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Private Practice Playbook

About the AMA STEPS Forward® Playbook series

This Playbook is part of the AMA STEPS Forward® interactive practice transformation program. Each Playbook in the series highlights key messages and provides links to free online toolkits, videos, podcasts, and practical tools to start creating change today. The objective of the Playbook series is to provide a high-level overview of a practice topic into which you can dive deeper at your own pace.

For the optimal experience—GO DIGITAL!

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About the AMA STEPS Forward® practice innovation strategies

The AMA STEPS Forward program offers practice innovation strategies that allow physicians and their teams to thrive in the evolving health care environment by working smarter, not harder. Physicians looking to refocus their practice can turn to AMA STEPS Forward for proven, physician-developed strategies for confronting common challenges in busy medical settings and devoting more time to caring for patients. This collection offers more than 70 online toolkits and other resources that help physicians and medical teams make transformative changes to their practices, in areas such as managing stress, preventing burnout, and improving practice workflow.

The AMA STEPS Forward® Innovation Academy expands on the program to give participants the flexibility to customize their practice transformation journey. The Innovation Academy offers a wide range of opportunities to learn from peers and experts, including webinars, tele-mentoring, virtual panel discussions, bootcamps, and immersion programs.

Learn more at stepsforward.org.

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Introduction

The goal of this Playbook is to introduce foundational terms and concepts that apply to private practice. Physicians who understand these terms can engage in more meaningful conversations with advisors, vendors, and other professionals.

What Is Private Practice?

In this Playbook, we define **private practice** as **a practice that is wholly owned by physicians.**

Private practice is an attractive option for physicians seeking the freedom and independence to practice in a setting that allows them to provide personalized medical care for their patients. It is inclusive of practice owners, employed physicians, and independent contractors.

Many physicians train in a landscape dominated by large medical organizations and are unaware of opportunities to enter private practice. And yet, about 50% of all physicians in the US are in private practice.[1] The shift away from private practice and toward health systems has not uniformly led to projected improvements in care delivery or reductions in the cost of care. This observation, coupled with already present concerns surrounding access to care, has led to questions about the long-term sustainability of private practices. Efforts to support and sustain private practices are crucial to the availability and success of this model of care, controlling health care costs, and ensuring work-life balance for physicians.[2]

Not all private practices are the same, and this Playbook will describe the characteristics, benefits, and challenges of different models.

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> Throughout the 20th century, small independent physician-owned primary care practices formed the bedrock of the health care system in the United States. [...] evidence shows that they deliver care that is equal to or better than that of practices owned by hospitals and health systems.
>
> ❞
>
> **Rittenhouse DR, et al.[3]**

Who Is This Playbook for?

- Physicians who are aspiring to open a private practice
- Physicians who are aspiring to enter an established private practice
- Practice managers
- Operations leaders

This Playbook contains opportunities to **EXPLORE MORE!** through 19 AMA STEPS Forward® toolkits and other essential AMA resources.

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Part 1: Is Private Practice Right for You?

Knowing your priorities regarding **how** you want to practice is important. There are a variety of private practice models, and they each have advantages and disadvantages. The greatest advantage for most physicians who choose private practice is flexibility and more autonomy to make decisions.

Before starting, step back and think about your priorities. Rank your priorities or identify potential deal-breakers to help you tailor your search. Answering the following questions can also help:

- How much autonomy or control do I want over my day?
- Am I interested in taking on financial and management responsibilities?
- How much financial risk am I (and the people who depend on me) comfortable with?
- How much time off do I want? Flexible or part-time schedule; call schedule; coverage?
- What is my practice's mission or affiliation?
- How will I earn my salary? (Compensation, including loan repayment programs)
- How innovative and tech-savvy is the practice?

The great variety of private practice options—and their pros and cons—can be broken down in several ways (Table 1). There is no wrong answer; you should base your private practice journey on your individual priorities.

Table 1. Features of Different Practice Models

EMPLOYMENT STATUS	AUTONOMY	MANAGEMENT RESPONSIBILITIES	FINANCIAL RISK	CALL COVERAGE	GOVERNANCE STRUCTURE	OTHER CONSIDERATIONS
Owner of solo practice	**HIGH** *You are the sole decision-maker*	**HIGH**	**HIGH** Potential for bonus and/or reduction in income depending on performance metrics	Personally responsible for arranging with other colleagues	Sole owner	Some enjoy the variety of taking on an entrepreneurial role It can be difficult to disconnect or take time away
Partner in a group practice	**MEDIUM** *You have a say, but you must collaborate with other partners*	**MEDIUM**	**MEDIUM** Potential for bonus and/or reduction in income depending on performance metrics	Set call schedule that is unique to each practice	Opportunity for partnership varies	Review partnership requirements and benefits carefully as they vary widely between organizations
Employed physician	**LOW** but variable *Your physician employer sets the rules and requirements*	**LOW**	**LOW**	Set call schedule that is unique to each practice	Physician partners make decisions	Very important to understand the culture of decision-making and physician support within the organization. The contract should include support staff, call, and patient volume/panel size

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The AMA Path to Private Practice

The AMA understands that the highest quality of patient care and greatest physician satisfaction occurs when physicians pursue practice arrangements that complement their unique style of practicing medicine.

For enterprising physicians seeking greater autonomy in their practice of medicine, a private practice can be an exceptionally fulfilling environment. The path to private practice is not without challenges, but a strong foundation can help ensure that physicians can overcome any hurdle.

Start on the path with the AMA's essential tools and resources that give physicians the head start they need to sustain success in an independent practice setting. Your journey begins here:

Payer Contracting and Payment Models

Additional considerations for physicians going into private practice are identifying payers to contract with and the desired payment models for the practice. This is a complex and detailed process, so working with an experienced health care attorney to negotiate these arrangements can be beneficial.

4

Location

Where a physician chooses to put down their practice's roots is the crucial first step in making the dream a reality. Take stock of the local market and assess the needs of the population in that area. Determine whether buying or leasing property is best. Once you settle on a geographic location and real estate plans, work with an experienced commercial realtor to select the ideal space. Ensuring a location meets all high-priority needs will go a long way toward the practice's success.

3

Professional Advisors and Peer Collaboration

It is vital for physicians to have a basic understanding of business operations. Engage in meaningful conversations with professional advisors during the decision-making process as you establish operations for your private practice.

1

2

Licensing and Credentials

Physicians must be both licensed and credentialed in the state they wish to practice medicine. This process often takes several months to complete, so it is recommended to start as early as possible.

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Professional Insurance

You may want to consider insurance policies commonly available to businesses and business owners. Policies like business overhead insurance and disability buyout insurance can protect the practice and any partners.

5

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7

Staffing

Use industry benchmarks to determine how best to staff your practice. The number of support team members you need in your practice will depend on the number of full-time physicians employed. Consider your administrative staff needs—receptionists, staff who complete billing, coding, prior authorization, referrals, and credentialing, managers, human resources, and others—which may vary by office.

Equipment and Supplies

Physicians need equipment and supplies to care for their patients. While it may seem obvious to include items such as bandages and gauze in a procurement list, what may be less obvious are furnishings, uniforms, and durable medical equipment (DME). A vendor to partner with on purchasing supplies can be a worthwhile investment. It's also a good idea to compare prices at various supply companies.

Building on the Path to Private Practice, the What to Look for in Your First or Next Practice toolkit details 8 STEPS to evaluate practice opportunities that can benefit even seasoned physicians considering a shift to a different practice type.

EXPLORE MORE!

What to Look for in Your First or Next Practice toolkit

Download the complete Path to Private Practice infographic poster (PDF)

Part 2:
Attending to Business

Starting in Private Practice Checklist

The health care landscape is changing rapidly, driven by the growth of payment models other than Fee for Service, regulatory changes, technology, and consumer demands, among other factors. AMA advocacy, resources, and research help make private practice a viable option for physicians. For physicians contemplating a move to private practice, several important considerations outlined below contribute to the success of this model of care.

STEP 1: Location

Where a physician chooses to put down their practice's roots is the crucial first step in making the dream a reality. Take stock of the local market and assess the needs of the population in that area. Determine whether buying or leasing property is best. Once you settle on a geographic location and real estate plans, work with an experienced commercial realtor to select the ideal space. Ensuring a location meets all high-priority needs will go a long way toward the practice's success (Figure 1).

Figure 1. Considerations When Choosing a Private Practice Location

Real Estate Purchase	Real Estate Lease	Setting	Structure Type	Additional Considerations
• Higher up-front cost, but fixed monthly costs will help you predict your future expenses. • Ability to expand by adding space in the future.	• Lower up-front cost, but monthly costs are variable and could change when lease expires. • Several barriers for future expansion.	• Rural • Suburban • Urban	• Hospital-affiliated • Stand-alone • Private medical office building • Retail store front	• Competition • Patient demographics • Traffic patterns • Signage • Parking • Proximity to hospital

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STEP 2: Licensing and Credentials to Practice and Prescribe

Physicians must be both licensed and credentialed in the state they wish to practice to care for patients. This process often takes several months to complete, so it is recommended to start as early as possible (Figure 2).

Figure 2. Overview of the Process for Licensing and Credentialling

Licensing & Certifications

- State physician
- State controlled substance
- United States Drug Enforcement Administration (DEA)
- Board certification (if applicable)
- Medical liability insurance*

Additional resources:

Navigating state medical licensure

Federation of State Medical Boards (FSMB): Federation credentials verification service

FREIDA™ physician credentialing

AMA Advocacy: physicians call for clarity on IMG credentialling, licensure

*Not a license but required by many hospitals.

IMG=international medical graduate

Credentialing – Phase 1

1. Identity & access management (I&A account). First step in obtaining a National Provider Identifier (NPI) number for payer enrollment.
2. National Plan & Provider Enumeration System (NPPES) enrollment. To obtain your NPI number.
3. Medicare group or clinic enrollment (PDF). To obtain the Medicare PTAN (Provider Transaction Access Number) for your practice.
4. Medicare individual enrollment (PDF). To obtain the Medicare PTAN for individual physicians. Link your individual enrollment to your practice PTAN for payment purposes

Additional resources:

National Provider Identifier Standard (NPI)

Know your options: Medicare Participation Guide (PDF)

Credentialing – Phase 2

These enrollments are less common but may be required based on your patient population or physician organization.

- Railroad Medicare enrollment. This is separate from traditional Medicare and should be completed once group/clinic & individual PTAN's are received.
- Medicaid enrollment (PDF). To enroll with the Medicaid plans in your state. Most physician or hospital organizations will require active participation with Medicaid to begin the credentialing process.
- Council for Affordable Quality Healthcare (CAQH) enrollment. Self-reporting professional and practice information portal between physicians and health plans or other health care organizations. This step is optional, but many physicians have found it to be a timesaver.

Additional resources:

Improving Health Plan Provider Directories white paper (PDF)

NOTE: There are several options for contracting with commercial or private insurance payers outlined in the resources provided in Part 2, STEP 4 of this Playbook.

EXPLORE MORE!

Navigating state medical licensure resource

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STEP 3: Professional Advisors and Peer Collaboration

It is vital for physicians to have a basic understanding of business operations. This knowledge can be obtained by engaging in meaningful conversations with professional advisors during the decision-making process as you establish operations for your private practice. These consultations provide invaluable guidance and may help you develop a business plan for day-to-day and long-term operations. Many financial institutions require a formal business plan to approve business or equipment loans. Personal guarantees may also be required.

Figure 3. Advisors to Guide Physicians Entering Private Practice

Legal	Finance	Compliance	Information Technology	Peer Collaboration

Consult for their expertise in:

Legal	Finance	Compliance	Information Technology	Peer Collaboration
Real estate	Practice finances and taxes	HIPAA regulations	Phone system	Shared call
Payer contracts	Personal taxes	Paper shredding	Internet	Vendor referrals
Practice business structure	Billing service	Sharps disposal	Network	Advisor referrals
		Other medical waste disposal	Connectivity	
			Computers	
			Phones	
			Tablets	

EXPLORE MORE!

Private Practice Business Considerations Guide (also see p. 45)

Private Practice Common Financial Terminology (also see p. 47)

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STEP 4: Payer Contracting and Payment Models

Additional considerations for physicians going into private practice are identifying payers to contract with and the desired payment models for their practice (Figure 4). This is a complex and detailed process, so working with an experienced health care attorney to negotiate these arrangements can be beneficial.

Figure 4. Different Forms of Payer Contracting and Payment Models

Payer Contracting	Payment Models
Payer types Medicare Medicaid Commercial **Contract types** Direct Physician organization	**Core** Fee for service Capitation Bundled payments **Supplemental** Pay for Performance (P4P) Shared savings Retainer based **Organizational** Medical home Accountable Care Organization (ACO)

EXPLORE MORE!

Physician Payment Models Guide (also see p. 51)

Private Practice Toolkit: Payor Contracting 101 (PDF)

Payor Contracting 101 & 201 webinar

Private Practice Checklist: Key Considerations in Forming, Operating or Joining a Clinically Integrated Network (CIN) (PDF)

STEP 5: Professional Insurance

Physicians may want to consider insurance policies commonly available to businesses and business owners to protect the practice and any partners. Examples include business overhead insurance and disability buyout insurance, though there are others to consider as well (Figure 5).

Figure 5. Professional Insurance Considerations for Private Practice

Directors and Officers (D&O)	Life	Business interruption	Employee dishonesty
	Cyber security	Property	Umbrella
Commercial liability	Workers' compensation	Disability	Medical liability
	Technology	Equipment	

EXPLORE MORE!

Protecting professional practices

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STEP 6: Equipment and Supplies

Physicians need equipment and supplies to care for their patients. While it may seem obvious to include items such as bandages and gauze in a procurement list, what may be less obvious are furnishings, uniforms, and durable medical equipment (DME). A vendor to partner with on purchasing supplies can be a worthwhile investment. It's also a good idea to compare prices at various supply companies. Figure 6 lists some basics to get you started equipping and supplying your practice.

Questions to ask yourself as you begin procurement:

- Will you purchase or rent items?
- Are you planning to purchase only new items, or can some items, such as office furniture, be used?
- Will you need financing, and if so, will this be through the vendor or a private bank?
- Do your professional organizations have group purchasing arrangements for discounted pricing?
- Do your medical supply vendors offer office supplies?

Figure 6. Equipment and Supplies For Starting a Private Practice

Medical Equipment	Office Equipment	Medical Supplies	Office Supplies
• Exam chairs and tables **Other equipment types:** • Diagnostic • Surgical • Durable medical equipment (DME) • Storage • Transportation • Acute care • Procedural	• Desks and chairs • Computers, tablets, and printers • Internet security • Server • File and storage cabinets • Supply shelving • Waiting room furniture • Televisions • Décor	• Non-surgical instruments • Wound and skincare kits • Syringes • Needles • Gloves • Sterilization • Swabs • Minor procedure supplies	• Paper products • Pens, pencils, and markers • Binders • Packing supplies • Workspace organizers • Labels • Stamps • Employee badges • Staplers and punches • Carrying cases • Safety and security items

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STEP 7: Staffing

Staffing ratios can be highly variable, and there are numerous considerations for creating a high-functioning, cohesive, and efficient team that delivers excellent care (Figure 7). The objective is to pinpoint a staffing ratio and team makeup that provides optimal support for physicians in your practice setting. Your specialty or subspecialty professional society may be helpful in providing data specific to your practice.

Calculating the number of support team members that a practice needs relies on determining the number of physicians employed as full-time equivalent (FTE). This can be misleading, however, as calculating FTE with the hours worked per week is frequently based on a standard 40-hour workweek. Research suggests that for every hour of direct face time with patients, a physician spends an additional hour on non-patient-facing desktop medicine (patient portal communication, responding to online requests, etc.).[4] Taking this into account, a physician with 28 patient scheduled hours likely works closer to 56 total hours per week. It is important to be aware of this when calculating FTEs and establishing your ideal staffing ratio.

Physicians should also consider competitive benefits packages as recruitment for the practice team is ongoing. Consider offering professional development for team members as another differentiator for your practice. For example, enable medical assistants to contribute in a more meaningful way to the practice team by increasing their skills and knowledge. The Medical Assistant Professional Development toolkit gives suggestions for creating personalized MA training for your practice to help your team practice to their highest potential and improve the quality of care the office can provide.

Note: While creating your own medical assistant professional development program will be invaluable to your practice, it does not take the place of a certified medical assistant training program accredited by organizations. Learn more about MA professional credentials, the different pathways to certification, and the potential skill variation in MAs certified through different pathways in the Medical Assistant Recruitment and Retention toolkit.

EXPLORE MORE!

Private Practice Staffing Guide (also see p. 54)

Medical Assistant Recruitment and Retention toolkit

Medical Assistant Professional Development toolkit

Success Story: Dermatology Practice Reaps Benefits of Empowered Medical Assistants and Detailed Note Templates

Success Story: Teamlets Led by Physicians but Run by Medical Assistants Improve Efficiency

Private Practice Guide: Implementing a Work-From-Home Program (PDF)

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Figure 7. Evaluating Clinical Care Team and Administrative Staffing Needs

Support Staff Per Full-time Equivalent (FTE) Physician Ratio

The number of full-time administrative and clinical team members needed to effectively support 1 full-time physician. The ratio of FTE support team members for every FTE physician will differ between practices, and there is no "right" ratio.

Calculating Staffing Needs

- Determine the total number of physicians in your practice expressed in FTEs. Each full-time physician counts as 1, while each physician that works less than full time counts as fraction of an FTE calculated by dividing their average number of hours worked per week by the full-time standard in your practice.
- Calculate your staffing needs by multiplying the total number of physician FTEs by the total number of FTE non-physician team members needed to effectively support 1 full-time physician in your practice.

Factors That Can Inform Your Staffing Needs

Administrative
- Is billing done in-house, or do you have a vendor?
- Are prior authorizations done in-house or via a vendor?
- What administrative tasks have you outsourced, and what administrative staff do you need to hire (eg, receptionists, staff who complete billing, coding, prior authorization, referrals, and credentialing, managers, human resources, and others)?
- Can you cross-train full-time team members to fill several part-time roles, such as an administrative member handling billing, prior authorization, and referrals, or a practice manager taking on human resources tasks?

Clinical workflows
- How many procedures are done in the office?
- How many clinical and non-clinical tasks are the responsibility of supporting team members?
- Are you performing telehealth visits?
- How many exam rooms do you have?
- How does your practice layout affect your workflows? How much time does it take physicians, support team members, and patients to move through your practice space to address their duties or visit needs?

Patient population
- What is your patient panel size?
- How many patients does each physician see per day?
- What are the needs of your patients? Do they require extra time for assessment and treatment plan review?
- Do your patients have social determinants of health (SDOH) or other needs that require a higher level of care?

Other
- Does your specialty society have staffing recommendations?

Additional Considerations

Staffing shortages	On-call schedule (for staff absences)	Training opportunities	Benefit packages	Remote employment options

Relevant Regulatory and Legal Information

No business owner, let alone a physician focused on patient care, anticipates running afoul of legal or regulatory issues. Being aware, informed, and prepared in this arena cannot be emphasized enough.

EXPLORE MORE!

Debunking regulatory myths website

Fraud and Abuse Laws

Physicians and staff should have a thorough understanding of fraud and abuse laws and concepts that apply specifically to medical practice (Table 2).

Table 2. Overview of Fraud And Abuse Laws Physicians Should Know[5]

LAW	DESCRIPTION
Anti-kickback Statute (AKS)	Prohibits the knowing and willful payment of "remuneration" to reward patient referrals or the generation of business involving any item or service payable by federal health care programs.
Physician Self-Referral Law	Commonly referred to as the Stark Law, it prohibits physicians from making Department of Human Services (DHS) referrals payable by Medicare to an entity that they or their immediate family members have a financial relationship with, like ownership, investment, or compensation.
Exclusion Statute	The Office of the Inspector General (OIG) is legally required to exclude individuals and organizations from participating in all Federal health programs if convicted of certain criminal offenses. If you are excluded, then Federal health programs will not pay for your services.
Civil Monetary Penalties Law (CMPL)	OIG may seek legal monetary penalties and sometimes exclusion from various programs for individuals and organizations that have violated certain rules. Penalties can range from $10,000 to $50,000 per violation.
False Claims Act	It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.

EXPLORE MORE!

Patient Records Electronic Access Playbook (PDF)

HIPAA privacy & security resources

HIPAA administrative simplification

HIPAA audits

The Nuts and Bolts of Achieving HIPAA Security Rule Compliance through Effective Risk Assessment (CME credit)

Understanding HIPAA

HIPAA is the acronym for the Health Insurance Portability and Accountability Act. HIPAA covers privacy, security, breach notification requirements, and administrative simplification requirements related to electronic transactions and code set standards. It is important to note that HIPAA is a "floor," meaning that states may have requirements that go above and beyond what the federal government requires. This Playbook focuses on federal mandates.

Understanding Information Blocking

Information blocking can occur in many forms.

Patients can experience information blocking when trying to access their medical records or sending their records to another physician.

Physicians can experience information blocking when trying to access patient records from other providers, connecting their electronic health record (EHR) systems to local health information exchanges, migrating from one EHR to another, and linking their EHRs with a clinical data registry. Physicians may also implicate the information-blocking rule if they knowingly take actions that interfere with accessing, exchanging, or using electronic health information (EHI), even if no harm materializes. In this way, physicians can benefit from and are the subject of information blocking regulations.

EXPLORE MORE!

Part 1: What is information blocking? (PDF)

Part 2: How do I comply with info blocking and where do I start? (PDF)

Information Blocking Regulations: What to know and how to comply (CME credit)

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Physician Payment and Delivery Models

The world of physician payment and delivery models has changed the health care industry as we knew it. The federal government and private payers are changing how they pay physicians and other health professionals. There is an ongoing movement towards models that are intended to improve quality and reduce costs through tracking and paying performance-based bonuses based on process, outcome, and cost measures or entering capitated risk arrangements. An AMA–RAND study investigated these models and their real-world impact on physician practices and found that payment models affect both physicians and practices in a variety of ways.

Figure 8. Physician Payment and Delivery Models

Core Payment Models	Supplementary Payment Models	Organizational Models
Fee-for-service Capitation Bundled or episode-based payments	Pay for Performance (P4P) Shared savings Retainer-based payment	Medical home Accountable Care Organization (ACO)

Consider your cash flow and revenue cycle model once you've selected a payment and delivery model. The STEPS Forward® Revenue Cycle Management toolkit breaks revenue cycle efficiency into 8 actionable STEPS, many of which leverage electronic systems instead of paper—for example, electronically verifying patient insurance and submitting claims, using electronic transactions to reduce prior authorization burdens, and leveraging electronic claims submission.

EXPLORE MORE!

Revenue Cycle Management toolkit

Physician Payment Models Guide (also see p. 51)

Prior Authorization

Prior authorization—sometimes called precertification or prior approval—is a health plan cost and quality control process. Physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage. When it is used, prior authorization should follow a standardized, automated process to minimize the burden placed upon both physicians and health plans.

EXPLORE MORE!

Tips to help physicians reduce the prior authorization burden on their practice (PDF)

Break Through the Prior Authorization Roadblock webinar slides (PDF)

AMA prior authorization initiatives and resources

Claims Submission and Payment Avenues

Imagine that you experienced a computer problem that prevented your claims from being sent to your clearinghouse. You didn't notice the computer problem for a month until the slowing in the cash flow rate and drop in practice revenue and bank balances became obvious. Now you are scrambling to resubmit claims via your clearinghouse and panicking about your potential lack of cash flow for the next 1 to 3 months while you await payment. In Table 3, you can find tips for simplifying claims submission and payment administrative aspects and learn how to leverage electronic transaction standards to improve practice efficiency.

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Table 3. Description and Resources for Common Claims Submission Methods and Payment Avenues

	DESCRIPTION
Clearinghouse	Acts as the middleman between your practice and the insurance payers. The clearinghouse will check electronic medical claims for errors to ensure the claims are processed correctly by the payer. Most EHR vendors have preferred clearinghouses that they work with and may offer discounted pricing for practices.
Electronic Eligibility Verification	Provides your practice with a patient's insurance eligibility and benefit information before or at the time of their visit. The practice can use this information to provide patients with an estimate of their financial responsibility before an exam or procedure.
Electronic Claims	Transmits a paperless patient claim form generated by computer software and electronically over a computer connection to a health insurer or other third-party payer for processing and payment.
Electronic Funds Transfer (EFT)	Automates your claims management revenue cycle by transferring claims payments electronically to a bank account of your designation.
Electronic Payments: Virtual Credit Cards	Delivers claim payments via payer-issued virtual credit cards (VCCs). When paying via VCCs, health plans send credit card payment information and instructions to physicians, who process the payments using standard credit card technology. Note that this payment method is associated with transaction fees that can reduce practice revenue.
Electronic Remittance Advice (ERA)	Gives details about the amount billed, the amount paid by the health plan, and the reasons for any differences between the billed and paid amounts in an electronic version of a paper explanation of benefits (EOB).

EXPLORE MORE!

Electronic transaction toolkits

Electronic claims toolkit (PDF)

Electronic funds transfer toolkit (PDF)

Know your rights and make ACH EFT work for your practice (PDF)

CMS guidance on VCCs, EFT/ERA and business associates—what you need to know (PDF)

The effect of health plan virtual credit card payments on physician practices (PDF)

Getting started with electronic remittance advice (PDF)

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Practice Revenue Streams

As you establish your private practice, it is easiest to think of your income coming from 3 different buckets: insurance payments, patient payments, and workers' compensation claims (Figure 9).

Figure 9. Three Forms of Physician Payment

Patient Payments

Practices collect payment when the patient is still in the office at the time of service. This is the vital first step in any effective patient payment policy and will increase your practice's cash flow, decrease accounts receivable and bad debt, and reduce billing and back-end collection costs.

Insurance Payments

Practices receive payment from insurance companies for services performed for their member patients.

Workers' Compensation

Practices may occasionally seek payment from other entities, such as property and casualty (P&C) insurers for workers' compensation claims. While there are many similarities in workflows between health insurance claims and P&C medical billing, practices need to be aware of key differences.

EXPLORE MORE!

Maximize Patient Collections After the Time of Service (PDF)

Managing Patient Payments: 7 STEPS to POC Pricing (PDF)

How to Calculate the Price of Treatment at the Point of Care (PDF)

Medical Billing for Workers' Compensation and Other Property and Casualty Insurance (PDF; AMA-member-access only)

The Fee Schedule

One of the key steps in assuring your practice is compensated appropriately is establishing a fee schedule for your services.[6] Practices should have 1 set fee schedule for all services. Insurance payers will adjust charges based on your contract, or physicians can manually offer discounts to self-pay patients. Federal law prohibits calling other practices and asking their fees to establish your own fee schedule. If you need additional guidance, the Centers for Medicare and Medicaid Services (CMS), the AMA, and other organizations have resources to help you (refer to the Resources and Further Information section of this Playbook).

EXPLORE MORE!

Resource-Based Relative Value Scale (RBRVS) overview

Claim Submission Workflow and Checkpoints

It is vital for the cash flow of your practice to institute claim submission workflows and daily checkpoints to ensure your claims were received by the clearinghouse, processed, and submitted to the insurer for processing and payment. Delays in claims submission could result in delayed payment for several months. Because it can take 1 to 3 months for a health plan to pay claims, anything that delays claim submission and payments can have serious downstream effects (eg, cash flow, missed deadlines, the expense of reworking claims, etc.).

Many payers also have timely filing deadlines for claim submission; you only have a certain number of days from the date of service for the payer to receive your claims, process, and remit payment. Claims received after the timely filing deadline will be rejected by the payer and will not be paid. The physician's office is responsible for confirming the claim was received by the payer.

PRO TIP:

All payers have different timely filing deadlines, so it is important to confirm timely filing when signing your contract with new payers.

Payer Audits

Several different types of audits could affect the timing of your payments. Often a payer will review your billing and patient records for appropriateness. Sometimes, physicians are not paid until an audit is complete and services were deemed medically necessary and correctly billed.

EXPLORE MORE!

Payer Audit Checklist (PDF)

Collection Issues

As many businesses can attest, collecting payment for services provided is a process that does not run on its own. Establish measurable goals for employees, with accountability for their contribution to the process. While you can hope that most of your practice's payments are collected promptly, there are steps to take when you don't receive payments in a timely manner. Practices should consider collection policies for insurance companies and patients separately.[7]

EXPLORE MORE!

Managing patient payments

Part 3:
Attending to Patients

Efficient Operations to Ensure More Time with Patients

Many physicians are drawn to private practice because of the potential for long-lasting relationships with patients, the ability to have more control over the patient–physician experience, and the knowledge that the care team and administrative staffing are the physician's responsibility. Succeeding in the private practice setting takes astute clinical judgment, effective collaboration with colleagues, and innovative problem-solving. One of those innovative problem-solving opportunities may be selecting and adopting your EHR.

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Electronic Health Record (EHR) Choice

There is no one-size-fits-all approach to EHR selection and adoption. Each practice should consider its own unique needs, high-priority features, and resources when deciding which EHR works for them.[8] Keep in mind that physicians spend almost half of their day on the EHR and desk work. Even during the patient visit, 37% of the time in the exam room is spent on these tasks. Research cites the clerical burden resulting from EHR adoption as a contributor to physician dissatisfaction in practice and subsequent burnout.[9]

The best time to minimize the burden is when implementing a new EHR system. This is a perfect time to be sure default settings, triaged messages, etc., are optimized. It is always best to set defaults to the most efficient team-based approach early on and adjust them, if needed, after using the system. Figures 10 and 11 detail considerations for selecting and implementing an EHR system; be aware that some features described may be included in the initial EHR package, whereas others are add-ons for an additional cost.

STEPS Forward toolkits and resources share guidance at every phase of the process, from selecting an EHR to implementing to improving how you work in your EHR with the *Taming the EHR Playbook* and techniques from the Getting Rid of Stupid Stuff toolkit.

Figure 10. Core EHR Considerations

Interface	• Ability to transfer data to or from existing technology (ie, lab and imaging software) • Billing and scheduling capabilities
Provider-to-Provider Communication	• Transfer patient information between clinicians via EHR platform
Local Health Care Systems	• Improve interoperability between practices in system • Possible discounts available
Specialty	• EHR designed for your specific specialty
Costs	• Software and upgrades • Support • Training • Team time

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Figure 11. Additional EHR Considerations

Patient portal	Document scanning	Scheduling and billing (Practice Management System)	Insurance eligibility reports

Clinical and administrative report console	Functionality to automate reminder calls and messages	Customization options

Charting	Prescription management	Clinical tasking	Orders and results management

Decision support	Health record management	Marketing support

Population health management	Health information exchange	Public health reporting	Quality measure reporting

Speech recognition	Telemedicine	Mobile device access

EXPLORE MORE!

Electronic Health Record (EHR) Software Selection and Purchase toolkit

EHR Implementation toolkit

Taming the EHR Playbook (PDF)

Getting Rid of Stupid Stuff (GROSS) toolkit

Increase Practice Efficiency

Waste in health care causes physicians and the care team to spend time, energy, attention, and money on activities that do not add value to patients. Attention to efficiency in every aspect of your practice will result in greater satisfaction for you, your team, and your patients while increasing access and income. Think ahead to what time-saving efforts you will implement in your private practice, who from the care team you will involve, and how you will measure success. Time-saving efforts need to come from the top down: from the level of practice leaders.

Scheduling Patients

Inefficient patient scheduling can dramatically impede the progress of your day. There are many effective methods to choose from, and you can experiment with different appointment schedules to learn what works best for the practice. Some different methods to explore are the typical method, the wave method, the need method, and the open-access method.

Lean Health Care

Lean thinking in a practice setting leads to a shift in culture where all team members are empowered to identify sources of inefficiency and innovative solutions to rectify problems. Lean works best with the buy in and involvement of everyone on the team.

Figure 12. Overview of Lean Health Care

What is Lean?	• A method to engage patients and the care team to improve population outcomes • Applying Lean principles can help practices run more efficiently and effectively
Focus of Lean	• To minimize waste in every process, which adds value for the patient, physician, and entire care team
Goal of Lean	• Empower the care team to take initiative to find and fix the root cause of critical problems seen during daily practice
Examples of waste	• Lengthy patient wait times • Clinics with flow of care that is not streamlined • Moving in and out of areas to find information • Duplicate testing when prior results cannot be found • Provisions of care that are not indicated

EXPLORE MORE!

Lean Health Care toolkit

Choosing Wisely® toolkit

Plan-Do-Study-Act (PDSA) toolkit

AMA | STEPS*forward*

In the spirit of maximizing efficiency in the practice, there are a few highlights from the *Saving Time Playbook* to consider implementing as you start your practice, such as setting up pre-visit planning, expanded rooming and discharge protocols, and team-based care. Standardizing and streamlining these practice fundamentals, or core workflows, will save time during and between visits.

Pre-Visit Planning

Pre-visit planning allows the care team to schedule future appointments, preorder labs and other necessary tests for the next visit, and arrange for tests to be completed prior to the next appointment (Figure 13). Pre-visit planning often allows a clinic to run smoothly and have more capacity to handle unanticipated issues as they arise.

Figure 13. Optimal Pre-Visit Planning Workflow

At the End of the Current Visit	Between the Current and the Next Visit	On the Morning of the Next Visit
1 Use a Visit Planner Checklist to Preorder Labs and Other Needed Tests for the Next Visit	**4** Use a Checklist to Review Pre-Visit Tasks	**6** Hold a Pre-Clinic Team Huddle
2 Schedule the Next Follow-Up Appointment	**5** Send Patient Appointment Reminders	**7** Use a Pre-Appointment Questionnaire to Gather Patient Updates
3 Arrange for Tests to Be Completed Before the Next Visit		**8** Perform a Handoff of the Patient to the Physician

EXPLORE MORE!

Pre-Visit Planning toolkit

Advanced Rooming and Discharge

Physicians cannot and should not be expected to do all the work needed for most office visits. Advanced rooming and discharge protocols are standard work routines that enable other team members to take on additional responsibilities. With advanced rooming and discharge protocols, the nurse, medical assistant (MA), or other clinical support team members can use their skills to create a smooth visit for the patient and a satisfying clinic session for the entire team.

Figure 14. Sample Advanced Rooming and Discharge Workflow

Patient check-in

Patient rooming

Take vital signs, determine chief complaint, update past family and/or social history, update immunizations, etc.

Areas where others could assist in the team documentation process while they are with the physician and patient in the exam room

Patient interview and examination

During the physician's discussion with the patient, the documentation assistant records the history and exam as directed by the physician.

Plan of care and clinical documentation

While the physician and the patient discuss the plan of care and next steps, the documentation assistant records the plan and fills in the details for the after-visit summary.

Prescription, order, and referral processing

Throughout the visit, the documentation assistant can place orders, ensuring that any orders are prepared for the physician's signature as appropriate.

Patient education and care coordination

Reinforce next steps of care as well as provide immunizations, patient education and health coaching, order and schedule laboratory tests, screenings, etc.

Patient check-out

EXPLORE MORE!

Advanced Rooming and Discharge toolkit

AMA | STEPS*forward*

Patient Pre-Registration

A streamlined pre-registration process saves time and reduces paperwork for both the patient and the team. Patients save time they would otherwise spend trying to understand and accurately answer registration questions presented to them in paper form. Physicians and other care team members can also spend more time on the visit and less time on paperwork while being confident they have a complete medical history.

The Patient Pre-Registration toolkit outlines a process where a new patient coordinator (NPC) conducts new patient pre-registration over the phone or in person before the initial visit to capture all the required demographic and payment information in the registration record. The new patient coordinator can also enter medical information, including the medication list, allergies, and medical history, directly into the EHR to reduce the data entry work required during the patient's initial visit. Eliminating paper and entering information directly into your practice's registration software and EHR prevents mistakes. An Example Patient Wait Time Process Flow is included in the Resources and Further Information section of the Playbook.

EXPLORE MORE!

Patient Pre-Registration toolkit

Transition to Team-Based Care for Better Care Coordination

Team-based care is a collaborative approach wherein team members share responsibilities to achieve high-quality and efficient patient care. Under the physician's leadership, team members coordinate pre-visit planning, advanced rooming and discharge activities, and team documentation (Figure 15). With the help of other team members, physicians can better connect with patients and remain focused on their primary patient care tasks. This model of care improves team member collaboration and pride in their work, efficiency, and patient satisfaction.

Figure 15. Elements of Successful Team-Based Care

Daily Team Huddles	Team Documentation	Care Coordination
Helps team members prepare so they are better able to anticipate any special situations or unique needs that may arise during the day	Team members other than the physician assist with documenting visit notes, orders, referrals, and prescriptions during a visit	Intentionally organizing patient care activities between 2 or more participants in a patient's care to facilitate the appropriate delivery of health care services
Generally, occurs before the team starts seeing patients and lasts 10 to 20 minutes	**GOAL:** Allow physicians to focus on and provide better care to the patient, reduce burnout, and improve efficiency	Includes determining where to send your patient next, what information to provide to the rest of the patient's care team, and how accountability is distributed among the team
GOAL: Communicate about patients and the flow of the clinic reliably, effectively, and efficiently		

EXPLORE MORE!

Team-Based Care toolkit

Daily Team Huddles toolkit

Team Documentation toolkit

Transitions of Care toolkit

Racial and Health Equity: Concrete STEPS for Smaller Practices

Since health equity and racial equity are outcomes and continuous and interrelated processes, it is vital to adapt a framework that can help move practices forward to advance racial and health equity for coworkers, for patients, and for the communities they serve. Recognizing that the path to equity is a dynamic, long-term journey, focus on initial catalytic steps and associated resources to translate that commitment to equity into action. Use practical questions during visits to support equitable patient care (Figure 16).

Figure 16. In the Exam Room: Questions for the First Visit

Questions for the first visit. Goal: Make the implicit, explicit.
1   "I don't want to assume anything about your identities. How do you identify racially, ethnically, and culturally, and what are your pronouns?"
2   Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?"
3   "What have your experiences been within the health care system?"
4   "Have there been any experiences that caused you to lose trust in the health care system?
5   "It is my job to 'get' you. You shouldn't have to work to 'get' me. If I miss something important or say something that doesn't feel right, please know that you can tell me immediately and I will thank you for it."
6   Put up visual cues of a safe space, such as Black Lives Matter (BLM) signage or a rainbow flag in support of LGBTQ movements.
7   Acknowledge and honor what patients are already doing—"Wow, you're already doing so much."
8   "What's happened to you?" vs "What are you doing?"
9   Curiosity can feel like colonizing language. Not "Can you explain to me why...?"; instead, "There is something I don't know that I really need to understand."

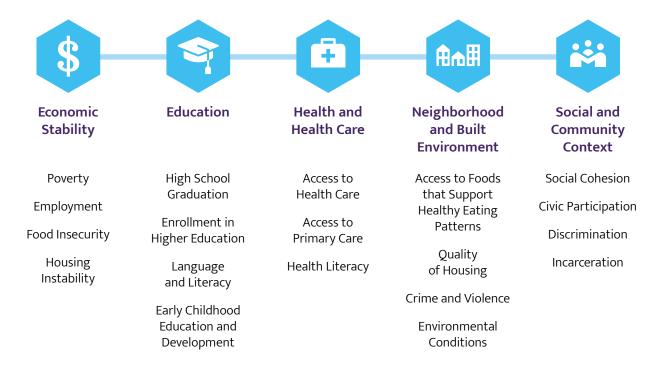*Courtesy of Southern Jamaica Plain Health Center, Boston, MA.*

EXPLORE MORE!

Racial and Health Equity: Concrete STEPS for Smaller Practices toolkit

Social Determinants of Health: Improve Health Outcomes Beyond the Clinic Walls

Social determinants of health focus on the social and economic conditions impacting health at a community level, while social needs focus on the individual level.[10] Figure 17 describes the 5 common domains of SDOH. It is most important for physicians to recognize that interactions among social determinants of health have a greater impact on health than any 1 social determinant alone. For example, people living in poverty-stricken areas experience more barriers and challenges regarding education, housing, unemployment, and stress. This confluence of negative social determinants of health and its effect on health status is often reflected in life expectancy disparities based on zip code.
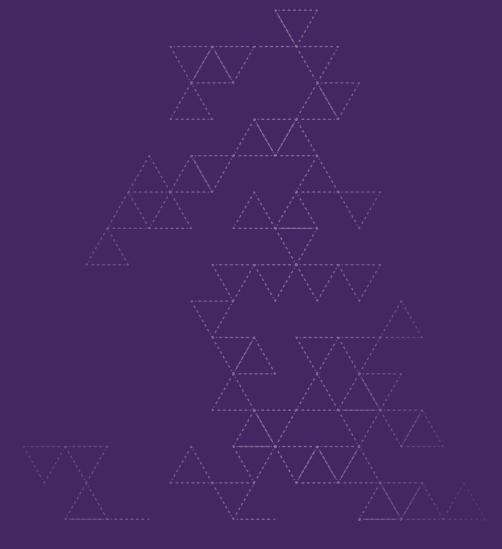
Figure 17. The 5 Social Determinants of Health

Economic Stability	Education	Health and Health Care	Neighborhood and Built Environment	Social and Community Context
Poverty	High School Graduation	Access to Health Care	Access to Foods that Support Healthy Eating Patterns	Social Cohesion
Employment	Enrollment in Higher Education	Access to Primary Care	Quality of Housing	Civic Participation
Food Insecurity	Language and Literacy	Health Literacy	Crime and Violence	Discrimination
Housing Instability	Early Childhood Education and Development		Environmental Conditions	Incarceration

Adapted from Healthy People 2020. Social determinants of health: interventions & resources. Office of Disease Prevention and Health Promotion. Accessed May 17, 2022. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources

EXPLORE MORE!

Social Determinants of Health toolkit

Part 4:
Grow Your Practice

Marketing

External tactics to attract new patients, such as creating a practice website and developing a social media presence, are relatively straightforward. Internal strategies to retain the patient base and increase loyalty rely on activities conducted within your existing patient base. To execute, you need a marketing budget and a plan for your marketing activities (Figure 18). Even the smallest budget with a solid marketing plan can be highly effective for individual physician practices. One practice was able to increase new patient volume by 7% due to a focused marketing effort that employed the talents of each team member.[11]

Figure 18. Key Features of a Marketing Budget and Plan

Marketing Budget	Marketing Plan
Account for this in the practice's operational budget **Important marketing budgeting considerations include:** Graphic design for online and print material Web design and hosting Internet listings Social media graphics	**A multi-faceted approach may have a broader reach:** Word of mouth Marketing agency Internet marketing strategy Print media Internet listings Social media Direct mailings

Social Media

Social media is a new and valuable way to connect with your patients to share current medical information and information about your practice. Social media pages are generally free to create and manage, although practices should consider seeking professional guidance if they don't have any experience on the platforms. Practices can develop a presence on "the big 4" social media platforms—Facebook, Instagram, Twitter, and LinkedIn—to maximize the return on time invested (Figure 19). Maintaining your practice's social presence requires effort, so you might focus your efforts on 1 or 2 platforms if you're just getting started.

Figure 19. The "Big 4" Social Media Platforms

Facebook	Instagram	Twitter	LinkedIn
Linked content	Visual content	Character limit	Most professional
Values community	Hashtag heavy	Trends	Thought-leadership
Professional groups	No linked content	Fast-paced	Build your network
Education	Convey an experience	Hashtag heavy	Links & hashtags

IMPORTANT: The practice owners should create all social media pages and restrict access to designated team members and agencies as needed. This assures the practice owns the social media accounts, and they do not belong to team members that could leave the practice at any time and take the accounts with them.

EXPLORE MORE!

Professionalism in the Use of Social Media

Professional Organizations

Professional organization membership may contribute to growing your practice. Membership allows you to meet physician colleagues within and outside of your specialty for collegiality and potential referrals, collaboration, and sharing of best practices and resources, such as staffing, supplies, vendors, etc. Physicians can join national associations such as the **American Medical Association's Private Practice Physicians Section** or the National Medical Association, among others (Figure 20). Membership in local chapters of professional associations, national medical specialty societies, or state medical societies can often offer opportunities to join affinity groups based on your interests.

Figure 20. Professional Organization Membership Opportunities

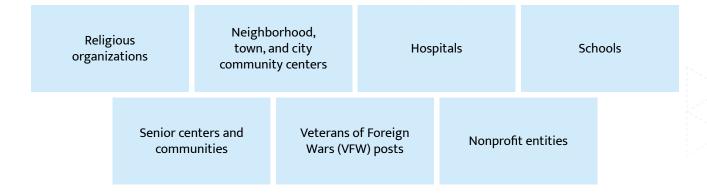| County medical society	State medical society	National medical societies	Specialty medical society	Service societies
	Payer committees	Hospital committees	Physician organizations	
Cultural medical societies	School boards	Medical condition associations	Local chamber of commerce	Local chapter of national medical associations

EXPLORE MORE!

AMA Federation Directory

About the Private Practice Physicians Section

AMA Membership

Community Organizations

Community organizations offer educational sessions to community members at no cost to the attendees (Figure 21). A partnership with such organizations provides a health education benefit to the population to combat disease and promote prevention. These engagements are also a way for patients to find physicians to manage their health, which helps practices grow.

Figure 21. Local Organizations to Engage the Community

Religious organizations	Neighborhood, town, and city community centers	Hospitals	Schools

Senior centers and communities	Veterans of Foreign Wars (VFW) posts	Nonprofit entities

Leverage Opportunities to Save Money

The American Medical Association has expanded the Member Value Program to bring you more resources and savings that fit you and your practice. Take advantage of the benefits that come with AMA membership (Figure 22).

Figure 22. AMA Member Benefits*

Home & Lifestyle
Find and finance your future home with physician-tailored resources

Auto & Transportation
Use AMA-negotiated discounts to buy or lease new and used cars

Health & Wellness
AMA members receive discounted access to a variety of fitness, wellness and meditation benefits

Travel & Entertainment
Travel safely for less

Loans & Financial Services
Realize savings to help organize personal finances and manage debt

Educational & Student Discounts
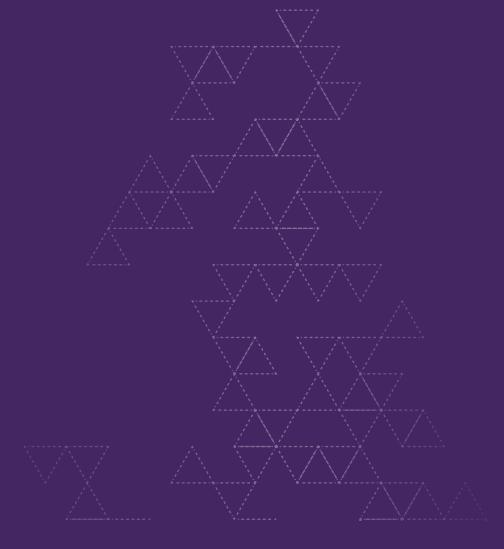Get discounts on test preparation courses and low rates for medical school loans

Practice Discounts
Discover special offers on technology, shipping, payment collection, and practice financing

*Benefits current as of May 2022. Check https://www.ama-assn.org/amaone/ama-member-benefits-plus for updates.

Resources and Further Information

Private Practice Business Considerations Guide

Business Plan

When a physician decides to open a new practice, there are various models and questions to consider. It is best to view all the logistics based on your practice situation and consider questions such as:

- Do you wish to rent, lease, or own your practice building or office space?
  - Each municipality has zoning ordinances that control what type of business can operate on each plot of land. It is important to talk with your realtor or landlord to verify that you can operate a medical office within the buildings you are considering for your business.
  - You need to notify your "potential" landlord about your business intentions if you decide to lease.
  - The first step is finding a realtor specializing in commercial real estate sales if you plan to own.

Whether you decide to own or lease, you will need to contact a bank for a commercial mortgage or financing options. They will require a **business plan** that will include your business startup costs. The business plan's initial purpose is to act as a guide to starting a business, obtaining funding, and directing operations. As the larger health care environment changes, the business plan must be focused on changes (ie, reimbursement, regulatory agencies, and patients) to reflect the current shifts and anticipate future shifts in the internal and external environment.

Critical components of a business plan include:

- **Executive Summary.** This will include the main details of your practice, such as the name, location, and the services you will provide. It will also cover your **mission statement:** why do you want to open your practice? What are your long-term goals?
- **Description of products and services.** Who are you treating? How large is your practice? What is your vision for the future of your practice?
- **Market analysis.** The target market must be well defined; without one, your plan will demonstrate little value. A SWOT (strength, weakness, opportunity, and threat) analysis is the best way to identify internal and external influences on your practice.
- **Financial viability.** To generate sufficient income to meet operating expenses and debt commitments while growing your practice.
  - Physicians must understand the payment structure around their services when explaining their business plan and **return on investment (ROI)**. Most financial institutions do not understand the current payment schedules in health care and will require additional explanation for capitation, bundled payments, and pay-for-performance income.
- **Team description.** You will want **job descriptions** for each employee at your practice. It will be helpful to match each physician to a team of health professionals who work closely together to meet the needs of the patient (ie, nurses, medical assistants, pharmacists, etc.). You should also identify the support staff needed for administrative work for all physicians in the practice (ie, billing, human resources, prior authorization, scheduling, etc.).
- **Marketing.** A brand will help your practice differentiate and elevate to patients. Things to consider when reviewing marketing include logo, website, print materials, social media pages, and search engine profiles. Will you contract with a third-party vendor or keep marketing in-house? Will you use paid advertising? How will you engage with current and potential patients on social media platforms?

- **Regulatory compliance and changes in the law.** Establish a pragmatic regulatory change management process that expects and encourages a high level of engagement and coordination among designated team members — leading to an identifiable path to ensuring compliance.

- **Conclusion.** Medical expertise is vital, but the patient's experience is critical: having what they want when they want it.

Practice Corporate and Legal Structure

Physicians may practice medicine through professional corporations, nonprofit organizations (including hospital services corporations and medical services corporations), limited liability companies, or partnerships.

NOTE: Certain states don't allow physicians to practice through traditional LLCs or regular corporations; the medical practice must be a professional corporation. It is important to check regulations within your state and consult with an attorney before selecting a legal structure for your practice.

FEATURES	C CORP	S CORP	LLC	GENERAL PARTNERSHIP	SOLE PROPRIETOR
Created by a state-level registration that usually protects the company name	X	X	X		
Business duration can be perpetual	X	X	X		
Owners not required to be United States citizens or residents	X		X	X	X
Allowed to be owned by another business	X		X		
Owners can report business profit and loss on personal tax returns		X	X	X	X
Owners can split profit and loss with the business for a lower overall tax rate	X				
Limited liability for debts and obligations	X				
Unlimited number of owners	X	X	X		
Annual meetings or record meeting minutes are not required			X	X	X

Private Practice Common Financial Terminology

While many physicians would like to practice medicine without handling the financial aspects this entails, a physician in private practice needs to understand at least the basics of financial management for the viability of their business. A lack of attention to the details of the financial side of your practice could lead to disaster and could prevent you from practicing in the way you would prefer.[12]

Common Accounting Acronyms[13]

TERM	ACRONYM	DEFINITION
Accounts receivable	AR	Funds owed to your practice for services invoiced
Accounts payable	AP	Funds owed to a vendor for services performed and invoiced
Current Asset	CA	A practice's cash and its other assets that will be converted to cash within one year of appearing in the practice's balance sheet heading
Fixed Asset	FA	Long-term assets that a practice has purchased and is using for services
Balance Sheet	BS	A financial statement that reports a practice's assets, liabilities, and shareholder equity
Cash flow	CF	The net amount of cash and cash equivalents being transferred into and out of a business
Cost of goods sold	COGS	The total amount your practice paid as a cost directly related to the sale of products
Credit	CR	A record of the money flowing out of an account
Debit	DR	A record of the money flowing into an account
Depreciation	DEPR	The amount of expense allocated during a specific period for certain types of assets that lose their value over time - for example, building and equipment
Earnings before interest, taxes, depreciation, and amortization	EBITDA	Used when assessing the performance of a company; helpful to determine how much profit the business generates by providing services in a given period
Equity	EQ	The amount of your practice's total assets that you own outright (ie, not financed with debt)
Accrued Expenses	AE	An expense that is recognized on the books before it has been paid
Fixed Expenses	FE	An expense that does not change from period to period
Operating Expenses	OPEX	A cost that a company incurs to perform its operational activities
Variable Expenses	VE	A cost that can change over time depending on the usage of products or services
Equity and owners' equity	OE	The amount of money that would be returned to owners if all assets were liquidated and all debt paid off

TERM	ACRONYM	DEFINITION
General ledger	GL	The record-keeping system for a practice's financial data, with debit and credit account records validated by a trial balance
Current liabilities	CL	A practice's debts or obligations that are due to be paid to creditors within 1 year
Long-term liabilities	LTL	A practice's debts or obligations that are payable beyond 12 months
Marketable securities	MS	Stocks, bonds, and other investments with enough demand to be converted to cash or sold quickly
Net income	NI	A practice's gross profit minus all other expenses and costs as well as any other income and revenue not included in gross income
Operating revenue	OR	Revenue generated from the day-to-day operations of the practice
Present value	PV	The concept that states an amount of money today is worth more than that same amount in the future
Profit and loss statement	P&L	A financial statement that summarizes the revenues, costs, and expenses incurred during a specific period
Return on investment	ROI	A widely used financial metric for measuring the profitability of gaining a return from an investment
Total revenue	TR	Sum of operating and non-operating revenue
Uncollectibles	UN	An account that cannot be collected because the client or payer is not able or willing to pay

The Basics of Accounting and Budgeting

Two primary accounting methods are accrual basis and cash basis.

- **Accrual accounting** recognizes revenues and expenses when services are rendered, not when funds have exchanged hands. This method is more accurate and harder to manipulate.
- **Cash accounting** recognizes revenues and expenses as they are added or subtracted from your bank account. Small-to-medium-sized practices often use this method because it is simpler to administer.

Understanding Financial Statements

Every business should monitor 2 key financial reports: **the balance sheet and the income statement.**

The **balance sheet** summarizes all the practice assets, liabilities, and equity values. In a balance sheet, the sum of the assets must always equal the sum of the liabilities plus the equity. Three key indicators of practice health on a balance sheet:

1. If current liabilities exceed current assets, the practice may be in danger of defaulting on accounts payable.
2. If liabilities unexpectedly grow, the practice is taking on more debt.
3. Shrinking equity without depreciation of assets and retained earnings.

The **income statement**, also called a profit and loss statement, details your practice's revenues and expenses. This financial statement lists the collections in your practice and basic categories for practice expenses for a specific period. Several ratios can be calculated from the income statement, giving insight into where the practice is spending its income. One of the most important uses for the income statement is comparing any current year's financial results to previous years. Watching your expense levels and ratios year after year or quarter by quarter will alert you to dangerous increases in expenses, reductions in collections, and sometimes even theft from the practice.

Understanding the Chart of Accounts

The **chart of accounts** lists numbers that identify each expense category in your practice by the department. Your accountant will help establish a chart of accounts that allocate expenditures for tax purposes and cost accounting. Correctly distributing fees is essential to efficient practice operations.

Managing Accounts Payable

Here are some tips for managing accounts payable for your practice:

- **Pay bills close to their due date rather than in advance.** The accounts payment process works best if bills are paid only once each month. Unless a substantial discount is offered for early payment, pay bills closer to 30 days from purchase. By paying bills closer to the due date, you keep the money in the bank working for you if possible and not in the vendor's bank earning interest.

- **Pay invoices, not vendor statements.** If payment is made from a statement, an invoice may mistakenly be paid twice.

- **Establish a workable accounts payable system early on.** Accurate tracking of supply costs reduces overspending and panic buying. It also provides information needed for budgeting and forecasting and gives the accountant the information necessary to prepare financial statements and tax returns.

Managing and Tracking Cash Flow

Imagine this:

You receive a large overpayment request from Medicare. Now you must decide if you will pay the request in a lump sum to avoid interest or opt to enroll in a high-interest repayment plan. By regularly managing and tracking your cash flow, you will be able to make an informed financial decision if a situation like this occurs.

It is crucial to have enough cash on hand to pay your bills and obligations to ensure your practice operates smoothly. Highly profitable practices with healthy cash flow may feel less pressure to project and manage cash flow. The high profits enable the practice owners to work within the shifting flow of collections and expenses. On the other hand, even healthy practices can have a cash flow crisis if circumstances conspire to limit collections or dramatically increase expenses.

Budgeting

Budgets help instill fiscal discipline, so you are able to plan for major expenses and purchases rather than incurring those costs on whims. **However, it is essential to remember budgets are guidelines, not laws.** Budgets will fluctuate depending on the volume of patients seen in your practice, administrative workload, and new or revised regulations.
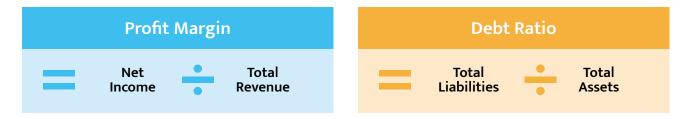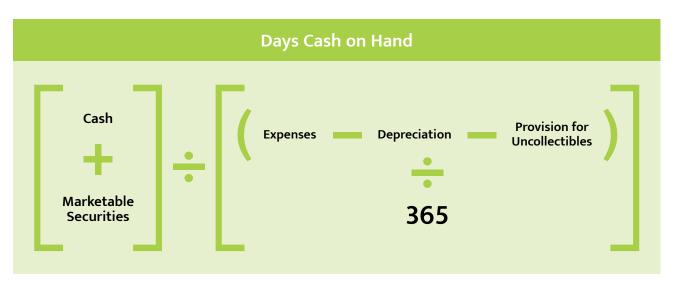
Benefits of budgeting include:

- Aiding group practices in holding all partners accountable for expenses or purchases.
- Delegating responsibilities and accountability to managers and supervisors by incentivizing maximum productivity of their departments.

Financial Ratios

Understanding your practice's financial ratios gives a complete picture of your practice's financial performance. You can calculate these simple ratios on your own, or you can ask your accountant to calculate them for you.
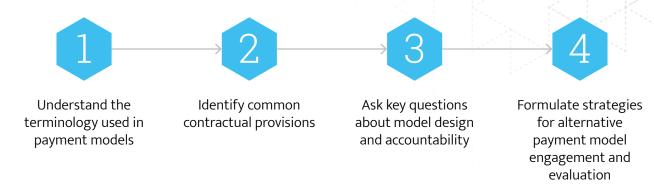
Key Financial Ratios

Profit Margin = Net Income ÷ Total Revenue

Debt Ratio = Total Liabilities ÷ Total Assets

Days Cash on Hand = [Cash + Marketable Securities] ÷ [(Expenses − Depreciation − Provision for Uncollectibles) ÷ 365]

Physician Payment Models Guide

Payment models can often be confusing, and the available models are frequently changing. The following process flow can be helpful for physicians as they seek to understand the scope of the payment landscape.

1	**2**	**3**	**4**
Understand the terminology used in payment models	Identify common contractual provisions	Ask key questions about model design and accountability	Formulate strategies for alternative payment model engagement and evaluation

While there are numerous options for physicians to review, the most common models fall into 3 main categories: core payment models, supplementary payment models, and organizational models.

Core Payment Models

The core payment models, or underlying payment models, can exist alone without other payment types.

MODEL	DESCRIPTION
Fee-for-service (FFS)	Practices receive a flat fee per service unit for each visit, test, and procedure performed. In this model, practices achieve higher revenue with more patients and procedures each day. However, whether these revenues cover the physician's cost of providing the services depends on many factors. **More information:** • Centers for Medicare & Medicaid Services (CMS): Overview of the Medicare Physician Fee Schedule Search • CMS: Search the Physician Fee Schedule
Capitation	Practices receive payment to manage a patient's care and health conditions per patient per period, with the period typically being 1 month. The health plan will apply attribution rules to decide which patients are included in a given physician practice. **More information:** • Understanding Capitation • Effects of Health Care Payment Models on Physician Practice in the United States—Follow-Up Study (PDF) 　Basic definition: pp. 10–12; 32–33 　Detailed overview: pp. 15–17; 37–39
Bundled or episode-based payments	Practices receive payment based on episodes of care as the payment base. Episodes are typically defined according to a set of diagnoses and services provided over a specified service time, especially for surgical procedures. These models may bundle hospital, physician, and post-acute care services together. These models allow practices to achieve higher revenue by avoiding complications, negotiating discounts, and choosing lower-cost settings for post-acute care. **More information:** • Evaluating bundled or episode-based contracts (PDF)

Supplementary Payment Models

The supplementary payment models can coexist with 1 or more core payment models but cannot exist on their own.

MODEL	DESCRIPTION
Pay for Performance (P4P) ie, Medicare Merit-based Incentive Payment System (MIPS)	Physicians in the practice are compensated by the payer according to an evaluation of practice performance on defined metrics. These metrics could be based on the quality of care and/or measures of costs or utilization of care. Practices may receive an increase or a reduction in their fee-for-service compensation. **More information:** • Evaluating pay-for-performance contracts (PDF)
Shared Savings Program	Practices receive fee-for-service payments throughout the contract year rather than capitation payments before or during the year. At the end of the year, total costs of care for the attributed patient population are compared to a cost target, which triggers a lump-sum bonus or penalty. This is often compared to a practice's historical performance, and such targets may be recalibrated after a set amount of time. The shared savings bonus payments can only be distributed retroactively due to the calculation of actual costs. **More information:** • CMS: About the Shared Savings Program
Retainer-based payment	Practices receive capitation payments from the patient to the practice directly. Retainer-based payment models are commonly known as concierge or direct primary care. In this model, payments are typically made per patient per year or month as a membership fee. The fee covers a defined range of services. The membership can be supplemented by other payment arrangements, such as fee-for-service, typically billed to the patient's insurance (separate from the membership fee) for services, not within the range covered by the membership fee. **More information:** • Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework (PDF)

Organizational Models

Organizational models for physician practices combine payment models to create additional payment models.

MODEL	DESCRIPTION
Medical home	Most practices following the medical home payment model receive fee-for-service payments as their primary revenue source. Medical homes often receive additional payments in enhanced fee-for-service payment rates, per-month patient care management fees, and pay-for-performance payments for high performance on measures of quality, patient experience, or cost. Physicians may also be subject to payment reductions if they miss cost and quality savings targets. **More information:** • Patient-Centered Medical Home (PCMH) Model
Accountable Care Organization (ACO)	ACOs are large health systems or collections of physician practices that jointly enter an ACO contract with a payer. Typically, ACO contracts pay via fee-for-service but can receive shared savings at the end of the year if it performs well on quality and patient experience measures and holds the total costs for its population of attributed patients below a defined target. The bonus is paid as a lump sum for the previous year, but other payment bases are possible. Physicians participating in ACOs may also be liable for shared losses if spending exceeds the benchmark. **More information:** • Accountable Care Organizations (PDF)

Physician Payment and Risk

As health care moves from volume-based models to value-based models, there needs to be a focus on the quality of care and potential risk-sharing between physicians and payers.

Risk in Payment Models

Before accepting risk-based contracts, physicians need a broader understanding and education of the risks, rewards, and the underlying cost of doing business. A physician who makes such an agreement takes on the risk and assumes responsibility for delivering or arranging health care services to patients when the total payment for providing those services can be greater or less than the total cost for such services.

The AMA guide, Key Considerations in Forming, Operating or Joining a Clinically Integrated Network (PDF), is invaluable when a practice is assessing readiness to join risk-based payment models.

TYPE OF RISK	DEFINITION
Downside risk[13]	Downside risk occurs when a physician could potentially incur costs greater than payments received for services.
Insurance risk[14]	Insurance risk is related to the health status beyond the physician's control, such as age, gender, and acuity differences.
Patient risk adjustment[15]	Patient risk adjustment uses a statistical process to calculate the health status of a patient into a number, called a risk score, to assist in the prediction of health care costs.
Nominal risk[16]	Nominal risk is contained in the Medicare Access and CHIP Reauthorization Act (MACRA), Advanced Alternative Payment Model (APM) states that participants must assume negligible risk or take the risk of an amount that is less than optimal but substantial enough to drive performance.
Performance risk[14]	Performance risk is the potential for higher costs from delivering unnecessary services, inefficiently delivering care, or committing errors in the diagnosis or treatment of a particular condition.
Full risk	Full risk is a two-sided risk that can subject health care providers to responsibility for 100% of health care costs for a population of patients but typically also provides an opportunity for higher shared savings gains.
Upside risk	Upside risk gives physicians a chance for a financial upside but no downside risk. The risk comes from the uncertainty that there will be a positive margin and its size.
Shared risk	Shared risk is a method where the physician and payer agree to share responsibility when payment differs from the cost of care.
Utilization risk	Utilization risk relies on the physician to take steps to limit unnecessary care.

Risk in patient populations

As the payment model landscape shifts from payment for each service provided to payments that vary according to costs and quality measures, physicians would benefit from a clear understanding of their patient population and its health risks. This understanding directly correlates to the financial risks of your practice.

Insurance companies and government payers use diagnosis coding to make comparisons of quality, cost, and estimations of resource use. To accurately capture patients' severity of illness, physicians will want to be aware of specific diagnosis coding. ICD-10 diagnosis coding will help payers assign appropriate insurance risk and position your practice for value-based payment by accurately reflecting individual patients' health or severity of illness. Higher risk assignment may also equate to higher pay for care management or under a capitation model. Risk adjustment methods have some significant limitations, however. They generally use historical information about patient diagnoses, so it may not lead to adequate compensation for the services patients need when they need them.

Further Reading

AMA–RAND Effects of Health Care Payment Models on Physician Practice in the United States

AMA–RAND Follow-Up Study (PDF)

Private Practice Staffing Guide

Hiring employees will be one of the toughest yet one of the most rewarding things you do as an employer. Practices that consistently do well financially also tend to have the best employees, and those 2 factors are inextricably linked. Good employees can make going to work a pleasure; difficult employees can try the patience of even the most forgiving employer. The key to having good employees is to find the best candidates and then provide good management to maintain high levels of motivation and dedication to the practice.

Even as an employee, a physician is viewed as an authority figure in a medical practice. The medical assistants, receptionists, billing staff, and supervisors expect physicians to understand and follow the rules. Therefore, as an employer you should have a working knowledge of the laws and statutes regulating the medical practice, and a thorough understanding of the internal personnel guidelines that pertain to managing employees, and be knowledgeable about customary compensation and benefits.

For example, new guidelines allow multiple-contributor documentation directly into the chart, saving the physician time. These documentation contributors can include certified or licensed team members(often medical assistants) or non-licensed non-certified team members, and even the patient. This opens the opportunity to hire pre-allied health students, transcriptionists, and others to assist with work. A shared understanding of this regulation by the physician and the practice staff can increase practice efficiencies and increase levels of professional satisfaction from all parties. The AMA Debunking Regulatory Myths website and the STEPS Forward® Team Documentation toolkit can help you navigate ways that supporting team members can assist the physician in patient care and documentation.

Staffing Your Practice

Staffing ratios can be highly variable, and there are numerous considerations for creating a high-functioning, cohesive, and efficient team that delivers excellent care. The objective is to pinpoint a staffing ratio and team makeup that provides optimal support for physicians in your practice setting. Your specialty or subspecialty professional society may be helpful in providing data specific to your practice.

Calculating the number of support team members that a practice needs relies on determining the number of physicians employed as full-time equivalent (FTE). This can be misleading, however, as calculating FTE with the hours worked per week is frequently based on a standard 40-hour workweek. Research suggests that for every hour of direct face time with patients, a physician spends an additional hour on non-patient-facing desktop medicine (patient portal communication, responding to online requests, etc.).[4] Taking this into account, a physician with 28 patient scheduled hours likely works closer to 56 total hours per week. It is important to be aware of this when calculating FTEs and establishing your ideal staffing ratio.

Evaluating Clinical Care Team and Administrative Staffing Needs

Support Staff Per Full-time Equivalent (FTE) Physician Ratio

The number of full-time administrative and clinical team members needed to effectively support 1 full-time physician. The ratio of FTE support team members for every FTE physician will differ between practices, and there is no "right" ratio.

Calculating Staffing Needs

- Determine the total number of physicians in your practice expressed in FTEs. Each full-time physician counts as 1, while each physician that works less than full time counts as fraction of an FTE calculated by dividing their average number of hours worked per week by the full-time standard in your practice.
- Calculate your staffing needs by multiplying the total number of physician FTEs by the total number of FTE non-physician team members needed to effectively support 1 full-time physician in your practice.

Factors That Can Inform Your Staffing Needs

Administrative

- Is billing done in-house, or do you have a vendor?
- Are prior authorizations done in-house or via a vendor?
- What administrative tasks have you outsourced, and what administrative staff do you need to hire (eg, receptionists, staff who complete billing, coding, prior authorization, referrals, and credentialing, managers, human resources, and others)?
- Can you cross-train full-time team members to fill several part-time roles, such as an administrative member handling billing, prior authorization, and referrals, or a practice manager taking on human resources tasks?

Clinical workflows

- How many procedures are done in the office?
- How many clinical and non-clinical tasks are the responsibility of supporting team members?
- Are you performing telehealth visits?
- How many exam rooms do you have?
- How does your practice layout affect your workflows? How much time does it take physicians, support team members, and patients to move through your practice space to address their duties or visit needs?

Patient population

- What is your patient panel size?
- How many patients does each physician see per day?
- What are the needs of your patients? Do they require extra time for assessment and treatment plan review?
- Do your patients have social determinants of health (SDOH) or other needs that require a higher level of care?

Other

- Does your specialty society have staffing recommendations?

Additional Considerations

Staffing shortages	On-call schedule (for staff absences)	Training opportunities	Benefit packages	Remote employment options

Building Bridges Between Practicing Physicians and Administrators

Sometimes physicians overlook the capabilities of their administrative colleagues, and as a result take on more responsibility than they should. Consider every member of your team may have more to offer than their current job description shows. An investment in your team's professional development and responsibilities is an investment in your practice. A practice that recognizes the skill sets and training of its team members—and puts those attributes into action—is a practice that thrives.

Building trust and transparency between practicing physicians and administrators has the potential to improve practice culture and patient experience. This bridge can result in improved working relationships, healthier workplaces, increased personal and organizational resilience, and improved patient–physician experiences.

EXPLORE MORE!

Building Bridges Between Practicing Physicians and Administrators toolkit

Medical Assistant Professional Development

Medical assistants (MAs) are at the front line of patient care and play an integral role in achieving practice goals such as increased patient satisfaction, improved quality of care, and enhanced team-based care. You can enable medical assistants to contribute in a more meaningful way to the practice team through professional development training.

Note: While creating your own medical assistant professional development program will be invaluable to your practice, it does not take the place of a certified medical assistant training program accredited by organizations.

EXPLORE MORE!

Medical Assistant Recruitment and Retention toolkit

Medical Assistant Professional Development toolkit

Team Meetings: Strengthen Relationships and Increase Productivity

Team meetings bring all members of the practice, such as the physician, nurse, MA, and office team members together to analyze the way work is currently being done and take steps to improve efficiency. Because all team members should be involved, you may have to send calls to voicemail during this time. In effective team meetings, each team member is encouraged to share ideas to improve the practice's workflow.

EXPLORE MORE!

Team Meetings toolkit

Appreciative Inquiry Principles toolkit

Team-Based Care

Providing care in a collaborative system, one in which team members share responsibilities to achieve high-quality and efficient patient care, improves team collaboration and pride in their work, workflow efficiency, and patient satisfaction.[4] With the help of other team members, physicians are better able to connect with patients and remain focused on their primary task of patient care.
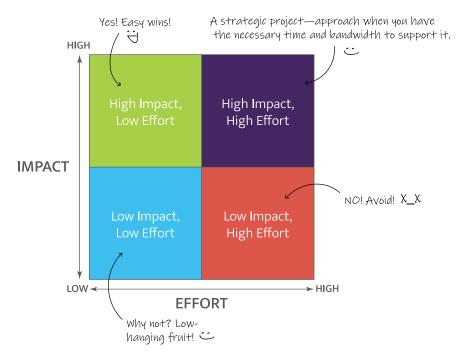
EXPLORE MORE!

Team-Based Care toolkit

Team Culture: Strengthen Team Cohesion and Engagement

Team culture in your practice is a set of underlying rules and beliefs that determine how your team interacts with patients and each other. Culture is the way an organization "does business." New team members may gradually absorb the practice's culture without being taught or even noticing, but that process is not ideal. Having defined expectations and ways to achieve them can make all those in the medical practice feel part of the team.

One way to foster collaboration is to select a small project as a team that would improve an aspect of your practice. The Impact-Effort matrix below is an example of a way to prioritize ideas for a quick win.
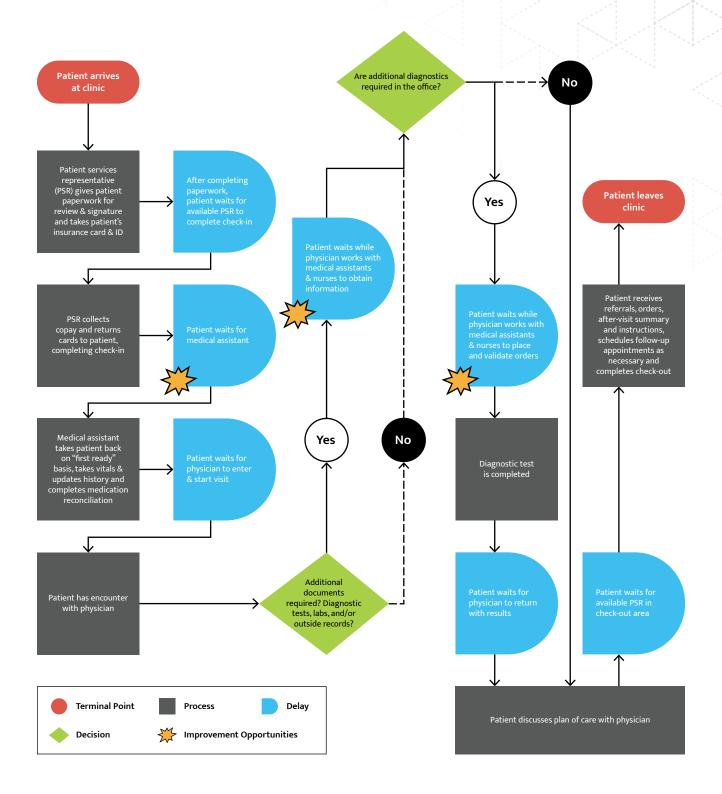
Impact–Effort Matrix Example

HOT TOPIC!

Bullying in the Health Care Workplace: A Guide to Prevention and Mitigation (PDF)

Example Patient Wait Time Process Flow

Patient arrives at clinic

Patient services representative (PSR) gives patient paperwork for review & signature and takes patient's insurance card & ID

After completing paperwork, patient waits for available PSR to complete check-in

PSR collects copay and returns cards to patient, completing check-in

Patient waits for medical assistant

Medical assistant takes patient back on "first ready" basis, takes vitals & updates history and completes medication reconciliation

Patient waits for physician to enter & start visit

Patient has encounter with physician

Additional documents required? Diagnostic tests, labs, and/or outside records?

Patient waits while physician works with medical assistants & nurses to obtain information

Are additional diagnostics required in the office?

No

Yes

No

Yes

Patient waits while physician works with medical assistants & nurses to place and validate orders

Diagnostic test is completed

Patient waits for physician to return with results

Patient discusses plan of care with physician

Patient receives referrals, orders, after-visit summary and instructions, schedules follow-up appointments as necessary and completes check-out

Patient waits for available PSR in check-out area

Patient leaves clinic

Legend:
- ● Terminal Point
- ■ Process
- ■ Delay
- ◆ Decision
- ✦ Improvement Opportunities

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Further Information

Regulatory and Legal Considerations

- A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse
- Department of Health & Human Services Office for Civil Rights, Summary of the HIPAA Privacy Rule (PDF)

The Fee Schedule

- AMA Medical Coding and Billing Resources, including the Physician Fee and Coding Guide (CPT 2022: Professional Edition)
- RBRVS Data Manager online edition
- CMS Physician Fee Schedule (PFS) Relative Value Files
- Medicare Physician Fee Schedule Search

EHR Choice

- How to Select Your EHR Vendor

Scheduling Patients

- Matulis JC, McCoy R. Patient-centered appointment scheduling: a call for autonomy, continuity, and creativity. *J Gen Intern Med*. 2021;36(2):511-514. doi:10.1007/s11606-020-06058-9

Transitions of Care

- Agency for Healthcare Research and Quality (AHRQ) Care Coordination Measures Atlas, Chapter 2: What is Care Coordination?

Social Determinants of Health

- Center on Society and Health: Mapping Life Expectancy

![RESEARCH | MEASURE | ACT | RECOGNIZE | CONVENE circular diagram]

Learn More About Practice Innovation

Take the next steps on the journey with the AMA STEPS Forward® practice innovation resources and assets.

Use the 5-pronged approach (Act, Recognize, Measure, Convene, Research) as your guide. Employ the evidence-based, field-tested, and targeted solutions described below to optimize practice efficiencies, reduce burnout, and improve professional well-being.

Act

- View the comprehensive portfolio of AMA STEPS Forward® resources at stepsforward.org, including toolkits, playbooks, videos, webinars, podcasts and calculators.
- The AMA's Mentoring for Impact program provides virtual meetings with a Professional Satisfaction and Practice Sustainability Group physician who can help develop a customized approach to remove obstacles that interfere with patient care. For more information, email stepsforward@ama-assn.org (include "Mentoring for Impact" in the subject line).

Recognize

- Participate in the AMA STEPS Forward® Recognition of Participation certificate program and find new ways to engage with your team
- Use the AMA Joy in Medicine™ Health System Recognition Program as a road map to support your organization's strategic efforts

Measure

- Take our practice assessment to identify and prioritize your workflow intervention efforts
- Encourage your organization to measure professional well-being on an annual basis

Convene

- Join us at the AMA STEPS Forward® Innovation Academy for timely and relevant webinars and more
- Attend the International Conference on Physician Health™ (ICPH), the American Conference on Physician Health (ACPH), and other upcoming conferences, summits, and events as they are announced

Research

- Stay abreast of meaningful research to guide your professional well-being strategies and interventions

Watch the video to learn more about AMA Professional Satisfaction and Practice Sustainability efforts, or visit stepsforward.org.

About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician's practice.

To learn more, visit https://www.ama-assn.org/practice-management/ama-steps-forward.

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