PRIMARY CARE PLAYBOOK

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

The HCA Physician Services Group is fully dedicated to serving our communities with high quality primary care practices across the country. That being said, I firmly believe in carefully examining and absorbing best primary care practice models so that we may continue to honor that commitment.

The PSG Primary Care Playbook serves as an overview of the organizational, structural, and functional attributes found in high-performing primary care practices. It addresses operational, clinical, and financial aspects of a practice; provides an overview with management hints and tips; and defines what excellence looks like in a primary care practice.

Our team looked at the 25 top producing primary care providers (PCPs) in the HCA Physician Services Group and, combining that with data from some of the leaders in the field of practice management, have produced this playbook.

What you will find is the best demonstrated practices in primary care, both inside and outside of the HCA Physician Services Group. Additional resources and examples to support each practice’s efforts can be found in the appendix.

We incorporated the evaluation of existing and new primary care practices into this playbook, providing a framework from which to identify gaps between the current operating model and the operating model of the ideal practice.

This document highlights the key aspects of each practice component and is not intended to be an all-inclusive, detailed manual. We will update this playbook yearly to ensure it stays current and relevant.

I want to thank you, in advance, for taking time to reflect on best primary care practices.

Sincerely,

Louis Joseph
Vice President of Operations
HCA Physician Services Group
Using the Primary Care Playbook

Purpose

The Primary Care Playbook equips primary care practice managers with the fundamental tools they will need to manage successful practices that exceed expectations with outstanding performance. This playbook was developed because standardizing excellence across the board is a key HCA Physician Services Group priority.

Using the Playbook

This playbook was created with the busy operator in mind. Each chapter begins with a brief overview, which outlines the key topics contained within, and concludes with key takeaways to ensure the reader recognizes and can remember the most important elements of the section as defined by PSG’s operational leaders.

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 that is the provider’s time, and creating an atmosphere where the focus is centered on excellent patient experience and results.

Additionally, this playbook covers key points and how-tos such as making various operations time efficient and effective and utilizing technology to drive improved results.

For the purposes of this playbook, primary care is defined as internal medicine, family practice, and pediatrics.

Please refer to the appendix for further resources.

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01

The Provider’s Time

Find ways providers can effectively utilize their time and how practices can maximize efficiency in order to produce outstanding results.

The importance of using time and space wisely cannot be highlighted enough. Key tips will be provided to help ensure that your practice is conditioned for success.

The most valuable asset of any practice is the provider’s time.

Physicians and advanced practice providers (APPs) are the providers that constitute the core of the clinical team.
Effective Time Utilization

The provider’s time is the medical practice. It is the reason patients come to the practice, and it is the generator of the majority of the practice’s revenue. The provider’s time is the asset that must be optimized to provide maximum value to patients and ensure financial success.

A key concept to optimize the provider’s time is to ensure that everyone is working to the top of their license or certification. Tasks that do not require a physician should be performed by someone else.

The practice should be laid out to maximize efficiency. Large office space may look impressive, but it makes providers less efficient since there is more walking than necessary. Primary care physicians should operate in approximately 1,000 square feet a piece. The most efficient providers operate in a pod structure, typically with three exam rooms.

Items, such as supplies, should be located as close as possible to where they are needed. Using an electronic medical record (EMR) can make an office more efficient if, deployed correctly. As technology becomes more powerful and compact and as the interface becomes easier to use, efficiency should rise.

Staff should keep in mind other efficiency ideas such as:

- Keeping things in a “line-of-sight” for the provider
- Co-locating processes and employees to save steps
- Using Wi-Fi wherever possible to streamline communications
- Finding ways to eliminate waste

Use of Time: Turning Good to Great

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<th>Good</th>
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<tbody>
<tr>
<td>Building/leasing no more space than necessary</td>
<td>Efficiently designed space</td>
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<tr>
<td>Creating a culture designed to protect the provider’s time</td>
<td>Use of professional process improvement teams for consulting at the practice</td>
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<tr>
<td>Establishing basic productivity measures and reporting on them monthly</td>
<td>Yearly upgrading of technology, focusing on efficiency</td>
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Understanding how to make scheduling work for you in a timely and effective manner will help achieve an orderly and manageable practice environment. How you schedule a provider’s time is a critical component to practice success.

Scheduling

Explore the fundamentals of scheduling and the significant do’s and don’t’s of the process.
Types of Scheduling

Medical practices use three general methods of scheduling: single intervals, multiple intervals, and block intervals.

- Single intervals are where each visit receives the same amount of time on the calendar regardless of the type of visit (new or established) or the chief complaint. An example is scheduling all appointments on the quarter hour.

- Multiple intervals are where the intervals between appointments depend on the type of visit or the chief complaint. An example would be an acute care visit with one complaint would receive 15 minutes on the calendar, while a new patient visit would be 30 minutes.

- Block intervals are the use of a single block of time for multiple appointments regardless of the type of visit or the chief complaint. An example would be all 10 morning appointments are asked to arrive at 9 a.m. and are seen in some order until the end of clinic.

Key Considerations

Practices must be careful to not over-complicate their scheduling system and avoid creating too many appointment types; 5 to 10 appointment types should suffice for a busy office.

The scheduling philosophy of the office is important: the busiest offices have a “can-do” attitude and some even incentivize their scheduling staff to make sure that the maximum number of patients are seen in a timely manner.

Some efficient practices have limited appointment types to only three categories: short (usually established patients), long (usually new patients or complicated established patients), and procedures.

Modified wave scheduling is a system where the practice clusters patients at the beginning of the hour, with appointments tapering off as the hour concludes. Scheduling a “bolus” of patients at the top of each hour creates heavier volume but offers the opportunity of staying busy since one or more patients may be late or not show.

Patients should also be encouraged to book appointments online. Making an appointment with the provider should be as easy as making a restaurant reservation online. Questions and screen changes should be kept to a bare minimum with an emphasis on simplicity and speed for mobile users. Also, if a provider does not have availability, another provider should be recommended to the patient.

One of the best resources for scheduling excellence is Mastering Patient Flow, 4th edition by Elizabeth Woodcock.
Clinical Services Offering

Examine the various components of in-clinic procedures and what needs to be addressed for care coordination.

Developing and maintaining quality clinical services in your primary care practice can include various components of in-clinic procedures. Ancillary services may play a role at your clinic or elsewhere. Effective methods to follow up with patients, as part of the continued care process, are also essential to a successful practice.
Clinical Tips

Primary care practices are evolving as healthcare changes. Most inpatient work has shifted to hospitals, while urgent care and walk-in clinics respond to patients wanting expanded hours and convenience.

Performing in-clinic procedures can be very rewarding for primary care providers, create efficiencies for patients who do not have to seek care elsewhere, and may enhance revenues for the clinic. There are several issues that must be addressed when providing in-clinic procedures at the primary care office: proper staff and provider training, emergency supplies, documentation of informed consent, knowledge and experience with CPT codes for all procedures performed at the clinic, and a team spirit that is created by the provider that allows all staff members to feel comfortable raising safety concerns before or during an in-clinic procedure.

An up-to-date list of the in-clinic procedures that providers are capable of performing and that the staff are capable of supporting should be maintained by the office manager. Documentation of staff training and updated re-training should be maintained at the office. To assure safe and efficient procedures, there should be routine inventory completed and signed off on a regular basis. Many practices have found that scheduling procedures at a consistent time during the week provides efficiencies for both the provider and clinic support staff. It is of great importance that a provider is singularly focused during their procedures.

An area of risk for in-clinic procedures concerns obtaining informed consent. At a minimum, informed consent must include the expected outcomes, potential risks, and reasonable alternatives to the procedure, as well as the fact that a procedure does not guarantee an outcome. This documented informed consent must be signed by the patient and/or the caregiver and scanned-in to the electronic health record (EHR) if a digital signature is not a part of the EHR.

The clinic support staff members including medical assistants, LPNs, and RNs are crucial to the success of in-clinic procedures. They too must focus on eliminating all distractions, being in the proper mental state to assist in the procedure, and understanding the risks and what to do in an emergency during a procedure. The provider is in charge of creating an atmosphere where every member of the support team feels comfortable and is expected to point out any concern or risk that may affect the safety of the patient or the success of the procedure.

Diagnostic Ancillary Services

Diagnostic ancillary services such as diagnostic lab, radiology, audiology, and pulmonary, incorporated into a primary care practice can provide great efficiencies to our patients and may be the right business decision for some practices. The provision of these services at the primary care office requires compliance with varying regulations like CLIA (Clinical Laboratory Improvement Amendment) and OSHA (Occupational Safety and Health Administration) along with state and local regulations. It is also important to know the up-to-date CPT coding requirements and documentation support to justify the provision of the services for billing purposes. Diagnostic ancillary laboratory studies performed at the office should interface with the EHR, in order to facilitate the documentation of these results in an electronic format, as required by meaningful use. For other ancillary services an efficient workflow that includes scanning results into the EHR may be suitable, but ideally a direct interface to the EHR should exist to create efficiencies and avoid improper filing of results.

The entire practice should have an agreed-upon policy for utilization and provision of the ancillary services at the primary care clinic. If the ancillary services are provided by the clinic, then every provider in the clinic should offer those services to all their patients equally based on medical necessity. Patients have a right to refuse to use ancillary services at any primary care practice and instead choose an ancillary service provider of their own choice. The clinic must allow patient choice in this matter and accommodate the patient’s selected ancillary service provider.

If ancillary services are not provided at the practice, then it is essential to have clear instructions for your patients on where and when to use the services. These clear instructions should be included on the after-visit summary that is provided to the patient at the time of checkout.

Continuity of Care

Continuity of care may also include utilizing telephonic, e-mail, or web-enabled. Appropriate information security and standard operating procedures need to be in place to ensure high quality, compliance, safety, and efficiency of communications.

The primary care provider plays a central role in providing continuity of care for patients and their caregivers. Multiple studies have shown that proper continuity of care can decrease hospitalizations, costs, and even prolong life. Some of the key features of excellent continuity of care include complete patient medical records with up-to-date specialist consultation notes and results of procedures performed outside of the primary care provider’s office, accurate patient and caregiver contact information, documentation of up-to-date and advanced directive choices of the patient, and consistent support staff at the clinic who know your patients by face and name.

Changes in healthcare have provided challenges to maintaining proper continuity of care within the primary care practice such as the increase in utilization of urgent care and retail pharmacy clinics. It is important that the primary care provider incorporate same-day and near same-day appointments into their overall appointment schedule to accommodate this need for access. At the same time, it is important to create strong working relationships with the local urgent care and retail pharmacy clinics to ensure that their medical information is forwarded to the primary care office. This is particularly true for patients with chronic diseases who need active care management in conjunction with treatment for urgent care issues that arise.

Another challenge to continuity of care is the introduction of part-time primary care providers. While part-time providers create access problems and continuity problems for chronic disease patients, studies show that patients report better satisfaction scores when they still have continuity with this primary care provider.

The EHR can provide several tools to help improve continuity of care. The patient portal (described in more detail in this playbook) can provide a new vehicle for communicating securely with patients when delivering news, gathering information, or disseminating chronic disease management education. The portal also enables patients to request medications directly from the primary care provider without having to distract staff or providers with phone calls throughout the day. EHRs can also allow providers to keep track of a singular problem list for their patients, thereby having an accurate longitudinal view of the patients’ complete medical picture. The EHR also allows for an easy to view history of the patient’s medications, allergies, and visits/contacts with the clinic and other healthcare facilities. And finally, many EHRs allow for access to health information exchange data that contains information on the patient from other facilities like emergency departments, hospitals, and other ambulatory practices.
A primary care provider will always be an essential member of the care team for every hospitalized patient, whether they are the attending physician at the hospital or an adjunct to the team (who does not round at the hospital) providing crucial information concerning the patient’s medical history. When the primary care provider chooses to round on their patients as the attending physician, there are many factors to consider. There must be a mutual agreement and acceptance of this practice from the provider’s partners in the clinic. It is the responsibility of the provider (not the manager) who chooses to round on hospitalized patients to have cross coverage when the provider is unavailable. It is also the responsibility of the provider to be physically present at the clinic when they have scheduled patient time. In the case of an emergency, when the provider is required at the hospital, it is the responsibility of that provider to have a covering physician care for his or her scheduled clinic patients. It is also the responsibility of the PCP to satisfy all requirements to remain a member of the medical staff in good standing of the hospitals where they attend. This includes all documentation requirements, attendance at medical staff meetings, and adherence to all medical staff bylaws.

For those primary care physicians that do not directly admit and attend to their hospitalized patients, it is essential to have an established working relationship with the providers who will care for your patients when they are hospitalized. This may be an agreement with a hospitalist group or individual provider who has agreed to admit and attend to the practice’s patients. This agreement should include the expectation that there will be timely communication to your practice’s staff of the patients’ plan of care upon discharge from the hospital. Also, this care arrangement should be explained to practice patients at the beginning of the patient/physician relationship, in order to avoid any confusion as to who will attend to them when they are admitted.

Caring for Patients in Long-Term Facilities

Primary care physicians have a very unique skill set that enables them to care for patients in multiple care settings, including long-term care facilities. When a provider chooses to care for patients in these facilities, there are a number of factors to consider. First, there must be a mutual agreement and acceptance of this practice from the provider’s partners in the clinic. It is the responsibility of the provider (not the manager) to assure that continuous coverage is available for the patients that are under the provider’s care at these long-term care facilities. Consistent, scheduled rounding times are a key to successful management of long-term facility patients. This enables both the physicians as well as the facility staff to prepare for the visits and have all documentation and questions ready for the arrival of the primary care physician. It is also the responsibility of the primary care provider to meet all the timely documentation requirements (both Medicare and facility specific requirements) of new patient admissions and established patient visits at the facility. Proper coding of long-term care facility visits is also a key skillset to master for any successful primary care physician who wishes to practice in this setting. Proper attention must be paid to the documentation requirements and coding of initial admission visits, routine visits, and acute illness visits. It is also the responsibility of the primary care physician to be assured that all requirements of being an active member of the long-term care facilities medical staff are met in a timely manner.

For the purposes of this playbook, managing the quality function of a primary care practice is divided into four broad areas:

a. quality culture
b. quality practices and procedures
c. practice management systems
d. quality measures and reporting programs

Physician quality will be discussed in a subsequent section.
Quality Culture

The practice culture is established by its leadership, its history, its compact, and its people. Each of those culture components materially impacts the 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. Practices 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 evidence-based guidelines are adhered to in the practice. Additionally, the practice commitment to maintain accreditation or accreditation-based standards is an indicator of quality.

Following are practices indicative of an organization that champions quality:

- Adherence to evidence-based medicine and electronic medical record (EMR) to guide providers and report outcomes
- Adherence to appropriate use criteria and mechanisms to guide providers and report outcomes
- Commitment to clinical standardization and the use of clinical guidelines
- Defined disease management protocols including patient triage clarity
- Implementation of meaningful use criteria
- Commitment to structured reporting in all services and in clinical communications from the practice (including clinical notes and procedure reports)
- Effective use of the EHR to assist in quality documentation and adherence to clinical standards
- Laboratory and imaging services maintain accreditation from the appropriate accreditation body including the requirement that clinical oversight is provided by the appropriate board certified physician

EHR Systems – Practice Management Systems

The practice management system is designed to assist with several different functions that are crucial to every primary care practice. The primary function is to enable scheduling of appointments, demographics, organized collections, and submit claims. Ideally, there is seamless unification of the EHR in the practice management system. Without this integration there is a significant loss in efficiencies due to the duplicative work that must be completed in both systems. It is important to have a single vendor contact for questions concerning issues with the software. Training and support should be provided from the vendor as part of the included cost of licensing.

Every modern primary care practice should utilize an EHR system that is certified to meet meaningful use and enables providers to meet all regulatory requirements. Adoption of the EHR is paramount for compliance with government programs, avoidance of penalties from the Centers for Medicare and Medicaid Services (CMS), provision of safe care for patients, and to capitalize on the efficiencies that the systems bring to patient care. The EHR system must include a patient portal that is available to every patient. The EHR should also provide an after-visit summary that is provided to every patient at the end of the visit in either printed or an electronic format on the patient portal. The EHR should include adequate technical support for providers and clinic staff at the time of implementation and throughout the contract with the vendor. This will be crucial during times of EHR upgrades and security patches.

Quality Measures and Reporting Programs

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, the reduction of an administrative burden, or more recently seen in patient steerable and/or narrow networks.

Voluntary programs are often sponsored registries that allow outcomes to be benchmarked and often have elements of improvement coaching involved.
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.

Practice Quality & Key Indicators: Turning Good to Great

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<tr>
<td>• Quality is a component of provider and staff recruitment, training, and evaluation</td>
<td>• Evidence-based medicine and appropriate use is supported by EMR and providers receive adherence feedback</td>
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<tr>
<td>• Adherence to evidence-based guidelines</td>
<td>• Clinical staff is enabled to manage in accordance with clinical standardized and disease management protocols</td>
</tr>
<tr>
<td>• Adherence to appropriate use criteria</td>
<td>• EMR is utilized to reduce variation and drive quality performance</td>
</tr>
<tr>
<td>• Commitment to clinical standardization including structured reports</td>
<td>• Quality is the practice CULTURE</td>
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<tr>
<td>• Defined disease management protocols</td>
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<td>• Implementation of meaningful use</td>
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Learn how physician quality is managed, to ensure that performance is up to par, as well as structured ways in which physicians can continue to certify, develop, and improve their quality through analytic feedback and review.

Physician Quality Management

Physician quality is managed in a variety of ways. 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, and 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.

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.
### Credentials

Physician credentialing refers to the physician’s initial and on-going training and board certification. Board certification is a mechanism to guarantee that an individual physician has the knowledge to perform as a primary care physician. Best practice would indicate that primary care physicians are expected to obtain and maintain Board Certification, issued by the American Board of Internal Medicine, American Board of Family Practice, the American Board of Pediatrics, and the osteopathic boards. Practice requirements may be more stringent than those of the facility, regarding specialty and subspecialty boards.

Other requirements are also typically required to maintain hospital privileging.

**Important decisions for practices to make regarding credentials:**

- Does the practice require board certification?
- 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 and should also be consistent between physicians
- 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 Primary Care Physician 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 indications of compliance and quality**
   - Coding frequency vs. national standards
   - Coding frequency vs. local peers in the same specialty

2. **Individual analysis of key indicators of compliance and quality**
   - Quarterly retrospective review of medical reports (consult notes/follow-up visit notes) to match levels of documentation and billing (5-10 charts/physician/quarter)
   - Use of peer review, likely through a third party provider
   - Quarterly retrospective review of procedure reports to evaluate appropriate use criteria, proficiency of the operator, and accuracy of the report

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

### Physician Quality Improvement & Credentials: Turning Good to Great

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<tr>
<td>• Physicians are board certified</td>
<td>• Physicians are board certified in the subspecialty areas that they work</td>
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<tr>
<td>• Credentialing policy regarding boarding, volume requirements, and CME are documented</td>
<td>• Peer review and quality improvement processes foster robust learning and transparent evaluation of clinical performance</td>
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<td>• Mechanism for tracking and recording credentialing requirements is established</td>
<td>• Regular coding and documentation audits and proactive engagement in continuous improvement</td>
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<td>• Professional standards policy established to manage non-standard behavior and performance</td>
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Discover the metrics that pinpoint how to evaluate physician and practice productivity as well as practical ways to increase productivity in your practice, to achieve optimum results.

For practice productivity, the focus is centered on utilization of physical capacity. For physician productivity, the focus is performance metrics and ratios.
A Healthy Practice

The health of the practice is measured by the productivity of the practice itself and the utilization and capacity of available physicians and non-physician providers.

There are several reasonable metrics that can be used to monitor and evaluate productivity. As each of the metrics is indicative of a different aspect of the practice, it is recommended that a short list of individual metrics is measured — and the aggregate of the outcomes considered in evaluating 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

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<tr>
<th>Metric</th>
<th>Description</th>
<th>Standard</th>
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<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>
<td>90 percent or more</td>
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<tr>
<td>No show rate</td>
<td>Rate of patients who do not present for scheduled appointments</td>
<td>5 percent or less</td>
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<tr>
<td>Non-scheduled patients seen</td>
<td>Number of patients to whom services were provided that did not have a scheduled appointment</td>
<td>2 per provider per day</td>
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<tr>
<td>Access</td>
<td>Third available appointment per appointment type, per provider</td>
<td>Within one week</td>
</tr>
<tr>
<td>New patients</td>
<td>Number of new patient visits</td>
<td>10 percent more of total visits</td>
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<tr>
<td>Registration</td>
<td>Pre- or site registration with insurance verification</td>
<td>50-80 patients per day</td>
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<td>Arrival with registration verification only</td>
<td>100-130 patients per day</td>
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<td></td>
<td>Arrival with registration verification and cashiering only</td>
<td>75-100 patients per day</td>
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<td></td>
<td>Appointment scheduling without registration</td>
<td>75-125 calls per day</td>
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<td>Appointment scheduling with full registration</td>
<td>50-70 calls per day</td>
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<tr>
<td>Telephones</td>
<td>Telephones with messaging</td>
<td>300-500 calls per day</td>
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<td></td>
<td>Telephones with routing (electronic system) only</td>
<td>1,000-1,200 calls per day</td>
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<tr>
<td></td>
<td>Telephone (nurse) triage</td>
<td>65-85 calls or messages per day</td>
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<tr>
<td>Scheduling</td>
<td>Practice services with follow-up scheduling, charge entry, and cashiering</td>
<td>60-80 patients per day</td>
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<td>Practice services with scheduling and charge entry</td>
<td>70-90 patients per day</td>
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Physician and APP Productivity

There are several standard metrics utilized to evaluate both physician and APP productivity. It is important to consider physicians and APPs with careful consideration of the practice’s incident to billing practices. Both physician and APPs 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 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. The wRVUs are associated with each Common Procedural Terminology (CPT) code provided by the provider; the wRVU values are determined by 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 primary care physician whose measurement and comparison to both internal and external benchmarks provides important information regarding productivity.

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 and 99221-99223 in the past 12 months per individual physician. New patients should be tracked and trended on a monthly basis.

Visits/Provider/Business Day – This number should be at least 25 per day for family practice and pediatrics and 20 per day for internal medicine.

Established Patient 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 patient visits should be around a ratio of 6:1. Return office visits should be tracked and trended monthly.

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:

Distribution of Physician Resources – The production function of the practice is driven by how and where physicians and advanced practice providers are utilized.

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.

Other factors impacting productivity include patient demographics such as age and income, office site locations (whether rural or urban), market competition, and the availability of primary care physicians. 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.

Practice Productivity: Turning Good to Great

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• Measure practice productivity metrics</td>
<td>• Establish minimum productivity expectation for physician and advanced practice providers</td>
</tr>
<tr>
<td>• Measure physician productivity by multiple metrics</td>
<td>• Measure practice productivity measures and benchmarks with external benchmarking sources</td>
</tr>
<tr>
<td>• Measure physician service volume by subspecialty</td>
<td>• Measure physician and APP productivity by multiple metrics and benchmark performance against external benchmarking sources</td>
</tr>
<tr>
<td>• Establish minimum practice productivity standards</td>
<td>• Measure physician service volume by subspecialty with external benchmarking sources</td>
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<td></td>
<td>• Develop productivity and business development goals relative to subspecialty and multiple practice factors</td>
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Physician Compensation Models

Learn the models of physician compensation plans and what each one entails. The models are divided into three main categories: productivity-based plans, base salary plus incentives, and fixed salary.

This section will also cover additional considerations such as whether physicians are allowed to practice part-time, minimum work standards, and the time off policy.

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 or percent of net revenue. 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. The benefit of a percent of net revenue model is that physician compensation is tied to payer mix. The downside is the tie to payer mix may prevent expansion into areas with a poor payer mix, and there is some physician risk if the revenue cycle is not operating effectively.
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, citizenship or behavior, and operational goals such as patient satisfaction. 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><strong>Productivity-based Plans</strong></td>
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</tr>
<tr>
<td>Clinical work is valued at a per wRVU or a percent of net revenue 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>
<td>WRVU incentivizes volume, while a percent of net revenue incentivizes volume with sensitivity to payer mix and collections.</td>
</tr>
<tr>
<td><strong>Base Salary Plus Incentives</strong></td>
<td></td>
</tr>
<tr>
<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>
<td>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.</td>
</tr>
<tr>
<td><strong>Fixed Salary</strong></td>
<td></td>
</tr>
<tr>
<td>Physicians are paid a fixed salary.</td>
<td>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.</td>
</tr>
</tbody>
</table>

### Key Physician Compensation Program Considerations:

All physician compensation must be at Fair Market Value (FMV). 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 percent to 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 work week, call responsibilities, weekend and holiday rotations, and similar items are typically addressed in a work standard policy.

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

### Physician Compensation: Turning Good to Great

- Compensation plan is simple and easily understood
- Compensation plan is in writing
- Compensation plan is financially sustainable
- Compensation plan meets tests for fair market value and other legal screens
- Plan recognizes both clinical and non-clinical value
- Compensation plan supports practice strategy
- Compensation plan and strategic plan are in alignment
- A portion of compensation is variable, dependent on achievement of goals
- Physicians characterize compensation plan as fair
- Bonuses paid quarterly
Patient Service Standards

Discover what factors influence and contribute to high levels of patient satisfaction as well as practical tips to improve patient satisfaction in your practice.

Making high patient satisfaction a top priority in the office is the recipe for a successful, thriving practice.

There are many factors that influence and contribute to superior patient satisfaction, as well as practical tips to improve patient satisfaction in your practice.
Patient Satisfaction

High patient satisfaction is a key indicator of a practice’s financial health and market strength. It is therefore an objective that every practice strive to reach top box scores and have patient satisfaction strategies and goals incorporated into their strategic plan.

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?
4. Are you satisfied with physician answering 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 their 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
- Practices are encouraged to draw on established patient satisfaction work such as Quint Studer’s Hardwiring Excellence and Results That Last or draw on the expansive Institute of Medicine’s satisfaction work
- Practices should have a formal service recovery function that includes notification to appropriate leaders and providers
- Staff should be empowered to fix problems
- Use “mystery shoppers” to test the system
- Enroll in the CG-CAHPS program
- Consider what methods “wow factor” practices use in patient satisfaction such as follow-up phone calls and other such strategies
- Provider and staff evaluations should include service as an objective

Patient Service Standards: Turning Good to Great

<table>
<thead>
<tr>
<th>Good</th>
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<tbody>
<tr>
<td>• Establish strategies and initiatives to manage and improve patient satisfaction</td>
<td>• Empower staff to act – resolving patient service issues</td>
</tr>
<tr>
<td>• Provide service excellence training and practice for providers and staff</td>
<td>• Establish a patient family advisory council and involve them in the workings of the practice</td>
</tr>
<tr>
<td>• Formalize a patient recovery process</td>
<td>• Recruit providers and staff on their ability to provide superior patient service</td>
</tr>
<tr>
<td>• Share patient satisfaction survey results with providers and staff</td>
<td>• Make patient service drive your practice culture – in the daily conversation, in daily expectations that is celebrated uniformly</td>
</tr>
<tr>
<td>• Act on daily alerts</td>
<td></td>
</tr>
</tbody>
</table>
Explore process management fundamentals that are divided into five categories: clinical processes, administrative processes, information technology processes, compliance processes, and business development processes.

These work together to develop effective, well-structured practice operations.
Process Management

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, the chart preparation process should be completed by specified staff. Steps to prepare a chart should be defined and an example of a chart standard should be illustrated. 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 care community management

Access and Business Development

The primary process impacting business development is access. Access is described from a patient perspective as the service availability of the practice. Access usually refers to provider availability for clinic visits, but also denotes access to physicians and APPs 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 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.

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
- 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

Operations & Access: Turning Good to Great

- Standardized processes for every key practice process
- Effective triaging of urgent patients
- Communicate with outreach and rural sites
- Processes that support capacity utilization, productivity, and growth
- Same day appointment mechanisms
- Creative access mechanisms for outreach and rural channels
Employees and Staffing

Find information about the importance of employing the right support staff, what qualities go hand-in-hand with success in your practice.

Understand the qualities of successful support staff and how they can achieve their full potential.
Support Staff

The key of any successful primary care practice starts with people. The providers must be excellent but without support staff they could not do their job. It is imperative to employ support staff that are competent, caring, and have a good work ethic. Staff that come to work in a practice should have a keen sense of the mission and vision of the office and strive to provide excellent patient care.

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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<tbody>
<tr>
<td>Nurse Practitioner/Physician Assistant (APP)</td>
<td>Most effectively works in concert with the supervising physician</td>
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</tr>
<tr>
<td>Office Nurse</td>
<td>RN/LPN</td>
<td>RN/LPN provide 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>Medical Assistant</td>
<td>MA</td>
<td>Responsible to room patients, take weight and vital signs, verify forms, and perform EKG’s and other clinical and clerical roles.</td>
</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 Clerk</td>
<td>MA or non-clinical</td>
<td>Responsible to manage patient insurance requirements for testing, procedure, or authorization.</td>
</tr>
<tr>
<td>Medical Office Specialist</td>
<td>Non-clinical</td>
<td>Responsible to greet patients, verify insurance, schedule future appointments, and collect balances and/or co-pays</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>
</tbody>
</table>

Staff Management: Turning Good to Great

- Well-defined job descriptions and roles
- Consistent job grading and pay scale management
- Staffing and productivity rationality
- All staff working at the “top of their license” by fully utilizing their capabilities and having only as many staff as are required to perform the necessary services.
- Talent management and growth plan for every practice role
- Job coaching
- Empowered leadership and management staff
- Care teams designed to provide exemplary service, and clinical expertise with staff working to the top of their license
- Regular assessments of clinical competency for unlicensed staff
Advanced Practice Providers

Gain insight into the value of utilizing APPs in primary care practices as providers to meet demands, how this is best accomplished, and what it all entails. This includes APP scope, responsibilities, staff support, models, and billing.

APPs

Practices in all markets are facing intensifying pressure to meet patient access demands, but a looming physician shortage makes meeting this goal challenging.

There is a significant opportunity to increase patient access and improve physician efficiency by utilizing APPs (nurse practitioners and physician assistants) within a primary care physician practice.
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 his or her 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. See Appendix A for resources to assist in determining the appropriate scope of practice for APPs indicated by state licensing boards and a link to prescriptive privileges.

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 his or her license in an effectively designed role, he or she 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.

Performance expectations: The APPs in the hospital role typically facilitate faster response times to referring physicians (hospitalist, ER), 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 models function generally independently of the physician provider, with supervising physician oversight, in a disease management or protocol driven clinic.

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 Options for APPs

Ensure that all billing is compliance with all application regulations.

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
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

Advanced Practice Providers: Turning Good to Great

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<tr>
<td>Physician-driven APP utilization standard</td>
<td>APPs working at the “top of their license” promoting both efficiency in the practice and provider satisfaction</td>
</tr>
<tr>
<td>Individual APP roles and responsibilities clearly defined</td>
<td>APPs driving disease focused, protocol-driven clinics</td>
</tr>
<tr>
<td>Clear expectations of the supervising physician</td>
<td>APPs facilitating care and easy practice access</td>
</tr>
<tr>
<td>Clarity on billing methodology and productivity expectations</td>
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Reputation Management (Social Media & Public Information)

See how managing social media and public information contributes to the overall reputation of your practice and how to develop strategies to actively maintain an excellent standing in the community.

Social Media and Public Information

Social media and the availability of public information provide both opportunities and challenges to primary care practices.

One challenge practices face with regard to this new category of information is accuracy. It is not uncommon 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 post on other social media sites is an excellent strategy. It is also important to monitor sites that are established and respond 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 (M3 Advocate system)

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 (Binary Fountain reports)

6. Don’t manufacture reviews

Reputation Management: Turning Good to Great

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<tbody>
<tr>
<td>• Assure that public sites have the correct information</td>
<td>• Social media is a component of the practice’s business development, patient service, and referring physician service plan</td>
</tr>
<tr>
<td>• Assign a staff member to monitor sites and register new physicians accurately</td>
<td></td>
</tr>
<tr>
<td>• Involve marketing in launching a site, and make sure messaging is in line with other promotions and the site is in compliance with policy</td>
<td></td>
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<tr>
<td>• Train staff on appropriate social media behavior</td>
<td></td>
</tr>
<tr>
<td>• Invite patients to participate and “like” the practice</td>
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</tbody>
</table>

Learn how the physician and administrative leadership dyad and the collaborative council structure models make for a successful primary care practice governance.

These models are important for providing clear delineation of duties and decision-making and in guiding operations, growth, and culture.
Practice Governance Structure

In a small practice (15 providers or less), there should be a capable practice manager and a designated physician leader.

Primary care practice governance in larger practices (15+ providers) should be composed of two major components: the physician and administrative leadership and the practice collaborative governance structure.

The large primary care practice should be led by a physician and administrative leadership dyad. The practice leaders are expected to manage the daily operations of the practice and the strategic, financial, and other performance metrics specified by the budget and policies and procedures. There should be a clear delineation of duties to avoid unnecessary conflict and confusion.

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 efficient operation, 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 most effectively lead a clinical business. The council meets regularly and is accountable for:

- Establishing 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 ensures strategic plan performance
- Establishing and adhering to a defined and openly transparent decision making process
- Managing practice key performance metrics relative to financial plan, clinical quality, customer satisfaction, human resource management, and operations performance
- Establishing practice performance standards concerning conduct, citizenship, service, and compliance, taking appropriate action where non-adherence occurs
- Establishing and enforcing practice policies as required and consistent with PSG policies and procedures

Practice Governance: Turning Good to Great

Good
- Effective practice administrator
- Effective physician leader
- Well-defined, written practice council charter

Great
- Effective dyad leadership
- Engaged council leading dynamic growth and strategy of the practice
- Clear delineation of responsibilities

Practice Compact

Learn about the practice compact – an agreement made between practice providers and administrators – what it means, how it is created, and how it is revised.

What is the 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 “two-way” provider and administrator tool that clearly articulates an agreed upon set of behavioral and performance rules that provide explicit development and management of the practice culture. The compact typically addresses all aspects of the practice including clinical, strategic, and administrative expectations, as well as behavioral expectations. The purpose of the explicit treatment of expectations is to provide a clear operating framework from which to manage the practice and also to provide guidance to the provider and administrator recruitment teams. A satisfactory compact develops a shared sense of strategic imperative and helps the practice mold and manage its culture and reach its full potential.
Outdated, unclear, or uncommunicated expectations diminish an organization’s ability to function smoothly and deliver optimal care.

Creating the 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
- The compact is part of a formal “on-boarding” process for all providers and managers
- The compact is widely known throughout the practice by all employees

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 performed as necessary to effectively manage the practice culture and be consistent with the realities of contemporary healthcare business.

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 performed as necessary to effectively manage the practice culture and be consistent with the realities of contemporary healthcare business.

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.

Practice Compact: Turning Good to Great

- Articulated compact understood by stakeholders
- Compact alignment with key policies, procedures, staff, and providers recruiting and training
- Compact involves all providers in its development
- Compact is signed by all of the providers

• Compact BECOMES the group culture
• Compact performance and compensation are linked
• Providers and staff are attracted to it
• The compact is part of the practice language; the compact manages people and the need for penalties is removed
• Compact expectations manage behavior

• 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-financially) those who become role models with the new expectations
Excellence in the primary care practice setting is a combination of many factors. A few fundamental building blocks are critical for success.

- High-quality care provided by caring and skilled professionals
- Embracing the concept of viewing the providers’ time as the practice’s most valuable asset
- Creating an environment where the focus is on a great patient experience and outcome
- Continuous improvement to make things efficient, effective, and timely for all concerned
- Using technology to drive better results

Medical practice operations is a dynamic, ever-changing field. By studying best practices from across the industry, we can be successful in bringing focus, discipline, and quality results to primary care providers taking care of patients.
## Appendix: Links, Resources, and Examples

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<tr>
<th>Section</th>
<th>Description</th>
<th>Application Note</th>
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### Suggested Reading

- **AMA: 15 questions to ask before signing an EMR/EHR agreement**
- **ACOP EHR Adoption Roadmap**
- **Medical Economics: Uncovering the bottom line of ancillary services**
- **OSHA.GOV**
- **CMS.GOV/CLIA**
- **ACP: Advice on implementing innovative rounding models**
- **Role of the Attending Physician in the Nursing Home**
- **A Toolkit for Clinicians Rounding in Long-Term Care Facilities**
- **Continuity Of Care Guide for Ambulatory Practices HIMSS**
- **Procedures for Primary Care by Pfenninger and Folwer**
- **Learn about Informed Consent**
- **Best Practices for Patient Portals HIMSS 2014**
- **Myth and Reality of Doctors Getting Overwhelmed by Emails: Forbes**
