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"Your infection may be antibiotic-resistant, but let’s see how it responds to intensive litigation.”
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FREE CODING ENCYCLOPEDIA and QUESTIONS ANSWERED
ICD-10 Readiness Still Underwhelms According to WEDI Survey

WEDI, or the Workgroup for Electronic Data Interchange, surveyed nearly 1200 vendors, providers, and health plans to gauge their readiness for the ICD-10 go-live date of October 1, 2015. Highlights include:

- **Providers:** 33% of the providers surveyed said they already completed their ICD-10 impact assessment but that was a decline from the more than 50% who reported back in 2014. For external testing, only 25% said they had begun external testing. For Medicare testing, 25% said they already tested with Medicare.

- **Vendor Results:** 60% of the 173 vendors surveyed said their ICD-10 services and software were either available or they had kicked off customer testing.

- **Health Plans Results:** The health plans fared slightly better than the providers or vendors. Eighty percent of health plans have begun internal testing, with 40% already completing the task. Nearly 25% of health plans said they were planning to test with most providers, and 60% said they would only test with a select group of providers. For 60% of the health plans, the No. 1 biggest challenge that has impacted ICD-10 readiness is competing internal priorities. Uncertainty over delays also topped the list.

Source: Healthcare IT News, June, 2015

ZocDoc Study: Americans Are Dropping Out of Healthcare

Americans are dropping out of healthcare, according to a new study by digital health company ZocDoc:

- **Delaying Care:** Eighty percent of Americans admit they are delaying or forgoing preventive care. When feeling unwell, 43% say they are more likely to turn to Dr. Google for self-diagnosis and treatment.

- **Facing Barriers:** One in four Americans say it’s tough to reach a person when they call a doctor’s office. If patients are not successfully scheduled on the first call, 26% report waiting at least a few weeks to try making an appointment again, if they even attempt to at all.

- **Migrating Online:** A full 80% of Americans are motivated to book an appointment online, with services like ZocDoc, because it is more convenient and they can do it at any time—even when the doctor’s office is closed.

Source: Healthcare Dropout Survey, blog.zocdoc.com/healthcaredropouts. To give your patients access to online booking and reviews and list your practice with ZocDoc, visit www.zocdoc.com/join.

Opioid Abuse and Prescribing Guidelines

The Pennsylvania Medical Society (PAMED) has been hard at work with initiatives aimed at tackling the state’s prescription drug abuse crisis. One element of the response to this crisis was the recent adoption of voluntary prescribing guidelines for the treatment of chronic noncancer pain.

Physicians Should Prepare for ICD-10 Launch

While many physicians fret about the approaching ICD-10 changeover, those who are well prepared stand to benefit immensely from the approaching deluge of new codes. With ICD-10 imminent, healthcare providers must use the small window of time left to educate themselves about the various options and work closely with health IT vendors to make sure the correct tools are in place. Physicians could suffer severe workflow disruption. Any ill-prepared practices will not transition smoothly, and during patient consultation there is no time to map ICD-9 codes to their new, and more complex, ICD-10 counterparts. Practices will run the risk of being denied reimbursement due to inaccurate coding. If you don’t have the right billing codes, you simply won’t get paid.

We recommend that providers immediately vet the ICD-10 readiness of their technology vendors. And with ICD-10 around the corner, physicians should resist the temptation to employ quick-fix technologies. Getting proof of performance from vendors and staff members is the best preparation measure you can take. Doctors should be demanding that proof now, before it is too late. There are free ICD-10 training modules at www.codapedia.com.

Source: Codapedia.com
pain. They are voluntary and not intended to replace a physician’s clinical judgment. They encourage healthcare providers to incorporate several best practices when caring for patients receiving opioids for the treatment of chronic noncancer pain.

“The growing epidemic of opioid abuse is one that concerns Pennsylvania physicians across the state,” said PAMED President Bruce MacLeod, MD, in a recent news release. “As an emergency physician, I see the devastating impact of prescription drug abuse on a regular basis. It’s an epidemic that does not discriminate on the basis of race, age, or gender, and no community is immune.” Highlights of the guidelines include that providers should:

- Conduct and document a history, including documentation and verification of current medication and a physical examination, before initiating chronic opioid therapy;
- Discuss the risks and potential benefits associated with treatment with the patient so that he or she can make an informed decision regarding treatment;
- Consider initial treatment with opioids a therapeutic trial to determine whether chronic opioid therapy is appropriate for the patient;
- Individualize opioid selection, initial dosing, and dose adjustments according to the patient’s health status, previous exposure to opioids, response to treatment, and predicted or observed adverse events;
- Carefully consider if doses above 100 mg/day of oral morphine or its equivalent are indicated;
- Reassess patients on chronic opioid therapy periodically and as warranted by changing circumstances;
- Carefully monitor patients for aberrant drug-related behaviors, and consider increasing the frequency of ongoing monitoring as well as referral for specialty care, including psychological, psychiatric, and addiction experts, for patients identified to be at high risk for such behaviors;
- Carefully determine if the risk associated with chronic opioid therapy outweighs documented benefit in patients who have engaged in aberrant drug-related behaviors;
- Discontinue chronic opioid therapy in patients who engage in repeated aberrant drug-related behaviors or drug diversion, experience no progress toward meeting therapeutic goals, or experience intolerable adverse effects; and
- Understand current federal and state laws, regulatory guidelines, and policy statements that govern the use of chronic opioid therapy for chronic non-cancer pain.

Source: www.pamedsoc.org/opioidguidelines

**PRACTICE MANAGEMENT**

**At Your Service!**

According to Cheryl Bisera, coauthor with Judy Capko of *The Patient-Centered Payoff* (Greenbranch Publishing, 2013), there are important points to consider in your practice’s quest for good customer service:

- **Parking:** Is it adequate in distance, availability, and handicap accessibility?
- **Suite Location and Signage:** Simply put, is your suite easy to find and get to?
- **Digital Forms:** Can new-patient forms be filled out and sent ahead of first visits?
- **Payment Options:** Do patients have the ability to pay via credit card, pay online, or create payment plans?
- **Live Phone Coverage During all Business Hours:** The doctor may be at lunch, but there’s no need to stop scheduling appointments and taking messages like refill requests.
- **Utilizing Electronic Health Record Notes:** Reduce the need for patients to repeat themselves with fewer duplicated questions; implement staff note-taking utilization from your charting system.

**Staying on Time:** Find the glitches that sabotage your schedule and fix them. Increased efficiency boosts profitability and the patient experience.

**Convenient Hours:** Creatively meeting patients’ needs with extended or weekend hours can boost revenue and doesn’t have to mean giving up your life.

**Restroom:** Sounds silly, but this basic facility requirement should be easy to find and pleasant to use.

**Web site:** Have your practice phone number at the top of every Web page. Making all pertinent information easy to find reduces unnecessary calls to the practice.

Source: *Dermatology Times*, June 2015

**RISK MANAGEMENT**

**Top Patient Safety Risks in Obstetrics**

An analysis of 882 obstetrical malpractice claims that closed from 2007 through 2014 revealed underlying vulnerabilities that expose doctors to liability and place patients at risk. Here are the most common allegations made by patients in these claims:

- **Delay in Treatment of Fetal Distress (22%):** Most common cause of delayed treatment was physician failure to act when presented with Category II or Category III fetal heart rate tracings predictive of metabolic acidosis.
- **Improper Performance of Vaginal Delivery (20%):** Almost all of the causes were brachial plexus injuries due to shoulder dystocia.
- **Improper Management of Pregnancy (17%):** Cases included failure to test for fetal abnormalities when indicated and failure to address abnormal findings.

Sources: www.thedoctorscompany/ obstetricstudy; *Medical Liability Monitor*, June 2015
Ten Communication Tips Regardless of the Type of Adverse Event

1. Provide patients with a number where you can be reached if there are additional questions.
2. Remember your body language—you are being watched closely!
3. Consider confidentiality. Make sure your discussions cannot be overheard.
4. Make sure you can have your conversation with your patients without being interrupted.
5. Give patients an opportunity to express their thoughts and ask questions.
6. Really listen.
7. Be compassionate and understanding of perspective—not defensive.
8. Turn off your phone and your beeper.
9. Consider whether you should have another healthcare provider with you as a witness.
10. Consider whether you should follow up with a letter to the patient. Should you document the meeting in the medical chart? And if so, what should it say?


How to Build a Meaningful Career

Do this:
- Make a priority list of what a meaningful career would look like to you.
- Invite four to five people to serve as a board of advisors as you explore what you want.
- Experiment with different elements of a job that you’d want either in your current position, outside work, or through conversations with people.

Don’t do this:
- Focus on your next role; instead, think about what you want from work over the long term.
- Let the stage of your career hold you back—even those deep into their careers can make changes.
- Neglect your finances so that when you want to make a change, you don’t feel you can.


Turn Career Blues into Career Leaps

 According to Jon Acuff, author of Do Over: Rescue Monday, Reinvent Your Work, and Never Get Stuck (Portfolio, 2015), you can reinvent your thinking about your job.

1. Don’t blame your employer; consider it your own responsibility to be happy at what you do. Ask yourself if your expectations are realistic. If not, adjust them or look for a new position that will meet those expectations.
2. Do-overs can be voluntary—a new job or career—or involuntary, like an unexpected layoff. In either case, give yourself permission to change, and have a plan in place.
3. Most of us spend 18 years preparing for college, the military, or a job, and then the next thing we prepare for is retirement. There is a 40-year gap when we don’t invest in our careers. If you hustle to better your relationships, your skills, and your character, you’ll build up a “career savings account” that will help you navigate your next move, whether it is within your current organization, going back to school, or propping you up after a layoff or merger.

Source: Southwest, June 2015

Search Firms Changing Up Compensation and Bonus Packages

Compensation bonus packages that reward CEOs for hitting quality benchmarks such as patient and physician satisfaction are becoming more common. Companies began moving away from perk-based bonuses, such as country club memberships, about five years ago, says Kathy Noland, VP at B.E. Smith. They received bad press for these perceived luxuries. Instead, they use a four-pillar incentive plan in which 25% of bonus is tied to performance on quality, workforce, growth/market share, or company strength. The quality metrics pillar takes into account a provider’s results in Centers for Medicare & Medicaid Services core measures, regulatory and accreditation results, and patient-satisfaction scores.

Source: Modern Healthcare, May 18, 2015

C-Suite? No Thanks.

As baby boomers retire, there will be plenty of executive suite vacancies to be filled by a new generation. But a recent leadership study by a tech company and www.Workplacetrends.com found that only 11% of employees aspire to C-level positions. Organizations aren’t doing enough to develop potential leaders, especially up-and-comers from the millennial generation. Boomer associate leadership with management roles and executive titles, but leadership is less title-driven for millennials. Indeed, many millennials already consider themselves leaders, regardless of title, if they exert influence within their organizations, have mastered an area of expertise, and mentor others.

Source: www.cio.com, June 1, 2015

Telemedicine: Some States Are Resisting

Telemedicine has survived one of the biggest legal challenges in Texas, but hurdles remain in Arkansas and some other states. Even though the country is moving fairly aggressively to promote telehealth legislation and regulation, and telemedicine is gaining
Criminal Investigations and Charges in Healthcare Fraud Cases

The Justice Department has adopted a procedure to ensure its civil divisions share all new whistleblower complaints with its criminal division to allow parallel investigations. As evidenced by the investigation into previously disclosed allegations that Tenet Healthcare Corp. hospitals paid kickbacks for maternity referrals, the Tenet fraud probe signals the government’s growing interest in criminal cases.

In a filing to the SEC this month, Tenet said four of its hospitals in Georgia and South Carolina are under criminal investigation related to a whistleblower lawsuit filed in 2009. “Parallel investigations maximize the department’s ability to secure the appropriate outcome in each matter—whether it be financial penalties, restitution, federal program exclusion, or criminal prosecution of both corporations and individuals,” said Leslie Caldwell, the Justice Department’s assistant attorney general for its criminal division.

Source: USA Today, June 3, 2015

PHYSICIAN ISSUES

Concentration in Ortho Market Associated with a 7% Increase in Physician Fees for Total Knee Replacements

Physician groups are growing larger in size and fewer in number. Although this consolidation could result in improved patient care, the resulting increase in market concentration could also allow larger groups to negotiate higher physician fees from private insurers. The authors of a study in Health Affairs examined the association between market concentration and physician fees in the case of total knee arthroplasty. In the period 2001 to 2010, the average professional fee for the procedure was $2537. During this time, in markets that moved from the bottom quartile of concentration to the top quartile, physician fees paid by private insurers increased by $168 per procedure. The increase nearly offset the $261 decline in fees that the authors observed absent changes in market concentration. The findings suggest that caution should be used in implementing policies designed to encourage further group concentrations, which could produce similar effects.

Source: Health Affairs, June 2015

Ten Reasons Doctors Should Ditch Voicemail

According to Arlen Meyers, MD, MBA, voicemail is so 1990s. JP Morgan agrees and is eliminating voicemail for thousands of employees who do not take calls from customers, at a savings of $10 a month per person.

“We should eliminate voice mail from the practice of medicine. It’s inefficient, annoying, inconvenient, and expensive, and there are other more efficient tools available that are better, smarter, and cheaper. But almost every doctor’s or central scheduling number asks that you leave a message. Of course, they say your business is important to them and they will be sure to get back to you within 24 hours,” said Meyers.

Imagine if doctors’ offices eliminated voicemail:

1. Prescription refills could be delivered the same day.
2. Communication would be possible with more than one person in the care team at a time.
3. Individuals would not be connected to a location.
4. The practice could use those new and free communication tools.
5. Information sharing with surrogates and other caregivers on your patient team would be possible.
6. Money would be saved by not having voicemail.
7. There would be no calls from politicians and other fundraisers who want votes and money.
8. Time savings would be coupled with more responsive communication.
9. Photos could be included.
10. Cute little emoticons could be used to improve the patient experience.

Source: Physician’s Money Digest, July 6, 2015

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Supreme Court Upholds Obamacare; Health Policy Heats Up Campaign Season

Mark Reiboldt*

There’s no question what the biggest healthcare news of the summer was after the U.S. Supreme Court upheld the legality of the Obama Administration’s Affordable Care Act (ACA) in late June. The high court released its 6-3 ruling on June 26, which was actually addressing a challenge against tax-credit subsidies to states providing coverage under the ACA for individuals and families. This was received by the White House and its Democratic allies on Capitol Hill as a major victory in their effort to continue implementing Obamacare throughout the country.

On the other side of the political aisle, the GOP and Obamacare opposition across the nation responded with their disappointment in the court’s ruling. Many politicians and lobbying groups also promised that this ruling did not automatically end the fight to stop Obamacare, and that they will continue to fight against this policy with every opportunity available.

This controversial ruling quickly proved to be a highly flammable accelerator on the Obamacare debate flame, which for the last few months had been relatively quiet. Advocates, politicians, and voters on both sides of this debate throughout the United States jumped into action with their various PR, social media, and grassroots efforts to rally supporters. This also carried over into the ongoing political races that were already heating up as the summer campaign season began to escalate, and it’s safe to say we can expect this issue, along with other recent Supreme Court rulings and White House actions, to play key driving roles in the political debate leading into next year’s national elections.

According to an article in The Hill published after the ruling, “ObamaCare’s victory at the Supreme Court is putting new pressure on Republican presidential candidates to map out a replacement to the healthcare law—a task that has eluded the party for more than five years. With President Obama’s law twice affirmed by the nation’s high court, congressional Republicans now say a victory in 2016 is their best chance to tear down the statute and replace it with a GOP-favored alternative. ‘I definitely think there will be pressure on these guys to put something out there,’ said Lanhee Chen, the policy director for Mitt Romney’s 2012 presidential campaign. ‘They will need to have a plan.’ However, few of the party’s dozen 2016 hopefuls have thus far offered concrete details about what their alternative to the law would look like. Chen said Louisiana Gov. Bobby Jindal and Sen. Marco Rubio (R-Fla.) are ‘arguably further along’ in their planning, a point echoed by other experts.”

Jindal’s plan, among other things, focuses on allocating $100 billion over 10 years to states that develop their own individual innovative healthcare reform models that can be implemented more effectively at the state level. His plan emphasizes the need for providers and payers to work together in controlling costs, while also ensuring greater access to higher-need beneficiaries, such as patients with certain preexisting conditions. As for Rubio, his suggested plan focuses on providing tax credits that can be used to cover the costs and other needs related to healthcare coverage. He also addresses the need to assist those patients with certain preexisting conditions through the use of high-risk insurance pools. And while these two GOP presidential hopefuls are the only candidates to introduce any substantive recommendations on healthcare reform, similar plans are expected from the rest of the GOP field very soon.

REFERENCE

How are your collections? Are your accounts receivable current? Very few practices are able to say they have very current accounts receivable. The question is how to collect efficiently and effectively. The answer is simple: start at the beginning of the patient encounter. Your front desk personnel are often the first point of contact with the patient. They come in contact with the patient at every visit. They often are the appointment makers. Train them to collect up front. This does not mean they should begin collections when the patient is in the office; rather, your staff should begin the process before the appointment is first made.

HAVE A WRITTEN POLICY

Start by having a written policy and procedure on how to collect money in your office. Be specific on what is expected of your front desk staff. Train them how and when to ask for payments. Continually coach your front desk staff to ensure they are comfortable asking for money. Not all employees are good at collecting money. Work with staff until they are comfortable.

All employees, not just the front desk staff, should have a script to follow on how to ask patients to make payment. Asking a patient if he or she wants to pay allows the patient to say “No.” Instead, the staffer should say, “You have a balance of [blank] dollars; would you prefer to pay by check or credit card?” This makes it more difficult for a patient to say no.

When the patient first calls to make an appointment, staff should gather pertinent information. If this is a first visit, gather the patient’s demographics and insurance information. For follow-up visits, your staff should confirm each patient’s demographic and insurance information. Have patients submit their insurance card prior to their appointment date.

Train your staff to ask specific questions and verify exact information.

This does not mean the staff should ask, “Are you still at the same address?” or “Is your insurance still the same?” Rather, your staff should verify the exact address and exact policy and identification number. Most patients don’t remember if they told their physician’s office when information changes. Train your staff to ask specific questions and verify exact information. It is too easy for a patient to say that everything is the same when in fact it has changed.

Once the information has been given to your staff member, verify the patient’s insurance eligibility and benefits. If a patient has not been seen in the office for more than a month or two, reverification should be obtained. It is easy for staff members to say that they don’t have time or they are too busy. The truth is, in today’s climate a practice can’t afford not to verify insurance. Not verifying insurance means not collecting at the time of service, when it might have. Verify insurance benefits often. One missed payment often means that the patient no longer has coverage.

When it is determined that a patient does not have insurance, that patient should be contacted prior to the visit to advise him or her that the practice policy is that payment is due at the time of service. If needed, a payment plan may be worked out to ensure timely payments. When
appropriate, keep a credit card on file to make monthly payments. Ensure that your practice follows secure and legal methods for keeping credit card numbers. Your policy must address self-pay patients or those with no coverage. Be clear that it is policy to collect at the time of service.

**TRAIN YOUR STAFF**

Train your staff to collect copayments at each visit. The best way to collect money is face to face. Therefore, it is also important that the front desk is aware of whether a patient has an outstanding balance. This, too, can be collected at the appointment. As the patient is at the front window, let him or her know what the balance is and ask to collect it. If it is not possible to collect an outstanding balance on the spot, be prepared to give the patient a statement of what is owed with a self-addressed envelope so he or she can mail in the payment.

Before a patient comes in for an appointment, front staff should be aware of when a referral is required. Calls should be made ahead of the appointment to remind patients that they need to bring in a referral. Without a proper referral, patients in HMOs can’t be seen. That leaves an empty space in the physician’s schedule, and this can cost the practice money. It is easier to telephone the patient before the appointment as opposed to adding potentially more time at the appointment.

**AUTHORIZE THE VISITS**

Precertification and predetermination for procedures or surgery is essential. It is often the front desk person who initiates the precertification. When this is not performed, it will affect collections from insurance companies. Train staff to get proper authorizations for the best results in collection.

Your policy must be clear regarding how auto accidents and personal injury matters are handled. When a patient is involved in litigation, your practice needs to know how to handle these patients. Your front desk staff needs to know whether to collect payment from the patient at the time of service or whether you have agreed to file a lien and wait for the claim to settle. Your staff may be filing a claim with their patient’s health insurance. Bottom line: keep your front desk staff informed. Knowledge truly is power.

When your practice is seeing a patient with Workers’ Compensation, a lien cannot be filed. It is in the practice’s best interest to receive written approval from the Workers’ Compensation insurance carrier before a patient is seen and for any procedures that the patient may require. There still may be an issue getting the claim paid, but at least you have something to fight with. Even Workers’ Compensation claims can be disputed, and a practice needs to protect itself to encourage prompt payment.

The Affordable Care Act and the high cost of insurance have caused many patients to have very high deductibles. It has become increasingly more difficult for practices to collect from insurance companies, as the insurance companies often use the approved amounts of the healthcare claim toward the patient’s responsibility. Practices need to protect themselves and find ways to collect deductibles and coinsurances efficiently.

More and more practices are looking into whether they can collect deposits for services rendered. The upside is that the practice has money in the bank. They can always collect the balance or refund the overpayment. The big question is whether that is legal in the contractual healthcare world.

**More and more practices are looking into whether they can collect deposits for services rendered.**

First, if the practice is out of network, it is definitely legal to collect a deposit. Practices can and should collect upfront. Verifying eligibility and benefits upfront allows a practice to know whether collection of a deposit is appropriate. It is acceptable to forewarn patients of their financial responsibilities and the practice’s expectations.

For those patients who are in network with their insurance and have high deductibles, the issue of deposits is often unclear. Practices need to be aware of what their insurance contract states with regards to collecting deposits.

When a practice is able to collect a deposit, it may request a deposit from a patient, but can’t demand it. For many insurance companies, that would be a contractual violation. Using a cost estimator when available allows a practice to have a better perspective on what is the patient’s liability. When a practice does ask for a deposit, the amount that is requested is based on current data from the cost estimator.

Upload your payer fee schedules. This will allow you to have an expectation of what is owed to you for each visit. Review your payer contracts to be aware of what is in the contract as well as if there is an end date for the contract.

**APPRECIATE THE VALUE OF YOUR FRONT DESK STAFF**

Your front desk employee is a valued employee. She is often the first contact with the patient and definitely the first person the patient sees when arriving at your office. It is important to appreciate her talents and allow her to be a team player. She needs to be trained thoroughly to allow her to do her job efficiently and effectively. She is not
a collector, yet she is expected to collect money from your patients.

Coaching your front desk person to ask for money should be ongoing. Role play with her to allow her to practice and be more comfortable when dealing with patients and tactfully asking for money. Teach her what to say and how to say it. Appropriate verbiage and body language is essential to getting your point across.

There are several things that a practice can do to make it easier for receptionists to collect money. Have petty cash available for change. If there is no change available, it is difficult to collect copays and balances.

Technology is a big part of society, and this is no different in healthcare. Have online payment available in your practice. If a patient is unable to make payment when face to face, this allows him or her another way to make payment. Be aware of online tools that help your practice improve collections.

Keep your computer systems and software programs current. Your staff needs to have access to verify eligibility and benefits online. It is much quicker and a better use of resources than sitting on the telephone on hold.

Have a private place for patients to discuss financial matters. If your receptionist is unable to collect payment or if the patient is difficult, moving him or her away from other patients and offering a quiet place allows staff to converse with the patient. The front desk person may need to turn the collection matter to a biller or collector in the practice. This person may be more qualified to discuss the financial situation as well as to make payment arrangements that the receptionist is not qualified to make. The front desk person should be comfortable asking for help when indicated and when he or she feels the situation warrants it.

Your entire staff can be trained to make collection calls during down times. When there are no physicians in the office, staff can use that time to make telephone calls to patients and insurance companies. Your receptionists should be encouraged to call insurance companies or patients when appropriate.

Your patients should be educated as well. They should be aware of your financial policy and the payment expectations of your practice. If a referral or payment is expected at the time of service, reach out to the patient prior to the appointment. This allows him or her to come to the visit prepared.

Collecting money is not easy, but it is essential.

When making decisions on how to best collect in your practice, it is important to be familiar with state and federal laws. It is far easier to follow a law when you are aware of it.

Improving your accounts receivable and collecting the money that is due to a practice is becoming increasingly more difficult. Practices need to be more creative and use all staff to improve collections. Your front desk person is face-to-face with your patients. She is not involved in the clinical aspect of their care. She builds a business rapport with your patients. It is an obvious win/win for the practice when you utilize her talents.

Collecting money is not easy, but it is essential. Verify and update your policies and procedures regarding collection of money due. Keep current with the changes that the government and insurance companies make to ensure you are asking for payments in a professional and efficient manner. It is time to think “out of the box” and train your front desk staff to help your billers and collectors collect and learn to ask for payments.

Give your staff the tools to succeed and you will find your bottom line improving. Your team depends on your ongoing coaching for these tools to be effective.
The rationale for being board certified has evolved over the past century. Many advocates endorse the idea of specialty boards because of the standards they uphold, including improvements in clinical practice for better patient care and provision of quality education and training. The recognition of specialty boards started with the National Board of Medical Examiners and eventually gave rise to the Liaison Committee for Specialty Boards. The most appealing feature of any organization is its ability to provide quality of care. Because the timeframe for recertification may vary greatly among specialties, an approach that encourages physicians to participate in ongoing education between the 6- to 10-year certification deadlines is encouraged. Recertification demonstrates the physician’s knowledge of new, innovative practices; true competency, however, should encompass a physician’s overall knowledge and ability to provide care that is both appropriate and effective. The standardization of healthcare is more evident now with healthcare reform underway, and with changes in the system. A physician’s services need to be acceptable, and certification is a step in assuring that a standard of care is being met.

**KEY WORDS:** Recertification; licensure; quality improvement; future of medicine.

Great advances in medical sciences have taken place within the past decade. With these advances also comes the task of mastering the knowledge that comes with understanding them. Guidelines may change every couple of years, but overall treatment does not change as rapidly. Physicians can be reassured that knowing the basic guidelines for health maintenance would be enough to prevent unnecessary screening practices. This becomes a bigger factor when certain screening tests are not covered by the patient’s insurance because they are considered outdated practice. The American Board of Family Medicine was the first specialty board to administer a recertification exam, and since then many others have followed suit.3 Because the timeframe for recertification may vary among specialties, an approach that engages physicians to participate in ongoing education between the 6- to 10-year certification deadlines is encouraged.

A statistical report from the American Board of Family Medicine noted that a far lower pass rate for recertification was recorded during the years 2011 to 2012 for family medicine boards.4 Closer inspection of these statistics revealed that there was a lag time between certifications because many physicians were using the extension policy, which can extend their certification by three years. This extension policy, implemented in 2007, has helped in the long term for people to be able to prepare adequately for the board examinations. This study reported that there was an almost 20% reduction in pass rate, mainly because those taking the examination were mostly candidates who did not pass the test.
the first time, and were retaking the exam, as opposed to people who were newly eligible for recertification.

Proponents of continuing education prior to recertification point out benefits such as reducing malpractice, marketing quality to the public, and a lowered educational burden when preparing for recertification.4 Opponents of this philosophy believe that recertification is time-consuming, does not help them in their daily practice, and is beneficial only for certain specialty groups. Most of those professionals who do not support recertification are physicians who have been in practice for more than 20 years, those who are quickly approaching retirement age, or those who otherwise believe recertification is unnecessary to deliver the care they provide. In contrast is a younger generation of physicians who have been required to take multiple examinations during their medical careers. These include shelf examinations after every rotation during medical school, in-service examinations yearly during residency, and then, finally, their specialty board examination at the end of residency. They recognize the connection between delivering quality care and continuing education, and see recertification as a way of staying relevant and up-to-date with the constant advances in medicine.

There is a growing need for improvement in all aspects of healthcare. One way to look at this is as a door-to-door approach, from the moment a patient walks in until the moment he or she leaves. This includes the doctor’s demeanor, his or her ability to diagnose, overall treatment, and education of patients at the time of discharge or leaving the office. All of these are what a patient would like to get from a doctor during an office visit or if admitted to the hospital. Maintenance of certification is broken down into many parts, and the part that is important for recertification is knowledge assessment. Theoretically and practically, the periodic assessment of medical knowledge should be beneficial for both doctor and patient. The practice of medicine is an ongoing educational process, and recertifications are a validation after continuing to pursue new medical knowledge.

The more fundamental and important belief is that specialty recertification provides better healthcare.

Constant progression in one’s specialty is a marker for the continued success of future specialists in that field. The Federation of State Medical Boards has tried to associate licensure and relicensure with a clinician’s ability to perform optimally. This qualification is more evident when it comes to hospital privileges and how the hospital wants to advertise its providers. The assumption is that board certification, along with additional certifications, will draw in a larger patient clientele. Most hospitals, therefore, would like physicians to maintain their certifications.

The more fundamental and important belief is that specialty recertification provides better healthcare. Physicians want to improve outcomes for their patients overall, if possible. In most specialties, what has evolved partly from maintenance of certification is quality improvement (QI). QI has become more of a team activity, but it also can be individualized to improve or set up initiatives to better serve the community they are practicing in. An example would be eliminating catheter-associated infections in the pediatric intensive care unit.5 Part of the push for maintenance of certification is the desire for overall improvement of hospitals and better scores on patient surveys. A benefit of having a team approach is that every department or group is able to take ownership of the patient outcome. On the other side of this would be that no one person would take the blame with an unfavorable outcome, because it is a multifaceted approach. A method that is implemented in one hospital may become popular and easily reproducible.

In one survey conducted in Oregon, a resounding 50% of physicians stated that their motivation for recertification was “to demonstrate an expertise in my specialty.”6 In the same survey, 43% stated it was needed for hospital privileges. The underlying necessity to stay current and the desire for satisfaction as a physician are motivations to recertify. The necessity aspect is important when a physician is facing legal action and the question is raised whether he or she is board certified. Should a physician encounter legal issues, board certification can be used as protection from attorneys, who can and will hone in on a physician’s lack of certifications and question his or her ability to provide competent care.

Recertification can legitimize a person’s competency, but the statement may not be completely true. Evidence-based care is something that most hospitals pride themselves on. A more appropriate term would be individualized care, because the common practice may not work for every patient. A drawback of recertification is that the examination tests your current knowledge with newer studies. The part that is not stated is that newer studies or newer guidelines may not always be the most appropriate. A physician who has had 10 or more years of experience can see firsthand how certain medications that once were in favor are no longer recommended. The other aspect is that medications that are no longer recommended may still be beneficial for certain populations. This facet of care is not limited to medications alone but applies to imaging studies as well.

Residents across the nation currently are studying to pass boards that test the best guidelines for them to practice medicine. At the same time, they are providing care for patients who are benefitting from care that is not always the first-line treatment or the modality of choice. The dilemma that many residents across specialties taking licensure or board exams face is this: the correct answer
on the test may not always be the practical one for an individual patient. Recertification demonstrates the physician’s knowledge of new, innovative practices; however, true competency should encompass a physician’s overall knowledge and ability to provide care that is both appropriate and effective.

A physician’s services need to be acceptable, and certification is a step in ensuring the standard of care is being met. The future of medicine will rely heavily on board certifications to maintain a standard level of knowledge, with each specialty having its own agenda as to what will be tested and how. As advances in all aspects of medical knowledge are made, the importance of the partnership between advancement and certification will only grow stronger.

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Who Can Enter Orders for Meaningful Use? An Evolving Challenge for Practice Managers

Donald A. Balasa, JD, MBA*

Meeting the required objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs is a high priority for most medical practice managers and their employers and staff. Failure to meet even one of the objectives established by the Centers for Medicare & Medicaid Services (CMS) results in the eligible professional receiving no incentive payment. A key element of the Incentive Program rules is the requirement that only “credentialed medical assistants” (in addition to “licensed healthcare professionals”) are permitted to enter medication, laboratory, and radiology/diagnostic imaging orders into the computerized provider order entry system and have such entry count toward meeting the CMS Meaningful Use threshold. The CMS rules for Stages 1 and 2 of the Incentive Programs are final, and proposed rules for Stage 3 were issued by CMS March 20, 2015. This article discusses the order entry requirements of the proposed Stage 3 rule, as well as the order entry provisions for Stages 1 and 2.

**KEY WORDS:** Medicare and Medicaid Electronic Health Record Incentive Programs; computerized provider order entry; meaningful use; credentialed medical assistant; eligible professional.

The electronic health record (EHR) has become an increasingly vital component of the American healthcare delivery system. The United States Congress accelerated the move away from paper medical records by enacting the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 that authorized incentive payments for eligible professionals (EPs), critical access hospitals (CAHs), eligible hospitals, and Medicare Advantage organizations that utilize Certified Electronic Health Record Technology in a meaningful way. The ARRA created two similar but distinct programs—the Medicare and Medicaid EHR Incentive Programs—and delegated the implementation and management of these programs to the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. CMS was empowered by Congress to issue regulations/rules establishing the specifics of the Incentive Programs. The CMS rules are extensive, and a complete analysis is well beyond the scope of this article. However, an issue confronting medical managers, healthcare providers, and staff on an almost daily basis is the following: Who is permitted to enter orders into the computerized provider order entry (CPOE) system for Meaningful Use (MU) calculation purposes under the CMS rules? This article provides some basic facts about the Incentive Programs, and then will answer this key question.

**FACTS ABOUT THE INCENTIVE PROGRAMS**

Who are EPs Under the Incentive Programs?

The following healthcare providers are considered EPs under the Medicare and Medicaid EHR Incentive Programs:

- Doctors of Medicine (MDs);
- Doctors of Osteopathy (DOs);
- Doctors of Dental Medicine and Surgery (DDMs and DDSs);
- Doctors of Optometry (ODs);
- Doctors of Podiatric Medicine (DPMs);
- Doctors of Chiropractic (DCs);
- Nurse Practitioners (NPs);
- Certified Nurse Midwives (CNMs); and
- Physician Assistants (PA-Cs) when working at a Federally Qualified Health Center or a Rural Health Clinic led by the physician assistant.

For which of the two Incentive Programs are these EPs eligible?
Physicians, osteopaths, and dentists may be eligible for both the Medicare and Medicaid EHR Incentive Programs. However, they are permitted to participate in only one of the two programs. Optometrists, podiatrists, and chiropractors are eligible only for the Medicare Incentive Program. Nurse practitioners, nurse midwives, and qualifying physician assistants are eligible only for the Medicaid Incentive Program.

Do these EPs participate in the Incentive Programs as individuals or as groups?
The law is very clear that EPs participate as individual healthcare providers, not as part of a group practice, clinic, or health system. Each EP individually must meet the Incentive Program requirements. An EP cannot rely on the data from another provider in the group to compensate for any deficiencies in meeting the mandatory CMS objectives.

Are any EPs disqualified from participating in an Incentive Program?
Yes. EPs who provide at least 90% of their covered professional services in hospitals or emergency departments are not eligible to participate in either Incentive Program.

How many stages of the Incentive Programs are there?
The Medicare and Medicaid EHR Incentive Programs have three stages. The CMS rules for Stages 1 and 2 are final. On March 20, 2015, CMS published a notice of proposed rulemaking (NPRM) for Stage 3 of the Incentive Programs.1 The official notice of this NPRM was published in the Federal Register on March 30, 2015. CMS accepted comments on its NPRM until May 29, 2015, and will issue the final rule after all comments have been considered. All subsequent references to Stage 3 of the Incentive Programs in this article, therefore, address proposed (not final) CMS regulations.

What does an EP need to do to receive an incentive payment?
Under Stage 1 of the Incentive Programs, CMS requires EPs to meet 15 Core Objectives and 5 of 10 Menu Objectives. For Stage 2, the CMS requirement is 17 Core Objectives and 3 of 6 Menu Objectives. In its March 20, 2015, notice of proposed rulemaking, CMS stated the following:

[O]ne significant change we propose for Stage 3 includes establishing a single set of objectives and measures (tailored to EP or eligible hospital/CAH) to meet the definition of meaningful use. This new streamlined definition of meaningful use proposed for Stage 3 would be optional for any provider who chooses to attest to these objectives and measures for an EHR reporting period in 2017; and would be required for all eligible providers—regardless of prior participation in the EHR Incentive Program—for an EHR reporting period in 2018 and subsequent years.1

Is an EP required to meet all specified CMS Objectives to obtain an incentive payment?
Yes. If an EP fails to meet any one required objective, the EP does not receive any incentive payment.

Are there hardship exemptions for the Incentive Programs’ requirements?
The CMS provides the following exceptions for participants in the Incentive Programs, as delineated in the Stage 3 NPRM:
- The lack of availability of Internet access or barriers to information technology infrastructure;
- A time-limited exception for newly practicing EPs or new hospitals that would not otherwise be able to avoid payment adjustments;
- Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis;
- (EP only) exceptions due to a combination of clinical features limiting a provider’s interaction with patients, or, if the EP practices at multiple locations, lack of control over the availability of CEHRT [Certified Electronic Health Record Technology] at practice locations constituting 50 percent or more of their encounters.1

What is the maximum amount EPs may receive under one of the Incentive Programs?
For the Medicare EHR Incentive Program, the maximum amount of payments is $44,000 over five years. For the Medicaid EHR Incentive Program, the maximum payment is $63,750 over six years.

Are the Incentive Programs mandatory?
No. However, the CMS guide “An Introduction to the Medicare EHR Incentive Program for Eligible Professionals” specifies that:
Medicare eligible professionals who do not meet the requirements for meaningful use by 2015 and in each subsequent year are subject to payment adjustments to their Medicare reimbursements that start at 1 percent per year, up to a maximum 5 percent annual adjustment.  

**COMPUTERIZED PROVIDER ORDER ENTRY**

**What are the order entry requirements under the Incentive Programs?**

- **Stage 1**: More than 30% of all unique patients with at least one medication in their medication list seen by the EP must have at least one medication order entered using CPOE.
- **Stage 2**: More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.
- **Proposed Stage 3**: Eighty percent of medication orders, 60% of laboratory orders, and 60% of diagnostic imaging orders must be entered using CPOE.

**Why do the proposed Stage 3 requirements refer to “diagnostic imaging orders” instead of “radiology orders”?**

Note the following paragraph from the CMS notice of proposed rulemaking for Stage 3:

> We propose to continue our policy from the Stage 2 final rule at 77 FR [Federal Register] 53986 that orders entered by any licensed healthcare professional or credentialed medical assistant would count toward this objective. A credentialed medical assistant may enter orders if they are credentialed to perform the duties of a medical assistant by a credentialing body other than the employer. If a staff member of the eligible provider is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, orders entered by that staff member would be included in this objective. We further note that medical staff whose organizational or job title, or the title of their credential, is other than medical assistant may enter orders if these staff are credentialed to perform the equivalent duties of a credentialed medical assistant by a credentialing body other than their employer and perform such duties as part of their organizational or job title. We defer to the provider’s discretion to determine the appropriateness of the credentialing of staff to ensure that any staff entering orders have the clinical training and knowledge required to enter orders for CPOE . . .  

**Are there exclusions for EPs who do not issue a certain number of orders in one of the three categories?**

EPs who issue fewer than 100 orders in one or more of the three categories (i.e., medication, laboratory, and radiology [diagnostic imaging in Stage 3]) in the reporting period are not required to meet the percentage thresholds for each category with fewer than 100 orders during the reporting period.

**Who can enter orders into the CPOE system and have such entry count toward meeting the order entry percentage requirements under the Incentive Programs?**

Note the following from the March 20, 2015, CMS notice of proposed rulemaking:

> In Stage 3, we propose to continue the policy from the Stage 2 final rule at 77 FR [Federal Register] 53986 that orders entered by any licensed healthcare professional or credentialed medical assistant would count toward this objective. A credentialed medical assistant may enter orders if they are credentialed to perform the duties of a medical assistant by a credentialing body other than the employer. If a staff member of the eligible provider is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, orders entered by that staff member would be included in this objective. We further note that medical staff whose organizational or job title, or the title of their credential, is other than medical assistant may enter orders if these staff are credentialed to perform the equivalent duties of a credentialed medical assistant by a credentialing body other than their employer and perform such duties as part of their organizational or job title. We defer to the provider’s discretion to determine the appropriateness of the credentialing of staff to ensure that any staff entering orders have the clinical training and knowledge required to enter orders for CPOE . . .

**Why does CMS not permit anyone who is not a “licensed healthcare professional” or a “credentialed medical assistant” to enter orders for MU purposes?**

CMS provides its rationale in the March 20, 2015, NPRM:

> . . . as stated in the Stage 2 final rule at 77 FR [Federal Register] 53986, it is apparent that the prevalent time when CDS [Clinical Decision Support] interventions are presented is when the order is entered into CEHRT, and that not all EHRs also present CDS when the order is autho-
rized (assuming such a multiple step ordering process is in place). This means that the person entering the order would be required to enter the order correctly, evaluate a CDS intervention either using their own judgment or through accurate relay of the information to the ordering provider, and then either make a change to the order based on the information provided by the CDS intervention or bypass the intervention. The execution of this role represents a significant impact on patient safety; therefore, we continue to maintain for Stage 3 that a layperson is not qualified to perform these tasks . . .

Does the CMS regulation limit who can enter information other than orders into the EHR?

No. Individuals who are not “licensed healthcare professionals” or “credentialed medical assistants” (i.e., laypersons) are allowed to enter information other than orders into the EHR. For example, the CMS rule does not prohibit laypersons from entering financial information, demographic data, a list of medications, patient history, and names of and contact information for other healthcare providers who treat a patient.

**COMPLIANCE**

How will CMS monitor compliance with the CMS EHR Incentive Programs?

CMS is authorized to send auditors to the offices of eligible professionals to determine whether the EPs are, and have been, in compliance with the requirements of the Incentive Program. CMS auditors have already completed a number of onsite audits of eligible professionals.

If EPs are found to not be in compliance with the applicable CMS regulations, what are the consequences?

If an EP is found to not be in compliance with one or more required objectives, the EP will not receive an incentive payment for the period in question, or will have to pay back any incentive payment already received for a prior period in which there was noncompliance.

**REFERENCES**

Why an Ambulatory Surgery Center Needs a Compliance Plan and Needs to Keep It Current

Debra Cascardo, MA, MPA, CFP*

Don’t make the mistake of thinking you’re immune to a compliance audit; to paying hefty fines; or being charged with significant penalties. The Office for Civil Rights on the Department of Health and Human Services’ (HHS) Web site is full of the names of healthcare organizations that never dreamed they could be found guilty of a compliance violations—and yet they were.

It doesn’t matter what size you are, what state you are in, or what specialty you practice. Unless you take action immediately, you are at risk of being selected to undergo a compliance audit, which could lead to violations, fines, penalties, or even legal action. Given the rapid changes in healthcare compliance, the threat of enforcement activity is greater now at any other time in our history.

Trust me, getting audited is not something you want to experience. You can avoid that by having a current compliance plan in place. Your plan should consist of a program of internal controls that enable your surgical center to efficiently monitor adherence to applicable statutes, regulations, and program requirements.

And according to HHS, the “I didn’t know excuse” isn’t going to fly. In fact, HHS has specific financial penalties spelled out for the “I didn’t know” defense.

YOUR MISSION MUST BE CLEARLY IDENTIFIED IN YOUR AMBULATORY SURGERY CENTER COMPLIANCE PLAN

Your ambulatory surgery center (ASC) must show it is committed to conducting its operations in accordance with state and federal laws and that it has a high standard of professional conduct.

Your compliance plan must provide a framework for establishing, implementing, and monitoring policies and procedures for preventing, identifying, and correcting fraud, waste, abuse, and other nonconformance with regulatory requirements, and to promote compliance with your center’s code of conduct at all levels of the organization. Your compliance plan should be tailored to your practice, and its size, complexity, resources, and culture, and it should evolve continuously to meet the changing regulatory landscape.

THE COMPLIANCE OFFICER’S DUTIES

The compliance officer has the primary day-to-day responsibility for the compliance plan and reports to the Medical Director, Board, or other authority. Because the center and its staff may be subject to legal penalties and other serious consequences as a result of regulatory noncompliance, your compliance plan should provide for education of the entire ASC staff, protections for staff who make good faith reports in connection with the compliance plan, and sanctions for staff who fail to meet your code of conduct.

THE ELEMENTS OF YOUR COMPLIANCE PLAN

In keeping with federal and state guidelines, your compliance plan should include the following elements:

- Written policies and procedures;
- Appointment of a compliance officer;
- Effective and ongoing compliance training program;
- Confidential compliance reporting;
- Sanctions/discipline for noncompliant conduct;
- Auditing and monitoring system to identify compliance risk areas;
- A system for responding to compliance issues; and
- Guarantee of nonintimidation and nonretaliation for good faith participation in the compliance program.

WRITTEN POLICIES AND PROCEDURES

Your plan should define the expected conduct of your staff with respect to regulatory compliance and other appropriate business practices through the establishment of a code

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of conduct. In addition, the plan should adopt policies and procedures that provide guidance on specific regulatory issues and facility practices. These policies and procedures will assist staff in identifying potential compliance issues such as fraud, waste, and abuse; describe the proper steps to take when compliance issues arise; and address both protections for staff who make good faith reports regarding regulatory compliance matters and sanctions for staff who are found to have engaged in improper practices.

Compliance policies and procedures, and staff adherence to such policies and procedures, should be reviewed on a periodic basis and in response to compliance issues identified through monitoring activities. In addition, any new areas of regulatory compliance should be addressed as they arise. Policies and procedures should be clearly communicated to the entire staff in writing and in training sessions on a quarterly basis.

**COMPLIANCE OFFICER**

A compliance officer should be appointed by and report on a regular basis to the Medical Director, Board, or other authority.

The compliance officer will be responsible for the day-to-day operation of the compliance plan and will take responsibility for the continued development, implementation, and operation of the program. The compliance officer will work closely with staff at every level of the ASC organization in carrying out his or her responsibilities.

The primary responsibilities of the compliance officer shall include:

- Overseeing and monitoring the implementation of the compliance plan;
- Reporting on a regular basis to the Medical Director, Board, or other authority;
- Recommending improvements to quality of service and efficiency and reduction of vulnerability to fraud, waste, and abuse, and monitoring the results of such methods;
- Recommending revisions to the compliance plan, code of conduct, or policies and procedures as required by regulatory changes or requirements of third-party payers;
- Developing, coordinating, and participating in educational and training programs on compliance issues in order to promote organizational compliance goals;
- Making independent contractors and agents who furnish goods and services to the ASC aware of the requirements of the ASC’s compliance plan;
- Coordinating with the ASC’s human resources and finance staff to ensure that staff and vendors are checked against the Medicare/Medicaid exclusion lists;
- Coordinating with the ASC’s credentialing staff to ensure that providers are checked against the Medicare/Medicaid exclusion list and National Practitioner Data Bank;
- Coordinating with the ASC’s clinical operations staff on regulatory issues of a clinical nature;
- Developing, coordinating, and monitoring the results of internal compliance reviews and other audit and monitoring activities on a periodic and as-needed basis;
- Assisting in the development of, and overseeing implementation of, appropriate responses to identified compliance issues; and
- Assisting in the development of policies and programs that encourage staff at all levels to report suspected compliance, safety, or other issues of importance to the ASC without fear of retaliation.

In order to foster a culture of compliance, managers shall be responsible for:

- Participating in the identification of risk in their departments;
- Assisting in the development and implementation of departmental compliance policies and procedures in consultation with the compliance officer;
- Training staff with respect to new compliance-related policies and procedures;
- Taking reasonable measures to ensure compliance with policies and procedures and applicable law and regulation by:
  - Monitoring employee adherence to policies and procedures;
  - Reporting and encouraging employees to report compliance issues;
  - Investigating suspected compliance issues in conjunction with the compliance officer;
  - Taking appropriate disciplinary action in accordance with policies and procedures; and
  - Implementing post-audit corrective action plans.

**TRAINING AND EDUCATION**

Your plan should provide training programs for newly hired staff, and on an ongoing basis for all staff, as necessary and appropriate to educate staff about regulatory compliance matters and your policies and procedures. This training should include information about the code of conduct and the following laws and their implementing regulations:

- Federal Anti-Kickback Law,
- Physician Self-Referral (Stark) Law and False Claims Act;
- HIPAA Privacy and Security; and
- Federal and state whistleblower protections.

The compliance officer will work with appropriate managers to facilitate staff understanding of and adherence to reimbursement requirements, establish methods to monitor changes to reimbursement rules and disseminate that information to appropriate staff, and develop and implement internal audits and other procedures to promote accurate and appropriate billing for services.
The compliance officer will periodically evaluate the training and education programs to assess their effectiveness.

**COMPLIANCE REPORTING**

The plan should encourage open, two-way communication within the organization to promote the effectiveness of its compliance program. Communication increases your ability to identify and respond to compliance problems and reduces the likelihood that fraud, waste, and abuse will occur.

Every staff member who becomes aware of or suspects a compliance issue is responsible for notifying the compliance officer or other appropriate individual. Include several ways for staffers to report a compliance issue. For example, they could:

- Notify the supervisor or manager, who will report to the compliance officer;
- Notify the compliance officer at his or her phone number or by regular or interoffice mail; and/or
- Contact a compliance hotline, which should be set up where employees may communicate anonymously and the compliance officer will treat all reports as confidential to the extent possible. (There may be times when an individual’s identity may become known or have to be revealed if governmental authorities become involved or in response to a subpoena or other legal proceedings.)

The compliance officer should maintain a log of any compliance concerns that are reported. This log should include a description of the issue and its resolution. The log will be treated as a confidential document and access will be limited to the compliance officer, legal counsel, and the Medical Director.

**SANCTION/DISCIPLINARY POLICY**

The compliance officer, in conjunction with the Medical Director and the Human Resources director or other appropriate person in your group, should establish policies and procedures for disciplinary action or sanctions with regard to conduct by staff that violates regulatory requirements, your code of conduct, or other compliance-related policies. Depending on the circumstances, staff may be subject to discipline for:

- Failing to report a suspected compliance problem;
- Participating in, encouraging, directing, facilitating, or permitting noncompliant conduct; and
- Failure of supervisory or management personnel to detect compliance issues in accordance with the policies and procedures or compliance plan or activities, where reasonable diligence on the part of the manager or supervisor would have led to the identification of such issues.

The compliance officer will participate in decisions regarding the appropriate disciplinary action to be taken with respect to an individual staff member in response to identified noncompliant conduct.

**AUDITING AND MONITORING/SCREENING**

In order to identify areas of risk and compliance deficiencies in your business processes, internal and external audits should be conducted, with a focus on adherence to federal and state regulatory requirements and your policies.

Audits should include the following areas:

- Billing and payment;
- Medical necessity and quality of care;
- Governance;
- Mandatory reporting;
- Credentialing; and
- Other risk areas as they are identified.

Reimbursement-related reviews and audits should be conducted by compliance coding analysts and the billing department.

The compliance officer should be notified of the results of any audits performed by department personnel, consultants, or outside auditors that identify potential compliance issues, regardless of whether the audit was initiated by the compliance officer.

*Employees who report a compliance issue shall not be subject to retaliation or intimidation.*

The human resources department will conduct a background check on all job applicants, including physicians. In addition, all staff, including physicians, will be checked against the Medicare and Medicaid exclusion lists before being hired and periodically thereafter. The purpose of the background investigation and screening is to determine whether the applicant or employee has been convicted of a healthcare-related offense or listed by a federal agency as debarred, excluded, or ineligible for federal program participation.

The compliance officer should oversee the screening of vendors and contractors by each department so that the ASC does not improperly contract with an excluded entity.

**RESPONDING TO COMPLIANCE ISSUES AND DEVELOPING CORRECTIVE ACTION PLANS**

Whenever the compliance officer identifies or learns of a compliance issue for which corrective action is indicated,
he or she will develop an appropriate plan to address the issue. The plan may include:

- Disclosure to third parties;
- Refunds of overpayments received;
- Risk assessment, audit, data analysis, and remedial measures;
- Disciplinary actions;
- Staff education or training;
- Development or modification of policies and procedures; and
- Obtaining the advice of legal counsel.

The purpose of the corrective action plan is to determine and implement the steps needed to bring the ASC into compliance and to facilitate future compliance. The compliance officer, in consultation with the Medical Director, should be responsible for making the determination of who was responsible for the compliance problem.

**RESPONDING TO GOVERNMENTAL INQUIRIES**

It should be the ASC’s policy to cooperate with and respond to all governmental inquiries and investigations. Any staff member who is approached by any governmental entity or other third party seeking to conduct an audit, investigation, or other inquiry into any services provided by the ASC’s business activities should immediately notify the compliance officer and follow the compliance officer’s instructions as to the procedures for preserving relevant records and responding to the inquiry.

**NONINTIMIDATION AND NONRETLATION**

Employees who, in good faith, report an actual or possible compliance issue must not be subject to retaliation or intimidation as a result of the reporting. Staff who have any concerns about possible retaliation should immediately report them to the compliance officer. Reports not made in good faith may subject the reporting staff member to disciplinary action.

**WALKING THE TALK**

While what you do is more important than any written plan, if you have a compliance plan, now is the time to revisit it. Be sure you are actually doing what the plan says. Having a plan you do not follow can put you into a reckless arena. You should be monitoring quarterly with probe audits. Given the nature of an ASC, you must make sure to assign responsibility for the tasks that need to be accomplished. You should limit who in the center communicates with outside agencies such as payers, auditors, and investigators. Although liabilities to surgical practice abound, they are manageable when confronted in an organized way. Having pathways and processes in place where your staff can raise compliance questions without fear or retribution is critical to your defense, should it be needed. Corrective action, including firing errant staff, should be taken, and the penalties for infractions made known. Transparency is the key to your success. Finally, remember that your compliance plan is a work in progress and needs to be reviewed on a regular basis. 

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The Efficiency of Ophthalmic Ambulatory Surgery Centers

Xinliang Liu, PhD,* Dawn M. Oetjen, PhD,† Reid M. Oetjen, PhD,‡ Mei Zhao, PhD,§ Yasar A. Ozcan, PhD,¶ and Li Ge, MD**

Ambulatory surgery centers (ASCs) are important providers of ambulatory surgeries. However, little research exists examining the efficiency of ASCs in providing ambulatory surgical services. This study examined the technical efficiency of ASCs that concentrated on performing cataract surgeries, which are among the surgeries most commonly performed in the outpatient setting. This study, based on data from all active ASCs that provided the two most common cataract surgeries in California, found that a large proportion of ophthalmic ASCs were operating at low technical efficiency levels. The amount of slacks in input and output variables was estimated for each ASC, and the mean slacks were reported. The numbers of cataract surgery patients and operating rooms were found to significantly affect the efficiency of ophthalmic ASCs.

KEY WORDS: Data envelopment analysis; ambulatory surgery centers; ophthalmology; cataract surgery; organizational efficiency.

With advances in medical technology and a heightened focus on cost, quality, and access to care, it is increasingly more common for inpatient surgeries to be performed in outpatient settings, such as ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs). Expenditures are much lower when surgeries are performed in outpatient settings, providing incentives for payers, such as the Centers for Medicare & Medicaid Services (CMS), to add surgical procedures to their lists of ambulatory surgeries that are eligible for reimbursement. In 2008, ASCs served 3.3 million Medicare beneficiaries, and the number of Medicare-certified ASCs reached 5175.1 Medicare combined program and beneficiary spending on ASC services was $3.1 billion in 2008, an increase of 9.7% over 2007.1

The growth of ASCs and their impact on services provided by acute care hospitals,1,2 the prevalence of physician ownership and related service overutilization,4,6 patient selection,6,7 and the quality of services provided by ASCs,8-11 have been extensively discussed and studied. However, little research has been done to examine the efficiency of ASCs in providing ambulatory surgical services. Iyengar and Ozcan12 initiated the discussion of the efficiency of ASCs by studying 198 ASCs, of all specialties, in Pennsylvania. Considering that ASCs tend to be highly specialized, we focused on ASCs that concentrated on cataract surgeries, which are among the surgeries most frequently performed in the outpatient setting. For example, regular cataract surgery, represented by CPT code 66984 (cataract surgery w/ IOL insert, 1 stage), accounted for 18.3% of all the ambulatory surgical procedures reimbursed by CMS in 2008 and ranked highest among all ambulatory surgical procedures.1 Potential factors that may affect the efficiency score of ophthalmic ASCs were also explored.

This paper contributes to the literature on the performance evaluation of health care organizations in several important ways. First, the study takes into consideration the highly specialized nature of ambulatory surgeries and potential differences in the operations of ASCs. By focusing on ASCs that provided cataract surgeries, the analysis is based on a homogeneous study sample. Second, the previous study on the efficiency of ASCs used facility level data.13 This study combines data at both patient and facility levels to better characterize the services provided by ophthalmic ASCs. Third, the Medicare Payment Advisory Commission (MedPAC) reported that ASCs have different cost structures compared with HOPDs. For example, a much larger share of expenditure is being spent by ASCs
on medical supplies. In practice, ASC managers need to contract with health care professionals, rent or purchase office space, purchase professional liability insurance, pay utilities, and so on, to maintain the operations of the facility in addition to paying for medical and surgical supplies. In our study, these expenses were included as input variables. This research aims to add to the sparse literature on the efficiency of ASCs.

**METHODS**

**Data and Variables**

Two data sets were used. The primary data source was the 2007 State Utilization Data File of Specialty Clinics compiled by the Office of Statewide Health Planning and Development (OSHPD) of California. All specialty clinics are mandated by public law to file with OSHPD an Annual Utilization Report that contains utilization data for their licensed services. In the study, the analysis was based on data of surgical clinics. This data set included information on location, control type, patient encounters, number of operating rooms, surgical operation volume, revenue and expenditure data, and uncompensated care.

The Agency for Healthcare Research and Quality (AHRQ) State Ambulatory Surgery Database (SASD) of California provided patient level information, including patient age, gender, race/ethnicity, diagnosis and treatment(s), and discharge information. The SASD includes 100% of the state’s ambulatory surgery discharge records collected from both hospital-affiliated and freestanding surgical centers. Patient level data were aggregated to the facility level in the analysis. California was selected in this analysis because it has the largest number of ASCs in the United States and accounts for the second largest number of visits out of all 17 participating states in the Healthcare Cost and Utilization Project (HCUP) SASD project.

**Analytical Technique**

Data envelopment analysis (DEA) was used to investigate the technical efficiency of ophthalmic ASCs. This technique has been widely used in multiple disciplines since the 1980s. A DEA analysis calculates efficiency scores by comparing the inputs and outputs for each decision-making unit (DMU), and an optimal efficiency frontier is constructed for all units as a whole. In the past, DMUs such as physicians, hospitals, nursing homes, and dialysis facilities have been studied. In this study, the DMUs are ASCs that provided outpatient cataract surgeries.

The variable returns to scale (VRS) input-oriented DEA model was used in the analysis. DEA models can be either input or output oriented. Input orientation is more appropriate in this case than an output-oriented model because ASC managers or physicians have more control over their inputs than their outputs. The size of ASCs can be measured by the number of operating rooms. Because the size of the facility may have important impacts on the efficiency of providing ambulatory surgeries, the VRS model was chosen to measure potential economies of scale.

**Inputs and Outputs**

The choice of the input and output variables was based on the literature on DEA applications. Iyengar and Ozcan included the number of operating rooms and labor as inputs and patient surgical visits differentiated by age groups (0–17, 18–64, and ≥65 years) as three outputs. Our study used the number of operating rooms as one of the inputs. Other inputs were spending on employee salary and benefits, contracting professional services, supplies, and other operating expenditures. Because ophthalmic ASCs are highly specialized, there is no need to incorporate a measure-of-service mix, which is commonly used in efficiency analysis of hospitals. The outputs employed were the numbers of regular cataract surgeries (CPT code 66984), after cataract laser surgeries (CPT code 66821), and all other procedures performed in the facility (Table 1).

We did not adjust for case mix in this study. In the ambulatory surgery setting, there is no existing case mix information. Although the Charlson Index or Elixhauser Index can be calculated based on patient diagnosis information, incorporating the comorbidity score into the measurement of outputs remains challenging. Additionally, cataract surgeries have low levels of invasiveness, and localized anesthesia is administered during the procedure. Therefore, the general condition of patients will not affect the results in this case, and unadjusted numbers of surgical procedures were used in this study.

**Tobit Model Analysis**

Following the method used by Chilingerian, the authors transferred the efficiency score into the inefficiency score. This measure has a zero censored distribution and can be

<table>
<thead>
<tr>
<th>Table 1. Two Cataract Procedures Studied</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedure</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Regular cataract surgery</td>
</tr>
<tr>
<td>After cataract laser surgery</td>
</tr>
</tbody>
</table>

YAG, yttrium aluminum garnet.
modeled using Tobit regression. Impacts of operations measures (i.e., number of cataract patients, number of all patients, number of patient encounters, number of operating rooms, number of total surgical procedures performed) on the level of efficiency were examined.

**RESULTS**

**Descriptive Statistics**

The study sample included 127 active ophthalmic ASCs that provided 112,927 regular cataract and after cataract surgeries in California in 2007 (Figure 1). The average number of operating rooms was almost 3.0, which was slightly greater than that for all Medicare-certified ASCs (2.6). At the mean level, the largest expense for ophthalmic ASCs was spending on salaries, wages, and employee benefits. The second largest expense was on an item such as rent/depreciation/mortgage interest, utilities, or professional liability insurance. The third largest expense was spending on medical and surgical supplies. Conversely, contracting with medical professionals did not constitute a large part of the total spending. The average numbers of regular cataract surgeries and after cataract surgeries were 765 and 125 per year, respectively. These two types of procedures amounted to 95% of all the ambulatory procedures the ophthalmic ASCs provided in the study year (Table 2).

**Efficiency Performance**

The overall performance of ophthalmic ASCs in terms of technical efficiency was not satisfactory. Thirty-two (25.2%) of the 127 ophthalmic ASCs were at the efficiency frontier (with an efficiency score of 1). The average efficiency score,
however, was 56.4% (efficient facilities included). The average efficiency score for all inefficient facilities was 41.7%. Compared with efficient ophthalmic ASCs, inefficient ophthalmic ASCs incurred a higher level of inputs, while their outputs fell short of those of their efficient counterparts (Table 3).

The smaller an ASC is, the more efficient it will be, keeping other factors constant.

A further examination of the input and output slacks indicated that efficient ophthalmic ASCs incurred lower expenses while performing more surgical procedures compared with inefficient ophthalmic ASCs (Table 4). On average, inefficient ophthalmic ASCs would have had to eliminate 0.07 operating rooms and reduce $251,547 in salaries, wages, and employee benefits; $187,819 in supplies; $113,947 in professional service contracting; and $447,847 in other expenses such as rent and utilities. Inefficient ophthalmic ASCs also would need to increase the numbers of regular cataract surgeries, after-cataract surgeries, and other procedures by 50.12, 45.33, and 8.02, respectively, to reach the efficiency frontier.

### Table 3. Descriptive Statistics for Inputs and Outputs, by Inefficient and Efficient ASCs

<table>
<thead>
<tr>
<th>Variable</th>
<th>Inefficient ASCs (n = 95)</th>
<th>Efficient ASCs (n = )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Min</td>
</tr>
<tr>
<td>Efficiency score</td>
<td>0.42 (0.20)</td>
<td>0.14</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages, and employee benefits</td>
<td>$1,584,329 ($1,161,319)</td>
<td>$193,177</td>
</tr>
<tr>
<td>Contract services with professionals</td>
<td>$300,735 ($999,545)</td>
<td>$0</td>
</tr>
<tr>
<td>Supplies</td>
<td>$1,101,191 ($999,771)</td>
<td>$109,944</td>
</tr>
<tr>
<td>Other expenses</td>
<td>$1,566,681 ($3,995,610)</td>
<td>$156,650</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular cataract surgery volume</td>
<td>731.72 (691.85)</td>
<td>0</td>
</tr>
<tr>
<td>After cataract laser surgery volume</td>
<td>101.73 (134.14)</td>
<td>0</td>
</tr>
<tr>
<td>Other procedures</td>
<td>29.61 (54.18)</td>
<td>0</td>
</tr>
</tbody>
</table>

ASCs, ambulatory surgery centers; SD: standard deviation.

### Table 4. Input and Output Slacks for Inefficient ASCs

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD, n = 95)</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. operating rooms</td>
<td>0.07 (0.22)</td>
<td>0.00</td>
<td>1.41</td>
</tr>
<tr>
<td>Salaries, wages, and employee benefits</td>
<td>$251,547 ($230,382)</td>
<td>$0</td>
<td>$1,091,608</td>
</tr>
<tr>
<td>Contract services with professionals</td>
<td>$113,947 ($619,155)</td>
<td>$0</td>
<td>$6,021,813</td>
</tr>
<tr>
<td>Supplies</td>
<td>$187,820 ($513,150)</td>
<td>$0</td>
<td>$4,902,318</td>
</tr>
<tr>
<td>Other expenses</td>
<td>$447,847 ($2,471,992)</td>
<td>$0</td>
<td>$2.42E+07</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular cataract surgery volume</td>
<td>50.12 (97.63)</td>
<td>0</td>
<td>440.28</td>
</tr>
<tr>
<td>After cataract laser surgery volume</td>
<td>45.33 (159.26)</td>
<td>0</td>
<td>922.00</td>
</tr>
<tr>
<td>Other procedures</td>
<td>8.02 (23.69)</td>
<td>0</td>
<td>162.33</td>
</tr>
</tbody>
</table>

ASCs, ambulatory surgery centers; SD, standard deviation.
A Tobit regression model with the inefficiency score (i.e., 1-efficiency score) as the dependent variable was estimated to explore factors that might affect the efficiency performance of ophthalmic ASCs (Table 5). Results of multivariate analysis indicated that a larger cataract surgery patient base (measured as the number of cataract patients) was associated with higher technical efficiency. In other words, treating more cataract patients (usually covered by Medicare) per year will lead to higher technical efficiency for an ophthalmology ASC. Furthermore, the number of operating rooms was negatively associated with the facility’s technical efficiency. This means that the smaller an ASC is, the more efficient it will be, keeping other factors constant.

**DISCUSSION**

With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, all types of healthcare organizations, including ASCs, face unprecedented pressure to control healthcare costs while maintaining the quality of care. This analysis lends context to ongoing discussions about the performance of ASCs. Based on data from all active ASCs that provided the two most common cataract surgeries in one state, this study found that a large proportion of ophthalmic ASCs were operating at low technical efficiency levels. Using DEA analysis, the amount of slacks in input and output variables was estimated for each ASC, and the mean slacks were reported. This study also identified two factors that may significantly affect the technical efficiency of an ophthalmic ASC: the number of cataract surgery patients and the number of operating rooms. To increase the technical efficiency of an ophthalmic ASC, efforts should be directed to attracting cataract surgery patients and keeping the number of operating rooms at a low level (e.g., below the national average of 2.6).

Findings from this study have valuable administrative implications regarding the operations of ASCs, especially ophthalmic ASCs. Several administrative actions can be taken by inefficient ophthalmic ASCs to improve technical efficiency. For example, Lean and Six Sigma methodologies, such as value stream mapping, can be used to improve operating room efficiency so that the facility can increase surgical procedure output given the current capacity. To attract more patients, ASCs should invest more in advertising the advantages of their services, such as more convenient locations, shorter wait times, and more timely scheduling. Furthermore, this study demonstrated that it is possible to estimate the slacks for individual facilities if appropriate data are available. Such information can be used to benchmark the performance of a specific facility and pinpoint strategies that are required to improve its technical efficiency. The study also has important policy implications. As mentioned earlier, cataract surgeries constitute the major part of ambulatory surgeries covered by CMS. Information on the efficiency of the service providers can be used to inform policy makers about efficiency variability and potential strategies and policies for providing cost-effective cataract surgeries.

In conclusion, this study provides valuable data on the efficiency performance of ophthalmic ASCs. Our results point to three areas in which further research is warranted. First, similar analysis should be conducted among ASCs that focus on providing other types of common ambulatory surgical procedures, such as gastroenterologic and urologic procedures. Second, data from broader geographic regions should be used in the analysis. For example, when CMS starts to require ASCs to report cost data, DEA analysis can be used to assess the efficiency of ASCs that provide procedures that are widely used by Medicare beneficiaries, such as cataract surgery and colonoscopy. Third, this analysis

<table>
<thead>
<tr>
<th>Inefficiency</th>
<th>Coefficient (SE)</th>
<th>t</th>
<th>p Value</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. cataract surgery patients</td>
<td>-0.00007 (9.01E-05)</td>
<td>-7.85</td>
<td>&lt;.001</td>
<td>(-0.0009, -0.0005)</td>
</tr>
<tr>
<td>Total no. patients</td>
<td>0.0002 (0.0001)</td>
<td>1.69</td>
<td>.094</td>
<td>(-3.1E-05, .0004)</td>
</tr>
<tr>
<td>No. total encounters</td>
<td>6.11E-05 (9.94E-05)</td>
<td>0.61</td>
<td>.540</td>
<td>(-0.0001, .0003)</td>
</tr>
<tr>
<td>No. operating rooms</td>
<td>0.8816 (0.0602)</td>
<td>14.63</td>
<td>&lt;.001</td>
<td>(.7624, 1.0009)</td>
</tr>
<tr>
<td>No. surgical procedures</td>
<td>-9.3E-05 (8.94E-05)</td>
<td>-1.03</td>
<td>.303</td>
<td>(-0.0003, 8.44E-05)</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.0568 (0.1595)</td>
<td>-6.62</td>
<td>&lt;.001</td>
<td>(-1.3726, -.7410)</td>
</tr>
</tbody>
</table>

SE, standard error.
included operations measures in the efficiency regression analysis. Other indicators such as ownership of the facility should be examined in future studies.

REFERENCES


Retirement is a process that usually and fortunately happens just once in a doctor’s lifetime. If the retiring doctor makes plans long before the retirement date and has good guidance from his or her advisors, then he or she will be financially secure and able to enjoy the postpractice years. This article discusses the importance of advisors and how to select one(s) that will lead you to a happy retirement.

KEY WORDS: Retirement; advisors; asset management; investments; budget; checklist.

This article is the second of a three-part series on retirement.

ADVISORS

The relationship with your financial advisor is a true partnership, where both parties are working toward a common goal—your financial stability and financial independence. A financial advisor may help manage your investments, perform portfolio evaluations, and serve as an educator to ensure you have a greater understanding of the investment environment. In addition to registered investment advisors, there are a number of other financial-based professionals who may be in a position to assist you with many financial planning areas. The following list of professionals, as well as their industry-focused professional designations and educational requirements, should serve as a guide in your search for advice:

- Accredited Asset Management Specialist (AAMS): This is a 12-module, self-study course. Modules cover asset management, investment policy, risk, return, performance, asset allocation, investment strategies, tax issues, retirement planning, insurance products, estate planning, ethics, and legal and regulatory issues.
- Accredited Tax Advisor (ATA): This self-study program includes six courses and is a graduate-level course. Prerequisites are a bachelor’s degree, professional experience, a description of goals, and tax planning experience.
- Accredited Tax Preparer (ATP): This course provides basic background on tax preparation issues for individuals and sole proprietorships.
- Chartered Financial Analyst (CFA): This is an intensive three-year program, with three six-hour exams. Prerequisites for the designation include a bachelor’s degree or comparable work experience, and three years of investment management experience.
- Certified Financial Planner (CFP): The Certified Financial Planner Board of Standards is a regulatory organization for financial planners. It awards the CFP designation to individuals who meet its requirements. The curriculum covers insurance, income taxation, retirement planning, investments and estate planning. In addition to self-study programs, classroom instruction programs are offered at colleges and universities across the country.
- Certified Investment Management Analyst (CIMA): Prerequisites are three years of investment management consulting experience, an interview, and a preliminary exam. The program covers due diligence, asset allocation, risk management, and other investment management consulting concepts.
- Certified Investment Management Consultant (CIMC): CIMC certification is a two-level, self-study course that covers investment management consulting. It also addresses asset allocation, formalizing investment policy, and active versus passive investment performance evaluation.
- Certified Specialist in Tax-Sheltered Accounts (CSTSA): The CSTSA self-study program is for advisers who work with 403(b) plans.
- Chartered Life Underwriter (CLU): The CLU self-study curriculum includes 10 courses—eight required and two electives. Prerequisites are three years of business experience and client service in the financial field.
- Chartered Financial Consultant (CHFC): The CHFC self-study program includes 10 courses—nine required and one elective. Prerequisites are three years business experience and client service in the financial field.
- **Chartered Mutual Fund Counselor (CMFC):** This nine-module, self-study course is a primer on mutual funds.
- **Chartered Retirement Planning Counselor (CRPC):** The CRPC program is an 11-module, self-study program for advisers who provide retirement planning for individuals.
- **Chartered Retirement Plans Specialist (CRPS):** The CRPS program is targeted at advisers who work with qualified and nonqualified retirement plans.
- **Master of Science/Financial Planning Concentration:** This graduate-level program focuses on financial planning, wealth management, tax planning, retirement planning, and estate planning. Participants must have a bachelor’s degree to enroll and must complete 12 courses for 36 credits.

It is always a good idea to interview a number of advisors to determine compatibility.

As is the case with all professional designations, having one does not necessarily mean a person is good at what he or she does. Word of mouth, through referrals made by friends and colleagues, is an excellent way to meet potential advisors. Even though they may come highly recommended, it is always a good idea to interview a number of advisors to determine compatibility. Only in this manner will you be able to determine who you are most comfortable partnering with in guiding you toward, reaching, and ultimately maintaining true financial independence and long-term security.

**RETIREMENT INVESTING**

The need for retirement planning does not end with the onset of retirement. A new retiree’s focus should shift from building wealth to managing and preserving it. One major challenge is making the investment portfolio supply cash flow for the duration of life—and through various economic and market conditions.

Factors that drive a portfolio’s longevity include asset mix, spending level, and the investment time frame. Certain aspects of these factors are within an investor’s control while others are not.

**Asset Mix**

*Asset mix* refers to the ratio of stocks to bonds in a portfolio. This determines risk exposure and expected performance, and is one of the most important decisions investors of all ages make when constructing an investment portfolio. Historically, stocks have outperformed bonds and outpaced inflation over time. Consequently, the larger the equity allocation, the greater a portfolio’s expected return—and risk.

Keep in mind that risk and return go together. A higher allocation to equities increases the risk of experiencing periods of poor returns during retirement. But if you can handle the risk, having more equity exposure in a portfolio enhances its return potential. Growth can bring higher cash flow, inflation protection, and portfolio endurance over time. While it is logical that investors should have an equity component in their portfolios, the actual weighting should be dependent on one’s time frame, risk tolerance, and spending flexibility.

**Spending Level**

Portfolio withdrawal typically is described in terms of either a specified dollar amount (e.g., $100,000 per year) or a percentage of annual portfolio value (e.g., 5% of assets each year):

- **Specified dollar amount:** Withdrawing a fixed amount each year and adjusting it for inflation can provide a stable income stream and preserve your living standard over time. But the portfolio may survive only if future withdrawals represent a small proportion of the portfolio’s value.
- **Percent of annual portfolio value:** Withdrawing a fixed percentage of assets based on annual asset value makes it unlikely that you will deplete retirement assets because a sudden drop in market value would be accompanied by a proportional decline in spending. But this method can produce wide swings in your living standard when investment returns are volatile.

Retirees who need relatively consistent cash flow may want to combine these two methods.

**Investment Time Frame**

Investment time horizon may be the hardest to estimate, especially if it is the same as your lifespan. In this case, you can only guess how long your portfolio must support spending. If you plan to bequeath assets, your investment timeframe may extend beyond your lifetime. This may influence your risk and spending decisions as well.

Timeframe forces a tradeoff between the short and long term. Retirees with a longer investment time horizon might choose a higher exposure to equities. But they may have to offset this risk by being more flexible about spending over time. Elderly retirees and others with a short time horizon may choose a less risky allocation or a higher payout rate, although they can experience rising spending levels, too. In any case, retirees should think carefully about equity exposure and avoid taking more risk than they can afford.

Planning involves assumptions about the future—assumptions that may not pan out. Although you cannot avoid making assumptions, you can ask whether they are realistic and consider how your lifestyle might change if
future economic and financial conditions are much different than projected.

For investors, perhaps the most difficult task is keeping track of various investment portfolios.

Although you cannot fully control these and other factors involved in portfolio endurance during retirement, having more wealth can improve the odds of having a less stressful financial life. A more substantial nest egg might enable you to take fewer risks, enjoy a higher sustainable spending rate, or extend the productive life of your portfolio.

INVESTMENT WEB SITES

Thanks to modern technology, it is easier than ever for physicians to take control of their financial situation. Whether you are researching investment options or performing financial planning retirement projections, online resources abound.

For investors, perhaps the most difficult task is keeping track of various investment portfolios. While it’s obviously important to know what you own, it is equally important to know how well, or not well, specific investments and the overall portfolio are doing, on both a dollar and a percentage basis, over varying time periods. Morningstar’s portfolio tracker (www.morningstar.com) is a great tool to use to keep a close eye on your investments. You can enter your holdings on a screen or import the data from Quicken, Yahoo, and even many online brokerage statements. Heavy on analytics, it provides overviews and performance charts, and allows you to view a visual map and analysis using several factors, including a breakdown of holdings by asset allocation percentages. Similar tracking can also be accomplished through the MSN Money Web site (http://www.msn.com/en-us/money/personalfinance).

One of the best overall financial sites is Yahoo Finance (www.finance.yahoo.com). Yahoo’s text-based interface makes navigating through the site simple as well as fast. The opening page provides up-to-the-minute market data, prices on individual stocks, and bond market commentary. From this site, you can also access respected outlets such as Briefing.com, Financial Times, and Business Week. Of particular interest is the stock research link, which takes you on a journey of exceptional research tools covering stocks, bonds, mutual funds, and options. International news also is available, as well as financial-based chat rooms.

Economic data, and the expectation of new data being released, certainly are major factors affecting stock market movement. Moody’s Analytics economy website (www.economy.com) provides access to raw data and general economic news, both domestic and worldwide, and helpful commentary to interpret it all.

For a general financial education, spend some time with the solid tutorials on market basics with The Motley Fool (www.fool.com). Ease is the key on this site, as all of the educational information and tools are easily accessible from the website’s “Fool’s School.” Another option for general market and retirement planning education is the CNN Money website (www.money.cnn.com). This site takes advantage of the long-time involvement of many experts with varied interests and specialties. It serves as a valuable reference for both investment novices as well as the more seasoned physician investor.

Given that there are more mutual funds to choose from than common stocks, there is an abundance of sites dedicated to evaluating both load and no-load mutual funds. The leader in the field of mutual fund research is Morningstar (www.morningstar.com). Via its Web site, visitors can obtain a one-page summary of almost any mutual fund. Included are analyst reports and the Morningstar ratings.

While most sites provide a variety of financial news, one of the best sites dedicated to U.S. and global events is the Wall Street Journal (www.wsj.com). Links on the home page will take you to news by region as well as topic.

For those who are students of technical analysis, the site to visit is Bigcharts (www.bigcharts.com), where you can easily chart individual securities and mutual funds.

There are, of course, many other sites investors may find valuable. For one of the most comprehensive glossaries of financial terms, go to www.investorwords.com. For a nice overall investment site, take a look at www.investorguide.com. For economics-based articles, both Bloomberg Business (www.bloomberg.com) and Barron’s (www.barrons.com) offer an online alternative to their written publications.

Bottom Line: Doctors are advised to prepare for retirement long before they remove the shingle from the door. Having success in retirement means having the proper advisors to prepare the pathway to this important stage in a physician’s life.
Real-Time Culture Change Improves Lean Success: Sequenced Culture Change Gets Failing Grades

Dr. Mitchell Kusy, PhD,* Marty Diamond, MSHA,† and Scott Vrchota, MS, MBA‡

Success with the Lean management system is rooted in a culture of stakeholder engagement and commitment. Unfortunately, many leaders view Lean as an “add-on” tool instead of one that requires a new way of thinking and approaching culture. This article addresses the “why, how, and what” to promote a Lean culture that works. We present a five-phased approach grounded in evidence-based practices of real-time culture change. We further help healthcare leaders understand the differences between traditional “sequenced” approaches to culture change and “real-time” methods—and why these real-time practices are more sustainable and ultimately more successful than traditional culture change methods.

**KEY WORDS:** Culture change; Lean success; five-phased real-time approach; evidence-based practices.

Do such terms as “continuous improvement,” “stakeholder-based system of management,” and “cross-functional participation” ring a bell in your Lean initiatives? If so, you are in good shape—up to a point. However, this is only part of the scope needed for sustainable Lean results. The missing piece? Real-time strategies that engage multilevels and multidisciplines at one point in time to embrace a culture that supports Lean.

**THE ISSUE: LEAN SHOULD NOT BE AN ADD-ON TOOL**

As most healthcare leaders know, the Lean management system is rooted in two primary goals: reduce waste and create end-use consumer value. Unfortunately, we have discovered that many leaders view Lean as an “add-on” tool instead of a new way of thinking about how to change the organizational culture to better position these Lean goals. Furthermore, most senior leaders over-promise what Lean can deliver in their zeal to bring others on board quickly and effectively. Subsequently, questions often arise among potential “Lean recruits” as to whether this process will be sustained in the long term. Further compounding the problem is a mixed bag of obstacles identified in the research by the Lean Enterprise Institute:

- 21% of middle management resist;
- 11% of supervisors resist;
- 10% of hourly employees resist;
- 19% see this as “the flavor of the month”; and
- 36% of organizations backslide to previous ways.

Interpreting these statistics, either singly or in combination, points to a complex array of dilemmas that will erode your chances of Lean success. Evidence-based practices in culture change have further indicated that these negative perspectives can dissolve even the best-intentioned efforts. Lean is not a program; it is a management system. It must be integrated into the culture of the organization. And culture change extends far beyond training and coaching. When Lean is aligned with the organization’s culture, it will drive more successful implementation and results.

**THE QUESTION: HOW SHOULD LEAN BE POSITIONED?**

Let’s take a step back and discuss exactly what represents an organizational culture, because that is a term that is often bantered about without concrete understanding. Organizational culture consists of values, beliefs, and norms.

- **Values** point to what is important to the organization as they proceed in any initiative—Lean or otherwise.
Beliefs stem from an understanding of why these values are important to the organization.

Norms represent the unwritten rules about the way people “do things around here.”

All three are critical dimensions of any organization’s culture.

With these three cultural dimensions as a backdrop, please consider your own Lean initiatives. Do those engaged in Lean initiatives understand what the Lean values are and how these are aligned with the values in your organization? Are they able to state why these Lean values are important to your organization? And can they point to the norms that promote Lean and those that work against it?

These critical questions are best answered in a real-time venue—not in activities like training and coaching alone. Training and coaching are not the most critical culture change methods. These are certainly important, but they are not how true culture change begins and sustains itself. A real-time strategy provides an opportunity for the most effective, seamless Lean culture change possible.

Real-time means that an evaluation of the current way of doing things and subsequent Lean actions are integrated into a cohesive process, with leaders and staff participating simultaneously. Sometimes it seems easiest to understand what real-time change is by addressing what it is not. The opposite of real-time change is a process that is sequential, in that involvement from others occurs in separate phases. For example, there may be a formal training program to help others understand Lean. Then a team implements Lean. Following this, there may be coaching of team leaders. This sequential process is not necessarily wrong; it’s just not enough. There needs to be better “pre” work regarding cultural understanding and better “during” work for better cultural alignment.

The result: Creation of a Lean culture

To engage in this “pre” and “during” work, we advocate strongly that key stakeholders from multiple levels and multiple disciplines come together in one room at the same time. Evidence-based practices in all sectors, including healthcare, have indicated that this creates a swift and enduring culture change. While we do recognize that some of the work even in a real-time perspective must be sequenced, we advocate a much greater focus on combining the “pre” and “during” work in the same event.

We have discovered that it is very difficult to do any effective culture change work without understanding the views of diverse stakeholders. The traditional way of engaging a culture around Lean incorporated the following template: leaders designed a plan, told others what it was, and tried to garner commitment along the way. People support what they help create; therefore, they must be brought into the process of change much earlier than is typically done with Lean initiatives.

We advocate five key phases for a Lean culture change. With our own clients, we have discovered that the short-term work to accomplish these leads to significant long-term gains. Figure 1 delineates these five phases.

Phase 1: Planning Team

Many leaders believe that the planning team is the executive team. It is not. To garner early commitment to the Lean process, the planning team must be a multidisciplinary, multilevel team. For example, it may consist of members such as the president/CEO, the senior vice president, the quality assurance manager, a physician department head, a nurse leader, one or two clinical providers, a maintenance supervisor, a clerical lead, and a customer service representative. This is simply a sampling of how the planning team could be constructed. Their goal is to plan what the Phase 2 culture-change Lean event will look like, not specific Lean strategies and implementation—this is the domain of the large-scale event. Figure 2 identifies some of the key decisions the planning team needs to make.

Healthcare leaders often have a fair degree of anxiety at the thought of giving up control in this process. For example, what if there are suggestions from this large-scale event that we cannot possibly do? The best answer we provide that allays significant anxiety is that decisions from the large-scale event are sources of input to the planning team and, ultimately, to the executive team. However, we
input to consensus—which is about support, not agreement. Consensus is a preferred source of decision-making over, for example, voting, because voting has a tendency to polarize a group into “winners” and “losers.”

**Phase 2: Large-scale Multilevel, Multidiscipline Real-Time Engagement**

Phase 2 is the enactment of the heavy-lifting work of the planning team. Key stakeholders selected by the planning team are now seated around any number of predetermined round tables—such that there are five to eight stakeholders at each table. These table participants are *maximum-mixture* groups, commonly known as “max-mix” groups by experts in the field of real-time culture change. For example, each max-mix group may consist of a mix such as a senior leader, a support staff member, a nurse practitioner, a lab technologist, a physician, a manager, and so on—a group designed to simulate the range of stakeholders in the organization. Groups of this max-mix combination are seated at round tables distributed throughout the room. Why round tables? There is no formal “head”—this levels the playing field. Figure 3 provides an illustration of these max-mix groups.

Next to each max-mix group stands a flipchart and markers ready for them to record top ideas that emerge from the discussions and are shared with the other max-mix groups in the room. We suggest that a key executive begin the engagement with a brief comment on his or her praise for all those in attendance and an inspirational note for a fruitful and energetic day. The facilitators then begin the day’s
1. Welcome, overview, purpose, and guidelines for the day.
2. Max-mix groups address the question: What have you heard about Lean—“the good” and “the bad”? Brainstorm and then come to consensus on your top 3 responses for “the good” and top 3 for “the bad.”
3. Large group discussion and decision: Each max-mix group shares their top 3 responses for each category. The large group then discusses and then distills these into a total of no more than 5 top responses from all the max-mix groups—5 for “the good” and 5 for “the bad.”
4. Mini-training program on Lean: Lean experts share goals, strategies, and results of Lean efforts in other healthcare organizations.

**Break**

5. Max-mix groups address the question: Based on your responses to the first activity regarding “the good” and “the bad” of Lean, as well as the mini-training program you have just engaged in, what questions do you have about Lean? Brainstorm and then come to consensus on your top 3 questions you have about Lean.
6. Large group discussion and decision: Each max-mix group shares their top 3 questions. The large group then discusses and then distills these into a total of no more than 5 top questions from the max-mix groups.
7. Expert responses: Lean experts address each of these top 5 questions with dialogue with the large group.

**Lunch**

8. Max-mix groups address the questions: Considering all that you know thus far about Lean, what aspects of our culture support Lean work? Which do not? Brainstorm and then come to consensus on your top 3 responses for each question.
9. Large group discussion and decision: Each max-mix group shares top 3 responses for each question. The large group then discusses and then distills these into a total of no more than 5 top responses from all the max-mix groups.
10. Max-mix groups address the question: What actions do we need to take to better support a Lean culture? Brainstorm and then come to consensus on your top 3 responses.

**Break**

11. Large-group discussion and decision: Each max-mix group shares its top 3 responses. The large group then discusses and then distills these into a total of no more than 5 top actions needed to better support a Lean culture.
12. Max-mix groups identify action steps: Each max-mix group is given one top action to discuss. They are to brainstorm and then come to consensus as to the 3 most concrete steps the organization should take to address their one top action they have been given.
13. Large-group activity: Each max-mix group shares with the large group its top 3 most concrete steps.
14. Final activity: The planning team extends its thanks and shares that they will distill these top concrete steps into a cohesive plan. This plan will be shared with everyone present and with the entire organization through an interactive newsletter that will be produced. In this newsletter, everyone in the organization will be able to not only review the actions and the progress made, but will have an opportunity to write in their questions, concerns, and reinforcement of this process through an online process. In addition, the planning team will share that a small number of selected teams will be invited to engage in formal Lean training, followed by their implementation of the Lean process in their teams. As “small tests of change,” these Lean teams will report results and invite feedback through the interactive newsletter process.

**Figure 4. A sampling of the activities engaged in during the large-scale, real-time event #1.**

**Phase 3: Lean Training and Coaching**

Phase 3 is where most Lean efforts begin—at the training and coaching stage. We hope you can see what we have suggested thus far in Phases 1 and 2 will get Lean participants better prepared for training and coaching. Since this is not an article on Lean training, but, rather, on culture change to better engage Lean efforts, we will not dwell on what needs to be included in good training and coaching. Rather, we will focus next on Phase 4. Before doing so, we have found two successful initiatives that will help engage the Lean effort more successfully at this stage. First, the selected teams who will specifically embark on the Lean process would certainly be invited to the training program. Second, we strongly suggest that an invitation go out to both the participants in the large-scale event and the entire organization. (Remember: all staff have been receiving information about Lean through an interactive newsletter process.)
Phase 4: Lean Teams Begin Their Work as “Small Tests of Change”

It is important to remember that in Phase 4 not only are Lean teams beginning their work within their designated teams, but their work is being showcased in the interactive newsletter. Consequently, they need to be positioned as pilots for the rest of the organization—as “small tests of change.” We have further discovered that interviews of the Lean teams allow them to announce successes as well as obstacles—and how they have addressed these obstacles. It’s also a great way for others to solicit feedback as to various ways the Lean team can address obstacles. As you can see, the new culture is now a more critical mass engaged in the Lean effort—not just those enacting the Lean process in their teams. What you are doing here is spreading the wealth of information and resources. Lean is an organizational commitment—not just a team commitment.

Phase 5: Reassembly of the Large-Scale Multilevel, Multidisciplinary Group

Now that the interactive newsletter has turned into a true culture change vehicle, and several teams have had opportunities to try out their Lean strategies as “small tests of change,” we are ready to put it all together with real-time engagement #2. Typically, this would be at the six-month mark—a long enough time to produce some results but short enough that there can still be revisions in the Lean culture change process. It is important to note that during all five phases, the planning team has been engaged. They have made sure the newsletter has been the chief communicative vehicle for the culture change, as well as guided the efforts, as needed, of the Lean teams. They have positioned the “small tests of change” with the executive team and have run interference for the teams, as necessary. They are engaged once more to plan the second real-time engagement event. Figure 5 identifies a sample of the activities that might be engaged in during the reassembly of the large-scale, real-time group.

THE OUTCOME

Based on our evidence-based practices, Lean initiatives only get so far in healthcare organizations. While training and coaching are mandatory, they do not create a sustainable culture. Alignment with the culture is needed—and alignment cannot be done without the large-scale engagement of key stakeholders throughout the healthcare system. Our large-scale, real-time method with its five phases offers a practical, simple, and organized way to accomplish cultural alignment. Engagement increases commitment, and this commitment is what the research has indicated is key to successful culture changes. And Lean is about culture change.

REFERENCE

New ERISA Fiduciary Regulation; Additional IRS Correction Methods; Bare-Bones Plans Under the Affordable Care Act

Gayle M. Meadors, PC*

NEW ERISA FIDUCIARY RULE ISSUED

On April 14, 2015, the Department of Labor issued a new, revised proposed rule concerning fiduciaries under Employee Retirement Income Security Act of 1974 (ERISA) retirement plans. A rule was proposed in 2010 but rescinded in 2011 after a tremendous amount of pushback by plan investment advisors, especially broker-dealers. This new version of the rule reflects the Department of Labor’s long-standing concerns that many plan advisors have conflicts of interest and do not act in the best interest of plan participants. In a change from the 2010 proposal, the new 2015 regulations extend to rollovers and individual retirement accounts.

Under the new proposal, a plan advisor would be required to act as a fiduciary in the sole best interest of plan participants, with the following exceptions for certain activities. In the following seven circumstances, the acts would not be subject to a fiduciary standard:

- Statements or recommendations made to an investor in a plan who has financial expertise, as long as the recommendation is made in an arm’s length transaction (An example would be a large financial institution dealing with the fiduciary of a large retirement plan, which fiduciary has financial expertise.);
- Statements or recommendations made to a fiduciary under ERISA to enter into a swap investment regulated by the Securities Exchange Act or Commodity Exchange Act;
- Statements or recommendations made to the ERISA plan fiduciary by an employee of the plan sponsor, provided the employee receives no compensation other than that otherwise earned;
- Marketing a platform of investment alternatives for use under a participant-directed plan, as long as the selection of the investments is made by the plan fiduciary;
- Identification of investment alternatives that meet criteria that are specified by the ERISA plan fiduciary;
- Provision of an appraisal fairness opinion regarding employer securities;
- Provision of investment education or retirement education.

The proposed regulation still permits the fiduciary advisor to be paid in various ways, including advisor fees equal to a percentage of plan assets, 12b-1 fees, commissions, and other revenue sharing.

Finally, the regulation requires, in cases where the advisor receives variable compensation, that the advisor commit in writing to advise solely in the client’s best interest, to establish procedures to avoid or mitigate conflicts of interest, and to disclose any and all conflicts of interest, such as hidden revenue sharing fees. As mentioned earlier, this regulation is proposed, meaning comments can be submitted and likely a hearing will be held before any finalization would occur.

NEW SAFE HARBOR TO CORRECT PLAN ADMINISTRATIVE MISTAKES

As many plan sponsors know, mistakes can sometime occur when administering a retirement plan no matter how careful everyone tries to be. For many years there has been an IRS program called the Employee Plan Compliance Resolution System (EPCRS) that allows sponsors to correct administrative mistakes—sometimes by making a submission to the IRS but often by self-correcting without any submission.

On April 2, 2015, the IRS announced further modifications to this program to address issues that have been a particular concern to plan sponsors. This announcement came in the form of Rev Proc 2015-28, 2015-16 Internal Revenue Bulletin. While one of the new safe harbors addresses mistakes made by plans that provide for automatic enrollment, the safe harbor of most interest to readers of

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this column is the one concerning employees who either were not properly enrolled or whose deferral election was not properly implemented. In the past, to correct these errors the plan sponsor had to make a contribution to the plan equal to 50% of the amount that should have been contributed. Plan sponsors complained this gave an unfair windfall to participants.

Under the new procedures, if the plan fails to properly implement an employee’s election or fails to enroll an employee in the plan at all, the error can be corrected if the following requirements are met:

- If the mistake in implementing the deferral election has lasted for three months or less, the plan sponsor does not have to make any corrective contribution but does need to send a notice to the employee.
- If the mistake in implementing the deferral election has lasted more than three months but not longer than the end of the second plan year after the year in which the mistake occurred, the plan sponsor must make a corrective contribution of 25% of the deferral that should have been made plus missed earnings and matching contributions. Again, a notice must be provided to the employee.

The notice that must be sent to an affected employee must include information as to how the failure occurred, a statement as to when the proper deferral will start, a statement concerning the corrective contribution (if any) to be made by the employer, an explanation that the participant can increase deferrals to make up for the missing deferrals, and, finally, plan contact information for any questions.

It is still recommended to plan sponsors that they repeatedly communicate to employees the need to check pay stubs and investment reports to make sure all plan elections and investment decisions have been properly implemented.

**AFFORDABLE CARE ACT AND BARE-BONES PLANS**

As previously discussed in this column, under the Affordable Care Act (ACA) employers with 100 or more employees in 2015 and 50 or more employees in 2016 and thereafter must provide affordable health insurance to full-time employees or else be subject to a penalty. The health insurance has to be both affordable and cover essential benefits. Due to some ambiguous drafting found in the ACA and a Department of Health and Human Services (HHS) calculator for essential benefit coverage, an argument could be made—and was, in fact, made by some benefits advisors—that health insurance that covered certain health services but which provided no hospitalization coverage or doctor visit coverage constituted health insurance meeting the requirements of ACA. The HHS calculator did allow plans to pass the essential benefits test without hospitalization benefits.

In Notice 2014-69 the IRS officially put an end to the possibility of such bare-bones policies being acceptable ACA insurance. It put employers on notice that it would be issuing a regulation preventing such plans from meeting the requirements of the ACA. Such final regulation has indeed been issued. Since some employers had relied on the HHS calculator, a one-year reprieve was granted to employers that had signed contracts for the bare-bones coverage on or prior to November 4, 2014.

This discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.
Business Entity Selection: Why It Matters to Healthcare Practitioners

Part III—Nonprofits, Ethics, Practice Implications, and Conclusions

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The Bureau of Labor statistics indicates only a 50% four-year survivability rate among businesses classified as “education and health services.” Gaining knowledge of IRS business entities can result in cost savings, operational efficiency, reduced liability, and enhanced sustainability. Each entity has unique disadvantages, depending on size, diversity of ownership, desire to expand, and profitability. Business structures should be compatible with organizational mission or vision statements, services and products, and professional codes of ethics. Healthcare reform will require greater business acumen. We have an ethical duty to disseminate and acquire the knowledge to properly establish and manage healthcare practices to ensure sustainable services that protect and serve the community.

KEY WORDS: Business entities; business ethics; corporations; IRS; liability protection; sole proprietorships; limited liability companies; partnerships; professional entities; practice and risk management; taxation.

This is the third part of a three-part series.

This is the last of a three-part series outlining IRS business entities and their potential risk and practice management implications. Part I introduced the lack of readily available resources integrated into a healthcare professional’s entry-level training and the challenges that surround the acquisition of knowledge to properly establish and manage a practice. The author further highlighted that knowledge acquisition is expensive and is commonly provided by outsourced professionals who may not represent the goals, vision, or values of a healthcare organization. Parts I and II provided evidence that suggests that gaining practical knowledge of IRS business entities can result in cost savings, operational efficiency, sustainability, and reduced liability. Part I introduced sole proprietorships and partnerships. Partnerships were further outlined as general and limited subclassifications. Part II introduced corporations, limited liability companies (LLCs), and professional entity designations. Corporations were divided into C and S corporations, and professional entities were further defined as professional corporations, professional limited liability companies, professional associations, or service corporations. Part III will discuss the nonprofit designation, and the ethical and practice implications surrounding entity selection, and will summarize this three-part series.

NONPROFIT ENTITIES

Nonprofit corporate formation may be a good choice due to the liability protections and tax advantages provided by this structure if the business meets certain intended purposes. Traditionally, the common themes of nonprofit businesses are religion, art, literacy, charity, science, education, or the interest of public safety. Nonprofit organizations and companies are viewed by the IRS as entities operating for the good of the public. Like a regular corporation, the nonprofit organization incorporates by filing Articles of Incorporation with the state.1 To encourage businesses to focus on social needs, nonprofit organizations are given a favorable tax status. One of the advantages extended to a nonprofit designation is that the IRS does not
require the business entity to pay federal taxes, as long as specific guidelines are followed.

**Nonprofit status may be enticing to contributors because donations may be tax deductible.**

For a nonprofit organization to be recognized as a tax-exempt charitable organization, along with Articles of Incorporation filed at the state level, a Form 1023 must be filed with and approved by the IRS.² For taxing purposes, organizations and companies can be classified as public or private charitable organizations (501c3), social welfare organizations (501c4), agricultural/horticultural organizations (501c5), labor organizations (501c5), and business leagues or trade organizations (501c6).³⁻⁵ To be tax exempt under a 501(c)(3) section, an organization must apply within 27 months following the establishment of an entity.³ Some nonprofit entities will qualify for federal and state tax exempt status, as well as property tax exemptions.

An additional advantage for nonprofits is that registered nonprofit status may be enticing to contributors because donations may be tax deductible on the benefactor’s individual tax return. This can serve as either a second method of generating capital or an alternative strategy to selling stock for nonprofit corporations.

The major difference between a nonprofit (also called a *not-for-profit*) and a for-profit business is that nonprofits operate for the benefit of those served in the spirit of the public good, whereas for-profit entities operate for the financial benefit of the owners or shareholders.¹ Overall, these distinctions should be clearly reflected in the stated mission and vision of a business. Both nonprofit and for-profit organizations can be formed as corporations or LLCs. Liability protection under either of these entity structures is the same as previously described in Part II, regardless of nonprofit or for-profit distinction.² Despite the added expense from formally filing as a business entity with nonprofit status, upfront and recurring costs are offset by the long-term debt and liability protection for directors and officers as well as savings from a tax-exempt status.

For reasons discussed in Part II of this series, most nonprofit entities operate as corporations with formal hierarchies requiring officer meetings and annual reports to facilitate the accountability and transparency likely expected by grant and gift funding sources. Nonprofits are eligible for certain grants from private and public sources. Nonprofit business entities, whether a corporation or LLC, have inherent advantages with building operating capital because donations made by individuals to a charitable nonprofit (501c3) are tax-deductible.¹² Consistent with other types of corporations, the nonprofit organization structure assures that it will continue to operate uninterrupted, despite retirement, removal, or death of an officer.

**ETHICS AND OTHER ENTITY CONSIDERATIONS**

Ethical considerations in business require careful examination of the entity’s internal and external operations. One of the main reasons individuals or groups incorporate a business is to shield the owners or shareholders of the company from personal liability related to potential injured plaintiff lawsuits or creditor debts incurred by the business. On the surface, it may appear that selecting a business entity and relying on its structure to limit liability for the protection of one’s life savings, personal assets, or one’s family and individual self-interests may be less than the ethical standard expected of healthcare professionals and administrative personnel. However, creating a “shield” from legal liability and creditors through entity formation does not necessarily mean that the owners or shareholders are free from accountability.

Despite the desire to shelter themselves and their families, business owners, especially professionals, have a responsibility to act legally and ethically. Internally, owners have a fiduciary duty to other owners or shareholders and employees to act with integrity and the highest degree of honesty and loyalty toward the best interests of the entity, its employees, and customers serviced.⁵ This duty can further be exemplified as a duty to act in good faith in negotiating and servicing contractual relationships with insurers, as well as a professional duty to avoid activities that only further self-interest.⁶ More global ethical considerations such as consequentialism are commonly implemented in business decision-making. Although taking a consequentialist approach when selecting and operating a business entity can be defended as a rational and objective way of problem-solving and imperative for practice viability in today’s business and litigious climate, one must be careful to ensure egoism does not override business decisions. This is particularly relevant to healthcare professionals, who have deontological responsibilities to act with beneficence and nonmaleficence by placing the good of the patient/client above their own. In settings such as charitable organizations or pro bono services, a utilitarian ethical approach may be employed so that finite resources can be used fairly and equitably for the good of the greatest number of people.⁷

Ultimately, the decision for prospective owners and administrators as to what business structure would be best should not rest solely on an IRS classification for mitigating tax and liability risks. For healthcare professionals, entity choice should be consistent with the mission and vision statements of the organization and should align with ethical practice standards. Arguably, there are organizations...
that on the surface appear to have captured loopholes and are using a nonprofit classification for less than noble reasons. For example, the National Football League (NFL) is classified as a tax-exempt, 501(c)(6) organization, despite being a multibillion dollar entertainment industry organization. Ethically, albeit not legally, the NFL should recognize that its profit margins are excessive as a result of taxation breaks and government subsidies, and some of its profits should be redistributed to those in need to more appropriately comply with the IRS’s interpretation of a nonprofit: “serving a purpose of public or mutual benefit other than the pursuit or accumulation of profits.”

**Incorporating as a for-profit or nonprofit can add credibility to an organization.**

Interestingly, professional healthcare organizations are reluctant to recommend business entity structure for aspiring practice owners. Many times, little information is available to healthcare personnel about the entities as related to any particular practice. However, in our litigious society, entity designation is an important risk management strategy, as are tort reform, liability insurance, and financial responsibility requirement laws. Financially, the savings from educated, well-informed decisions can be staggering. Depending on total revenue of a business entity and the annual income of the individual owner/shareholder, a 40% corporate tax rate on a C Corporation that generates $1 million will reduce the net funds available to the individual shareholders by over $250,000. The average payout on a publicly disclosed negligence claim is over $285,000. These financial data, although not the sole consideration for entity selection, must be carefully weighed and integrated into administrative planning decisions.

**PRACTICE IMPLICATIONS**

Some may argue that because of the recent and projected cuts in physician fee schedules from third-party payers and market basket cuts from the Centers for Medicare & Medicaid Services (CMS), the risk of C corporations being subject to federal corporate taxation is not a significant factor in light of shrinking healthcare profit margins. This is not necessarily accurate. Shrinking profit margins have inspired some entrepreneurial-minded administrators to expand, add additional clinics and partners, and diversify business service “product” lines to improve revenue and marketability of their services. Consequently, executives associated with these expanding corporations must weigh the advantages in flexibility of financing and stock options with the potential disadvantages of “double taxation.”

Some individuals perceive that owning a “corporation” can assist with marketing and branding efforts. Incorporating as a for-profit or nonprofit can add credibility to an organization. This is not unique to healthcare. However, because healthcare revenue payment differs from most other product or service-based businesses, further consideration of entity selection relates to reimbursement. Most healthcare practices rely on payment from third-party insurance companies as their primary source of revenue. To be considered eligible to bill for and receive reimbursement for services, the individual provider or group practice must become a credentialed healthcare provider with the insurer. To become credentialed, one must first register the business entity of choice with their state, and then file for a federal employer identification number (EIN). Regardless of the selected IRS classification, receipt of an EIN allows the individual provider or healthcare practice to seek provider credentialing from third-party payers and is also a necessary step prior to hiring employees.

Moving forward, business entity selection is important with healthcare reform. The Affordable Care Act of 2010 has encouraged the formation of Accountable Care Organizations (ACOs). An ACO is a group of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high-quality care to the Medicare patients in a given geographic region. These provider groups are financially incentivized by the CMS for improved health outcomes, such as reduced hospitalization rates, for example. To function as an ACO, a health delivery system likely will have different internal business entities in addition to strategic alliances with outside organizations to meet the health needs of their community. That being said, the clear and purposeful establishment of formal business entities is vital to profit sharing among providers as well as risk and strategic management of an ACO.

**CONCLUSION**

In conclusion, whether a small healthcare practice or a large healthcare delivery system, administrative personnel and medical providers with ownership and/or fiduciary responsibilities should be educated as to how the structure of their business entity(ies) will impact the nature and operation of their current and future practice(s). Practice administrators should consider and weigh many factors in their decision-making: liability protection; tax advantages and disadvantages; the ability to expand ownership and raise capital; stock options and fringe benefits for themselves and prospective employees; as well as the ease and cost of initial and annual filings for the entity with their respective state. The major considerations comparing sole proprietorships, partnerships, corporations, and LLCs are summarized in Table 1.

It would be convenient if there was a standard answer to the question of what type of business entity best suits
healthcare practices. While it appears that LLCs, S corporations, and C corporations provide the greatest number of advantages to healthcare entities while also mitigating individual and organizational liability, each situation is different based on the desires, goals, objectives, and philosophy of the business. As outlined in parts I, II, and III of this series, many factors, including complexity, expenses, projected expansion, transferability of ownership, financing, taxation, liability, number of owners, division of profits and losses, and ethics should be considered when selecting an IRS entity. Beyond the impact on officers and shareholders, survivability rates and solvency of healthcare-related businesses are crucial to meeting the needs of local and regional communities. This article provides information to assist healthcare providers, managers, and scholars with meeting these goals.

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Building Trusting Relationships in the Medical Practice Team: Thirty Rules to Live By for You and Your Staff

Laura Hills, DA*

A medical practice team without trust isn’t really a team; it’s just a group of individuals who work together in a medical practice, often making disappointing progress. This is true no matter how capable or talented the individuals are. Your staff may never reach its full potential if trust is not present. This article offers medical practice managers 30 rules for building trust in their practices: 15 rules that will help them in their leadership roles, and 15 rules to teach and discuss with their employees. It suggests a trust-building screening question to include in job interviews to determine if applicants have a high capacity for trust. It also describes Reina and Reina’s “Three C’s of Trust,” a model that practice managers may find useful as they develop trust competencies in their staffs. This article also includes 10 inspiring quotes that will help medical practice employees build trust and five easy-to-facilitate trust-building exercises that managers can use with the medical practice team.

**KEY WORDS:** Trust; trust building; trustworthy; team building; relationship; communication; commitment; The Three Cs of Trust; character; capability; delegate; agreements; mistakes; truth; feedback; confidentiality; collaboration; setbacks; obstacles; betrayal; breach of trust.

Trust is, without question, one of the most complicated aspects of the relationship between two people. Trust on the team level can be even more complex because of the number of players involved—yet trust in your medical practice is essential. It will increase the quality of communication, commitment, and loyalty among your team members. According to Hakanen and Soudunsaari, “Trust can be considered the foundation that enables people to work together.” And, they suggest, it can also increase your chances as a practice manager of creating a successful organization.

**Trust is most often eroded by subtle, minor, and unintentional acts that happen every day.**

Trust is tested every day in the medical practice. You may let others down, and they may let you down. Others may ask you to support them, and you may need to seek support, especially through great challenges. Most people associate broken trust with big offenses such as lying, embezzlement, or manipulating others. However, such instances are relatively rare. The hard truth is that trust is most often eroded by subtle, minor, and unintentional acts that happen every day, not with the big things. So, as the practice manager, you must focus first on preventing big breaches in trust but also on the everyday behaviors in your practice that can foster or erode trust between team members.

**FIFTEEN TRUST-BUILDING RULES FOR THE MEDICAL PRACTICE MANAGER**

Trust in your medical practice begins with you, the practice manager. Your attitudes, intentions, and behaviors will be the first and most important step toward building trusting relationships in your medical practice team. This is good news because you are in control of what you bring to the table.
The Three Cs for Building Trust

Trust-building consultants Dennis and Michelle Reina have developed a model that they commonly refer to as *The Three Cs of Trust*. The Reinas argue that these Cs provide both the understanding and the practical behaviors you will need to build and sustain trust in your relationships. Reina and Reina’s Three Cs of Trust are:

1. **Trust of character**: Trust of character implies a mutual understanding between people that they’ll hold true to their promises and that they’ll do what they say they will do. You earn trust in character when you keep agreements, honor intentions, and meet your own and others’ expectations. Trust in character is the baseline for trust in your relationships. You earn it when you practice six behaviors: managing expectations; establishing boundaries; delegating appropriately; encouraging mutually serving intentions; keeping agreements; and being consistent.

2. **Trust of communication**: Trust of communication allows you and your medical practice team to know where you stand with one another and with your shared work. It’s the trust that creates an environment of openness and transparency. It empowers you both to give and to receive the information you need to do your job, take responsibility for and learn from your mistakes, and talk through issues and concerns with an eye toward deep understanding and effective resolutions. Trust of communication will help you create relationships within your medical practice that are infused with positive energy, a sense of community, and shared purpose. The six behaviors that contribute to communication trust are: sharing information; telling the truth; admitting mistakes; giving and receiving constructive feedback; maintaining confidentiality; and speaking with good purpose.

3. **Trust of capability**: Trust of capability is the trust others have of you when they have confidence in your competence to manage their demands and expectations. It takes more than task-specific skills to develop trust of capability; you also need to have the attitude, interest, and confidence that will help you work well with others. Trust in capability also extends beyond current capabilities. It relies on your faith in your ability to grow, learn, and develop. When there is high team trust in capability, team members involve one another and make decisions collaboratively. They share information, exchange ideas, and brainstorm solutions. The four behaviors that contribute to trust of capability are: acknowledging people’s skills and abilities; allowing people to make decisions; involving others and seeking their input; and helping people learn new skills.

**REFERENCE**


Talking about trust with your medical practice team is a highly recommended strategy, and with good reason. Getting the subject out in the open can help you identify obstacles to building trust and lay a strong foundation for team trust. However, talk alone is not going to be sufficient. Your employees will take their cues much more from what you actually do than from what you say.

The way to begin building trusting relationships in your medical practice is for you to lead by example.

The way to begin building trusting relationships in your medical practice is for you to lead by example. That means that you must model the trusting behaviors you expect in your employees. Through your trusting and trustworthy behavior, you will be able to demonstrate what trust in others looks like. Here are 15 rules to help you do this:

1. **Share relevant information with your medical practice team immediately**. Nothing erodes trust more quickly than the suspicion that higher-ups are keeping secrets. Speculation and rumors start, and misinformation is accepted as truth. This is often followed by questions and denials. And in too many instances, the correct information comes to light too late, or it is never offered. The more openly you communicate with your team members, and thereby prove that you have no hidden agenda, the more comfortable they’ll feel trusting you. Don’t lie to your staff. Avoid half-truths and omissions. And if you can’t speak openly about something you’re asked about, say so. When your employees know that they can trust without hesitation whatever comes out of your mouth, you are building trust that can be unshakable.

2. **Delegate**. Your staff members won’t feel that you trust them if you give them little or nothing to do without your control. Therefore, you must delegate authority as well as tasks to your medical practice team. Speak of your trust and confidence as you delegate, and mean what you say. For example, you might say, “I know I can count on you to do a wonderful job with this” or “I have great confidence in your ability to do this.” This combination of demonstrating your trust by delegating authority, coupled with your sincere words of trust, can be very powerful.
3. Discourage cliques. Cliques can make others feel isolated and can undermine trust among group members. If you sense that you have a clique forming in your medical practice, start an open discussion about cliques with your team members. See what they think about them and their effect on other group members. For more information about discouraging cliques, please see “Managing Cliques and Exclusionary Behavior within Your Medical Practice Team” in the March/April 2014 issue of this journal.²

4. Address breaches in trust directly. It is essential for you to find out how trust issues in your medical practice started so that you can come up with a strategy for overcoming them. If you do not know the origin of the problem, and your team members are not forthcoming with information, try administering an anonymous questionnaire. Ask your staff about the level of trust within the group and why or whether they think there’s a lack of trust. For more information about overcoming trust problems in your staff, please see “What to Do When Trust Has Been Breached in Your Practice” in the November/December 2013 issue of this journal.³

5. Regard your employees as your equal partners. Trust is established when even the newest rookie, part-timer, or lowest-paid employee feels important and part of the medical practice team. Seek ideas and opinions from all of your team members. Value each person.

6. Focus on shared goals. Trust results when employees feel that everyone is pulling together to accomplish a shared vision, rather than a series of personal agendas. According to Bowman,⁴ “This is the essence of teamwork. When a team really works, the players trust one another.”

7. Be willing to say no. You can’t do everything your medical practice team may want you to do. Taking a stand calmly and with good reason can actually enhance the trust between you and your employees. They may not like it, but they will know that you won’t overcommit and that you mean what you say.

8. Follow through on your commitments to your team. Or, give early notice when you can’t follow through. Reliability builds trust. According to Derby,⁵ “No reasonable person expects that every person can meet every commitment all the time.” However, you can mitigate the damage by letting your team members know when you can’t live up to your commitment as soon as you know and by leveling with them about your reason. Ask your staff to help you figure out another strategy.

9. Be predictable. Although surprises are nice from time to time, stability and uniformity are far more important to building trust. Your employees will trust you more if they know how you are likely to respond to different challenges. Uniformity may sound boring, and we would all like some surprise in our life. But you need to be predictable when the going gets rough to make things work in the long run. Predictability builds trust.

10. Don’t hold grudges. You may be disappointed or angry about something an employee says or does. If so, deal with the issue directly. Then let go of your negative feelings. An employee who has made a mistake and been called out for it may mistrust you afterwards, because he or she assumes that you are still mad or that you have it in for him or her. Employees who feel that they’re in the doghouse generally don’t trust their bosses.

11. Link rules to values. When rules for your team members support beliefs that they share, they’re more likely to respect them. They will trust that the rules come from a good place, not from your personal agenda or a desire simply to control them or to make their lives more difficult.

12. Don’t make moral judgments. Talk about values for your medical practice early and often, but do not...
lecture your employees from on high. Share the values and, most importantly, walk your talk. Your team members may not agree with everything you have to say. And in fact, in some cases, there will be more than one good way to do things. But they must behave in accordance with your practice values. As long as they do, there should be no problem. Don’t make them mistrust you by seeming as though you feel morally superior to them. And don’t talk down to your employees. There is no situation when doing so is acceptable.

13. Start and end staff meetings on time. Otherwise, your staff won’t trust that you will start or end the meeting when you said you would. Even worse, they will not trust that you value and respect their time.

14. Be loyal to your employees. A medical practice manager who demonstrates firm and constant support for the staff is one that every member of the team will want to trust. Stand up for your employees.

15. Use body language to build and foster trust. For example, don’t shift your eyes away from your employees when you are speaking with them. They may suspect that you’re not telling them the truth or that you’re trying to hide something from them. Look at them directly whenever you communicate with them. Likewise, make sure your facial expressions match your words. Telling your employees that everything is OK with a pained and worried look on your face will make them mistrust you. As well, keep your arms open when you speak with your employees, not closed across your chest. Keep your hands in sight, not behind you or in your pockets. And relax your hands. A clenched fist will not encourage your team to trust you. For more information on how you can use body language to build trust, see “Reading and Using Body Language in Your Medical Practice: 25 Research Findings” in the May/June 2011 issue of this journal.

SCREEN JOB APPLICANTS FOR TRUST

Ideally, your medical practice will hire employees who have a high capacity for trust. That will make your job and everyone else’s job much easier than if you hire individuals who are mistrustful. Turning such a person around can be very difficult.

Therefore, the next time you have a job opening, include at least one question about trust. Try to gauge trust by seeing how each candidate reacts to a subjective scenario that plays out differently depending on the level of trust involved.

No one will trust a teammate who hogs the glory.

For example, you might instruct each applicant to imagine that he or she has created a new schedule or inventory system (or another tool related to the prospective job) and that another employee has changed it, without telling him or her. Ask the applicant to describe what he or she thinks the change could be the reasons for the change and what he or she might do in such a situation. If the applicant immediately views the change as negatively or personally motivated, that can tell you quite a bit about his or her willingness to trust others. But if he or she feels that the change could be

Five Trust-Building Exercises to Try with Your Medical Practice Team

You can help your team build trust by leading them through exercises that challenge them to trust one another. The exercises below are fun and easy to facilitate. They will help you foster trust and also increase morale among the members of your medical practice team.

1. Blindfolded Wine Waiter: Divide your staff into groups of six and blindfold five of the participants in each group. Instruct each group to find, uncork, and pour a bottle of wine into six glasses. Each blindfolded team member must carry out one element of the task: find the bottle; find the corkscrew; take the wine glasses out of the box and set them on the table; open the bottle; pour the wine into the glasses.

2. Blindfolded Obstacle Course: Put team members in pairs and ask one to wear a blindfold. Scatter chairs and other objects on the floor. Ask the sighted employee to guide his or her partner verbally through the course.

3. The Human Knot: Divide your staff into groups of six or eight. Instruct each group to stand in a tight circle. Upon your command, ask participants to close their eyes, place their hands in the center, and find two hands to hold. Once everyone is holding two other hands, ask them to open their eyes. Tell them that they have to untie the knot and make a circle without letting go of each other.

4. Eye Contact: Divide your staff into pairs and ask them to stand facing each other. Instruct them to stare into their partner’s eyes for at least 60 seconds. Neither participant should be wearing glasses or sunglasses. There may be some giggles at first, as it can feel somewhat awkward during the first try. However, your employees will get better with the exercise as they relax and trust one another. Offer a prize to the pair that can maintain eye contact the longest, without laughing.

5. Storytelling: Divide your staff into groups of three or four. Instruct each group to share stories about low- and high-trust situations they’ve seen or personally experienced. Encourage them to change the names or to avoid specific details when the story is about low trust.
well-intentioned, that can indicate that he or she is a trust-
ing individual.

**FIFTEEN TRUST-BUILDING RULES FOR THE MEDICAL PRACTICE TEAM**

According to Horsager, “People seldom talk about trust as a competency to learn and practice.” Yet the lower the trust, the more time everything takes, the more everything costs, and the lower the loyalty of everyone involved, Horsager argues. Lack of trust is your biggest expense, he says. By contrast, Horsager argues that greater trust “brings superior innovation, creativity, freedom, morale, and productivity.”

As the practice manager, you are in the perfect position to teach your team members explicitly the skills they will need to be trusted by others. Here are 15 trust-building rules for you to teach to and discuss with your employees:

1. **Say what you mean and mean what you say.** Don’t beat around the bush. Be consistent, honest, and straightforward with your coworkers.

2. **Don’t drag your feet.** Your coworkers won’t trust that you will get things done when you say you will if you have a history of missing deadlines. Don’t make people wait for you. Get your work done and be there when you say you will.

3. **Be constructive.** Respond to disappointments, miscommunications, and misunderstandings with the goal of making things better. Start with the assumption that your teammate had positive intentions. Ask yourself, “What can I learn from the experience so that it doesn’t happen again?”

4. **Embrace your differences.** Recognize that teams are stronger when people bring diverse skills, experiences, and viewpoints with them. In fact, a team of clones generally isn’t the strongest team. Seek opportunities to leverage the team’s collective strengths.

5. **Challenge with passion, not poison.** You don’t have to agree with everything a coworker says. However, you must respect your teammates all the time, even when you disagree. Encourage thoughtful, civil debate.

6. **Be forthcoming with information.** Uncertainty feeds fear, and fear erodes trust. Share what needs to be shared with your coworkers. Provide ongoing and useful feedback so your teammates know where things stand.

7. **Don’t place blame.** Honest mistakes happen, and it’s easy to blame the person who makes them. However, an unpleasant atmosphere of mistrust can develop when everyone starts pointing fingers. Instead, encourage everyone on your team to think about the mistake in a helping way. Ask: How can you mitigate the damage and move forward together? How can you make sure that this mistake doesn’t happen again?

8. **Do what’s right, regardless of personal risk.** We all know intuitively what’s the right thing to do in most situations. Trust will come to those who put others before themselves. When you’ve done something wrong, come forward about it, even if admitting so will be difficult. It’s better to own your errors in judgment, and to apologize for them, rather than to say and do nothing.

9. **Don’t take advantage of trust.** As you gain increasingly higher levels of trust in your medical practice, you’ll be given more privileges. Don’t abuse those privileges. If you have access to information or resources to do your work, that doesn’t mean that you can put them to personal use. With greater authority comes greater responsibility.

10. **Hold confidences.** Your teammates won’t trust you if you demonstrate that you can’t be trusted. Don’t gossip, even if others are doing so.

11. **Pay full attention.** Your coworkers won’t trust that you’re listening to them if you interrupt them or divert your attention to other things. Active listening builds trust.

12. **Acknowledge the work of others.** No one will trust a teammate who hogs the glory. Give credit where it is due or your coworkers will think that everything you do is motivated by your ambition and ego.

13. **Commit to what you’re doing.** People believe in and trust those who are committed to the quality of their work and who have the fortitude to withstand adversity. Do your job well not because you have to please your boss, but because you care enough to do it well. Don’t waste people’s time by dashing off mediocre work that needs to be redone.

14. **Communicate about obstacles.** Open the lines of communication right away when something is blocking your ability to get your work done well and on time. Bring possible solutions and be flexible in working toward a positive result. Every setback can become an opportunity to build trust with your teammates, but only if you work through those setbacks together.

15. **Don’t say I’ll do my best.** It may be tempting to use language like this because, after all, all you can do is do your best and you never can know for sure if you will succeed or fail. But unfortunately, prematurely anticipating failure and leaving the door open to escape accountability will not help you establish trust with your teammates. Trust is built and fostered when you make firm and definite commitments that you can keep.

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**SUGGESTED READINGS**


Empowering Physicians with Financial Literacy

Yuval Bar-Or, PhD*

Most doctors complete their medical training without sufficient knowledge of business and finance. This leads to inefficient financial decisions, avoidable losses, and unnecessary anxiety. A big part of the problem is that the existing options for gaining financial knowledge are flawed. The ideal solution is to provide a simple framework of financial literacy to all students: one that can be adapted to their specific circumstances. That framework must be delivered by an objective expert to young physicians before they complete medical training.

KEY WORDS: Financial literacy; physician; decision-making; education; business.

THE NEED FOR FINANCIAL LITERACY

Doctors should view financial literacy as a matter of necessity and urgency. Instead, many procrastinate or take only half measures. The harsh reality is that doctors face more financial challenges than ever:

- Increasing specialization means more years of training, which, in turn, delays earnings (putting doctors farther behind college peers who begin earning salaries much sooner in other professions);
- Increasingly complex regulations make it more challenging to launch and manage a medical practice;
- Heightened competition places tremendous pressure on private practices;
- Fraud continues to harm small and large medical practices;
- Earnings have decreased for many specialties as private practices have been merged or acquired (often by lower-paying hospital systems); and
- Wealth management has become more complex (and hence more confusing and intimidating).

In the face of such challenges, one would think the medical community (i.e., medical schools, teaching hospitals, medical societies) would be highly motivated to equip graduates with every skill needed to succeed, including financial literacy education that meets reasonable standards of objectivity and expertise. But to date, no systematic solutions have emerged. Instead, we have a smattering of partial, ad hoc remedies, which include relying on books, discussions with mentors, participating in blogs, and attending financial advisor seminars.

Reading Books

Although a good book can be an excellent introduction to those seeking knowledge, there are at least two drawbacks. First, most books on financial literacy and investing are written by providers of financial services. These financial advisors and insurance agents are well aware that writing a book can help establish them as “experts.” Thus, there is always lingering doubt regarding the objectivity of the content. Second, books often raise more questions than they address. The educational benefit is diluted when there isn’t anyone available to answer those follow up questions. The typical financial advisor/author isn’t interested in answering questions for free. She or he wants to convert follow-up interest into paying clients.

Listening to Mentors

Hoping to prepare their students for real-world challenges, senior physicians may dispense their own financial advice. Such efforts are well-intentioned, but can backfire. Often the mentor draws passionately on his own experiences (typically lessons learned the hard way). But those historical
circumstances and experiences are rarely identical to those of their eager students. Hence, the strongly worded advice (often blanket statements that overlook nuance and subtlety) may be completely wrong, however well-intentioned.

Sadly, there can also be less honorable motives. One doctor recommended that a colleague use a contractor he knew to be guilty of criminal negligence. Why did he provide the recommendation? Because he was too embarrassed to admit having been fleeced by the contractor.

The bottom line is that your medical gurus and peers are great doctors, but it’s too much to expect them to be true experts in other fields that require full-time commitment. Finance and economics are not rocket science. Any physician easily has the intellectual capacity to gain this knowledge, but I’ve yet to meet one who has enough time to do it comprehensively, objectively, and with the energy to remain current on ever-changing regulations and best practices.

**Participating in Blogs**

Increasingly, doctors (physicians and dentists) share wisdom and knowledge using blogs. These are also generally well-intentioned efforts. The challenge, again, is that it’s impractical to stay current on financial literacy knowledge while holding down a full-time job as a medical provider. I’ve seen very popular blogs providing incorrect advice, including blanket statements reflecting only superficial understanding. Blogs also attract numerous comments with questionable educational value.

*Your medical gurus and peers are great doctors, but it’s too much to expect them to be true experts in other fields.*

For example, a recent post by a doctor seeking advice on how to invest an inheritance garnered close to 100 comments. Over 90% of the responses urged him to spend the money on some combination of booze, strippers, poker, and blackjack. Setting moral judgments aside, having to sift through so many unhelpful comments dilutes the educational benefit for those seeking real, meaningful knowledge. Finally, some successful bloggers have capitalized by accepting money from advertisers or providers of financial services. This is a very slippery slope. Acceptance of sponsors with commercial agendas inevitably calls into question the objectivity of the content.

**Attending Financial Advisor Seminars**

Hospitals and private practices often allow financial advisors or insurance agents to deliver so-called educational seminars on the premises. In reality, these typically turn out to be thinly veiled marketing sessions. In many ways this is an example of letting the fox into the henhouse. It’s an approach with limited upside but considerable downside for attendees (i.e., they may learn something, but they may also be taken advantage of under the guise of implied endorsement by the hospital). So why does this practice persist? For several reasons:

- As noted earlier, there is the hope that someone may actually learn something.
- Events are free and provide food (medical students and residents rarely turn down a free meal).
- Administrators can mentally check off the box that financial literacy education has taken place—although, as noted earlier, this is often more wishful thinking than reality.

**DEFICIENCIES OF CURRENT OPTIONS FOR OBTAINING FINANCIAL LITERACY**

Some serious deficiencies in each of these options were already documented earlier in this article. They also have one other deficiency in common: each is an isolated effort that doesn’t fit into a systematic, organized, pedagogically proven structure. Options 2 and 3 are also highly dependent on a single passionate person, the mentor or blogger. When that person retires or loses interest, the entire effort, however successful to that point, ends.

Because these approaches are not comprehensive, they do not equip students with an overall framework for making decisions. For example, a book rarely gives the hands-on experience and confidence to finalize decisions.

*When you have a solid understanding of your own financial circumstances and a comprehensive plan, you no longer have to scramble to make decisions in a vacuum.*

Unfortunately, it is very common for people, physicians included, to make financial decisions reactively rather than proactively and in isolation rather than as part of a bigger plan. For example, they suddenly feel vulnerable and rush out to buy insurance, or they receive an inheritance and hastily try to deploy it into investments. The superior alternative is to formulate a comprehensive and consistent financial plan in advance (i.e., proactively). In medicine it’s always better to be proactive. That is why doctors recommend exercise, healthy diets, regular checkups, and bicycle helmets. The same logic applies to financial decisions.
When you have a solid understanding of your own financial circumstances and a comprehensive plan, you no longer have to scramble to make decisions in a vacuum—you have a context within which to make those decisions.

Let’s consider some examples. You realize that your disability insurance may not be properly fine-tuned, or you are debating between term and permanent insurance, or between renting and purchasing a home. Last year you read a book on financial planning, but most of what you read has faded from memory.

**Ad hoc decisions may make you feel in control, but you are most likely making suboptimal decisions and leaving money on the table.**

So you turn to your mentor for advice, or you post a question on a blog, or you ask a question during a lunch seminar offered by a local financial advisor. The respondent provides a snappy answer. It sounds authoritative. But he or she doesn’t know that you are contemplating divorce, or considering a job at a hospital in a different part of the country, that your elderly parent will likely require assistance, that your child has been diagnosed with a learning disability that may affect college attendance, or that you inadvertently withheld some relevant information regarding your current income and expenses or assets and liabilities. The upshot is that the snappy response you received is likely to be at best incomplete, and at worst dead wrong. This is also the fundamental problem with finance gurus on television. They greet their audience with toothy smiles, amiably chat with callers, and then dispense advice with dramatic flair. But drama is not a responsible substitute for relevance. There is no way they can provide solid advice based on a 45-second conversation.

Ad hoc decisions may make you feel in control, but you are most likely making suboptimal decisions and leaving money on the table. Inefficiencies lurk everywhere: in your default 401(k) or 403(b) allocations, your insurance deductibles, a lack of investment diversification, unnecessary expenditures, undiagnosed risk exposures, poorly drafted estate planning documents, incorrect tax filing selections, emotionally driven investment decisions, and more.

**THE IDEAL SOLUTION**

The ideal solution is to provide a comprehensive framework of financial literacy that students can adapt to their specific circumstances (proverbially, teach them how to fish instead of throwing a few fish at them). Included in that framework should be a critical mass of basic knowledge. That critical mass need not be very extensive or painful to achieve. It simply needs to give a basic understanding of the big picture, providing context within which to make decisions. One of those decisions can be to hire a capable advisor.

The financial literacy education framework that follows is based on my personal experience delivering a broad selection of financial and business literacy solutions to doctors, including extensive debriefings of those audiences. The sample includes physicians at several hospitals, extends across various medical specialties, and spans professional development stages (i.e., medical/dental students, residents, fellows, attending physicians, private practice employees and owners, and wizened doctors holding senior posts at medical schools and hospitals).

**ELEMENTS OF A COMPREHENSIVE FINANCIAL LITERACY FRAMEWORK**

- Strive to deliver a total of three courses on personal finance: (1) toward the latter part of medical school; (2) near the end of residency; and (3) near the end of fellowship. That is, ideally, students should be exposed to this material three times. Repetition is important for the subject matter to take root properly. The content of the three courses should be adapted to address the immediate needs of attendees based on their stage of professional development.
- Deliver a course on business finance toward the latter part of residency. Programs whose graduates are destined for academic medicine may not need to offer this, although some basic business knowledge can prove useful for just about anyone, including physicians interested in administrative roles in academic medicine programs.
- A full personal finance course should extend over 8 to 10 hours and should cover all the major concepts, including such topics as investing, insurance, asset protection, contract negotiations, home purchases, college savings, and more.
- A full business finance course should extend over 8 to 10 hours and should cover all the major concepts, including forming the management team, securing real estate, formulating a business plan, assessing technology solutions, hiring and managing staff, financial management, billing, and so on.
- Use an objective and expert instructor. The instructor could be a senior doctor who has studied the objective material, embraced it, and can deliver it comprehensively, or an external expert, as long as he or she does not have a conflicting agenda (i.e., does not make a living selling financial products or services). An MBA degree is not an automatic qualification for personal finance knowledge. In fact, most MBA programs focus on corporate skills, not personal finance.
- Use objective teaching materials. If an employee of your organization is handling the teaching, the materials should come from a credible source (i.e., borrowing www.greenbranch.com | 800-933-3711
Presentation slides from a financial advisor may not meet objectivity/credibility requirements.

- Deliver the course in a classroom setting, with all the seriousness, dedication, and professionalism you’d want to find in a great course on your favorite medical subject.
- Make attendance mandatory. This will ensure that students take the course seriously.
- Subsequent to the training, provide ongoing access to experts, so that questions can be answered in timely fashion. Questions and answers can be exchanged through e-mail correspondence with the instructor, or through participation in a blog that is committed to an educational experience.
- Courses may be delivered remotely by videoconference, although our experience has shown that face-to-face is the more compelling choice. Access to recorded videos allows students to review material at their convenience.

The ideal framework just described may be difficult to launch initially. Less ambitious implementations are better than nothing.

The teaching is especially effective when students have an opportunity to implement what they have learned quickly. I’ve had students who (immediately after our sessions) called insurance agents, financial advisors, and other experts, and finalized decisions they’d been putting off for months and even years, including securing life and disability insurance, making changes to investment portfolios, opening up retirement accounts, refining entrepreneurial business plans, making personnel changes at work, selecting group insurance policies, and tightening controls to thwart fraud. This real-world, hands-on dimension drives the messages home and converts class discussion into life-long wisdom.

CONCLUSION

Medical professionals should be properly equipped to make constructive financial decisions for themselves, their families, and their private practices. The best time to gain critical knowledge for decision-making is before such decisions become urgent. Money-related decisions are fundamental to our society. Financial literacy empowers doctors by giving them control over their financial assets and helping them to make proactive decisions about their financial futures. Proper financial literacy helps set up doctors for success.
Direct Pay/Concierge/Blended Care: Where Is The Sweet Spot?  
Part II—Seen from Your Patients’ Perspective

Susan Childs, FACMPE*

Physicians are actively considering the direct pay and concierge models as plausible options in providing more patient-oriented care. What are the major considerations and how do we obtain accurate data that may help in sophisticated decision-making? Part I of this article introduced the models, typical patient contract configurations, physician/provider considerations, and commercial payers. In Part II, we discuss the access, cost, and value from a patient’s point of view. We also consider patient loyalty and self-care, approaches for introducing and inviting patients, and how to work with other providers and in community relations. Lastly, we share some creative concierge models that are evolving.

KEY WORDS: Private medicine; membership medicine; concierge healthcare; cash-only practice; direct care; direct primary care; direct practice medicine; boutique medicine; immediate care.

This is the second part of a two-part article.

ACCESS, COST, AND VALUE FROM THE PATIENT’S POINT OF VIEW

Access
Some say that primary care physicians soon will be at a premium and difficult to find. The message could be, “We are accessible to you when you need us,” “Sign on with us now; we can accommodate you,” or “We offer a schedule of care to patients when their regular provider is not be available.”

Cost
As a patient compares cost, he or she should consider purchasing a high-deductible plan that would cover a catastrophic event, and establish a health savings account (HSA) to pay for primary care office visits during the year. For example, in the traditional model, the patient would pay a total of $900 (6 × $150) for those 6 appointments, whereas using the concierge model, he or she would pay only a total of $600 (12 × $50). However, if the patient remains relatively healthy, and needs only two or three office visits during the year, it could actually cost more to leave the concierge model.

One way to attract new clients is to establish a lab client account with pass-through billing at a reduced rate. This provides additional cost savings for the patient.

Value
The patient must confirm that his or her high-deductible health plan qualifies for an HSA. (Such plans typically require no copays, just a high deductible.) “Retainer” or concierge fees may not be considered an HSA-qualified medical expense.

If established patients move with you, you have truly captured their loyalty. Benefits to them include:

- A schedule that offers affordable care to prospective patients;
- Elimination of a possible barrier to care: the insurer; and
- Fees that go directly for care, not to an insurance company.

CONTRACT, SELF-CARE, AND HIGH-CONTACT CARE

Patient Contract
It may make sense to have a patient contract. Healthy patients will look for healthy practices, and healthy practices will look for healthy patients.
Self-Care
In our consulting practice, we love to watch the transformation when patients become more financially responsible for their healthcare, resulting in enhanced and improved self-care. Whether it is because of a high deductible or a concierge retainer fee, the most typical behavior is to avoid the financial cost of a doctor’s visit, if possible. This personal and financial investment is a win–win scenario for all parties on many levels. The patient’s attention to preventive care and screenings is heightened, and if he or she is truly committed to self-care, that results in an investment in the established and agreed-upon patient–physician agreement.

High-Contact Care
According to an analysis involving patients of the concierge-medicine firm MDVIP published in 2012 in the American Journal of Managed Care, high-contact care can be beneficial for patients. The study compared hospitalization rates between MDVIP and non-MDVIP members in five different states. In 2010, it was also reported that MDVIP enrollees were up to 62% less likely to be hospitalized.

OTHER PROVIDERS AND COMMUNITY RELATIONS AND ASSOCIATIONS
It is crucial to maintain good relations with other providers and the community. The goal is to build on what you’ve worked so hard to establish! The fact that you can even consider opening a concierge or direct-pay practice shows that you have worked very hard and built a loyal patient base. This is where your experience can really help and why patients will be ready to move with you. Carry that loyalty over to your other professional relationships.

Spread the love! Remain affiliated and actively engaged in the sharing of patient care just as you were before, just with a different referral protocol.

This is also an opportunity to welcome and bring in other providers to assist in care on a direct-pay concierge level. For example, massage and physical therapists, a psychologist, and a nutritionist would be good additions to the practice, just to name a few. Any service that you think may enhance or complement the care you provide is a plus for all parties.

Of course, challenges will arise as you have the need to refer your patients outside your office for further care—for instance, for a stress test or physical therapy. This is where the patient’s financial expense can increase greatly.

Take this time to see where you stand. Run referrals reports, and start a “wish list” of your dream practice. As you are making your decision to go concierge, gather all of the information you can. Use all of your resources as you explore this idea and begin early introducing the concept to your peers and patients. Remain visible and active at local events.

Who Does It and When?
The marketing begins as soon as you have made your decision—with respect to your current contract, of course. In addition to standard marketing efforts, being creative and open to approaches to reaching prospective patients can lead one to a farmers market, health fair, Chamber of Commerce function, and many other settings. Use whatever venue best allows you to convey your offerings to the (preferably healthiest) prospective patients.

One should be prepared for possible attrition. Your schedule should also offer openings, as continual advertisement and invitation at the right time and place can help create momentum and a flow of prospective patients for your practice.

Some models first approach patients in the office the physician will actually be leaving to assist with marketing and patient transition issues.

HOW ARE PATIENTS INTRODUCED AND INVITED TO CONCIERGE AND DIRECT-PAY PRACTICES?
“The Sell”
There are several approaches to marketing your concierge practice directly to patients. Some are standardized by company and have a finely honed process with a fast-paced patient engagement program. Your marketing will depend on your location and the patient populations your practice may draw from.

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IDENTIFY ESSENTIAL REPORTS AND PROCESSES TO BENCHMARK AND FORECAST
How Much Easier Is It to Track Without Payer Involvement?
Think about this: your concierge or direct-pay practice will provide a predictable income. What a pleasant change! Insurance contracts only tell you how many subscribers they
have, but there is no guarantee that the subscribers will be coming to your office.

**It will not be long before there will be just as many choices for direct-pay and concierge offices as there are for traditional practices.**

When you are setting up your new office, consider whether you need a full-blown practice management (PM) and electronic medical record (EMR) system. A well-organized product, possibly with an inventory control program, can be helpful. If you are looking for positive outcomes reporting, you can either design your own system or go with an open source. You may want to consider a light EMR. It is appealing because:

- It offers an edition specifically for direct primary care and concierge practices.
- The system is cloud-based.
- Membership management is built in at no additional cost, and can be customized to fit different types of membership structures, whether age-based, tiered, or a combination of both.

It will not be long before there will be just as many choices for direct-pay and concierge offices as there are for traditional practices.

**Financial Profits and Costs**

This is the time to really push the envelope with the capabilities of your system. Review the data the same way you would with a traditional model. It is essential to know, specifically, your costs. Track, track, track everything. Creation of a pro forma financial forecast or budget will give you the information you need to make the right decision for your practice.

**TWO EXAMPLES OF CREATIVE DIRECT-PAY AND CONCIERGE MODELS**

**Virginia and Truck-Stop Medicine**

Among the truck stops just off I-81 in Virginia, Dr. Rob Marsh offers care to long-haul drivers in the Charlottesville area and also to local residents. He also makes house calls and provides hospital care. Along with a hot shower, one can also be seen for a medical condition, get a flu shot, and even have a prescription filled!

Marsh wanted to offer medical care to truck drivers so they could have access and continuity of care, which can be challenging for a driver. His clinic schedules appointments for area residents, and allows truck drivers to obtain care on a walk-in basis. The truckstop owner loves the arrangement so much that he is actually adding other perks to make it a “searchable stop” for travelers and truckers alike.

The schedule can be challenging. Like most of us, truckers tend to try to work all day before being seen. So evening hours are a must. Again, each provider has his or her own unique population. You know them best!

Many patients remit in cash, allowing an income without the usual insurance reimbursement hoops.

Marsh has other providers, including nurses who go cab to cab to give flu shots, for example. In the truck stop, a nurse may offer to check your blood pressure.

This is a great example of creative thinking. Imagine where you would like to provide care, and go from there.

**Upstate Concierge Medicine in New York**

Upstate Concierge Medicine (UCM) is a telemedicine and medical concierge service run by Michael R. Bibighaus, MD, an emergency medicine physician, and Keith D. Algozzine, the CEO.

“The easiest way to think of us is that we are a virtual urgent care,” Algozzine said. “It is not our intention to replace the primary care physician or specialist. UCM is saving local companies time and money. We can avoid probably 75 percent of urgent care visits, probably 50 percent of ER visits by a simple phone call.”

The current charge is $12 a month for individuals and $14 for families. UCM does not prescribe “high-risk” prescriptions, such as narcotics and controlled substances. They offer 24/7 access via phone, e-mail, video, or message. “We could take care of 10,000 people with probably eight doctors,” said Algozzine.

**Fundamental**

Our office works with a physician in a pain practice who truly listens to the patient. This is one of his greatest contributions as he takes the time and helps patients work through their pain. It is stunning how many physicians feel hindered in their ability to give all the time they believe is really needed to get the whole picture.

When helping another physician transition to a concierge practice, we asked why he wanted to change so late in his career. Seemingly, he had it made. He was one of his practice’s founders and could write his own ticket from that point on. His response was that he “had seen 15 patients that afternoon . . . most of them had Medicare, and he knew, and was afraid, he missed something.”

This compelling dynamic will continue to drive concierge and direct-pay medicine. Physicians and patients want the same thing—the time with each other to decide together what the healing process should be without a third entity interrupting care due to “(non) covered services.”
WHERE TO GO FROM HERE

Start your analysis today regarding a restructuring of your fees. Play “what if?” Start with an analysis of your patients’ needs. You are more aware of what they need than anyone else. Be creative. After developing the needs list, then review your costs. Prepare a business plan and a pro forma financial forecast. What are you waiting for? Let’s get started!

REFERENCES


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Is It Really Worth It?

Timothy W. Boden, CMPE*

I was recently booking airline tickets for a nice young couple who signed up to work for an English-language training center our family operates in east-central China. I used one of the well-known online travel services, navigating my way through familiar screens asking for travel preferences and seat requests.

Just before I clicked on the button to confirm the sizeable purchase, a bold, underlined message in a large font appeared on the screen to offer me the familiar warning: THIS FARE IS NONREFUNDABLE—ARE YOU SURE YOU WANT TO CONTINUE?

Well, yes, I wanted to enjoy the savings that come with nonrefundable airfares. Sure, we know there’s risk involved. That’s why the travel agencies offer travel insurance that will reimburse you if you have to cancel or change your itinerary. (And they make a tidy profit, too!) The travel and hospitality industry has successfully altered the public’s expectations with nonrefundable airfares, hotel reservations, car rentals, and more. They’ve managed to convince us to risk financial penalties in exchange for better prices.

CAN WE GET AWAY WITH THAT?

Not long ago I found myself sucked into a discussion—a debate, really—about how medical practices should address appointment no-shows. Statistics indicate that most offices experience an average 5% to 7% no-show rate. While that doesn’t sound like a big deal, it actually has a significant economic impact on your practice.

Calculate the cost for yourself: How many patients do you see in the office per week? Of course, that varies widely from specialty to specialty, from market to market. If a physician averages a modest 125 patients per week, that would mean somewhere between six and nine no-shows. Of course, many busy practices see far more patients than that.

Physicians often underestimate the value of an office encounter.

Next, estimate the average revenue per appointment. There’s more than one way to look at this. First, you have the direct revenue which includes the fee for the encounter, and may include ancillary services offered inside your office. Your billing system should be able to report the data you need to calculate your average per-visit revenue. It might surprise you—it can rather easily top $200 per visit. But let’s dial it back a bit for a conservative estimate: At an average $150/visit, a 5% no-show rate will cost you almost a $1000 per week in lost revenue. As if $52,000 in lost revenue weren’t enough . . . it gets worse!

Physicians—especially procedure-based specialists like surgeons—often underestimate the value of an office encounter because they focus only on the modest fees generated by the visit. But there’s a direct connection between how many people you see in the office and how many cases you take to the operating room. A surgeon generating $750,000 in net professional revenue per year probably saw only about 40 or 50 patients per week (2000 to 2400 patients per year). A simple calculation reveals that each office encounter is “worth” far more than the small amount of visit-generated revenue.

But wait! Don’t forget that you incurred administrative and payroll costs when your staffers spent time on the phone to set up the appointment (and reschedule it later). And for hospital-owned practices, the lost-revenue costs skyrocket when you calculate the per-physician hospital revenue generated by each doctor.

In other words, no-shows really are a big deal. And in today’s productivity-driven medical practice, they are a bigger deal than ever.

CHARGING NO-SHOW PENALTIES ONLY MAKES CENTS

It’s no wonder that practices—especially those with inordinately high no-show rates—often consider instituting a policy whereby they charge patients a missed-appointment fee. It only seems fair these days, they reason. After all, it will recoup at least some of the costs and lost revenue.

Patients often refuse to pay the no-show fees.

Typically, doctors’ offices set their no-show fee somewhere around $25—barely scratching the surface of the losses incurred by the practice. Furthermore, don’t expect a very high collection ratio—patients often refuse to pay the no-show fees.

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No-show fees, therefore, aren’t a very effective strategy for mitigating those costs. Proponents quickly argue, “That’s not the point—no-show fees are meant as a penalty, a deterrent.” At least a formal no-show penalty communicates to patients that the physician’s time and services are valuable, and not to be taken for granted.

Patients notoriously fail to recognize medical practices as businesses that depend on them for revenue—like a retail store depending on its customers. They tend to believe that the doctor won’t miss them if they don’t show. Clearly, there’s a learning curve for the practice to address. But is a no-show fee the best educational tool?

Some practices would respond, “Yes, absolutely!” I’ve heard of practices that have seen significant improvements in no-show rates after instituting penalties. “Repeat offenders”—often responsible for a disproportionate share of no-shows in a primary care practice—may very well reform their bad habits once you bring it to their attention with a new, get-tough policy.

**ON THE OTHER HAND . . .**

Depending on a number of other factors, that same get-tough policy could drive some patients out of your practice. If you practice in a competitive market with good alternatives for your disgruntled patients, you might anger them enough to make them seek care elsewhere. You might even find that the patients who feel most empowered to walk away are the ones with the best insurance plans!

Vocal opponents of no-show fees often forward the following arguments in support of their point:

- You may lose patients because of the fees.
- You generate dissatisfaction and ill will that angry patients loudly proclaim among family, friends, and in online reviews.
- You will have a hard time actually collecting no-show fees. (Some practices have tried to improve the collection rate by requiring the patient’s credit card information when booking the appointment and warning him or her that a fee will be charged.)

- You risk alienating patients with a practice image that seems cold and inflexible, and cares more about money than people.

**SO WHAT’S THE RIGHT ANSWER?**

Maybe there’s a middle ground where the practice can institute no-show fees as part of a larger effort to improve the transaction “contract” between doctors and patients. If you feel you must use no-show fees, avoid focusing on the fee.

Instead, develop and clearly communicate a policy (via posters, handouts, handbooks, and your Web site) that simply explains why an appointment constitutes a promise on the part of the patient. At the same time, the doctor promises to be there, too. Explain why that time slot has real value for everyone concerned. Help patients understand that no-shows and late cancellations do more than inconvenience the doctor—they also rob other patients of the opportunity to get medical care.

It seems to make the most sense to charge no-show fees as part of a progressive series of consequences (like employee discipline). Don’t charge the fee for a first-time offender. And set a limit for how many times they can blow off their appointments. Remind them that the practice has the right to dismiss patients who don’t take the appointment “contract” seriously.

No one seems to know for sure if “the best-run practices” typically charge no-show fees or not. But top performers do have less downtime in their daily patient schedules. They have improved their numbers with whatever has worked for them. You can address no-shows with creative scheduling (like open- or advanced-access scheduling). Some practices plug the gaps by maintaining “standby” lists for patients hoping to get in sooner than scheduled; they start calling standbys when they have a sudden opening.

In the end, the practice that clearly communicates that patients come first (with or without no-show fees) will come out on top.
Checking Your Vendors’ References: Don’t Cut Corners

Timothy W. Boden, CMPE*

Physicians and practice managers sometimes demonstrate a little too much trust when making major purchases. The vendor assures you that its product is high-quality, reliable, and easy to implement. Due diligence on your part demands that you ask for appropriate references—satisfied customers who will tell you the truth about their experiences. But you need to go further: Don’t simply rely on the vendor’s list of satisfied buyers. Do your best to compare “apples to apples.” Find practices that are similar to your own in size, setting, and specialty.

KEY WORDS: Major purchases; comparison shopping; vendor references; RFP.

When considering a major purchase, an equipment lease, a new professional services provider, or a supply-purchasing agreement, you’ll want to know about other customers’ experiences with each vendor you review. Of course, each vendor happily provides you with a list of other practices that sing its praises and recommend you become a client as well.

Press your vendors to provide relevant references.

It’s like going through the references provided by prospective employees. Few applicants will list former bosses who won’t give a positive recommendation. You need to dig further to get a more realistic impression of how well a vendor delivers on its sales-pitch promises.

You can use these two proven strategies for expanding the reference list beyond the vendor’s control:

■ Ask around. Use your personal network to discover other practices that use a given vendor’s services or products. Call other physicians or managers. Ask around at your next conference or seminar. Ask, “Do you know anyone who has used XYZ product? Do you know if they’ve had a positive experience? Have they dropped that vendor or product?” Ask your friends and acquaintances to help you contact the ones you don’t already know.

■ Ask the competition. As you narrow your field of vendors, ask each for specific references that include clients they’ve won over from the others. For example, if you’re shopping for a new electronic medical records system, ask the sales rep from Vendor 1 if his or her company has a client that used to be with Vendor 2, and vice versa. When you contact that reference, ask specific questions about why he or she left the previous service provider. This way you can hear some of the “bad news” about each vendor.

MAKE THE MOST OF YOUR REFERENCE CALLS

Press your vendors to provide relevant references. Insist on a list of medical practices that resemble your own in size, medical specialty, payer mix, and patient volumes. If you’re looking at technology to deploy over multiple practice sites, talk to a multisite practice using the same technology.

Pay attention to subtle differences, too. For example, your 55-year-old physicians may not agree with a reference’s 30-something doctors regarding a high-tech product’s “user friendliness.” Ask about market conditions, patient types, and local competitors. Do your best to achieve an “apples-to-apples” comparison.

Depending on the product or service you’re reviewing, try to speak with more than one person at each practice. Remember that physicians and managers often have a very different view about a product or service than the workers in the trenches. A less-than-optimum configuration looks like a minor annoyance to an administrator, but it can become a major pain for the staffer who deals with it day in and day out.

Don’t settle for written references—while somewhat useful, they don’t compare to personal interviews.
Telephone calls are better, but don’t implement systems or equipment without making at least one site visit arranged by each of your vendor-finalists. Nothing compares to seeing the product in a real-world setting and talking to the people with daily experience.

**IMPORTANT QUESTIONS**

Effective reference calls and site visits start with careful planning. Prepare a list of specific questions and topics to pursue, and note the persons you want to ask. Then contact the administrator or physician who will be coordinating your visit on the other end. Before your visit, send a list of staffers by position or department and a summary of what you’d like to ask of each. Show every consideration to minimize the disruption caused by your visit.

*Nothing compares to seeing the product in a real-world setting and talking to the people with daily experience.*

When you create your question list, it makes the most sense to start with broad, general questions, then zero in on important details about the product or services you’re shopping for. Some very general questions that could prove useful in almost any situation include:

- How did you find this vendor, and what is your prior relationship with it?
- What other vendors did you review before choosing this one?
- Describe your interactions with the vendor: Did you set up the contract? Do you deal with it on a day-to-day basis?
- In general, what do you like best about the vendor or its product?
- What do you like the least?

- How does day-to-day experience compare with the sales pitch?
- Tell me about a situation in which the vendor disappointed you. How did it respond to your disappointment?
- Describe how the vendor’s customer-support system works? Would you describe support staff as “responsive”? How quickly do they return calls?
- Would you consider the vendor flexible to meet your practice needs?
- Knowing what you know now, would you choose this vendor again? Do you plan to renew your contract? Do you hope to modify your contract?
- Did your installation/conversion/implementation go smoothly?
- Does the vendor provide appropriate training? Is additional training expensive?
- Would you consider your purchase price fair? Have ongoing costs been higher or lower than what you anticipated?
- What advice would you offer us if we select this vendor? Did you make any mistakes that we can avoid?
- Would you consider the vendor to be financially stable and well-structured as a corporation? Do you feel confident it will be around for the foreseeable future?

As you work out the exact wording for your questions, however, avoid asking too many “yes or no” questions. Encourage the reference spokesperson to keep talking by asking open-ended questions. Instead of simply saying “Do you like [a particular feature]?” ask, “Rate [a particular feature] on a scale of 1 to 10.” Then follow up with more questions to learn the reason for that rating.

At the end of the interview or site visit, thank the reference generously—but be sure you ask permission to return with any follow-up questions that might pop up later. Always take the approach that you’re asking the reference for a real favor. A little humility (and a few thoughtful compliments) will go a long way toward establishing an open relationship that will yield an honest impression to help you make a good purchasing decision.
The Personality of Caregiving and the Three Transformational Steps to Move from Conflict to Collaboration

Lon Kieffer, RN, NHA, SSB*

There are books and experts that use slogans and sayings that claim to affect workplace employee engagement. However, healthcare is unique. None of these experts seem particularly focused on or remotely interested in, or even able to recognize, the unique opportunity we have in a healthcare setting when it comes to engagement. The differentiation is the personalities of the people who migrate to healthcare careers and professions. The personalities of the family caregivers that fill our lobbies, cubicles, and exam tables need to be considered when we talk about “engagement.” This article briefly describes three transformational steps to begin moving healthcare employees and customers/clients from motivations of self-actualization to team engagement.

**KEY WORDS:** Engagement; employee engagement; personality profile; Maslow hierarchy; caregiver personality; cognitive distortions; leadership; empowerment; customer engagement.

We all know what it means to be engaged. It means that at some point in the near future, you will stand before an unnaturally assembled group of witnesses and be asked to perform a difficult and intimate task in a stressful and emotionally laden environment.

**Professional relationships, like marriages, can be won or lost one conversation at a time.**

Doesn’t this sound like a typical day of work in a caregiver setting?

Professional relationships, like marriages, can be won or lost one conversation at a time. A successful engagement is not ordained; it is earned! The failure rate of marriage according to some statistics is as high as 60%, and we all know that turnover in healthcare is a huge challenge. Why is turnover so high? In short, it is because the prospect of the engagement does not meet our individual and/or collective expectations.

Here’s the good news: in the ranks of healthcare we have a uniquely qualified, highly motivated, and “engagement-prone” subset of the population that actively seeks not just employment but long-term meaningful careers.

Here is my bias: our prospective employees and the decision-makers and influencers within the families we serve have something in common, in larger percentages than the general population. These people have a caregiver personality (as identified by Myers-Briggs). They seek roles in healthcare for their career choices; and when families or loved ones are in crisis, these are the same personalities/people that heed the call.

Myers-Briggs describes the caregiver personality as follows:

- Caregivers are focused externally according to how they “feel” and how things fit within their personal value system.
- Caregivers gather specific, detailed information about others to form supportive judgments, and they are generally highly supportive of others.
- Caregivers are dependable and take their responsibilities very seriously. They value security and stability, and are good at anticipating and meeting the needs of others.
- Caregivers need approval from others. They are hurt by indifference and don’t understand unkindness. They...
get personal satisfaction from the happiness of others, and they want to be appreciated for who they are, and what they give.

- Caregivers have a strong need to be liked, and to be in control, and often change their own manner to be more pleasing to whomever they’re with at the moment.

So far so good, right? The perfect engaged employee or customer! But not so fast. Here’s where it gets challenging.

**Caregivers weigh their values and morals against the world around them.**

Caregivers’ value system is defined externally. They weigh their values and morals against the world around them. They may have a strong moral code, but it is defined by the community that they live and work in. They derive their values from the company they keep—or the company they work for.

Caregivers surrounded by a strong, ethical value system will most likely be the kindest, most generous (engaged?) souls. Caregivers who do not have the advantage of a good external value system, however, may develop very questionable values, but they may still genuinely believe in the integrity of their skewed value system.

These particular caregivers are dangerous employees indeed—driven to control and manipulate, and unable to see the big picture. They’re usually quite good at manipulating others to achieve their own ends, all the while believing they are doing what they are doing in the service of others.

In short: if the employer or the healthcare system or the environment does not provide a strong, ethical, and well-defined set of values and beliefs (i.e., core values) and adhere to them in an accountability-based environment, the caregiver can find all kinds of “self-righteous” justification to act and behave in a manner diametrically opposed to the goals of the organization:

- Caregivers have a natural tendency to want to control their environment. They demand structure and organization, and seek closure.
- Caregivers respect and believe in the laws and rules of authority, and believe that others should do so as well. Their need for security drives their ready acceptance and adherence to the policies of the established system. This may cause them to blindly accept rules without questioning or understanding them.
- This desire for structure and purpose makes caregivers who are not natural leaders extremely prone to informal leadership that might provide direction, structure, a feeling of “belonging” that can compete with or fill a void in formal leadership.

At their best, caregivers are warm, sympathetic, helpful, cooperative, tactful, down-to-earth, practical, thorough, consistent, organized, enthusiastic, and energetic. They enjoy tradition and security, and will seek stable lives rich in contact with friends and family.

Caregivers without ideal structure or support may be prone to being quite insecure and focus all of their attention on pleasing others (informal leaders). They also may be very controlling or overly sensitive, imagining bad intentions when there were none.

So there you have it: the good, the bad, and the ugly of the caregiver personality—a personality that by the laws of attraction makes up a much larger subset of those we employ and serve in a healthcare setting.

In this powerful “portrait” we see the huge leg up this natural selection of employees/customers provides us when facing the challenge of employee/customer engagement. The advantage is: they are already engaged! They want to please us; to have, create, enjoy, and protect a positive and mutually pleasing relationship. In fact, they derive their own satisfaction by pleasing and satisfying you, as manager, and meeting and exceeding your goals!

The challenge is to provide the necessary structure and support to ensure that they are engaged in the right things: the organizational/formal leader’s agenda rather than the informal or “default” agenda created by the more dominant controlling personalities inherent in any organization.

**Caregivers take their responsibilities very seriously.**

Realistically, if the formal leader in a healthcare setting is clear and consistent about goals and objectives and provides structure that offers security, stability, positive feedback, and appreciation, he or she has a recipe for success. Caregivers take their responsibilities very seriously. They are very dependable, and they seek security and stability. They need approval from others, and they want to be appreciated for who they are and what they give.

Engaging the caregiver personality in the workplace is really quite simple. We have a motivated, “engagement-prone,” naturally selected group of people (personalities) that are ready, willing, and able to work, serve, and please us by meeting our organizational goals.

**The most effective tools for adult learning are those that are consistent and pervasive.**

In reality, the secret to engagement is to provide them a secure and nurturing environment, with clear structure,
mission, and vision supporting short, mid- and long-range goals.

Colin Powell said, “It is the job of leaders to eliminate uncertainty.” While I don’t think it is possible to eliminate all uncertainty, I do believe it is possible to eliminate uncertainty in the workplace regarding morals, values, ethics and beliefs, and goals.

The most effective tools for adult learning are those that are consistent and pervasive. We should have our values and mission statement and code of ethics (i.e., core values) plastered everywhere: on our Web sites; our rack cards and handouts; posters on our walls; on the back of employee ID/name badges; above the time clock (do you still use them?) . . . and most of all . . . in our employee orientation paperwork; in welcoming packets for new customers/patients; and at the bottom of every employee evaluation.

Certainly this is overly simplified. But it’s not just about having a vision and mission statement and posting your core values. There are more intermediate, real person-to-person strategies to employee engagement.

Even Jim Collins, author of numerous books on leadership, and his idea of having a BHAG (Big, Hairy, Audacious Goal) that the entire organization embraces is a bit too macro in approach. It is as if such things as engagement can be ordained. As we said earlier, successful engagement must be earned one conversation at a time!

I call these “PRO-PER conversations,” where PRO means professional and PER means personal. They are a critical and easy-to-achieve method of communication that follows three key steps and transforms us from individuals in potential conflict to a harmonious “team” collaborating to meet individual and organizational goals.

These conversations are not simply informational; they are transformational. They are rooted in validation and collaboration.

A PRO-PER conversation occurs on two levels: a professional plane and a personal plane. The individuals participating in the conversation, as well as their professional and personal needs, will be respected. An honest “three-step” exchange occurs methodically to move from conflict to collaboration. These steps are the keys to transforming the heart of caregiving:

- **Awareness:** When you recognize (or think you have recognized) a failed expectation, embrace it and express your feelings from a position of accountability. Don’t blame or make excuses: “Hello Mr. Jones. I feel as though I have let you down by not calling sooner. I am here now and will do everything I can to get things resolved. Did I let you down? What were your expectations of a return phone call?” At this point Mr. Jones (the PER) is able to safely express his disappointment or is invited to move away from these expectations and the emotional reasoning (a cognitive distortion) that he is using to allow himself to be upset for no rational reason.

- **Acceptance:** The next step is to recognize the inherent limitations in expectations by mutually establishing parameters. “Mr. Jones, I am passionate about this and totally committed to meeting your needs, but I need to know your expectations and acknowledge that I’m going to fail to meet them from time to time.” At this point, the PRO can establish ground rules and negotiate and commit, (i.e., promise to exceed these newly and jointly established goals). One-sided and perhaps unrealistic expectations are removed. Sometimes this doesn’t work, and you are left with a void. That may be all right, as you started with an expectation that had not previously been expressed, but a gallant effort was made to move forward.

- **Allowance:** Each individual is now encouraged to make and keep a commitment—a promise to each other and to the overall relationship. This is no longer two individuals having a potentially conflict-based conversation/relationship; it is, instead, now collaborative. “Mr. Jones, as we discussed, if you ever have an urgent need and you express it as such, I promise you that I or someone on our team will get back to you right away!”

Here is how to have a PRO-PER conversation:

- **Awareness:** When you recognize (or think you have recognized) a failed expectation, embrace it and express your feelings from a position of accountability. Don’t blame or make excuses: “Hello Mr. Jones. I feel as though I have let you down by not calling sooner. I am here now and will do everything I can to get things resolved. Did I let you down? What were your expectations of a return phone call?” At this point Mr. Jones (the PER) is able to safely express his disappointment or is invited to move away from these expectations and the emotional reasoning (a cognitive distortion) that he is using to allow himself to be upset for no rational reason.

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can be. Otherwise I promise to call within two days [or one day, whatever is the policy of the practice.] I want you to hold me accountable to keeping this promise!"

We have now created an engaged environment where we have chosen to allow one another into an accountable and collaborative relationship.

This is just one example. The PRO-PER designation does not imply that this exchange must be between a PROfessional and a PERsonal caregiver; however, it does imply that both professional and personal needs are being addressed. The process is simple:
1. You express and own a feeling that you want to validate (awareness).
2. You remain accountable for an unemotional honest exchange of limitations and expectations (acceptance).
3. You collectively and collaboratively commit (via mutual promises) that this dialogue is ongoing and circular if need be as your journey continues (allowance).
4. Each of these steps is rooted in engagement of the caregiver personality.

REFERENCES

Additional Reading

There are two books, in particular, that I have used in my own practice and in leading healthcare employees. The tips and suggestions in these books are perfect recipes to support the pre-engaged tendencies and needs and desires of caregivers. I highly recommend that you read these books.

In The Employee Engagement Mindset: The Six Drivers for Tapping into the Hidden Potential of Everyone in Your Company, by Timothy R. Clark (McGraw-Hill, 2012), Clark’s six drivers can be summarized as follows:
1. Connect: plug into the power! Develop great culture- and value-based relationships based on organizational mission, vision, and goals.
2. Shape: make it your own! Encourage customizing, personalizing, and tailoring professional experiences based on personal preferences while pursuing organizational goals, acknowledging real constraints.
3. Learn: move at the speed of change! Put people at the forefront of change in real-time. Engage them in the process rather than disseminating information/direction.
4. Stretch: go to your outer limits! Create and provide a “safe” environment that means leaving a comfort zone to push the outer limits of performance (a sort of “ask for forgiveness rather than permission” attitude with an overriding belief in and understanding of the guiding values/mission).
5. Achieve: jump into the cycle! It must be clear and present when you achieve. An awareness of achieving is the reward of “the stretch” and becomes self-reinforcing. Reward in and of itself!
6. Contribute: get beyond yourself! This is the ultimate and culminating driver of engagement. Wanting to make a difference! (Compare this to the caregiver personality taking satisfaction in pleasing others.)

The second book, Employee Engagement – 2.0: How to Motivate Your Team for High Performance; A “Real World’ Guide for Busy Managers, by Kevin Kruse (CreateSpace Independent Publishing Platform, 2012), provides a very practical approach, applicable to healthcare. Kruse encourages leadership to use the following four key elements to achieve true employee engagement:
- Communication;
- Growth;
- Recognition; and
- Trust.

The author offers a fantastic and fantastically easy acronym in order to remember these four keys; but I will not steal his thunder as I highly encourage you to buy his easy-to-read and practical book.
“Recalculating Route”

Neil Baum, MD*

If you travel with a GPS, it’s likely you’ve had this happen. Your GPS is programmed to get you to your destination in a safe and reliable way until you miss a turn or an exit on the freeway. You go straight instead of turning where the system wants you to turn, and in an irritated voice, the GPS responds with “recalculating route.”

It’s amazing how human the equipment sounds when you’ve gone against its recommendation. Maybe that happens in your medical practice, too. Your hospital does something like start hiring physicians that will compete with your practice, or an insurance company wants to renegotiate your contract and reduce your reimbursement. You find that you may be forced to “recalculate your route.”

It’s possible that there is a good reason for taking a new path instead of the familiar trail.

It’s possible, however, that there is a good reason for taking a new path instead of the familiar trail. Maybe you’ve been going the distance in your medical practice and using the same route or skills that you learned decades ago in medical school or in your residency or fellowship training. Maybe it’s time to change the direction or simply to recalculate your route.

THE INTERNET

Probably nothing has changed the course and direction of modern medicine more than the Internet. The Internet has leveled the playing field between doctors and patients. Just a few decades ago, physicians had all of the information, and patients merely accepted everything that the doctor told them. That was the day of coming to the doctor with a chief complaint, having an examination, and receiving a prescription, with the doctor patting the patient on the back and offering to see him or her again in a few weeks.

The modern patient arrives in the office with a briefcase or folder full of material that he or she has downloaded from the Internet.

Not today! The modern patient arrives in the office with a briefcase or folder full of material on his or her medical problem that the patient downloaded from the Internet. The patient has as much information as the doctor—or even more. Yes, much of it is inaccurate or not from credible sources, but, nonetheless, the patient has medical information. The doctor, therefore, must take into account the information that the patient has, sort out what is accurate and what is not, and then make recommendations and a plan of action that take into consideration the knowledge that the patient brings to the doctor-patient encounter. It is time to recalculate your route regarding the patient encounter: you can expect every patient is going to be Internet savvy, and you will no longer be the only one in the equation that has all of the information.

AFFORDABLE CARE ACT

In the past we enjoyed low volumes of patients and very acceptable reimbursements and profit margins. Not today! The passage of the Affordable Care Act means that between 20 and 40 million patients who were previously uninsured...
will be added to the healthcare system. Many of these previously uninsured patients will be older and sicker and require more time and medical resources. Compounding this situation is that there is no increase in the number of physicians being produced in our medical schools to care for this large number of patients that will be added to the healthcare system. As a result we will have to recalculate our route. We will have to become more efficient and be able to see more patients in the same amount of time, with the same staff, and yet preserve patient satisfaction.

FROM THE OPERATING ROOM TO THE OFFICE

Just a few years ago most procedures were conducted in the hospital, the operating room, or in outpatient surgery centers. Not today. More doctors are moving to an office-based practice where procedures once done in the hospital are now performed in the office setting. Thirty years ago, I performed five to six prostate operations a month in the hospital. Today, I perform a microwave procedure in the office under a local anesthetic. I estimate that in the near future 80% of all procedures will be done in the office or in one-day surgery centers, not in hospital operating rooms.

It’s time to recalculate your route if your route has been to offer robotic surgery to your patients, it may be time to consider hiring someone else to gather this information from new patients. Remember, doctors should do what only doctors can do, and delegate all other activities.

ANCILLARY INCOME

Only a few decades ago, doctors received a fee for their services, which included seeing patients in the office and performing procedures in the hospital. There was no opportunity for any additional income. Today it is different. We now have an opportunity to earn additional income by owning diagnostic equipment such as CT scanners, having in-office laboratories, and owning outpatient surgery centers. This opens up revenue streams that can compensate for decreased reimbursements that nearly every practice faces. If you don’t have any additional revenue streams beside the fees that your receive for the face-to-face care you provide, then recalculate your route.

USING NURSE PRACTITIONERS, MEDICAL ASSISTANTS, AND PHYSICIAN ASSISTANTS

Doctors for the most part are maxed out. They don’t have enough time to see the patients they already have. As recently as 100 years ago, nurses were not allowed to even take a patient’s blood pressure. Now physician assistants are assisting doctors and providing care for patients under a physician’s supervision, making the doctor more efficient and more productive. If you are micromanaging your practice and doing everything yourself, then it’s time to recalculate your route. It is time to delegate to nurse practitioners, medical assistants, and physician assistants. Again, what can easily be done by others should not be done by physicians.

OPEN SURGERY TO ROBOTIC SURGERY

Surgery has a long tradition of change and innovation. However, nothing has changed the course of modern surgery away from the traditional open surgical procedure more than the use of laparoscopy and then robotic surgery. Although the results of robotic surgery as compared with open surgery are controversial, the public and the media have touted the advantages of robotic surgery over traditional open surgery. If you are a surgeon and aren’t offering robotic surgery to your patients, it may be time to recalculate your route.

HOUSE CALLS TO OFFICE AND BACK TO HOUSE CALLS

Seventy-five years ago, doctors routinely made house calls. Then there came a period when doctors believed that they
needed more equipment than they could carry in their black bags and requested that the patients come to the office or meet them in the emergency department. Today the pendulum is swinging back to doctors once again making house calls. There is a budding industry of physicians who only conduct house calls and have reduced their overhead to their cell phone and their automobile. If you are in primary care, you may want to recalculate your route and offer house calls to your patients.

**FEE-FOR-SERVICE TO CONCIERGE MEDICINE**

Doctors have watched their reimbursements decrease and their incomes go south. (This might also be a reflection of poor investments and poor financial planning.) As a result, some established physicians with upscale patients who require more medical care are offering 24/7 access to the physician at an annual fee ranging from $1500 to $3000. This concept, concierge medicine, is catching on, and is attractive to physicians who don’t want to be involved with the paperwork that has been inundating the medical profession in the past two decades. If you have patients who can afford the annual fee and you are willing to offer this kind of service, you may consider recalculating your route.

**YELLOW PAGES TO SOCIAL MEDIA**

I began practice 35 years ago, and the first thing I did after placing my name on the door of my office was to obtain a small Yellow Pages ad in the local phone book. These days, I doubt even five patients per year locate me via the Yellow Pages. But hundreds are able to find me through the use of Google and social media. If you still have more than your name, address, and phone number and perhaps your practice Web site in small print in the Yellow Pages, then it’s time to recalculate your route.

**PAPER TO ELECTRONIC MEDICAL RECORDS**

For many years the standard of care was for physicians to make notes on paper for each patient and keep a file for each patient in a large filing cabinet. The computer changed all of that. We had to recalculate our paper route!

**Bottom Line:** Medicine is changing at a very rapid pace. It is difficult for physicians to keep up with all of these changes. However, the physician who doesn’t make modifications and changes is going to find him- or herself without patients to care for. Therefore, it is necessary to take a look at our practices from 20,000 feet up. If we don’t like what we see, then it just may be time to recalculate our route.
INSTRUCTIONS TO AUTHORS

An electronic version of the Instructions to Authors is available at www.greenbranch.com.

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ABC’s of PQRS
Your 2015 Guide to Successfully Participating in the Physician Quality Reporting System

By: Joy Rios, MBA, CHTS-PW

This practical, action-oriented guidebook by Joy Rios, MBA, CHTS-PW will help healthcare professionals navigate the new industry landscape, where providers are paid for reporting quality measures and will receive payment adjustments based on their performance rates.

Healthcare is moving from a pay-for-service model to a pay-for-performance model. Many in fact, arguably most—healthcare professionals do not understand how this will happen. It’s being introduced gradually through the Physician Quality Reporting System (PQRS) and the Value-based Modifier Program. Neither program is very well understood in the industry, yet if providers choose not to participate, they will start to see significant penalties—up to 9% reductions in Medicare reimbursements, depending on the size of the provider’s organization and their participation in other incentive programs. What’s more is that each provider’s quality results—whether good or bad—will be publicly available online as part of the Physician Compare program.

To avoid those penalties, healthcare professionals across the country must navigate the complex quality reporting system or pay the price. This book will help you learn the system and then work it.

ABC’s of PQRS gives you a full spectrum of content:

• Discussion of how the program came to be, to put PQRS in context
• Providing explicit examples of penalty scenarios
• Addressing the various ways to report (Registry, EHR, QCDR, Web Interface, Claims, and CAHPS)
• Examines how other quality programs are interrelated with PQRS—specifically the Value-based Modifier Program (VM)

If you are unclear about the program requirements, confused about how to start, are having difficulty knowing which measures to report, or you don’t understand how PQRS reporting will affect your future reimbursements, this book is for you.

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About The Author

Joy Rios, MBA, CHTS-PW, is a California native and a health IT enthusiast, with a passion for technology and sustainability. She regularly trains healthcare professionals on EHR Incentive (Meaningful Use), PQRS, and Value-based Payment Programs through online workshops.

A Certified Healthcare Technology Specialist with a focus on Practice Workflow, she writes regularly for various health IT publications; and she Tweets regularly at @askjoyrios.