Section II
Executive Summary – UNC P&A
Summary of Important Recommendations

- **Top 10 Recommendations – UNC P&A**
- **Situation**
- **Summary of Important Recommendations**
- **Summary of Interventions** *[Confidential]*

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Top 10 Recommendations – UNC P&A

1. **Reaffirm the Board of Directors as the organization responsible for the governance of the UNC P&A with the authority to establish operating strategies, policies, rules and procedures governing UNC P&A.**
   - Restructure the existing Budget and Finance Committee to be an Executive Committee responsible for the day-to-day operations and management of UNC P&A.
   - Create bylaws that include:
     - Policy formulation and decision making.
     - Oversight of performance and provision of a vision and direction for UNC P&A's future.
     - Standards development and approval.
     - Financial policy and oversight.
   - Establish the Executive Director position as a full-time position with responsibility for the overall operations and administrative leadership of the unified practice.

2. **Develop a strategic plan for UNC P&A.**
   - Develop written goals and objectives for UNC P&A.
   - Objectives are intended to set realistic expectations for the performance of UNC P&A leadership and to allow leadership to develop sound business plans.

Top 10 Recommendations – UNC P&A

3. Develop a mission-based management approach (CARTS) to account for revenue and expense at the mission level and for faculty time and effort. Use CARTS as a budgeting and strategy tool going forward.

- Utilize CARTS funds flow methodology to estimate departmental revenue targets for zero-based budgets for UNC SOM departments.
  - C Clinical Practice Income (UNC P&A, UNC Hospital clinics, other)
  - A Administrative Fees (UNC Hospital, UNC SOM, other)
  - R Research Grants (direct portion applied to salary)
  - T Teaching Payments
    - » Graduate Medical Education
    - » Undergraduate Medical Education
  - S Strategic Support (UNC Hospital, UNC SOM, philanthropy)
    - » Clinical Programs
    - » Research Activities
    - » Core/mission-critical program operating at a deficit

Top 10 Recommendations – UNC P&A

4. **Implement a departmental compensation plan that is based on CARTS mission-based allocation of funds available for compensation.**
   - Provide incentives to improve productivity.

5. ***[This recommendation is confidential and has been redacted.]***

6. ***[This recommendation is confidential and has been redacted.]***

7. **Improve clinical productivity of the faculty.**
   - Establish expectation for clinical time for each faculty.
   - Establish specialty-specific, pro-rated work RVU benchmark for each clinical faculty member.
   - Provide monthly feedback on work RVU production, including variance from the individual benchmark.

Top 10 Recommendations – UNC P&A

8. **Develop and implement a benchmarked staffing model to monitor and report support FTEs in ambulatory clinics.**
   - Overall staffing levels for ambulatory care should equal 1.0 staff FTE per 1,000 visits per year.
   - Review clinical mix of nursing staff to include RN, LPN and MAO functions. Staff clinics with appropriate level of nursing personnel to balance patient care needs with clinical efficiency and fiscal responsibilities.
   - Conduct employee satisfaction surveys and exit interviews to understand both compensation issues and non-compensation satisfiers related to staff retention.

9. **Adopt the proposed mission-based payment recommendations from the hospital to the departments.**
   - All arrangements with physicians must include a signed contract or letter agreement.
   - Contracts should include performance expectations and goals.

10. ***[This recommendation is confidential and has been redacted.]***

Situation – Funds Flow > CARTS

Assessment

- NCI employs a mission-based management methodology with the acronym “CARTS” to analyze the multifaceted activity of an academic or teaching physician.
- The separation of activity and compensation into distinct “buckets” allows for benchmarking and evaluating each mission in isolation.
  - Motivating factors can be different for different missions.
- Each of the areas below is analyzed through the CARTS methodology and compared to NCI benchmarks for similar organizations.

C	**Clinical Practice Income**	**Faculty Practice, Hospital clinics, other**
A	**Administrative Fees**	**Hospital, School of Medicine (SOM), other**
R	**Research Grants**	
T	**Teaching** **→ Graduate Medical Education (Hospital)** **→ Undergraduate Medical Education (SOM)**	
S	**Strategic Support** **→ Clinical programs** **→ Research activities** **→ Core/mission critical program operating at a deficit**	**Hospital, SOM, Philanthropy**

Situation – Funds Flow > CARTS

Assessment

- CARTS represents both sides of the payment equation, i.e., the payer and the payee.
  - For a hospital, health system or SOM, it represents payment for the services it receives from physicians, both faculty and voluntary.
    - Teaching
    - Indigent care
    - Professional services provided under global payment agreements
    - Medical administrative services
      - » Medical Directors, Unit Directors, etc.
      - » General department administrative support for SOM
  - It may also represent strategic support for both research and mission-critical services by both hospital and SOM.
  - For a department, a faculty practice plan or a practicing physician it represents the various sources of revenue available for compensation and program/practice development.
    - The source of funds is clearly defined.
    - Performance expectations should be clear.
    - Accountability is clearly outlined.

Situation – Funds Flow to School and Departments

Assessment

- The hospital purchases MD professional services from the departments.
  - $16.8M is transferred to the departments for Medical Directors, Chair support and clinical program growth and development.
    - Medical Directors and Chairs support: $13.1M.
  - There is an additional $3.6M budgeted for FY05 portion of the clinical programs growth and development commitments made to new Chairs by the hospital.
- In addition, the hospital purchases an additional $8.3M of non-MD services from the departments
  - Payments total $25.1M annually.

Academic Dept.	Med Dir& Chairs	Clinical Prog Sup '05	Sub Tot	Other Staff	Total
Anesthesiology	587,000		587,000	-	587,000
Dermatology	44,707		44,707	-	44,707
Emergency Medicine	700,000		700,000	-	700,000
Family Medicine	130,491		130,491	-	130,491
Medicine	4,865,090	1,500,000	6,365,090	-	6,365,090
Neurology	318,330	300,000	618,330	-	618,330
OB/GYN	318,975	-	318,975	-	318,975
Ophthalmology	47,205	34,185	81,390	-	81,390
Orthopaedics	83,970	1,000,000	1,083,970	-	1,083,970
Otolaryngology	174,278	-	174,278	-	174,278
Pathology & Lab. Med	3,114,971		3,114,971	-	3,114,971
Pediatrics	919,799	300,000	1,219,799	-	1,219,799
Physical Med. &	163,000		163,000	-	163,000
Psychiatry	151,943		151,943	-	151,943
Radiation Onc.	88,575		88,575	-	88,575
Radiology	500,000		500,000	-	500,000
Surgery	940,760	541,000	1,481,760	-	1,481,760
Sub-Total	**$ 13,149,094**	**$ 3,675,185**	**$ 16,824,279**	**$ 8,298,994**	**$ 25,123,273**

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Situation – Funds Flow > CARTS: Teaching

Assessment

Resident Expenses

- There are 436 Residents paid by UNC Hospital.
  - The Medicare reimbursement cap is 375 Residents (for the IME cap).
  - In addition, the hospital pays for 60 Residents, which support its mission.
  - The direct costs of hospital-funded Residents is estimated to be $19.1M.
- There are also 113 University Residents paid by the hospital, but reimbursed by the departments.
- There are 118 Residents and Fellows paid by the departments, 60 of which are out-placed to other institutions.

Department	Hosp Funded	Est. Dir Cost of Hosp Funded	Univer-sity	SOM /Other	Total
Anesthesiology Total	51	$ 2,241,375	0	2	53
Dental Total	12	$ 527,382	0	17	29
Dermatology Total	8	$ 351,588	4	0	12
Emergency Medicine Total	12	$ 527,382	11	1	24
Family Medicine Total	24	$ 1,054,765	1	0	25
McLendon Labs Total	0	$ -	6	0	6
Medicine Total	82	$ 3,603,779	16	52	150
Neurology Total	12	$ 527,382	2	0	14
Ob/Gyn Total	24	$ 1,054,765	5	0	29
Otolaryngology	12	$ 527,382	3		15
Ophthalmology Total	6	$ 263,691	2	0	8
Orthopaedics Total	19	$ 835,022	2	0	21
Pathology Total	13	$ 571,331	4	2	19
Pediatrics Total	34	$ 1,494,250	15	24	73
PM&R Total	11	$ 483,434	0	0	11
Preventive Medicine Total	3	$ 131,846	0	5	8
Psychiatry Total	36	$ 1,582,147	24	1	61
Radiation Oncology Total	4	$ 175,794	0	0	4
Radiology Total	20	$ 878,970	5	8	33
Surgery Total	53	$ 2,329,272	13	6	72
Grand Total	**436**	**$ 19,161,556**	**113**	**118**	**667**

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Situation – UNC P&A > Faculty Survey

Assessment

- An overview of the survey results, ranked from lowest to highest, is found in the table below.

Organizational Area	Score
Financial Management	2.44
Employee Issues	2.55
Marketing and Managed Care	2.68
Patient Care System	2.78
Health System Governance, Leadership and Culture	2.83
Practice Plan Governance, Leadership and Culture	2.84
Physician Issues	2.88
Outpatient Facilities and Equipment	3.18
Outpatient Personnel	3.25
Inpatient Facilities and Equipment	3.36
Inpatient Medical Records	3.37
Information Technology	3.42
Departmental Governance, Leadership and Culture	3.42
Outpatient Medical Record	3.46
Accessibility of Diagnostic Testing Services	3.51
Inpatient Personnel	3.53
Referrals and Consultations	3.54
Inpatient Consultations	3.69
Quality of Diagnostic Testing Services	3.71

Situation – UNC P&A > Organization and Governance

Assessment

- UNC faculty physicians are organized and defined as modified by the Health Affairs (HA) Code of the University of North Carolina as UNC P&A.
  - UNC P&A is defined as an accounting entity, clearly embedded in the University both from a financial and governance standpoint.
- Under its present organizational structure, it operates under the authority of the Dean of the School of Medicine and is directed by its officers and various Board structures.
- UNC P&A has operated with a Board of Directors that has had uncertain responsibility and authority.
  - It has been unclear what items require Board approval and, therefore, many decisions have been made by its leadership without clear Board authority and knowledge.
  - Interviews suggest that larger than expected reserves have accumulated in UNC P&A accounts rather than having them distributed to the respective departments.
  - The degree of centralization of UNC P&A operations is perceived by a number of Department Chairs to have adversely affected the performance and communication of the management organization.

[Portions of the Assessment are confidential and have been redacted.]

Situation – UNC P&A > Financial Reporting and Budgeting

Assessment

- The Department Chairs' ability to effectively administer their day-to-day operations and manage the performance of the clinical and research missions is limited due to the nature of the financial and operational data that is available.
  - Internal financial information, when presented, is not always consistent with its specific mission.
  - Funds are frequently transferred between missions to cross-subsidize other missions.
- The University's chart-of-accounts is not well suited for accurately tracking clinical practice expenses, and this shortcoming is compounded by cross-subsidization between missions.
- Financial reports describing the financial performance of UNC P&A practices may be inaccurate because of incomplete attribution of revenue and expense to the clinical mission, as well as by the use of clinical funds as a revenue source for research.
- Clinical revenue is frequently used to cross-subsidize research and unproductive clinical activity.
- Faculty salaries are negotiated with a base component determined by University requirements. Total negotiated amount pegged to AAMC standards (frequently between 25th and 50th% tile).
  - With minor exceptions, components are not at risk, and bonuses are granted according to uncertain criteria.
  - There has be great reluctance to reduce salaries, and shortfalls are often covered by use of reserves or cross mission use of clinical funds.

[Portions of the Assessment are confidential and have been redacted.]

Situation – UNC P&A Organization

Assessment

- Scheduling, pre-registration, insurance verification and registration are decentralized and report to the respective Department/Division Chair, not to UNC P&A, which results in inconsistent commitment to and performance of these essential Patient Access functions.
- Clinical Business Associates (CBA) are hired and supervised by each clinical department with primary responsibilities for front desk operations in UNC P&A clinics (check-in, registration, check-out, charge entry).
- Currently, a Quality Assurance department is being established.
- Centralization is envisioned for compliance, QA, managed care, patient complaints, payment posting and collections and financial reporting.
- Several Cluster teams have been discussed with functions being decentralized to the Cluster.
  - Clusters of departments will vary.
  - Goal is to reduce cost and improve service to the departments.
- A MSO community-based practice provides MSO services for community-based clinics.
  - Contract for services provided is above market rates.
  - Billing and collecting – 7.75% of net revenue.
  - EDI fees/transaction cost is in addition to those fees.
- Clinics are staffed by the departments.
  - Staffing standards vary across clinics.
  - Access also varies.
  - These areas are not the responsibility of UNC P&A.

Situation – UNC P&A > Physician Productivity

Assessment

- The UNC P&A compensation file lists 645 physicians.
- The UNC P&A billing system shows clinical production of 100 work RVUs or greater for FY04 for 662 physicians (physicians billing under 100 work RVUs annually were excluded). The billing file would include those faculty who departed during the fiscal year.

[Portions of the Assessment are confidential and have been redacted.]

Situation – UNC P&A

The following pages are confidential and have been redacted:

- **Physician Compensation**
- **Payer Mix**
- **Payer Mix Improvement: Cash Impact**
- **Cash Collections**

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Situation – UNC P&A > Ambulatory Care Access

Assessment

- Forty-four percent of weekly visits are seen on Monday and Tuesday.
- Volumes decrease to 16% on Fridays, which is expected in academic practices.
- There is less variation than expected from day-to-day during the week.
- Fifty-seven percent of appointments are seen on morning sessions; 43% seen in afternoon sessions.
- As anticipated, the lowest volume of patients are seen on Friday afternoons (6.5%).

[Portions of the Assessment are confidential and have been redacted.]

Situation – UNC P&A > Coding

Assessment

- UNC P&A coding patterns for E&M services are similar to national profiles.

  [Portions of the Assessment are confidential and have been redacted.]

Situation – UNC P&A > Operating Costs

Assessment

- Operating costs include all non-physician and non-staff costs. These are direct costs, such as medical supplies, rent, malpractice, IT, billing services, legal services and health system allocated cost for shared services.
- Accurate UNC P&A cost data is not available for analysis. Although the UNC P&A income statements reflect overhead costs, the clinical mission and the direct and indirect operating costs associated with the mission have not been clearly delineated.
- No model is developed to benchmark overhead costs.
- Frequently, overhead costs are high in academic practices due to multiple layers of taxation and health system costs, which tend to be higher than the cost of operating community practices. However, the national RBRVS reimbursement methodology pays a practice expense (PE and MP) component to academic physicians in the same manner as it pays community practices.
- When overhead costs are not at market levels, physician compensation suffers.

Situation – UNC P&A > Operating Costs

Assessment

- The UHC group on faculty practice similarly reports operating costs per work RVU ranging from $21 to $43.
- When the invoices for FY03 are broken down into their respective work and overhead components, it provides a template to managed costs.
- In the table, a proposed overhead rate is established for each department.

DEPARTMENT NAME	WRVU Total	TRVU Total	OVERHEAD RATIO
ANESTHESIA	314,391	385,641	18%
DERMATOLOGY	24,596	58,037	58%
EMERGENCY MEDICINE	89,983	119,601	25%
FAMILY MEDICINE	50,319	95,702	47%
MEDICINE	355,416	617,761	42%
NEUROLOGY	60,392	102,107	41%
OBSTETRICS-GYNECOLOGY	154,306	286,698	46%
OPHTHALMOLOGY	50,712	112,873	55%
ORTHOPAEDICS	71,461	140,629	49%
OTO - HEAD AND NECK SURGERY	57,781	125,920	54%
PATHOLOGY	59,699	100,069	40%
PEDIATRICS	199,602	286,825	30%
PHYSICAL MEDICINE AND REHAB	17,274	29,314	41%
PSYCHIATRY	66,269	94,884	30%
RADIATION ONCOLOGY	87,414	128,890	32%
RADIOLOGY	211,352	319,802	34%
SURGERY	296,743	493,115	40%
TOTAL	**2,167,709**	**3,497,867**	**38%**

Situation – UNC P&A > Provider-Based Clinics

Assessment

- Currently, two models exist to provide physician O/P services. UNC P&A bills as a Place of Service (POS) 11, which CMS defines as a physician office setting. Hospital-based clinics are billed as POS 22, which CMS defines as O/P hospital. While services rendered to patients may be identical, billing models and reimbursement differs.
- In FY03, when reviewing E&M visits (specifically codes 99201-99215), it was noted that 78% of services are billed as POS 11 and 22% of services are billed as POS 22. Additional practices have transitioned recently to POS 22, including some pediatric services.
- UNC HCS has questioned which is the better model under certain circumstances, and how a funds flow model should be designed for provider-based practices.

Summary of Important Recommendations

- **Funds Flow, CARTS and GME**
- **Faculty Practice Plan and Ambulatory Operations**
- **Revenue Cycle**
- **Case Studies**
- **Summary of Interventions** *[Confidential]*

NAVIGANT CONSULTING

Summary of Important Recommendations

Funds Flow, CARTS and GME

Clinical

- Establish expectation for clinical time for each faculty.
- Establish specialty-specific, pro-rated work RVU benchmark for each clinical faculty member.
- Provide monthly feedback on work RVU production including variance from the individual. benchmark.

Administrative

- Confirm the recommendations on administrative roles that will require the responsible VP on the hospital side and the Inpatient Medical Officer to review the individual contracts and agree to the amount of work that they wish to purchase and the budgeted amount they are willing to pay for the services.
  - Contracts should be renewed annually to determine if the work was performed adequately and if it is still required.
  - All arrangements with physicians must include a signed contract or letter of agreement containing at least a clear job description or definition of duties, expected outcomes and time limits (one-year agreements preferred), accountability and reporting relationships, compliance review by legal counsel, fair market value analysis of the compensation and “without cause” termination provisions for both parties.

Summary of Important Recommendations

Funds flow CARTS and GME

Administrative and Strategic

- NCI recommends a reduction in transfer payments to the departments from $13.1M to $9.9M, a reduction of $3,163,358 overall.

Teaching

- Monitor all resident costs, contracts and payments through the GME office.
- Appoint a GME committee that includes hospital and SOM/Departmental members to re-evaluate the mix of resident positions for strategic and mission-based justification.

  [Portions of the Assessment are confidential and have been redacted.]

Funds Flow – Non-MD Staffing Provided by UNC P&A

- Hospital VPs will negotiate with P&A to purchase services that they require from UNC P&A.
- Classify strategic investments in a program separately and require a business case justification for those investments.

Summary of Important Recommendations

Funds Flow, CARTS and GME

Medicine

- Move Urgent Care clinical revenue and expense to the ED.
- PCPs who perform O/P work in the Department of Medicine to have all ancillary testing performed by the hospital. Clinical FTE to receive payment in lieu of ancillaries.

Anesthesia

- Provide per diem payments for coverage of Labor and Delivery to compensate for poorly compensated services.
- Provide strategic support for CRNAs after transfer of the CRNAs to the Anesthesia department.
- Transfer partial savings from expense reduction of CRNAs, through improved staffing, to department.

Family Practice

- Increase administrative support to $550K for usual medical direction and strategic services.

Emergency Medicine

- Reduce administrative support to $150K for usual medical direction and service chief functions.
- Transfer urgent care to the ED.

Neurology

- Adjust administrative payments.

OB-Gyn

- NCI recommends a total of $155K for hospital-related administrative functions
- GME Assistant Dean position should be funded from GME funds.

Otolaryngology

- NCI recommends payment to Chair for ENT medical direction to be adjusted from $174K to $50K.

Summary of Important Recommendations

Funds Flow, CARTS and GME

Pathology and Laboratory

- Medical Director and Chair payments to total $925K with an additional $438K for clinical work.
- Bill anatomic pathology professional services to non-governmental payers to generate additional funding and decrease need for hospital supplementation.

Pediatrics

- NCI recommends payments for administrative and strategic services of $979K.
- Provide strategic support for primary care of $40K for 11.4 clinical FTE General Pediatricians.

Physical Medicine & Rehabilitation

- Provide payments of $143K for administrative support; reduce payment for I/P medical direction.

Surgery

- Increase payments for administrative and strategic support to be $960K.
- Provide strategic investment for trauma coverage of $1,000 per day.

Neurosurgery

- Neurosurgery to become a separate department to facilitate recruitment/retention of new faculty.

Transplant

- Study financial performance of this division and compare with like programs to determine if additional support is warranted.

Radiology

- Provide payments for administrative support of $300K.

Summary of Important Recommendations

Faculty Practice Plan and Ambulatory Operations

Organization and Governance

- Reaffirm Board of Directors responsible for the governance of UNC P&A with authority to establish operating strategies, policies, rules and procedures governing UNC P&A's operations.
- Restructure existing Budget and Finance Committee to be an Executive Committee.
- Develop standing committees for Finance, Operations and Contracting.
- Create bylaws for the new practice organization that include all organizational structures, including the new Executive Committee.
- Establish Executive Director position as a full-time position.
- Develop a strategic plan for UNC P&A.

Budgeting

- Implement departmental compensation plan based on CARTS mission-based allocation of funds available for compensation.
- Utilize CARTS funds flow methodology; target for zero based budgets for UNC SOM departments.

UNC P&A Organization

- Create a CFO position.
- Fill the role of Medicine Administrator.
- Re-negotiate the community-based practice contract(s) to reach market rates.

Summary of Important Recommendations

Faculty Practice Plan and Ambulatory Operations

Physician Productivity

- Establish expectation for clinical time for each faculty.
- Establish specialty-specific, pro-rated work RVU benchmark for each clinical faculty member.
- Provide monthly feedback on work RVU production, including variance from the individual benchmark.
- For physicians working above target production levels, establish benchmarks at current levels.
- For those below benchmarks, establish goals to increase production.
- Ensure that production increase for UNC P&A is at or greater than 7%.

Clinical Cash Distribution and Department Compensation Model

- Develop a clinical faculty compensation plan for UNC SOM departments. Plan to include incentive compensation for productive physicians and downside risk to base compensation for underperformance.

Payer Mix

[Recommendations are confidential and have been redacted.]

Summary of Important Recommendations

Faculty Practice Plan and Ambulatory Operations

Payer Mix Improvement – Cash Impact

- Renegotiate managed care contracts as they come up for renewal.
- Research departments with particularly low collections; identify opportunities for improvement.

[Portions of the recommendations are confidential and have been redacted.]

Cash Collections – Anesthesia

- Implement recommended improvements to the revenue cycle.
- Develop a reasonable agreement with the UNC HCS to financially support Anesthesia services with the expectation of defined production levels, hours of coverage and overhead costs.

Ambulatory Care Access

- Flex staffing to meet patient demand.

[Portions of the recommendations are confidential and have been redacted.]

Coding Opportunity

- Review each division and physician to identify outliers.
- Provide regular coding education to faculty.

Summary of Important Recommendations

Faculty Practice Plan and Ambulatory Operations

Ambulatory Practice Staffing

- Develop/implement benchmarked staffing model to monitor and report support FTEs in ambulatory clinics.
- Overall staffing levels for ambulatory care should equal 1.0 staff FTE per 1,000 visits per year.
- Review clinical mix of nursing staff to include RN, LPN and MAO functions.
- Target goals to reduce ambulatory practice employee turnover rate from current 14.5% to 16.1% range to best practice level of 12%.
- Offer options of flexible schedules and part-time employment in the ambulatory area.
- Hire staff with public relations and hospitality skills from outside the health care industry. Invest in training them for non-clinical roles.

Operating Costs

- Develop/implement benchmarked overhead expense model to monitor, manage and control operating and indirect costs.
- Use MGMA cost survey by specialty as one guideline to identify what overhead costs should be.

Malpractice Costs

[Recommendations are confidential and have been redacted.]

Summary of Important Recommendations

Faculty Practice Plan and Ambulatory Operations

Provider-Based Clinics

- Establish provider-based practices upon thorough financial review of a practice's payer mix and reimbursement environment. If Medicare APCs, technical payments from managed care payers and cost report recoveries for Medicare and Medicaid provide additional revenue to the enterprise, provider-based practices should be implemented.
- UNC P&A to operate all ambulatory practices with a service agreement between UNC P&A and the hospital and an appropriate level of shared risk for costs.
- A provider-based model will be successful if a balance for all entities is achieved. There must be a level of integration that aligns the interests of the physicians and the hospital, and the management structure must encourage active participation and endorsement of mutually beneficial strategies.
- Develop a management services agreement between the faculty practice plan and the hospital. The purpose of the agreement is to delineate a funds flow methodology and outline an operational structure that will place the hospital and the physicians at equal risk for overall performance.

Scorecard

- Daily "flash report" should include a short list of practice statistics.
- Monthly scorecards should report, track and trend multiple categories of statistics.
  - Generating these data elements from existing systems will require dedicated effort and tools and well as adequate IT resources.
- Consider purchasing decision support system to meet reporting needs without driving up IT costs excessively.

Summary of Important Recommendations

Revenue Cycle/UNC P&A

Organizational Structure

- Consolidate leadership of the entire revenue cycle for physician practices to one executive.
- Develop a revenue cycle training overview for clinical department administrators and managers.
- Implement a comprehensive centralized Patient Access model.
- Establish system-wide Patient Access Council (PAC) with representation from UNC P&A and UNC Hospitals.

Pre-Arrival Services

- Standardize data elements collected during scheduling process.
- Develop a Centralized Pre-Arrival Unit.
- Require real time electronic insurance verification for unscheduled patients.
- Create a “no authorization, no service” policy for elective patients.

Registration and Patient Access

- Continue to promote time-of-service payments and coordinate with UNCH.
- Enhance efforts to collect time-of-service payments.
- Review options to ensure patient interview privacy at time-of-service.

Registration Data Quality

- Establish accountability for registration data quality.
- Develop an extensive Patient Access Data Quality Improvement initiative.

Summary of Important Recommendations

Revenue Cycle/UNC P&A

Financial Counseling

- Encourage UNC P&A and UNCH meetings with targeted third parties for contract compliance.
- Evaluate charity policy in coordination with UNCH.

Total Uncollectibles

- Enhance upfront collections process.
- Continue to maximize application processes for Medicaid and other coverage alternatives.

Payment Variance

- Enhance internal Payment Variance follow-up program.

Cost to Collect

- Design and implement a productivity management system within the UNC P&A revenue cycle with particular focus on Patient Access and the Business Office.
- Evaluate current vendor contracts, performance, cost and return. Determine if RFPs should be submitted for competitive pricing and contract negotiations.

Charge Lag / Cycle Time

- Reduce average cycle time from DOS to bill date.
- Evaluate handheld technology solutions that can facilitate improvement in charge processing.

Suspended Charges / Unbilled

- Standardize charge entry process and implement 24-hour charge capture policy.

Summary of Important Recommendations

Revenue Cycle/UNC P&A

Aged AR

- Prioritize workflow activities in the business office to address high-dollar aged accounts more aggressively.
- Focus business office workflows based off no response and denial-related follow-up activities.
- Reevaluate business office workflows and business rules to ensure optimal follow-up technique and aged accounts are aggressively pursued.
- Focus on cash acceleration to reduce aged invoices receivable greater than 90 days old.
- Improve self-pay collections by targeting new access and financial counseling procedures.

IT Systems and Functionality

- Evaluate and confirm need for bi-directional query access to coding applications between UNC Hospitals and UNC P&A.
- Implement protocols for capturing and addressing revenue cycle issues.
- Evaluate and implement Medical Necessity software in conjunction with UNCH.
- Optimize resource scheduling tool. Evaluate enterprise-wide scheduling to be used for both UNC P&A and UNC Hospitals for potential purchase ASAP (2005-2006).
- Evaluate use of CT Vision for increased functionality.
- Expand and implement Sovera aggressively across UNC P&A.
- Evaluate current INVISION system purging criteria with UNC Hospitals.
- Evaluate and confirm need for bi-directional query access to coding applications.

Summary of Important Recommendations

Case Studies – Orthopaedics
New Patient Appointment Availability

- Perform a comprehensive analysis to identify specific specialty clinics with least availability for new patient visits.

Patient No-Show Rates

- Set a reasonable goal to reduce patient no-shows.

Faculty Physician Productivity

- Set target RVUs for each clinical provider to monitor productivity and growth. Explore use of mid-level providers and/or the hiring of additional clinical faculty as practice grows.

Payer Mix

- Develop and implement policies regarding the collection of self-pay accounts that will balance the mission of patient care with fiscal responsibilities of the department.

Cash Collections

- Develop a strategy to increase collections from self-pay patients, manage self-pay population and increase access to better payers.

Summary of Important Recommendations

Case Studies – Orthopaedics

Clinic Staffing Mix/General Operating Costs

- Review clinical mix of nursing staff.
- Staff clinics with appropriate level of nursing personnel to balance patient care needs with clinical efficiency and fiscal responsibilities.

General Operating Costs

- Perform detailed analysis of Orthopaedic's overhead to identify areas for expense reduction.

Documentation & Coding Review

- Implement mandatory, ongoing training and education program for physicians and coding staff.
- Create a "Resource Manual" from publicly available information; review with providers when reviewing audit results.
- Devise an ongoing Audit Program and appoint an overseer.
- Conduct periodic audits and review all audit results with providers.

Summary of Important Recommendations

Case Studies – Cardiology

New Patient Appointment Availability

- Perform comprehensive analysis to identify specific clinics with lowest availability for new patient visits.
- Set a reasonable goal to increase access for patients through increased clinic times or realignment of current clinics to include more new patient visits.

Patient No-Show and Walk-In Rates

- Develop plan to reduce patient no-show rate through patient appointment reminders.

Faculty Physician Productivity

- Develop target goals for faculty production and implement incentives for increased faculty production.
- Improve scheduling appointment templates to improve productivity.

Payer Mix

- Develop a strategy to increase managed care population/commercial patient population.

Summary of Important Recommendations

Case Studies – Cardiology

Cash Collections

- Perform a quantitative RBRVS analysis by payer to determine where collection problems exist.
- Develop target RBRVS % for each payer, and implement plan to reach target.
- Collect all payments at time-of-service for those payers that require co-pays, and develop a sliding scale payment plan for self-pay patient.

Documentation & Coding Review

- Implement mandatory, ongoing training and education program for physicians (Residents, students and attendings) and coding staff utilizing many mechanisms.
- Create a “Resource Manual” from publicly available information and review with providers when reviewing audit results.
- Devise an ongoing Audit Program and appoint an overseer.
- Conduct periodic audits and review all audit results with providers.

Summary of Interventions – UNC P&A

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