Restructuring the Front Office Staff for Efficiency

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Statement of Problem

Financial performance in a medical group is key to the survival of the practice. A four-person orthopedic practice in a competitive urban market was experiencing an increase in overhead with a financial decline. The medical practice operations were becoming increasingly more complex and cost containment strategies needed to be implemented. It was crucial to the practice to have efficient business practices during this time of declining reimbursement, heightened competition for patients, and an increased number of uninsured patients.
The current office manager was ineffective in optimizing employee productivity -- too often placing employees in non-specialized positions where their skills did not match their current job descriptions, thus creating an unproductive team. Effective communication between the office manager and physicians was declining. The physicians were made aware of important issues too late or not at all, leaving them to make hasty decisions instead of well thought out strategies. Monthly administration meetings were not effective, nor did the meetings stay on course. The physicians spent more time on unimportant issues and not enough time focusing on important issues. The clinic had not set any long-term plans or goals to ensure the survival of the practice. The personnel were becoming frustrated with high turnover rates, inconsistent processes, and no accountability from either fellow staff members or management to enforce the accountability. The practice had come to a crossroad. The physicians identified the need to implement change and “restructure” the current organization by either hiring an administrator or transforming the current office manager before the physicians faced financial demise.

**Alternatives Considered**

*Hire Consultant*

The physicians contemplated the hiring of a medical consultant knowing that an experienced consultant could help the group in its restructuring process. The physicians felt that if the right consultant was hired, then maybe the current office manager could learn the needed skills to advance their clinic to the next level. The physicians also realized that having an unbiased person to evaluate and right-size the staff would be beneficial. The consultant could help the current office manager identify problems, and in turn show how to effectively resolve the problem by thinking out of the box.

The physicians had also been down this road before with a consulting firm. They had found the last consulting group to be very expensive and ineffective in their restructuring recommendations. The staff did not commit to the changes being recommended; therefore, the current manager did not follow through with the change recommendations, as there was less conflict to deal with by continuing status quo. The group agreed that the practice had outgrown the current office manager, who was ineffective with the staff. The current office manager, who had no experience in managing a medical office, had been approached by the physicians and
asked to advance from the billing department into the role of office manager. This decision, while effective for the time being, did not turn out to be a long-term solution for this growing physician practice.

*Hire Administrator*

The hiring of an experienced and capable administrator to carry out projects to completion and lead the group into the future was discussed. The group had already identified that the staff were lacking in the ability to set and meet goals. The physicians felt a strong leader that the staff could look to for guidance and help could turn their clinic in the right direction. The physicians also wanted an administrator that had a strong background in managing clerical and clinical personnel in the multi-physician practice, along with experience in adding ancillary services to the clinic. The physicians knew that finding an administrator that the group could agree upon could take time. They also realized that the salary commands, as well as the benefits package, of an experienced administrator would be higher. The physicians worried that the new administrator would not have a good knowledge base of the practice dynamics in their area, and wondered if this would have a negative effect on the practice. The physicians also felt a sense of loyalty toward several employees, and feared that the staff would have a difficult time adjusting to a new administrator. This point also brought up the fact that all physicians would have to relinquish staffing involvement to the new administrator, which would be hard for some to achieve.

*Elect Physician to Direct Office Manager*

The physicians discussed the possibility of electing a physician to work closely with the current office manager in order to help gain a more authoritative role within the office. The physician would meet with the office manager weekly and review the day-to-day operations, while offering suggestions and direction with problems.

The physicians were hesitant to this idea knowing that the position would need to be held by each of them for a period of six months to one year, and a back-up physician would have to be up to speed on the day-to-day happenings in the event of the assigned physician’s absence. The group would also need a consensus on the election of the physicians to serve in this role who were also willing to devote the time needed to accomplish the goals of the group. None of the
physicians wished to devote the needed time to accomplish this task, claiming that the loss of revenue would exceed the purpose. The compensation of $1,000 per month was simply not worth the time constraints for the physicians.

**Hire Interim Manager**

The hiring of an interim manager while the physicians sought out an administrator for the group could stabilize the practice, putting it back on course to increase revenue. The group also liked the idea that this would be a short-term commitment on the part of the practice. The physicians knew that this could be not only costly, but the practice dynamics would be unknown to the interim manager. The physicians also knew that if they went this direction and the interim manager’s changes were not in agreement with the newly hired administrator’s plan, then staffing dissatisfaction could be a problem.

**Selecting A Solution**

The physicians met to discuss all the different alternatives available to the group. The physicians were quick to point out that the previous consultants the group had hired had failed in transforming the practice and present office manager. This had caused the physicians and some key employees to lack confidence in the present manager.

The physicians had examined the current days in the accounts receivable, benchmarking them against the most current data available through Medical Group Management Association (MGMA) and realized that they were higher than average. This made the physicians understand that the financial viability of the clinic was dependant upon strong leadership, and with the current office manager’s deficiencies in leadership, none of the physicians were willing to hold the position of supervision of the manager.

The group agreed that with the clinic’s rising complexities from its continued growth, along with the rapidly changing healthcare industry, the original makeup of the clinic was outdated and an experienced administrator could help in restructuring the practice. The physicians also
recognized that hiring an interim manager to stabilize the practice while searching for an administrator should be considered.

Decision

With the help and advice of the physicians’ accountant, the physicians took a team approach to be proactive in their decision to move forward with the hiring of an administrator. It was decided that the hiring of a consultant again was a waste of time, effort, and monies, when the current office manager was ineffective in managing their medical practice. Each of the physicians agreed that they needed a strong and experienced leader to help restructure their current practice, help the physicians set goals, and develop a strategic plan in order to move forward in the current healthcare environment. The physicians realized that bringing in an interim manager would allow them to “stay the course” while trying to hire a new administrator, but they were not convinced an interim manager was the right fit.

The physicians spoke to the current office manager regarding the group’s situation, and it was agreed that the current office manager would resign from the group. A three-week notice was given allowing the physicians time to hire an interim manager. Ads were placed on-line with both BONES Association and MGMA to search for an administrator with the desired experience for the group practice.

After one week, an applicant that the group was interested in was willing to come and work as an interim manager for a one-month period while the physicians continued to seek a new administrator. The next week the interim manager arrived to work with the current office manager during the manager’s last week of employment. During this week, the interim manager performed a detailed assessment of each employee and their role in the practice. The practice management software was analyzed to see if the employees were using it to the fullest capabilities. Patient flow was observed to see where the flow bottlenecked, pushing patient wait times in excess of two to three hours. Office hours were examined to see if more convenient hours could be invoked.
At the beginning of the second week, the interim manager met with the physicians to detail out what had been learned and where improvements could be made. The interim manager recommended to the physicians that the front desk would be the starting point of the restructuring. The interim manager outlined the restructuring plan, assuring the physicians that the changes would need to happen regardless of who they hired as an administrator. The physicians agreed that they wished to go forward with the restructuring recommendations.

Implementation

Front Desk Restructuring

Communication Development

The restructuring process began at the front desk. During the interim manager’s evaluation of each of the employees and their duties, it was quickly determined that there was a communication process lacking between the office and the patient wanting to schedule an appointment. Office scripts were developed to ensure effective communication processes were conveyed to the patients on the pertinent policies of the office prior to their visit, such as what information to bring with them upon their first appointment, what insurance plans the office participated with, and what methods of payment the office accepted.

The telephones were to be answered by the third ring, and patients were asked if they could be placed on hold.

An automated patient reminder system was put in place to call and remind patients of their appointments two days prior to the scheduled appointments to reduce the no-show rate.

Patient Registration Reviewed

The practice had not updated registration forms in several years. Forms were not reviewed for completeness; therefore, the capturing of pertinent patient information in order to get paid was
lacking. The patient registration forms were updated and designed to follow the data input of the practice management software, which aided in more comprehensive data entry. All the different physician history and physical forms were standardized into a single form.

**Scheduling**

Scheduling templates were created with the involvement of each physician to establish better patient flow patterns. Open-access scheduling was created to accommodate same-day appointments for urgent care patients without backlogging the entire clinic.

Pre-registration of new patients was developed to speed up the initial check-in process. Forms were put on the practice’s website for patients to download, or the information was taken via telephone.

The office personnel were provided with a listing of all insurance plans the clinic participated with so patients could be informed prior to scheduling if the clinic was in their insurance plan network.

The clinic developed a no-show policy in order to discharge noncompliant patients. All no-show patients were called for rescheduling of their appointments, and each no-show was documented in their chart.

**Patient Check-In**

Upon patient check-in, eye contact was made with the patient as they were greeted. Patient demographics were verified, and copies of insurance cards and a photo ID were obtained. After each chart was updated, it was dated and initialed in order to monitor the error ratio on data entry. Patients were immediately made aware of any extended waiting times, and asked if they would prefer to reschedule. Co-payments were also collected upon check-in.

**Patient Encounter Form**
The patient encounter form was updated, eliminating infrequently used codes and adding more frequently used codes. Codes were put in a more physician-friendly format for quicker locating of codes. The form was also redesigned to be computer generated, which eliminated the need to hand-write pertinent patient information on the form and reduced printing costs.

Billing Personnel Restructuring
The billing office was frustrated with current policies and procedures and was enthusiastic about invoking change that would benefit their department. In order to optimize the billing department, the current billing personnel were divided into different specialty areas within their department.

Insurance Preauthorization
A surgery scheduling position was further developed to obtain insurance benefits and pre-authorizations for surgical patients. The benefits were entered into the practice management system so that all personnel had access to the information. The physicians were approached and a surgery scheduling form was developed providing the surgery scheduler with surgical procedure codes, surgical urgency, special equipment needs, surgical time needed, anesthesia type, and surgery center or hospital preference. This enabled the surgery scheduler to provide the patient with a more accurate quote of their financial obligations. This also allowed the billing department to collect surgical prepayments before the surgery occurred.

Charge Entry
There was no real-time check out available to patients, so patients were accustomed to walking out of the office and never being asked to pay for any services. A checkout position was created to capture all the office charges daily, holding the physicians accountable for turning in encounter forms daily that were accurately filled out with both procedure codes and diagnosis codes. As patients exited the exam room they were escorted to the checkout desk. Fees, both current and past due, were collected and posted, re-check appointments were scheduled, and daily charges were entered. Encounter form tracking reports were printed daily to match up to patients seen in the office that day. Any missing encounter forms were located to ensure all charges were captured for the day.
The checkout personnel were assigned to verify benefits on all new patients and enter the information into the computer. Referrals were entered into the practice management system warning personnel if a referral had expired. The checkout employee was also responsible for posting all mailed-in patient payments. This position coordinated with the billing department, front desk, and surgery scheduling in their day-to-day operations.

The office payment options were reviewed to make sure that the office accepted the most frequently used credit cards. It was decided that a medical loan program through a national company would be added to give more payment options to patients.

Surgical charge entry was irregular and physicians lagged in getting the proper information to the department in a timely manner. The physicians agreed to use a surgical charge sheet that captured the patient information, procedure codes, and diagnosis codes on each patient. Notations were made if an assistant was utilized and who the assist was. The form was faxed to the office after each surgery while the physician was dictating his operative notes, ensuring timely charge entry.

Coding software was purchased to facilitate the surgical coders in scrubbing each claim before submission, and to give feedback to the physicians if there was a procedural bundling question or other coding discrepancy.

Reports were run on a weekly basis to compare the surgery-scheduling list to the surgery charges entered into the computer, making sure that all surgical charges had been captured. On-call physicians were prompted daily for information on emergency room visits or hospital consults. The interim manager monitored the time frame from when the procedure was performed against when the procedure was billed to the insurance company.

Payment Entry
Depending upon workloads, payment posting lagged anywhere from two weeks to two months. With the checkout desk handling patient payments and the surgical coders collecting pre-payments for surgeries, the billing department could now concentrate on timely posting of insurance checks. The billing department was trained in time-saving items, like batch posting payments when insurances such as Medicare paid on multiple patient encounters with one check. The group reviewed appeal processes, developing form letters from the physicians to support the appeals. The staff had a more complete understanding of denials and how to appeal, so that all insurance denials were worked immediately to ensure timely action.

**Fee Schedule**

The fee schedule was reviewed and updated. Insurance fee schedules were entered into the computer system for accurate write-downs. This also allowed the billing department to dispute any contractual payments not paid according to contract rates.

**Accounts Receivable**

The accounts receivable had not been worked diligently or in a timely manner. A plan of action was organized to turn this around. The accounts receivable was divided among the billing department by account type and payer type. The accounts were worked placing highest precedence on largest and oldest balances.

Patients were currently being counseled on their financial obligations, and a financial policy was developed outlining payment plan options. A better collection system was developed with statements sent out on a weekly basis. Past-due letters were also generated electronically to all patients that had not made a payment within the last 30 days. Patients were blocked from making further appointments if they had a past-due balance unless they spoke to the billing department to make payment arrangements before their next visit.
The collection agency’s performance was evaluated, and a better collection percentage rate was negotiated. Any patient accounts over 90 days that were still in-house were sent to the collection agency.

A credit balance report was printed and assigned to personnel to begin researching refund requests and credit balances on patient accounts.

On a daily basis, all personnel who posted payments, charges, adjustments, or refunds were required to reconcile their daily input into the computer by balancing their deposit to the computer payments, and their charges to encounter forms or surgical charge sheets. The following morning, the interim manager would add up the entire individual daily close reports in order to reconcile against the practice management system daily close report.

**Claim Filing**

Next on the review list was electronic claim filing. The insurance database was updated to ensure that all claims that could be sent electronically were submitted in that format. Claims were to be sent on a daily basis, and clearinghouse reports were to be reconciled daily - making certain that no claims were denied for lack of information. If a claim was denied, it was to be resolved immediately and resent with the next day’s batch of claims.

**Medical Records Restructuring**

**Charting Organization**

The medical records department was in need of systems to organize the department for maximum efficiency. Charting organization was poor, with patient information and clinical information combined in a very onerous way. Indexes were ordered for the charts according to what types of documentation physicians accessed the majority of the time. As charts were pulled for the next day’s clinic, each chart was re-indexed. Charting labels were automated, pulling pertinent patient information out of the practice management system and printing it onto a label.
that was placed on the outside of each chart. A second label was printed with the patient’s name and chart number so it could be placed on the end tab of the chart for easy identification when filing and retrieving charts. Workers’ compensation patients were placed in colored charts, so that they were easily identified. All clinical stickers, such as year stickers and allergy stickers, were placed consistently in the same place on each chart.

**Filing Protocols**

As documentation entered the clinic, it was alphabetized for faster filing. Daily filing of all documentation and charts was instituted, which enabled others to find needed information easily without searching.

**Records Request**

Records requests were responded to within five days. Authorization forms were obtained before any release of record. Proof of identity was also checked before information was released. All records requests, other than from patients and insurance companies, required a pre-payment before records would be copied and released. Any legal requests were immediately brought to the attention of both the interim manager and the physician.

**Physician Paperwork**

Paperwork needing physician review was placed daily in an inbox on each physician’s desk. After the physician reviewed the information, it would be returned to medical records for processing.

**Record Retention Protocols**

With the filing cabinets unable to hold any more patient charts, it was agreed that all medical charts over two years old would be purged on a yearly basis and scanned into electronic storage software.

A disposal protocol was established in the office for any document that contained patient information.
Transcription Restructuring

In-house Transcription

In-house transcription was backlogged for three weeks. The department could not keep up with only one full-time employee. It was identified that another full-time employee was necessary to decrease turn around days and increase production. A goal of 24-hour turn around was set. The physicians developed templates with the transcription department in order to standardize the transcription process. Form letters were also developed to speed referral letters being sent to outside physicians.

Outsourced Transcription

In an effort to get on track with the backlog of transcription, an outside transcription company was hired. The company guaranteed a 24-hour turn around time, had a low error ratio and could securely transfer data back to the clinic.

Significance of Outcomes and Lessons Learned

The effects on personnel during an office restructuring can be stressful. Change can be very difficult for some, while others seem to embrace the change with open arms. The building of trust between administration and employees is challenging, because the administration knows how significant the impact of the changes will affect the clinic, but the employee only sees heavier workloads and more accountability.

Retraining current employees was both time consuming and rewarding. The employees’ acceptance of new processes and job descriptions waxed and waned depending upon how heavy the workloads were. There was a high turnover of employees during the first six months after hiring the new administrator. This meant costly and time consuming hiring and training of new employees.
New work schedules were also developed for smoother-running clinics, which meant that clinic schedules were no longer built around the employees’ personal lives but what was best for the clinic and patient care.

Refusing to get involved with personnel complaints, the physicians quickly referred all problems to the interim manager, nor did the physicians allow unhappy employees to manipulate them when disgruntled with the work processes.

During the second week on the job for the interim manager, a more systematic and organized flow began to develop. The physicians watched as the office began transforming into a more efficient workplace. Two of the senior physicians approached the interim manager at the end of the second week and the administrator position was offered to the interim manager. Accepting the position of administrator, all the processes could be incrementally implemented and seen to completion.

The office showed consistency in the processes implemented after only two months. Daily routines were established and the patient flow began to smooth out instead of peak and valley. The billing department benefited from the front desk restructuring and the checkout position that had been created. Transcription had come full circle and had met the goal of a 24-hour turn around time. It was determined that it was a good idea to keep the out-of-house transcription service for overflow.

After three months there was a higher sense of teamwork among employees. Employee communication increased, with employees helping each other understand the importance of accurate data entry. The accounts receivable report was shared with the billing department, who saw how the days in accounts receivable had begun to reduce in size. (See Appendix A) The physicians were patient during the transition period as existing personnel left and new personnel replaced them. The group knew that in order to meet their goal, they had to accept the strict and structured day-to-day work plan. The real turning point came at month six, when all processes had been implemented and were now being fine-tuned. New and existing personnel had been arranged by matching their skills to the clinic’s job descriptions. Office efficiencies
were continuing to progress, customer service had been drastically improved, and the physicians were realizing a remarkable financial gain.

**Recommendations**

The reorganization of staff can strengthen practices by forcing all members of the team to become accountable for their actions. It is vital to have the steadfast support of the physicians before beginning. The physicians need to understand that employees can be manipulative, and by undermining the administrator in trying to resolve an employee problem would make matters worse.

Running reports bimonthly and monthly, such as accounts receivable aging by insurance carrier and by patient balance, days in accounts receivable, charges, payments, and collections by physician, insurance pending and denials, and charge posting lag reports is imperative to show the clinical progress to the physicians.

Keep the staff involved with the clinical progress, so that when goals are met the staff members responsible are given credit for the progress. Buying lunch for the office as a reward is a small price to pay, and goes a long way with employees.

Verbal communication on a daily basis with staff is important so that when problems arise they feel comfortable coming to the administrator for help. Make staff meetings not only instructional, but challenge the employees to participate by asking the team for help in solving a problem. This makes the employees feel that they can contribute to solve problems, and teamwork is built.

Communicate with the patients through patient satisfaction surveys and verbal communication. Patients are usually willing to let the office know what is wrong, and give suggestions on how something can be done better.
As an administrator, be prepared to spend the majority of the day on the floor with the staff. These actions show leadership and commitment to making the practice and employees succeed. Sit with each of the employees to review the procedures and daily routines. Learn each staff member’s strengths and weaknesses, and then align the employee with the right job for their skills. Make sure that the employees have the right tools to do the job required of them. Do not be afraid to confront difficult issues or release a weak link on the team. The sooner a difficult employee is released the stronger the team becomes.

**Bibliography**


Lythgoe, Marti S. “Computerized Telephone Reminder System Facilitates Wellness and Prevention”. pgs. 64-68. Copyright 2000. Greenbranch Publishing LLC.


