CARDIOLOGY PLAYBOOK

Turning good into great
for the benefit of patients nationwide
Executive Summary

The PSG Cardiology Playbook is an overview of the organizational, structural, and functional attributes found in highly performing cardiology practices. This playbook addresses operational, clinical and financial aspects of a practice; provides an overview along with management hints and tips and defines what excellence looks like in a cardiology practice.

This document includes the best demonstrated practices in cardiology found both inside and outside of HCA Physician Services Group. Additional resources and examples to support each practice’s efforts can be found in the appendix.

This playbook supports the evaluation of existing and potentially new cardiology practices, and provides a framework from which to identify gaps between the current operating model and the operating model of the ideal practice.

The playbook addresses the key aspects of each practice component and is not intended to provide an all-inclusive, detailed manual.

Ken Washington
President of Practice Operations

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Using this playbook

Purpose

In alignment with HCA's strategic priority of providing patients with the highest quality of care and service while maintaining efficiency levels that lead the industry, the HCA Physician Services Group Cardiology Playbook outlines key ways in which operators and physician leaders can integrate proven best practices into their daily operations to support practice growth, quality, and service delivery.

Using the Playbook

When using this playbook, it is important to note the essential ingredients that are critical for achieving practice excellence. These include high quality care provided by kind and experienced professionals, embracing the practice’s most valuable asset which is the provider’s time, and creating an atmosphere where the focus is centered on excellent patient experience and results.

This playbook is broken into specialty sections, such as staffing, financial management, and practice growth strategies. Each section within the playbook is broken into three sections:

1. Overview – a brief summary of the section
2. Body – detailed guidelines and processes
3. Key Takeaways – the key best practices to take away from this section

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This section provides an overview of the two components that comprise effective practice governance structure.

Cardiology practice governance is composed of two major components, the physician and administrative leadership, and the practice collaborative governance structure.

The cardiology practice is led by a physician and administrative leadership dyad. The practice leaders are expected to manage the day-to-day operations of the practice and the strategic, financial, and other performance metrics specified by the budget, policies, and standards.

The second major component of the practice governance structure is the physician and administrator collaborative council structure. The council makes important decisions for the practice and guides its operations, growth and culture. The council is composed of both physicians and administrators and is the hub of the dyadic decision model. The dyadic decision model is based on the belief that the combination of skills and talents of both clinical leaders and business leaders is required to effectively lead a clinical business. The council meets regularly and is accountable for the practice’s key performance metrics and strategic plan.

Typically, the council is accountable to:

- Establish the strategic direction of the practice by developing a strategic plan that aligns the practice goals and the enterprise, division and/or host hospital(s) goals and ensure strategic plan performance
- Establish and adhere to a defined and openly transparent decision making process
- Manage practice key performance metrics relative to financial plan, clinical quality, customer satisfaction, human resource management and operations performance
- Establish practice performance standards concerning conduct, citizenship, service and compliance, taking appropriate action where non-adherence occurs
- Establish and enforce practice policies as required

Practices may also appoint regular standing committees or ad hoc committees for specific purposes. Standing committees are permanent in nature, established by the practice council, and have a written charter outlining its purpose, duties, leadership and members. Typical standing committees would be a quality committee, a clinical operations committee, and an EMR committee. These committees are often formed in larger practices. Ad hoc committees would be temporary in nature to support a project or initiative such as the development of a new service or outreach site. Finally, any ad hoc committees established should have a specific purpose and duration.

Key Takeaways

- High performing cardiology practices are led through a dyad leadership structure that consists of a physician and an administrative leader
- Cardiology practices need a well-defined, written practice council charter that is managed consistently and effectively
- It is important that cardiology practices have an engaged practice council that sets and leads the strategy and growth of the practice
This section provides an overview of how to create, manage, and revise a practice compact.

A practice compact is a written document outlining the performance and behavioral commitments the practice providers and administrators make to the organization and to each other.

The compact is a bi-directional provider and administrator tool that clearly articulates an agreed upon set of behavioral and performance rules. It also provides guidelines for the development and management of the practice’s culture.

The compact typically addresses all aspects of the practice including clinical, strategic, administrative, and behavioral expectations. The purpose of the explicit treatment of expectations is to provide a clear operating framework from which to manage the practice, and to provide guidance to the provider and administrator recruitment teams. A satisfactory compact develops a shared sense of strategic imperative and helps the practice reach its full potential. Outdated, unclear, or uncommunicated expectations diminish an organization’s ability to function smoothly and deliver optimal care.

Creating a Compact

Creating a compact is a collaborative effort between providers and the practice leadership. It is critical that all of the practice providers are involved in the process and the physician leaders of the practice lead the discussions. The creation of the compact should be through structured provider group conversations with significant pre-work to properly shape the sessions. The completed compact should be endorsed by all of the providers and the practice leadership. The compact should be promoted largely in the practice and should become part of the practice language.

- In order to create a compact the practice must assemble an aligned provider and administrator leadership council that can effectively manage change
- The first step in creating the compact is to articulate the practice mission, vision and values
- The second step to creating a compact is to assess the practice culture by examining provider and administrator behavior as either enabling the group’s ability to achieve the shared vision, or as a barrier to success
- The third step is to identify behaviors and practices that are required to support the practice vision and the “gives” and “gets” required for both the administrators and providers to commit to the prescribed culture
- The fourth and final step is to articulate the behaviors and practices that are supportive of achieving the practice vision and the series of “gives” and “gets” required
- The compact should be signed by all providers and by the organization’s non-physician leaders
- The compact should be included in the practice’s recruitment process with all new providers and administrative leadership
- Each provider and administrator should have an annual evaluation based on their responsibilities under the compact
- The council should evaluate the organization’s responsibilities under the compact

Revising the Compact

The compact should be reviewed by the practice leadership on a periodic basis. Updates to the compact should be focused and infrequent, but as necessary to effectively manage the practice culture and be consistent with the realities of contemporary healthcare business.
Operationalizing the New Compact:

There are several levers for operationalizing the new compact:

1. Review all policies to make sure they align with the new compact
2. Align resources so both the group and providers can live up to their commitments in the compact
3. Provide measures and ongoing feedback to providers regarding key measures in the compact
4. Tie some portion of compensation to meeting the expectation in the new compact
5. Acknowledge (non-financial) those who become role models with the new expectations

Hints and Tips

It is critical that all providers be engaged in the process. The group must understand the strategic and business imperatives facing the group and healthcare in general.

Providers must understand the vision and strategy so they can readjust their expectations based on the new realities of medicine.

The journey is at least as important as the destination. Multiple conversations are important to understand how the current status quo hinders group performance.

The use of an outside facilitator is strongly encouraged to help address the difficult issues.

Leadership needs to be prepared for test cases that invariably arise. How they handle the providers who continue to live with prior compact expectations will be observed by others.

Key Takeaways

- The compact is a bi-directional provider and administrator tool that clearly articulates an agreed upon set of behavioral and performance rules
- The compact typically addresses all aspects of the practice including clinical, strategic, administrative, and behavioral expectations
- Compact performance and compensation must be linked to be successful
- The compact should become a part of the practice language and be the foundation of the practice’s culture
Clinical Services Offering

This section identifies typical service offerings that exist within cardiology practices across the United States.

Cardiology practices are one of the few remaining specialties that have a strong presence in both ambulatory and hospital sites. While the subspecialties differ in the concentration of work in different settings, cardiologists practice in both acute clinical environments and simple ambulatory clinics. In general, there has been a shift in emphasis from the inpatient or hospital environment to the outpatient and ambulatory environment. It is projected that the movement toward the less acute environment will continue, and an increasing number of procedures, therapies, and treatments will be deemed appropriate to provide in the outpatient and ambulatory setting. Cardiologists are also one of the first specialties to embrace telehealth services and the industry has a long tradition of supporting remote hospitals and emergency departments. In order to lead a practice effectively, it is critical for the administrator to understand the nature of the services that his or her physicians provide and the ever-evolving nature of cardiovascular treatments, therapies, and procedures.

The following table provides an overview of the typical services provided by cardiologists.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Site of Service</th>
<th>Service Offering</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management</td>
<td>Office</td>
<td>Evaluation and management services</td>
<td>Provided by physician and advanced practice (APP) providers</td>
</tr>
<tr>
<td>Disease specific clinics</td>
<td>Office</td>
<td>(Atrial Fibrillation, Heart Failure, Syncope)</td>
<td>Typically protocol driven clinics staffed by APP and registered nurse (RN) with supervising oversight by physicians</td>
</tr>
<tr>
<td>Medication therapy monitoring</td>
<td>Clinic</td>
<td>clinics</td>
<td>Most often RN driven and virtual, typical clinics are anticoagulation clinics (Coumadin), lipid clinics and amiodarone clinics</td>
</tr>
<tr>
<td>Electrocardiogram (EKG)</td>
<td>Office</td>
<td>High volume, low risk test commonly used in the office setting</td>
<td></td>
</tr>
<tr>
<td>Device clinic</td>
<td>Office</td>
<td>Electrocardiogram (EKG)</td>
<td>Typically RN managed clinic under the purview of electrophysiology (EP) program that monitors and manages implanted devices</td>
</tr>
<tr>
<td>Event monitors, Holter monitor</td>
<td>Office</td>
<td>and other</td>
<td>Multiple varieties of longitudinal heart rhythm testing devices typically deployed from the device clinic or other office setting</td>
</tr>
<tr>
<td>Vein center</td>
<td>Ambulatory</td>
<td>Treatment of vein claudication in the outpatient center</td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Site of Service</td>
<td>Service Offering</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
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</tr>
<tr>
<td>Medical</td>
<td>Hospital</td>
<td>Evaluation and management services</td>
<td>Provided throughout the hospital in many settings including medical floors, telemetry floors, ICU environments and emergency departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnostic cardiac cath</td>
<td>Catheter based cardiac diagnostic study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peripheral angiography</td>
<td>Catheter based peripheral vascular diagnostic study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percutaneous coronary intervention (PCI)</td>
<td>Catheter based procedures utilized to open closed coronary arteries (coronary angioplasty and stents)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balloon angioplasty</td>
<td>Catheter based procedure utilized to open closed coronary arteries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stenting</td>
<td>The use of a stent, small metal mesh tube, to retain an open artery and prevent restenosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peripheral intervention</td>
<td>Opening of non-coronary arteries using many of the same techniques as coronary intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Septal closure devices</td>
<td>Device utilized to non-surgically close defects in the atrial septum (patent foramen ovale and atrial septal defect are most common defects)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Atherectomy</td>
<td>Removal of hardened and calcified plaque in the artery using atherectomy catheter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thrombectomy</td>
<td>The use of a specific catheter to remove debris from the artery prior to angioplasty or stenting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balloon valvuloplasty</td>
<td>Procedure used to open narrowed heart valves, typically performed on children and adolescents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vena cava filter</td>
<td>Placement of a metal filter in vena cava to prevent migration of blood clots to the lungs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aortic stent grafting</td>
<td>Non-surgical aortic aneurysm treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Device implantation</td>
<td>Placement of pacemakers, defibrillators and combination devices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lead revisions or changes</td>
<td>Changing or revising the wires through which rhythm therapy is delivered that connect the pacemaker or other device to the heart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generator changes</td>
<td>Changing generator or the battery in implanted devices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ablation therapy</td>
<td>Therapeutic treatment of abnormal heart rhythms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electrophysiology studies</td>
<td>Diagnostic heart rhythm study</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Site of Service</th>
<th>Service Offering</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cath Lab</td>
<td>Hospital</td>
<td>Ventricular assist device (VAD)</td>
<td>Temporary and permanent artificial heart technology typically used prior to heart transplantation</td>
</tr>
<tr>
<td></td>
<td>Emergency Department</td>
<td>Consultative services</td>
<td>Consultative services provided at the request of the emergency room in that department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute myocardial infarction (AMI)</td>
<td>Heart attack</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nuclear stress testing</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treadmill testing</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Echocardiography</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stress echo</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transesophageal echo (TEE)</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td>Ambulatory and/or Hospital-based</td>
<td>Clinic testing department, hospital outpatient department (HOPD), hospital cardiology or radiology department</td>
<td>Cardiac CT</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiac MRI</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiac PET</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vascular ultrasound</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tilt study</td>
<td>Diagnostic heart test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardioversion</td>
<td>Therapeutic treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sleep study</td>
<td>Diagnostic study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pulmonary function</td>
<td>Diagnostic study</td>
</tr>
</tbody>
</table>

In addition to the typical services described above are the newer structural heart procedures such as TAVR, Mitral Clip, Lariat, Watchman as well as Chronic Total Occlusion (CTO) procedures and others. It is important to stay current, clinically, with the procedures and programs that cardiologists may wish to introduce to the program.
While the subspecialties differ in the concentration of work in different settings, cardiologists practice in both acute clinical environments and simple ambulatory clinics.

It is projected that there is a movement toward the less acute environment, and an increasing number of procedures, therapies, and treatments will be deemed appropriate to provide in the outpatient and ambulatory setting.

Cardiologists are also one of the first specialties to embrace telehealth services and the industry has a long tradition of supporting remote hospitals and emergency departments.

In order to lead effectively, it is critical for the administrator to understand the nature of the services that its practice physicians provide.

Key Takeaways

- While the subspecialties differ in the concentration of work in different settings, cardiologists practice in both acute clinical environments and simple ambulatory clinics.
- It is projected that there is a movement toward the less acute environment, and an increasing number of procedures, therapies, and treatments will be deemed appropriate to provide in the outpatient and ambulatory setting.
- Cardiologists are also one of the first specialties to embrace telehealth services and the industry has a long tradition of supporting remote hospitals and emergency departments.
- In order to lead effectively, it is critical for the administrator to understand the nature of the services that its practice physicians provide.
Every provider and practice desires to provide quality care. For purposes of this playbook, managing the quality function of a cardiology practice is divided into four broad areas:

a. quality culture
b. quality practices
c. quality measures
d. reporting programs

Physician quality will be discussed in a subsequent section.

Quality Culture

A practice’s culture is established by its leadership, history, compact, and people. Each of those culture components materials affects a practice’s approach to clinical quality. The vision and expectation of clinical quality should be incorporated into governing documents, job descriptions, policies, and procedures of the practice. At the core of a quality culture is the belief that patients are the organization’s first priority, and delivery of effective and safe care is the reason for the existence of the organization. Practice’s should recruit and train for quality, expect quality, and celebrate quality.

Quality Practices and Procedures

A key indicator of practice quality is the degree to which providers attempt to reduce variation in care as well as the degree to which the practice adheres to evidence-based guidelines. Additionally, the practice commits to maintain accreditation or accreditation-based standards is an indicator of its quality.

Following are practices indicative of an organization that champions quality:

- Adherence to evidence based medicine and a mechanism (EMR) to guide providers and report outcomes
- Commitment to structured reporting in all services and in clinical communications from the practice (including clinical notes and procedure reports)
- Adherence to appropriate use criteria and mechanisms to guide providers and report outcomes
- Effective use of the EMR to assist in quality documentation and adherence to clinical standards
- Commitment to clinical standardization and the use of clinical guidelines
- Imaging services maintain accreditation from the appropriate accreditation body (most commonly the Intersocietal Accreditation Commission that accredits all typical cardiology imaging modalities)
- Defined disease management protocols including patient triage clarity
- This includes the requirement that clinical oversight is provided by the appropriate board certified physician
- Implementation of meaningful use criteria
Quality Measures and Reporting Programs

The cardiology landscape is rich in the development and utilization of quality metrics and reporting registries. Cardiology professional societies champion registries such as the National Cardiovascular Data Registry (NCDR) series, the Society of Thoracic Surgeons (STS) registry, and others in which programs standardly participate. Not only do the registries provide a guidepost to quality, it is also believed the registries will be a mechanism for public reporting in the near future. For the purpose of this playbook, the scope of the discussion will be limited to those quality measures and reporting programs specifically geared to the practice setting.

Quality measurement and reporting programs typically fall into three categories: government programs, private payer programs, and voluntary programs. Government programs have increased with the advent of the Affordable Care Act. Required programs such as the Physician Quality Reporting System, electronic prescribing, and the introduction of the value-based modifier are constantly changing, upgrading, and becoming more difficult to manage at the practice-level. At the outset of the programs, successful participation resulted in quality bonus payments. However, the bonuses have subsided and have evolved into payment penalties. The quality performance therefore has a financial disincentive. However, this data is a matter of public record and therefore has potential to enhance or diminish the reputation and perceived quality of the practice.

Private payer programs have also proliferated and vary payer to payer. Private programs are sometimes state or region-specific and are not standard. Participating in private payer programs often has an incentive either in the payment itself, in the reduction of an administrative burden, or more recently seen in patient steerage and/or narrow networks.

Voluntary programs are often sponsored registries that allow outcomes to be benchmarked and often have elements of improvement coaching involved. The American College of Cardiology PINNACLE Registry is widely accepted in the cardiology community.

Hints and Tips for Quality Measurement and Reporting Programs

- The practice should have defined quality metrics, outcome objectives, and goals
- The measurement and reporting program should provide feedback to the goals
- Quality measurement programs should be incorporated into the practice EMR, as available by vendor, and other structured reporting
- Practice providers and staff should be trained and involved in the achievement of the objectives and goals
- Quality metrics will change over time, but a group that has the underlying structure as outlined, should be well positioned to adapt and document its provision of excellent patient care.

Key Takeaways

- Quality must be a component of provider and staff recruitment, training, and evaluation
- All clinical leaders should adhere to evidence-based guidelines and appropriate use criteria that is supported by EMR
- Clinical staff should manage in accordance with clinical standardized and disease management protocols
- The practice’s EMR is used to reduce variation and drive quality performance
05

Physician Quality Improvement and Credentials

This section provides an overview on managing physician quality, primarily through the credentialing and privileging process, quality reporting process, and through peer review.

Physician quality is managed through the credentialing and privileging processes, quality reporting processes, and in collaboration with the accepted peer review and quality processes of the organization. It is critical to understand that peer review has legal and regulatory implications with regard to the protected nature of the review. Additionally, peer review requirements vary from state to state. It is important that practices work and consult with legal operations to address peer review programs and/or issues within the practice.

Credentials

Physician credentialing refers to the physician’s initial and on-going training and board certification. Board certification is a mechanism to ensure that an individual physician has the knowledge and skill set to perform as a cardiologist. Cardiologists are expected to obtain and maintain Cardiovascular Disease Board Certification, issued by the American Board of Internal Medicine. Secondary procedural boards are also becoming an important surrogate. Secondary boards include Interventional Boards, Electrophysiology Boards, Advanced Heart Failure Boards, as well as boards for many of the imaging modalities: Echo, Nuclear, Vascular Ultrasound and CT. In accordance with PSG policy, all physicians must be specialty boarded. It is a division-specific decision whether subspecialty boards are required. Additionally, practice requirements may be more stringent than those of the division or facility regarding specialty and subspecialty boards.

In addition to board certification, procedural and imaging physicians are typically required to perform specified numbers of procedures to maintain credentials. Volume requirements are also typically required to maintain hospital privileging.

Important decisions for practices to make regarding credentials:

• Does the practice require cardiologists to obtain cardiology boards
• Does the practice require subspecialists (interventionalists, EP, heart failure specialists, imaging specialists) to obtain subspecialty boards
• Does the practice require all subspecialists to retain board certification
• Will the practice “grandfather” physicians with specified experience into practicing within subspecialties that are not boarded

Operational considerations:

• Credentialing policies should be in writing and incorporated into physician employment contracts
• Practices must maintain a mechanism to document all credentialing and licensing requirements
• Practices should have a consistent approach to continuing medical education (CME) in terms of payment and time off responsibility
The Modern Cardiology Practice: Physician Quality Improvement

A contemporary process to address a physician’s developmental opportunities has to be rooted on key, non-traditional elements:

1. Group analysis of key indicators of compliance and quality
   a. Coding frequency vs. national standards
   b. Non-invasive procedural frequency vs. national standards
   c. Invasive procedural frequency vs. national standards

2. Individual analysis of key indicators of compliance and quality
   a. Quarterly retrospective review of medical reports (consult note/follow-up visit notes) to match levels of documentation and billing (5-10 charts/physician/quarter)
   b. Quarterly retrospective review of procedure reports to evaluate appropriate use criteria, proficiency of the operator and accuracy of the report
      I. Echo/TEE
      II. Cath
      III. Nuclear studies
      IV. PCI
      V. Pacemakers/ICD (5 procedures/physician/quarter)

3. Process Improvement
   The retrospective review is performed with randomly selected cases (group and individual reviews) not triggered by outcomes or complaints. Therefore, the process itself is prospective, leading to constructive criticism and group/personal performance improvement.

Key Takeaways

- Physicians must be boarded in cardiovascular diseases and in the subspecialty areas that they work
- Credentialing policy regarding boarding, volume requirements, and CME must be documented
- Peer review and quality improvement processes should foster robust learning and transparent evaluation of clinical performance
This section provides guidance on measuring physician, APP, and practice productivity and utilization. It also reviews common productivity measures and variables that can impact productivity.

Hints and Tips for Practice Productivity Measures

• Ideally the practice has identified both performance expectations and minimum productivity standards in each of the areas that it is measuring.

• Measures should be regularly (at least monthly) monitored, trended, and compared to the expected outcome and to an external benchmark.

Practice Productivity

The most effective evaluation of the practice’s overall productivity is the utilization of its physical capacity. Typically, the capacity is the ability to see patients in the office, to provide testing and the ability to take care of patient needs such as scheduling, medical records, and test results. See several useful measures to evaluate and monitor practice productivity below.

Recommended Practice Productivity Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam room capacity utilization</td>
<td>Capacity is determined by 100 percent utilization of available exam rooms during all business hours, deploying a standard visit template</td>
</tr>
<tr>
<td>No show rate</td>
<td>Rate of patients who do not present for scheduled appointments</td>
</tr>
<tr>
<td>Non-scheduled patients seen</td>
<td>Number of patients to whom services were provided that did not have a scheduled appointment</td>
</tr>
<tr>
<td>Echo capacity utilization</td>
<td>Percentage of total echo lab capacity, deploying standard template</td>
</tr>
<tr>
<td>Nuclear capacity utilization</td>
<td>Percentage of total nuclear lab capacity, deploying standard template</td>
</tr>
<tr>
<td>Access</td>
<td>Third available appointment per appointment type, per provider</td>
</tr>
<tr>
<td>New patients</td>
<td>Number of new patient visits</td>
</tr>
<tr>
<td>Return patients</td>
<td>Number of return patient visits</td>
</tr>
</tbody>
</table>
Physician and APP Productivity

There are several standard metrics utilized to evaluate both physician and advanced practice provider productivity. It is important to consider both physician and advanced practice providers with careful consideration of the practice’s incident to billing practices. Both physician and advanced practice providers can be evaluated by the same metrics; however, only physicians will show the benefit of incident to billing. This section will focus on key performance metrics and ratios to monitor, as well as promote benchmarking utilizing many different benchmarking sources as best practice. This section also highlights the potential impact of key practice and physician variables on productivity outcomes.

Provider Productivity Measures

Work Relative Value Units (wRVU) – The most common measure of clinical productivity is a measure of the wRVUs. wRVUs are associated with each Common Procedural Terminology (CPT) code provided by the provider; the wRVU values are determined by the Center for Medicaid and Medicare Services (CMS) and published annually in the Federal Register.

Individual Physician Patient Panel Size – This refers to the unique number of patients that an individual physician has seen in the past 18 months. Individual panel size is strongly influenced by subspecialty and years in practice.

Service Volume - There are a number of consistent services provided by the cardiologist whose measurement and comparison to both internal and external benchmarks provides important information regarding their productivity. Due to the dramatically different nature of the cardiologist practice at the subspecialty level, it is important to develop service volume goals and expectations, and benchmark at the subspecialty level.

Following are some of the standard service volume metrics.

Total New Patients to the Practice (Office + Hospital) Per Designated Physician – This refers to the number of claims for CPT Codes 99201 – 99205, 99221 – 99223 in the past 12 months per individual physician. New patients to the practice by physician will indicate the strength of the physicians/groups referral channels. New patients should be tracked and trended on a monthly basis.

Return Office Visits (Excluding 99211) Per Designated Physician – The number of claims for CPT Codes 99212 – 99215 in the past 12 months per individual physician. Return office visits by physician will indicate if the practice is seeing their established patients on a too few or too great frequency. Return office visits to new patients should be around a ratio of 6:1. Return office visits should be tracked and trended monthly.

Percent of Outpatient Imaged Stress Studies to New Patient Office Visits & Consult (Office + Hospital) – The ratio of total imaged stress studies as a percent of total new patients to the practice (Office + Hospital). Imaged Stress Studies include stress tests, stress echoes, nuclear studies, and PET studies performed in an office or outpatient hospital location. The metric is a measure both of new patient productivity as well as an indicator of appropriateness. This is an important directional metric and therefore should be tracked semiannually.

Distribution of Physician Resources – The production function of the practice is driven by how and where physician and advanced practice providers are utilized. For example, if a practice chooses to utilize an EP physician in outreach sites performing evaluation and management work, they should not expect the electrophysiologist to perform high on the wRVU benchmark. Careful consideration of strategic importance versus density of wRVU opportunity is critical in making clinical assignments.

Subspecialization – Cardiology practices are typically composed of cardiologists who are subspecialized or focused in treating certain types of cardiovascular patients. Typically, there are more general cardiologists than proceduralists. And, the composition of the cardiology practice is material in their production capabilities.

General Cardiologist – Since general cardiologists (non-invasive) manage patients through testing, diagnosis, treatment, and recovery in both outpatient and inpatient settings, they usually have higher office visits, hospital visits, and imaging interpretation volume than other cardiologist subspecialists. General cardiologists wRVUs tend to be lower because of their concentration of evaluation and management services that are generally less wRVU dense than the cardiology procedure CPT codes.

Invasive – Non-interventionalist – Invasive cardiologists usually provide similar office and hospital visit volume as general cardiologists. The difference between the two subspecialties is the general diagnostic catheterization and other non-interventional volume provided by invasive cardiologists.

Interventional - Interventional cardiologists provide PCIs and other catheterization lab procedures and therefore, generally see fewer office and hospital patients than a general cardiologist. Interventionalists will likely have higher wRVUs than both invasive and

Variables Impacting Productivity

It is important to consider several additional factors in both choosing and utilizing productivity metrics. Following are variables that may impact metric interpretations and expectations:

Hospital Visits Per Designated Physician – The number of claims for CPT Codes 99221 – 99223 in the past 12 months per individual physician. Hospital visits by physician measures the inpatient volume; this measure varies greatly depending on the cardiologist rounding practices and the strength of a given hospital’s hospitalist program. Hospital visits should be tracked monthly.

Percent of Catheterizations to New Patients to the Practice – The percent of catheterizations to new patients is one of several measures that evaluates the productivity of new patient visits and it can also be an indicator of appropriateness. This is an important directional metric and therefore should be tracked quarterly.

Percent of PCI (Percutaneous Coronary Intervention) to Cath – The percent of PCI to catheterizations indicates the percent of patients receiving catheterizations that evolve into interventions. This metric is not only an important productivity measure, but also an indicator of appropriateness. The PCI:Cath measurement is an important directional metric and therefore should be tracked quarterly.

Interventional PV (Peripheral Vascular) Extremities Per Designated Physician – Some interventional cardiologists perform vascular interventions. Extremity vascular procedures are the most common. Interventional PV cases should be tracked monthly.
general cardiologists. Variability in interventionalist productivity is most impacted by the volume of procedures performed, but also by the degree of evaluation and management assignments.

Cardiac Electrophysiologist – Electrophysiologists productivity levels tend to be the highest of the cardiovascular subspecialties. Their time is usually focused on providing dense wRVU procedures and providing evaluation and management services.

Congestive Heart Failure (CHF)/Transplant – Cardiologists focused on heart failure and transplant patients tend to produce the least wRVUs of all of the cardiology subspecialties. Due to the complexity of CHF and transplant patients and the frequency of evaluation and management visits, these physicians usually see fewer patients in the office and hospital and see them more frequently. There are no MGMA reports focusing on CHF/transplant cardiology productivity.

Adult Congenital Cardiologists – Adult congenital cardiologists, like CHF cardiologists, usually see fewer patients in the office and hospital due to the complexity of managing this patient population, and consequently – produce fewer wRVUs. There are no MGMA benchmarks on adult congenital cardiologist production.

Cardio-oncologist – This is a new cardiology subspecialization. These cardiologists usually function as general cardiologists in addition to providing multidisciplinary care to cardio-oncology patients. Due to the complexity of treatment of cancer patients and the nature of multidisciplinary work, these providers will likely see fewer patients in the office and hospital and have lower wRVUs when performing cardio-oncology services. There are no MGMA reports focusing on adult cardio-oncologist production.

Years in Practice – A physician’s volume of patient visits and procedures is often related to the years they have been in a given practice location. Typically, physicians that have been in one practice location for a longer duration of time have larger patient populations and established referral channels. Additionally, as advancements in cardiac medicine have increased a cardiac patient’s life expectancy, physicians that have established patient panels usually have fewer new patients and higher follow-up patient visits.

Referral Channels – Understanding a physician and practice’s referral channels is important when establishing patient volume and physician productivity goals. Practices who enjoy referrals from internal medicine doctors generally are referred patients who are more likely to require a procedure or complex testing whereas family medicine doctors are likely to refer patients early in the disease process. Practices located in high-density hospital environments are more likely to have high productivity results. Practices dominated by urgent care referrals tend to have lower density practices than those who service busy emergency rooms, though not necessarily low patient volumes. Generally, younger physicians tend to refer to younger cardiologists and older physicians tend to refer to their established referral source. Understanding the nature and volume of referral channels helps establish appropriate productivity expectations and business development objectives.

Other factors affecting productivity include patient demographics such as age and income, office site locations (whether rural or urban), market competition and the availability of cardiologists. Understanding how these critical variables impact key performance measures helps us interpret the productivity data, set appropriate productivity goals, hire and recruit appropriately, and provide valuable guidance to aid in improvement in clinical care, volume growth, and practice stability.

Key Takeaways

- Establish minimum productivity expectations for physicians and advanced practice providers
- Measure practice productivity by multiple metrics and always benchmark using external sources
- Develop productivity and business development goals relative to subspecialty and practice factors
Physician Compensation Models

This section provides guidance on common physician compensation models and reviews considerations such as part-time employment, call, and minimum work standards.

Physician compensation plans vary among groups and are usually a function of the group’s history and culture. Most employed physician’s compensation plans are driven by productivity or at a minimum are productivity related. Most plans have some valuation of wRVU whether they convert on a 1:1 basis or have a threshold requirement. The benefit of a wRVU system is that it is an external system annually established by Medicare and therefore correlates to the payment system. The downside of a wRVU system is the government does not always value CPTs fairly, or keep up with the effort and training required to perform a particular wRVU.

While productivity predominately drives compensation plans, it is important to align other incentives as well. Migration towards models compensating both clinical productivity and non-clinical metrics is evident. Non-clinical metrics can include clinical quality, achievement of program related goals such as establishing a heart failure program or outreach site, citizenship or behavior, and operational goals such as timely discharge. It is anticipated this migration will continue and best practices will incorporate up to 20 percent in variable, goal related physician compensation.

Physician Compensation Plan Models

<table>
<thead>
<tr>
<th>Description</th>
<th>Application Note</th>
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<tbody>
<tr>
<td>Productivity Based Plans</td>
<td>Clinical work is valued at a per wRVU or other productivity basis at an established conversion rate. The converted productivity units are either accumulated and distributed to physicians based on a predetermined formula or paid directly to the physician creating the productivity unit.</td>
</tr>
<tr>
<td>Base Salary Plus Incentives</td>
<td>Physicians are paid a fixed base salary with various incentives for the achievement of quality, operations, and productivity goals and at-risk for performance. Typically, the base salary is anchored to a benchmarked scale or to a minimum productivity threshold.</td>
</tr>
<tr>
<td>Fixed Salary</td>
<td>Physicians are paid a fixed salary.</td>
</tr>
</tbody>
</table>

Because of the degree of subspecialization in a cardiology practice and the inherent opportunity to earn wRVUs based on the typical work of the subspecialty, most practices recognize the need to incorporate a sharing component in the distribution formula, particularly when using a wRVU methodology.

As reimbursement continues to move toward a value basis, the base plus model continues to enjoy favor. Incentives, though initially a small component of total compensation, are rising each year with the expectation it will eventually approximate 20-30 percent. Physicians who do not present for scheduled appointments.

Fixed salary compensation plans tend to be shorter in duration and appropriate for new physician hires during a probationary period (1-2 years) while they are growing their practice. The fixed salary approach is also an effective approach with super-specialists like advanced heart failure and transplant, congenital heart, and cardiac-oncology physicians.

Key Physician Compensation Program Considerations:

Weekend, weekday, and holiday call responsibilities are generally required to participate fully in any physician compensation plan. Physicians who are allowed to be excused from call responsibilities are generally penalized 25 – 35 percent of their compensation.

Practices must determine whether physicians will be allowed to practice part-time. Practices also must create a mechanism to request changes in status and a methodology to address compensation. In most practices, IF part-time physicians are allowed, they still must meet call requirements. Additionally, most part-time arrangements are for a certain time period with caveats that change in status requires approval.

Minimum work standards are typically established as a component of the compensation plan. Issues such as the number of days per week, call
Establish minimum productivity expectations for physicians and advanced practice providers

Measure practice productivity by multiple metrics and always benchmark using external sources

Develop productivity and business development goals relative to subspecialty and practice factors

Key Takeaways

- Establish minimum productivity expectations for physicians and advanced practice providers
- Measure practice productivity by multiple metrics and always benchmark using external sources
- Develop productivity and business development goals relative to subspecialty and practice factors

Time off policy is typically a component of the physician compensation plan.

Responsibilities, weekend and holiday rotations and similar items are typically addressed in a work standard policy.
Patient Service Standards

This section provides recommendations on maintaining high patient satisfaction within the cardiology practice.

Key Patient Satisfaction Questions

1. Would you recommend the practice to a friend or family member?
2. Are you satisfied with wait times to see a physician?
3. Are you satisfied with time spent with the physician, to answer your questions?

Hints and Tips to Improve Patient Satisfaction

- Practices should consider establishing a patient family advisory council to get patient input on practice operations and impact on patient satisfaction.
- Practice administrators should look at their reports and alerts daily; administrators should share the results with both providers and staff – making them aware of both positive and negative feedback.

- Staff should be empowered to fix problems.
- Consider what “Wow factor” practices consider best practices in patient satisfaction such as follow up phone calls and other such strategies.
- Provider and staff evaluations should include service as an objective.

Key Takeaways

- Empower staff to act and resolve patient service issues.
- Establishing a patient family advisory council and involving them in the workings of the practice can have a great impact on patient satisfaction.
- Practices with high levels of patient satisfaction recruit providers and staff on their ability to provide superior patient service.
- Make patient service drive your practice culture – in the daily conversation, in daily expectations that is celebrated uniformly.
- Share patient satisfaction survey results with providers and staff and formalize a patient recovery process.

High patient satisfaction is a key indicator of a practice’s financial health and market strength.
Operations Standards and Access

This section provides best practices for a variety of operational areas such as access, business development, and referral channel management.

Practice operations are well managed when the key processes are in control. In order to obtain and retain process control, a process management and continuous improvement operating framework should be incorporated into the operating model. A process management approach should include processes that are well defined in activity and staffing, and that are written and supported by standard operating procedures where indicated. For example, specified staff should complete the chart preparation process. Steps to prepare a chart should be defined and an example of the practice’s chart standard should be illustrated and shared. Well-defined processes provide line managers with the basis to operate effectively and with autonomy.

Although there are many processes that together drive the operations of a practice, the primary processes are organized into five categories and include the following:

- **Clinical Processes**: patient rooming, urgent and emergent patient management, nurse triage, and device clinic
- **Administrative Processes**: call center management, registration and scheduling, patient recall and pre-procedure planning
- **Information Technology Processes**: EMR certification, electronic tasking and messaging, chart preparation, clinical decision support for AUC, standards and chronic disease management, and standardized templates
- **Compliance Processes**: HiPAA, vendor policy, physician owned entity, clinical scope of practice, and financial policy
- **Business Development Processes**: Access and referral channel management

Access usually refers to provider availability for clinic visits, but also denotes access to physicians and advanced practice providers in many practice settings. Access can also refer to nurse triage and clinical advice as well as other patient required and desired interactions. Access from a referring physician perspective may mean access to the practice with regard to referring a patient for services, but also denotes access to the cardiologist by the referring physician to discuss patient care issues. Managing access is managing the availability of the practice to its stakeholders who have a variety of needs.

**Patient Access and Referral Channel Management**

Patients require access to the practice via multiple channels: EIR physician referral, primary care referral, specialty physician referral, APP referral, and even word of mouth referral. Not only will patients access the practice from multiple referral channels, they also access the practice from multiple sites of care: office, inpatient-hospital, emergency department, outpatient-hospital, rural hospital, freestanding emergency department, urgent care center, retail care site, ambulatory surgery center, and even virtually through the internet. Understanding the referral channels and the sites of care will assist the practice in driving practice growth.
Hints and Tips to Manage Practice Access

• Understand the channels driving growth

• Consider offering robust programs to enhance critical growth channels

• Monitor essential information such as: referrals from each site of care and service performance at each site

• Understanding your referring physician base – which doctors are retiring, where are new physicians such as hospitalists or primary care physicians entering the market

• Communicate with outreach and rural referral channels and be creative in finding access points to meet their needs

• Cater to urgent care centers and retail care sites, providing them same day access or other easy access for their patients

• Growth is correlated with new patients therefore, monitor the new patient-to-existing patient ratio in the practice and manage provider patient panels to ensure new patients have adequate access

• Develop mechanisms to accommodate same day appointments

Key Takeaways

• Processes should support capacity utilization, productivity, and growth

• Cultivating referral sources is an essential strategy for a successful operation

• Same day appointment mechanisms help to facilitate patient satisfaction and practice growth

• Creative access mechanisms for outreach and rural channels stimulate growth
Staffing Management

This section provides guidance on effective staffing protocols for clinical and non-clinical staff within a cardiology practice.

Cardiology practices employ both clinical and non-clinical staff. The combination of roles in any given program is native to it. The goal is to allow staff to work to the “top of their license” by fully utilizing their capabilities and having only as many staff as are required to perform the necessary services.

Some of the typical staffing positions include:

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Credential</th>
<th>Application Note</th>
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</thead>
<tbody>
<tr>
<td>APP</td>
<td>Nurse Practitioner Physician Assistant</td>
<td>Most effectively works in one of three models focused on managing patient visits independently (see CV Playbook Section XII, APP)</td>
</tr>
<tr>
<td>Heart Failure Nurse</td>
<td>RN</td>
<td>RN focusing on the treatment of HF patients. This population of patients requires significant management of medications and other factors. Much of the management is protocol driven and within the scope of license in many states. RNs focusing on heart failure patients work in a variety of settings including in a heart failure clinic, in telehealth or nurse triage roles, in hospital rounding roles.</td>
</tr>
<tr>
<td>Valve Clinic Nurse (Also other specialty clinic roles such as Afib, Transplant, VAD)</td>
<td>RN</td>
<td>RN focusing on the evaluation and management, pre and post procedure of complex valve patients. As these patients are complex, they often require extensive testing and are frequently evaluated by multiple physicians – these RNs operate as quarterbacks and navigators.</td>
</tr>
<tr>
<td>Inpatient Rounding Nurse</td>
<td>RN</td>
<td>Assists providers in the hospital by “pre-visiting” hospitalized (or hospital located) patients, assuring proper orders, test results, and clinical data are ready and available for physician consult, visit, or discharge. Rounding nurses typically play an important role in the rapid management of hospital consults and timely patient discharge.</td>
</tr>
<tr>
<td>Clinic/Office Nurse</td>
<td>RN</td>
<td>RN support to providers as a component of ambulatory services. Often provides patient education and other supplementary services to the office visit.</td>
</tr>
<tr>
<td>Triage Nurse</td>
<td>RN</td>
<td>RNs who respond to patient questions, triage urgent patient needs, titrate medications according to protocol, manage patient lab and test results, and other clinical matters. RNs must be experienced cardiac nurses and be able to operate autonomously. RNs working in a protocol driven environment. Nurse triage commonly oversees anticoagulation (Coumadin) clinic responsibilities and amiodarone management.</td>
</tr>
<tr>
<td>Device Clinic Nurse</td>
<td>RN</td>
<td>Oversight of device clinic staff; often interrogates devices and manages threshold testing.</td>
</tr>
<tr>
<td>Device Clinic Tech</td>
<td>MA</td>
<td>Under the supervision of device clinic RNs, interrogates devices and manages remote monitoring and other alerts. These techs commonly instruct patients who require Holter and other event testing.</td>
</tr>
<tr>
<td>Coumadin Clinic Tech</td>
<td>MA</td>
<td>POS blood testing for anticoagulation testing.</td>
</tr>
<tr>
<td>Patient Rooming Tech</td>
<td>MA</td>
<td>Medical assistant who is responsible to room patients, take weight and vital signs, verify forms, perform EKG’s and other clinical clerical roles.</td>
</tr>
<tr>
<td>Job Title</td>
<td>Credential</td>
<td>Application Note</td>
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</tr>
<tr>
<td>Registration and Scheduling Clerk</td>
<td>Non-clinical</td>
<td>Responsible to register and schedule patients for clinical encounter; manages demographic, clinical and financial/payer information.</td>
</tr>
<tr>
<td>Pre-authorization or Referral Clerk</td>
<td>MA or non-clinical</td>
<td>Responsible to manage patient insurance requirements for testing, procedure or referral authorization.</td>
</tr>
<tr>
<td>Check in and check-out Clerk</td>
<td>Non-clinical</td>
<td>Responsible to greet patients, verify insurance, schedule future appointments, collect balances and/or co-pays.</td>
</tr>
<tr>
<td>Pre-procedure Planning Coordinator</td>
<td>MA or RN</td>
<td>Responsible to prepare and transition patient to a procedure setting including scheduling, clinical preparation for visit and logistical preparation for a procedure. Sometimes performed by RN as a component of office visit teaching.</td>
</tr>
<tr>
<td>Medical Records Clerk</td>
<td>Non-clinical</td>
<td>Responsible to perform chart prep and other processes required to keep records up to date and to assure patient data is available for office and other visits as required.</td>
</tr>
<tr>
<td>Medical Record Abstrator</td>
<td>MA or RN</td>
<td>This role is critical during a medical records conversion, either from one EMR to another or from paper to electronic. Responsible to build a patient record from a previous record by evaluating existing records and abstracting important clinical data for insertion into new record.</td>
</tr>
</tbody>
</table>

**Key Takeaways**

- All staff should be working at the “top of their license” by fully utilizing their capabilities.
- Successful practices have talent management and growth plans for every role and offer job coaching to all employees.
- Care teams should be designed to provide exemplary service and clinical expertise.
Advanced Practice Providers (APP)

This section provides guidance on integrating APPs into a cardiology and how to ensure these leaders are operating at the top of their license.

Scope of Practice and Utilization

APPs should be practicing at the top of their licensure. They are providers and the majority of their work evaluation and management services, and contribution to an episode of care as part of a global period, should be reimbursable. An APPs scope of practice is dictated by their state license and the scope of practice of their supervising or collaborating physician. There are differences between nurse practitioner (NP) and physician assistant (PA) scopes of practice, with additional differences existing from state to state that make understanding the scope more challenging.

Roles and Responsibilities

APP roles and responsibilities must be in accordance with state regulations, but also should be purposeful in design when considering how the APP supports a particular clinical team, patient panel, chronic disease management program, or special population. An understanding of the APPs role allows the design of scheduling templates and productivity expectations relative to routine follow-up visits, post hospital visits, or hospital-based rounding services.

Staffing Support

Staffing support provided to the APP is a function of their role and responsibility. If the APP is operating to the top of their license in an effectively designed role, they will need staff support for several functions, similar to a physician provider. For example, if it is the expectation that the APP see patients in 15-minute intervals, then the chart preparation process that aggregates and organizes records in advance of the visit should be deployed for the APP as it is deployed for the physician. The same would be true of patient rooming, performing an EKG, and other tasks typically performed by staff to make physicians more efficient.

The design of the production expectation of the APP will determine staffing support.

Typical Care Models

Hospital-based APP models can function independently or collaboratively with physician providers. The scope of practice allowable by both the state and hospital privileging rules will dictate the role design.

APPs used effectively in the hospital setting include: cardiovascular hospitalists, pre-rounding support to physician providers, and discharge coordination.

Performance expectations: The APPs in the hospital role typically facilitate faster response times to referring physicians (hospitalist, ED), more effective and faster patient transfer processes, more complete documentation and record management (this can be an RN role dependent on hospital privileging rules), and timely and effective discharge and transition care. The most effective metrics to assess APPs in this setting (depending on billing practice) is response time, throughput, and productivity based on the physician’s billing, which should be higher than if a physician was independently performing those services.

Office-based APP model functions generally independently of the physician provider, with supervising physician oversight, in a disease management or protocol driven clinic. Cardiology practices are uniquely positioned to incorporate APPs into subspecialty disease management clinics such as heart failure clinics and other diagnostic specific clinics such as Afib clinics. Generally, these clinics serve one of two functions. The chronic disease management or heart failure) clinic cares for patients in a specified...
disease state that require frequent visits, and whose objective is to monitor and administer established care plans for patients that able to maintain their care in low acuity environments. A protocol driven clinic, such as Afib clinic, achieves both patient access goals and is one of several compressed care models. An effective protocol driven clinic provides rapid access to patients for a protocol driven rapid work-up and determination of therapy arms. The result is rapid diagnosis to treatment, effective patient teaching and training, and appropriate triage of patients to the least acute care environment. The outcome of the clinic from a cardiologist perspective is that bottlenecks are removed, and the patients are referred to a post-APP clinic visit to the cardiologist (EP), which is more likely an appropriate course of referral and has the required work-up results allowing the physician to make treatment decisions rapidly. There are four appropriate metrics to evaluate these clinics: APP productivity, patient access, time from diagnosis to treatment, and increased physician upstream productivity.

These APP models can also function independently or collaboratively with physician providers in a general office setting. The scope of practice allowable by the state will dictate role design. APPs used effectively in the office setting have established templates and appropriate staffing support. They are expected to see a full panel of patients. In order for APPs to be effective and productive in this role, they must have wide acceptance from physicians. Effective practices establish APP utilization policies that indicate certain routine office visits, rapid post hospitalization visits, and walk-in patients as examples of appropriate APP utilization. Utilization of APPs in outreach and through telehealth are also very effective models, allowing for more consistent provider coverage and true extension for the practice physicians. The best metric in this model is a productivity metric, wRVU, patient encounters, or template capacity utilization.

Billing Practices

An APP can bill under his or her own provider number or in conjunction with the physician provider number, as a shared visit or incident to scenario. The billing options have different requirements and should be selected based on the design of the APP role. If the APP’s productivity will be captured in either a shared visit or incident to approach – the physician’s productivity will reflect the APP’s work. Additionally, if the APP performs services during the global period, the reimbursement is captured in the global payment attributed to the physician. In those cases, a mechanism to measure the productivity of the APP other than direct wRVU generation is important. Practices can look at one of two methods to value the APP productivity in these scenarios. The physician/APP team should create higher relative productivity than the physician alone and productivity expectations should be established with that understanding, or a mechanism to record APP encounters must be established. Evolved practices are able to value and justify APPs in both collaborative and independent roles.

Billing Options for APPs

Bill Visits Under APP Provider Number

• Paid at 85 percent of allowed amount
• State scope of practice requirement must be met

Bill Shared Visit Under Physician Provider Number

• Requires face-to-face physician/patient visit
• Hospital
• Initial or subsequent visit
• Discharge visits

Bill Incident to Visit Under Physician Provider Number

• Only applies in the office setting
• Physician/patient face-to-face not required
• Not allowed for new visits or new problems

Billing Practices

Hints and Tips For APP Utilization

• Practice physicians must fully embrace the utilization of APPs as providers
• APP clinical roles and responsibilities and consistent care and productivity expectations must be established
• Commitment by physicians to develop and monitor clear care plans and protocols to be utilized in the APPs role design
• Clear expectations of the supervising and/or collaborating physician as to their role and responsibility related to APPs

Key Takeaways

• APPs should be working at the “top of their license” promoting both efficiency in the practice and provider satisfaction
• APPs should drive disease focused protocol driven clinics
• APPs should facilitate compressed care and easy practice access
• APPs should function as cardiovascular hospitalist and transition managers
Reputation Management (Social Media & Public Information)

This section provides guidance on managing a practice’s online social media presence and reputation.

Social media and the availability of public information provide both opportunities and challenges to cardiology practices. One challenge practices face with regard to this new category of information is accuracy. It is common for public sites to post physician and practice data including physician background, locations, and phone numbers that are inaccurate.

Managing social media and public information requires both proactive and reactive strategies. From a proactive perspective, developing a strong online presence and reputation by asking satisfied customers to write a review, “like” the practice on Facebook, or on other social media sites is an excellent strategy. It is also important to monitor sites that are established by responding appropriately to comments, posting interesting information and positive patient videos or comments, and managing the accuracy of information.

Hints and Tips for Reputation Management

1. Verify your information and make sure information is correct on your profiles so patients know they are viewing and reviewing the correct practice
2. Tell patients about your practice’s and physicians’ online presence
3. Develop a plan to ask for patient reviews and only ask patients to leave a review on one site, so they are not overwhelmed with options
4. Send an email marketing campaign
5. Create a friendly competition as this will encourage your entire office to work toward improving your online reputation
6. Don’t manufacture reviews

Key Takeaways

• Assure that public sites have the correct information
• Assign a staff member to monitor sites and register new physicians accurately
• Involve marketing in launching a site, make sure messaging is in line with other promotions, and the site is in compliance with policy
• Make social media a component of the practice’s business development, patient service, and referring physician service plan
Financial Management

This section provides an overview of effective financial management practices for the modern cardiology practices. These include revenue cycle management, budget management, patient financial policy, and coding compliance.

Practice financial management is a critical responsibility of the practice administrator. The responsibility falls generally into the following areas: revenue cycle (front end only), budget, financial policy, billing, and coding compliance.

Key Takeaways

- Providers should successfully complete annual education
- The practice has coding, billing, and compliance checks and balances in place
- The practice should have clean transition management between practice and CBO
- The practice should:
  - Adhere to a budget
  - Have a consistent point of service (POS) collection
  - Patient financial policy that is clear and understood by patient
Practice Growth Strategies

This section provides guidance on key practice growth strategies that cardiology practice can employ. These include both clinical and non-clinical factors that are proven to impact growth.

Practices are successful and grow when patients are satisfied, referring physicians appreciate the quality of care provided at the practice, and when access to the practice for both scheduling and advice is easy. Practice growth is also determined by performance in other clinical and non-clinical areas, such as capacity, access management and efficient operations. Capacity refers to both a practice’s physical capacity to accommodate patients in the variety of settings and the capacity of providers to see patients. It is important that the practice understands its access points, and manage its schedule and physical plant in a manner that accommodates growth. Additionally, optimizing providers by deploying care teams including APP’s and maintaining scheduling availability are the details of practice management that will either facilitate growth – or hamper it.

Clinical Growth Factors

Cardiology is a constantly evolving and expanding clinical practice. Expanding the practice’s service offering to new or complementary services is a primary way practices grow. Perhaps the most recent example of service offering growth occurred across the nation with addition of the transcatheter aortic valve replacement (TAVR) procedure. This new percutaneous valve treatment created growth opportunities not only in the procedure itself, but also through increased surgical valve patients, clinical work-ups, including imaging, and long term follow-up care. Practice managers can stay current with emerging technologies by working with their physicians. Other valuable sources of reference include industry websites, technology based list serves and publications, and clinical societies such as the American Heart Association and the American College of Cardiology.

A second clinical factor impacting growth is the management of appropriate use criteria (AUC). Appropriate use criteria are scientifically based rules that have established patients’ clinical criteria necessary to receive certain services. AUC assures patients don’t receive unnecessary care – however, it is also useful in ensuring that patients aren’t “under-cared” for or not receiving indicated therapies and diagnostics. Some examples of objectives might be operationalizing clear criteria as to when a patient should be referred to a valve clinic or atrial fibrillation clinic, or post event follow-up testing. There are several strategies important to managing appropriate use criteria. The first, and foremost, is the clinical consensus of the physicians in the utilization of the criteria and the symptoms and circumstances where the criterion are actionable. Additionally, it is critical that physicians define standard clinical documentation in order that the necessary data is present to provide the trigger. Leveraging EMR capabilities with alerts, both during a patient visit and in preparation for a patient visit, are additional strategies.

The other clinical factor critical to growth is a practice’s reputation and the clinical quality of its providers. Several sections of this playbook discuss clinical quality and reputation, but what is important to know is that every year more and more clinical performance data will be publicized and that may impact growth. The savvy practice and marketing team will find ways to communicate excellent clinical quality to its patients and referral channels.

Non-Clinical Factors

SERVICE! SERVICE! SERVICE! Patients and referring physicians (and their offices) respond to great customer service. Practices that think like a customer and manage their responsiveness to patients and referring physicians, their turn-around times for reports and information, and they have good access to the staff and physicians that can solve problems – grow! Practices and physicians who say, “Yes!” to patient consults and transfers – grow. Practices that make the referral process easy, incorporating technology solutions that streamline process where available/applicable – grow. Practices with efficient operations, whose leaders communicate well and on a timely basis - grow. Practices whose physicians and staff are kind, compassionate and take time with patients, patients’ families, and referring physicians – grow. Practices with adequate access and physical entry points to both the facility and ambulatory services - grow. Expanding to new physical locations and expanding hours or services at those locations are significant non-clinical factor impacting growth is the practices payer strategy, network participation, which drives access to patients contractually.
Other Growth and Business Development Strategies

There are several proven growth and business development strategies that a practice should consider. Following are examples of best practices:

1. Referral channel management
   - Hire a business development representative to visit primary care physicians, urgent care facilities, and other practice referral channels to communicate practice offerings and serve as an experience enhancer for the practice
   - Create a referring physician advisory council whose purpose is to obtain input from referring physicians as to their satisfaction with the practice
   - Provide patient and referring physician education opportunities
   - Develop patient co-treatment initiatives with primary care or other referring physicians such as a primary and secondary risk management and vascular screening

2. Develop or participate in a multi-disciplinary program such a vascular program or a cardio-oncology program

3. Create outstanding communications, patient portal, and educational materials for patients, patient families, and referring physicians for the purpose of engaging practice stakeholders

4. Other patient engagement strategies include the development and expansion of support clinics (anticoagulation, device), patient and family advisory councils, caregiver support functionality, remote health monitoring and app utilization, and finally, community participation in cardiovascular and other health related initiatives.

Key Takeaways

- Successful practices have an access management strategy that includes a seamless patient referral processes
- Incorporate patient experience results into performance evaluations of providers and staff
- Establish both a patient and family advisory council and a referring physician advisory council
- Practice has an embedded business development representative to support growth
- The practice’s physical site and operations should provide a great patient, patient family and referring physician experience