Primary Care Practice Facilitation Curriculum

Module 4: An Introduction to Practice Organization and Management

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Primary Care Practice Facilitation Curriculum

Module 4. An Introduction to Practice Organization and Management

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Contents

Module 4. An Introduction to Practice Organization and Management

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General knowledge of the organization of primary care practices and their management
- Knowledge of practice management resources
- Cultural competency

Time

- Pre-session preparation for learners: 2 hours
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the work of a primary care practice and the way it is commonly organized and managed.
2. Identify the different types of staff commonly employed in primary care practices.
3. Describe common revenue sources for practices and their implications for quality improvement work.
4. Discuss the role of practice managers and administrative staff in quality improvement.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information. (2 hours):

1. Read the module.
2. Review/scan information on practice administration and set-up:
3. Burns P, Hirschfield J. So You Want to Start a Health Center…? A Practical Guide for Starting a Federally Qualified Health Center. Bethesda, MD: National Association of Community Health Centers; 2011. Available at: http://www.nachc.com/client/documents/So%20you%20want%20to%20Start-Final%20July%202011.pdf
    a. Reiboldt M. Starting, Buying, and Owning the Medical Practice (Practice Success Series), 1st ed. Chicago, IL: American Medical Association; 2012. (Available for purchase through the American Medical Association.)

4. Review/scan information on practice interaction with their medical neighborhood (care coordination and accountable care organizations):
    a. Taylor EF, Lake T, Nysenbaum J, et al. Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. White Paper AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality; June 2011. Available at: https://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf
    Toward Accountable Care Consortium. The Physician's Accountable Care Toolkit. The Physician's Foundation; North Carolina Medical Society; 2012. Available at: http://www.ncmedsoc.org/non_members/legislative/ac/ACO-GuideNC.pdf

During the session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What were some important lessons you learned in the module and pre-work?
2. Based on the module, what types of information should you collect from a practice you are beginning to work with on its organizational structure, management, financial model, and operations?
3. What implications do these have for quality improvement work?

Activity. Vision map of areas where practice organization and management affect quality improvement (30 minutes)

1. Ask learners to divide into groups of three.
2. Ask each group to identify a facilitator for the activity.
3. Have the facilitator lead their group in creating a crosswalk that shows how practice structure, financial model, administration, and management map to:
    a. Ability to implement the five key elements of the patient-centered medical home (PCMH; see Module 25, The Patient-Centered Medical Home: Principles and Recognition Processes, for a list of key elements)
    b. Capacity for continuous quality improvement
4. At the end of the exercise, ask each group to present their crosswalk to the larger group and discuss any important insights they had in completing the exercise that can inform their work as PFs with practices.

Optional activities after the session for further learning

1. Ask the learners to explore and complete training available through the National Association of Community Health Centers based on interest or need. The trainings are available at: https://www.nachc.com/complete-list-of-trainings.cfm

Module 4.

Practice organization and management form the foundation of all primary care practices. As a practice facilitator (PF), it is important to have a solid understanding of how primary care practices are organized and managed, and how they get paid. This knowledge will help you make more comprehensive assessments of a practice, better tailor quality improvement (QI) approaches and interventions to the practice, and build practice capacity for continuous QI.

This module describes the work of a primary care practice, its workforce and their roles, and the most common daily workflows. Next it reviews common business structures used when forming a primary care practice, common organizational charts, financial models, and billing.

This module is intended to provide new PFs with an introduction to practice structure and administration. More experienced PFs and those with prior experience should look for opportunities to contribute additional information to discussions about the contents of this module.

The Work of Primary Care

Deliver a comprehensive range of services. The delivery of a comprehensive range of primary care services is the principal work of a primary care practice (Donaldson, Yordy, Lohr, et al., 1996; Starfield, 1992). Primary care services are typically thought of as being divided into three categories:

1. *Preventive care* is when primary care practitioners work with patients to reduce risk for disease and prevent development of disease. They do this by providing periodic health assessments, risk assessments, screening, counseling, and patient education. This also includes screening patients to detect those in the early stages of a disease to enable early care (Donaldson et al., 1996).
2. *Acute care* is when a patient seeks health care because of symptoms. Health concerns can range from relatively minor illnesses (such as a cold virus) to a complex set of symptoms that could be serious or even life threatening. Symptoms can be physical, mental, or a combination of both.
3. *Chronic care* is when primary care practitioners work with patients to manage chronic health conditions, such as diabetes and heart disease, and maximize the patient's wellness within the context of these conditions, often over long periods.

Primary care practices are typically organized to provide care across all three of these categories.

Practices may also provide additional services in house or refer patients to services in the following areas:

- Health education and coaching services
- Laboratory services
- Radiology services
- Pharmacy services
- Transportation assistance
- Dental services
- Social services
- Behavioral health services
- Care coordination and/or care management
- Community support services and schools
- Child care
- Early intervention programs
- Other services

As a PF, you will want to understand the range of services each practice you work with provides, who provides them, which are offered in-house and which are referred out to the "medical neighborhood," and how the services are organized.

If you are working with federally qualified health centers (FQHCs), rural health centers (RHCs), or similar organizations, these practices are required to provide a wider range of services for their patients. These organizations receive grants from the federal government and increased reimbursement rates for care to support this expanded care. For more information about the services these organizations are required to provide see http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html.

Larger practices may create "clinics"—typically defined by a particular time of day, location in the practice, and set of clinicians—for delivering specialized care, such as women's health services or pediatrics. If the organization is large enough, it may have administrative divisions for adult services, pediatric services, or senior care among others.

Coordinate patients' care across the medical neighborhood. Another essential task of primary care is the coordination of patient care internally, across the medical neighborhood, and across social and other services related to patients' health. This means primary care practices must have appropriate staff and resources to coordinate care with their patients across any other health care settings with which the patients interact (Donaldson et al., 1996). The goal of this coordination is to assure patients' needs and preferences are met and the best possible outcomes are attained at the lowest cost (Agency for Healthcare Research and Quality, 2014).

Increasingly practices are hiring specialized staff to assist with care coordination. Care coordinators or care managers are specifically charged with coordinating care by facilitating referrals, transitions between hospitals and outpatient settings, and access to needed ancillary

services. A practice may also use persons with non-medical backgrounds who can help patients navigate various health care specialties and settings. These individuals may be community health workers or nurses outside of the practice or a member of the staff whose role is to advocate for the patient across all levels of care and often to coordinate with social services and other supports.

As a PF, you will want to be familiar with successful models of care coordination and understand how each of the practices you work with have organized themselves to coordinate the care of their patients.

Arrange for the patient to receive care from the same clinicians whenever possible. Primary care practices should be organized to support continuity in patient care. This means that patients see the same clinician or care team for most visits, as this will build a relationship with these professionals. To accomplish this, practices assign or "empanel" patients to specific care teams. The care team builds a relationship with the patients, gets to know their preferences, and works in partnership with the patients to help them attain their health goals (Donaldson et al. 1996; Starfield 1992; Willard and Bodenheimer, 2012).

As a PF, you will want to understand how each practice you work with supports this continuity and how well this is working. For example, does the practice empanel patients to clinicians or care teams? If so, how effective is this empanelment process and on what percentage of visits are patients seen by a member of the care team they are assigned to? Is the staff trained to schedule patients with a member of their care team, and can patients get an appointment to see someone when they need and want to or do they have to wait for extended periods of time? All these and many more factors impact continuity. Good continuity of patient care can be very difficult to accomplish.

In small one- and two-provider practices continuity occurs by default, but even in these instances it is easily disrupted. Patients may seek care at other practices because they could not get an appointment when they wanted. The clinician may rely heavily on referrals to the medical neighborhood if the services he or she provides are fairly narrow, which can also impact continuity. Patients may come on and off insurance coverage or may switch to a plan where the primary care physician they were seeing is not a provider, thereby interrupting continuity. When patients do not feel a connection to a clinician or practice they may seek care wherever it is most convenient (e.g., seeking care from organizations with competing models of primary care delivery, such as retail and urgent care clinics that emphasize speed and convenience over comprehensiveness).

Some primary care practices serve as training sites for medical residents and include them on care teams. Once residents' training is complete, they move on. This can disrupt continuity if the practice does not have a plan in place for managing the frequent changes in staff.

Many factors work to disrupt continuity. As a PF, you will want to become familiar with the

degree of importance that a practice places on continuity, how they are organized to support it, how successful they are at achieving their goals in this area, and any factors that impact their ability to maintain continuity. Even if the practice is not interested in working with you on this particular issue, you should keep this in mind as it has implications for PCMH transformation and many other aspects of practice operations, staffing, and workflow. As a PF, you typically will start your work with the practice in the areas that are the greatest priority for them. But as you work with them over time, you will also want to encourage them, through conversation, education, and introduction to exemplars, to consider other issues and areas that are not a priority to them, but that are important for overall practice improvement. In other words, you will want to help them "grow" the value they place on these other important areas.

Provide administrative, organizational, and technical services that make it possible for clinicians to deliver comprehensive, coordinated, continuous primary care. Clinicians and care teams need support to provide primary care to patients. Administrative activities such as hiring, training, QI, physical plan maintenance, marketing, billing, financial management, regulatory compliance, information technology (IT), interaction with the medical neighborhood, and workflow are essential to the delivery of good primary care. Without these supports and functions, clinicians and care teams could not do their job, and patients would not be able to engage effectively with the practice. These supportive activities and structures are discussed in a later section of this module, but it is important for PFs to recognize that the enterprise of primary care is a "team sport"—not just in the exam room but also in the administrative offices and behind the scenes. Table 4.1 provides a summary of the clinical and supportive administrative "work" of a primary care practice.

Table 4.1. The work of a primary care practice

Administrative Work
Human resources
Physical plant and materials management
Information technology management
Financial management and billing
Reporting and regulatory compliance
Quality improvement
Business development and marketing
Designing and managing workflow
Risk management
Administrative clerking and scheduling
Oversight and leadership
Transportation
Security
Medical records
Clinical Work
Medical care, including radiology, pharmacy, and lab

Behavioral and mental health care
Integration of care
Health education
Self-management support
Specialty care referral management
Population management
Medication management
Patient and care team communication management
Connecting patients to community resources
Coordinating patients' care across multiple settings and specialties

Who Plays What Roles in a Primary Care Practice?

Consistent with the two types of "work" that take place in a primary care practice, there are also generally two types of staff: administrative staff and clinical staff. *Administrative staff members* provide supportive services to clinical staff and to the organization, including management, finance, billing, human resources, health information technology, regulatory reporting, business development, marketing, risk management, and quality improvement. *Clinical staff members* deliver care to patients.

Administrative staff. In addition to the Chief Executive Officer, Chief Finance Officer, Chief Operations Officer, and Chief Medical Officer, who are typically both administrators and clinicians, other administrative staff include administrative clerks, office staff, book keepers, IT directors and staff, and other positions. Support services provided by the administrative staff include:

- **Human resources.** These services include hiring and evaluating employees, overseeing benefits, and making sure clinicians and staff are properly trained and licensed for the tasks they perform. Human resources also includes assuring positive morale, monitoring compliance with employment law, and maintaining appropriate and effective work relationships among employees.
- **Physical plant and materials management.** This position involves overseeing the upkeep and maintenance of the building and exterior spaces, cleaning, and assuring that needed materials and equipment are present and operating correctly**.**
- **Information technology management.** IT activities involve the maintenance of hardware, network, and software functions. Smaller practices often use consultants to carry out these functions, and this can be a problem if the consultant is not available. These individuals also oversee the security of data systems and will be important to you if your work involves accessing data or improving electronic health record (EHR) systems. As a PF you should become familiar with who in the organization fulfills the IT functions and the scope of this work.

- **Data manager for QI.** A relatively new role emerging in practices is the QI data manager. This position helps practices bridge their EHR and data management with QI. This can include developing reports that link data to improvement efforts. It can also include helping to make EHR changes that support QI goals such as implementing Clinical Decision Supports and alerts and helping the care team generate actionable reports on service gaps for their patients.
- **Financial management and billing.** This position manages the organization's budgets, cash flow, payroll, and financial obligations to vendors. It also incorporates coding and billing, establishing contracts with payers, monitoring eligible and allowable services, and providing feedback on visits to help clinicians understand how their productivity affects the financial solvency of the practice. The axiom "no money, no mission" holds true in every business, and a primary care practice is no exception. As a PF you should have a basic understanding of a practice's financial situation. This is important for you to assess how feasible certain work will be with the organization, and also to prioritize your work with them. If the practice is experiencing serious financial problems, then your first task may need to be to locate expertise that can help them assess and improve their financial situation before you move into other types of work with them.
- **Reporting and regulatory compliance.** This function is essential to keeping a practice in business. It includes creating insurance carrier reports and responses to their requests for information, as well as using data to produce reports on patient visits, demographics, and services. The staff involved in these activities creates the reports used for quality reporting and required by insurers and federal and state agencies. This function also includes preparation for and management of compliance audits, which may include billing and coding audits, biannual facility audits, and program-specific audits.
- **Administration and scheduling**. These two roles often touch both administrative and clinical functions. Front desk staff are often patients' first contact with the practice and their clinical team when they come for care and, as such, play a particularly important role in setting the tone for the visit and the overall experience, yet these staff may have less training and support than others. Practices may fail to recognize the pivotal role front desk staff play in the patient experience.
- **Quality improvement.** Typically QI is thought of as a function of clinical staff, but in truth it should involve the entire organization. As mentioned earlier, primary care is a team effort—not just among clinical care team members but across all staff. Administrative functions such as hiring, staff training and evaluation, physical plant design and maintenance, scheduling, and coding and billing have a significant impact on the process and quality of patient care. Because of this, QI necessarily bridges both clinical and administrative staff and functions and should include both.
- **Risk management.** This essential function is often delegated to a risk management team that reviews patient safety issues, events, and other areas that could create legal exposure for the practice. Sometimes practices view risk management and quality improvement as synonymous. They are not. Risk management focuses on reducing mistakes and related legal exposure. Quality improvement, while it may encompass work that can reduce risk,

extends far beyond this. As a PF, you should become familiar with how each of your practices organizes these two functions and be alert for indications that a practice is attempting to combine these two functions. When this occurs, you should take note and look for an opportunity to engage leadership around the need to separate (but coordinate) these two functions.

- **Business development and marketing.** This function is critical to the enterprise of primary care. The practice may have a sophisticated approach to marketing themselves and internal staff that support business development work. Often though, practices will rely on a local medical service organization (MSO) or one or more independent practice associations (IPAs) to assist them in these functions. As a PF, you will want to understand how they carry out these functions and what organizations or groups if any they have engaged to assist them. Staff from MSOs and IPAs can be a resource as you work with the practice. With permission from the practice, of course, you may find it helpful to visit with them and get their observations of the practice's strengths, challenges, and ideas they may have for supporting the practice.
- **Oversight and leadership**. These functions may be filled in larger organizations by chief executives, finance, and operations officers, or in smaller organizations by the actual owner. In addition to organizational leadership, there are also leadership functions at the clinical level that are often filled by a medical director while a practice or office manager oversees the administrative staff.

The administrative staff in a practice is a vital part of any improvement work. The practice's financial officer and operations director and their staff can be valuable sources of information about financial drivers for the practice, incentive programs available through the different health plans, rules around eligible and allowable services, and administrative resources and issues that can support quality improvement of clinical care. Many believe that QI work should be housed in the administrative section of the practice and work across both administrative and clinical areas.

Consider engaging administrative staff as members of the QI team and as advisors to the practice's QI team's work. To facilitate this, get to know the administrative staff at the same time you are building relationships with clinical staff. Introduce yourself and set up times to meet to get their ideas. Ask for their input on the planned improvements. Of course, you should do this in collaboration with your practice champion, so you do not jump ranks or create unnecessary conflicts.

Clinical staff. Clinicians in a primary care practice include physicians, physician assistants, and nurse practitioners. Other clinical staff includes registered nurses, licensed practical nurses, and nurse midwives. In some practices, behavioral health professionals, dentists, pharmacists, pharmacy technicians, and some specialty providers (such as podiatrists and eye care professionals) may be part of the practice team or come into the primary care setting periodically.

Medical assistants (MAs) assist physicians and other clinicians in delivering patient care by greeting patients, updating and filling out medical records and other forms, taking vital signs, drawing blood, and preparing patients for exams, among other tasks.

Other individuals on the clinical staff may include care coordinators (who may have a nursing or other background), clinical pharmacists, social workers, health educators, health coaches, and nutritionists or dieticians.

Some practices also include lay persons on their staff. These individuals often serve as community health workers, health promoters, or peer coaches for patients.

Functions carried out by clinical staff include medical care, behavioral and mental health care and integration, health education, referral management, population health management (or managing care for specific groups of patients), self-management support, medication management, communication management, referral to specialty care with followup, and connecting patients to community resources.

Table 4.2 provides definitions of some clinical disciplines and types of staff found in primary care practices. State and local professional associations can be a good source of additional information about the different professionals.

You will want to become familiar with the scope of practice of each clinical professional. This becomes particularly important when a practice is implementing team-based care and working on redesigning workflows to allow people to work at the "level of their license," meaning they can practice to their full professional capability. More information is available on this topic in Module 29: Implementing Care Teams.

The scope of practice is typically defined at the state level. It is helpful to know where to look to determine scope of practice. This can be particularly useful when you are helping a practice form care teams, redefine clinical roles, or add new services. Often you can look to the state association for the specialty or professional degree for information on laws governing scope of practice.

For unlicensed assistive personnel like Medical Assistants (MAs), this information is usually also available through the professional association for the discipline. It is worth noting that the scope of practice of MAs is particularly important, as they play a key role on care teams, but their scope is very much dependent on the rules of the specific practice. As a PF, it will be important to understand the rules governing the practice of MAs and other assistive personnel

and of resources that you can share with the practice that they can use to assure they are in line with these determinations.

Table 4.2. Clinical staff and descriptions

Discipline/ Degree	Description
Physicians: Medical doctor (MD) and doctor of osteopathy (DO)	Physicians include both medical doctors and doctors of osteopathy. Both types are licensed to deliver medical care and prescribe medications. Both MDs and DOs complete 4 years of medical school, an internship and a residency. Each must pass exams to be licensed in their state and practice in healthcare facilities that are licensed and accredited.
Family physician	Family physicians are specialists in family medicine and deliver care to individuals of all ages and both sexes. Family physicians emphasize continuity of care and comprehensiveness of care. Family physicians are trained in the biopsychosocial model of care and provide care that considers the individual in the context of their family and community.
Internist	Internists are specialists in internal medicine, a specialty that provides medical care to adults.
Pediatrician	A pediatrician delivers basic medical care to children.
Physician assistant (PA)	PAs are licensed health professionals who practice medicine with physician supervision. They can diagnose and treat illnesses, and in most states can also treat patients and write prescriptions.
Nurse practitioner	Nurse practitioners are licensed health professionals who can diagnose and treat health care conditions that fall within their specialty and can prescribe medications. Depending on the state, NPs may practice autonomously or under the supervision of a physician. NP training places particular emphasis on care management, preventive care and patient education.
Registered nurse (RN)	An RN has graduated from an accredited nursing school and passed a state licensing exam. An RN assesses, plans, and implements nursing care for patients, and may also provide care management support.
Licensed practical nurse (LPN)	LPNs work under the supervision of an RN or physician and administer most medications, care for wounds, take vital signs, keep medical records, and collect samples.
Licensed pharmacist	A licensed pharmacist has completed their doctorate in pharmacy at an accredited school and passed a national and sometimes also state licensing exam. They dispense medications and other remedies to patients, and advise clinicians and patients on the safe and effective use of medications.

Medical assistant (MA)	MAs are trained in standard clinical laboratory procedures. They perform venipuncture, injections, electrocardiograms, measurement of vital signs, and more. Certified MAs have passed an additional certification test. With the advent of team-based care, the role of MAs has been expanding. Expanded roles include: pre-visit planning, reconciling medications, panel management, motivational interviewing and coaching, performing tests and procedures to the degree allowed by their license and the rules of the state, and serving as a primary point of contact for patients with the care team.
Behavioral health provider	Behavioral health providers are licensed mental health professionals (such as Ph.D. psychologists or licensed clinical social workers). They assist patients in managing emotional and mental illnesses alone and in combination with other medical diagnoses.
Social worker	Social workers are licensed professionals with masters or doctoral degrees who are trained to assist individuals and families with psychosocial needs. Some also do care coordination support.
Care coordinator	Care coordinators help patients access care, help coordinate care, and facilitate exchange of information with patients and across settings.
Health educator	Health educators are individuals trained to educate patients on factors that support wellness, manage illness, and reduce risk for disease.
Certified diabetes/asthma educator	Certified diabetes educators and asthma educators are licensed health care professionals, including registered nurses, registered dietitians, and pharmacists who have completed specialty training in diabetes or asthma health education.
Health coach	Health coaches are individuals trained in health education, peer support, and motivational interviewing. They help clients set and attain health goals through behavior and life style change.
Community health worker	Community health workers are members of the local community who are engaged to help others from their community attain and maintain good health. They are often trained in communication skills, social support, motivational interviewing, and health education skills.

Adapted from http://www.highmountainhealth.com/index-1310.html Reproduced with permission.

Practice managers. Practice managers are special in the world of primary care administration. They work across clinical and administrative areas and oversee the practice's day-to-day processes and activities. Smaller practices often do not need or have the resources for separate staff for human resources and other administrative functions, so the practice manager may serve all these roles. This can include hiring, training, and managing nonclinician staff; aiding the medical director in managing clinical staff; and overseeing workflow issues. The work of a practice manager also includes supporting improvements to clinical and administrative processes.

A special note about practice managers and QI. While all employees of a practice play important roles in carrying out the work of primary care, the practice manager deserves special mention as a resource for supporting quality improvement. Introduce yourself to the practice manager and

arrange a time to meet with him or her early in your involvement with the practice. This will enhance your chances of engaging the practice manager as a key support for your work with the practice.

Practice managers can provide insight into practice culture and offer ideas on improvement priorities, as well as who might be good members of the QI team, and the feasibility of changes being considered by the team. They also serve as a gatekeeper to key staff and clinicians in the practice, so establishing a strong relationship with the practice manager is key. They can help you and the improvement team gather performance data, conduct root cause analyses, design and implement new workflows, and develop plans for sustaining changes. Solicit their input on improvement goals and methods and look for ways to include them in the improvement work.

Special staffing issues in small practices. The mix of clinicians that a practice employs impacts the practice's ability to schedule patients and deliver care to walk-in patients. In small- and medium-sized practices, the absence of a single physician can have a huge impact on the practice's ability to see certain patients and patients' ability to access care. These types of issues have significant implications for your work in quality improvement. They can help you understand why it is difficult for clinicians to participate in QI meetings. More importantly, you will need to have a good understanding of the practice's vulnerability in these areas as you work with them to redesign key workflows and introduce new approaches to care, such as group visits.

You will want to pay attention to the clinician mix, as it has implications for your work to build capacity and improve quality. For example, it may be that on Mondays, the only clinicians available are internists, so pediatric visits cannot be scheduled those days. Or perhaps the practice has an obstetrician/gynecologist who practices a half-day on Wednesdays, so women's health visits might be concentrated on those days. Or, the pediatrician may be available on Wednesdays and Thursdays, so pediatric visits are scheduled for those days. Scheduling is more flexible for practices with family medicine physicians who can see both children and adults.

In smaller practices, individuals may play several different roles in the organization. For instance, a physician from a small private practice may act as both the lead physician and the director of quality improvement. The practice manager may also be part of the front desk staff. In addition, smaller practices may not have the human resources available to support QI work. For example, many solo and small practices cannot afford to have an IT expert on staff or even as a consultant. These staffing and resource constraints will determine what can be leveraged to support QI.

Your role with the practice and the types of supports you and your team provide as you help them build organizational capacity and improve quality will vary based on the resources available in each practice. You may find you will need to provide a different type and range of support to smaller practices than you do to larger practices with more clinical and administrative staff. For example, if a small practice does not have an IT staff, you may need to provide hands-on support to the practice to help them optimize their IT systems until you can help them find an outside IT consultant or build their own internal capacity to provide these functions themselves.

This will take time. In contrast, in a larger practice with already existing in-house IT support, your job will be different and require skills for engaging and coordinating with the existing staff.

Practice Workflow

The work of primary care is carried out through administrative and clinical workflows that are often complex and have evolved over time, sometimes without the opportunity to reflect on the effectiveness or efficiency of the workflow itself. The idiosyncratic nature of workflows across practices is why comments like, "If you've seen one primary care practice, you've seen one primary care practice," ring true.

Workflows for clinical tasks are typically based on visit types. Examples include: new patient visits, initial health assessment for a Medicare patient, newborn check, and comprehensive diabetes care visits for diabetic patients. The unique patient and payer mix of each practice determines the relative frequency and importance of each of these. In addition, each visit type may have unique variations based on each patient's payer. Moreover, with the advent of EHRs, substantial portions of many clinical workflows involve "clicks" on an EHR. Thus, understanding and mapping workflows requires understanding and mapping how clinicians and staff navigate through their EHR for each visit type. Module 10 in this curriculum provides information on workflow mapping and redesign. A few examples of common primary care workflows are:

- Patient check-in
- Office visits by visit type
- Prescribing and medication refills
- Appointment scheduling
- Lab orders
- Lab orders results management
- Referral generation
- Office discharge

Similarly, **workflows for administrative tasks** are typically organized around key tasks, such as scheduling, billing, financial reporting, and new staff orientation.

Much of your time will be spent helping practices understand and evaluate their existing workflows, and then helping them enhance or redesign their workflows to improve quality, efficiency, and incorporation of key elements of the PCMH. As such, you will need to become familiar with the key workflows for each of the practices you work with and knowledgeable about exemplary workflows you can use to help practices improve theirs.

Business Structures in Primary Care

The most common business structures for primary care practices are privately owned businesses, nonprofit organizations and free clinics, hospital-owned practices, and federally qualified organizations including FQHCs, FQHC lookalikes, RHCs, and community health centers (CHCs). Primary care practices can also be part of integrated health systems, such as Kaiser Permanente or the Veterans Health Administration.

As a PF, you will want to learn the structure of each practice you serve. This will have implications for the types of resources they have, the types of reporting they are required to do, and the forms of payment they are eligible to receive, as well as the leadership required for the particular practice structure.

Private or independent practices (IPs) are practices owned and operated by one or more physicians and, in some instances, also physician assistants and/or nurse practitioners. IPs have the flexibility to structure and govern their internal systems as they deem appropriate, while abiding by regulations. IPs vary in size from very small solo clinician practices to larger group and multispecialty practices.

Private practices are often entrepreneurial in nature. Small private practices in particular are often family owned and operated. This creates unique challenges for your work, and you will want to become familiar with the unique needs and dynamics of a family-owned business.

Nonprofit practices are typically mission driven and focused on caring for a particular vulnerable group of patients defined by geographical location (such as a low-income community) or a special need (such as geriatrics). Nonprofit practices vary in size from the small solo practices to larger organizations with ten or more primary care providers. They must maintain a board of directors that provides oversight of the organization’s management and financial operations.

Some nonprofit practices are eligible for and apply for designation as a FQHC or RHC based on their location or the underserved population cared for; this allows them to receive a higher rate of reimbursement for patient care and other benefits. FQHCs are required to provide a range of comprehensive primary health care services that includes health education, transportation, care management, dental care, and services in addition to medical care. They are also required to provide regular reporting to the federal government’s Health Resources and Services

Administration and complete yearly audits of their services (Health Resources and Services Administration, n.d.).

Organizational Charts

Organizational charts of primary care practices vary widely. Smaller practices may be relatively flat, with the owner/physician as the practice director and an office manager in charge of administrative activities. Larger multisite organizations typically have several layers of leadership, including a set of senior executives that include a chief executive officer, chief financial officer, and chief medical officer, and then a second layer of leadership at each practice. Figures 4.3 and 4.4 show examples of organizational charts from a small and a large primary care practice.

Figure 4.3. Organizational chart for a solo practitioner practice

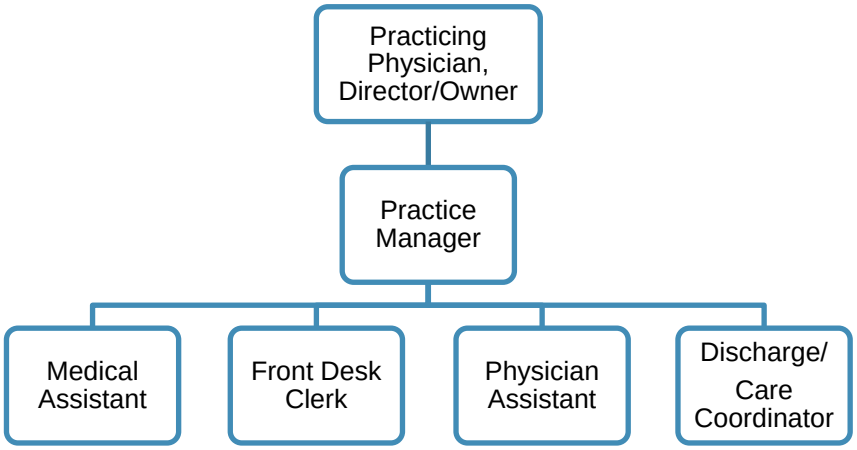
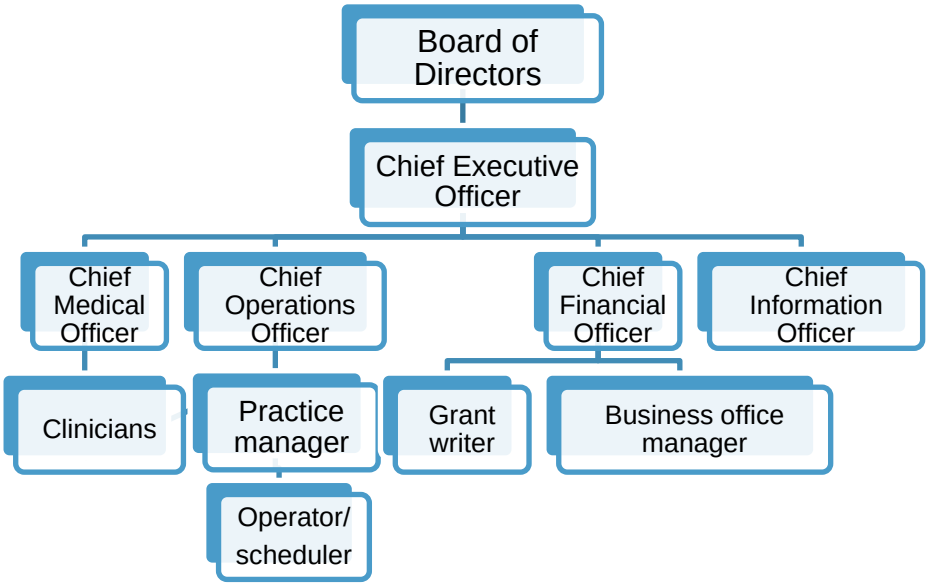


Figure 4.4. Organizational chart for a large practice with multiple sites



Organizational or Corporate Culture

Organizational culture is the foundation for all practice activities. It is determined by a variety of factors ranging from the organization's formal business structure (nonprofit or for-profit); the leadership style of top management; its location; the demographics of its patients; the skills, experience, and personalities of its staff and clinicians; its organizational history and mythology; and its financial situation and revenue model, among many other things. Every practice has its own unique culture, and this culture will be an important factor in any work that you undertake with the practice. Because of this, you will want to observe and be aware of the corporate culture in each practice and fit the methods you use to it.

Where Does the Money Come From To Pay Salaries and Overhead?

Practices generate revenues in a variety of ways. Their primary source of revenue is, or course, payment for the direct care of patients. The most common models of payment include self-pay, fee-for-service, capitated payments, blended payments, FQHC/CHC models, and emerging models such as direct pay.

In **self-pay**, patients pay out of pocket for their care. FQHCs are required to provide a sliding fee scale for patients based on ability to pay and federal and state formulas for poverty.

In the **fee-for-service** model, practices are paid by a third party for service encounters with a patient at a negotiated rate.

In **capitated contracts**, practices receive a set payment per-member per-month (PMPM) that covers a specified set of services. Practices receive this payment regardless of whether a patient comes in for care or not.

Blended payments combine capitation with fee-for-service or pay-for-performance programs. Clinicians receive a PMPM fee for each patient under their care to cover a set of services.

Direct payment is specific to a new type of primary care practice that has emerged over the past few years called **concierge or boutique practices**. Concierge practices are ones where clinicians have opted out of insurance plans, and patients pay out of pocket for services provided to them by these practices. For example, a patient might pay $2,000 for a year of concierge primary medical care from a physician. This fee would cover doctor visits and care coordination but not labs and specialty care, which would be covered by the patient's insurance.

Payment for health care is rapidly changing. New models are emerging, such as shared savings models and bundled payments, and are being tried in various places around the country. In addition, models for supplemental or enhanced payment, such as pay for performance and pay for value, are growing in popularity across the country.

As a PF, you should be familiar with not only the payer mix of each practice you work with, but also the various models by which they are being paid. These may have implications for the work you undertake with each practice.

A note about coding and billing. Practices must comply with specific rules and regulations regarding allowable and eligible services. For example, the rules that prevent a practice from billing for more than one service per patient in a day were set by the federal government and depend on how the term "encounter" is interpreted. Other rules are determined by individual payer organizations.

When a patient receives care from the practice, the clinician documents the services in the EHR (if the practice has an EHR). A super bill is also created for each visit that includes visit type, diagnoses, conditions for which the patient was seen, procedures conducted during the visit, and labs ordered. Practices can receive reimbursements in just a few weeks or wait months or sometimes years to receive payments (Weida and O'Gurek, 2014). Table 4.3 provides a list and description of commonly used coding systems.

Table 4.3. Coding systems

International Classification of Diseases (ICD) codes	ICD codes are used by health care professionals to indicate diagnosis for all patient encounters. Available at: http://www.cms.gov/Medicare/Coding/ICD10/index.html.
Current Procedural Terminology (CPT) codes	In CPT coding, numbers are assigned to all services and tasks health care providers deliver to a patient. CPT codes were developed by the American Medical Association (AMA) and are continually evolving.
Healthcare Common Procedure Coding System (HCPCS)	HCPCS is an alternate to the AMA CPT codes used by Medicare, Medicaid, and other health insurers. HCPCS incorporates the American Medical Association's CPT codes.

Other sources of practice revenue. In addition to payment for medical services, many practices may have other sources of revenue, such as program grants and research. FQHCs and RHCs also receive federal grants to cover costs of some services.

As a PF, you should have a basic understanding of each practice's revenue model and payer mix, as this will have implications for improvement work at the practice. For example, where does the practice generate most of its income? Are most of its patients self-pay, or do they have Medicare? Medicaid? Commercial insurance? What pay-for-performance programs are available to practices that you might help them qualify for? Finally, what payer regulations might limit what is possible in terms of new or modified services?

While it is not necessary or realistic for every PF to become an expert on each practice's financial and revenue models and systems, it is important to know what questions to ask and who to ask as you work with them. Sample questions that PFs might ask to understand financial and payer issues in the practice include:

- Is the practice financially stable, or is it having trouble meeting financial obligations?
- Does the practice have the financial expertise available either on staff or through consultants to ensure a solid financial system and approach? What is the payer mix of the

practice? What are the implications of this on service delivery? What are the implications for practice workflow? Who receives what services from the practice, and who is referred out?

- What pay-for-performance programs exist for each payer, and what are the requirements for each? Do any of these overlap with the QI work that you are supporting? Is there a way to align current QI work to support these activities?
- What, if any, service grants does the practice hold? Is there any value in aligning current QI work with these grants?
- Are there implications of improvements being considered for practice finances? What are the expected costs? Are there any payer restrictions that could create barriers to implementing the proposed changes? Are there ways to resolve these? How have other practices that have implemented similar improvements resolved them and could these be used here?

External Resources for Primary Care Practices

Practices may also participate in and receive support from external service organizations that function to support primary care practices. For example, both private and nonprofit practices may become members of organizations such as independent practice associations that provide services for them. IPAs negotiate contracts with payers on the behalf of their membership and may also help organize care for provider members, inspect and credential providers, establish referral processes, distribute payment to practices, and support utilization management and reviews (Wolper, 2004).

Management service organizations also may provide support to a primary care practice. The MSO may be contracted for services through a practice's IPA or independently by the practice. MSOs assist with claims processing, credentialing, determining eligibility and benefits for patients, quality and risk management, and utilization management. They can also function as a liaison between payers and providers, keeping them informed of new policies and procedures, and provide business development support to their members (Wolper, 2004).

Primary care associations and state primary care offices are other resources for primary care practices. They offer training and other supportive information and resources for primary care practitioners and practices. National cooperative agreements are service organizations that receive funds from the Health Resources and Services Administration to support FQHCs and lookalikes. State primary care offices are another resource. Lists of these organizations by state can be found at: http://bphc.hrsa.gov/qualityimprovement/supportnetworks/index.html

The National Association for Community Health Centers and local community clinic and rural health care associations are other sources of resources for FQHCs, RHCs, and CHCs.

Summary

The organizational structure, staffing structure, and payer mix of a primary care practice has significant implications for your work with a practice. These factors help define priorities for the practice, its capacity for transformation and improvement, and the types of facilitation support that may most benefit it. As a PF, it will be helpful to you and each practice you work with to understand these features and how they relate to your work with practices on improving quality.

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