This document is intended to serve as a guide for completing the MGMA 2017 Practice Operations Survey. An explanation of each survey question and the provided answer options are included. For additional participation resources, check out our Survey Participation Resources page (www.mgma.com/participate).

Getting Started:
- Complete your Practice Profile before completing the Practice Operations Survey.
- Please provide the requested information on your organization to the extent you can provide it. The quality of our reported results depends upon the completeness and accuracy of every response.

Guide Contents:
- Demographics
- Operations
- Governance
- Scheduling
- Financial Management
- HR Management

Please note: Multispecialty practices will be asked to break out data for each specialty in the Practice Operations Survey.
DEMOGRAPHICS

*What is your practice NPI number?*

The National Provider Number (NPI) is a unique, 10-digit identification number assigned to health care providers to submit claims or conduct other transactions specified by the Health Insurance Portability and Accountability Act (HIPAA). A “health care provider” is defined as an individual, group or organization that provides medical or other health services. If you are unsure of your practice’s NPI number, you can look it up here: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?subAction=reset&searchType=org

*For the purpose of reporting the information in this questionnaire, what fiscal year was used?*

Enter the beginning month, beginning year, end month and end year of your most recently completed fiscal year. Data reported for periods less than 12 months will not be eligible for submission. If your medical practice was involved in a merger or acquisition during the 2016 fiscal year and you cannot assemble 12 months of practice data, you may not be able to participate. Please call Data Solutions at 877.275.6462, ext. 1895, if you are uncertain about your eligibility to participate.

What is your practice’s legal organization?

**Business corporation:** A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders need not be licensed in the profession practiced by the corporation.

**Limited liability company:** A legal entity that is a hybrid between a corporation and a partnership, because it provides limited liability to owners like a corporation while passing profits and losses through to owners like a partnership.

**Not-for-profit corporation/foundation:** An organization that has obtained special exemption under Section 501(c) of the Internal Revenue Service code that qualifies the organization to be exempt from federal income taxes. To qualify as a tax-exempt organization, a practice or faculty practice plan would have to provide evidence of a charitable, educational, or research purpose.

**Partnership:** An unincorporated organization where two or more individuals have agreed that they will share profits, losses, assets, and liabilities, although not necessarily on an equal basis. The partnership agreement may or may not be formalized in writing.

**Professional corporation/association:** A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders must be licensed in the profession practiced by the organization.

**Sole proprietorship:** An organization with a single owner who is responsible for all profit, losses, assets, and liabilities.

**Other:** If your practice’s legal organization is not listed, describe in the “Other” text box.
What demographic classification best describes the area surrounding the primary location of your practice?

**Rural/Nonmetropolitan (4,999 or fewer):** The community in which the practice is located within a “metropolitan statistical area” (MSA), as defined by the United States Office of Management and Budget, and has a population of 4,999 or fewer.

**Nonmetropolitan (5,000 to 10,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA), as defined by the United States Office of Management and Budget, and has a population of 5,000 to 10,000.

**Nonmetropolitan (10,001 to 50,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA), as defined by the United States Office of Management and Budget, and has a population of 10,001 to 50,000.

**Metropolitan (50,001 to 100,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA) or Census Bureau defined urbanized area with a population of 50,001 to 100,000.

**Metropolitan (100,001 to 250,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA) or Census Bureau defined urbanized area with a population of 100,001 to 250,000.

**Metropolitan (250,001 to 500,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA) or Census Bureau defined urbanized area with a population of 250,001 to 500,000.

**Metropolitan (500,001 to 1,000,000):** The community in which the practice is located within a “metropolitan statistical area” (MSA) or Census Bureau defined urbanized area with a population of 500,001 to 1,000,000.

**Metropolitan (1,000,001 or more):** The community in which the practice is located within a “metropolitan statistical area” (MSA) or Census Bureau defined urbanized area with a population of 1,000,001 or more.

**Is your practice a Federally Qualified Health Center (FQHC)?**

A reimbursement designation that refers to several health programs funded under Section 330 of the Public Health Service Act of the United States of America’s Federal Government. These 330 grantees in the Health Center Program include:

- Community Health Centers which serve a variety of underserved populations and areas;
- Migrant Health Centers which serve migrant and seasonal agricultural workers;
- Health Care for the Homeless Programs which reach out to homeless individuals and families and provide primary and preventive care and substance abuse services; and
- Public Housing Primary Care Programs that serve residents of public housing and are located in or adjacent to the communities they serve.

FQHCs are community based organizations that provide comprehensive primary and preventive health, oral, and mental health/substance abuse services to persons in all stages of the life cycle, regardless of their ability to pay.
Is your practice a Rural Health Clinic (RHC)?
A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and nonphysician providers (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a nonphysician providers. RHCs may also provide other health care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

How does your practice store information for the majority of patients served?
Choose the method in which the practice stored health/medical records for the majority of patients served by the practice. A fully functional Electronic Health Records (EHR) would include the followin four functions:
- Collect patient data;
- Display test results;
- Allow providers to enter medical orders and prescriptions; and
- Aid physicians in making treatment decisions.

How many years has your EHR been fully implemented in your practice?
Enter the number of years that an EHR has been fully implemented. If your practice has had more than one EHR, enter the number since the first EHR was fully implemented.

Total physician FTE
Report the number of FTE physicians in your practice. An FTE physician works whatever number of hours the practice considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard.

To compute the FTE of a part-time provider/staff divide the total hours worked by the individual by the number of hours that your medical practice considers to be a normal workweek. For example, an individual working in a clinic or hospital on behalf of the practice for 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 divided by 40 hours). An individual working full-time for three months during a year would be 0.25 FTE (3 divided by 12 months). Do not report an individual as more than 1.0 FTE regardless of the number of hours worked.

Total nonphysician provider FTE
Report the number of FTE nonphysician providers in your practice. Nonphysician providers are specially trained and licensed providers who can provide medical care and billable services. Examples of nonphysician providers include audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon assistants.
Total support staff FTE
Report the number of FTE support staff in your practice. Examples of support staff include individuals who hold positions in general administrative, patient accounting, general accounting, managed care administration, information technology, housekeeping, maintenance, security, medical receptionist, medical secretaries, transcription, medical records, registered nurses, licensed practice nurses, medical assistants, nurse’s aides, clinical laboratory, radiology and imaging, and other medical, administrative, ancillary, and front office support services.

Total practice medical revenue
Total medical revenue is the sum of fee-for-service collections (revenue collected from patients and third-party payers for services provided to fee-for-service, discounted fee-for-service, and non-capitated Medicare/Medicaid patients), capitation payments (gross capitation revenue minus purchased services for capitation payments), and other medical activity revenues. Other medical revenue includes grants, honoraria, research contract revenues, government support payments, and educational subsidies plus the revenue from the sale of medical goods and services.

OPERATIONS

Indicate the days and hours your practice was open for seeing patients.
For each day of the week, indicate the open time and close time that your practice was available for seeing patients. For days where the practice was closed, select “Not Open” dropdown. If your practice operated 24 hours a day, select “Open 24 Hours” from the dropdown.

What best described your practice operations during the lunch hour?
Continued to see patients with phones on: Practice remained open and continued to see patients during the lunch hour while also providing phone coverage; business as usual.
Continued to see patients with phones off: Practice remained open and continued to see patients during the lunch hour but no phone coverage was provided.
Not open for patient visits, yet had continued phone coverage: Practice was not open for patient visits during the lunch hour but was available via phone coverage.
Not open for patient visits, yet had a phone recording: Practice was not open for patient visits during the lunch hour but had a phone recording.
Not open for patient visits, yet had an answering service: Practice was not open for patient visits during the lunch hour but had an answering service providing phone coverage.
Other, please specify: If none of the above, select “Other” and please specify in the text box your practice operations during the lunch hour.
What percent of your patient population used a patient portal to:

**Schedule appointments:** Indicate the percent, in whole numbers, of your patient population that used a patient portal to schedule appointments. If this functionality wasn’t offered in your patient portal or you did not have a patient portal, indicate that by entering “0”.

**Pay bills online:** Indicate the percent, in whole numbers, of your patient population that used a patient portal to pay their bills online. If this functionality wasn’t offered in your patient portal or you did not have a patient portal, indicate that by entering “0”.

**Access test results:** Indicate the percent, in whole numbers, of your patient population that used a patient portal to access test results. If this functionality wasn’t offered in your patient portal or you did not have a patient portal, indicate that by entering “0”.

**Communicate with providers and medical staff:** Indicate the percent, in whole numbers, of your patient population that used a patient portal to communicate with the providers and medical staff at your practice. If this functionality wasn’t offered in your patient portal or you did not have a patient portal, indicate that by entering “0”.

**View, download or transmit medical records:** Indicate the percent, in whole numbers, of your patient population that used a patient portal to view, download or transmit medical records. If this functionality wasn’t offered in your patient portal or you did not have a patient portal, indicate that by entering “0”.

**Did you manage your online presence?**

Indicate “Yes” if your practice took steps to manage its online presence and reputation. If your practice took no action to manage its online presence, answer “No”. Managing your online presence may include reviewing appropriate representation of your practice’s brand via social media and online platforms.

**How often did you conduct patient satisfaction surveys?**

**Every patient visit:** Patient satisfaction surveys were provided to patient for all visits.

**More than once a month:** Patient satisfaction surveys were conducted at least twice each month on average.

**Monthly:** Patient satisfaction surveys were conducted once a month on average.

**Quarterly:** Patient satisfaction surveys were conducted every three months on average.

**Twice a year:** Patient satisfaction surveys were conducted every six months on average.

**Annually:** Patient satisfaction surveys were conducted every six months on average.

**Less than once a year:** Patient satisfaction surveys were conducted less than once a year on average.

**Never:** Patient satisfaction surveys were never conducted.
How were your patient satisfaction surveys conducted?

If you answered “Every patient visit”, “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or ”Less than once a year” to the question How often did your practice conduct patient satisfaction surveys, then indicate how your patient satisfaction surveys were conducted.

**In-house:** Patient satisfaction surveys were conducted in-house. Your practice was responsible for distributing the patient satisfaction surveys to patients for completion and subsequently collecting the completed surveys.

**Outsourced:** Patient satisfaction surveys were outsourced. A third-party company was responsible for distributing the patient satisfaction surveys to patients for completion and subsequently collecting the completed surveys.

**Combination of in-house and outsourced:** Patient satisfaction surveys were conducted both within the practice and using a third-party company.

**Other, please specify:** If another method was used to conduct patient satisfaction surveys, select “Other” and please specify in the text box those additional methods.

How were your patient satisfaction surveys delivered?

If you answered “Every patient visit”, “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or ”Less than once a year” to the question How often did your practice conduct patient satisfaction surveys, then indicate how your patient satisfaction surveys were delivered.

**Over the phone:** Patient satisfaction surveys were delivered via a phone call to patients in order to gather the patient’s feedback.

**Email:** Patient satisfaction surveys were delivered via email to patients in order to gather the patient’s feedback.

**Text:** Patient satisfaction surveys were delivered via text messaging to patients in order to gather the patient’s feedback.

**Mail:** Patient satisfaction surveys were delivered via mail to patients in order to gather the patient’s feedback.

**In office:** Patient satisfaction surveys were provided in-office to patients in order to gather the patient’s feedback.

**Other, please specify:** If another method was used to deliver patient satisfaction surveys, select “Other” and please specify in the text box those additional delivery methods.

Was your patient satisfaction survey CAHPS certified?

If you answered “Every patient visit”, “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or ”Less than once a year” to the question How often did your practice conduct patient satisfaction surveys, then indicate whether or not your patient satisfaction survey was CAHPS certified.

Indicate “Yes” if your practice’s patient satisfaction survey was certified through the CAHPS (Consumer Assessment of Healthcare Providers and Systems) program. If your practice’s patient satisfaction survey was not CAHPS certified, answer “No”.
How often did you review the results from your patient satisfaction surveys?

If you answered “Every patient visit”, “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or “Less than once a year” to the question *How often did your practice conduct patient satisfaction surveys*, then indicate how often your patient satisfaction survey results were reviewed.

**More than once a month:** Patient satisfaction survey results were reviewed at least twice each month on average.

**Monthly:** Patient satisfaction survey results were reviewed once a month on average.

**Quarterly:** Patient satisfaction survey results were reviewed every three months on average.

**Twice a year:** Patient satisfaction survey results were reviewed every six months on average.

**Annually:** Patient satisfaction survey results were reviewed once a year on average.

**Less than once a year:** Patient satisfaction survey results were reviewed less than once a year on average.

**Never:** Patient satisfaction survey results were never reviewed.

Did your practice make actionable decisions with the results from your patient satisfaction surveys?

If you answered “Every patient visit”, “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or “Less than once a year” to the question *How often did your practice conduct patient satisfaction surveys*, then indicate whether or not your practice made actionable decisions with the results from the patient satisfaction surveys.

Indicate “Yes” if your practice made actionable decisions with the results from the patient satisfaction surveys. If your practice’s did not make actionable decisions with the results from the patient satisfaction surveys, answer “No”.

Who reviewed the patient satisfaction survey results? (Check all that apply)

If you answered “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or “Less than once a year” to the question *How often did you review the results from your patient satisfaction surveys*, then indicate who reviewed the results from the patient satisfaction survey.

**Providers:** Check this box if providers reviewed the patient satisfaction survey results.

**Administrator:** Check this box if the administrator reviewed the patient satisfaction survey results.

**Executive leaders:** Check this box if executive leaders reviewed the patient satisfaction survey results.

**Senior leaders:** Check this box if senior leaders reviewed the patient satisfaction survey results.

**Management leaders:** Check this box if management leaders reviewed the patient satisfaction survey results.

**Staff:** Check this box if staff reviewed the patient satisfaction survey results.

**Board of directors:** Check this box if the board of directors reviewed the patient satisfaction survey results.

**Other, please specify:** If others reviewed the patient satisfaction survey results, check the “Other” box and please specify in the text box who else was involved in reviewing the patient satisfaction survey results.
Did your practice report on any quality metrics?
Indicate “Yes” if your practice reported on any quality metrics. If your practice did not report on any quality metrics, answer “No”. Quality measures and activities for practice reporting are outlined by CMS to reward high-value, patient-centered care.

GOVERNANCE

Who led the practice operational decisions?
- **Physicians and administrator collaborated**: Physicians and administrator collaborated on practice operational decisions.
- **Physician led**: Physicians led practice operational decisions.
- **Administrator led**: Administrator led practice operational decisions.
- **Other, please specify**: If neither physicians and/or administrator led practice operational decisions, select “Other” and please specify in the text box who led the practice operational decisions.

Who led the practice strategic decisions?
- **Physicians and administrator collaborated**: Physicians and administrator collaborated on practice strategic decisions.
- **Physician led**: Physicians led practice strategic decisions.
- **Administrator led**: Administrator led practice strategic decisions.
- **Other, please specify**: If neither physicians and/or administrator led practice strategic decisions, select “Other” and please specify in the text box who led the practice strategic decisions.

Who was primarily responsible for patient safety?
- **Group President/CEO**: The group/practice president/CEO was the primary person responsible for patient safety.
- **Chief Medical Officer**: The chief medical officer (CMO) was the primary person responsible for patient safety.
- **Designated physician(s)**: Designated physician(s) was the primary person responsible for patient safety.
- **Administrator**: Administrator was the primary person responsible for patient safety.
- **Other, please specify**: If other(s) was the primary person responsible for patient safety, select “Other” and please specify in the text box who was primarily responsible for patient safety.
- **Do not have a designated person**: If you did not have a designated person primarily responsible for patient safety, select “Do not have a designated person”.

Who was primarily responsible for clinical quality?

Group President/CEO: The group/practice president/CEO was the primary person responsible for clinical quality.

Chief Medical Officer: The chief medical officer (CMO) was the primary person responsible for clinical quality.

Designated physician(s): Designated physician(s) was the primary person responsible for clinical quality.

Administrator: Administrator was the primary person responsible for clinical quality.

Other, please specify: If other(s) was the primary person responsible for clinical quality, select “Other” and please specify in the text box who was primarily responsible for clinical quality.

Do not have a designated person: If you did not have a designated person primarily responsible for clinical quality, select “Do not have a designated person”.

How often did the administrator and physicians meet?

Daily: Physicians and administrator met daily on average to discuss practice topics.

Weekly: Physicians and administrator met once a week on average to discuss practice topics.

Monthly: Physicians and administrator met once a month on average to discuss practice topics.

Quarterly: Physicians and administrator met once every three months on average to discuss practice topics.

Twice a year: Physicians and administrator met twice a year on average to discuss practice topics.

Annually: Physicians and administrator met once a year on average to discuss practice topics.

Less than once a year: Physicians and administrator met less than one time per year on average to discuss practice topics.

Never: Physicians and administrator never met to discuss practice topics.

How often did senior leaders communicate with staff regarding goals and opportunities?

Daily: Senior leaders communicated goals and opportunities with staff daily on average.

Weekly: Senior leaders communicated goals and opportunities with staff once a week on average.

Monthly: Senior leaders communicated goals and opportunities with staff once a month on average.

Quarterly: Senior leaders communicated goals and opportunities with staff once every three months on average.

Twice a year: Senior leaders communicated goals and opportunities with staff twice a year on average.

Annually: Senior leaders communicated goals and opportunities with staff once a year on average.

Less than once a year: Senior leaders communicated goals and opportunities with staff less than one time per year on average.

Never: Senior leaders never communicated goals and opportunities with staff.
Which of the following patient services were centralized? (Check all that apply)

**Registration:** Check this box if registration was a centralized service where the management of patient registration was coordinated for multiple departments, practices or entities within your system.

**Scheduling:** Check this box if scheduling was a centralized service where the management of patient appointment scheduling was coordinated for multiple departments, practices or entities within your system.

**Billing:** Check this box if billing was a centralized service where the management of patient billing and collections was coordinated for multiple departments, practices or entities within your system.

**Referral management:** Check this box if referral management was a centralized service where the management of patient referrals was coordinated for multiple departments, practices or entities within your system.

How did you manage inbound telephone calls?

**Front desk staff:** Front desk staff were responsible for answering inbound telephone calls, calls coming in.

**In-house call center:** Inbound telephone calls, calls coming in, were answered by an in-house call center. A centralized group of staff within the practice other than front desk staff were responsible for answering inbound telephone calls.

**Outsourced call center:** Inbound telephone calls, calls coming in, were answered by an outsourced call center. A third-party company was responsible for answering inbound telephone calls.

**Other, please specify:** If others were responsible for answering inbound telephone calls, calls coming in, select “Other” and please specify in the text box those additional methods.

How many FTE staff were in the call center?

If you answered “In-house call center” to the question *How did you manage inbound telephone calls*, then indicate the number of full-time-equivalent (FTE) staff that were in the call center.

What was the average inbound call volume per day?

If you answered “Front desk staff” or “In-house call center” to the question *How did you manage inbound telephone calls*, then indicate the average number of inbound telephone calls, calls coming in, received per day.

What was the average call length in minutes for inbound calls?

If you answered “Front desk staff” or “In-house call center” to the question *How did you manage inbound telephone calls*, then indicate the average duration in minutes per telephone call for inbound calls, calls coming in, measured from when the call is answered and including any hold time, talk time and until the call is completed.
What was the average speed of answer in seconds for inbound calls?

If you answered “Front desk staff” or “In-house call center” to the question How did you manage inbound telephone calls, then indicate the average amount of time in seconds it takes to answer inbound telephone calls, calls coming in.

What was the average call abandonment percentage rate for inbound calls?

If you answered “Front desk staff” or “In-house call center” to the question How did you manage inbound telephone calls, then indicate the average abandonment percentage rate, in whole numbers, for inbound telephone calls, calls coming in. Call abandonment rate is percentage of total calls that were disconnected.

SCHEDULING

What percent of your practice’s total appointments were same-day appointments?

Indicate the percent, in whole numbers, of your practice’s total appointment slots that were scheduled the same-day patients call to accommodate for last-minute appointment requests.

For scheduled appointments, what was the average wait time (in minutes) the patient was in the:

Waiting area before being brought to the exam room: Indicate the average amount of time in minutes a patient was in the waiting area before being brought back to the exam room.

Exam room before seeing the provider: Indicate the average amount of time in minutes a patient was waiting in the exam room before seeing the provider.

Have you taken action to improve patient wait times in the last 12 months?

Indicate “Yes” if your practice has implemented new policies/procedures within the last 12 months to improve patient wait times in the waiting area and/or exam room. If your practice has taken no action towards improving wait times, answer “No”.
What was the average scheduled appointment slot-time length (in minutes) for:

New patient visits: Indicate the average amount of time in minutes that was scheduled for new patient visits.

Established patient visits: Indicate the average amount of time in minutes that was scheduled for established patient visits.

Preventive care visits: Indicate the average amount of time in minutes that was scheduled for preventive care visits.

Follow-up/post-op visits: Indicate the average amount of time in minutes that was scheduled for follow-up/post-op visits.

On average, what was your third next available appointment (in business days) for:

To calculate your third next available appointment, begin by counting the number of working days from the start of each day to the third open appointment. If the third next available appointment was the day you start on, reflect that by entering “0”, if it was the day after then indicate that by entering “1” and so forth.

Do not count days when the office is closed for business. However, days where the provider is unavailable due to vacation, administrative time, sick leave, etc. should be included in your count. If a certain number of appointment slots are reserved for same-day appointments, do not include those in your count for third next available appointment.

New patient visits: Using the guidelines above to calculate third next available appointment, indicate the number in business days for new patient visits.

Established patient visits: Using the guidelines above to calculate third next available appointment, indicate the number in business days for established patient visits.

Preventive care visits: Using the guidelines above to calculate third next available appointment, indicate the number in business days for preventive care visits.

Follow-up/post-op visits: Using the guidelines above to calculate third next available appointment, indicate the number in business days for follow-up/post-op visits.

For scheduled appointments, what was the average per provider for:

Number of appointment slots per day for new patient visits: Indicate the average number of appointment slots per provider that were in your schedule per day for new patient visits.

Number of appointment slots for established patient visits: Indicate the average number of appointment slots per provider that were in your schedule per day for established patient visits.

Number of appointment slots per day for preventive care visits: Indicate the average number of appointment slots per provider that were in your schedule per day for preventive care visits.

Number of appointment slots per day for follow-up/post-op visits: Indicate the average number of appointment slots per provider that were in your schedule per day for follow-up/post-op visits.

Number of appointment slots reserved for same-day appointments: Indicate the average number of appointment slots per provider that were reserved for same day appointments per day.
What was your practice’s no show rate percentage?
Indicate your practice’s average no show rate percent, in whole numbers, where appointments were scheduled but patients did not show up for their scheduled appointment.

How much did you charge for no show appointments?
Indicate the amount you charged for no show appointments. If you did not charge for no shows, reflect that by entering “0”.

How many minutes late until a patient was considered a no-show?
Indicate how many minutes late until your practice considered a patient who did not show up for a scheduled appointment as a no-show.

What was your practice’s appointment cancellation rate percentage?
Indicate your practice’s average appointment cancellation rate percent, in whole numbers, where appointments were scheduled but patients called to cancel their scheduled appointment.

FINANCIAL MANAGEMENT

What percent of copayments were collected at time of service?
Indicate the percent, in whole numbers, of copayments that were collected from patients at time of service. If you did not collect copayments at time of service, indicate that by entering “0”.

What percent of patient due balances were collected at time of service?
Indicate the percent, in whole numbers, of patient due balances that were collected from patients at time of service. If you did not collect patient due balances at time of service, indicate that by entering “0”.

What best described your billing function structure?
In-house: Medical billing operations were performed in-house, within your practice.
Outsourced: Medical billing operations were outsourced to a third-party company.
Combination of in-house and outsourced: Medical billing operations were performed both inhouse and outsourced.
Other, please specify: If another method was used to perform medical billing operations, select “Other” and please specify in the text box those additional methods.
What was the average number of commercial claims a biller posted in a day?
If you answered “In-house” to the question What best described your billing function structure, then indicate the average number of commercial claims a biller posted in a day. A claim is written request for payment submitted to a third-party.

What was the average number of government claims a biller posted in a day?
If you answered “In-house” to the question What best described your billing function structure, then indicate the average number of government claims a biller posted in a day. A claim is written request for payment submitted to a third-party.

What was the average number of follow-up claims a biller posted in a day?
If you answered “In-house” to the question What best described your billing function structure, then indicate the average number of follow-up claims a biller posted in a day. A claim is written request for payment submitted to a third-party.

What percentage of practice claims were denied on first submission?
Indicate the percent, in whole numbers, of practice claims that were denied on first submission. A claim is written request for payment submitted to a third-party.

What was your average charge-posting lag time between date of service and claim drop date to payer?
If you answered “In-house” to the question What best described your billing function structure, then indicate the average charge-posting lag time between date of service and claim drop date to payer. Report the number of days between when a patient was seen and when the charge was posted for third-party payment. If the payment was posted immediately after seeing a patient, represent that by entering “0”. If the payment was posted within the same day, but hours later, represent that by entering in a decimal value (e.g. half a day later should be represented by entering “0.5”).

What pricing model was used with the billing service?
If you answered “Outsourced” to the question What best described your billing function structure, then indicate the pricing model that was used with your billing service.

- **Percentage-based:** The billing service charged a percentage of collections.
- **Fee-based:** The billing service charged a fixed dollar rate per claim.
- **Hybrid:** The billing service charged on a percentage basis for certain carriers or balances and flat fee for others.
What percent of collections did the billing service charge?
If you answered “Percentage-based” to the question What pricing model was used with the billing service, then indicate the percent, in whole numbers, of collections the billing service charged.

What was the fee per claim the billing service charged?
If you answered “Fee-based” to the question What pricing model was used with the billing service, then indicate the fee per claim the billing service charged.

Who was responsible for coding the practice's patient encounters?
An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient’s condition, where the provider exercises clinical judgment that may or may not be billable.

Providers: Providers were responsible for coding the practice's patient encounters for billing submission.
Coders: Coders were responsible for coding the practice’s patient encounters for billing submission.
Other internal staff: Other internal staff, not providers or coders, were responsible for coding the practice’s patient encounters for billing submission.
External coding source: A third party company, not internal practice staff or providers, was responsible for coding the practice’s patient encounters for billing submission.
Computer/EHR system: Practice computer/EHR system coded the practice’s patient encounters for billing submission.
Other, please specify: If others were responsible for coding the practice’s patient encounters for billing submission, select “Other” and please specify in the text box who was responsible for coding the practice’s patient encounters.

What was the average number of patient encounters a coder processed in a day?
If you answered “Coders” to the question Who was responsible for coding the practice’s patient encounters, then indicate the average number of patient encounters a coder processed in a day. An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient’s condition, where the provider exercises clinical judgment that may or may not be billable.

Were patient encounters reviewed by coders prior to billing?
If you answered “Providers” to the question Who was responsible for coding the practice’s patient encounters, then indicate whether or not your patient encounters were reviewed by coders prior to billing.
Did your practice have an annual budget?
Indicate “Yes” if your practice had an annual budget. If your practice did not have an annual budget, answer “No”.

Did your practice have a capital budget?
If you answered “Yes” to the question Did your practice have an annual budget, then indicate whether or not your practice had a capital budget.

Did your practice have an operations budget?
If you answered “Yes” to the question Did your practice have an annual budget, then indicate whether or not your practice had an operations budget.

How often did you compare your year-to-date status relative to your budget?
If you answered “Yes” to the question Did your practice have an annual budget, then indicate how often you compared your year-to-date status relative to your budget.

More than once a month: Year-to-date status relative to your budget was reviewed at least twice each month on average.
Monthly: Year-to-date status relative to your budget was reviewed once a month on average.
Quarterly: Year-to-date status relative to your budget was reviewed every three months on average.
Twice a year: Year-to-date status relative to your budget was reviewed every six months on average.
Annually: Year-to-date status relative to your budget was reviewed once a year on average.
Less than once a year: Year-to-date status relative to your budget was reviewed less than once a year on average.
Never: Year-to-date status relative to your budget was never reviewed.

How often did you conduct financial analysis/benchmarking with your budget?
If you answered “Yes” to the question Did your practice have an annual budget, then indicate how often you conducted financial analysis/benchmarking with your budget.

More than once a month: Financial analysis/benchmarking was conducted with your budget at least twice each month on average.
Monthly: Financial analysis/benchmarking was conducted with your budget once a month on average.
Quarterly: Financial analysis/benchmarking was conducted with your budget every three months on average.
Twice a year: Financial analysis/benchmarking was conducted with your budget every six months on average.
Annually: Financial analysis/benchmarking was conducted with your budget once a year on average.
Less than once a year: Financial analysis/benchmarking was conducted with your budget less than once a year on average.
Never: Financial analysis/benchmarking was never conducted with your budget.
Who was accountable if the practice did not meet the budget? (Check all that apply)

If you answered “Yes” to the question Did your practice have an annual budget, then indicate who was accountable if the practice did not meet the budget.

Providers: Check this box if providers were accountable if the practice did not meet the budget.

Administrator: Check this box if the administrator was accountable if the practice did not meet the budget.

Executive leaders: Check this box if executive leaders were accountable if the practice did not meet the budget.

Senior leaders: Check this box if senior leaders were accountable if the practice did not meet the budget.

Management leaders: Check this box if management leaders were accountable if the practice did not meet the budget.

Staff: Check this box if staff were accountable if the practice did not meet the budget.

Board of directors: Check this box if the board of directors were accountable if the practice did not meet the budget.

Other, please specify: If others were accountable if the practice did not meet the budget, check the “Other” box and please specify in the text box who else was accountable if the practice did not meet the budget.

Did you have a credit card on file program?

Indicate “Yes” if your practice had a credit card on file (CCOF) program. If your practice did not have a credit card on file program, answer “No”.
When was the last time your employee handbook was revised?

Within the last year: Your employee handbook was reviewed, revised and distributed to employees within your practice within the last year.

Within the last 2 years: Your employee handbook was reviewed, revised and distributed to employees within your practice within the last two years.

Within the last 3 years: Your employee handbook was reviewed, revised and distributed to employees within your practice within the last three years.

Within the last 4 years: Your employee handbook was reviewed, revised and distributed to employees within your practice within the last four years.

Within the last 5 years or longer: Your employee handbook was reviewed, revised and distributed to employees within your practice within the last five years or longer.

Never: Your employee handbook never gets revised.

Do not have an employee handbook: Your practice does not have an employee handbook.

Practice turnover: list the total number of positions, the number of people who left and the number of people hired for the following positions:

Business operations support staff: Indicate the total number of business operations support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the business functions of the practice, including general administration, patient accounting, general accounting, managed care administration, information technology, housekeeping, maintenance, and security.

Front office support staff: Indicate the total number of front office support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the front office duties of the practice, including medical reception, secretarial functions, transcription, medical records, and other administrative support.

Clinical support staff: Indicate the total number of clinical support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform the clinical support duties of the practice including registered nurses (RNs), licensed practical nurses (LPNs), medical assistants, and nurse’s aides who assist clinical services.

Ancillary support staff: Indicate the total number of ancillary support staff positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes staff who perform support duties for the ancillary services provided by the practice, including clinical laboratory, radiology and imaging, and other medical support services.

Physicians: Indicate the total number of physician positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period.
Nonphysician providers: Indicate the total number of nonphysician provider positions at your practice, the number of people who left those positions and the number of people hired for those positions during the reporting period. This includes audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners (NPs), occupational therapists, optometrists, physical therapists, physician assistants (PAs), psychologists, and surgeon’s assistants.

Did you have an employee appreciation program?
Indicate “Yes” if your practice had an employee appreciation program. If your practice did not have an employee appreciation program, answer “No”.

How often did you conduct employee satisfaction surveys?
More than once a month: Employee satisfaction surveys were conducted at least twice each month on average.
Monthly: Employee satisfaction surveys were conducted once a month on average.
Quarterly: Employee satisfaction surveys were conducted every three months on average.
Twice a year: Employee satisfaction surveys were conducted every six months on average.
Annually: Employee satisfaction surveys were conducted once a year on average.
Less than once a year: Employee satisfaction surveys were conducted less than once a year on average.
Never: Employee satisfaction surveys were never conducted.

Who reviewed the employee satisfaction survey results? (Check all that apply)
If you answered “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or “Less than once a year” to the question How often did you conduct employee satisfaction surveys, then indicate who reviewed the results from the employee satisfaction survey.

Providers: Check this box if providers reviewed the employee satisfaction survey results.
Administrator: Check this box if the administrator reviewed the employee satisfaction survey results.
Executive leaders: Check this box if executive leaders reviewed the employee satisfaction survey results.
Senior leaders: Check this box if senior leaders reviewed the employee satisfaction survey results.
Management leaders: Check this box if management leaders reviewed the employee satisfaction survey results.
Staff: Check this box if staff reviewed the employee satisfaction survey results.
Board of directors: Check this box if the board of directors reviewed the employee satisfaction survey results.

Other, please specify: If others reviewed the employee satisfaction survey results, check the “Other” box and please specify in the text box who else was involved in reviewing the employee satisfaction survey results.
How often did you conduct provider satisfaction surveys?

**More than once a month:** Provider satisfaction surveys were conducted at least twice each month on average.

**Monthly:** Provider satisfaction surveys were conducted once a month on average.

**Quarterly:** Provider satisfaction surveys were conducted every three months on average.

**Twice a year:** Provider satisfaction surveys were conducted every six months on average.

**Annually:** Provider satisfaction surveys were conducted once a year on average.

**Less than once a year:** Provider satisfaction surveys were conducted less than once a year on average.

**Never:** Provider satisfaction surveys were never conducted.

Who reviews the provider satisfaction survey results?

(Check all that apply)

If you answered “More than once a month”, “Monthly”, “Quarterly”, “Twice a year”, “Annually” or “Less than once a year” to the question How often did you conduct provider satisfaction surveys, then indicate who reviewed the results from the provider satisfaction survey.

**Providers:** Check this box if providers reviewed the provider satisfaction survey results.

**Administrator:** Check this box if the administrator reviewed the provider satisfaction survey results.

**Executive leaders:** Check this box if executive leaders reviewed the provider satisfaction survey results.

**Senior leaders:** Check this box if senior leaders reviewed the provider satisfaction survey results.

**Management leaders:** Check this box if management leaders reviewed the provider satisfaction survey results.

**Staff:** Check this box if staff reviewed the provider satisfaction survey results.

**Board of directors:** Check this box if the board of directors reviewed the provider satisfaction survey results.

**Other, please specify:** If others reviewed the provider satisfaction survey results, check the “Other” box and please specify in the text box who else was involved in reviewing the provider satisfaction survey results.

What percent of health insurance premium cost did your practice pay for providers?

Indicate the percent, in whole numbers, of health insurance premium cost your practice paid for providers. This percentage amount should reflect the policy cost for the covered provider and not include any family coverage.

**100%:** The practice paid 100% of the health insurance premium cost for providers.

**75-99%:** The practice paid between 75% and 99% of the health insurance premium cost for providers.

**50-74%:** The practice paid between 50% and 74% of the health insurance premium cost for providers.

**24-49%:** The practice paid between 24% and 49% of the health insurance premium cost for providers.

**1-24%:** The practice paid between 1% and 24% of the health insurance premium cost for providers.

**0%:** The practice did not pay any of the health insurance premium cost for providers.
What percent of health insurance premium cost does your practice pay for staff?

Indicate the percent, in whole numbers, of health insurance premium cost your practice paid for staff. This percentage amount should reflect the policy cost for the covered staff and not include any family coverage.

100%: The practice paid 100% of the health insurance premium cost for staff.
75-99%: The practice paid between 75% and 99% of the health insurance premium cost for staff.
50-74%: The practice paid between 50% and 74% of the health insurance premium cost for staff.
24-49%: The practice paid between 24% and 49% of the health insurance premium cost for staff.
1-24%: The practice paid between 1% and 24% of the health insurance premium cost for staff.
0%: The practice did not pay any of the health insurance premium cost for staff.

Did your practice offer a voluntary 401(K) employer funded match?

Indicate "Yes" if your practice offered a voluntary 401(K) employer funded match. If your practice did not offer a voluntary 401(K) employer funded match, answer "No".

What was the maximum percentage amount of the employee contribution to their 401(K) that was matched by your practice?

If you answered “Yes” to the question Did your practice offer a voluntary 401(K) employer funded match, then indicate the maximum percentage amount, in whole numbers, of the employee contribution that was matched by your practice.

What best described the practice's time off policy for sick and vacation?

Separate sick and vacation time: Sick time and vacation time are accrued separately.

Combined as personal time off (PTO): Sick time and vacation time are combined and accrued as a single bank of paid time off (PTO).

Other, please specify: If your practice has a policy where sick time and vacation time are not accrued separately or combined, select “Other” and please specify in the text box your practice’s time off policy for sick and vacation time.

If holidays were separated out, how many paid days were staff provided for designated holidays?

If your practice offered paid time off for holidays outside of sick time and vacation time, indicate how many paid days’ staff were provided for your practice designated holidays.
How many days of sick time were accrued annually for:
If you answered “Separate sick and vacation time” to the question What best described the practice’s time off policy for sick and vacation, then indicate for each how many days of sick time were accrued annually for Providers, Exempt Staff and Nonexempt Staff.

How many days of vacation time were accrued annually for:
If you answered “Separate sick and vacation time” to the question What best described the practice’s time off policy for sick and vacation, then indicate for each how many days of vacation time were accrued annually for Providers, Exempt Staff and Nonexempt Staff.

How many days of PTO were accrued annually for:
If you answered “Combined as personal time off (PTO)” to the question What best described the practice’s time off policy for sick and vacation, then indicate for each how many days of PTO were accrued annually for Providers, Exempt Staff and Nonexempt Staff.