STROUDWATER

PRACTICE MANAGEMENT IN RURAL SETTINGS:
HIGH-IMPACT FIXES FOR IMMEDIATE IMPROVEMENT

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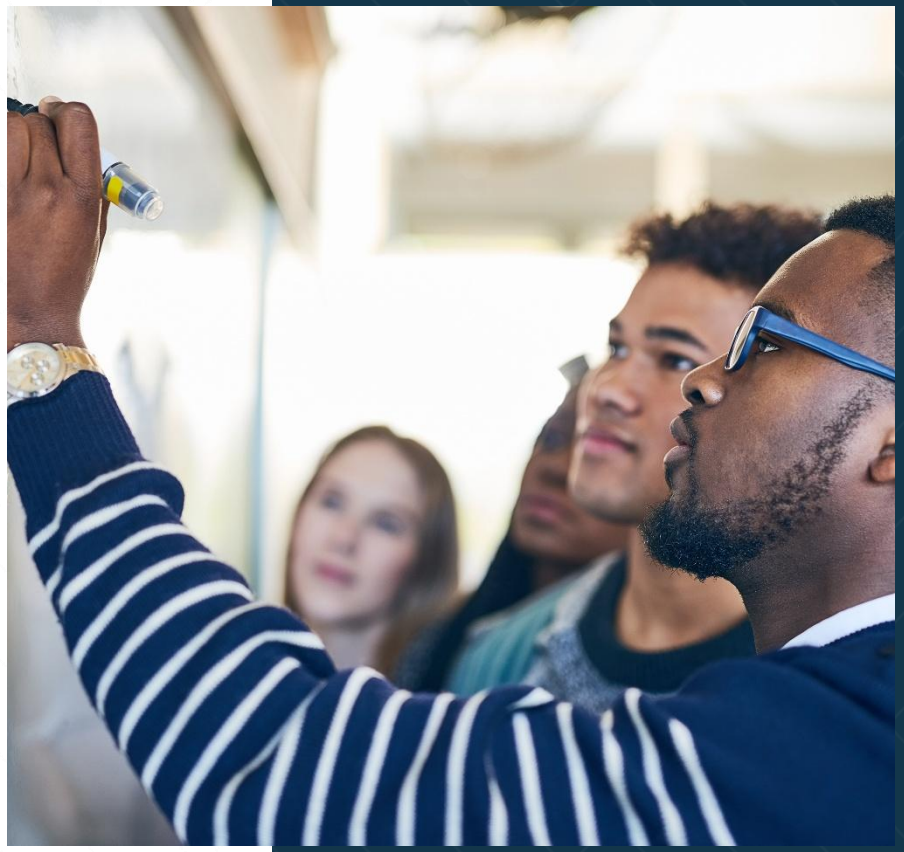
KEY LEARNING OBJECTIVES

By the end of this session, participants will be able to:

Identify and isolate the operational bottlenecks unique to rural practices (distinguishing perceived underutilization from true workflow constraints)	Implement scheduling, access, and throughput optimization strategies without expanding administrative headcount	Apply a practical performance framework to monitor provider productivity and clinic efficiency in resource-constrained environments



What is the primary operational barrier currently limiting your rural clinic's performance?

A. High no-show rate and unfilled scheduling gaps
B. Staff shortages and limited administrative headcount
C. Low provider productivity / perceived underutilization
D. Patient transportation and geographic access challenges
E. Coding, billing, or revenue cycle issues

POLLING QUESTION 1

THE RURAL REALITY

THE RURAL REALITY: THIS IS A DIFFERENT PRACTICE

THE CONSTRAINTS	THE OPPORTUNITY
Thin staffing — every person wears 3–4 roles	More operational flexibility than large health systems
Geographic distance creates access barriers AND no-show pressure	Changes can happen faster — no complex governance
Complex reimbursement (RHC all-inclusive rate; CAH cost-based)	High ROI on small improvements in thin-margin environments
Limited specialist access shifts more complexity to primary care	2025–2026 regulatory changes create an advantage for those who move first
Provider recruitment and retention under constant pressure	Community trust = patient loyalty that urban practices can't match
No economies of scale — everything costs more per unit	

Note: This session applies to all rural clinics. RHC-specific billing content will be flagged clearly. If you are not RHC-designated, the operational and workflow strategies apply equally — only the specific billing codes differ.

WHY 2025 – 2026 WAS THE YEAR OF OPERATIONS

"The rural clinics that survive the next decade will not be the ones with the best buildings or the biggest budgets. They will be the ones that outperform on operations."

— Stroudwater Associates, 2024

Regulatory Shift	Market Shift	Financial Pressure
RHC productivity floor eliminated (Jan 2025) — focus shifts from volume quota to cost-per-visit management	Post-pandemic patient behavior shift: higher no-show rates, more demand for telehealth, lower panel loyalty	Rural hospital closure rate accelerating — clinics must demonstrate financial sustainability
G0511 care management code terminated (July 2025) — transition to individual PFS codes now required	Workforce competition intensifying — rural providers considering urban positions at higher rates	Payer mix pressures increasing — Medicaid managed care expansion affects rural collections

WHERE RURAL PRACTICES LOSE MONEY

Access and Scheduling:

- Poorly designed templates and long appointment wait times drive patients away.

Provider Underutilization:

- Open slots and high administrative burdens prevent providers from seeing the patients who are waiting for care.

Revenue Cycle Gaps:

- Significant revenue is lost to undercoding (estimated at 10–20%), missed charges, and high denial rates.

Patient Leakage:

- When local access is poor, patients travel to urban centers, taking vital healthcare dollars out of the community.

DIAGNOSING THE BOTTLENECK

DIAGNOSING YOUR BOTTLENECK: PERCEIVED VS. REAL

THE CORE MISDIAGNOSIS:

- Open slots on the schedule look like a demand problem or a provider productivity problem. In most cases, they are neither. They are a process problem.

THE SELF-DIAGNOSTIC — THREE QUESTIONS:

- Ask these about your clinic right now:

#	Question	If YES → Your Likely Bottleneck
1	Do you have open slots but patients still wait 7+ days for an appointment?	Scheduling structure — wave or advanced access template needed
2	Are providers regularly finishing 30+ minutes late or charting after hours?	Throughput — MA rooming protocol and EHR template optimization needed
3	Is your E&M coding more than 60% Level 3 (99213) across all providers?	Coding accuracy — documentation training and E&M audit needed

DIAGNOSING YOUR BOTTLENECK: PERCEIVED VS. REAL

THE THREE HIDDEN BOTTLENECKS:

The Batching Trap: Front desk checks in 5 patients at 9:00 AM instead of staggering — creates a crush, then a lull

The Documentation Drudge: Providers spending 15+ minutes charting between patients due to poor EHR templates

The Phone Bottleneck: A single phone line tying up all admin staff, preventing outreach and reminders

PROVIDER SCHEDULES AND SUGGESTED “FIXES”

SCHEDULING FIX 1: MODIFIED WAVE SCHEDULING

THE PROBLEM:

Traditional 15-minute rigid block scheduling creates artificial bottlenecks — one late arrival or extended visit cascades through the entire day.

THE FIX — HOW WAVE SCHEDULING WORKS:

Block	Structure	Logic
Top of hour	Schedule 2–3 patients simultaneously	Accounts for 1 no-show or late arrival — provider always has someone ready
Mid-hour	Stagger 1–2 complex visits, longer appointments	Prevents mid-morning crush; gives breathing room
End of hour	Reserve for acute/walk-in or catch-up	Flex buffer absorbs overflow; acute access preserved

SCHEDULING FIX 1: MODIFIED WAVE SCHEDULING

AUDIT ACTION — DO THIS FIRST:

- Pull 2 weeks of schedule utilization: What % of slots were filled? What % of patients arrived on time?
- Group similar visit types: all well-checks in the morning; complex chronic visits in the afternoon. Reduces provider mental context-switching by ~25%.
- Calculate your no-show cost: [No-show rate %] × [visits/day] × [revenue/visit] × [250 working days] = annual revenue lost to no-shows

GETTING PROVIDER BUY-IN:

- Show the data first. Providers respond to evidence, not mandates. A 2-week schedule utilization report is your best tool.
- Pilot with one willing provider for 30 days. Let the results make the case.
- Frame it as giving the provider control — they're never waiting for a late patient; someone is always ready.

SCHEDULING FIX 2: ADVANCED ACCESS (SAME-DAY MODEL)

THE CONCEPT:

Advanced access means holding a portion of each day's appointments for same-day booking — reducing lag time and eliminating the root cause of most no-shows: the appointment booked so far in advance that the patient's situation has changed.

KEY METRIC TO WATCH:

Third Next Available (TNA) Appointment — the gold standard for measuring true access.

Target for rural FM: ≤ 7 business days

Above 14 days: your lag time is driving patient leakage to urgent care and urban centers

Step	Action	Measure
Step 1 (Weeks 1–4)	Hold 20% of each day's slots as 'same-day only.' Fill the remaining 80% normally. Do NOT open the same-day slots until 7:00 AM that morning.	Track: same-day fill rate, third next available (TNA) lag time
Step 2 (Month 2+)	If same-day slots fill consistently (>85%), expand to 30%. If under 70%, hold at 20% and investigate why. Do not expand until data supports it.	Track: no-show rate change, patient satisfaction scores, provider satisfaction

TACKLING THE RURAL NO-SHOW: PREVENT + RECOVER

- Why Rural Patients Miss Appointments — The Real Reasons:

PREVENT the No-Show	RECOVER the Slot
Text reminders: 98% open rate vs. ~20% for phone calls	15-minute tardiness rule: at 15 minutes past appointment time, front desk immediately offers to convert to telehealth
Multi-step outreach: text 72 hrs out, text 24 hrs out, call 2 hrs before for chronic no-showers	Same-day waitlist: maintain a 5–10 patient same-day list who have said 'call me if anything opens up'
Proactive telehealth: for patients with known transportation barriers, offer virtual as the default option at booking — not as a fallback	Audio-only fallback: if video fails, transition to telephone visit immediately — do not cancel
Panel-based risk scoring: flag patients with 2+ prior no-shows for double-booking or mandatory confirmation call	Zero-prep virtual slots: schedule 1–2 telehealth visits at historically volatile times (after lunch, end of day) — a virtual no-show costs you nothing

NO-SHOW COST CALCULATOR:

- Formula: No-show rate × visits/day × revenue/visit × 250 days = annual revenue lost
- Example: 10% no-show × 18 visits/day × $175/visit × 250 days = $78,750 lost per provider/year
- Even a 3% reduction in no-shows at this rate = $23,625 recovered annually, per provider.

TELEHEALTH AS A SCHEDULE MANAGEMENT TOOL

RHC (Medicare):

- Medical telehealth: bill G2025, flat rate ($97.53 in 2026) — *not* the AIR
- Behavioral health telehealth - paid at the AIR
- Originating site only: Q3014 facility fee (~$31)
- 10/1/26: G2025 replaced by individual HCPCS codes + modifiers 93/95

Non-RHC:

- Bill standard CPT/HCPCS codes with telehealth modifiers
- Verify Medicare rules and payer-specific coverage terms

Strategy	How to Implement It
1. Real-Time Visit Conversion	At 15 minutes past, front desk offers telehealth. Staff need a single-sentence script and one-click process in your EHR. Train this in 20 minutes.
2. Proactive Low-Complexity Slots	Move medication management, lab reviews, and routine chronic follow-ups to designated telehealth slots. These visits have the highest no-show risk and lowest room prep burden. A telehealth no-show = zero cost.
3. Volatile Time Blocks	Book 1–2 telehealth slots immediately post-lunch and at end-of-day — historically the most volatile times. If the patient shows: full visit. If not: provider uses the time for charting. No loss.
4. Audio-Only Backup	Rural broadband is unreliable. Establish an immediate 2-minute protocol: if video fails, switch to telephone visit automatically. Do not cancel. CMS permits audio-only for most established patient visits.

How effectively is your clinic currently using telehealth as a schedule management tool?

A. Heavily utilized – it's part of our daily workflow
B. Moderately used – we do it, but it's inconsistent
C. Rarely used – technical or billing confusion holds us back
D. Not used at all

POLLING QUESTION #2

PATIENT THROUGHPUT AND PANEL MANAGEMENT

PATIENT THROUGHPUT AND TOP-OF-LICENSE STAFFING

THE BOTTLENECK:
Providers performing tasks that a medical assistant or LPN could do — such as medication reconciliation, preventive care screening updates, and pre-populating the chief complaint — are losing 5–7 minutes per encounter.

THE FIX — AGGRESSIVE ROOMING PROTOCOL:

- **MA / LPN DOES:**
  - Medication reconciliation — review list, flag changes
  - Preventive care gaps — pull overdue screenings from EHR
  - Chief complaint in EHR — HPI starter in dot phrase format
  - Vitals + pre-visit questionnaire (PHQ-2, pain scale, etc.)
  - Set up exam room with visit-specific supplies

- **PROVIDER DOES:**
  - Reviews MA pre-work before entering the room (30 seconds)
  - Diagnosis, complex medical decision-making
  - Treatment plan and patient education
  - Closes the note instead of starting it

PATIENT THROUGHPUT AND TOP-OF-LICENSE STAFFING

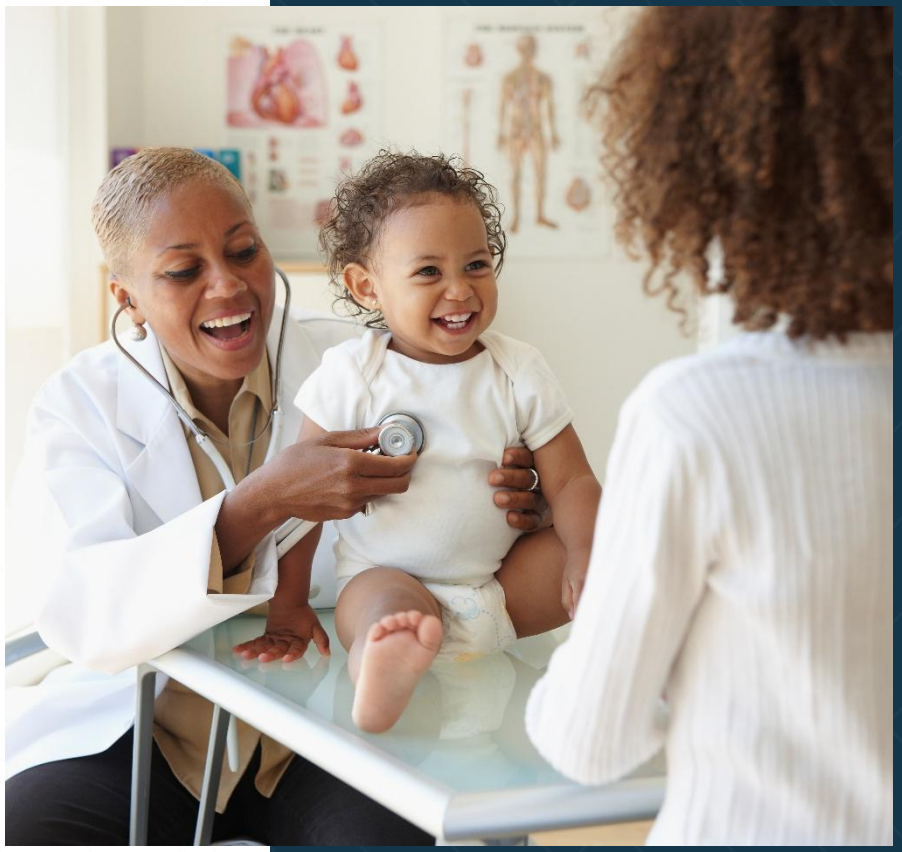
THE ROI:

- 5–7 minutes saved per encounter × 18 patients/day = 90–126 minutes of recovered provider time daily
- 90 minutes ≈ 1–2 additional visits per day per provider
- 1 additional visit/day × $175/visit × 250 days = $43,750 in additional annual revenue per provider

GETTING PROVIDER BUY-IN:

Most provider resistance comes from concern about documentation accuracy.

Fix: Build a standardized rooming checklist directly into the EHR template. The provider sees exactly what the MA completed before entering the room. One 30-minute training session, one checklist, consistent results.



PANEL MANAGEMENT: THE UNTAPPED REVENUE IN YOUR EXISTING PATIENT LIST

THE INSIGHT:	Most rural practices have more capacity than they realize — not in open schedule slots, but in their existing patient panel. Patients with chronic conditions who are overdue for a visit represent immediately actionable revenue. No new patients. No new staff. No new technology.
HOW TO RUN A GAP-IN-CARE REPORT:	Step 1: Pull a gap-in-care report from your EHR (Epic, eCW, athena, NextGen all have this built in) Step 2: Filter for patients seen in the last 18 months with diabetes, HTN, or COPD who have NOT had a visit in 6+ months Step 3: Assign one MA per provider to outreach — 10 calls per day, simple script: 'Dr. [Name] wanted to check in on how you're doing and get you scheduled for your follow-up.' Step 4: Track: how many contacted, how many scheduled, how many showed

PANEL MANAGEMENT: THE UNTAPPED REVENUE IN YOUR EXISTING PATIENT LIST

THE MATH:	Typical rural FM panel of 1,200–1,500 patients surfaces 80–150 overdue chronic care patients from this query 3 additional scheduled visits/week × 48 working weeks × $175/visit = $25,200 in additional annual revenue per provider No new patients. No capital expenditure. No new staff — just 30 minutes of MA outreach per day.
GETTING BUY-IN:	For providers: frame as 'patients who need you' rather than 'gaps to close.' Clinical motivation is stronger than revenue language. For leadership: show the revenue projection in the proposal.

Of the strategies we've covered so far — scheduling, no-show reduction, telehealth, top-of-license staffing, and panel management — how would you describe your clinic's current state?

A. We've implemented most of these already
B. We've tried a few but haven't fully committed
C. We know we need to make changes, but haven't started
D. This is new territory — we're starting from scratch

POLLING QUESTION #3

RURAL CLINIC METRICS

YOUR MINIMUM VISIBLE DASHBOARD – SIX METRICS THAT DRIVE EVERYTHING

Metric	Rural Target	Caution Threshold	Financial Stake
No-Show Rate	< 8%	> 12%	Each 1% reduction ≈ $15K–$30K/yr per provider
3rd Next Available (Lag)	≤ 7 days	> 14 days	Lag >14 days drives patient leakage to urban centers and urgent care
Visits / Provider / Day	16–20	< 14	+4 visits/day = $100K–$150K additional annual revenue per provider
wRVUs / Provider / Year	3,800–5,500	< 3,200	Rural range — do not compare to national urban median without adjustment
E&M Level 4 Rate (99214)	≥ 25% of visits	< 15%	Rural panels are complex — coding < 25% L4 likely indicates systemic undercoding
Claim Denial Rate	< 6%	> 10%	Each denial costs $25–$30 to rework; delays cash flow 30–60 days

CODING ACCURACY – THE REVENUE LEAK NOBODY TALKS ABOUT

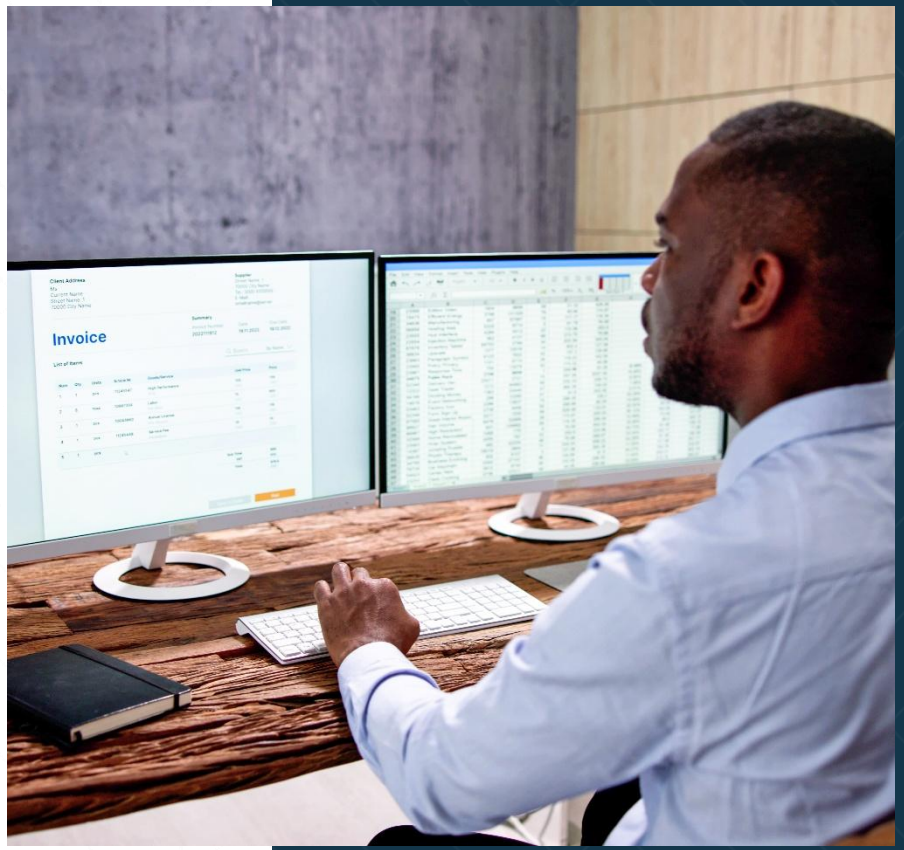
THE PATTERN:
Rural primary care practices tend to code at Level 3 (99213) at significantly higher rates than comparable urban practices — despite managing equally or more complex patient populations. This suggests systemic undercoding, not lower acuity.

E&M Level	Key Criteria (2021 AMA Guidelines)	Common Rural Miss
99213 — Level 3	Low-mod complexity decision-making OR 20–29 min total time	Chronic condition managed and stable — providers often code L3 when L4 is clearly supported
99214 — Level 4	Moderate complexity decision-making OR 30–39 min total time	2+ chronic conditions addressed, prescription drug management, ordering labs/imaging — any of these supports L4
99215 — Level 5	High complexity decision-making OR 40–54 min total time	Uncontrolled chronic condition + new problem with workup — frequently undercoded in rural settings

CODING ACCURACY – THE REVENUE LEAK NOBODY TALKS ABOUT

THREE-STEP CODING AUDIT (do this in 30 days):

- Step 1: Pull a coding distribution report — what % of your established patient visits are L2/L3/L4/L5?
- Step 2: Compare to benchmark: rural FM target is ≥25% Level 4, ≥5% Level 5
- Step 3: If below benchmark, schedule a 1-hour coding education session with your biller and all providers. Focus on documentation triggers for Level 4 — not up-coding, but accurate coding of what is actually documented.



Sources:

- AMA: 2021 E&M Office Visit Coding Revisions — Implementation Guide
- CMS: Evaluation and Management Documentation Requirements — 2021 Update
- MGMA: 2023 Practice Operations Survey — E&M Coding Distribution by Specialty and Setting
- AAFP: E&M Coding Education Resources for Family Medicine (aafp.org/coding)

RHC UPDATES

RHC UPDATES – TWO CHANGES THAT REQUIRE IMMEDIATE ACTION

NOTE FOR NON-RHC ATTENDEES:
The next two slides cover regulatory changes specific to federally designated Rural Health Clinics. If you are not RHC-designated, the underlying principle — transitioning from bundled billing to individual CPT codes for care management — reflects a broader shift worth understanding.

CHANGE 1 — PRODUCTIVITY STANDARDS ELIMINATED:

WHAT CHANGED:	WHAT THIS MEANS FOR OPERATIONS:
The legacy 4,200 visits/FTE (physicians) and 2,100 visits/FTE (NPPs) productivity floors were eliminated effective January 1, 2025	Focus shifts from meeting a volume floor to managing cost-per-visit and care quality
RHCs are no longer required to meet a volume 'quota' to maintain cost-based reimbursement eligibility	Financial modeling should now account for actual visit volume, not a minimum threshold
	Opportunity: right-size your provider schedule based on demand, not regulatory minimums

RHC UPDATES – TWO CHANGES THAT REQUIRE IMMEDIATE ACTION

NOTE FOR NON-RHC ATTENDEES:
The next two slides cover regulatory changes specific to federally designated Rural Health Clinics. If you are not RHC-designated, the underlying principle — transitioning from bundled billing to individual CPT codes for care management — reflects a broader shift worth understanding.

CHANGE 2 — G0511 CODE TERMINATED:

WHAT CHANGED:	WHAT YOU MUST DO NOW:
G0511 — the bundled RHC care management code — was terminated effective July 1, 2025 G0511 was used to bill CCM, RPM, PCM, and other care management services as a single RHC code	Bill the individual PFS/HCPCS codes that represent each specific service furnished Chronic Care Management: 99490, 99491, 99439 Principal Care Management: 99424, 99425, 99426, 99427 Remote Patient Monitoring: 99453, 99454, 99457, 99458 Revenue continuity depends on successful transition — bill the right code for what was actually done

FINANCIAL RETURN

WHAT IS THE FINANCIAL RETURN OF DOING THIS WORK?

- If a rural clinic implements even three of the strategies discussed today, here is what the aggregate financial impact can look like:

Initiative	Annual Impact — Conservative	Annual Impact — Moderate	Per Provider
No-show reduction (10% → 7%)	**$23,625**	**$47,250**	Per provider
Top-of-license throughput (+1 visit/day)	**$43,750**	**$65,625**	Per provider
Panel management — chronic care outreach	**$25,200**	**$37,800**	Per provider
Coding accuracy (L3→L4 shift, 10% of visits)	**$18,000–$30,000**	**$40,000–$60,000**	Per provider
TOTAL (3-provider clinic)	**$330,000+**	**$600,000+**	**Aggregate**

ASSUMPTIONS:

- $175 average revenue per visit (RHC AIR approximation; adjust to your actual rate)
- 18 visits/provider/day baseline
- 250 working days/year
- 10% no-show rate baseline
- L3→L4 reimbursement delta ≈ $30–$45/visit depending on payer mix

GETTING BUY-IN

GETTING BUY-IN: THE IMPLEMENTATION LAYER MOST CLINICS SKIP

THE PRINCIPLE:
"You cannot mandate buy-in. You can only earn it — one data point, one pilot, one honest conversation at a time."
— Practice Management Consultant, MGMA Annual Conference (2023)

Audience	What They Care About	Data to Bring	The Specific Ask
Leadership / Board	Margin, regulatory compliance, and risk	No-show cost ($), G0511 revenue gap, coding accuracy variance vs. benchmark	Approve a 60-day pilot with 3 defined success metrics and a review date
Physicians / APPs	Time, clinical autonomy, and workload fairness	Their personal wRVU percentile, end-of-day charting time vs. peer	Try one change for 30 days. You choose which one. We measure together.
Front Desk / Schedulers	Simplicity, clarity, and not being blamed when things go wrong	Current call volume, reminder failure rate, no-show rate trend	Written script + new workflow + 2-hour training before go-live
MAs / LPNs	Recognition, professional growth, and clear expectations	Time spent on non-clinical tasks vs. clinical prep	Rooming checklist + 30-min training; recognition in team meetings

GETTING BUY-IN: THE IMPLEMENTATION LAYER MOST CLINICS SKIP

THE UNIVERSAL RULE:

- Lead with their data, not your plan. Every change you propose should have a current metric and a target associated with it.
- “Our schedule utilization is 74%, and our no-show rate is 11%, and here is what two clinics similar to ours achieved with this change” wins.

IMPLEMENTATION ROADMAP

YOUR IMPLEMENTATION ROADMAP – REALISTIC, PHASED, AND MEASURABLE

Phase	Actions	Success Metrics	Who Owns It
Weeks 1–2 Diagnose	Pull 2 weeks of schedule utilization	Baseline metrics established; pilot provider identified	Administrator + biller
	Calculate your actual no-show rate and cost		
	Run coding distribution report (% L3/L4/L5)		
	Identify one provider willing to pilot		
Weeks 3–6 Pilot	Launch text reminders for all providers	No-show rate trend; end-of-day charting time; same-day fill rate	Scheduler + MA lead
	Begin wave scheduling with pilot provider		
	Train MAs on rooming protocol for pilot provider		
	Train front desk on 15-min telehealth pivot		

THE MOST IMPORTANT THING ON THIS SLIDE:
Start with the Diagnose phase — not the Pilot phase. The single most common implementation failure is jumping to solutions before understanding which problem is actually biggest. Two weeks of data collection changes everything.

YOUR IMPLEMENTATION ROADMAP – REALISTIC, PHASED, AND MEASURABLE

Phase	Actions	Success Metrics	Who Owns It
Months 2–3 Expand	Present pilot data to leadership + providers	Revenue per visit change; TNA lag time; wRVU trend	Medical director + administrator
	Expand scheduling template to all providers		
	Begin panel management outreach (gap-in-care report)		
	Start E&M coding education with biller		
Months 3–6 Sustain	Embed workflows in new staff onboarding	Stable improvement across all 6 dashboard metrics	Leadership team
	Review 6 metrics monthly at ops meeting		
	Complete G0511 billing transition (RHCs)		
	Schedule 6-month operational reassessment		

THE MOST IMPORTANT THING ON THIS SLIDE:
Start with the Diagnose phase — not the Pilot phase. The single most common implementation failure is jumping to solutions before understanding which problem is actually biggest. Two weeks of data collection changes everything.

SUMMARY: THREE THINGS TO REMEMBER

01

Your bottleneck is almost certainly structural, not cultural. Open slots are rarely a demand problem. Pull your schedule data before drawing any conclusions about provider productivity or patient engagement.

02

Every change needs a financial case.

- Don't go to leadership with 'we should do wave scheduling.' Go with: 'Our no-show rate costs us $X per year. Here's a 60-day pilot with three measurable outcomes and a review date.'

03

Buy-in is the implementation.

- The best scheduling template in the world fails without provider and staff adoption. Lead with their data, start with a pilot, and let results do the persuading.

"The rural clinics that survive the next decade will not be the ones with the best buildings or the biggest budgets. They will be the ones that outperform on operations."

Stroudwater Associates, 2026

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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