Section IV
Faculty Practice Plan & Ambulatory Operations – UNC P&A

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NAVIGANT CONSULTING

Summary of Recommendations

Organization and Governance

- Reaffirm Board of Directors as the organization responsible for the governance of UNC P&A with the 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.
- Adopt the proposed organization structure.

Summary of Recommendations

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.]

Payer Mix Improvement – Cash Impact

- Improve access for plans identified as better payers.
- Renegotiate managed care contracts as they come up for renewal.
- Enforce a policy to collect payment at time-of-service for self-pay.

Summary of Recommendations

Cash Collections

- Research departments with particularly low collections; identify opportunities for improvement.
- If payer issues are found, follow up with managed care companies; renegotiate.
- Improve collection of patient portion of Medicare charges, increasing the overall RBRVS Medicare collection rate from 90% RBRVS to 95% RBRVS.
- Improve self-pay collections. A reasonable target would be 50% RBRVS.
- Establish, implement and enforce policies to collect patient portions at the time-of-service.
- For self-pay patients, implement a discounting policy for prompt payments.

Cash Collections – Anesthesia

- Develop and implement a UNC-wide payer mix strategy.
- Implement recommended improvements to the revenue cycle.
- Develop a reasonable agreement with 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.

[The remainder of these 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 Recommendations

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 MOA functions.
- Target goals to reduce ambulatory practice employee turnover rate from current 14.5% to 16.1% range to best practice level of 12%.
- Conduct employee satisfaction surveys and exit interviews.
- Offer options of flexible schedules and part-time employment in the ambulatory area.
- Hire staff with public relations and hospitality skills from outside the healthcare industry – invest in training them for non-clinical roles.

Operating Costs

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

Malpractice Costs

[Recommendations are confidential and have been redacted.]

Summary of Recommendations

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 as well as adequate IT resources.
- UNC P&A should consider purchasing a decision support system to meet these reporting needs without driving up IT costs excessively.

Faculty Practice Plan – Faculty Survey

Assessment

- A faculty survey was distributed via e-mail to all clinical faculty in order to better understand the faculty's perspective with regard to key areas of UNC HCS and UNC P&A operations. The survey tool is found in Appendix A.
- 324 responses were received (approximately 49% response rate). Responses spanned all 19 UNC P&A departments.
- Average time on faculty was 9.5 years.
- The academic rank of the respondents was as follows: Assistant Professor 35%; Associate Professor 31%; Professor 34%; Department Chair 0%.
- The following scale was used for the survey responses:
  - 1 Unacceptable, hinders performance
  - 2 Needs improvement
  - 3 Acceptable
  - 4 Good or noticeably improving
  - 5 Excellent, no change needed
- The overall survey score was 3.14, which is favorable compared with NCI's experience with other academic practices. By academic rank, the scores varied as follows: Assistant Professor 3.19; Associate Professor 3.12; Professor 3.10.
- Scores for individual items ranged from a low of 2.0 for "Knowledge of Managed Care Arrangements" to a high of 4.1 for "Access to Webcis."

Faculty Practice Plan – 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

Faculty Practice Plan – Faculty Survey

- Faculty survey – results detail:

Organizational Area	Score
Outpatient Facilities and Equipment	**3.18**
O/P Facilities and Equipment: General Office Design and Layout	2.97
O/P Facilities and Equipment: Medical Equipment	3.30
O/P Facilities and Equipment: Maintenance & Repair	3.15
O/P Facilities and Equipment: Med/Pharmacy Supplies	3.31
Outpatient Medical Record	**3.46**
OMR Chart Format	3.10
OMR Transcription Turn Around Time	3.97
OMR Transcription Accuracy	3.54
OMR Access to Office Records	3.54
OMR Access to Other Clinical Records	3.32
OMR Access to Hospital Records	3.31
Outpatient Personnel	**3.25**
O/P Quality of Nursing Care	3.58
O/P Availability of Nurses	2.96
O/P Quality of Clerical Staff	3.20
Availability of Clerical Staff	3.25

Faculty Practice Plan – Faculty Survey

Organizational Area	Score
Patient Care System	**2.78**
PCS Access-Appointment Availability	2.77
PCS Patient Registration	2.84
PCS Scheduling and Appointment System	2.52
PCS Patient Satisfaction	3.00
Marketing and Managed Care	**2.68**
Marketing and Managed Care Practice Growth	3.03
MM Community Reputation	3.15
MMC Managed Care Rates	2.41
MMC Participation in MC Contracts	2.48
MMC Marketing Efforts	2.21
MMC Knowledge of MC Arrangements	2.02
MMC Relationship with Referring Physician	3.43
Financial Management	**2.44**
FM Insurance Billing and Collections	2.30
FM Patient Billing and Collections	2.31
FM Coding and Fee Schedule	2.69
FM Budgeting Process	2.47

Faculty Practice Plan – Faculty Survey

Organizational Area	Score
Information Technology	**3.42**
IT Access to Web CIS	4.10
IT Functionality of Web CIS	3.44
IT User Friendliness of Web CIS	3.26
IT Improvement from Upgrades	3.36
IT Telephone System	2.95
Physician Issues	**2.88**
Physician Issues: Physician Productivity	3.28
Physician Issues: Compensation and Benefits	2.48
Physician Issues: Recruitment, Retention and Turnover	2.76
Physician Issues: Group Culture	3.01
Physician Issues: Role and Utilization of Mid-level Providers (PAs, NPs)	2.63
Physician Issues: Credentialing Process	3.15
Employee Issues	**2.55**
Employee Issues: Staffing Levels	2.55
Employee Issues: Recruitment and Retention	2.48
Employee Issues: Staff Training and Development	2.74
Employee Issues: Staff Salaries and Benefits	2.46
Employee Issues: Employee Satisfaction	2.55

Faculty Practice Plan – Faculty Survey

Organizational Area	Score
Referrals and Consultations	**3.54**
RC Quality of Consultations	3.80
RC Accessibility of Consultations	3.18
RC Information obtained from Colleagues	3.64
Quality of Diagnostic Testing Services	**3.71**
Quality of Diagnostic Testing Radiology	3.66
Quality of Diagnostic Testing Pathology	3.76
Accessibility of Diagnostic Testing Services	**3.51**
Accessibility of Diagnostic Testing: Radiology	3.33
Accessibility of Diagnostic Testing: Pathology	3.69
Inpatient Facilities and Equipment	**3.36**
Inpatient Facilities Design and Layout	3.30
Inpatient Facilities and Quality of Medical Equipment	3.45
IFE Accessibility of Medical Equipment	3.32
IFE Equipment Maintenance and Repair	3.30
IFE Accessibility of Medical Supplies	3.41

Faculty Practice Plan – Faculty Survey

Organizational Area	Score
Inpatient Medical Records	**3.37**
Inpatient Medical Records Chart Format	3.17
IMR Transcription Turnaround Time	3.71
IMR Transcription Completeness and Accuracy	3.48
IMR Access to Office Records	3.28
IMR Access to Other Clinic Records	3.25
IMR Access to Hospital Records	3.32
Inpatient Personnel	**3.53**
I/P Personnel Quality of Nursing Care	3.71
I/P Personnel Availability of nurses	3.25
I/P Personnel Quality of Clerical Staff	3.20
I/P Personnel availability of Clerical Staff	3.06
I/P Personnel Pharmacy Staff	3.89
I/P Personnel Respiratory Therapists	3.67
I/P Personnel OT/PT	3.70
I/P Personnel Registered Dieticians	3.55
I/P Personnel Social Work	3.77
Inpatient Consultations	**3.69**
I/P Consultations - Quality of I/P Consult	3.77
IC Accessibility	3.62

Faculty Practice Plan – Faculty Survey

Organizational Area	Score
Health System Governance, Leadership and Culture	**2.83**
UNC Health System: Governance, Leadership Medical Leadership	3.29
UNC Health System: Administrative Leadership	2.98
UNCHS Organizational Structure	2.81
UNCHS Communication	2.71
UNCHS Ability to Deal with Conflict	2.64
UNCHS Ability to Make Decisions	2.80
UNCHS Ability to Change and Implement Decisions	2.65
UNCHS Effectiveness of Board and Board Committees	2.75
Practice Plan Governance, Leadership and Culture	**2.84**
UNCFPP Effectiveness of New Leadership	3.07
UNCFPP Organizational Structure	2.91
UNCFPP Communication within the Organization	2.85
UNCFPP Ability to Deal with Conflict	2.76
UNCFPP Ability to Make Decisions	2.75
UNCFPP Ability to Change and Implement Decisions	2.71
Departmental Governance, Leadership and Culture	**3.42**
Dept Governance: Medical Leadership	3.72
Dept Governance: Administrative Leadership	3.49
Dept Governance: Relationship with the Hospital	3.24
Dept Governance: Relationship with the SOM	3.50
Dept Governance: Autonomy of Medical Group	3.23
Dept Governance: Accountability	3.36

Faculty Practice Plan – Faculty Survey

Several open ended questions were included in the survey. A sampling of these responses follows:

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

What are the top three items UNC's leadership needs to focus on in FY05?

- Physician and staff contentment and retention. UNC suffers from loss of staff, loss of experience and a resulting shortage of manpower on a daily basis due to staff (OR staff, ICU RNs, physicians) leaving for more money or support elsewhere. UNC would be a better place if people were incentivized more effectively to do their jobs as well as possible here at UNC.
- 1) Developing a vision. 2) Having a true clinical and administrative leader. 3) Pairing authority with responsibility and identifying responsibility.
- Integrating the Medical School and Hospital systems. Improving patient relations, especially in O/P scheduling, arbitrary appointment changes. Reducing staff turnover. Improve conditions for RNs, especially.
- Ownership
- Faculty retention
- 1) Providing clinicians the resources (time, money, modern equipment) to provide excellent patient care and teach. 2) Focus on content, not appearances of change.
- 1) Increase salaries. 2) Improve scheduling system. 3) Improve access to consultants.
- 1) Preserving the clinical mission of the medical center. Clinical care is what lends credibility to the institution in the eyes of the taxpayers who support it. 2) Preserving the service mission of the institution. 3) Keeping the paying customer happy so that that person can subsidize the first two priorities on this list. That means more flexible and responsive clinical systems with a consumer-minded philosophy.
- Balance clinical demands against other missions. Defining unique service mission to public (hospital for the people of NC). Improving physical plant, including IT support.

Faculty Practice Plan – Faculty Survey

What are the top three items UNC's leadership needs to focus on in FY05 ?

- Physicians, physicians, physicians. We are losing excellent faculty staff to other hospitals. Someone needs to remember that UNC cannot build an excellent reputation without excellent, happy physicians (and nursing staff). We also need to find ways of supporting our younger faculty (better mentorship and clinical support).
- Financial stability – with increased diversion of federal money towards war, it is likely that federally funded and subsidized programs will need to make cutbacks. We need to be in a position to survive even if Medicare, Medicaid, Tricare all have severe cuts.
- Improving the "culture" of pessimism. Improving compensation to attract and retain the best doctors. Overcoming bureaucratic inertia.
- 1) Building a team atmosphere – so that everyone understands the mission and buys in. 2) Improving clinical efficiency – decreasing registration times, improving patient transport, improving nursing effectiveness, etc. 3) Improving customer satisfaction on all levels.
- 1) Providing a clear incentive program that incorporates clinical practice, teaching and research. 2) Marketing. 3) Building camaraderie within departments that is often negatively impacted by divisional financial pressures.
- Distribution of work needs to be equitable. Faculty need to be held accountable for their time and behavior and should be compensated accordingly. Discrepancies in salaries are demoralizing. Parking is awful.
- Clear mission and vision that incorporates the health care practice of the clinicians. The operating model needs to be more fluid; we still administer the practice of health care as if we were living in the 1960s.

Faculty Practice Plan – Faculty Survey

Name one decision made within the last three months that resulted in a positive change.

- Dean's open forums and meetings.
- Tough. We have had two decisions made by leadership that resulted in negative change. Otherwise, status quo.
- Renovating Burn Center!!!! Thanks very much!!!!
- Unable to name.
- Gary Park and Bill Roper.
- Can't think of any.
- New administration.
- Providing maternity leave benefits.
- Parental leave policy, though I wish it were more efficiently implemented and with less anger from the administrative leadership.
- More communication by medical and administrative leadership.
- I like the new e-mail newsletter re: what is going on with physicians in the hospital.
- Impromptu tours by administrative leaders are a good way to show that the administration cares about our area.
- Improvement of the Webcis.
- New leadership on Board.
- Decrease in UNC P&A taxes.

Faculty Practice Plan – Faculty Survey

Name one thing you would change to improve patient care.

- More nurses.
- More staff for patient registration, check-out and scheduling.
- Reduce and review need for all clerical barriers to facilitate patient care; many are redundant and outdated. Improve operating room efficiency.
- Patients should be able to receive timely referrals with sub-specialists.
- Better communication between colleagues.
- More parking.
- Get the Ritz Carlton attitude. We need to have pride in this wonderful institution.
- Get more translators!!!

Faculty Practice Plan – Faculty Survey

Has your personal level of job satisfaction changed within the last year? How has it changed?

- Dissatisfaction related mainly to how difficult it is to deliver clinical care – the system is too cumbersome. Selected comments are listed below:
  - It is slowly and continually dropping. With the new Dean, President of UNCH and restructuring of UNC P&A, there is still hope for positive change, but more concrete change needs to be seen by the general physician staff. Again, my major frustration is with my need to perform many of the administrative duties that my clinical program's administrative director is currently being paid to perform, but is incapable of doing.
  - It has improved because any change would result in a better environment in the ED. Even the possibility of change improves satisfaction.
  - Yes – job has become one of increasing work load and decreasing resources.
  - Yes – I feel better that the administration is really trying to fix things.
  - I am very tired. Long days, many weekends. If it weren't for the patients, I'm not sure it would be worth it. It's the satisfaction that at the end of the day I know I made a difference in someone's life. It's that connected feeling.
  - I have been very satisfied.
  - Although I think that the bureaucracy does not adequately support service delivery, I have good job satisfaction and am generally satisfied with the level of care that I am delivering.

Faculty Practice Plan – Faculty Survey

Has your personal level of job satisfaction changed within the last year? How has it changed?

- About the same, but generally high in spite of average marks above. I believe in the institution and believe that things can get better relatively easily.
- I am more optimistic as a result of the leadership changes, but at the same time I have never worked so hard in my life. The level of effort required of me is unsustainable. There is a short window of opportunity for the new leadership to develop a plan and start to make decisive changes.
- It has improved as I have gotten involved in institutional committees working for change.
- Decreased. The dichotomy in salary between University and private practice has always been excessive, but UNC has NOT kept pace with even other universities.
- Diminished due to more onerous bureaucracy, officious administrative staff and less efficient UNC P&A staff.
- I am lucky. I love what I do. I have been around long enough. I know the system.
- I have an extraordinarily high level of career satisfaction, which has nothing to do with my "job" at UNCH.
- I have been discouraged by the lack of personal feedback.
- It has declined considerably. I love my patient care. I hate the administrative aspects of working in this environment.
- I've always been happy with my job. It could be easier and I could get paid better, but that's not the main reason why I'm here. I still want a raise though.

Faculty Practice Plan – Faculty Survey

Who are the leaders and/or role models you respect in this organization?

- The names of 136 individuals were submitted as an answer to this question. Thirty-six people were mentioned by three or more respondents. This is an unusually long and encouraging list!
- Those seen as leaders of this organization (ranked from highest to lowest of the top ten) are:
  - Gary Park
  - William Roper
  - Marschall Runge
  - Anthony Meyer
  - Robert Golden
  - Andrew Greganti
  - Frank Longo
  - Alan Stiles
  - Shelley Earp
  - Gene Orringer
- The following are selected comments reflecting the most common themes:
  - Bill Roper, as he is mobilizing strategy for change; Gary Park because he is visible and acts as if things matter to him personally.
  - Gary Park for his on-the-ground and very visible presence; has personal contact with all members of the "team."

Faculty Practice Plan – Faculty Survey

Who are the leaders and/or role models you respect in this organization?

- I am very optimistic that the Dean will take an interest in this and effect change.
- I have great respect for all that the leadership is trying to do. I am most frustrated with the slow pace of improvement in UNC P&A, although I have hopes that wide recognition of this problem will result in accelerated improvement.
- My role models are the Senior Physician Faculty throughout the institution, who embody the qualities and characteristics which I consider to be necessary in a good physician. Their experience in the field of medicine and their ability to have weathered the major changes in the practice of medicine with dignity and professionalism are remarkable. UNC should be extremely proud: The medical faculty contained herein are some of the BEST!
- Surgeons who do their job with precision and care every day and, in spite of mistreatment and low pay, have continued on here because they believe in the beauty of education.
- It is amazing to see the changes with Mr. Park and Dr. Roper. It's fantastic. Hope springs eternal. But I see some real interest and caring. It's very exciting.
- Daniel von Allmen, MD, Pediatric Surgery Division Chief. I would walk through fire for him because I know he would do the same for me.

Faculty Practice Plan – Faculty Survey

What would you like NCI to achieve during this consulting engagement?

- Move us closer to a flexible, iterative, data-driven process and structure that integrates, enhances, and promotes our multiple missions and nurtures the talents of all who work here. That effort should define our health care system.
- Restructure, vitalize and modernize leadership.
- Increase patient sensitivity, improve morale, outline plan to increase collections.
- Forward ideas for change to UNC HCS administrators. Make summary of results available for all survey participants.
- Make some real suggestions about how to improve patient care and delivery.
- Assist with merging into one system.
- Have a realistic assessment of the limitations that prevent UNC from being a hospital of excellence. I would hope that action items recommended by you would be implemented in a way that can be observable by those who work here, and not just an expensive endeavor of futility.
- Reassure us that we are doing a great job. Support our academic mission as well as our patient care mission. Help us identify areas of growth and promising potential for development. Insure that our administrators understand the need for us to stay on the cutting edge of medicine by investing in these areas, even if it is money losing in the short term. Thanks for carefully reviewing our policies and procedures and for helping us improve.
- Dig hard and deep to address the issues at hand, provide honest feedback.

Faculty Practice Plan – Faculty Survey

What would you like NCI to achieve during this consulting engagement?

- Make UNC more "user-friendly" for patients.
- List of concrete potential interventions that have promise to improve patient care, patient satisfaction, margin, employee satisfaction, physician satisfaction.
- Give us the means to prosper.
- I simply want Navigant to utilize experience gained in academic centers with similar problems and make a firm set of recommendations that define the difficult changes that will be required for us to become a more efficient, patient-friendly and referring physician-friendly system.
- A recommendation from Navigant that focuses on hospital throughput issues, leadership structure, and employee satisfaction would improve the organization and lead to better patient care.
- Ability to blend traditional academic pursuits (teaching, research) with realities of business side of medicine in the 21st century.
- Fix UNC P&A.
- I hope Navigant will propose strategies at many and varied levels which will ultimately have this result: As a physician, I may be able to provide high-quality patient care EASILY, without encountering a "hassle" at every other turn. Teasing through the varied "hassles" that have become the NORM these days leads finally, in almost every instance, to an inadequacy of "support staff" for physician work, be it nurses, clerical workers or administrative positions.
- Make sure we have a true leader – one that can lead the troops into battle. Leaders do not need the spotlight. Leaders take care of their people. Leaders make others look good. Leaders take the blame. Leadership is character.

Faculty Practice Plan – Faculty Survey

Recommendation

- As part of UNC P&A's strategic plan, address those areas of particular concern to practicing faculty. These are as follows:
  - **Financial Management**
    - Insurance billing and collections
    - Patient billing and collections
    - Budgeting process
  - **Employee Issues**
    - Staff salaries and benefits
    - Recruitment and retention
    - Staffing levels
    - Employee satisfaction
  - **Marketing and Managed Care**
    - Managed care arrangements and participation in contracts
    - Marketing efforts
    - Managed care rates
  - **Physician Compensation**
    - Physician satisfaction with the work environment
  - **Access to care and scheduling system**

Faculty Practice Plan – Faculty Survey

The following are comments from faculty regarding areas needing the most improvement. Issues identified are as follows:

- **Financial Management**
  - It's a mess.
  - What budgeting process? I have never seen one.
  - This is where we have the most problems, reimbursement, billing and coding!!!
  - UNC P&A is comparable to the Haliburton of medicine: dysfunctional, ineffective and a monetary drain.
  - This area is a disaster. The bookkeeping system is so obscure that as a MD, PhD with ten years of leadership in the institution, I need my administrator to help me remember what the reports mean. Disaster.
  - This has been the most frustrating aspect of working at UNC. Coding, billing, assigning patient stays – all difficult. Budget seems archaic, and expenditures are not correlated with profits. It's impossible to be innovative.

Faculty Practice Plan – Faculty Survey

Issues identified

- **Employee Issues**
  - Clinic receptionists are our window to the public; some are impolite and poor patient advocates.
  - Poor telephone access, under-educated clerical staff, some nursing staff lack motivation.
  - Some nurses seem to be on academic time.
  - They all try, it appears overwhelming for them at times.
  - Often without clerical support and all pitch in to complete. (I have been told that I am a good secretary).
- **Marketing and Managed Care**
  - No need for marketing, we are overflowing.
  - Marketing efforts would likely increase clinic activity further – at this point, that's not what I want – wouldn't be able to handle more clinical work.
  - I have little knowledge of our managed care arrangements.
  - I have NO idea what has been negotiated for me.

Faculty Practice Plan – Faculty Survey

Issues identified

- **Physician Issues**
  - For one of the top Family Practices in the country, we are in the bottom quarter of salaries. Often feel competing with teaching, administration and patient care and need to do more patient care but not enough time with other commitments (and we don't get compensated).
  - Three different services – each an island among themselves, little active group culture.
  - The bureaucratic load created by the University greatly reduces my productivity.
  - Compensation plan needs to be more incentive-based.
  - Clinicians need to feel appreciated and listened to; in the past they were talked at. The good news is that these are smart folks with substantial room for improvement. Good sense of mission in the organization.
- **Access to Care and Scheduling System**
  - From patient perspective, scheduling is most frustrating issue.
  - Plenty of people in clinic, but very inefficient and they do not contribute to patient care or efficiency.
  - SMS is a disaster – we need to abandon this system STAT; it's not fixable and is a major barrier to functioning efficiently.

Faculty Practice Plan – Faculty Survey

Issues identified

- **Access to Care and Scheduling System**
  - We need "open access" scheduling same-day or next-day appointments are available. As an internist practicing primary care medicine, I have made efforts to not congest my schedule. The most frequent compliment I receive pertains to my availability.
  - All I hear about are complaints about people answering the phones, how long it takes, no one is polite, no one answers the phones in a timely fashion, the wait in the clinics is too long, etc.
  - Parking is unacceptably difficult and expensive. Registration is time consuming. Our institution in not "user-friendly", and I have had patients go elsewhere for care specifically for those reasons.
  - Patients are not treated as the reason we exist.
- Favorite quote from faculty: “Good luck changing a dinosaur into a small mammal!”

Responsibility

- P&A Leadership

Timeframe

- 2006

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.

Organization and Governance

Assessment

- The HA code also stipulates that the University will maintain accounts for revenue from all professional activities of the faculty and that accounting and reporting systems be maintained and utilize the University's chart of accounts and object codes.
  - Use of the University accounting methodologies and use of funds across missions has led to poor understanding of the operational performance of UNC P&A.
  - There appears to be no accurate profit and loss statement that reflects the actual performance of the faculty practice.
- There has been a concerted effort to decentralize the billing and practice management functions, starting with pilot projects in the Departments of Surgery and Neurology.

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

Organization and Governance

Recommendation

- Reaffirm the Board of Directors as the organization responsible for the governance of UNC P&A with the authority to establish operating strategies, policies, rules and procedures governing UNC P&A's operations.
  - The Board of Directors is designed to be inclusive, representing the interests of all departments and individuals.
  - The Board of Directors should be comprised of the following individuals:
    - UNC P&A President, who shall be automatically appointed by virtue of his/her position.
    - Department Chairs representing each of the following SOM clinical departments:

Anesthesia	***Orthopaedics***
Dermatology	***Otolaryngology***
Emergency Medicine	***PM&R***
Family Medicine	***Pathology***
Medicine	***Pediatrics***
Neurology	***Psychiatry***
OB/GYNE	***Radiation Oncology***
Ophthalmology	***Radiology***
	Surgery

Organization and Governance

Recommendation

- The Board of Directors shall be comprised of the following individuals:
  - Five at-large, non-chair faculty members, who shall be appointed by the Board of Directors representing one from each of the following groupings of departments:
    - Medicine
    - Surgical Departments and Divisions
    - Maternal and Child Health
    - Hospital-Based Departments
    - Neurosciences
  - Four non-voting members who shall consist of the following:
    - Dean of the SOM or designated representative
    - Hospitals Director
    - Executive Director of UNC P&A
    - Finance Director of UNC P&A

Organization and Governance

Recommendation

- The role of the Board of Directors shall be to provide oversight, set policy and approve all operational activities for the UNC P&A.
  - Oversee, set policy and provide guidance to the UNC P&A Executive Committee and management for UNC P&A operations.
  - Review the activities of and reports from UNC P&A committees.
  - Oversee UNC P&A's planning and marketing activities.
  - Approve and implement guidelines for the execution of provider contracts for clinical services.
  - Set policy and approve the approaches for charging for UNC P&A services and recovering overhead.
  - Select at-large members for the Executive Committee and members of other UNC P&A committees.
  - Review and make recommendations regarding policies that affect the UNC Hospitals and the SOM.
- The Board of Directors shall meet at least quarterly.

Organization and Governance

Recommendation

- Restructure the existing Budget and Finance Committee to be an Executive Committee responsible for the day-to-day operations and management of the UNC P&A.
  - This Committee will be small, functional and able to deal in a timely fashion with the operational details of running a large, multi-specialty group practice.
  - Membership to include the UNC P&A President, Executive Director and eight additional faculty members comprised of a mix of Department Chairs and non-chairs (clinically active faculty).
    - Executive Director is non-voting.
    - President is non-voting, except as tie-breaker.
    - Voting members are the eight clinical faculty members.
  - Committee goals to include:
    - Supports, advises and contributes to the success of the practice plan.
    - Represents the interest of the full-time clinical faculty.
    - Deploys system resources in ways that benefit stakeholders and ensures the long-term financial viability of UNC P&A.
    - Formulates a vision for the clinical organization to include measurable goals and objectives.
    - Leads change and communicates a consistent message throughout the organization.
    - Develops physician leadership.

Organization and Governance

Recommendation

- Form an Executive Committee responsible for the day-to-day operations and management of UNC P&A.
  - The Executive Committee will meet at a minimum each month and preferably every two weeks.
  - Membership of the Executive Committee to be determined by a vote of all clinical faculty, or a vote of the Chairs to select the Chairman representation, and a vote of the clinical faculty to select faculty representation.
  - Clinical Chairs to determine composition of eight faculty members and selection process.
  - Composition may include designated seats for defined clinical services, or a democratic process of selection regardless of specialty. Designated services may include:
    - Hospital-Based Services
    - Women's and Children's Services
    - Primary Care
    - Surgical Services
    - Medical Services

Organization and Governance

Recommendation

- Develop the following standing committees with other committees to be ad hoc:
  - Finance
    - Billing and Compliance
    - Financial Reporting
  - Operations
    - Facilities Management
    - Physician Relations
    - Staffing
    - Clinical Operations
    - Quality of Care (including responsibility for service standards and patient satisfaction)
    - Information Systems
  - Contracting
    - Internal Liaison and Rate Determination
    - External Rate Negotiation
- Create bylaws for the new practice organization that includes all organizational structures, including the new Executive Committee with responsibilities that include, but are not limited to:
  - 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.

Organization and Governance

Recommendation

- Establish the Executive Director position as a full-time position with responsibility for the overall operations and administrative leadership of the unified practice.
  - Reports to the President of UNC P&A and serves as a member of its Executive Board.
  - Recommended responsibilities for the Executive Director to include oversight and direction of:
    - **Practice Operations**
      - Provides leadership to the clinical operations, fostering an environment that is service-oriented for patients, referring physicians and staff.
      - Ensures integration of industry best practices to achieve standards of excellence in clinical operations.
      - Supports the establishment of clinical initiatives, protocols, systems and standards to optimize the performance of ambulatory patient care activities.
    - **Professional Fee Billing**
      - Oversees management of the revenue cycle and billing process, ensuring performance to agreed-upon goals.
      - Establishes principles, policies and standards for professional fee billing, monitoring and communicating performance.
      - Identifies information technology needs and opportunities to improve efficiency and increase cash collections.

Organization and Governance

Recommendation

- Recommended responsibilities of the Executive Director to include oversight and direction of:
  - **Financial Management**
    - Creates and manages systems for the flow of funds to the clinical departments.
    - Oversees budget; achieves agreed-upon financial results on an annual basis.
    - Assists in providing meaningful financial and statistical reports, which meet the needs of the clinical practices and the SOM.
  - **Contracting**
    - Coordinates, analyzes, evaluates and monitors all contracts as they relate to professional fees.
    - Represents clinical departments in contract negotiations, and provides communication to clinical practices regarding all professional fee contracting activities.
    - Assists in developing contracting guidelines for professional services consistent with the contracting efforts of UNC.

Organization and Governance

Recommendation

- Recommended responsibilities of the Executive Director to include oversight and direction of:
  - **Strategic Planning and Marketing**
    - Identifies new practice opportunities and other clinical activities that support the mission and success of the UNC P&A.
    - Collaborates with UNCH in strategic planning and program development related to professional services in support of the overall mission.
    - Participates in planning/implementation of off-campus programs across clinical services, providing leadership in the establishment of off-site clinical programs and the necessary operational systems to support them.
  - **Communications and Teamwork**
    - Meets regularly with management staff to discuss goals, initiatives and progress.
    - Mentors practice administrators regarding practice management and clinical operations.
    - Develops/implements mechanisms to provide feedback, evaluation and training.
    - Maintains work plans showing measurable achievements and recognizing individual and team accomplishments.
    - Recruits, coaches, develops and retains qualified, competent staff.
    - With the President, creates a work environment that fosters teamwork, cooperation, innovation, open communication and respect.

Organization and Governance

Recommendation

- 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.
  - Goals are to portray a clear vision for UNC P&A and include:
    - Aligned departmental, institutional and faculty objectives that foster academic programs consistent with the goals of the clinical departments, SOM and faculty.
    - Serve as the clinical voice for the faculty within UNC and foster the development of clinical and academic physician leaders.
    - Develop policies and procedures for clinical practice management that will facilitate improved clinical practice operations, customer service and cost effectiveness.
    - Support recruitment and retention of superior clinical faculty, consistent with institutional needs and departmental objectives.
    - Monitor and improve the financial performance of the faculty practices.
    - Develop and implement a consistent and meaningful funds flow.
    - Monitor performance of each practice providing regular feedback to faculty, clinical practices and departments on performance of each provider and practice.
    - Manage billing operation to optimize cash flow for clinical activities and departments.

Organization and Governance

Recommendation

- Develop a strategic plan for UNC P&A.
  - Goals are to portray a clear vision for the UNC P&A and include:
    - Develop standards for contracting for professional services, including faculty participation, and ensure that contracts are consistent with departmental capabilities, goals and program needs.
    - Increase market share by attracting a patient base necessary to sustain clinical and academic programs and enhance relationships with community physicians.
    - Improve and optimize customer service, including service to patients, staff and referring clinicians.
    - Assist in development/implementation of clinical information systems to support clinical practice, teaching and research and communication among providers.

Responsibility

- Organizational Structure: UNC Dean SOM
- Management Structure: UNC Dean SOM
- Strategic Plan: UNC P&A President

Timeframe

- Second Quarter 2005: Organizational Structure and Management Structure
- Second and Third Quarters 2005: Strategic Plan

Financial Reporting

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.
  - State funds are preferentially used to pay salaries of staff and physicians because of the add-on for benefits that accompanies state funds.
- 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 percentile).
  - With minor exceptions, components are not at risk, and bonuses are granted according to uncertain criteria.
  - There has been great reluctance to reduce salaries, and shortfalls are often covered by use of reserves or cross mission use of clinical funds.

Financial Reporting

Recommendation

- The physician compensation section of this report contains a spreadsheet that incorporates the previous principles and illustrates a hypothetical example.
  - To make it relevant to the departmental budget, accurate recording of expenses for the clinical mission plus administrative overhead to run the department must be maintained in a system that uses an MGMA chart-of-accounts, without mixed mission use of funds.
  - Cash available to cover overhead, which represents the clinical portion of net revenue, is then compared to total departmental expenses plus the variance (positive or negative) of total compensation in comparison to total cash available for compensation.
    - Any deficit must then be used to reduce the clinical conversion factor (CCF) and, thus, total physician compensation, resulting in breakeven performance.
    - Any surplus can be added to reserves or used as a bonus pool.
- The example referenced above also illustrates how the compensation and budgeting model depend on traditional GAAP accounting to produce a statement of expenses and then a profit and loss statement for the department.

Financial Reporting

Recommendation

- Implement a departmental compensation plan based on CARTS mission-based allocation of funds available for compensation.
  - Incentives to improve productivity can be achieved by using a tiered CCF.
  - Three tiers are used with values determined by using a CCF that starts at 10% less than the calculated value and rises to 10% more than the calculated factor.
    - Productivity at less than 80% of the 63rd percentile is assigned the lowest CCF.
    - Productivity at 80% to 105% of the benchmark are assigned the calculated CCF.
    - Productivity at greater than 105% of the benchmark achieves the highest CCF.
  - Salary will drop no more than 10% each year for two years.
  - Set a guaranteed floor conversion factor as part of strategic direction going forward.
  - After two years, clinical salary is determined by actual productivity.

Financial Reporting

Recommendation

- Implement a departmental compensation plan based on CARTS mission-based allocation of funds available for compensation and adhering to the following principles.
  - All sources of clinical cash are pooled, eliminating differences in payer mix.
  - A CCF is determined by dividing Net Patient Revenue by Total Relative Value Units (tRVUs).
  - Clinical cash is distributed to physicians based on the Work Relative Value Units (wRVUs) individually generated.
  - Other sources of revenue, including both salaries and benefits, are added to the formula for determining the CFF to determine total cash available for compensation.
  - An overhead tax is applied to all non-clinical practice sources of revenue so that each mission supports a proportionate share of the benefit expense.
  - Overhead in excess of cash available to cover overhead will reduce the clinical cash available to be distributed to physicians.
  - All expenses are considered common, except those previously determined to be unique and attributable to an individual physician. See examples on pages 72-79.

Financial Reporting

Recommendation

- Clinical Practice Income
  - Clinical income should be defined as revenue generated by UNC faculty physicians in clinical practice.
    - Fees generated for billable services and contract revenue irrespective of payer source less any contractual allowances are equal to Net Revenue.
    - Collections, less practice expense and Dean's and Chair tax, equal practice net income.
      - Practice expenses benchmarked to comparable faculty groups in other academic medical centers.
      - Support staffing also set at benchmark levels.
      - Practice expenses do not include physician base clinical salaries but do include malpractice insurance expense and space costs.
    - The practice net income will be sent to the appropriate UNC SOM Department for final "assembly" of physician salaries.

Financial Reporting

Recommendation

- 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

Responsibility

- UNC P&A President

Timeframe

- Third and Fourth Quarters 2005

Budgeting

Assessment

- Departmental budgeting is based on historical spending and not on annual, zero-based determination of cost.
  - Unfunded research and non-productive clinical appointments have resulted in departmental deficits that have been covered by accumulated reserves and state funds.
  - There are no clearly-defined standards about salary coverage by grants, and Chairs are not held accountable for budget performance.
  - Information is available regarding productivity, but not used in calculation of cash available for compensation or for planning physician need.

UNC P&A Organization

Assessment

- UNC P&A has recently undergone organizational structure and personnel changes.
  - The Executive Director is also Administrator of the Department of Medicine.
  - There is currently no CFO.
  - The Director of Ambulatory Care left and the Medical Director for Ambulatory Care now has two roles – medical direction and administration.
- There are currently three directors:
  - Managed Care, Billing/Collections and Administration.
- A pilot program has been developed decentralizing administrative functions.
  - Neurology, Surgery
  - Decentralized functions include: coding, claims,reimbursement and financial counseling.
  - The primary goal of the pilot is to improve revenue, increase communication, interaction and collaboration with physicians, clinical department administration and key functional resources, including coder, financial counselor, claims representative and reimbursement analyst.
  - UNC P&A will assess the financial and operational performance of these two decentralized billing and collections pilots in the first quarter of FY05. No formal targets were identified for the pilots, however, management stated that both quantitative (accuracy, denials, costs) and qualitative measures (customer service, communication) will be used to evaluate the effectiveness of the pilots.

UNC P&A Organization

Assessment

- Scheduling, pre-registration, insurance verification and registration are decentralized and report to the respective Department/Division Chair, not to the UNC P&A. This 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. The CBAs primary responsibilities are for the front desk operations in the 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 to be centralized under the COO but clustered into department-focused teams.
  - 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.

UNC P&A Organization

Recommendation

- Create a CFO position.
- Fill the role of Medicine Administrator.
  - See recommendations regarding Registration and Pre-arrival in Section V, Revenue Cycle.
- UNC P&A to develop access standards for departments.
- Pursue the department Cluster approach and discontinue goal of decentralization to departments.
- Re-negotiate the community-based practice contract to reach market rates.
- Adopt the proposed organizational structure as shown on the following page.

Responsibility

- UNC P&A President

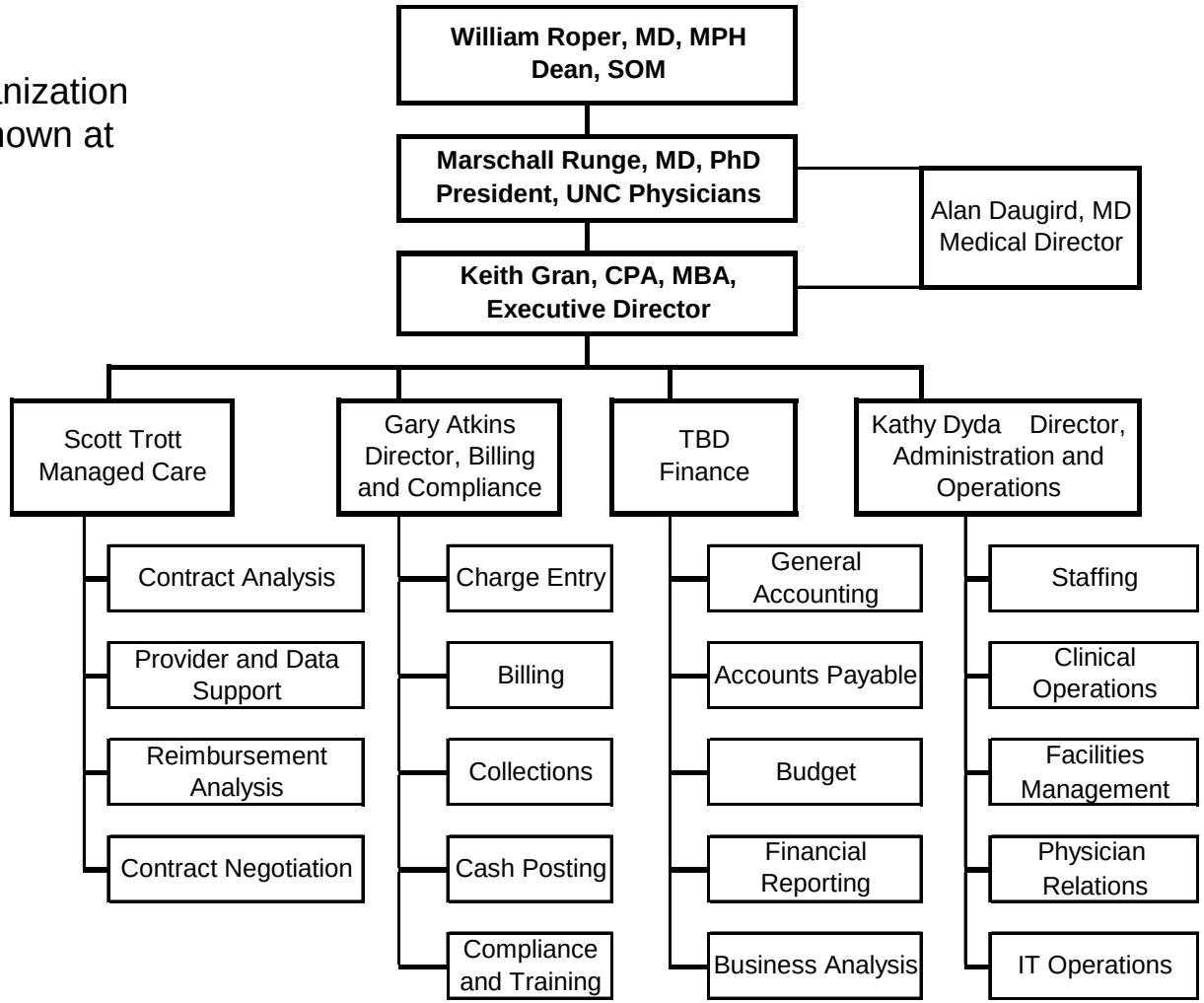
Timeframe

- Third Quarter 2005

UNC P&A Organization

Recommendation

- The recommended organization chart for UNC P&A is shown at the right.



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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.]

Physician Productivity

Recommendation

- 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 those 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%.

Responsibility

- UNC P&A Leadership
- Clinical Department Chairs

Timeframe

- Second Quarter 2005, Ongoing: Start monthly feedback to faculty
- Third Quarter 2005: Establish expectations of clinical time and production; incorporate into the FY06 budgeting cycle

Physician Compensation

Assessment

- Faculty receives one paycheck to cover all missions and all efforts. All revenue sources are used to pay faculty, including UNC P&A clinical revenue. However, there is no clear break-out of clinical compensation from other compensation, and revenue sources outside of UNC P&A are also used to cover clinical compensation.
- The faculty salaries reported in the UNC P&A income statements do not represent all clinical compensation.
- Some departments have begun to develop compensation plans. There is no UNC P&A level incentive plan. Not all faculty receive incentive compensation or annual increases.
- There is no evidence that faculty compensation is reduced for unproductive faculty, although this may indeed be the case.
- The faculty perception is that compensation is low as compared to other academic practices. This is a factor affecting faculty retention.

Physician Compensation

Assessment

- The table below reflects all faculty compensation as reported in the payroll file.

Department	Faculty Compensation
ANESTHESIOLOGY	$ 7,323,183
DERMATOLOGY	$ 1,375,145
EMERGENCY MED	$ 2,948,375
FAMILY MEDICINE	$ 4,781,889
MEDICINE	$ 27,168,299
NEUROLOGY	$ 3,236,820
OB-GYN	$ 6,627,889
OPHTHALMOLOGY	$ 1,706,828
ORTHOPAEDICS	$ 3,277,802
OTOLARYNGOLOGY	$ 3,102,822
PATHOLOGY	$ 5,619,991
PEDIATRICS	$ 11,191,509
PM&R	$ 933,417
PSYCHIATRY	$ 7,695,037
RAD ONC	$ 1,745,818
RADIOLOGY	$ 6,647,399
SURGERY	$ 11,742,061
TOTAL	**$ 107,124,284**

[The remainder of the Assessment is confidential and has been redacted.]

Physician Compensation

Recommendation

- Develop a clinical faculty compensation plan for UNC SOM Departments that identifies production targets according to clinical effort and uses clinical revenue sources to compensate physicians.
  - Distribution parameters and metrics to be developed by UNC P&A for use by Department Chairs in distributing the clinical portion of the departmental plan.
- Plan to include incentive compensation for productive physicians.
- Plan to include downside risk to base compensation for underperformance.

Clinical Cash Distribution and Department Compensation Model

Plan Principles

- Clinical cash is distributed to physicians based on the Work Relative Value Units (wRVUs) individually generated.
- Clinical cash is pooled, eliminating differences in payer mix.
- Other sources of revenue, including both salaries and benefits, are added to the formula.
- An overhead tax is applied to all non-clinical practice sources of revenue.
- Overhead in excess of cash available to cover overhead, reduces the clinical cash distributed to physicians.
- All expenses are considered common, except those previously determined to be unique and attributable to an individual physician.

Physician Compensation

Clinical Cash Distribution and Department Compensation Model

Plan Principles

- Incentives to improve productivity are derived by using a tiered CCF.
  - Three tiers are used with values determined by using a CCF that starts at 10% less than the calculated value and rises to 10% more than the calculated factor.
    - Productivity at less than 80% of the 63rd Percentile is assigned the lowest CCF.
    - Productivity at 80% to 105% of the benchmark are assigned the calculated CCF.
    - Productivity at greater than 105% of the benchmark achieve the highest CCF.
- Salary will drop no more than 10% each year for two years.
- After two years, salary is determined by actual productivity for all missions.
- The departmental compensation model is built up by individual physician. Each physician has his/her own account and the actual RVUs produced by each individual physician determines their own clinical cash component.
- A problem can occur if the rest of the department is so unproductive that they cannot cover overhead. In that case, they need to reposition some of the less productive physicians or agree on strategic support to protect the very productive ones.
  - A guaranteed floor CCF going forward as part of strategic investment.
- Refer to the example which follows as a recommended approach to a clinical compensation model.

CARTS Clinical Cash Distribution Model - EXAMPLE

Provider Name	Total FTE	75th % tile wRVUs	FTE adjusted 75th % tile	Original Current wRVUs *	Productivity Factor	Earned FTE	Cash Collections	Cash Conversion Factor	Clinical Cash
	0.30	4,568	1,370	412	30%	0.09		$28.60	12,445
	0.20	4,568	914	846	93%	0.19		$31.77	28,386
	0.10	4,568	457	367	80%	0.08		$31.77	12,325
	0.10	4,568	457	7	2%	0.00		$28.60	211
	-	4,568	0	37	0%	0.00		$28.60	1,127
	0.20	4,568	914	648	71%	0.14		$28.60	19,581
	0.10	4,568	457	205	45%	0.04		$28.60	6,183
	0.05	4,568	228	2	1%	0.00		$28.60	72
	1.00	4,568	4,568	603	13%	0.13		$28.60	18,200
	1.00	5,177	5,177	1,588	31%	0.31		$28.60	47,947
	1.00	5,177	5,177	5,657	109%	1.09		$34.95	208,772
	0.20	4,568	914	246	27%	0.05		$28.60	7,429
	0.20	4,568	914	1,096	120%	0.24		$34.95	40,451
	1.00	5,177	5,177	2,936	57%	0.57		$28.60	88,658
	1.00	5,177	5,177	2,314	45%	0.45		$28.60	69,884
	1.00	4,568	4,568	1,926	42%	0.42		$28.60	58,171
Total FM	**7.45**		**36,468**	**18,891**		**3.81**	**2,169,351**		**619,840**

CARTS Clinical Cash Distribution Model - EXAMPLE

Clinical Cash	Affiliate Compensation (VA etc)	19900 Funds	Hospital	Dean's Office	Grants	Gifts & Endow	Teaching	Strategic Support	Cash Available to Division	Actual Salary and Benefits	Variance
12,445	66,778	93,911		17,550	18,223		42,000	130,134	381,041	308,035	73,006
28,386		106,821			149,644		-		284,851	279,544	5,307
12,325	137,826						10,000		160,151	149,366	10,785
211				26,080	104,726		10,000		141,017	130,806	10,211
1,127		81,666			121,271		-		204,064	204,610	(546)
19,581					54,599		20,000		94,180	126,533	(32,353)
6,183				79,642			12,000		97,825	121,307	(23,482)
72	84,902				45,904		5,000		135,878	136,576	(698)
18,200	8,412		28,850				103,200		158,662	212,336	(53,674)
47,947			165,045				48,000		260,992	242,225	18,767
208,772							90,000		298,772	212,913	85,859
7,429							28,000	79,254	114,683	223,876	(109,193)
40,451							28,000		68,451	49,478	18,973
88,658							100,000		188,658	161,214	27,444
69,884				32,748	5,752		120,000	164,585	392,969	225,210	167,759
58,171							96,000		154,171	162,368	(8,197)
619,840	**297,918**	**282,398**	**193,895**	**156,020**	**500,119**	-	**712,200**	**373,973**	**3,136,363**	**2,946,397**	**189,966**

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CARTS Clinical Cash Distribution Model - EXAMPLE

Total Cash Collections = $2,169,351
Clinical Cash = $ 619,840
Cash Available for OH = $1,549,512

	Net	Adjusted to Comp
	Calc	Calc
Cash Available for OH	1,549,512	
OH	3,449,015	
OH Over/Short	(1,899,503)	0
S&B Over/Short	189,966	(1,709,538)
Total Over/Short	(1,709,538)	(1,709,538)

CARTS Clinical Cash Distribution Model - EXAMPLE

Expense Detail

Department of LKC Expense Detail FY04 - Baseline	FY05 Projection	
Administrative Staff S&B	$	1,684,737
Medical & Non-Medical Supplies	$	300,210
Purchased Services	$	207,891
Utilities	$	595,530
Malpractice	$	105,000
Other	$	114,840
Rents and Space Costs	$	18,000
Administrative Allocation	$	422,807
Total	**$**	**3,449,015**

Source: Input by Department/PSS

CARTS Clinical Cash Distribution Model – EXAMPLE

Department P&L

Department of LKC Clinical Income Statement FY04 - Baseline		FY05 Projection
Income		
Clinical Income	$	2,169,351
Other Strategic Support		
Affiliate Compensation (VA, etc.)	$	308,725
19900 Funds	$	374,243
Hospital	$	193,895
Dean	$	156,020
Grants	$	538,171
Gifts and Endowments	$	-
Teaching	$	649,485
Administrative Support	$	373,973
Subtotal Strategic Support	$	2,594,512
Total Department Income	$	4,763,853
Clinical Compensation	$	2,946,397
Expenses		
Practice Expenses	$	3,449,015
Other Expenses	$	77,989
Subtotal Expenses	$	3,527,004
Total Clinical Income / Loss	**$**	**(1,709,538)**

Source: Input by Department/PSS

Clinical Cash Distribution and Department Compensation Model

Example: **XXXXX, M.D.**

63% tile Benchmark for Pediatrics = 4,593 wRVU

Actual Worked RVUs = 1,769 **BMark RVUs = 4,593** **Productivity Factor = 39%**

Rptd FTE = 1.0 **Earned FTE = 0.39**

Cash Conversion Factor	X	Work RVUs	=	Clinical Cash
$33.14	X	1,769	=	$58,624

Cash Conversion Factor (CCF)

<80%	CCF - 10%	$33.14
80% - 105%	CCF Actual	$36.83
>105%	CCF +10%	$40.51

Clinical Cash Distribution and Department Compensation Model

Example: **XXXXX, M.D.**

63% tile Benchmark for Pediatrics = 7,228 wRVU

Actual Worked RVUs = 8,926 **BMark RVUs = 7,228** **Productivity Factor = 122 %**
Rptd FTE = 1.0 **Earned FTE = 1.0**

Cash Conversion Factor	X	Work RVUs	=	Clinical Cash
$40.51	X	8,926	=	$361,592

Cash Conversion Factor (CCF)

<80%	CCF - 10%	$33.14
80% - 105%	CCF Actual	$36.83
>105%	CCF +10%	$40.51

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Clinical Cash Distribution and Department Compensation Model

Example: **XXXXX, M.D.**

63% tile Benchmark for General Pediatrics = 4,593 wRVU

Actual Work RVUs = 2,076 **BMark RVUs = 2,297** **Productivity Factor = 90 %**
Rptd FTE = 0.5 **Earned FTE = 0.459**

Cash Conversion Factor	X	Work RVUs	=	Clinical Cash
$36.83	X	2,076	=	$76,459

Cash Conversion Factor (CCF)

<80%	CCF - 10%	$33.14
80% - 105%	CCF Actual	$36.83
>105%	CCF +10%	$40.51

Clinical Cash Distribution and Department Compensation Model

Responsibility

- UNC P&A leadership to form a work team in order to determine the principles and policies associated with a clinical cash distribution plan and associated metrics of performance.
- UNC P&A Board to set practice plan-wide initiatives.
- UNC P&A CFO to address financial reporting need, and IT needs to administer a clinical cash distribution plan.
- UNC P&A leadership to address issues associated with adequate cash collections for services rendered as discussed in other report sections.
- Department Chairs to determine departmental metrics for clinical production. Work RVUs are to be one component of clinical production.

Timeframe

- Third and Fourth Quarters FY 2005: Compensation plan design, financial support system design and clinical metrics determination
- First Quarter FY 2006: Begin administering new clinical compensation plan
- Third Quarter FY 2004: Begin UNC P&A budgets for FY05, which clearly define the clinical component of compensation

Physician Benefits

Assessment

- MGMA multi-specialty physician benefit costs are $31,500 per year.
- Benefits cost UNC 4% above those of multi-specialty groups. This is a common finding in a University setting, which often offers more liberal retirement benefits.

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

Recommendation

- Benefit costs appear reasonable. There are no recommendations for changes to benefits.

Responsibility

- N/A

Timeframe

- N/A

Payer Mix

These pages are confidential and have been redacted.

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Payer Mix Improvement – Cash Impact

Assessment

[The Assessment is confidential and has been redacted.]

Recommendation

- Refer to prior recommendation for Payer Mix.
- Improve access for plans identified as better payers.
- Renegotiate managed care contracts as they come up for renewal focusing on improved professional fee rates. Recent negotiations have proven successful.
- Enforce a policy to collect payment at time-of-service for self-pay.
  - This strategy is effective in shifting payer mix.

Responsibility

- UNC P&A Leadership
- UNC HCS Managed Care Director

Timeframe

- 2006 – 2008

Cash Collections

Assessment

- NCI obtained a data file from the UNC P&A billing system. This consisted of 1,432,387 individual invoices for FY03. The file contained the following data elements:
  - Department number and name
  - Place of service code
  - Service location
  - Faculty number and name
  - Resident identifier
  - Service date and posting date
  - Invoice number
  - CPT code with modifiers and units
  - FSC number, name and FSC Category 2 description
  - Primary and secondary ICD-9 code
  - Charge amount
  - Third party and patient payment amounts
  - Current invoice balance
  - Contractual and bad debt adjustments

Cash Collections

Assessment

- The billing data base does not match with the UNC P&A income statements. For example:
  - The UNC P&A income statements report Gross Charges as $392,577,918. The billing database contains charges equaling $371,405,105.
  - The UNC P&A income statements report Net Patient Revenue as $150,791,204. The billing database contains third-party and patient payment equaling $122,203,500.
- The billing database shows the following:
  - The remaining A/R balance for these invoices created in the prior fiscal year is $53,816,685, or 15% of charges
  - 48% of charges are written off to contractual adjustments.
  - Another 3.5% of charges are written off to bad debt.
- For the purpose of this analysis, NCI is using the billing database excluding the following:
  - Allied Health Sciences
  - Center for Learning and Development
  - Nurse Anesthetists
  - Optical Shop
  - Pharmacy Billing
  - Recovery of Administrative Costs
- Anesthesia will be addressed separately to take into account the differences associated with time-based services and ASA units.

[The remainder of the Assessment is confidential and has been redacted.]

Cash Collections

Recommendation

- Research departments with particularly low collections from both a payer and internal process perspective to identify opportunities to improve reimbursement.
- If payer issues are found (e.g., certain payers not reimbursing particular services), follow up with managed care companies, renegotiating where necessary.

Responsibility

- UNC P&A Executive Director

Timeframe

- Third Quarter 2005

Cash Collections

Assessment

[The Assessment is confidential and has been redacted.]

Recommendation

- Improve the collection of the patient portion of Medicare charges, increasing the overall RBRVS Medicare collection rate from 90% RBRVS to 95% RBRVS.
  - This would result in an additional $1.4M in cash collections annually.
- Improve self-pay collections. A reasonable target would be 50% RBRVS.
  - This would result in an additional $2.1M in cash collections annually.
- Policies must be established, implemented and enforced to collect patient portions at the time-of-service.
- For self-pay patients, implement a discounting policy for prompt payments.

Responsibility

- UNC P&A Executive Director

Timeframe

- Third and Fourth Quarters FY2005: Develop and implement of policy related to self-pay patients and patient portions for Medicare
- 2006: Reach recommended collection targets

Cash Collections – Anesthesia

Assessment

[The Assessment is confidential and has been redacted.]

Recommendation

- Develop and implement a UNC-wide payer mix strategy.
- 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.

Responsibility

- Chair, Anesthesiology
- CEO, UNC Hospital

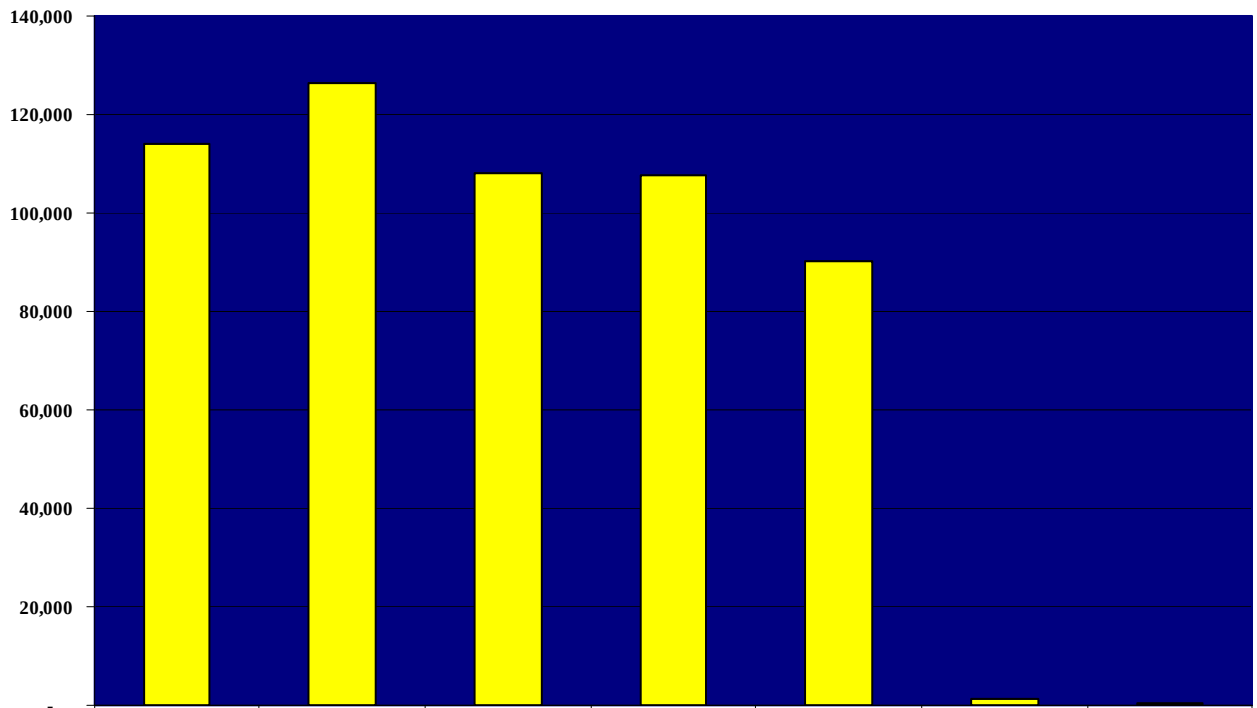
Timeframe

- Third Quarter 2005: Budget purposes – Agreement to take effect for FY06

Ambulatory Care Access

Assessment

- The table below shows arrived visits by day of week.



	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Total Arrived	114,310	126,652	108,112	107,720	90,196	1,424	656

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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.
  - 57% of appointments are seen on morning sessions.
  - 43% of appointments are seen in afternoon sessions.
- As anticipated, the lowest volume of patients are seen on Friday afternoons (6.5%).

Recommendation

- Flex staffing to meet patient demand. Part time-staff should be utilized on Mondays and Tuesdays.

Responsibility

- Department and/or Ambulatory Care Administrators

Timeframe

- Third Quarter 2005

[The remainder of Ambulatory Care Access is confidential and has been redacted.]

Coding Opportunity

Assessment

- UNC P&A's coding patterns for E&M services are similar to national profiles.
  [Portions of the Assessment are confidential and have been redacted.]

Recommendation

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

Responsibility

- UNC P&A Leadership

Timeframe

- Third Quarter 2005
- Education is an ongoing initiative

Ambulatory Practice Staffing

Assessment

- Accurate UNC P&A staffing data is not available for analysis. Although the UNC P&A income statements reflect staffing costs, the clinical mission and the staffing costs associated with it have not been clearly delineated.
- No model is developed to staff practices with appropriate skill mix and FTE levels to adequately support ambulatory care visit volumes.
- Employee-related issues were the second lowest scoring category of the faculty survey. Faculty expressed significant concerns regarding staff recruitment, retention, turn-over, compensation, adequate staffing levels and employee morale.

Recommendation

- Develop and implement a benchmarked staffing model to monitor and report support FTEs in ambulatory clinics. A suggested model can be found in Section VI, Case Studies.
  - Overall staffing levels for ambulatory should equal 1.0 staff FTE per 1,000 visits per year.
- Review clinical mix of nursing staff to include RN, LPN and MOA functions. Staff clinics with appropriate level of nursing personnel to balance patient care needs with clinical efficiency and fiscal responsibilities.

Responsibility

- UNC P&A Executive Director

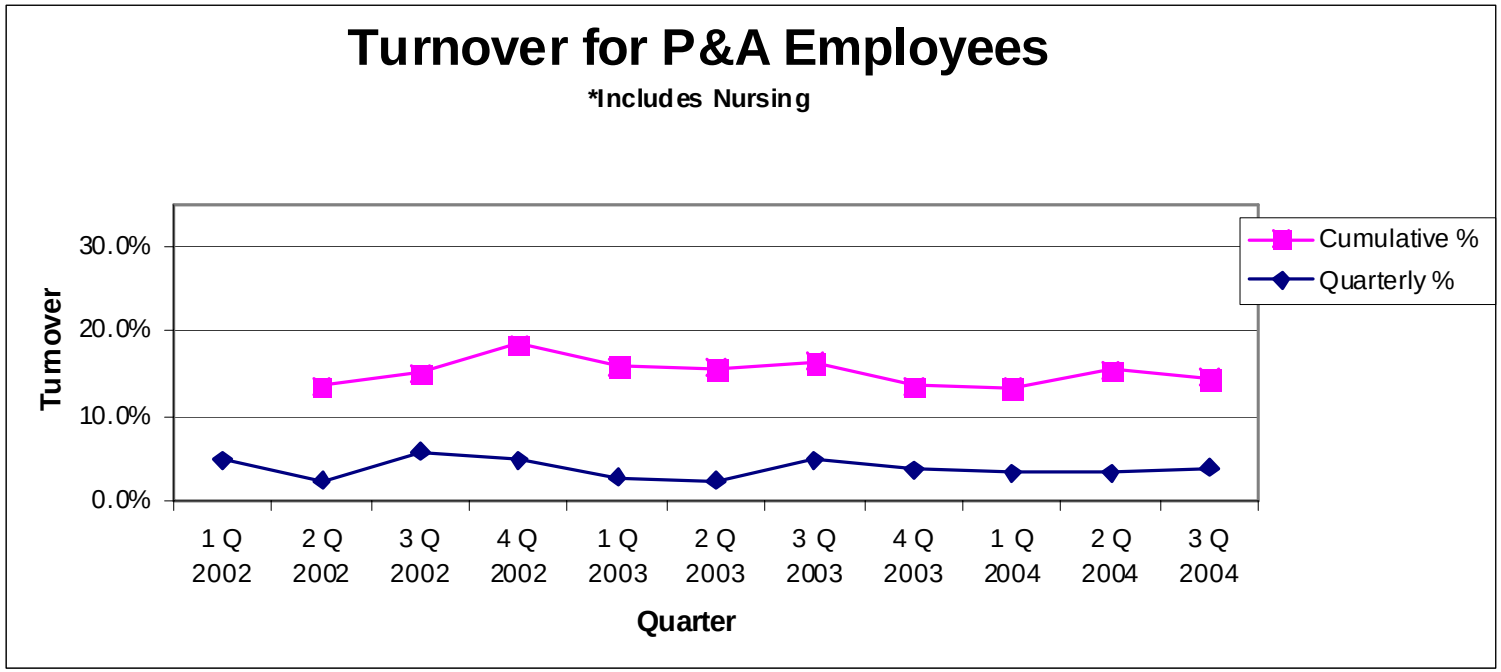
Timeframe

- 2006

Ambulatory Practice Staffing

Assessment

- Staff turnover rates for UNC P&A run 14.5% per year. The rate has remained fairly steady. The graph below shows the UNC P&A turnover rate.

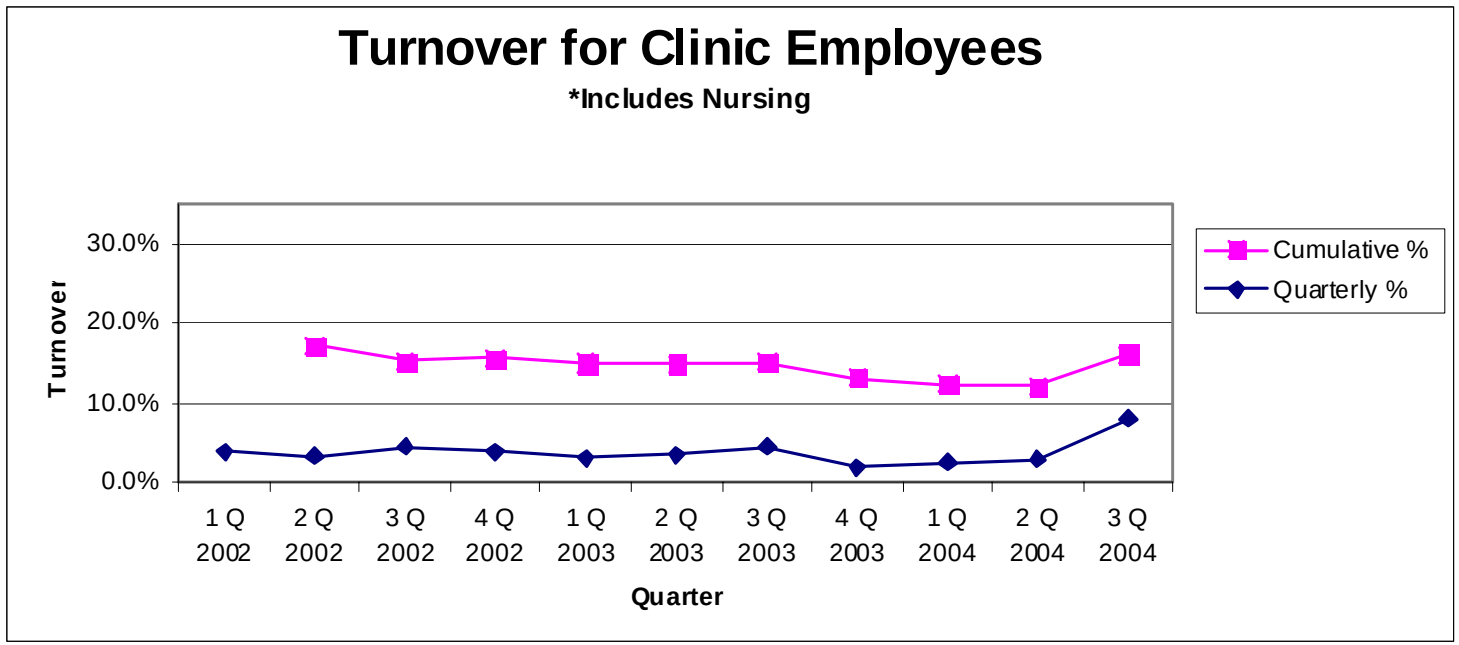


NAVIGANT CONSULTING

Ambulatory Practice Staffing

Assessment

- Staff turnover rates for the hospital clinics run 16.1% per year. The rate has remained fairly steady. The graph below shows the clinic turnover rate.



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Ambulatory Practice Staffing

Recommendation

- The industry average for employee turnover is 12% in the best quartile and 15% at median (Source: MGMA best practices). UNC should target goals to reduce ambulatory practice employee turnover rate from the current 14.5% to 16.1% range to the best practice level of 12%.
- Conduct employee satisfaction surveys and exit interviews to understand both compensation issues and non-compensation satisfiers related to staff retention.
- Offer options of flexible schedules and part-time employment in the ambulatory area where volumes drop off at the end of the week.
- Hire staff with public relations and hospitality skills from outside the health care industry. Invest in training them for non-clinical roles.

Responsibility

- UNC P&A Leadership
- UNC Human Resources

Timeframe

- 2006, Ongoing

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.

Recommendation

- Develop and implement a benchmarked overhead expense model to monitor, manage and control operating and indirect costs.
- The MGMA cost survey by specialty may be used as a guideline to what overhead costs should be, but should not be the only tool used.
  - MGMA practices tend to be more office based in many specialties, whereas academic practices, which deliver a high acuity level of care, tend to me more hospital-based. Operating costs vary greatly by specialty. A hospital-based specialty, such as Anesthesia, should have low operating costs of about 7%, whereas an office-based practice, such as Pediatrics, typically has operating costs of about 30%.

Operating Costs

Assessment

- The UHC group on faculty practice similarly reports operating costs per work RVU ranging from $21 to $43.
- When invoices for FY03 are broken down into respective work and overhead components, it provides a template to managed costs.
- In the table at the right, 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%**

Source of Table: P&A Data Request

Operating Costs

Recommendation

- The previous table suggests a total overhead rate. At the UNC P&A level, this averages to 38%, which implies the remaining 62% of revenue should be available to cover faculty compensation and benefits, mid-level provider compensation and benefits and Dean's tax.
- As a suggested approach, this total overhead percentage should break down 50/50 between staffing costs and operating/overhead costs.

Responsibility

- UNC P&A Executive Director

Timeframe

- 2006

Malpractice Costs

This page is confidential and has been redacted.

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 the services rendered to the patients may be identical, the 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. A discussion of provider-based practices with useful implementation information is outlined below.

Recommendation

- Provider-based practices should be established 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.

Provider-Based Clinics

Historical Background

- Payers reimburse physicians based on a national relative value scale (RVU). The reimbursement covers three distinct components: physician work, practice expense overhead and malpractice costs.
- Government payers and some managed care plans reduce physician payments when a POS 22 is billed, but then provide additional technical payments to the facility (hospital).
- O/P hospital services are paid by Medicare through an Ambulatory Payment Classification system (APC). Additional supplemental payments may be available to the hospital at the end of the year following submission of required cost reports.
- Academic medical centers create a platform where physician services are closely linked to hospital ambulatory programs. Subsequently, there exists an opportunity to increase revenues based on the provider-based model.

How It Works

- In a provider-based model, the main provider (hospital) assumes the overhead expenses for the physician practice, excluding provider and administrative costs. Overhead expenses include clinic personnel, drugs, supplies and indirect expenses, such as purchased services, building and occupancy costs and corporate overhead. Physicians bill the professional component only to government payers with a site-of-service as “outpatient hospital.” This designation reduces the payment to the physician and the hospital bills for the overhead component through the facility bill (or APC for Medicare). The reduction in the physician’s reimbursement is offset by the fact that the physicians no longer have to pay the overhead for the practice out of their reimbursement.

Provider-Based Clinics

Example

CPT Code	Description	Medicare POS 11
99213	Office Visit	$50.27

CPT Code APC Code	Description	Medicare POS 22
99213	Office Visit - professional	$34.28
601	Office Visit - technical	$48.49
Total Payment		**$82.77**

Assessment

- **Advantages of Provider-Based Model**
  - The combination of the decrease in payment to the physician, and the additional payment to the facility may result in a significant overall increase in revenues to the health system for cost-based Medicare, Medicaid and Champus. Combined increases are CPT-specific.
  - Disproportionate share payments (DSH) may also be available for un-reimbursed costs of providing care to uninsured and Medicaid patients.
  - There is greater flexibility to finance expanded clinical services with the additional revenue.
  - There is an opportunity for flexible management structures that partner the facility and the faculty practice plan.

Provider-Based Clinics

Assessment

- **Disadvantages of Provider-Based Model:**
  - There are greater billing complexities and potential inefficiencies.
  - Potential loss of physician control of practice staff.
  - Potential loss of physician accountability for financial performance.
  - Potential negative impact on patients from receiving two bills.
  - Patients experience higher out-of-pocket costs.
- **Provider-Based Criteria:**
  1. All facilities, including satellite facilities, must operate under the same license.
  2. Professional staff must have clinical privileges at the hospital.
  3. Medical director(s) maintains a reporting relationship with the Chief Medical Officer of the hospital.
  4. The provider Medical Staff committees are responsible for QA, UR, coordination and integration of services.
  5. Medical records are integrated into a unified retrieval system (or cross referenced).
  6. Financial integration.
  7. Public awareness.
  8. Administrative functions are coordinated with the hospital.

**Additional requirements must be met for off-campus locations.

Provider-Based Clinics

Recommendation

Achievement Of Success

- In order to achieve success, a provider-based model will be successful if you achieve balance for all entities. 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.
- A recommended funds flow model is demonstrated on the following pages.

Responsibility

- UNC P&A Leadership and UNC HCS Leadership

Timeline

- N/A – Adapt for current provider-based clinics effective July 1, 2005

Provider-Based Clinics – Funds Flow

REVENUE SOURCES		
Type	**Physician Practice Group**	**Main Provider (Hospital)**
Government Payers, Managed Care Payers who pay a technical fee	Medicare: Payment from Part B services at a reduced site of service	Medicare: APC Payment supplement payments from cost report
	Medicaid: Professional services payments	Medicaid: Facility Fee, supplemental cost report payments
	Other Payers: Payments from services at a reduced site of service	Other Payers: Technical Revenue
Most Managed Care Payers	Full Global Payments	None
Self-Pay	Full Self-Pay Payment	None

Provider-Based Clinics – Funds Flow

EXPENSE RESPONSIBILITY	
Physician Group Practice	**Main Provider (Hospital)**
Physician Compensation	Clinical Staff
Physician Benefits	Clerical Staff
Mid-level Providers	Rent
Professional Billing Services	Drugs and Supplies
Malpractice	Equipment
Practice Plan Administration	Information Services
	Indirect/Allocated Costs

Provider-Based Clinics – Funds Flow

FUNDS FLOW RESPONSIBILITY	
From Physician Group Practice to Main Provider (Hospital)	**From Main Provider (Hospital) to Physician Practice Group**
For the managed care and self-pay payer mix (those payment sources that do not pay a technical fee), the practice plan will calculate the practice expense portion using RVU methodology. The PE % applied against cash collections will be transferred to the main provider to cover overhead expenses. **100% revenues received for drugs, ancillaries and supplies will be transferred to the main provider.**	**Management Fee (if applicable)** **Billing Fee for Collection of PE Revenue**

Summary of Interventions

This page is confidential and has been redacted.

Scorecard

Assessment

- The clinical chairs and UNC HCS senior leadership recognize the need for timely information in order to manage their organization.
- Income statements provide a historical snap-shot, but are inadequate to use in observing and/or projecting trends that can affect the fiscal health and customer satisfaction levels of the organization.
- Most practice plans do not utilize a daily flash report in the format often used by hospitals, however, it would be reasonable to report on a short list of statistics on a daily basis.
- The use of monthly scorecards is critical. Trends over time as compared to prior years will assist leadership in spotting problems before there is major negative impact. These scorecards should exist on a departmental and on a UNC P&A roll-up level. They should also contain targets/benchmarks.
- Quarterly scorecards should be more comprehensive and include quality indicators.

Recommendation

- Daily “flash report” should include a short list of practice statistics. These may include:
  - Charges Posted
  - Cash Posted
  - Arrived Visits

Scorecard

Recommendation

- Monthly scorecards should report, track and trend multiple categories of statistics.
  - Examples are provided on the following pages.

Productivity Metrics	FY2006 Q1	FY2006 Q2	FY2006 Q3	FY2004 Q4	Prior Year	Target
Work RVUs						
Total RVUs						
CFTE time						
Imputed CFTE Effort						
% CFTE Access Avail.						
Ambulatory Visits						
% New Patients						
Hospital Visits						
Total Visits						
Total Procedures						

Scorecard

Recommendation

Financial Metrics	FY2006 Q1	FY2006 Q2	FY2006 Q3	FY2004 Q4	Prior Year	Target
Charges						
Cash						
Collections % RBRVS						
Cash per tot RVU						
Time of Service $$						
Staff Cost per Total RVU						
Overtime %						
Agency Staff $$						
Operating Cost per total RVU						
Profit Margin per Total RVU						

A/R Metrics	FY2006 Q1	FY2006 Q2	FY2006 Q3	FY2004 Q4	Prior Year	Target
A/R Days						
Denial Rates - Registration						
Denial Rates - Other						
Mix % Government						
Mix % Self-pay						
Mix % Managed Care						
% A/R Over 90 days						
Charge Lag Days						
Bad Debt Adjustments						
# Edits Pending						
A/R WIP $$						

Scorecard

Recommendation

Operations Metrics	FY2006 Q1	FY2006 Q2	FY2006 Q3	FY2004 Q4	Prior Year	Target
Third Available Appt New						
Third Available Appt Estab.						
No Show Rate						
MD Cancel Rate						
Visits/Exam Room/Hour						
Amb. Staff/1,000 Visits						
Ave Time to Answer Phone						
% Calls Answered in 30 Sec						
Call Abandonment Rate						
# Phone Calls per Visit						

HR Metrics	FY2006 Q1	FY2006 Q2	FY2006 Q3	FY2004 Q4	Prior Year	Target
Staff FTEs total						
% RN Mix						
FTE Clinical Support Staff						
FTE Clerical Support Staff						
FTE Technical/Ancillary						
FTE Management						
FTE Central P&A						
FTE Billing Office						
Employee Turnover Rate						
New Faculty Hires						
Faculty Departures						

Scorecard

Recommendation

- Generating these data elements from existing systems will require dedicated effort and tools and well as adequate IT resources.
- UNC P&A should consider purchasing a decision support system that will meet these reporting needs without driving up IT costs excessively, and will provide clinical departments with additional information that is user-designed and easily customizable.
  - A recommended system used by many academic practices is PDS (Practice Diagnostic Systems), which uses Microsoft Excel and Cognos PowerPlay technology (www.PDS-online.com).

Responsibility

- UNC P&A Executive Director
- UNC HCS IT Director

Timeframe

- Third and Fourth Quarters FY 2005: Design and installation

Performance Measures

- By FY 2006: Reporting to be in place