 – Set up a two-year capital budget within one month.

**Innovation**
Objective 1 – Establish a marketing plan for the practice within one year.

**Productivity**
Objective 1 – Initiate a system that tracks individual production on a monthly basis within six months.
Objective 2 – Increase professional production by 5 percent within one year.

You can see that goals and objectives provide the framework for developing yearly operating plans. Objectives bridge the strategic-plan goals with the short-term operating plans. What's missing is how you will pay for meeting these objectives and what revenue will be gained through their implementation. To accomplish this, you need a budget.

Budgeting can be thought of as the money plan. It's the tool that shows expected income and the expenses necessary to pay for the objectives. Budgets also help with:

- Unifying planning and control functions;
- Aiding in the creation and coordination of short-term plans and communicating these plans to all managers;
- Motivating managers to achieve the goals of their departments by providing target measures;
Lessons for Financial Success

- Providing authorization for staff to use and acquire resources during the budget period and expand existing or implement new activities;
- Enabling managers to anticipate favorable conditions so that money can be used to implement desired objectives, or, if unfavorable conditions exist, taking steps to minimize the impact; and
- Establishing benchmarks to control ongoing activities and set criteria for evaluating management performance.

Without a budget, a practice would have little control on spending and would not be able to predict revenue and profit.

Some budgets are simple, while others are more complex. A medical practice should prepare different budgets depending on the mission, approach to management and organizational culture and structure. Typical budgets that a medical practice may prepare include:

- **Provider compensation forecast** – The remainder of revenue after the operating costs and salaries of nonphysician providers and salaried physicians are paid that is available for distribution to the physician owners and shareholders.

- **Statistics budget** – Also referred to as a service volume forecast, which predicts the volume of services a practice can expect to perform. It is the foundation for all other budgets and crucial to the budgeting process. More often than not, a practice will assign relative value units (RVUs) to particular services. RVUs help a manager predict a total number of patient visits and can be thought of as a common denominator that relates all services on the same scale. If your practice does not use RVUs, the services might need to be budgeted individually.

- **Operating budget** – Includes the revenue and expense budget that predicts the practice’s financial performance. In most practices, the operating budget predicts the practice’s profit or loss. For planning purposes, apply the formula:

  \[ \text{total revenue} - \text{total operating expenses} - \text{provider compensation forecast} = \text{profit}. \]

  If the amount calculated is positive, the profit can be pooled into provider compensation. If it is negative, adjustments should be made because physician owners and shareholders will not be paid as expected.

  - **Revenue budget** – Based on the statistics budget, a practice manager should prepare a revenue budget on a monthly basis, which will help predict monthly revenue. The revenue budget includes the practice’s ability to collect accounts receivable depending on the mix of services and the mix of payers.

  - **Expense budget** – Also based on the statistics budget, the expense budget focuses on each expense category and includes a labor budget (fixed and variable labor expenses), a supplies budget (non-labor expenses such as variable costs associated with services) and what
the business world refers to as the administrative and general (A and G) budget (fixed costs such as interest, depreciation, utilities, rent, cleaning and housekeeping). The expense budget goes through extensive revisions as projects and staffing levels are approved. Staffing decisions have the greatest impact on the expense budget and should be monitored.

After preparing these budgets, a manager may now calculate expected profit or loss on both an annual and a monthly basis and decide whether or not the budget satisfies the practice's goals. Once the operating budget is approved, the manager can prepare other key budgets such as:

- **Capital budget** – A capital budget is necessary if a practice's goals require additional capital expenses. The capital budget summarizes the practice's expectations acquiring capital assets that have lives greater than one year, such as land, equipment and other fixed assets. It can be considered a detailed list and acquisition schedule based on medical necessity or economic benefit to the practice. The return on investment must also be calculated to justify acquisitions.

- **Cash budget** – A period-to-period estimate of the practice's cash levels. Days in accounts receivable becomes a critical measurement in a managerial cash budget, and this type of aging analysis should be applied to each payer so that you know when you will receive payments that can be used to run the practice. An organization does not want to have too much cash on hand because that would limit opportunities for short-term investment. Too little cash on hand is a problem as well, because the practice may need to borrow, which inevitably involves paying interest. Preparing an adequate cash budget involves looking at the expense budget, the revenue budget, the practice's balance sheet from the previous year and an aging analysis.

These budgets form the comprehensive budget that you can present to the practice’s governing board. The Examples section contains a sample budget. You also can find a thorough budget worksheet in the Chapter 4 – online tools page.

**Payer contracting**

Both private and governmental (Medicare and Medicaid) insurance payers play a large role in medical practice reimbursement for services. With Medicare and Medicaid, you cannot negotiate your fees, but you can stay current on changes by getting more politically active with both local and state initiatives affecting healthcare in your community. Know your state's regulations such as whether it regulates payer fee disclosure. Some states regulate payer fee disclosure and others do not.

Today, the political healthcare climate is ripe with potential change. Medical practices need their voices heard so that change works for all. With that said, the current private payer situation can be daunting at best. Effectively
navigating the system takes work and patience. Most importantly, you should know the allowable fee schedules for each of your payers. Too often, practices engage in a payer contract without knowing the reimbursement amount for specific services.

Negotiating and renegotiating with payers will force you to evaluate your contracts so that you get paid appropriately for the services you provide to patients. Also knowing how dependent the practice is on each payer can help form your contract discussions.

The Best Practices section contains a payer-contracting checklist and guidelines from an MGMA better-performing practice that can make this process a little easier.

Marketing strategies
Most successful medical practices invest time and money in marketing their practices. One practice may benefit more than another from specific marketing approaches. Marketing may seem to be just one more thing to add to an already full to-do list. But competition can be fierce in today’s healthcare market, and you should take the lead in promoting your practice.

The size, specialty and location of your practice can help determine the best approach to promoting it. Large practices may have more money to spend on marketing campaigns, and specialty practices can target specific audiences such as parents or seniors.

Relying on positive word-of-mouth from current patients will bring new patients to your practice and can be the most rewarding and effective approach to practice marketing. You can also participate in community outreach activities such as health fairs, senior centers and charity functions to help get the practice’s name out to many individuals. You may also take a traditional approach with ads in phone books, or on radio or television. Today, many practices have Web sites that contain basic information about the practice, contact information, services provided and physician profiles. A Web site can provide a positive image to potential patients.

If your practice is a single-specialty practice, you may want to focus your efforts on marketing to referring physicians. Building a relationship with these physicians can go a long way in driving business to your practice. Some practices host golf outings, lunches and open houses for referring physicians.

It’s important to know that marketing is not just creative advertising. This aspect of the business includes research to plan investment strategies and the services and equipment that are needed to stay competitive.

Regardless of the approach you decide to take, start with a plan that will aid you in developing the best course for your practice. The Examples section contains a nine-part model with a suggested marketing action plan that will help you start marketing your practice or enhance your current marketing plan.
SUCCESS STORIES

Corpus Christi Women’s Clinic
Since 1981, the Corpus Christi Women’s Clinic has served Nueces County, performing 25 percent of the town’s deliveries (more than 40,000 to date). Its wide spectrum of women’s health services ranges from infertility to urogynecology to laser hair and vein removal. Currently the practice has 10 physicians, two nurse practitioners and 59 staff serving in one location. MGMA has designated Corpus Christi Women’s Clinic a better-performing practice because of the practice’s outstanding record in profitability and cost management.

Efficiencies
Practice administrator S. Craig Winkle believes in a practical approach to financial health and cost consciousness. He cites support staff numbers as an example. “I tell physicians, if you want $400 of income an hour, you don’t do $12 per hour paperwork. That’s why we have plenty of support staff. Result: high volume, high collection ratio.” Another source of savings is requiring the business office to handle surgery scheduling, so nurses can devote their time to patient care. This also affords the business office greater ease in tracking and billing for surgeries.

Winkle reports, “About four years ago when two physicians retired without replacements in place, I took my research on payer mix and per-patient cost to the physicians. I told them that if they wanted to maximize profitability with limited physician capacity, we must carefully manage the number of lower-pay patients. Medicaid pays far less than private insurance. So we encourage physicians not to book up with Medicaid patients, but rather to always leave some space for higher-pay patients. The clinic will utilize capacity with all payers but will not increase capacity for lower-pay patients.”

He emphasizes that with costs rising, quality care is dependent on gaining and retaining patients. The goal: To have a completely filled schedule with a balanced payer mix. Winkle works with the payers, communicating with them about rates and codes for new products. He says, “Physicians often want to do new treatments with heavy costs, maybe a $1,000 supply cost. I research such requests but deny them until the payers will pay appropriately. My motto: Never get ahead of the payment stream.”

Challenges
Winkle emphasizes cost-management issues such as employee costs. Using MGMA survey data and regional figures, he keeps wages in line. The clinic offers the full array of benefits, including a strong profit-sharing plan. There are bonuses for some job categories with measurable elements.

He says, “We work hard on retaining employees. It is difficult to find new people motivated to help others in a team environment — with sensitivity to
patients.” He notes that generally an OB/GYN practice is “happy medicine. But for some patients, a visit could be the worse day of their lives and staff can’t be seen as uncaring or indifferent.”

Winkle also focuses on medical malpractice costs. He and other staff went to the state legislature three to four times every session. Because of a recent constitutional amendment limiting awards in Texas, the malpractice situation has improved, but is always under attack by attorneys.

**Physician and management leaders**

The clinic has a physician management committee elected by the staff. Winkle says, “Four physicians meet with me on a monthly basis and I keep them involved with financial measures. I counsel those having difficulty with production-pay realities; if revenue drops, so does pay. We send all physicians to coding meetings where they learn that if coding is not done right, we can’t maximize collections.” Winkle also has five department managers to keep the practice running smoothly and efficiently.

**Financial goals**

Winkle keeps close watch on the economy. “If insurance reimbursement trails off or patients forgo treatment, we don’t want excess capacity when we have fewer patients. We also watch what the government is doing to Medicare, because all the other payers will follow suit.”

The administrator notes that three new physicians are working to create a 2009 budget that is superior to the 2008 budget. “We plan a 3 percent COLA increase across the board. We recognize that something always can affect the budget; for example, a physician’s pregnancy or an injury.”

**Cost-management specifics**

“As a CPA, I count everything all the time. I look for bottlenecks in processes. I use job costing to look at inputs and outcomes and where we can change things. In particular, I look at each line item with an eye on what can be improved, even if it is a necessary cost,” says Winkle.

Here are some of Winkle’s cost-saving suggestions:

- Rent a phone system with phone lines from one source. “We are spending slightly more than we did on just monthly phone lines, but have no repair costs and did not buy a new system to replace the 1991 system when we moved in 2006. We can decrease or increase the number of phones and/or lines any time”;
- Use only networked copy machines that can print/fax/scan, replacing many other machines and supplies. The costs for copies purchased in high volume (toner and maintenance) are much lower than having separate machines;
- Monitor laboratory costs. “We do not do any type of test in our own laboratory on a regular basis unless it is profitable and has a volume that will sustain the capital cost of new equipment. Even after this step, we send labs out to reference labs if some payers do not pay well on a certain test. This avoids the overhead (staff, supplies, and billing) to do any break-even testing. We mostly use rental laboratory equipment so that the cost of use follows the revenue of the tests. It is much less costly if we change our mind about certain testing or a better method comes along”;
- Use a postal service. “They charge us regular postal rates but they, in turn, presort the mail to pay less, keeping the difference as a fee. This also means we have no employee costs in mailing, no monthly lease for a mailing machine, no mistakes in the postage spent”;
- Major equipment. “I usually look for demo machines or overstocks by manufacturers. I lease if the item will become obsolete within a few years and purchase the rest. I also like deals where, if you buy a supply in volume, you get the equipment for free. I find it much easier to charge the physician who uses the supply unit than to get the group to buy a surgery device because many times, only four to six physicians want to do certain procedures and the others do not want to pay for a machine they do not use”; and
- Use electronic time clocks. Keep overtime to a minimum with real-time data.

**Oregon Orthopedic & Sports Medicine**

This practice, just outside Portland, Ore., started in the early 1970s as the first orthopedic surgery center in the county and surrounding area.

**Efficiencies**

The focus of this practice, says Fred Flaherty, administrator, “is productivity first and cost second. We look at the surgeons and see how they work and want to work regarding staff, space, equipment and supplies. I believe you should not let cost drive you; instead focus on productivity and profit.”

**Innovation**

Noting that computers have adopted a key role in healthcare in the past decade, Flaherty says, “We try to make innovative changes in processes as we move away from non-electronic, paper systems. We are always aware of the kind of technology coming on the scene, research it thoroughly and plan its integration carefully. Over the past two years, we have migrated to a document-imaging system. The system allows our surgeons and staff to be efficient and effective.”

**Physician leaders**

Flaherty reports that all of the practice’s physicians have a strong work ethic and are very conscious of how resources are used — a great cost advantage.
He meets with all the physicians every month to report on operations and finance. He provides dashboard indicators and can drill down to the details as needed. Comparisons are then made to MGMA data.

**Financial goals**
Flaherty reports that this group likes to do things in a dynamic way. For example, while they keep strategic-planning factors in mind, they do not have a formal retreat to develop a strategic plan. Rather, they focus on specific projects anticipated in the next two years or less. One example is adding a new surgeon or more physician assistants and how that will impact revenue and costs. Only projects with positive projections are approved. Financial goals and budgeting are therefore straightforward, taking into consideration projects, the economy, population growth and expected returns.

**Financial performance areas**
The administrator concentrates on aggregate indicators such as net revenue after operating costs. Another focus is on billing and collections. If there is any issue, he discusses it with the individual physician. He notes that “the key to productivity/profitability in a practice is how the physicians impact their own revenue. Their behavior is highly correlative to financial health and cost management.” The practice has some shared revenue, but primarily it uses an individual physician income model.

The information gained from such analysis is put in front of the entire group. Because the physicians are highly profit oriented, they encourage each other to adhere to a strong work ethic. As Flaherty works with the group, he specifically focuses on:

- **Economies of scale.** Determine how to leverage space, how to fill space, how to handle purchasing and inventory;
- **Economies of scope.** Look carefully at the product/service mix. In this case, the practice has chosen not to offer spine and neck surgery but to focus instead on its defined, broad spectrum of services and core ancillary services, such as diagnostic imaging and durable medical equipment.
- **Economies of experience.** Capitalize on the ability to produce more by learning through doing. Accrual of knowledge is a key advantage in a competitive business. Capture that knowledge and maximize it — don’t let it just sit in the back of your head.

**Digestive Health Specialists**
Success factors

Gastroenterology continues to be an important field of medicine and keeps this practice very busy. Donaldson attributes much of the success to the longevity of the physicians and management staff. The founding physicians are still with the practice and overall the practice experiences low turnover.

“The physicians practice medicine and allow the business leaders to do their jobs,” Donaldson says. “The physicians allow me to do what I do best, and I work to help them do what they do best.”

Physicians can be efficient in what they do because of established scheduling procedures, scheduling review and automated appointment reminders to patients. Efficient processes also contribute to the success. Donaldson is a big believer in information technology and supported the conversion to an electronic medical record (EMR) system years ago. They also have a new practice management system, which has allowed much of the staff to operate more efficiently. The practice does not store paper reports, but rather uses Adobe® PDF format to store reports electronically, and have multiple scanners throughout the practice to scan all paperwork.

“You should never reinvent the wheel, but look for areas to be better and more efficient,” Donaldson says.

This particular practice has also incorporated physician assistants (PAs) who help accommodate more patients and allow the practice to open more ancillary services. It was one of the earlier practices to begin using PAs.

Donaldson also attributes success to managing the payroll. They take the approach of fixing issues instead of just throwing more people at it and not seeing results.

“Payroll is one of our biggest expenses and you have to get your best value out of it,” Donaldson says. “We pay our people well and seem to be in the low range of support-staff-to-physician ratio benchmarks, which works for this practice and specialty.”

Self-pay patients and health savings accounts (HSAs)

Self-pay patients do visit the practice and receive a substantial discount for prompt payment at time of service. Although the practice has a relatively high fee schedule, Donaldson doesn’t put much emphasis in the amount of charges billed. Collections play a more significant role in the profitability status of the practice.

“Because of the increase of self-pay patients and a few high-deductible health plans, we had to hire a full-time collections manager to keep up, and this affected our bottom line somewhat,” Donaldson says. “We experienced an increased cost of collecting that dollar. It isn’t as simple as it was before when all we had to collect was a $20 copayment.”
Practice operations
The practice takes a team approach to billing because they are not large enough to break out the work by payer. Instead they break the work out by function — hospital billing, insurance filing and payment posting. In addition, they developed a policy and procedures manual for each physician that includes the steps to complete the various job functions within the practice. This allows for effective cross-training, new employee training and the ability for other employees to pick up the work when another is out sick or on vacation.

Biweekly team leader/staff meetings spur discussions on issues important to the practice. Together they work out plans to help the various aspects of the practice meld to become a more efficient workplace. Communication is key to motivating employees to fix issues and perform at their peak. Employees also attend Medicare meetings and payer meetings to keep current with upcoming changes.

Marketing the practice
Digestive Health Specialists markets to primary care physicians and staff, not to patients directly. The practice relies on referring physicians for much of their business. Donaldson and staff build relationships with the primary care physicians by hosting golf outings, lunches and, most recently, a colon cancer awareness program.

Final thoughts
The key to success, according to Donaldson, is the ability to adapt to change.

“Healthcare overall is not very innovative,” Donaldson says. “Healthcare has found new procedures and technology, but we haven’t re-evaluated how we deliver healthcare. We are in the break/fix mode and not in prevention or early detection mode and resist change. This needs to improve, and we must look at the big picture to remain successful and provide the best care to patients.”

BEST PRACTICES
Contracting and managing your payers can be an overwhelming process. Provided you have an adequate practice management software application, a calendar and a file cabinet you can conduct very effective contract management, monitoring and renegotiation with your payers.

Here’s a summary checklist to help you with payer contracting:

- Organize your contracts and calendar them for review annually;
- Consider issues other than reimbursement when evaluating an agreement. If a payer asks something of your practice, ask for something in return;
- Know your value to the payer before initiating recontracting;
Know the payer’s value to your practice, and know your bottom line before initiating recontracting;

Know your cost of doing business before negotiating. Your costs are your costs, and nobody can argue them with you. If it costs you $35 for a patient to come in the door, why would you take less for an office visit? Physician practices are not immune to the laws of economics;

Establish fee schedules for your contracts, and monitor them. Be vigilant and insist on being paid appropriately; and

Watch for denials. If you are being paid per the terms of your agreement, but denials are reducing the overall reimbursement of the contract, and those denials are not consistent with Medicare’s correct coding initiative (CCI) or other generally accepted rules, question whether or not you wish to remain contracted with the payer.


**Negotiating higher reimbursement from an insurance company**

*By Marc Mertz, FACMPE*

This excerpt, taken from an article published in the MGMA Performance and Practices of Successful Medical Groups: 2004 Report Based on 2003 Data, provides a realistic view of working with payers.

The cost of providing medical services (staff salaries, malpractice insurance, medical supplies, rent, etc.) continues to increase each year, the reimbursements received from insurance companies (as well as the government) remain relatively flat or have decreased.

Most medical practices accept payer contracts, and the corresponding fee schedules, without question. In fact, many practices do not know the amount that insurance companies pay them each year.

Practices that do review contracts and attempt to negotiate higher reimbursement are usually met with great opposition from the insurance company. In most cases, insurance companies convince the practice that the fees are not negotiable, and that they must “take it or leave it.” While this may be the case in some situations, there is usually room for negotiating a higher rate of reimbursement if the practice approaches the negotiations correctly.

So, where do you start? Regardless of your specialty, practice size or location, you need to start with access to data.

**Collect data**

To start the process, obtain a list of your most common current procedural terminology® (CPT®) codes. In primary care practices, most of your practice’s revenue will be tied to a handful of evaluation and management (E&M) codes.
Rank your codes by the dollar volume of charges and include enough in your list so that you account for at least 75 percent of your total practice charges. Many practices have computerized practice management systems that can easily generate reports of codes and their frequency of use.

If your practice bills manually, you should have a staff member track the codes that you use most frequently. This can either be an analysis of the past several months or the start of a new process. Next, using your list of top CPT codes, review explanations of benefits (EOB) that you have received from your top payers. Be sure to look at the allowed amounts, not the amounts that were actually paid, which are adjusted by copayments. You can use a spreadsheet program to create a matrix that displays each of your top payers and their reimbursement by CPT code. This will allow you to quickly compare each plan’s reimbursement level.

Although it may not be perfect, Medicare bases its fee schedule on a system of relative value units (RVU) that assigns a level of work and practice expense to each code. As a result, it is the best indicator with which to compare insurance companies’ reimbursement levels. Include a column in your spreadsheet for Medicare and its allowed amounts. You can then use a simple formula to calculate each insurance company’s current reimbursement as a percentage of Medicare.

**Pick a “winner”**

Now that you have an idea of your current situation as well as a reimbursement target, you should next determine with which insurance company you want to negotiate. For negotiations to be successful, you need to have leverage. In this case, your leverage will be your practice’s participation with the insurance company. If they are unwilling to increase their reimbursement level, you must be prepared to limit or end your participation with that plan. Therefore, you should not start with your largest payers. Pick a plan that represents 5 percent to 10 percent of your practice’s income. The best target would be a plan that is aggressively trying to improve market share or is new to the market. Do not focus on Medicare or Medicaid — the government will not negotiate with you. You also want to pick a plan that pays you at a below-average level.

Although an increasing number of plans base their reimbursement levels on a percentage of Medicare’s resource-based relative value scale (RBRVS) amounts, there are many that do not have a consistent method of determining their fees. As a result, many plans’ fees vary when compared to Medicare’s allowed amount. For example, while they may pay 125 percent on one code, they might only pay 75 percent of Medicare's allowed amount on another. When contracting with physicians, insurance companies often present a portion of their fee schedule. You must be aware that these reimbursement levels might look attractive, but they may be codes that you rarely use. It is important to identify your top codes and review actual payments from your EOBs.
Your negotiations should focus on converting the insurance company to a fee schedule based on a higher percentage of Medicare’s allowed amounts. This will not only ensure you of improved overall reimbursement, but the consistency of the reimbursements will make it much easier to monitor the insurance company’s compliance with the negotiated payment amounts. Next, identify your goal reimbursement for the plan. This amount will vary based on your market, the plan’s current reimbursement and other factors. Your target rate should also make the insurance company one of your best-paying plans. In addition to your target, you should also identify a “walk-away” level. This number should represent the lowest level you are willing to accept. If the insurance company will not agree to pay you this amount, you will close your practice to new patients with that plan or terminate your participation entirely. You should be cautious to not be too aggressive. If a plan currently reimburses at an average of 110 percent of Medicare it is unlikely that they will agree to jump to 130 percent or higher.

**Start the negotiations**

Contact the insurance company’s local representative, in writing, stating that the current reimbursement levels are inconsistent and below the local average. The letter should request a meeting with a representative from the insurance company who is authorized to negotiate reimbursement levels. Usually, the local provider relations representative is not authorized to do this. The letter should be written so that it does not sound threatening or demanding, but it should mention the number of patients your group currently treats and the popularity and reputation that your physicians enjoy in the community. In addition, you should indicate your group’s desire to continue caring for the plan’s patients.

When your insurance company agrees to meet with you, begin the meeting by once again expressing your group’s desire to continue seeing the carrier’s patients and explain that in the current environment of increasing expenses, you cannot afford to accept the current reimbursement. To support this, you should present charts that clearly demonstrate the inconsistency of the carrier’s current reimbursement. These charts should also compare the plan’s current rates to those of other local commercial payers (without using plan names) and Medicare. Representatives frequently do not have an explanation for their plan’s lower and inconsistent reimbursement.

Next, present your group’s request for consistent and higher reimbursement. Your practice provides a valuable service to the plan’s members and should be compensated fairly. You should make it clear that your group will no longer participate with the plan should they refuse to make concessions. In return for the higher reimbursement, you can offer your group’s assistance in meeting plan goals such as formulary compliance or patient satisfaction. By doing so, you demonstrate that you are not looking for a handout, but are willing to do a little extra in return for higher reimbursement.
While the negotiation process may take many directions, you should remain dedicated to your objective. Always act professionally, but understand that the insurance company representative’s job is to try to avoid paying you more money. This is not a social encounter. Focus on irrefutable facts such as other plans pay you more for the same service, their reimbursement levels are inconsistent and lack logic and that your practice’s participation is valuable to the insurance company.

It is rare that the insurance company’s representative will be authorized to increase your reimbursement during the initial meeting, but he or she can take your request under consideration and contact you with a decision at a later date. Before leaving the meeting, be sure to establish your expectations for when you would like to receive a response.

If all goes as planned, you will receive a positive response from the insurance company. The offer may not be as high as you would have liked or requested. Do not hesitate to make a counter offer — especially if the offer falls below your “drop-dead” rate. At times, plans will request that you sign a nondisclosure agreement stating that the outcome of these negotiations not be communicated to other practices. You should be willing to sign this document. More plans look for multiyear agreements and you may wish to offer this up front, along with automatic annual increases.

In addition, be aware of the Medicare year used if the company agrees to tie reimbursement to Medicare. While it would appear to be an easy task to use the current year’s data, many plans use RBRVS scales that are more than two years old. Be sure to adjust your “120 percent of Medicare” offer based on the Medicare year used.

If the insurance company will not accommodate your requests, you must be firm and willing to close your practice to new patients or terminate your agreement with the plan. As much as physicians hate to discontinue treating established patients due to insurance coverage, it may be necessary. Explain to patients that their insurance company fails to compensate you at a market rate, and that you cannot afford to continue working with them. You may consider encouraging your patients to speak to their employers, who may contact the insurance company to express concern over losing your practice as a participating provider.

If the insurance company meets your request, you will be asked to execute an addendum to your current contract. Be sure that the effective date for your new reimbursement starts as soon as possible and not months in the future. Also, alert your staff to the new rates and effective dates and encourage them to report any inconsistencies.

Now that one insurance company has agreed to revisit and increase its reimbursement level, you can begin the process with other payers that are below your target.
Summary of steps
Your chances of successfully negotiating a higher reimbursement level from an insurance company are dramatically improved when you take the following steps:

- **Understand the situation**: Determine the reimbursement level of the insurance company for your services;
- **Present accurate and detailed information**: Generate reports that demonstrate the insurance company’s reimbursement level and compare it to other insurance companies in the market;
- **Know what you want**: Set a reimbursement goal and a minimum level that you are willing to accept;
- **Understand the market**: Payers will not agree to extreme rate increases. However, the loss of your group’s participation would create a marketing concern for the carrier; and
- **Be willing to walk away**: If the insurance company does not respond favorably, you must be prepared to close your practice to the plan’s patients. In today’s ever-tightening healthcare market, increasing your reimbursement for services can help make your practice more successful.

**EXAMPLES**

**Sample budget**
Budgets may also be referred to as profit plans because they show the planned activities that the business expects to do to achieve its profit goal. You should prepare a budget based on the same fiscal year as the practice’s financial statements.

<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service forecast</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>55,000</td>
<td>4,059</td>
<td>4,300</td>
<td>$8,359</td>
<td></td>
<td>15%</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>31,000</td>
<td>2,155</td>
<td>2,459</td>
<td>$4,614</td>
<td></td>
<td>15%</td>
</tr>
<tr>
<td>Encounters</td>
<td>32,000</td>
<td>2,155</td>
<td>2,210</td>
<td>$4,365</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Total procedures</td>
<td>50,000</td>
<td>4,099</td>
<td>4,122</td>
<td>$8,221</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee-for-service collections</td>
<td>$3,002,177</td>
<td>222,356</td>
<td>245,788</td>
<td>$468,144</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>Other revenue</td>
<td>42,149</td>
<td>3,100</td>
<td>3,456</td>
<td>$6,556</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>Total practice income</td>
<td>$3,044,326</td>
<td>225,456</td>
<td>249,244</td>
<td>$474,700</td>
<td></td>
<td>16%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total employee salaries</td>
<td>$946,156</td>
<td>$78,846</td>
<td>$78,846</td>
<td>$157,692</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Employee retirement contributions</td>
<td>78,854</td>
<td>6,571</td>
<td>6,571</td>
<td>13,142</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Other employee benefits</td>
<td>69,537</td>
<td>5,795</td>
<td>5,795</td>
<td>11,590</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Temporary support staff</td>
<td>21,400</td>
<td>1,783</td>
<td>2,559</td>
<td>4,342</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Information technology depreciation</td>
<td>44,925</td>
<td>3,744</td>
<td>3,744</td>
<td>7,488</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Information technology supplies and maintenance</td>
<td>9,788</td>
<td>816</td>
<td>852</td>
<td>1,668</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Telephone/Internet access</td>
<td>3,200</td>
<td>670</td>
<td>201</td>
<td>871</td>
<td></td>
<td>27%</td>
</tr>
<tr>
<td>Drugs</td>
<td>136,285</td>
<td>11,400</td>
<td>11,659</td>
<td>23,059</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Medical and surgical supplies</td>
<td>72,238</td>
<td>6,256</td>
<td>6,152</td>
<td>12,408</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Building rent</td>
<td>208,012</td>
<td>17,334</td>
<td>17,334</td>
<td>34,668</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Building maintenance and utilities</td>
<td>11,450</td>
<td>954</td>
<td>988</td>
<td>1,942</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Property taxes</td>
<td>6,235</td>
<td>3,117</td>
<td>—</td>
<td>3,117</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Furniture and equipment maintenance</td>
<td>9,340</td>
<td>778</td>
<td>812</td>
<td>1,590</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Furniture/equipment depreciation</td>
<td>28,650</td>
<td>2,388</td>
<td>2,388</td>
<td>4,776</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Administrative supplies and services</td>
<td>51,737</td>
<td>4,312</td>
<td>4,533</td>
<td>8,845</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Laboratory equipment depreciation</td>
<td>53,666</td>
<td>4,472</td>
<td>4,472</td>
<td>8,944</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Laboratory maintenance and supplies</td>
<td>35,000</td>
<td>2,900</td>
<td>3,120</td>
<td>6,020</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Radiology equipment depreciation</td>
<td>24,020</td>
<td>2,002</td>
<td>2,002</td>
<td>4,004</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Radiology maintenance and supplies</td>
<td>6,733</td>
<td>561</td>
<td>575</td>
<td>1,136</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>Accounting services</td>
<td>4,800</td>
<td>395</td>
<td>450</td>
<td>845</td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td>Legal services</td>
<td>13,287</td>
<td>1,159</td>
<td>1,100</td>
<td>2,259</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td>General liability insurance – administrative and general (A and G)</td>
<td>6,739</td>
<td>591</td>
<td>591</td>
<td>1,182</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Professional liability insurance</td>
<td>49,024</td>
<td>—</td>
<td>49,024</td>
<td>49,024</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Promotion and marketing</td>
<td>8,330</td>
<td>694</td>
<td>725</td>
<td>1,419</td>
<td></td>
<td>17%</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>$1,899,406</td>
<td>157,538</td>
<td>204,493</td>
<td>$362,031</td>
<td></td>
<td>19%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
### Sample budget

<table>
<thead>
<tr>
<th>Sample budget</th>
<th>Annual budget</th>
<th>January</th>
<th>February</th>
<th>March through December</th>
<th>Year to date total</th>
<th>Year to date percent of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount available for distribution to physician owners</td>
<td>$1,144,920</td>
<td>67,918</td>
<td>44,751</td>
<td>$112,669</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Physician salaries</td>
<td>$900,000</td>
<td>$60,000</td>
<td>$60,000</td>
<td>$120,000</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Physician distribution</td>
<td>57,255</td>
<td>—</td>
<td>—</td>
<td>$0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Physician retirement contribution</td>
<td>107,700</td>
<td>6,600</td>
<td>6,600</td>
<td>$13,200</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Physician meetings and travel</td>
<td>23,750</td>
<td>1,980</td>
<td>2,562</td>
<td>$4,542</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Physician other fringe benefits</td>
<td>56,215</td>
<td>4,848</td>
<td>4,985</td>
<td>$9,833</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td><strong>Total physician compensation and benefits</strong></td>
<td><strong>$1,144,920</strong></td>
<td><strong>$73,428</strong></td>
<td><strong>$74,147</strong></td>
<td><strong>$147,575</strong></td>
<td><strong>13%</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Net income after physician distributions

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net income after physician distributions</strong></td>
<td>$0</td>
<td>$(5,510)</td>
<td>$(29,396)</td>
<td>$(34,906)</td>
</tr>
</tbody>
</table>


---

**Nine-part marketing model**

This action plan will help you to begin marketing your practice or enhance your current plan.

1. **Make marketing a priority.**

   Use this high-level checklist to stay on track with your practice’s marketing plan or help determine your strengths and weaknesses:
   - Marketing is a top priority for us.
   - We have a month-by-month marketing plan and budget.
   - We have a clearly defined geographic or other type of target market.
   - Our service mix is comprehensive for our target market.
   - We can describe the benefits we provide to our patients.
   - We have a well-defined, meaningful “edge” that differentiates our practice from the competition.
   - We have written an effective and compelling marketing message.
   - We have a Web site that gives good information about us and how to find us.
   - We constantly work to build and improve relationships with our referral base.
   - We have a variety of strategies to get visible in our target market.
   - Our marketing educates people about who we are and what we do.
- Our retail presence is an asset for us — visible, professional, welcoming and accessible.
- We recognize that our “brand” is built upon every interaction our patients and referral sources have with us.
- We have contracts with the largest and/or best-paying insurers in the area.
- We have strong relationships with our local hospital(s).
- We follow up with patients and referral sources to stay at the top of their mind.

2. **Lay a strong strategic foundation.**
   Answer these key strategic questions:
   - What are your goals?
   - What’s your marketplace like?
   - What’s your share of referral sources? Are there untapped areas for growth?
   - Who are your patients? Define your market as best you can by geography, payers and demographics.
   - What is your financial profile? Analyze your payer mix, accounts receivable and financial ratios to determine your profitability and where you may be losing money.
   - What is your service mix?
   - What sets your practice apart from other practices?
   - What proof can you offer to distinguish your practice? Use quality and outcome indicators, patient satisfaction surveys, awards, credentials and patient testimonials.
   - What is your marketing message?

3. **Build your referral base.**
   Be proactive. Visit with referral sources to plan ways to help each other succeed.

4. **Establish visibility in your community.**
   Build trust and credibility by informing patients and referral sources about the practice. Get involved in community issues; participate in community health fairs and screenings.

5. **Make your location welcoming.**
   The practice should be accessible and the interior comfortable and inviting.

6. **Develop your service strategy.**
   Monitor key service benchmarks, such as scheduling appointments, answering phones, registration, communication and referrals.
7. **Measure and improve your quality and utilization.**
   Quality can mean different things — measure what's important to your practice or specialty and communicate the results.

8. **Improve hospital and insurer relations.**
   Build relationships with hospitals and insurers to gain visibility and increase revenues.

9. **Develop and follow a marketing action plan.**
   Successful practices establish annual, quarterly, and monthly marketing action plans detailing each activity, budget, and responsible party.

Reprinted with permission. Andrew Neitlich, The Healthcare Marketing Institute, Osprey, Fla. You can find more depth and detail about this topic at healthcaremarketinginstitute.com.

**Marketing strategies**

Corpus Christi Women’s Clinic (see practice success story earlier in this chapter) uses these approaches to stay in the public eye:

- Use the Yellow Pages and a Web site. Be where the shoppers look;
- Remember that word of mouth is it for an OB/GYN. Every patient visit is an opportunity for future business. Avoid bad patient experiences;
- Maximize public relations opportunities. Place physicians on “Ask a Physician” television shows, and encourage them to speak in public at civic meetings or women’s groups. Arrange media interviews with physicians about particular procedures;
- Concentrate on the right advertising spots. Calculate how many of your patients will see your message; and
- Ask for female vendor representatives. Recognize that the professional women who service your account will promote you via word of mouth.

**SUMMARY**

This chapter introduced a few concepts associated with costs, planning, managing payers and marketing your practice. You should now see that cost management can be a vital and innovative process in any medical practice and that without planning, a practice may not be able to fulfill its obligation to patients and its vision of delivering the best care.

Politics aside, insurance payer relationships remain crucial to getting paid at appropriate rates. More importantly, you can influence those relationships in a positive manner.

And, without patients your practice would not survive. Marketing tactics affect your practice’s profitability. Introducing new ideas or improving existing marketing efforts will allow you to maintain a sustainable patient base.
DISCUSSION TOPICS

Practice what you just learned with the discussion topics.

1. Review the practice’s strategic plan and see how the operational plan and budget correspond to it.
2. What does your practice’s marketing plan look like? What can you suggest to either create a marketing plan or improve the existing plan?
3. How many insurance payers (in addition to Medicare) does the practice work with? Are the contracts up for renewal soon? What can you suggest doing before the contracts are signed?

GLOSSARY

Budget – A financial plan that supports the operation plan and includes income and expenses.

Direct Costs – Costs that can be traced or created by a service, product or activity.

Fixed Costs – Costs that do not change with activity level.

Indirect Costs – Costs that support the practice but cannot be traced to only one service, product or activity.

Operation Plan – Short-term goals that support the broader goals in the strategic plan.

Strategic Plan – Long-term goals and objectives that cover a period of five to 10 years.

Variable Costs – Costs that vary with volume or activity level changes.

BENCHMARKING DATA FROM MGMA SURVEY REPORTS


<table>
<thead>
<tr>
<th>Business operations and financial management – survey results</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major capital investments made by the practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquired equipment and materials to provide new ancillary services</td>
<td>28.97%</td>
<td>22.60%</td>
</tr>
<tr>
<td>Acquired new practice management system/upgraded the existing system</td>
<td>15.17%</td>
<td>15.87%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
### Business operations and financial management – survey results

<table>
<thead>
<tr>
<th>Action</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired lab equipment</td>
<td>13.79%</td>
<td>7.73%</td>
</tr>
<tr>
<td>Acquired nuclear equipment</td>
<td>4.83%</td>
<td>4.35%</td>
</tr>
<tr>
<td>Acquired new electronic medical record (EMR)/electronic health record (EHR)</td>
<td>10.27%</td>
<td>12.02%</td>
</tr>
<tr>
<td>Acquired new providers or merged with another practice</td>
<td>32.41%</td>
<td>23.67%</td>
</tr>
<tr>
<td>Built new, acquired or expanded clinic facilities</td>
<td>27.40%</td>
<td>15.38%</td>
</tr>
<tr>
<td>Installed new phone system</td>
<td>20.69%</td>
<td>10.14%</td>
</tr>
<tr>
<td>Opened and made investment in ambulatory surgery center</td>
<td>3.45%</td>
<td>2.42%</td>
</tr>
<tr>
<td>Purchased property</td>
<td>4.83%</td>
<td>4.83%</td>
</tr>
<tr>
<td>Remodeled existing facilities</td>
<td>32.41%</td>
<td>22.12%</td>
</tr>
<tr>
<td>Did not make any capital investments</td>
<td>16.55%</td>
<td>20.77%</td>
</tr>
</tbody>
</table>

### Actions taken to advertise or market the practice

<table>
<thead>
<tr>
<th>Action</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad campaign</td>
<td>33.10%</td>
<td>32.21%</td>
</tr>
<tr>
<td>Articles in local newspapers</td>
<td>46.90%</td>
<td>48.33%</td>
</tr>
<tr>
<td>Community health fairs/screenings</td>
<td>45.52%</td>
<td>37.32%</td>
</tr>
<tr>
<td>Direct mail</td>
<td>24.14%</td>
<td>20.67%</td>
</tr>
<tr>
<td>Internet (practice Web site)</td>
<td>69.18%</td>
<td>58.85%</td>
</tr>
<tr>
<td>Letters or postcards to referring physicians</td>
<td>20.00%</td>
<td>13.88%</td>
</tr>
<tr>
<td>Newsletter to patients</td>
<td>13.79%</td>
<td>12.56%</td>
</tr>
<tr>
<td>Open house</td>
<td>13.79%</td>
<td>14.90%</td>
</tr>
<tr>
<td>Radio advertising</td>
<td>21.38%</td>
<td>20.77%</td>
</tr>
<tr>
<td>Television advertising</td>
<td>13.79%</td>
<td>14.01%</td>
</tr>
<tr>
<td>Visits with referring providers and their staff</td>
<td>42.47%</td>
<td>29.81%</td>
</tr>
<tr>
<td>Yellow pages – book</td>
<td>71.03%</td>
<td>72.73%</td>
</tr>
<tr>
<td>Yellow pages – online such as DexOnline</td>
<td>27.59%</td>
<td>26.79%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
Lessons for Financial Success

Business operations and financial management – survey results

<table>
<thead>
<tr>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the above</td>
<td>4.83%</td>
</tr>
<tr>
<td>Other</td>
<td>9.66%</td>
</tr>
</tbody>
</table>

Most effective means of attracting new patients to the practice

<table>
<thead>
<tr>
<th></th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising</td>
<td>3.01%</td>
<td>1.12%</td>
</tr>
<tr>
<td>High patient satisfaction</td>
<td>14.29%</td>
<td>17.88%</td>
</tr>
<tr>
<td>Market presence</td>
<td>7.52%</td>
<td>9.50%</td>
</tr>
<tr>
<td>Referrals from established patients</td>
<td>24.81%</td>
<td>18.99%</td>
</tr>
<tr>
<td>Referrals from other physicians</td>
<td>45.11%</td>
<td>44.13%</td>
</tr>
<tr>
<td>Web site</td>
<td>3.01%</td>
<td>1.68%</td>
</tr>
<tr>
<td>Other</td>
<td>2.26%</td>
<td>5.03%</td>
</tr>
</tbody>
</table>

Use the following financial measurements against those of your practice to help improve revenue and manage costs. The data table below presents median, better-performing practices data and median MGMA Cost Survey Report data for a subset of specialties:\textsuperscript{1,2,3}.

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost Survey</td>
<td>BP*</td>
</tr>
<tr>
<td>Total gross charges per full-time-equivalent (FTE) physician</td>
<td>$1,284,930</td>
<td>$1,076,662</td>
<td>$3,114,200</td>
</tr>
<tr>
<td>Total RVUs per FTE physician</td>
<td>14,374</td>
<td>12,231</td>
<td>36,777</td>
</tr>
<tr>
<td>Physician work RVUs per FTE physician</td>
<td>6,855</td>
<td>6,024</td>
<td>12,611</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$779,161</td>
<td>$690,032</td>
<td>$1,387,198</td>
</tr>
<tr>
<td>Total medical revenue after operating cost per FTE physician</td>
<td>$339,885</td>
<td>$272,460</td>
<td>$752,850</td>
</tr>
</tbody>
</table>

(Table continues on next page)
<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost</td>
<td>BP*</td>
</tr>
<tr>
<td>$309,905 total medical</td>
<td>$255,064</td>
<td>$706,006</td>
<td>$525,913</td>
</tr>
<tr>
<td>revenue after operating and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nonphysician provider (NPP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56.27% total operating</td>
<td>61.19%</td>
<td>47.44%</td>
<td>52.17%</td>
</tr>
<tr>
<td>cost as a percent of total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$441,010 total operating</td>
<td>$428,238</td>
<td>$700,672</td>
<td>$587,388</td>
</tr>
<tr>
<td>cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59.41% total operating and</td>
<td>65.11%</td>
<td>51.46%</td>
<td>54.49%</td>
</tr>
<tr>
<td>NPP cost as a percent of total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$469,131 total operating</td>
<td>$467,591</td>
<td>$731,751</td>
<td>$628,709</td>
</tr>
<tr>
<td>and NPP cost per FTE physician</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Better–performing practice


APPENDIX

Visit mgma.com/lessons for interactive tools that will help you practice the concepts presented in this chapter.
Lessons for Financial Success

CHAPTER 5

Productivity, Capacity and Staffing

WHAT YOU WILL LEARN

✓ Ideas to rightsize a medical practice's staff
✓ Techniques to empower employees
✓ Tips for physician recruitment and compensation
✓ Ways to measure productivity
✓ Ideas to better manage workflow and patient flow
INTRODUCTION

Productivity can be the key to making a medical practice successful. Productivity includes empowering employees, ensuring that you have the appropriate amount of staff for each physician, recruiting and retaining physicians, and examining workflow efficiencies and patient flow throughout the practice. Information technology can also add to your practice’s efficiency by streamlining processes. Technology has a place in each medical practice, but not all aspects work for everyone. In this chapter, you will see some different approaches and ideas so that you can make the best determination for your practice.

WHAT'S COVERED

This chapter covers productivity, empowering employees, retaining and recruiting physicians, and improving work and patient flow through examining processes and determining if technology will yield improvements. You will also see strategies for staffing a practice to gain the most efficiency. In Best Practices and Examples, you will find suggestions to use in your practice’s daily operations along with excerpts from success stories in the MGMA Performance and Practices of Successful Medical Groups Report that describe real-life medical practice examples.

IN THIS CHAPTER

✓ Overview
✓ Productivity, capacity and staffing essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix

OVERVIEW

Ensuring that you have the right staff numbers for each physician enhances your practice’s productivity. Determining this number takes close examination of processes and does not necessarily mean that you will lay off employees. Further, employees work best when empowered; they feel secure in knowing that they have the support of management and physicians. It's essential to measure the level of employee satisfaction and make adjustments based on your findings.
Physicians work hard. Measuring their productivity provides one benchmark on which to base physician compensation.

Also essential to a practice’s success is finding the right physician for your practice, which isn’t an easy job. An effective interview process helps identify the physician who best matches your practice’s vision and mission. After finding a new physician, you must orient him/her to your practice’s culture and the surrounding community to help ensure his/her success.

Practice productivity is the cornerstone of every practice, and it must be efficient. Examining workflows and patient flows will provide a path to see how your practice performs. Evaluating processes – as they relate to overall operations – allows you to see efficiencies and areas for improvement.

**PRODUCTIVITY, CAPACITY AND STAFFING ESSENTIALS**

**Rightsizing your staff**

Rightsizing is the systematic review of staffing levels, tasks and work processes to determine the appropriate number and mix of staff needed to meet medical practice goals. This process is practice-specific and influenced by physician expectations, physician productivity and internal practice-limiting factors such as a practice’s facility and technology, as well as the practice’s culture, strategic plan and operational goals.

To rightsize a staff does not necessarily mean to engage in layoffs. Rather, it means managing employees at a level that best fits your practice’s needs. This may mean that you need to hire more staff or that you require a different skill mix to meet the practice’s goals and objectives. Staff costs represent a major factor in a medical practice’s operating costs. (See Exhibit 5.1.) However, staff must be seen as a resource, not a cost to be cut in difficult financial times.

Rightsizing staff even without layoffs may still result in cost reductions if the practice is able to operate with a lower-cost staff. Some practices may be able to re-engineer and use more lower-cost medical assistants and fewer higher-cost registered nurses.

Also consider another important factor – your employees have the knowledge to run the practice. You need this knowledge. By rightsizing the staff, you ensure that staff maintain acceptable workloads and provide effective service and quality care.

Practices staff at different levels, based on such factors as size of practice, specialty and services provided. Data from the MGMA Cost Survey Reports demonstrate a relationship between appropriate staffing levels and profitability. Data reported by practices also suggest that productivity, revenue, expenses and profits increase with the number of staff per full-time-equivalent (FTE) physician, and the increase in revenue associated with the increased productivity exceeds expenses, thereby making profits higher. However, the relationship between
Lessons for Financial Success

staffing and profit implies that the impact on profit is not necessarily the result of having more staff, but having the right staff doing the right things.

So, how do you rightsize? Rightsizing staff involves five steps:

1. Benchmark the current state – Determine if there are opportunities for change or improvement based on practice data and compared to peer groups and better-performing practices. Look at the following six measures to assess staffing levels:
   - Staff FTE per FTE physician and FTE provider;
   - Staff FTE by staff category and by job classification level per FTE physician;
   - Staff FTE per various outputs such as relative value units (RVUs), work relative value units, patients and patient visits;
   - Staff FTE per various inputs such as specialty and facility square footage;
   - Staff cost per FTE physician; and
   - Staff cost as a percent of total medical revenue.

2. Analyze current productivity – Understand the current productivity levels of the support staff. First, you must establish expected workload ranges by task or function and compare current staff productivity measures against these ranges.

Exhibit 5.1  Example of total operating costs for a medical practice

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Supply and Drugs</td>
<td>13%</td>
</tr>
<tr>
<td>Building and Furniture</td>
<td>12%</td>
</tr>
<tr>
<td>Administrative Supplies and Services</td>
<td>9%</td>
</tr>
<tr>
<td>Insurance</td>
<td>4%</td>
</tr>
<tr>
<td>Other Operating Costs</td>
<td>2%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>3%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>3%</td>
</tr>
<tr>
<td>Radiology and Imaging</td>
<td>2%</td>
</tr>
<tr>
<td>Total Support Staff</td>
<td>51%</td>
</tr>
</tbody>
</table>
3. Analyze the current practice model – Determine the model by which the practice operates. This includes the staff number and function allocated to each physician, method of check-in and check-out processes, medical record management, scheduling procedures and telephone processes. Many models exist, and it’s important to monitor current processes and determine what works and what needs improvement.

4. Analyze process performance – Separate key business processes and create a flowchart for each. Begin this step by determining the starting and ending point of the business process and identifying each step in between. The flowchart will provide a picture of the process and allow you to identify redundant steps, unnecessary steps and other areas of improvement.

5. Take action – Share data with physicians and staff so that everyone understands the current status, may be able to provide suggestions and will be more likely to accept change. If changes are made to staffing levels or skill mix, be sure to measure patient satisfaction scores, physician productivity, staff costs as a percent of total medical revenue and revenue after operating costs, both before and after the changes are made.

**Empowering employees**

Think back to a time when you received poor service at an organization. Ever wonder why? Perhaps the employee was not satisfied with the job, the pay or the hours, and did not have an opportunity to express those concerns to management. Instead, the employee took out that irritation on customers.

Don’t let that happen in your practice.

The question lies in how to determine if employees are satisfied, and if not, what issues are preventing their satisfaction.

Large and small practices alike can benefit from asking employees about their level of satisfaction on many different topics by simply using an employee satisfaction survey. Better-performing practices conduct employee satisfaction surveys at least once per year. This anonymous approach to asking about the organization, customer service, compensation, benefits, working environment, professional growth, communication, and employee attitude toward supervisors and physicians can provide vital information to everyone involved. Results of the survey can provide a picture of a practice’s needs and strengths.

A sample employee satisfaction survey in the *Best Practices* section (shared by the San Dimas Medical Group, Inc. [SDMG], Bakersfield, Calif.) illustrates one approach to gathering employee attitudes on many aspects of their work environment. In this survey, the practice encourages employees to suggest a solution for those areas in which they “strongly disagree.” Providing a method
for employees to suggest ideas involves them in potential solutions and prevents them from using the survey merely to complain.

Measuring just for the sake of measuring will not work. To get the most benefit from an employee satisfaction survey, you must share the results with physicians and staff. Together, you can identify areas for improvement and create a plan to institute change. Employees will feel more engaged and motivated to work together toward achieving goals. You will also identify the strengths of the practice and understand the areas where you are getting it right.

Make sure that employees know that all survey results will be summarized (including comments) but that employees’ identities will remain confidential. An off-the-record survey will yield more honest results.

**Measuring productivity**

Many practices use RVUs to measure physician productivity. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians and is associated with each current procedural terminology (CPT®) code. Each calendar year, the Centers for Medicare & Medicaid Services (CMS) publishes RVU tables with each procedural code and an associated RVU weight. This objective method of determining physician productivity provides an approach to paying physicians based on their work.

The RVU unit consists of three components:

1. Physician work (time, mental effort, technical skill, judgment, stress and level of a physician’s education);
2. Practice expense (direct expenses such as supplies, nonphysician labor, equipment expenses and indirect expenses); and
3. Malpractice expense.

No method of measurement is foolproof. While RVUs provide consistency, it’s important to remember that they fluctuate with annual changes to the Medicare fee schedule. Practices must be careful to update their fee schedules when changes are made.

Many practices do not support this method of measurement and pay physicians a base salary with an equal percentage of profit paid to each physician. This method also works. You must decide the method best suited for your practice. If you choose to use the RVU approach, it’s important to keep all data available for physicians and develop a dashboard report by physician that provides each physician’s RVUs and other related benchmarks so that they can compare their work levels to those of other physicians in the practice. The *Benchmarking Data from MGMA Survey Reports* section provides benchmarks to help you evaluate physician productivity.
Recruiting and retaining physicians

Your practice deserves to have the “right” physicians providing care to your patients. But how do you find the right physicians who support your mission and goals, match the culture and lifestyle of the practice and contribute their best effort because they enjoy their jobs? It starts with an effective interview process that helps determine the appropriate candidates in an objective and efficient manner. The Best Practices section contains an interview process checklist that will help guide you in future physician interviews.

After hiring a new physician, you must integrate him/her into the practice’s culture and community. A physician orientation program helps begin this process. Orienting a new physician includes more than just discussing office hours, vacation and on-call coverage. It should include the method of compensation, productivity measurements, the practice’s approach to customer service and its employee culture. Providing a new physician with an established physician mentor also helps him/her adjust to the practice and to the community. Stress that communication is key to success and encourage a new physician to ask questions and offer suggestions to issues.

Improving workflow and patient flow

Operational changes in workflows and patient flows improve productivity. Examining processes such as telephones, scheduling and patient check-in procedures to see where time may be wasted on redundant or outdated tasks is the first step. While it’s important to study these tasks independently, to achieve the best possible improvement to practice workflow and patient flow, also look at these processes as part of the whole to identify bottlenecks and efficiencies.

For example, a practice that collects patient data (including insurance information) before the visit either by phone or by providing forms on the practice’s Web site saves time when a patient arrives for an appointment. Like all of us, patients are busy, and they appreciate you saving them time. Many practices now collect copayments and past-due amounts when patients arrive instead of at check-out to ensure payment for services.

These efficiencies will not be effective unless you have also evaluated your scheduling process. An effective scheduling process allows physicians to see an optimum number of patients each day, which leads to more satisfied patients as well as a stronger financial bottom line. By having an efficient scheduling process, you maximize physicians’ time and reduce patients’ waiting time both in the waiting room and when scheduling an appointment. The Examples section contains a list of questions to help you evaluate your scheduling process.

Technology plays a role in efficiency but may not be the ultimate solution. For example, processes should be evaluated and updated before implementing an electronic health record (EHR) or electronic medical record (EMR). Applying technology to messy processes will not allow you to achieve the results you expect. Instead, evaluate the practice’s processes as mentioned earlier, then
create a project to implement an EHR if you have support from the practice’s leadership. This support is crucial to the success of an EHR because changing from a paper-based system to an electronic system is not easy and requires dedication and determination from everyone involved. A January 2007 MGMA Connexion article, “Think lean – redesign workflow to adopt EHR”, suggests these ideas to successfully implement an EHR:

- Get leadership buy-in for a new way of thinking and clear communication of goals;
- Agree to standardization – as much as possible – among physicians, departments and locations;
- Involve everyone in the redesign process – have all staff help document current processes;
- Acknowledge that change brings fear;
- Make clear that training and support will accompany the EHR implementation and process redesign;
- Designate people with knowledge of each process to serve on the redesign team;
- Assign analytical facilitators or consultants to lead the redesign effort;
- Provide formal lean training to process-redesign team members;
- Use input from everyone in the practice to create a list of key processes affecting the EHR;
- Consider the EHR’s capabilities and analyze the diagrams for improvement opportunities;
- Diagram the proposed redesigned processes, documenting EHR set-up requirements and reviewing them with your vendor. Test to find potential system roadblocks. Revise as needed;
- Present the redesigned processes to practice representatives and decision-makers for input and approval;
- Define benchmarks for measuring improvement, creating timelines and responsibilities to assess progress; and
- Exercise patience – you will neither fully understand nor be ready to take advantage of all EHR capabilities immediately.

The Best Practices section contains an EMR/EHR readiness assessment that will help you assess current office processes and establish goals and opportunities for EHR implementation.

Perhaps your practice already implemented an EHR, but you are looking for additional efficiencies. Many practices integrate an e-prescribing module that
helps reduce prescription errors. This technology allows physicians to ensure proper dosage and identify conflicts with patients’ allergies or interactions with other medications. Computer-printed prescriptions also help pharmacies read and interpret instructions before dispensing medication to patients.

E-prescribing systems are available with various functions – from the most simple systems to the most complex. The most accepted electronic prescribing levels are:

- Electronic reference only – Include drug information, dosing calculators and formulary information, but this information does not display while prescribing;
- Stand-alone prescription writer – Searches by drug name and creates the prescription, but does not include long-term patient data;
- Supporting patient data – The type of patient data includes demographic, allergy, formulary and health plan information;
- Drug management – Includes prior medications for patients that are available for renewal and interaction checks;
- Connectivity – Permits electronic connectivity from the practice to the pharmacy, pharmacy benefit manager and intermediaries; and
- Full integration – Fully interacts with EHR system.

In addition to the improved level of patient safety, implementing an electronic prescribing system enhances the quality of patient care and increases office efficiencies by:

- Promoting appropriate drug usage for chronic conditions (preventing errors of omission). For example, reminding the physician and the patient that a patient who has had heart disease should be taking aspirin and beta-blocker drugs;
- Providing information about health plan formularies and drug coverage to assist patients in understanding the cost of their medications;
- Transmitting prescriptions electronically to pharmacies, thus eliminating an important source of transcription error and delay;
- Facilitating a rapid process of renewing medications as well as ensuring that patients and physicians do not miss needed renewals;
- Allowing access to critical health information to all authorized caregivers by electronically tracking a patient’s current medication profile; and
- Increasing patient satisfaction by sending the prescription electronically to the pharmacy at the time of the patient encounter. In many cases, the prescription can be filled by the time the patient arrives at the pharmacy.
SUCCESS STORIES

The Baton Rouge Clinic
Weathering the storm — in this case, three storms — is not just a cliche. At the time of this interview, Hurricane Gustav had just roared through Louisiana, damaging the Baton Rouge Clinic and closing it for days. The practice’s experience helping patients and other clinics pounded by Hurricanes Katrina and Rita three years earlier gave them fortitude in preparing and reacting to Gustav’s damage. Power went out for the entire area and some employees lost their homes. However, once the storm passed, the leadership met to develop a plan to reopen and voted to pay all employees for the three days the clinic was closed. All employees wanted to come back to work, even those who had lost almost everything.

“We are a physician-owned clinic,” says Edgar Silvey, chief executive officer (CEO). “And these physicians understand and respect the loyalty and allegiance of their employees. That’s one of the reasons we have been successful over the years and can ride out any storms sent our way.”

Success factors
Identified as a “distinguished practice” — a practice selected as a better-performing practice multiple times over the last 10 years — the Baton Rouge Clinic can point to several success factors. One is working with local employers and employer groups because these employers provide much of their patient base. The majority of the patient base comes from the six-parish area surrounding the practice, but the practice also addresses subspecialty patient needs by offering multiple ancillary services including radiology, cardiovascular and laboratory services. The clinic also provides certain subspecialties that patients cannot find elsewhere.

“We work closely with the Louisiana Business Group on Health,” Silvey says. “We pay attention to their needs, which has served us well over the years. The majority of our patients work for these employers who pay for the care, so it makes sense to listen and provide the services they need.”

Silvey also attributes a unique governance structure to their success. The physicians lead and provide direction but allow the lay managers to run the practice. A nine-person, elected executive committee and seven subcommittees keep the practice running by focusing on marketing, finance, quality improvement, physician recruiting, compliance, professional liability and technology. Part of the pay structure includes what Silvey calls “citizenship pay,” where committee members receive 1.5 percent of the total dollars distributed to the physicians in the previous year for attending at least 75 percent of the committee meetings throughout the year.

Another success factor, created in 1990, is a mission statement that describes what the practice does and aids in decision making for future practice plans.
According to Silvey, each decision must meet two of the following criteria:

1. Does it make the practice of medicine more enjoyable?
2. Does it improve patient care?
3. Does it have a positive financial reward?

The point of this process is that the practice may choose to add a service or change a workflow, but it may not make any money as a result. Not all decisions are financially rewarding. For example, the clinic has a large Coumadin clinic that doesn’t make any money but provides a needed service for patients and also improves the quality of life for physicians. Physicians supervise the tasks in this clinic, but can now better allocate their time to other patients.

Innovative processes
Communication lines among the practice leadership remain open through bimonthly meetings in which physician owners and non-owners come together to ask questions and educate one another.

“No one outside the practice believes me when I talk about these meetings, but they work,” Silvey says. “The meetings help build consensus and camaraderie.”

Physician pay at the Baton Rouge Clinic is also uniquely constructed. Silvey credits cost accounting and a modified profit formula developed with the help of two MGMA consultants. The formula breaks down as follows: 80 percent is based on the physicians’ true professional fees, 10 percent is split evenly among the physicians and the final 10 percent is based on the number of patients seen.

“It makes incentivizing the physicians much easier,” Silvey says. “If you work harder, you make more money.”

In addition, the implementation of centralized scheduling a few years ago keeps workflow moving and, according to Silvey, they will add staff, programs or services as long as it makes sense to do so. Creating efficiencies has allowed this practice to achieve success and maintain the distinction of being a better-performing practice for many years.

Technology
E-prescribing has also improved efficiency at the clinic. Though learning a new process proved difficult at first, this addition has been successful and has lessened the number of phone calls from patients and pharmacies. Before a prescription is written, the physician can check a patient’s formulary and use of generics so that changes do not have to be made later. More importantly, the practice has achieved success without an EMR system. Instead, they implemented a chart tracking system to keep workflow moving.
Lessons for Financial Success

“We’ve adopted a philosophy that we are not going to [use] technology just to [use] it,” Silvey says. “To implement a change, it has to benefit us in many ways. We don’t upgrade many times either because the new whistle may not be as good as the old whistle.”

However, Silvey used an MGMA consultant to audit the practice’s technology a year ago and the practice is working toward many of the consultant’s suggested improvements and process changes. As a result, Silvey set a three-year target starting in January 2009 for implementing EMR.

“I had to set a date or it wouldn’t move forward,” Silvey says. “The new system will require us to become more standardized and change many of our processes, which will likely be the most difficult to do.”

Fairfax Pediatric Associates, PC
Innovative technology and the careful study of process workflows are two major contributors of success in this pediatric practice. Since 1964, Fairfax Pediatric Associates, PC, in Fairfax, Va., has made it a mission to investigate and implement processes and procedures that benefit both patients and the quality of life for physicians and staff.

Success factors
Kim Stevenson, administrator, notes, “Our physicians value quality of life so they made the strategic decision more than five years ago to have our advice nurses triage evening calls. Physicians are on call by pager for second-level triage and for hospital and emergency room calls. The on-call doctor is only contacted when the protocol dictates.” This approach diminished those “sleepless nights” for the on-call physicians and has allowed greater productivity throughout the day.

Another factor to this practice’s success: Budget everything. Each department knows its budget for staffing and expenses, and manages to the budgeted numbers. If the situation changes — for instance, with the release of a new vaccine — the overall effect on the budget is applied and the adjusted targets are monitored. In addition, department managers have hiring authority and require vigorous training programs to ensure that each staff member performs to his or her fullest capability. The management’s bonus structure ties directly to meeting or exceeding budgetary goals.

“We have minimal budget variances in both the revenue and expense side, which demonstrates how well we know our business and our community,” Stevenson says.

Efficiencies and innovations
Stevenson refers to a survey approach suggested and designed by the practice’s physician-administrative leader. The practice used this survey instrument to
measure patient wait time, a benchmark that the practice wanted to improve. During a three-week period, each patient received a form upon arriving for an appointment and was asked to track the time taken for each step in their visit: check-in, wait room, exam, procedures and check-out.

“This exercise was enlightening and allowed us to determine our choke points,” Stevenson says. “We definitely could see the difference in provider time taken with the patients based on the type of appointment — wellness or acute.”

From this study, the practice will incorporate time differences based on appointment type into its open scheduling system. “Our goal is to improve the patients’ experience with wait time,” Stevenson says.

Another efficiency in which the practice maximized productivity is the advice line. More than just voice mail, this phone option allows parents to choose one of three selections: (1) prescription refill, (2) nonacute/wellness questions and (3) acute illness questions. The advice nurses answer messages in the acute box first and then triage the remaining messages.

“One great aspect of this approach is the ability to chart while answering the call,” Stevenson says. “And some of the advice nurses work from home because we are set up with virtual private network (VPN) connections that allow them to work as if they are in the office.”

Communication enhances productivity at Fairfax Pediatric Associates. Since 1994, when Stevenson started, the role of the administrator has grown and the practice divested many of the responsibilities to a nursing manager and an office manager. Regular board meetings, originally attended by only the physician owners and administrator, now include all physicians, nurse practitioners and managers. This allows managers to hear issues and voice their opinions, and then communicate important information to their respective staffs.

“It just saves time and allows everyone to be on the same page,” Stevenson says.

**Technology**

Fairfax Pediatric Associates views itself as leaders in the local pediatric community in implementing electronic solutions. All claim filings, patient billing, referrals and remittances are electronic. For example, e-commerce plays a large role in the practice’s efficiencies; all medical and office supply ordering is conducted online, invoices are downloaded and posted and payments are performed electronically. Stevenson says about 80 percent of the practice’s bills are paid with an American Express card; as a result, the practice receives a 2-percent cash discount for paying on time. This amounts to between $20,000 and $25,000 in savings each year.
In addition, Stevenson says, “We were one of the first large practices to convert from paper to EMR. We have a laboratory interface between our EMR and LabCorp® where all orders are made electronically and results are added to the patient’s record electronically. We’re also using electronic prescribing and are currently working with our software vendor on a ‘results only’ interface with our hospital system for labs, radiology and transcription.”

Surprisingly, it did not take much convincing to get all the physicians on board with EMR. Most were involved in the decision-making process and, once implementation began, they all adapted fairly quickly. An EMR physician champion worked with all of the providers to obtain input in designing the visit templates (a major undertaking) and training each provider as they “went live.” Staff adapted quickly as well, because the implementation team provided frequent communication about the new system and subsequent changes long before they became a reality.

Stevenson believes that information technology helps in improving clinical care and visit documentation. They improved workflow for laboratory orders, results and prescription refill processing by performing these tasks electronically. In addition, going electronic has allowed for the efficient sharing of information — no more couriers carting charts back and forth or a medical records clerk faxing documents to either location. This has saved the practice about $10,000 in courier fees.

“We no longer lose valuable staff hours to locate misplaced or misfiled paper charts,” Stevenson says.

Commonwealth Orthopaedics & Rehabilitation, PC
Commonwealth Orthopaedics & Rehabilitation formed in 1994 when two small, four-physician orthopedic surgery groups merged. Commonwealth’s offices are spread across the Northern Virginia/Washington D.C. area.

Success factors
Geographic coverage and service growth have always guided the practice.

“To become a major player in our market, we needed to provide multiple patient access points (offices) across the region. A large centralized facility would not work due to travel times associated with traffic congestion. Geographic coverage was initially accomplished by merging with existing physician groups that shared the same practice ideals. Since the initial mergers, practice growth has shifted to hiring new physicians to fill shortages in existing markets as well as seek opportunities in new markets,” says William L. Harvey, CEO.

In terms of service growth, Commonwealth was sending out substantial physical therapy (PT) business and was not satisfied with the results — so it began offering this service.
“When we got in the PT business, we put the focus on quality with a hands-on, manual therapy emphasis. The therapists have a manageable patient workload enabling them to focus on the patient’s needs. The feedback from our patients is off the charts, to the point patients come to us because of our therapy services,” Harvey says.

The practice made another strategic move: opening an ambulatory surgery center in 1999 and another in 2001. Each has three operating rooms and both are Joint Commission-accredited.

“Again, our focus was on quality. We wanted the same gold-standard accreditation as hospitals. Each center provides comprehensive outpatient orthopedic surgical services staffed by our own anesthesiologists, CRNAs, and perioperative and post-anesthesia care nurses,” Harvey says. “Similar to PT, we are able to provide our patients with an efficient, high-quality surgical experience specifically tailored to their orthopedic needs.”

**Challenges**

Commonwealth adds providers based on market conditions including current physician workload, patient accessibility, competition by subspecialty and population growth. The CEO notes that the group now focuses much of its physician recruitment on subspecialists. This trend to subspecialties presents an interesting challenge because the original physicians are mostly general orthopedists. Today, most orthopedists want to specialize in a particular area, such as sports medicine, total joints, hand, spine, or foot and ankle.

“This requires a more focused approach to our planning and recruitment as we transition our practice from a more general orthopedic practice to a specialty-based practice over time,” Harvey says.

**Strategic planning**

“One of the tenets I have promoted from day one is that a physician-owned practice must be physician directed. Administrators, with professional management training, provide guidance. In addition to advising the physicians on direction, my job is to provide a structure and framework on how to determine and implement that direction. I am very fortunate in having worked with a core group of three to four physician leaders since the beginning of Commonwealth that has also served as our executive committee,” Harvey says.

Moreover, the chief financial officer, chief operations officer and CEO meet with the committee three times per month to manage the daily affairs of the organization in addition to directing its planning efforts.

From a strategic planning perspective, “All of our physicians and management team go out of town for an annual retreat. My role is to work with my physician leadership and management team to identify topics, plan the sessions, facilitate discussion, document goals and objectives into an annual
plan, revisit it regularly and follow up on progress. As part of the annual process, Commonwealth performs a strengths, weaknesses, opportunities and threats (SWOT) analysis that serves as a backdrop for its planning efforts,” Harvey says.

**Physician compensation**

Compensation for physicians is 100-percent productivity-based, with the owners also receiving ancillary income. When physician owners retire, they continue to receive income distributions from ancillary services for three years. This buy-out strategy encourages physicians to continue investing in practice growth during their final years with the practice. Employed physicians are paid a guaranteed salary with a productivity bonus.

**Efficiencies and innovations**

A few years ago, the practice implemented a digital X-ray in one of its offices to determine if this technology would be worth the investment. Over time, Commonwealth expanded to a second and third office, culminating in practice-wide deployment. While the capital investment was significant, the operational efficiencies resulting in improved patient-throughput have been dramatic, given the integral nature of the diagnostic X-ray in an orthopedic practice.

One of the group’s recent innovations is its use of “secret shoppers.” These individuals make appointments and come to the office with a specific problem. When they get to the physician, they identify themselves. To maintain secrecy, they make a copayment and the physician discharges them.

“This qualitative research method provides a wealth of information on how we can improve our service delivery,” Harvey says. “We are not afraid of such information. We know our patients compare their choices, and we need this information to continually improve.”

**Staffing motivators and incentives**

With ongoing shortages for both clinical and administrative personnel, Commonwealth created several recruiting strategies including sign-on bonuses for physical therapists and an employee referral bonus program for all positions.

“If an employee recommends a new hire, he or she receives a $1,500 recruitment bonus,” Harvey says. “To recruit therapists, we are working with local physical therapy schools to offer scholarships for students in return for their agreeing to work for us for two years.”

Clinical professionals receive an annual continuing-education allowance and the group also provides tuition assistance for those becoming X-ray technicians. Commonwealth has quarterly bonuses for PT, ASC and billing staff...
based on profitability and employee performance measures, and is developing an incentive program for physician office staff as well.

**Cardiology Associates of Kentucky**

Cardiology Associates of Kentucky began in 1973 with a single physician in a small room at a local hospital.

**Success factors**

A few years ago, the practice added an in-office catheterization lab, which Becky Wiggins, practice manager, identifies as one factor to their success. The addition of this service allowed the practice to shift from a hospital- to an office-based diagnostic center. This yielded greater physician productivity and pleased patients because they found it easier to schedule their appointments and receive treatment.

“With this service, patients do not get bumped for emergencies as they would in a hospital setting,” Wiggins says. “If a patient has a 7:30 a.m. cath scheduled, the cath is performed at 7:30 a.m.”

Another ancillary service, overnight studies at the sleep center, benefits patients and the practice. Because sleep apnea can accompany a number of cardiovascular conditions such as high blood pressure, abnormal heart rhythms and congestive heart failure, it is important to study a patient's sleep habits. This can be done by the practice’s board-certified sleep specialist.

The practice's fully accredited diagnostic labs have also contributed to its success. “We were the first cardiology practice in the central Kentucky area to have fully accredited diagnostic labs. This was accomplished years before the payers made it a requirement,” Wiggins says. “It has boosted productivity and we are extremely proud of this achievement.”

According to Wiggins, another success factor is that the physicians share responsibilities equally. For example, the physicians split on-call schedules, satellite clinic rotations and cath lab time. This gives physicians the opportunity to experience all areas of the practice and increases their productivity because they can provide multiple services to each patient as needed.

**Efficiencies and innovations**

One operational change that improved productivity involved revamping the sign-in procedures for the more than 200 patients arriving daily for diagnostic testing, as well as for those arriving for medical appointments at the main clinic. The practice separated the sign-in space for these two different patient flows by putting them in separate areas.

“Making just this one change made a significant difference in our patient flows,” Wiggins says. “This did more to improve patient flow than any other single thing we have done.”
Another important process change occurred when they decided to transfer the myriad paper charts into a document imaging system.

“This was the single greatest task that helped us improve efficiency,” Wiggins says. “This change improved efficiency in all aspects of the practice.”

In addition, having a dedicated scheduling department where one staff member handles in-office scheduling and another handles hospital scheduling has worked well in developing and maintaining positive relationships between the hospital staff and patients.

Benchmarking many of the common data points, such as patient visits, procedures and collections, occurs at this practice. However, the practice also closely monitors one additional data point: referring physician trends. For example, when a physician sees that referrals are down from a specific practice, he or she will contact that referring physician to try and discover any issues and find solutions. In many cases, physicians visit the referring physicians to educate them about the services available and find out what can be done better.

“We are very closely tied to our referring physicians and try to keep the relationships positive,” Wiggins says. “We review the referring-physician trends monthly at each board meeting so that we stay on top of it.”

Culture

Staff responds well to the physicians’ high expectations. The physicians rely on each staff member, which makes all employees feel valued and appreciated. Most importantly, the practice follows a true group practice model because they rely on individual physicians to have expertise and knowledge in specific areas and they share that knowledge with each other.

“The knowledge shared is not always behind closed doors,” Wiggins says. “Physicians openly ask questions and share new ideas and technology options at the board meetings.”

Also, physicians are very open with the staff. Both nonclinical and clinical staff may ask questions of any physician to better understand processes and procedures. For example, a scheduler needs to understand specific procedures so that he or she can alert the patient to any pre-procedure needs or explain the reason for the procedure’s length.

“Knowledge is shared across the staff. Our physicians are great at educating us in all we do,” Wiggins says.
BEST PRACTICES

Physician recruitment interview process

Before the on-site interview:
The physician recruitment interview process begins after identifying a candidate.

1. Define the organization — Understand and communicate the practice’s values, mission, drivers for the practice’s success and unique aspects of the practice.
   – Document this information and include it in correspondence and recruitment materials.

2. Document the job — Prepare a written job description for each position in the practice and relate it to the practice’s vision.
   – Include practice location (if a multi-location practice), outreach requirements, anticipated volume of procedures and patients, call frequency, call coverage area and anticipated hours worked per week. Also specify benefits including vacation, continuing medical education and retirement programs.
   – Review and approve the job description with practice leaders.
   – Include the job description in the physician’s employment agreement.

3. Perform candidate reference check — Call candidate references before scheduling an on-site interview.
   – Prepare a reference questionnaire.
   – Involve a limited number of practice physicians (four to five for a larger practice) in the recruitment process and have them conduct the reference interviews.
   – Prepare physician interviewers to be effective participants in the recruitment and interview process.
   – Schedule and conduct the reference interviews.
   – Document interview findings.

4. Create the recruitment package — Prepare a recruitment package that includes comprehensive information about the practice and enhances its image.
   – Send the package to the candidate several weeks before the on-site interview.
5. Schedule the on-site interview — This is a last chance to determine if a candidate fits the expectations of the practice before expending resources for an on-site interview.
   - Make a follow-up call to the candidate to ensure receipt of the recruitment package.
   - Respond to any questions regarding the package.
   - Clarify any concerns that may have been raised during the reference checks.
   - Instruct the candidate to bring the recruitment package to the onsite interview for a more detailed review of the practice offerings.
   - Schedule the on-site interview, and make transportation and lodging arrangements if the lead physician has reviewed all of the pre-visit information, including the results of reference checks.

The on-site interview

1. Follow the itinerary — Maximize your time with the candidate to showcase your organization.
   - Develop a structured itinerary for the candidate and his/her spouse.
   - Determine time frame for an effective on-site visit. This can be up to a full day, depending on the scope of the practice.
   In addition to interviews with key members of the practice, the site visit should include a tour highlighting practice features, meetings with key staff to discuss operational strengths and a casual social event such as lunch or dinner with practice physicians.

2. Identify roles and responsibilities for the interviews — Everyone in the interview process should know their roles.
   - Instruct each practice physician to evaluate the candidate in one particular area of interest to avoid duplicate efforts. These interest areas should include training background, professional goals, personal interests and desired practice attributes.
   - Prepare an interview questionnaire for each interviewer.
   - Provide the interviewing physicians with copies of the information collected during the reference interviews, along with the resume.
   Note: Only the managing partner and administrator should discuss compensation and contract terms with the candidate.

3. Include the spouse — The spouse’s opinion is critical to the acceptance decision.
   - Determine the spouse’s visit goals beforehand and arrange activities such as house hunting, meeting with a realtor, evaluating schools and job searching.
   - Arrange a lunch with other practice spouses to discuss and provide advice on transition issues.
4. Meet with the managing partner and administrator — Determine the real issues.
   – Review the recruitment package in more detail.
   – Monitor candidate questions and concerns to gain insights about his/her compatibility with the group. Use this feedback to make adjustments in your recruitment process.
   – Discuss compensation and contract terms at this time. Give the candidate an in-depth review of the compensation program. Provide realistic expectations of compensation as a nonpartner and what is expected as a partner.

5. Wrap up the interview — Address any lingering concerns.
   – Conduct a wrap-up session with the candidate to focus on three areas:
     The candidate's expectations of the practice.
     Additional information required by the candidate to make a decision.
     Time frame and next steps in the process.
   Note: Use the wrap-up session to clarify any questions and resolve any misunderstandings.

6. Assess the candidate — Synthesize the interview to assess the candidate.
   – Discuss key observations and identify any issues for follow-up with members of the interview team. Give each interviewer a candidate evaluation form right after – preferably the same day as – the interview.
   – Determine if the candidate is a fit and identify any other matters that need to be addressed before making a formal offer.

Employee satisfaction survey

The following employee satisfaction survey was adapted from that of the San Dimas Medical Group, Inc., Bakersfield, Calif., as originally published in the MGMA *Performance and Practices of Successful Groups: 2007 Report Based on 2006 Data*.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORGANIZATION / TEAMWORK / CUSTOMER SERVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The people with whom I work make personal efforts to improve their skills to make a better contribution to their jobs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The people with whom I work make personal sacrifices when required to help our work group succeed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I would recommend SDMG’s services as the best that a customer could buy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel that our patients’ needs come first.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I would recommend SDMG as one of the best places to work in the community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I intend to stay with SDMG for the next several years.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I would stay with SDMG even if I were offered a similar job with slightly higher pay.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel responsible to help SDMG be successful and I am committed to doing quality work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel responsible to help my supervisor be successful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I trust the leadership of SDMG to do the right thing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SDMG demonstrates the importance of retaining employees.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I see myself as a valued member of the team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I am empowered to do my job to the best of my ability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SDMG recognizes the importance of my personal and family life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*(Survey continues on next page)*
<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My coworkers are willing to help one another during times of heavy workload.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My coworkers support my needs as a person and not just as a worker.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMPENSATION**

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am paid fairly in relation to my duties and responsibilities within SDMG.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I am paid fairly in relation to my duties and responsibilities compared to outside organizations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The performance appraisal process we use works well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel there is potential for future financial growth at SDMG.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Staff is rewarded for outstanding performance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I receive non-monetary recognition for doing my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BENEFITS** (e.g., medical, dental, vision, long- and short-term disability, life, vacation, 401(k), bereavement, cafeteria plan, gym, tuition reimbursement, uniform allowance, etc.)

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The benefit package adequately covers my needs as well as those of my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I receive full information about benefits and how they affect me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Strongly agree</td>
<td>Agree</td>
<td>Strongly disagree</td>
</tr>
<tr>
<td>----------</td>
<td>---------------</td>
<td>-------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>WORKING ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDMG does its best to create a workplace in which I feel free from fear, discrimination, intimidation and harassment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I receive adequate training to do my work right.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My physical working conditions are better than can be expected in this industry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>The equipment we use is in good working condition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I am given the appropriate supplies to perform my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel that there is job security at SDMG.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I have a good understanding of the policies that apply to employees.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>OPPORTUNITIES FOR PROFESSIONAL GROWTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My job description is well defined and I know what is expected of me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My work is challenging and interesting to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor/administrator encourages my development.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>In the last year at work, I had an opportunity to learn and grow.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SDMG promotes employee education and career opportunities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Requests for educational programs are responded to fairly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Survey continues on next page)
<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNICATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am informed of things I need to know.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>We have a good channel of communication when we have problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Employees are asked for input relating to changes that directly affect the work they do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Instructions I receive on how to do my job are clear and concise.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SDMG encourages employees to participate in planning changes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My ideas and opinions are heard and respected.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Performance-correcting feedback is communicated in a respectful manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Comments:

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUPERVISOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My supervisor treats all employees fairly and consistently, without favoritism.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor values my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>In the last week, I have received recognition or praise from my supervisor for doing good work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor creates an environment of mutual trust, respect and open communication.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor's management style achieves effective results.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor disciplines fairly and evenly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>My supervisor has the ability to foster the growth and development of the team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Survey continues on next page)
<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My supervisor cares about me as a person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Requests for time off are handled fairly and in a timely manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ADMINISTRATOR**

| My administrator treats all employees fairly and consistently, without favoritism. | 1 | 2 | 3 |
| My administrator values my work.                                             | 1 | 2 | 3 |
| In the last week, I have received recognition or praise from my administrator for doing good work. | 1 | 2 | 3 |
| My administrator creates an environment of mutual trust, respect and open communication. | 1 | 2 | 3 |
| My administrator's management style achieves effective results.             | 1 | 2 | 3 |
| My administrator disciplines fairly and evenly.                             | 1 | 2 | 3 |
| My administrator has the ability to foster the growth and development of the team. | 1 | 2 | 3 |
| My administrator cares about me as a person.                                | 1 | 2 | 3 |
| Comments:                                                                  |    |   |                 |

**PHYSICIANS**

| The physicians understand the issues faced by employees.                  | 1 | 2 | 3 |
| The physicians care about the employees.                                  | 1 | 2 | 3 |
| The physicians take an active role in management decisions.              | 1 | 2 | 3 |

*(Survey continues on next page)*
<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The efforts made by the physicians cultivate an environment of mutual respect and teamwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>In the last week, I have received recognition or praise from a physician for doing good work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I can communicate openly and honestly with one or more of the physicians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I feel extremely comfortable bringing a problem or concern directly to the attention of one of the physicians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Comments:

Do you have any questions for administration and/or the physicians that you would like answered in a newsletter or staff meeting forum, e.g., processes, policies, etc.?

Additional comments:
Emr/Ehr practice readiness assessment

Adoption, speculation, hoopla, resistance and fear surround discussions of EMRs and EHRs. Practices across the country have either boldly stepped into the EMR/EHR arena or are holding back for many reasons. Many practices’ strategic plans contain EMR/EHR as an item for the future, but some best intentions never result in implementation. This best practice will help you assess current office processes by examining workflow patterns, patient flow patterns, prescription drug processes and more. The assessment will help the practice establish goals, prioritize improvement opportunities and understand the requirements of an EMR/EHR system.

Date of assessment: _____ / _____ / ______

1. What are the workflow issues that cause the greatest problems in your office? (Check all that apply.)

   ___ Unavailability of medical records
   ___ Inability to stay on office schedule
   ___ Poor legibility of medical records
   ___ Inability of patients to access provider when necessary
   ___ Patient waiting times
   ___ Inefficient use of resources
   ___ Chart chasing
   ___ Phone and fax processing
   ___ Results (e.g., lab) tracking
   ___ Patient satisfaction
   ___ Medication refills
   ___ Timely referrals
   ___ Other ____________________________

2. What workflow solutions have you implemented or considered? (Check all that apply.)

   ___ Hired a practice management consultant
   ___ Hired additional clinicians (e.g., nurse practitioner, physician assistant)
3. **What is the average number of laboratory orders per day?**

4. **Of these orders, what percentage is referred to each of the following settings?**

   ____ % in-office
   ____ % practice-owned offsite lab
   ____ % Quest Diagnostic
   ____ % LabCorp
   ____ % community hospital/medical center
   ____ % other ____________________

5. **Thinking about how your practice receives lab reports, estimate the percentage received by each of the following methods.**

   ____ % electronic
   ____ % hard copies
   ____ % fax
   ____ % other ________

6. **On average, about how many calls each week do you or your staff make to the lab about lab reports?**

   ____ None
   ____ Fewer than 5
   ____ 5–10
   ____ More than 10
7. What is the average number of radiology orders per day? __________

8. What is the average number of other diagnostic test or procedure orders per day? __________

9. Who places the orders? _____________________________________________

10. What is the average number of new prescriptions per day?
    ___ None
    ___ Fewer than 10
    ___ 10–19
    ___ 20–29
    ___ 30–39
    ___ 40–49
    ___ 50–59
    ___ More than 59

11. What is the average number of prescription refills per day?
    ___ None
    ___ Fewer than 10
    ___ 10–19
    ___ 20–29
    ___ 30–39
    ___ 40–49
    ___ 50–59
    ___ More than 59

12. On average, how many patients per day need their prescriptions rewritten?
    ___ None
    ___ Fewer than 5
    ___ 5–10
    ___ More than 10
13. Estimate the average number of follow-up calls or faxes your practice receives each week for prescription issues.

___ None
___ Fewer than 10
___ 10–19
___ 20–29
___ 30–39
___ 40–49
___ 50–59
___ More than 59

14. To what extent are any of the above orders and/or results automated? (Will it be able to integrate with a practice management system?)

15. What is the average number of calls per day from other individuals (such as other physicians, pharmacists or insurers) that require chart pulls?

16. What are other reasons (aside from the above) that cause a chart to be pulled?

17. What is the average amount of time it takes to pull a chart?

18. What is the process for locating a misplaced/missing chart?
19. How much of the administrative staff’s daily work is spent on inefficient tasks such as searching for charts?

___ Under 1 hour
___ 1–2 hours
___ More than 2 hours
___ Other __________________________

20. How often does this occur?

21. How many referrals to specialists do you make each week?

___ None
___ Fewer than 5
___ 5–10
___ More than 10

22. To what extent are these automated?

23. What types of manual logs does the clinic maintain?

24. Do you use transcription services?

___ Yes
___ No

24a. If yes, what are your average transcription costs per month? $ _______
25. **What is your current method of billing? (Check all that apply.)**

   ___ Electronic
   ___ Paper-based
   ___ Contracted external services
   ___ Other ____________________________

26. **Do you have problems with or concerns about your coding?**

   ___ Yes
   ___ No

27. **Are there any plans for significant changes within the clinic in the next few years such as growth, new providers or specialty, impending retirements, new affiliations, moves?**

---

EXAMPLES

Operational changes for improved productivity
Efficiencies and operational changes that improved productivity at Fairfax Pediatric Associates: (see practice success story earlier in this chapter):

- EMR — the practice has become a paperless environment, including labs and prescriptions;
- Centralized phone answering for both offices and centralized scheduling;
- Voice mail for the advice line so parents are not kept on hold, but receive a call back based on the urgency of the call;
- Electronic appointment reminders, claims, remittances and patient bills; and
- In-house accounts receivable (rather than outsourcing).

SUMMARY
This chapter introduced a few concepts associated with rightsizing staff, empowering employees, measuring productivity, recruiting and retaining the right physicians, and using information technology in your practice.

You now have concepts and ideas to help you determine the right number of employees for each physician in your practice as well as how to empower those employees to excel at their jobs.

Without physicians, your practice would not survive. But each practice has its own culture and work ethic, and you must find physicians who support both. Strong interview and new-hire orientation processes help your practice retain both physicians and employees.

Practice productivity is the cornerstone of every practice, but it must be efficient. Examining workflows and patient flows provides a path to determine your practice's performance. Evaluating processes both individually and as a whole allows you to see both efficiencies and areas for improvement.

DISCUSSION TOPICS
Practice what you just learned with the discussion topics.

1. What are your practice's staff levels per FTE physician? Can you determine if improvements should be made?
2. Consider surveying your employees on job satisfaction and determine if improvements are needed.
3. What is your practice’s current technology level? Does your leadership support an EHR? If so, what can you do to begin the process?
GLOSSARY

**Electronic medical/health record (EMR/EHR)** – Computerized record of patient health information generated by one or more encounters in any care-delivery setting. The record includes patient demographics, progress notes, problems, medication, vital signs, past medical history, immunizations, laboratory data and radiology reports.

**Patient flow** – Steps patients take during a visit such as check-in, wait time, exam room, check-out.

**Relative value units** – Nonmonetary units of measure that indicate the value of healthcare services and the difference in resources consumed when providing different procedures and services.

**Rightsizing** – The systematic review of staffing levels, tasks and work processes to determine the appropriate number and mix of staff needed to meet medical practice goals.

**Workflow** – a sequence of connected steps.
### BENCHMARKING DATA FROM MGMA SURVEY REPORTS

Better-performing practices take steps to improve their processes. Data below shows results from the MGMA *Performance and Practices of Successful Medical Groups: 2008 Report Based on 2007 Data*.

<table>
<thead>
<tr>
<th>Methods used to increase physician productivity performance levels</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefing physicians prior to daily appointments</td>
<td>9.03%</td>
<td>13.04%</td>
</tr>
<tr>
<td>Comparing individual performance to internal and external peers</td>
<td>63.45%</td>
<td>58.94%</td>
</tr>
<tr>
<td>Employing nonphysician providers such as PAs, NPs and CRNAs</td>
<td>62.07%</td>
<td>50.48%</td>
</tr>
<tr>
<td>Ensuring efficient patient flow through the practice</td>
<td>78.62%</td>
<td>63.94%</td>
</tr>
<tr>
<td>Ensuring optimal staffing to leverage physician time</td>
<td>75.17%</td>
<td>53.85%</td>
</tr>
<tr>
<td>Establishing productivity-based compensation program for physicians</td>
<td>63.89%</td>
<td>49.76%</td>
</tr>
<tr>
<td>Establishing productivity targets for the practice</td>
<td>22.22%</td>
<td>23.19%</td>
</tr>
<tr>
<td>Establishing productivity targets for individual physicians</td>
<td>23.61%</td>
<td>22.22%</td>
</tr>
<tr>
<td>Linking support staff compensation or incentives to physician productivity</td>
<td>9.72%</td>
<td>5.80%</td>
</tr>
<tr>
<td>Providing mentoring, coaching or training for underperforming physicians</td>
<td>22.92%</td>
<td>21.26%</td>
</tr>
<tr>
<td>Providing open access or extended hour schedules</td>
<td>29.17%</td>
<td>19.42%</td>
</tr>
<tr>
<td>Recruiting new physicians for a fit with productivity expectations of the practice</td>
<td>41.38%</td>
<td>35.27%</td>
</tr>
<tr>
<td>None of the above</td>
<td>0.00%</td>
<td>3.88%</td>
</tr>
<tr>
<td>Other</td>
<td>2.78%</td>
<td>1.46%</td>
</tr>
</tbody>
</table>

*(Table continues on next page)*
### Human resource management survey results

<table>
<thead>
<tr>
<th>Effect of nonphysician provider use</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added ancillary services</td>
<td>22.07%</td>
<td>13.81%</td>
</tr>
<tr>
<td>Accommodated patient demand</td>
<td>60.27%</td>
<td>55.24%</td>
</tr>
<tr>
<td>Enhanced revenue</td>
<td>59.59%</td>
<td>50.00%</td>
</tr>
<tr>
<td>No revenue gain or loss</td>
<td>3.45%</td>
<td>6.25%</td>
</tr>
<tr>
<td>Reduced revenue</td>
<td>0.00%</td>
<td>0.96%</td>
</tr>
<tr>
<td>Improved patient safety</td>
<td>13.79%</td>
<td>13.94%</td>
</tr>
<tr>
<td>Increased patient base</td>
<td>40.69%</td>
<td>30.95%</td>
</tr>
<tr>
<td>Increased patient satisfaction</td>
<td>46.90%</td>
<td>45.71%</td>
</tr>
<tr>
<td>Increased physician productivity</td>
<td>55.17%</td>
<td>50.72%</td>
</tr>
<tr>
<td>Other</td>
<td>2.07%</td>
<td>3.37%</td>
</tr>
</tbody>
</table>

### Hospital patient coverage

<table>
<thead>
<tr>
<th>Hospital patient coverage</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed hospitalists</td>
<td>6.02%</td>
<td>6.04%</td>
</tr>
<tr>
<td>Physicians treated their patients</td>
<td>28.57%</td>
<td>35.16%</td>
</tr>
<tr>
<td>On-call physicians treated patients</td>
<td>45.11%</td>
<td>35.16%</td>
</tr>
<tr>
<td>Used separate hospitalist group</td>
<td>5.26%</td>
<td>4.40%</td>
</tr>
<tr>
<td>All of the above</td>
<td>7.52%</td>
<td>8.79%</td>
</tr>
<tr>
<td>Other</td>
<td>7.52%</td>
<td>10.44%</td>
</tr>
</tbody>
</table>

### Turnover

<table>
<thead>
<tr>
<th>Turnover</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptionist and medical records staff</td>
<td>30.00%</td>
<td>25.00%</td>
</tr>
<tr>
<td>Nursing and clinical support staff</td>
<td>20.00%</td>
<td>16.67%</td>
</tr>
<tr>
<td>Billing/collections and data entry staff</td>
<td>13.81%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nonphysician providers</td>
<td>2.72%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

(Table continues on next page)
Information management survey results

<table>
<thead>
<tr>
<th>Description of health/medical records system used for current patients</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dictation and transcription system stored electronically</td>
<td>7.41%</td>
<td>11.41%</td>
</tr>
<tr>
<td>Fully integrated EMR or EHR</td>
<td>29.63%</td>
<td>27.17%</td>
</tr>
<tr>
<td>Partially integrated EMR or EHR</td>
<td>17.78%</td>
<td>16.30%</td>
</tr>
<tr>
<td>Paper medical records/charts filed in record cabinet</td>
<td>40.74%</td>
<td>42.93%</td>
</tr>
<tr>
<td>Scanned image of a paper medical record using a digital image management system (DIMS)</td>
<td>4.44%</td>
<td>2.17%</td>
</tr>
</tbody>
</table>

Use the following financial measurements against those of your practice to help improve revenue and manage costs. The data table below presents median, better-performing practices data and median MGMA Cost Survey Report data for a subset of specialties1,2,3.

<table>
<thead>
<tr>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP*</td>
<td>BP*</td>
<td>BP*</td>
</tr>
<tr>
<td>Cost Survey</td>
<td>Cost Survey</td>
<td>Cost Survey</td>
</tr>
<tr>
<td>Total gross charges per FTE physician</td>
<td>$1,396,908</td>
<td>$1,076,662</td>
</tr>
<tr>
<td>Total RVUs per FTE physician</td>
<td>13,010</td>
<td>12,231</td>
</tr>
<tr>
<td>Physician work RVUs per FTE physician</td>
<td>6,088</td>
<td>6,024</td>
</tr>
<tr>
<td>Total support staff per FTE physician</td>
<td>5.43</td>
<td>4.75</td>
</tr>
<tr>
<td>Total procedures per FTE physician</td>
<td>13,299</td>
<td>10,804</td>
</tr>
<tr>
<td>Total operating cost per FTE physician</td>
<td>$528,008</td>
<td>$428,238</td>
</tr>
<tr>
<td>Total operating and NPP cost per FTE physician</td>
<td>$545,895</td>
<td>$467,591</td>
</tr>
</tbody>
</table>

(Table continues on next page)
<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost Survey</td>
<td>BP*</td>
</tr>
<tr>
<td>Total operating cost as a percent of total medical revenue</td>
<td>60.38%</td>
<td>61.19%</td>
<td>52.66%</td>
</tr>
<tr>
<td>Total operating and NPP cost as a percent of total medical revenue</td>
<td>64.65%</td>
<td>65.11%</td>
<td>54.59%</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$864,137</td>
<td>$690,032</td>
<td>$1,304,574</td>
</tr>
<tr>
<td>Total medical revenue after operating cost per FTE physician</td>
<td>$369,354</td>
<td>$272,460</td>
<td>$619,062</td>
</tr>
<tr>
<td>Total medical revenue after operating and NPP cost per FTE physician</td>
<td>$310,921</td>
<td>$255,064</td>
<td>$588,101</td>
</tr>
</tbody>
</table>

*Better–performing practice


Use the following productivity measurements against those of your practice to help measure physician compensation and productivity. The data table below presents the 25th percentile, median and 75th percentile data from the MGMA *Physician Compensation and Production Survey Report* for a subset of specialties.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>25th percentile</th>
<th>Median</th>
<th>75th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology: invasive-interventional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>16,148</td>
<td>20,364</td>
<td>26,295</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>8,359</td>
<td>10,225</td>
<td>13,015</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>1,291</td>
<td>2,030</td>
<td>3,157</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$583,393</td>
<td>$793,914</td>
<td>$972,989</td>
</tr>
<tr>
<td><strong>Cardiology: noninvasive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>10,122</td>
<td>18,056</td>
<td>25,768</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>5,352</td>
<td>7,274</td>
<td>9,849</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>1,430</td>
<td>2,260</td>
<td>3,347</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$422,813</td>
<td>$568,695</td>
<td>$742,769</td>
</tr>
<tr>
<td><strong>Family practice without OB</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>6,920</td>
<td>8,830</td>
<td>10,874</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>3,868</td>
<td>4,664</td>
<td>5,555</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>2,906</td>
<td>3,764</td>
<td>4,844</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$285,507</td>
<td>$363,214</td>
<td>$449,157</td>
</tr>
<tr>
<td><strong>Internal medicine: general</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>5,845</td>
<td>8,251</td>
<td>10,456</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>3,546</td>
<td>4,554</td>
<td>5,632</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>2,629</td>
<td>3,434</td>
<td>4,307</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$264,273</td>
<td>$345,265</td>
<td>$423,456</td>
</tr>
<tr>
<td><strong>Orthopedic surgery: general</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total RVUs</td>
<td>11,298</td>
<td>15,377</td>
<td>20,636</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>6,462</td>
<td>8,256</td>
<td>10,504</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>2,187</td>
<td>2,891</td>
<td>3,699</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$620,382</td>
<td>$797,705</td>
<td>$1,023,055</td>
</tr>
</tbody>
</table>

*(Table continues on next page)*
### Surgery: general

<table>
<thead>
<tr>
<th></th>
<th>25th percentile</th>
<th>Median</th>
<th>75th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total RVUs</td>
<td>10,331</td>
<td>12,811</td>
<td>15,592</td>
</tr>
<tr>
<td>Physician work RVUs</td>
<td>5,792</td>
<td>7,170</td>
<td>8,843</td>
</tr>
<tr>
<td>Physician ambulatory encounters*</td>
<td>1,075</td>
<td>1,488</td>
<td>2,021</td>
</tr>
<tr>
<td>Collections for professional charges**</td>
<td>$423,946</td>
<td>$535,803</td>
<td>$681,082</td>
</tr>
</tbody>
</table>

* Nonphysician provider excluded.

** Technical component of clinical services and nonphysician provider excluded.


### APPENDIX

Visit mgma.com/lessons for interactive tools that will help you practice the concepts presented in this chapter.
Physicians face increased operating costs in an uncertain economy while experiencing the administrative complexity of the U.S. health care system. That complexity drives up costs due to duplicated efforts, lack of standardization, rework and other forms of waste.

Few physicians have formal training in the management techniques that can be used to minimize a practice’s operational inefficiency. Without either personal business acumen or the ability to hire a professional administrator, physicians in solo and small practices need information on effective business procedures.

In response to this need, the MGMA Center for Research, funded by a grant from the United Health Foundation, developed “Lessons for Financial Success” a five-chapter resource packaged with online tools designed to assist physicians and office managers to reduce waste, improve practice efficiency and work flow, and pass the savings on to their practice’s bottom line.

Learn from the best in the field with success stories and best practices from MGMA better-performing medical groups, practices selected for having superior productivity, cost efficiency and business office operations.

**Topics Covered**
- Benchmarking Basics
- Accounts Receivable and Collections
- Profitability and Cost Management
- Patient Safety and Quality
- Productivity, Capacity and Staffing

**A Key Resource That Includes:**
- Benchmarking data from MGMA publications, including the MGMA *Performance and Practices of Successful Medical Groups Report*, the MGMA *Cost Survey Report* and the MGMA *Physician Compensation and Production Survey Report*
- Success stories from medical practices on cost management, productivity, business office operations and staffing
- Best practices for implementing effective solutions to common medical practice issues
- Information from the *Physician Practice Patient Safety Assessment* on improving patient safety