



# ADDITIONAL/ OTHER DATA

## DEFINITIONS

Reference these definitions to guide you in pulling any Additional Data Files report fields.

### **Percent of patient population that logged in to the patient portal**

The percent, in whole numbers, of the practice's patient population that not only enrolled, but also logged in to the patient portal. A patient portal is a secure, online platform where patients can perform administrative tasks associated with their care. Examples of these tasks include scheduling appointments, paying bills, accessing test results, communicating with providers and medical staff, viewing medical records, filling new prescriptions, and requesting prescription refills.

### **Percent of patient population that used the patient portal to do the following:**

- Schedule appointments
- Pay bills online
- Access test results
- Communicate with providers and medical staff
- View, download or transmit medical records
- Fill a new prescription
- Refill prescriptions

### **Expected time (in hours) for staff to respond to patient portal communications**

The expected number of hours staff had to respond to patient portal communications. If the amount of time varied by activity, report the average.

### **Average length of time (in minutes) patients spent on hold after an initial answer**

The average length of time in minutes per telephone call that patients spent on hold after the call was initially answered.

### **Average call length in minutes for inbound calls**

The average duration in minutes per telephone call for inbound calls, calls coming in, measured from when the call is answered and including any hold time, talk time and until the call is completed.

### **Average speed of answer in seconds for inbound calls**

The average amount of time in seconds it takes to answer inbound telephone calls, calls coming in.

### **Average call abandonment percentage rate for inbound calls**

The percentage rate, in whole numbers, of total inbound calls, calls coming in, that were disconnected and/or not answered.

### **Percent of practice's total appointments that were same-day appointments**

The percent, in whole numbers, of the practice's total number of appointment slots per day that are scheduled for same-day patients to accommodate for last-minute appointment requests.

### **Average wait time (in minutes) the patient was in the:**

- Waiting area before being brought to the exam room
- Exam room before seeing the provider

### **Average throughput or total cycle time for the patient from check-in to check-out**

The number of minutes between when a patient arrives at the practice and when they leave the practice including time spent waiting in the waiting area, exam room and checkout time.



# ADDITIONAL/ OTHER DATA

## Average scheduled appointment slot-time (in minutes) for the following:

*A designated block of time allotted to providing patient care.*

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.
- **Post-Operative Visits:** An appointment scheduled after a surgical procedure.

## Average third next available appointment (in business days) for the following:

The number of business days from the start of each day to the third open appointment. This does not count days when the office is closed for business, however, days where the provider is unavailable due to vacation, administrative time, sick leave, etc. should be included in the count. Appointment slots reserved for same-day appointments, should not be included the count for third next available appointment.

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.
- **Post-Operative Visits:** An appointment scheduled after a surgical procedure.

## Average number of appointment slots in a schedule per day per provider for the following:

*A designated block of time allotted to providing patient care.*

- **New Patient Visits:** An individual who has not previously received care from a provider in the same group practice, within the past three years.
- **Established Patient Visits:** An individual who has previously received care from a provider in the same group practice, within the past three years.
- **Preventive Care Visits:** Typically, a yearly appointment intended to prevent illness and detect health concerns early before symptoms are noticeable.
- **Post-Operative Visits:** An appointment scheduled after an initial visit or performed procedure.
- **Same-day Appointments:** The total number of appointment slots per day that are scheduled for same-day patients to accommodate last-minute appointment requests.
- **Unfilled Appointments:** Total appointment slots that were not filled by a scheduled patient visit or purposely unscheduled per day.

## Practice's no-show rate percentage

The percentage rate, in whole numbers, measuring appointments that were scheduled but patients did not show up for or reschedule their scheduled time, as a percent of total appointments.

## How much did you charge for no-show appointments?

The amount charged when a patient does not show for a scheduled appointment.

## How many minutes late until a patient was considered a no-show?

The number of minutes that a patient has after their scheduled appointment starts until a patient is marked as having not shown.



# ADDITIONAL/ OTHER DATA

## **Practice's appointment cancellation rate percentage**

The percentage rate, in whole numbers, measuring appointments that were scheduled but patients or the provider/practice called to cancel their scheduled appointment, as a percent of total appointments.

## **Percentage of appointments that were rescheduled within 30 days of cancellation**

The percentage, in whole numbers, of appointments that were rescheduled within 30 days after cancellation by either the patient or by the provider/practice.

## **Percent of copayments that were collected at time of service**

The amount owed prior to receiving a service by the patient that typically supplements insurance coverage.

## **Percent of patient due balances that were collected at time of service**

The amount owed by the patient after applying the insurer's negotiated discount and the insurer's payments.

## **Average number of claims a biller submitted for payment in a day for:**

*A written request for payment submitted to a third party.*

- **Commercial:** The number of commercial claims (excluding Medicare Advantage) submitted in a day.
- **Government:** The number of government claims submitted in a day. Government claims would include Medicare (excluding Medicare Advantage), Medicaid, and any other federal, state, or other government body.
- **Follow-Up:** The number of outstanding claims and unpaid balances with payers (including commercial and government) submitted in a day.

## **Percentage of claims that were denied on first submission**

The percentage, in whole numbers, of claims that were denied by payers on first submission. A claim is a written request for payment submitted to a third party.

## **Average charge-posting lag time between date of service and claim drop date to payer**

The number of days between when a patient was seen (date of service) and when the claim was posted for third-party payment.

## **Average number of patient encounters a coder processed in a day**

An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition, where the provider exercises clinical judgment that may or may not be billable.

## **Value-Based Contracts Follow-Up Questions**

If your organization participates in value-based contracts, you will be prompted to provide data on the following questions.

## **The number of contracts held by your practice by payer type:**

- **Commercial:** The number of commercial payer contracts (excluding Medicare Advantage) held by your practice.
- **Government:** The number of government programs participated in by your practice. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state, or other government body.
- **Medicare Advantage:** The number of Medicare Advantage payer contracts held by your practice. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits (and more). However, the benefits are instead offered through contracts with private insurers.

## **How many covered lives were attributed to this practice?**

The total number, in whole numbers, of covered lives across all your practice's payer contracts.



# ADDITIONAL/ OTHER DATA

## The number of contracts held by your practice that included a risk or value-based program or reimbursement methodology by payer type:

- **Commercial:** The number of commercial payer contracts (excluding Medicare Advantage) held by your practice that included a risk or value-based program or reimbursement methodology.
- **Government:** The number of government programs participated in by your practice that included a risk or value-based program or reimbursement methodology. Government payers would include Medicare (excluding Medicare Advantage), Medicaid and any other federal, state or other government body.
- **Medicare Advantage:** The number of Medicare Advantage payer contracts held by your practice that included a risk or value-based program or reimbursement methodology. Medicare Advantage is part of the Medicare Program, and may include Part A, B and D benefits, however, the benefits are instead offered through contracts with private insurers.

## How many covered lives were attributed to value-based contracts in this practice?

The total number, in whole numbers, of covered lives across all your practice's value-based contracts.

## Across all payer types and all payer contracts, which specific measure(s) were a focus for your practice?

Regardless of the payer or contract, describe which quality measures were a focus for your practice.

## Among your practice's covered lives attributed under value-based contracts, what was your practice's:

- **Hospital admission rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's hospital admission rate.  
*To calculate, divide the number of hospital admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.*
- **Hospital 30-day readmission rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, who experienced unplanned readmission to a hospital within 30 days of a previous hospital stay. A 30-day hospital readmission refers to when a patient is admitted to a hospital within 30 days or less of being discharged from a hospital for a previous stay.  
*To calculate, divide the number of patients tied to value-based contracts with hospital readmission within 30 days by the total number of hospital discharges for patients tied to value-based contracts.*
- **Emergency department utilization rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's emergency department utilization rate.  
*To calculate, divide the number of inpatient and/or outpatient emergency department admissions experienced by patients tied to value-based contracts by the total number of patients tied to value-based contracts.*
- **30-day post-operative infection rate:** Specifically, for patients under value-based contracts, indicate the percent, in whole numbers, of your practice's 30-day post-operative infection rate. Post-operative infection is defined as any infection that occurs within 30 days of operation and may be related to the operation itself or the postoperative course.  
*To calculate, divide the number of post-operative infections experienced by patients tied to value-based contracts within 30 days of operation by the total number of patients tied to value-based contracts.*