Operational Anticipatory Guidance for Pediatric Practices

EXPLORATORY PROFESSIONAL FINAL MANUSCRIPT

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INTRODUCTION

A local physician passionately compares caring for the pediatric practice that he founded to nurturing a child. From an administrative perspective, this comparison expands to parallel stages of growth and developmental milestones of a child to that of a group practice. Just as age-appropriate anticipatory guidance topics exist for children, financial and operational principles are available for practice administrators and physicians to deploy. A child requires unique parenting emphasis at different ages. Likewise, a pediatric practice requires distinct managerial tools and leadership strengths when facing challenging milestones.

A pediatric group practice organized in 2001 has overcome significant operational challenges over the years. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added complexity and overhead to operations. Implementation of electronic medical records (EMR) required re-engineering patient throughput processes. The latest challenge is transforming care delivery from acute care to health status management in the form of a patient-centered medical home (PCMH). In addition to forcing a shift in clinical focus, PCMH also requires multiple operational changes. Reimbursement converts from an encounter-based methodology to episode-based reimbursement with financial incentives for achieving quality metrics. Staffing requirements and core competencies must now include care coordination. While the aforementioned (challenges) are the result of external regulations and health care
system dynamics, they are superimposed on significant internal challenges such as clinic
growth, changes in leadership, relocation and economic swings that have occurred
concurrently.

**OBJECTIVE**

Engaging a literature review of pediatric practice characteristics and operational
challenges, this paper will explore historical forces that contribute to the operational
complexity of contemporary pediatric group practices. In addition, it will discuss in
detail ACMPE’s Body of Knowledge (BOK) domains of Organizational Governance,
Information Management and Business Operations in reference to this operational
complexity.

The conclusion of this paper will offer the use of a concept from clinical pediatrics,
*anticipatory guidance*, using ACMPE BOK precepts as elements of a project-
management matrix. The matrix translates *skills* defined in the BOK to *decision-making*
tools. The illustration includes specific, current pediatric practice projects and recurring
management projects. Applicable to both the inexperienced administrator and
seasoned professionals new to the pediatric specialty, this concept expands the utility of
the authoritative guide for medical practice executive knowledge into a dynamic,
practical tool for successful navigation of anticipated and unexpected administrative
challenges.
LITERATURE REVIEW: PEDIATRIC PRACTICES

History of Pediatric Practices

Pediatrics describes the primary care medical specialty dealing with the development, diseases and health of children. By definition, the essential nature of primary care services includes first contact, continuity, comprehensiveness, and coordination of needed services. Since continuity of care and relationship-building is a predominant theme in pediatric practices, it is unsurprising that the American Academy of Pediatrics (AAP) was the first entity to introduce the concept of a “medical home” in 1967. The AAP initially defined the medical home as the central location for a child’s medical record. Over time, this idea has evolved and expanded to outline a patient-centered approach while providing and coordinating continuous, comprehensive care.

Prior to the early 1990’s, most private pediatricians provided care in solo or 1-2 provider practices. As managed care flourished, larger group practices formed and hospitals began to purchase practices. Management needs and operational complexity reached new levels as practices grew in size and technology became available for practice operations. Table 1 outlines the progression of selected pediatric practice operational components during this time span.
TABLE 1. PROGRESSION OF PEDIATRIC PRACTICE MANAGEMENT COMPONENTS, EARLY 1990’S TO CURRENT. SOURCE: GENERAL KNOWLEDGE AND EXPERIENCE OF AUTHOR.

<table>
<thead>
<tr>
<th><strong>Administrative Issue</strong></th>
<th><strong>Prior to 1992</strong></th>
<th><strong>2002</strong></th>
<th><strong>2007</strong></th>
<th><strong>2012</strong></th>
<th><strong>2013 AND BEYOND</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling Tools</td>
<td>Appointment Book</td>
<td>Appointment Book or DOS based electronic practice management scheduler</td>
<td>Windows based, stand alone, Practice Management Systems</td>
<td>Full scope computerized Practice Management System integrated with EMR with scheduling dependencies</td>
<td>Electronic; Portal access for patients to request/schedule appointments remotely</td>
</tr>
<tr>
<td>Leadership</td>
<td>Physician / Office Manager</td>
<td>Business Office Manager/ Physician Owner</td>
<td>Administrator/ Managing Partner</td>
<td>Executive Committee (Administrator + physician leadership)</td>
<td>Various depending on affiliations (ACO/PCMH/Clinically Integrated Networks) and Ownership (Hospital/Health System)</td>
</tr>
<tr>
<td>Provider Staff</td>
<td>1-2 MDs</td>
<td>1-3 MDs</td>
<td>2-7 MDs, APNs</td>
<td>5+ MDs, multiple APNs/PAs</td>
<td>ACOs / Clinically Integrated Networks/Hospital Systems</td>
</tr>
<tr>
<td>Referral Patterns</td>
<td>Referrals not required. Patients had open access.</td>
<td>Driven by patient preference and insurance network</td>
<td>Driven by insurance network</td>
<td>Driven by network insurance / early ACO &amp; clinical integration affiliations</td>
<td>Driven by quality outcomes and financial efficiency; clinically integrated networks</td>
</tr>
<tr>
<td>Visit Type</td>
<td>Acute Illnesses / Well Child</td>
<td>Acute Care /Well Child/ Sports Physicals /Camp Physicals Behavioral Health</td>
<td>Acute Care /Well Child /ADHD/ Sports / Camp Physicals/ Episodes of Care Evolving</td>
<td>Episodes of Care /ADHD/ Managing Health / Case Management &amp; Care Coordination</td>
<td></td>
</tr>
<tr>
<td>Quality Monitoring</td>
<td>Retroactive; problem focused</td>
<td>Payor retrospective reviews / credentialing reviews</td>
<td>Payor retrospective reviews/ in-house coding/outcomes</td>
<td>Quality Metrics for selected diagnoses/ payor audits</td>
<td>Ongoing internal and external review of outcomes data by payers, employer groups, clinically integrated network partners</td>
</tr>
</tbody>
</table>

**Historical Operational Challenges of Pediatric Practices**

In 1977, Avrum L. Katcher identified several pediatric practice management challenges that continue to be relevant. Specifically, “Pediatricians are not usually taught administrative or management skills during residency training. In common with many
physicians, the young pediatrician is taught to value an image of professional behavior rather than managerial skill” [4].

In addition to the lack of preparation for pediatricians to be business-minded, the nature of pediatric diseases is changing. “A decade from now, the impact of infectious diseases will continue to decline while psychosocial disorders increase in importance.” (Nazarian, 1995) Pediatricians find that helping children with learning disabilities, attention deficit disorder, behavior problems, depression, eating disorders, substance use, pervasive developmental disorders, and the ravages of family dysfunction constitute up to 25% of office visits [5]. Planning for appropriate access and adaptive practitioner schedules that support this shift in predominant diagnoses presents a significant operational challenge.

Preventive care or health maintenance visits are a major aspect of pediatric practices. The essential clinical elements of preventive care visits are pre-defined and predictable based on the child’s age with a majority of time spent in anticipatory guidance. By definition, anticipate means to foresee and deal with in advance [6]. In clinical pediatrics, anticipatory guidance refers to the advice and education that practitioners provide to parents to help adopt more healthful ways of living and to prevent potential health problems [7]. The specific content and focus of anticipatory guidance is dependant on the child’s age. For all age groups, topics generally covered include nutrition, exercise and safety practices.
Childhood immunizations, a standard element in many health maintenance visits, require significant operational attention. From a financial perspective, expenditures for immunizations represent the highest supply expense for pediatric practices and a significant factor when planning cash flow. Vaccine reimbursement’s impact on private practices is evidenced by the AAP’s advocacy efforts. The AAP was pivotal in lobbying for code changes to Current Procedural Terminology (CPT) for immunization administration. Implemented in January 2011, the coding changes recognize the additional work for counseling when providing vaccines, particularly for combination vaccines with multiple components. These coding changes provide a mechanism to receive enhanced reimbursement for immunization administration. Likewise, on the clinical operations side, vaccine administration presents a critical area of focus for risk management. Strict control of vaccine refrigerator temperatures, obtaining parental consent, and staff training on ever-changing vaccine schedules, demand a significant allocation of resources and intense attention to detail.

To emphasize the impact that immunizations have on pediatric practice operations, the progression of the primary childhood vaccination schedule (shown in Table 2) closely mirrors the changing complexity of operations of a pediatric practice illustrated in Table 1.
Although validation of a scientific correlation between operational complexity and childhood immunization schedules requires additional research, the surface comparison is intriguing.

**Current and Future Challenges of Pediatric Practices**

Proactive pediatric practices adopted Electronic Medical Record (EMR) systems in the late 1990’s and early 2000’s. The pace and breadth of adoption increased when the opportunity of financial gain through achieving meaningful use began motivating providers. For pediatricians whose practice is at least 30% Medicaid, incentives can total $63,750 over a six-year period. As of early 2010, a National Ambulatory Medical Care Survey (NAMCS) reported that 51% office-based physicians have implemented an EMR system with 25% reporting implementation at a “basic” level. After taking the leap of implementation, the challenge becomes using an EMR to facilitate clinical
management of patients, improve communication and enhance efficiency of clinic operations. Documenting a practice’s success in improving patient outcomes leads to achieving meaningful use. The level of automation and process simplification made possible by EMR breathed new life into the concept of “medical home”.

Organizational Transition to Patient-Centered Medical Home (PCMH)

Restructuring a pediatric practice from treatment of episodic illnesses to a coordinated health management system affects each person and operational component within the practice. Center-stage with both private and public insurers, this restructuring is no longer an option, but reality. The American Academy of Pediatrics outlined three components of an ideal medical home in a 2011 policy statement. The ideal medical home translates evidence into high quality pediatric care that is measurable; provides coordinated pediatric primary and specialty care for all children; and sustains pediatric practice through fair payment, cost-efficiency and recognition of the value of primary care.

Clinically, the PCMH model promotes evidence-based care and the strengthening of the provider-patient relationship. Externally, purchasers are interested in the cost-savings realized through improved coordination and management of chronic disease. Operationally, pediatric administrators face hiring for unfamiliar roles in care coordination and adapting budgets to outcomes and incentive–based payment structures. These three perspectives represent different stakeholders - patients,
providers, payers and staff. Initially separate, realignment of these perspectives into the operational areas of information management, business operations, financial management and human resources highlights the similarities and common interests of each stakeholder.

*ICD 10 Implementation*

Diagnosis coding will change to Internal Classification of Diseases Revision 10 (ICD-10) on October 1, 2014. EMR vendors, claims clearinghouses, private and public insurers and coding experts are working diligently to complete the required infrastructure on schedule. From an operational perspective, this change will compete as one of the most financially challenging ever faced by pediatric practices. The estimated provider training costs vary, depending on the source. An average projection is $28,500 per provider. Although significant, training cost will seem minor if claims processing delays occur as predicted. Careful cash flow management, including substantial operational lines of credit, will be a part of the ICD-10 transition.

For the pediatric administrator the biggest hurdle may be ensuring provider flexibility and buy-in. Changing coding habits and documentation patterns that providers have ingrained into their daily routine is not an easy task. Additionally, this transition will require adjusting provider schedules to allow additional time for documentation, and preparing staff for patient frustration due to decreased appointment availability. Modification of support tables and documentation tools within a practice’s EMR will be
of paramount importance in moderating provider stress during this transition.

Competing stakeholder interests associated the ICD-10 transition align into operational areas of business operations, information management, organizational governance and financial management.

**MANAGEMENT CONCEPTS**

**Executive Skills**

The classic management book, *The Effective Executive*, by Peter Drucker 12, emphasizes basic executive skills that are applicable regardless of the industry. He describes workers who are in leadership roles as *knowledge workers*. Knowledge work is not defined by quantity, but by results. Drucker goes on to define executives as “those knowledge workers, managers, or individual professionals who are expected by virtue of their position or their knowledge to make decisions in the normal course of their work that have significant impact on the performance and results of the whole”.

Drucker’s research led him to define the following five “habits of the mind” that must be acquired to be an effective executive.

1. **Effective executives know where their time goes** and work systematically at managing the portion of their time that is under their control.

2. **Effective executives focus on outward contribution.** They gear their efforts to results rather than to work. They start out with the question, “What results are expected of me?” rather than with the work to be done.

3. **Effective executives build on strengths.** They build on their own strengths, the strengths of their superiors, colleagues, and subordinates; and on the strengths of the situation. They do not start out with the things they cannot do.
4. **Effective executives concentrate on the few major areas where superior performance will produce outstanding results.** They force themselves to set priorities and stay with their priority decisions.

5. **Effective executives, finally, make effective decisions.** They know that this is, above all, a matter of system --- of the right steps in the right sequence. They know that an effective decision is always a judgment based on “dissenting opinions” rather than on “consensus on the facts.” What is needed is the right strategy rather than razzle-dazzle tactics.

Drucker reminds the reader that the measure of the executive is to “get the right things done”. Executives are paid for effectiveness. Leaders can learn to be effective. In the arena of medical practice management, the precepts of being an effective executive complement the industry specific knowledge base contained in the Body of Knowledge for Medical Practice Executives.

**Body of Knowledge for Medical Practice Executives**

The Body of Knowledge (BOK) for Medical Practice Executives *(Appendix A)* defines and legitimizes the unique knowledge and skill set for the medical practice management profession. The BOK sets the standards that preserve the profession’s integrity and promote its growth. Developed and published by the American College of Medical Practice Executives (ACMPE), the standard-setting and certification division of MGMA-ACMPE, the BOK serves as the most comprehensive, authoritative resource for those who seek board certification in medical practice management.
The Body of Knowledge organizes areas of responsibility into eight domains. Threaded throughout the domains are the core competencies of Professionalism, Leadership, Communication Skills and Critical Thinking Skills. The eight domains are Business Operations, Financial Management, Human Resource Management, Information Management, Organizational Governance, Patient Care Systems, Quality Management and Risk Management. The writer selected the domains of Organizational Governance, Information Management and Business Operations to correlate with contemporary pediatric management challenges.

**Organizational Governance (BOK Domain)**

Maintaining effective governance and leadership through policies and the strategic direction of the organization is essential to long-term success. Included within the domain of Organizational Governance are tasks related to corporate and legal structure of the organization, corporate culture, strategic planning, production and compensation standards, clinical staff conduct and performance, physician leadership development and advocacy activities at the local, state and national levels 13.

Although every practice is defined legally as an organization type, the missing link for effective governance often lies with physician owners being unprepared to be business leaders within the organization. “We went into pediatrics to practice medicine, not business. But, at the end of the day, at the end of the year, that’s what we’re all in – both together” 14. While managerial and leadership issues are not a natural fit for the personality
of many pediatricians, effective administrators can be the catalyst to assist physicians in becoming valuable directional leaders.

_Growth & Development of Physician Leaders_

Clinical advances and patient care issues that influence the operational aspect of a pediatric practice are often the impetus a physician needs to become intimately concerned with administrative issues. An opportunity in which to “grow” pediatric physician leadership is through issues related to childhood immunizations. Physicians appreciate the clinical usefulness of new immunization products, but also are concerned about variability in cost, product availability and levels of reimbursement; issues that blend care of the patient and care of the practice.

Being a champion of a clinical issue is within a pediatrician’s comfort zone. The physician with a passion for quality and efficient patient care is a natural leader for patient care committees, but may not be effective on the Finance Committee. The successful administrator will take advantage of individual physician strengths and areas of interest when assigning or guiding physicians to leadership roles. The variety of skills and personalities that make a dynamic and successful clinical group also present an array of talent for effective physician leadership.
The Physician-Administrator Relationship

As with issues pertaining to patient care, pediatricians also often have strong motivation to be actively involved when responding to new regulations. The implementation of HIPAA, the Health Information Portability and Accountability Act of 1996 had a direct impact on patient throughput, facility security and transmission of insurance claims. Physician stakeholders wanted and needed to be involved in organizational planning to protect their interests.

HIPAA encompassed regulations for patient privacy, standardization of electronic transmission of insurance claims, National Provider Identifier (NPI) and provisions for electronic signatures. Portions of the planning for meeting HIPAA implementation targets did not require physician input. However, complete implementation on the privacy standards required physician involvement and compliance.

The practice administrator’s job description often provides the framework for the physician/administrator relationship. Trust develops through experience and collaborative efforts. Engaging physician owners when defining a practice’s response to regulation changes is an opportunity to strengthen the physician/administrator team.
Information Management (BOK Domain)

Oversight of implementation and management of evolving technologies, practice management systems and electronic health records require strong information management capabilities. The demand on practice administrators in this realm has never been higher. Reporting requirements for PCMH certification, meaningful use attestation, and payor-specific quality metrics currently facing pediatric practices necessitates robust reporting functionality. Decisions regarding participating in Health Information Exchanges are on the horizon. The use of patient portals that allow direct access to and exchange of medical information between providers and patients via a secure internet connection is growing. These trends illustrate the importance that leadership in the area information management plays in a contemporary pediatric practice.

Assessing Technology Needs

Pediatric functions, such as immunization forecasting and weight-based dosing, often are not available in EHR systems. Determining mechanisms to add this functionality was the focus of a research project sponsored by the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare & Medicaid Services (CMS). The Model Children’s Electronic Health Record (EHR) Format resulted from this project. This model is a set of instructions for EHR vendors that defines functionality and data requirements that are essential to pediatrics. Administrators can use this model to advocate for
improved pediatric-specific functionality when negotiating with EHR vendors and as a reference list when evaluating new systems.

Planning and Implementing Technology Modifications

Technology modifications may take the form of hardware upgrades, software upgrades, interfaces, or adding automation to enhance patient care or billing functions.

Comprehensive planning for all technology projects whether large or small is essential to success. As with all projects, implementation is the beginning, not the end.

Evaluation of a technology implementation or modification project requires asking questions that parallel responsibilities and tasks identified in other BOK domains.

- Was the project meet budget?
- Have staff adapted to the implementation/ modification as anticipated?
- Were there unexpected problems?
- Were there unexpected benefits?

The list of questions will vary by project, but an evaluation following implementation of new or modified technology is necessary. The process may require many cycles of evaluation before achieving “completion”.

Business Operations (BOK Domain)
The tasks outlined in the Business Operations domain and the Financial Management domain are most likely the tasks that a layperson would name if asked the role of a medical practice administrator. Encompassing operational planning, purchasing, facilities management and maintenance, selection of external business partners, and marketing and communication plans, the Business Operations domain covers core operations. A required skill for all of these tasks is planning. Planning requires data. Practice professionals believe that a data-driven and disciplined approach to operations will help re-engineer their practices. Internal practice trends, census data for the practice's service area, and regional or national survey data combine to give pediatric administrators a complete picture. However, understanding the driving forces of the observed pediatric practice is the first and most important step.

Interpreting the Vital Signs of a Pediatric Practice using Key Indicators

As in any specialty, a dashboard of key operational indicators is a valuable tool for pediatric practice administrators to routinely generate and analyze. Common indicators for pediatric practices include Days in Accounts Receivable (A/R), physician production, relative value unit (RVU) production, payor mix, collection percentages, number of office visits, number of new patients, and the ratio of sick visits and well-child visits. Although many of these indicators appear purely financial in nature, careful monitoring of financial indicators often serves to focus marketing efforts and impact decisions to expand or retract services. Therefore, pediatric administrators and governing boards
cannot ignore the interdependency of financial performance and planning for business operations.

Unlike the primary care specialties of family practice and internal medicine, patients “age out” of pediatric practices to adult medicine providers between ages 16 and 21. Table 3 illustrates the 2005 distribution, by age group, for preventive medicine services.

<table>
<thead>
<tr>
<th></th>
<th>Primary Care Physicians (Peds, FP/GP, internist+ OB/Gyn)</th>
<th>General Pediatricians</th>
<th>Pediatric Subspecialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Preventive Medicine Services</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>99391 Established patient, under 1 year</td>
<td>29.8%</td>
<td>32.4%</td>
<td>30.0%</td>
</tr>
<tr>
<td>99392 Established patient, 1 through 4 years</td>
<td>30.5%</td>
<td>33.1%</td>
<td>30.1%</td>
</tr>
<tr>
<td>99393 Established patient, 5 through 11 years</td>
<td>19.0%</td>
<td>20.3%</td>
<td>21.0%</td>
</tr>
<tr>
<td>99394 Established patient, 12 through 17 years</td>
<td>15.6%</td>
<td>13.0%</td>
<td>17.1%</td>
</tr>
<tr>
<td>99395 Established patient, 18 through 39 years</td>
<td>5.1%</td>
<td>1.2%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Source: 2005 Medstat MarketScan®. Published annually by the Medstat Group of Thomson Reuters, MarketScan® is a database of adjudicated claims submitted to self-insured plans of large US employers in 50 states and DC. Only claims adjudicated for plan members under age 22 are included in this report.

Notes: CPT® is a trademark of the American Medical Association. MarketScan: Copyright © 2005, the MEDSTAT Group, Inc. All Rights Reserved.

The age stratification of the Medstat MarketScan® information emphasizes the significant decline in the percentage of preventive medicine visits by pediatric patients after the age of five, with a marked decrease after age 12. With 65.5% of preventive care provided by general pediatricians to patients under the age of five, monitoring the number of newborns and new patients entering the practice is critical. A healthy pediatric practice requires a consistent flow of newborns into the practice.
Medical Group Management Association (MGMA) Annual Surveys are an excellent source of benchmarking data for indicators such as Days in A/R, provider productivity and staffing ratios. Historical practice data, however, is the only source for comparing new patients, payor mix and ratio of sick and well care in an individual pediatric practice over time. Monitoring an internal trend over time allows the pediatric administrator to implement a marketing strategy or a new recall methodology, and evaluate the impact quickly. The dashboard of operational indicators, and the trend identified, becomes a useful management tool for operational and strategic planning.

The Body of Knowledge as an Executive Tool

Appendix B illustrates translating the tasks and knowledge items organized by domain in the Body of Knowledge for Medical Practice Management into a Decision Matrix.

Private pediatric practices are in the midst of one of the most challenging eras in the history of medical practice. The revolutionary changes on the horizon dilute the benefit of utilizing experience and history as a reliable predictor of the future. To lead their organizations successfully through projects such as implementation of ICD-10 and transitioning to PCMH, pediatric practice administrators need to own the competencies of professionalism, leadership, effective communication skills, and critical thinking skills. This matrix can serve as anticipatory guidance for problem solving and project management when pinpointing specific tasks or responsibilities, by domain, that are relevant to the presenting problem. Whether the management decision is a “once in a
lifetime event”, ICD-10, or a recurring event, such as hiring a provider, outlining the situation based on BOK domains will add structure and direction to the planning process. Pediatric administrators can develop a pattern of anticipating the needs of a project within the scope of each domain and creating a checklist that is applicable for each management challenge.

CONCLUSION

As Drucker said, effective executives have the ability to get the right things done. The BOK organizes the tasks and integrates the core competencies; the effectiveness of the executive is selecting the right tools to achieve the desired results. The writer recommends the Decision Matrix as a tool to enhance administrative effectiveness.

The clinicians in pediatric practices work with prescribed content for many visits --- sports physicals, age-appropriate developmental physicals and a growing number of metrics for diagnosis-specific episodes of care. Since pediatric providers are comfortable with anticipatory guidance on the patient care side, it is a natural fit to adopt a similar mind-set for the business side of pediatrics using the ACMPE Body of Knowledge as anticipatory guidance for business operations and project management.
Works Cited


<table>
<thead>
<tr>
<th>Domain</th>
<th>Individual job responsibilities, activities and functions</th>
</tr>
</thead>
</table>
| **Business Operations**      | • Develop, implement and monitor business operation plans.  
• Develop, implement and oversee systems for the purchase of materials and equipment.  
• Manage facilities planning and maintenance activities to meet the organization’s current and future needs.  
• Develop and implement a marketing and communication plan.                                                                                                                                 |
| **Financial Management**      | • Develop and implement the organization’s budget to achieve organizational objectives.  
• Establish internal controls for cash management.  
• Implement and maintain a process for external financial audits.  
• Develop and implement revenue cycle management and accounts receivable management.  
• Analyze and monitor financial performance and report financial results to stakeholders.  
• Direct the payroll process.  
• Establish and maintain the organization’s banking, investment and other financial relationships.  
• Develop relationships with individual insurance carriers to optimize contract negotiations and maintenance of existing contracts.                                                                                                                                           |
| **Human Resource Management** | • Coordinate the recruitment and orientation process of clinical and nonclinical staff.  
• Manage the retention of clinical and nonclinical staff.  
• Develop and monitor an effective staffing strategy.  
• Develop, implement and evaluate performance management programs for clinical and nonclinical staff.  
• Develop and implement staff compensation and benefit plans.  
• Provide systems, processes and structure for administrative and clinical training for medical providers, employees and students.  
• Establish systems and processes for awareness, education and compliance with employment laws and regulatory standards.  
• Provide personal commitment to enhance knowledge, skills and abilities in healthcare administration.                                                                                                                                 |
| **Information Management**    | • Develop and maintain appropriate internal communication pathways for clinical and nonclinical staff.  
• Develop a technology plan that establishes the criteria for selection and implementation of information technology, including computer systems, Internet strategies and telecommunication.  
• Plan and design a technology security process to protect patient and practice data systems.  
• Manage medical information systems including medical records, medication administration and health care related document storage.  
• Develop and implement processes to comply with mandated reports of specified patient issues to regulatory agencies.                                                                                                                                 |
| **Organization Governance**   | • Facilitate the establishment and monitoring of the appropriate corporate legal structure for the organization.  
• Facilitate organization governance structure and maintain proper corporate record-keeping of strategic decisions.  
• Lead the integration of the corporate mission statement into all aspects of the organization’s culture.  
• Lead development of the organization’s strategic plan and its implementation.  
• Establish, communicate, implement and monitor production and compensation standards for physicians and mid-level professional staff.  
• Implement and/or support organization leadership management of clinical staff conduct and performance expectations or programs.  
• Foster the growth and development of physician leaders as knowledgeable, participative stakeholders.  
• Encourage and lead participation in advocacy endeavors at local, state and national levels.                                                                                                                                 |
| **Patient Care Systems**      | • Establish and monitor business processes to ensure effective and efficient clinical operations.  
• Provide relevant and accurate resources to enhance patients’ knowledge, understanding and participation in their medical care.  
• Develop and implement a referral management process.  
• Design efficient patient flow patterns to maximize physician schedules.  
• Manage front office operations to maximize patient satisfaction, collection of payments and customer service efforts.  
• Implement a plan to control pharmaceutical supplies.                                                                                                                                 |

APPENDIX A
### MGMA Body of Knowledge

<table>
<thead>
<tr>
<th>Domain</th>
<th>Individual job responsibilities, activities and functions</th>
</tr>
</thead>
</table>
| **Quality Management** | • Design and implement a quality management system that leads to the improvement of health care delivery and ensures patient safety.  
• Monitor the peer review process for clinical staff.  
• Develop and oversee patient satisfaction and customer service programs.  
• Identify, develop and maintain benchmarks for establishing practice performance standards.  
• Create internal processes and systems to participate in pay-for-performance programs to enhance health care quality.  
• Develop and monitor a program for staff, business and equipment credentialing and licensure. |
| **Risk Management** | • Develop and implement a risk management plan to ensure a safe environment for patients, staff and visitors.  
• Develop and implement policies and procedures to manage the impact of adverse legal events.  
• Establish a plan for disaster response and recovery.  
• Develop and implement a compliance program for federal and state laws and regulations. |

**Source**: American College of Medical Practice Executives. *Body of Knowledge for Medical Practice Management*

American College of Medical Practice Executives, 2008 Print
## APPENDIX B: THE ACMPE BODY OF KNOWLEDGE AS ANTICIPATORY GUIDANCE

### Decision Matrix for Management Decisions in Pediatric Practice

<table>
<thead>
<tr>
<th>Pediatric Practice Challenges</th>
<th>ACMPE Body of Knowledge Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10</td>
<td>Identify &amp; utilization of outsourced expertise</td>
</tr>
<tr>
<td></td>
<td>Budgeting Revenue cycle management</td>
</tr>
<tr>
<td></td>
<td>Purchasing</td>
</tr>
<tr>
<td></td>
<td>Marketing Plan</td>
</tr>
<tr>
<td></td>
<td>Marketing Plan</td>
</tr>
<tr>
<td></td>
<td>Monitor business operation plan</td>
</tr>
<tr>
<td></td>
<td>Budgeting</td>
</tr>
<tr>
<td></td>
<td>Facilities planning</td>
</tr>
<tr>
<td></td>
<td>Facilities planning</td>
</tr>
</tbody>
</table>

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**Note:** The table above outlines various decision areas in pediatric practice and the associated challenges, focusing on the ACMPE Body of Knowledge Domains. Each domain is linked to specific strategies and plans. The matrix is designed to help in anticipatory guidance and decision-making processes, ensuring comprehensive and effective management in pediatric practice environments.