2022 MGMA Practice Operations Survey Guide

Due Date: April 29, 2022

This document is intended to serve as a guide for completing the 2022 MGMA Practice Operations Survey. An explanation of each survey question and the provided answer options are included. For additional participation resources including FAQs, Excel survey help, change notices and participation benefits, check out our Survey Participation Resources page (**mgma.com/participate**).

Getting Started:

- Surveys can be accessed at **data.mgma.com** by clicking on the "Participate in a Survey" button on the far left.
- The Practice Profile must be completed in full before beginning any of the MGMA surveys. It is intended to help tailor your survey to be relevant to your practice(s).
- The quality of our reported results depends upon the completeness and accuracy of every response. Learn more **about our participation benefits.**
- Questions with an asterisk * are required. Questionnaires with required questions left blank may not be eligible for submission.
- Questions with a gold star ☆ must be completed in order to be evaluated and considered an MGMA Better Performer.
- Complete for your practice's 2021 fiscal year.
- Practices that are "Multispecialty with specialty care only" will be asked to break out data for each specialty in the Practice Operations Survey.

Guide Contents:

MGMA

DEMOGRAPHICS

*For the purpose of reporting the information in this survey, 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 2021 fiscal year and you cannot assemble 12 months of practice data, you may not be able to participate. Please contact Data Solutions at 877.275.6462, ext. 1895 or **survey@mgma.com**, if you are uncertain about your eligibility to participate.

***Beginning month:** Enter the beginning month of your most recently completed fiscal year.

***Beginning year:** Enter the year that your most recently completed fiscal year began.

***Ending month:** Enter the ending month of your most recently completed fiscal year.

***Ending year:** Enter the year that your most recently completed fiscal year ended.

*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.

*Total advanced practice provider FTE

Report the number of FTE advanced practice providers in your practice. Advanced practice providers are specially trained and licensed providers who can provide medical care and billable services. Examples of advanced practice providers include audiologists, certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), clinical social workers (CSWs), 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 receptionists, 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.

VALUE-BASED

*What value-based programs did your practice participate in?

If you answered "Yes" to participating in value-based contracts in the Practice Profile, please indicate which value-based program(s) your practice participated in.

Commercial: Indicate "Yes" if your practice participated in commercial payer value-based program(s) (excluding Medicare Advantage). If your practice did not participate in commercial payer value-based program(s) (excluding Medicare Advantage), answer "No." If you are not sure, answer "Unsure."

Government: Indicate "Yes" if your practice participated in a government payer value-based program(s). If your practice did not participate in a government payer value-based program(s), answer "No." If you are not sure, answer "Unsure."

Government payer value-based program(s) may include CMS's Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Medicare Advantage: Indicate "Yes" if your practice participated in a Medicare Advantage value-based program(s). If your practice did not participate in a Medicare Advantage value-based program(s), answer "No." If you are not sure, answer "Unsure."

Medicare Advantage is a part of the Medicare Program, and may include Part A, B and D benefits, however, the benefits are instead offered through contracts with private insurers.

What reimbursement methodologies were utilized in your practice's value-based contracts?

Bundled payment: Indicate "Yes" if your value-based contracts utilized a bundled payment reimbursement methodology. If your value-based contracts did not utilize a bundled payment reimbursement methodology, answer "No." If you are not sure, answer "Unsure."

Bundled payment (may also be known as "episode-based payment") refers to a method of reimbursement where a single comprehensive payment covers all services related to an episode of care. If actual costs exceed the payment amount, the provider is accountable for the difference.

Full capitation: Indicate "Yes" if your value-based contracts utilized a full capitation reimbursement methodology. If your value-based contracts did not utilize a full capitation reimbursement methodology, answer "No." If you are not sure, answer "Unsure."

Full capitation (may also be known as "global capitation") refers to a method of reimbursement where providers may receive a fixed amount of money per patient over a defined period (such as per member per month) covering all health care services, such as primary care, hospitalizations, and specialist care. Providers are responsible for costs exceeding the fixed amount. However, they are also able to receive financial gains when costs are below the fixed amount.

Partial capitation: Indicate "Yes" if your value-based contracts utilized a partial capitation reimbursement methodology. If your value-based contracts did not utilize a partial capitation reimbursement methodology, answer "No." If you are not sure, answer "Unsure."

Partial capitation refers to a method of reimbursement where providers may receive a fixed amount of money per patient over a defined period (such as per member per month) where a set of services, such as laboratory or primary care, may be covered. However, services provided outside of scope are reimbursed using fee-for-service.

Shared Risk: Indicate "Yes" if your value-based contracts utilized a shared risk reimbursement methodology. If your value-based contracts did not utilize a shared risk reimbursement methodology, answer "No." If you are not sure, answer "Unsure."

Shared risk (may also be known as "upside and downside" or "two-sided") refer to a method of reimbursement where providers share in savings and in potential losses. When the actual cost of care exceeds the projected cost, the provider is accountable for the excess costs. However, when the actual cost of care is below the projected costs, the provider receives a percentage of the difference.

Shared Savings: Indicate "Yes" if your value-based contracts utilized a shared savings reimbursement methodology. If your value-based contracts did not utilize a shared savings reimbursement methodology, answer "No." If you are not sure, answer "Unsure."

Shared savings (may also be known as "upside only" or "one-sided") refers to a method of reimbursement where providers share in savings but not risk. When the actual cost of care is below the projected costs, the provider receives a percentage of the difference. If costs exceed the projected cost, the provider is not responsible.

Other (please specify): Indicate "Yes" if your value-based contracts utilized a reimbursement methodology not already listed. If your value-based contracts did not utilize a reimbursement methodology not already listed, answer "No." If you are not sure, answer "Unsure."

IF YES, PLEASE SPECIFY.

*For each payer type, please indicate the number of contracts held by your practice.

Commercial: Indicate the number of commercial payer contracts (excluding Medicare Advantage) held by your practice.

Government: Indicate the number of government programs participated in by your practice. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state, or other government body.

Medicare Advantage: Indicate the number of Medicare Advantage payer contracts held by your practice. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits (and more). However, the benefits are instead offered through contracts with private insurers.

*How many covered lives were attributed to this practice?

Indicate, in whole numbers, the total number of covered lives across all your practice's payer contracts.

*For each payer type, please indicate the number of contracts your practice held that included a risk or value-based program or reimbursement methodology.

Commercial: Indicate the number of commercial payer contracts (excluding Medicare Advantage) your practice held that included a risk or value-based program or reimbursement methodology.

Government: Indicate the number of government programs your practice participated in that included a risk or value-based program or reimbursement methodology. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state or other government body.

Medicare Advantage: Indicate the number of Medicare Advantage payer contracts your practice held that included a risk or value-based program or reimbursement methodology. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits (and more), however, the benefits are instead offered through contracts with private insurers.

*How many covered lives were attributed to value-based contracts in this practice?

Specifically, across your practice's value-based payer contracts indicate, in whole numbers, the number of covered lives that your practice was responsible for.

Value-based contracts are contractual arrangements in which payment for providing healthcare goods and services is tied to terms that are based on clinical quality, patient outcomes, cost effectiveness and other specified measures of the appropriateness and effectiveness of the services rendered.

For each payer type, please indicate the average number of quality measures your practice reported on across its payer contracts.

Commercial: Indicate the average number of quality measures your practice reported on in a commercial payer contract (excluding Medicare Advantage).

Government: Indicate the highest number of quality measures your practice reported on in a government program. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state, or other government body.

Medicare Advantage: Indicate the highest number of quality measures your practice reported on in a Medicare Advantage payer contract. Medicare Advantage is part of the Medicare Program, and will include Part A and B benefits (and more), however, the benefits are instead offered through contracts with private insurers.

Across all payer types and all payer contracts, which specific measure(s) were a focus for your practice?

Regardless of the payer or contract, describe which quality measures were a focus for your practice.

Did your practice participate in an alternative payment model (APM)?

Indicate "Yes" if your practice participated in an alternative payment model (APM). If your practice did not participate in an APM, answer "No." If you are not sure, answer "Unsure."

An Alternative Payment Model (APM) is a payment approach to paying for medical care that holds providers accountable for achieving specific quality performance goals in an efficient manner. In turn, group practices participating in an APM receive added incentive payments to achieve those goals.

APMs can apply to a specific clinical condition, a care episode, or a patient population. APMs utilize reimbursement methods that are different from traditional fee-for-service payments, but an APM may also retain elements of fee-for-service payments as part of its reimbursement structure.

Did your practice participate in the CMS Merit-based Incentive Payment System (MIPS)?

Indicate "Yes" if your practice participated in the (MIPS). If your practice did not participate in MIPS, answer "No." If you are not sure, answer "Unsure."

Merit-based Incentive Payment Systems (MIPS) was established by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Eligible clinicians are subject to upward, neutral, or downward payment adjustments based on performance in four performance categories: quality, cost, promoting interoperability (formerly advancing care information), and improvement activities. Each MIPS performance category is weighted to contribute to a final MIPS score, which is calculated out of 100 points. Scoring 60 points or higher will avoid a penalty, while higher scores may qualify for a modest bonus.

☆What was your practice's MIPS composite performance score (CPS)?

If you answered "Yes" to participating in MIPS, please indicate your practice's CPS.

A CPS under MIPS has a maximum score of 100 points and is based on four categories: quality, promoting interoperability, cost, and improvement activities. These four categories are weighted and used to determine a final CPS.

*Among your practice's covered lives attributed under value-based contracts, what was your practice's:

Hospital admission rate: Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's hospital admission rate.

To calculate, divide the number of hospital admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.

Hospital 30-day readmission rate: Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, who experienced unplanned readmission to a hospital within 30 days of a previous hospital stay.

A 30-day hospital readmission refers to when a patient is admitted to a hospital within 30 days or less of being discharged from a hospital for a previous stay.

To calculate, divide the number of patients tied to value-based contracts with hospital readmission within 30 days by the total number of hospital discharges for patients tied to value-based contracts.

Emergency department utilization rate: Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's emergency department utilization rate.

To calculate, divide the number of inpatient and/or outpatient emergency department admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.

30-day post-operative infection rate: Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's 30-day post-operative infection rate.

Post-operative infection is defined as any infection that occurs within 30 days of operation and may be related to the operation itself or the postoperative course.

To calculate, divide the number of post-operative infections experienced by patients tied to value-based contracts within 30 days of operation by the total number of patients tied to value-based contracts.

Did your practice risk stratify the patient population?

Indicate "Yes" if your practice risk stratified the patient population. If your practice did not risk stratify the patient population, answer "No." If you are not sure, answer "Unsure."

Risk stratifying the patient population refers to segmenting patients into distinct groups of similar complexity (e.g., chronic care management patients and non-chronic care management patients) using objective and subjective data. By identifying and segmenting the patients that are most at-risk, practices may be able to provide them greater access and resources, which in turn could reduce costs and improve care.

Did your practice track social determinants of health (SDOH) in care management plans?

Indicate "Yes" if your practice tracked SDOH in care management plans. If your practice did not track SDOH in care management plans, answer "No." If you are not sure, answer "Unsure."

SDOH refers to conditions in the environments where people are born, live, learn, work, and play that affect a wide range of health, functioning, and quality of life outcomes and risks. SDOH can be five key areas: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.

Did your practice receive payment from any payer for care coordination and/or chronic care management?

Indicate "Yes" if your practice received payment for care coordination and/or chronic care management. If your practice did not receive payment for care coordination and/or chronic care management, answer "No." If you are not sure, answer "Unsure."

Examples may include per member per month payments, flat rate reimbursement, or reimbursement for CPT codes 99490, 99487, 99489 and 99491, which are for chronic care management and complex chronic care management.

Did your practice perform hierarchal condition category (HCC) coding?

Indicate "Yes" if your practice did perform HCC coding. If your practice did not perform HCC coding, answer "No." If you are not sure, answer "Unsure."

HCC coding refers to a risk-adjustment model developed by the Centers for Medicare & Medicaid (CMS) to pay differentially based on disease burden and demographics.

HCC relies on ICD-10 coding, which are grouped into categories and assigned a risk factor. There is weighting, or hierarchy, which assigns higher values to more serious conditions, in addition to demographic factors (such as age and gender). Two conditions in the same category are counted only once. Using the HCC model, the condition must be reported annually to be credited to that patient.

What was your practice's generic dispensing rate (GDR)?

Indicate the percent, in whole numbers, of your practice's GDR for patients covered under value-based contracts.

GDR refers to the number of generic prescriptions filled divided by the total number of prescriptions filled.

*What was your practice's total medical revenue specific to value-based contracts?

For your practice's value-based contracts specifically, indicate your total 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.

OPERATIONS

How many hours was your practice open each day?

For each day of the week, indicate the total number of hours your practice was open. If your practice is not open on that day, please enter "0". If your practice was always open on that day, please enter "24".

What percent of your patient population logged in to the patient portal?

Indicate the percent, in whole numbers, of your patient population that not only enrolled, but also logged in to the patient portal. If you did not have a patient portal, indicate that by entering "0."

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."

Fill a new prescription: Indicate the percent, in whole numbers, of your patient population that used a patient portal to fill a new prescription. If this functionality wasn't offered in your patient portal or you did not have a patient portal, indicate that by entering "0."

Refill prescriptions: Indicate the percent, in whole numbers, of your patient population that used a patient portal to refill a prescription. If this functionality wasn't offered in your patient portal or you did not have a patient portal, indicate that by entering "0."

What was the expected time (in hours) for staff to respond to patient portal communications?

Indicate the expected number of hours staff had to respond to patient portal communications. If the amount of time varied on activity, please enter the general rule of thumb or average expectation.

*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 once a year 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 often did you review the results from your patient satisfaction surveys?

If your practice administers patient satisfaction surveys, please indicate how these surveys were conducted.

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.

GOVERNANCE

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 your practice 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.

What was the average length of time in minutes patients spent on hold after an initial answer?

Indicate the average length of time in minutes per telephone call that patients spent on hold after the call was initially answered.

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.

*What was the average throughput or total cycle time for the patient from check-in to check-out?

Indicate the average throughput, or total cycle time, in minutes, for patients.

Throughput, or total cycle time, represents the number of minutes between when a patient arrives at the practice and when they leave the practice including time spent waiting in the wait room, exam room and checkout time.

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.

Post-operative visits: Indicate the average amount of time in minutes that was scheduled for post-operative 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.

Post-operative visits: Using the guidelines above to calculate third next available appointment, indicate the number in business days for post-operative 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 per day 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 post-operative visits: Indicate the average number of appointment slots per provider that were in your schedule per day for post-operative 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.

Number of appointment slots per day that were unfilled: Indicate the average number of appointment slots per provider that were not filled or were unscheduled 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, or reschedule, their scheduled appointment.

What was your practice's no-show rate percentage for telehealth appointments?

Indicate your practice's average no show rate percent for telehealth appointments only, in whole numbers, where appointments were scheduled but patients did not show up, or reschedule, their scheduled appointment.

For pre-scheduled telehealth appointments what was the average time in minutes patients spent on hold?

Indicate the average time in minutes that patients spent on hold waiting to speak with the provider for telehealth appointments specifically. Please provide in whole numbers.

How much did you charge for no show appointments?

Indicate the dollar amount you charged for no-show appointments. If your practice did not have a no-show policy or did not charge, please indicate 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. If your practice did not have a no-show policy, please leave your answer blank.

*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 or the provider/practice called to cancel their scheduled appointment.

What was your practice's cancellation rate percentage for telehealth appointments?

Indicate your practice's average cancellation rate percent for telehealth appointments only, in whole numbers, where appointments were scheduled but patients or the provider/practice cancelled their scheduled appointment.

What percentage of appointments were rescheduled within 30 days of cancellation?

Indicate the average percentage of appointments that were rescheduled within 30 days of cancellation. Include appointments canceled by the patient and by the provider/practice.

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 was the average number of commercial claims a biller submitted for payment 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 submitted for payment 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 submitted for payment 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 submitted for payment 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 submitted for payment 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 submitted for payment in a day. A claim is written request for payment submitted to a third-party.

*What percentage of claims were denied on first submission?

Indicate the percent, in whole numbers, of 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").

How soon did providers close a patient chart after an encounter?

Indicate the time frame (in hours) a provider had to complete patient charts after an encounter.

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.

*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.

HR MANAGEMENT

*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.

Advanced practice providers: Indicate the total number of advanced practice providers 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.

*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.

*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.