Operations Audit

Name of Practice:

Evaluator:

Date:

This audit form is meant for the exclusive use of medical group managers to provide a comprehensive list of items to consider for a management review on a periodic (e.g., annual) basis. It should not be considered all-inclusive, and should only be used as a management tool. The form is based on the Eight Categories in the American College of Medical Practice Executive's "Body of Knowledge for Medical Practice Managers" (© ACMPE 2001).

☐ Financial Management

Compare expenses as percent of net medical revenue against normative data for your specialty (see notes at end of audit form) by dividing your expenses per category by your net medical revenue. For example, if your medical supplies were $20,000 for the year and your total revenue (or net collections) was $500,000, the "medical/surgical supplies" category would be 4% of net medical revenue ($20,000 divided by $500,000).

Expense Category
Total Non-Physician Salaries
Total Non-Physician Employee Benefit Expenses
Total Information Services Expenses
Total Laboratory Expenses
Total Radiology/Imaging Expenses
Total Physical Therapy Expenses
Total Optical Expenses
Total Medical/Surgical Supply Expenses
Total Building/Occupancy Expenses
Total Furniture/Equipment Expenses
Total Administrative Supplies/Service Expenses

Total Insurance Premiums
Total Outside Professional Fees
Total Promotion/Marketing Expenses
Total Other Interest Expenses
Total Health/Business/Property Taxes
Total Other Non-Physician Expenses
TOTAL NON-PHYSICIAN EXPENSES

[Your total non-physician expenses divided by your revenue equals your 'Overhead rate'. For primary care physicians, this should be approximately 55%; for medical specialty physicians, this should be approximately 50%; for surgical specialties, this should be approximately 35%.]

Compute Cost per Patient Visit – Total costs divided by Total patient visits:

Compute Cost per RVU – Total costs divided by Total RVUs:

[Track the cost per patient visit and per RVU over time; watch for increases to identify when your productivity is slowing while maintaining the same cost structure. It's best to have these ratios stay the same - or go down.]

Evaluate each service line by (1) volume and (2) revenue:

- Surgery
- Procedures
- Ancillaries (split lab, imaging, etc.)
- Office visits
- Hospital visits
- Other locations (nursing home, home, etc.)

What is the volume (by encounter), and what is the contribution to revenue? In other words, measure the percent of your encounters that are surgeries v. the percent of your collections from those surgeries. Look for service lines in which the volume is high, but the yield (collections) is low. Consider those services -- are they loss leaders (i.e., do we need them to promote our other service lines) or are they simply unprofitable?
Evaluate annually as reimbursement policies -- and your ability to collect -- change (e.g., laboratory used to be very profitable, and now is very unprofitable in many markets).

Billing & Collections

Category	Questions such as:

Policies & Procedures	Do I maintain written policies and procedures that are consistently applied and routinely updated?
Registration	By whom, how, and when is accurate, timely registration information captured?
Coding	What education do my providers receive regarding coding specific to the specialty? Measure their E&M bell curves for established and new patient visits, as well as consults (if applicable). Also, use collections per encounter by provider to benchmark coding.
Charge capture	What are the controls for the capture of emergency room visits? Hospital consults? Hospital visits? Office services (e.g., immunizations)
Charge entry	On average, when are my charges entered with reference to the date of service? Same day? Two weeks? Four weeks? Are they accurate? Do we proactively 'scrub' our charges to eliminate problems -- before we submit the claims?
Billing	Are the bills understandable and informative to patients? Why do patients call to discuss their bills? Are we recording their information accurately when they present their insurance card, or are they calling to correct us?
Collections	What is my current total days in accounts receivable? For each payer? Do we know what we're supposed to collect -- and collect it?
Receipt management	Are cash controls in place to ensure that all money is accounted for? Who is responsible for keying in payments? How do I know that they are correct? How do I track denials? How do I appeal them for payment?
Reporting	Who, and how often, reviews the collection rate, days in receivable and payer mix?
Budget process	What is the budget process? How do I determine future revenue? Do I account for changes in payer mix, coding patterns, reimbursement, increased

financial responsibility of patients, and my billing office operations?

*Look for the **STEM**…*
***S**treamlined processes,*
***T**imeliness,*
***E**fficiency, &*
***M**onitoring of results!*

☐ Human Resources Management

Compare staffing against normative data for specialty:

EMPLOYEE CATEGORY
Total FTE Employees Per FTE Physician (sum of categories listed below)
Administrative Staff
Business Office
Managed Care Administrative
Information Systems
Housekeeping
Other Administrative Support Staff
Registered Nurses
LPN's
Medical Assistants, Etc.
Medical Receptionists
Medical Secretaries/Transcribers
Medical Records
Clinical Laboratory
Radiology/Imaging
Other Medical Support Service

NOTE: a practice with higher volume WILL need more staff, so be sure to incorporate your volume and efficiency into the analysis when comparing your practice to normative data.

For further analysis, ask each employee to write down what they do. Take a hard look at what everyone does -- is there a task that is unnecessary? (e.g., are we making appointments for patients being referred to a dermatologist for Botox injections; why not let the patients do this themselves?) Is there a task in which we don't need to pay for the level of training that we're paying for? (e.g., a registered nurse rooming patients -- only) Are there personnel who spend more time organizing their work than actually doing it? (e.g., they use a dozen highlighters, and have folders and bins for everything... they organize 80% of the day, and do 20% of the day). During a staff meeting, share the job descriptions with everyone; this is great to do every year or so to be quell complaints about "what does *she* do?"

Observe the following for effectiveness:

- ◊ Organizational chart
- ◊ Job descriptions
- ◊ Personnel policy manual
- ◊ Training and new employee orientation
- ◊ Continuing education
- ◊ Performance evaluation tools (consider 360° reviews)
- ◊ Communication process (e.g., staff meeting)
- ◊ Compensation & Benefits – Competitive in Market?
- ◊ Incentives (financial & other)

- ◊ Cross training -- are there any functions in my practice that only one individual can do?
- ◊ Productivity monitoring & measurement – can I compare my staff against national norms and/or one another?

□ Marketing & Planning

How much time each week do I spend in planning for the future?

What type of marketing & planning activities do I conduct at present?

Am I planning for the future? Examples:

- Do I know my cost of doing business?
- Have I anticipated next year's Medicaid cap rate reductions? Medicare's RBRVS changes?
- What is the marketing strategy for my new satellite office?
- Do I need to recruit a mid-level provider to accommodate that new contract that I signed?
- Have I analyzed the contract renewals that are ready to be signed?

□ Information Management

Observe the functionality of your management information system, with regard to:

- Billing
- Collections
- Referral management
- Managed care

- Coding
- Scheduling
- Reporting

Consider the time that you purchased the system… did the system's claims become reality?

What are you doing that your computer SHOULD be able to do? (e.g., typing labels on a typewriter that sits beside the computer monitor)

How can I use my management information system to enhance my operations performance? (e.g., using the recall function to track test results; printing charge tickets to a printer in / near the nurses station to alert them of the arrival of the patient; etc.)

☐ Risk Management

- What is our compliance plan?
- Do we have copies of the corporate history?
- Do we maintain a record of the organization?
- Do we have policies and procedures related to practice safety and patient safety?
- Do we have a QA program?
- Do we maintain patient confidentiality? How?
- Do we maintain internal controls? How?

Patient/Customer Satisfaction

- Patients
- Insurance Companies
- Employers
- Referring Physicians

Recommendations include:

✓ Follow up on chart transfers by calling patients
✓ Visit insurance companies and employers for face-to-face conversations

- ✓ (Specialists' office) Conduct focus groups of primary care office managers
- ✓ Written survey

□ Governance & Organizational Dynamics

Define Mission:

Define Values:

Define Philosophy:

Consider…Have the physicians "bought in" to the mission/values/philosophy? Staff? What are we doing that is not related to our mission, and therefore, not "value-added"?

Draw the Organization Chart, including the Governing Body (e.g., Board of Directors):

Consider…Is it organized for efficient & effective decision-making? Fair & equitable representation? Clear lines of authority & accountability?

Does it promote leadership & accountability?

Does it cultivate excellent physician/administrator team dynamics?

Does it advance the development of new leaders?

Is the compensation plan fair and motivational? Is it aligned with the mission and values of the organization?

☐ Business and Clinical Operations

Medical Records

- Format and organization
- Standards
- Forms
- Filing system
- Record availability
- Retention, storage and destruction policies

When and **How** does the record coordinate with the patient?

Patient Access

- Telephone availability
  - ✓ Mystery Patient Survey
  - ✓ Anecdotal remarks from Patients and Referring Physicians
  - ✓ Telephone System Reports

- Hours of operation
  - ✓ Compare to hours that physician is actually seeing patients (e.g., if your office opens at 8 a.m., when does the physician actually SEE the first patient?)

- Triage function
  - ✓ Observe timeliness of response to patients' messages by monitoring a sampling of messages
  - ✓ Is the triage nurse handling questions for patients who could be scheduled -- and treated face-to-face?

- ✓ Is the triage nurse handling questions from patients who were just seen -- and could have been provided this information while they were in the office instead of being forced to call?

- Provider availability
  - ✓ Time to new patient appointment
  - ✓ Time to established patient, non-emergent appointment
  - ✓ Time to acute/emergent appointment
  - ✓ New patients as a percent of total appointments

- Scheduling policies & procedures
  - ✓ No-show rate
  - ✓ Number of "slots" available
  - ✓ Cancellation conversion rate
  - ✓ KEY: am I seeing patients -- or trying to deflect demand? [See literature re: open or advanced access scheduling for ideas to improve]

Patient Flow

- Check In
- Patient Intake
- Provision of Care
- Check-out

Develop a flow chart of your office, including the whereabouts of (1) paper; (2) people (staff) and (3) patients in your flow chart.

Measure the productivity of each physician and mid-level provider; recommended measurement is Work RVUs. Compare internally, as well as externally. Note that CODING patterns can influence most productivity measurements, so evaluate coding in addition to efficiency when taking action to improve performance.

For further analysis, conduct a timing study that requires your staff to time stamp each patient at each step in your flow chart (or choose which steps you want to measure). For example, (1) registration; (2) actual appointment time; (3) patient escorted to exam room; (4) physician enters exam room; (5) physician exits exam room; and (6) patient checks out of the

practice. Utilize the encounter form as your "source document" for the study.

Key Benchmarking Indicators

KEY INDICATOR	Your Practice	
Total net medical revenue per FTE physician [Net fee-for-service revenue + (gross capitation revenue less net capitation revenue) + (gross revenue from other medical activities, to include grants, sale of medical goods, etc., less cost of sales and/or cost of other medical activities)] divided by number of FTE physicians		(a)
Total operating cost per FTE physician [Total general operating cost, to include information services, medical & surgical supply, building, furniture & equipment, liability premiums, outside professional fees, marketing, laboratory, radiology, and all other non-staff operating expenses] divided by number of FTE physicians		(b)
Revenue after operating cost per FTE physician (a) minus (b)		(c)
Total physician cost per FTE physician Physician compensation plus physician benefits (do not include malpractice) divided by number of FTE physicians		(d)
Total operating cost as % of total net medical revenue Total general operating cost (see "b") divided by total net medical revenue (see "a")		
Revenue after operating cost as a % of total net medical revenue (c) divided by total net medical revenue (see "a")		
Total physician cost as a % of total net medical revenue Total physician cost (see "d") divided by total net medical revenue (see "a")		
Total support staff per FTE physician The number of full-time (1.0 FTE) support staff to the FTE count for the part-time support staff (I.e., 0.5 FTE for 20 hour per week receptionist). divided by number of FTE physicians. Note: include all staff except mid-level providers. if the practice employs mid-level providers, repeat the same ratio, except include the mid-level providers in the denominator.		

Total RVUs (or Work RVUs) per FTE physician

Sum of all RVUS performed divided by number of FTE physicians.

Square feet per FTE physician

Sum of the square footage, as defined by the total number of finished and occupied square feet within outside walls, including hallways, closets, elevators and stairways, divided by number of FTE physicians

Total gross charges per FTE physician

Gross fee-for-service charges plus usual and customary charges for patients covered by capitation contracts divided by number of FTE physicians

Percentage of total A/R 0 over 120 days old

Percentage of A/R, as defined by amounts owed to the practice by patients, third party payers, etc. that is more than 120 days old

Adjusted FFS collection percentage

Collectible revenue (exclusive of contractual and non-contractual adjustments) divided by gross charges

Number of Days gross FFS charges in A/R

Total A/R divided by Average daily gross charge (which equals Annual gross charges divided by 365)

To Benchmark Your Key Indicators with Other Practices, use Industry surveys, such as those available from the Medical Group Management Association (MGMA), or contact Elizabeth Woodcock at elizabeth@elizabethwoodcock.com for assistance.

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