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Cheryl Bisera is an author, speaker, and the founder of Cheryl Bisera Consulting, an image development and marketing firm focused on the healthcare industry. Her firm's key differentiators are attention to internal marketing, practice branding, and patient

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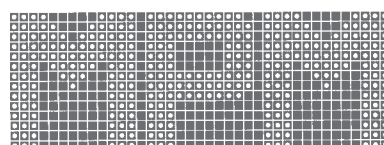
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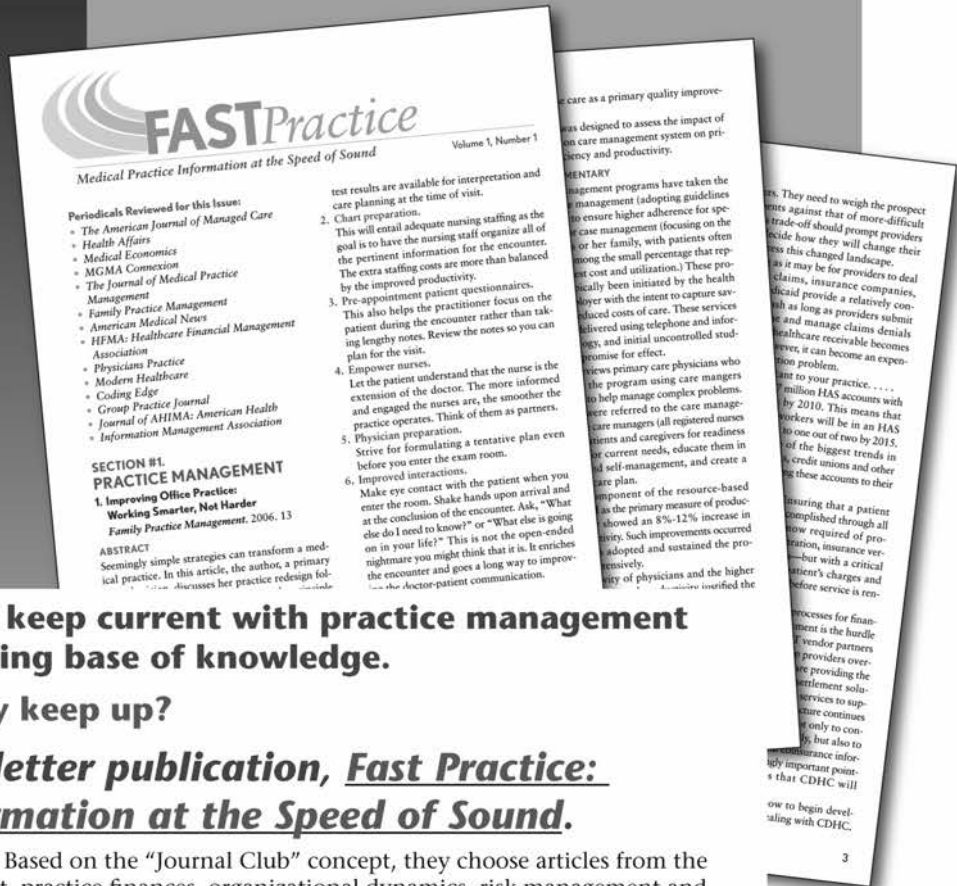
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Medical Practice Management

news

From the Editors of *The Journal of Medical Practice Management**

May/June 2016

INSURANCE

High-Cost Patients Split in Three Camps, Based on Insurance Status

The phenomenon of a small number of patients accounting for most of a payer's costs is consistent across Medicare, Medicaid, and commercial coverage, according to a new paper in the *New England Journal of Medicine*. But how those costs pile up is quite different, and the authors offer insights into how Accountable Care Organizations (ACOs) can direct interventions at the different patient groups, tailored to their distinct needs.

Claims data involving the costliest 1% of patients in each payer category for Partners HealthCare of Massachusetts were examined and uncovered some interesting facts:

- Among Medicare patients, the costliest 1% had an average of eight chronic conditions, most with cardiovascular risk factors. Common conditions were congestive heart failure and chronic kidney disease, suggesting the need for better care coordination. The average annual spending for these patients was \$146,584.
- Medicaid patients with high costs also had multiple problems, but the striking feature here was the high incidence of mental illness; almost a fifth had bipolar disorder. The situation seems to cry out for better care management strategies, especially among dual-eligible (Medicaid and Medicare) patients. Average annual spending

for these high-cost patients was \$85,347.

- For those with commercial insurance, the most common reason for high spending was a catastrophic injury or neurological event—something harder to predict. Fewer chronic conditions were seen here, and the chief challenge among this group is management of high-cost specialty pharmaceuticals. Average annual spending for the high-cost patients here was \$101,359.

As the authors note, the challenge for ACOs will be figuring out management strategies as they take control—and responsibility—for patients who have not previously had insurance. Moving away from the old fee-for-service model, by itself, may not be sufficient to bring down spending. There will have to be incentives in place to reward good care and cost-reduction of high-risk populations, they write, and contracts that spell out what these incentives are.

Source: *New England Journal of Medicine*, 2016; 374:203-205.

Government Halts Cigna's Medicare Advantage Enrollment

The Centers for Medicare & Medicaid Services (CMS) is imposing sanctions on Cigna as a result of a number of issues, including a "longstanding history of noncompliance." The government halted enrollment into Cigna's Medicare Advantage and prescription drug plans and has blocked the insurer from marketing its Medicare plans,

according to *The Wall Street Journal*. The timing of the penalty comes after the annual Medicare open enrollment period, which will limit the impact; and despite the sanctions, Anthem stated it remains committed to its \$48 billion acquisition of Cigna.

Source: www.ajmc.com/newsroom/what-were-reading-government-halts-cignas-medicare-advantagenrollmentutm_source=Informz&utm_medium=AJMC&utm_campaign=MC%5FMinute%5F1%2D25%2D16%sthshash.j1BWbDrs.dpuf

PRACTICE OPERATIONS

Examining a Healthcare Price-Transparency Tool: Who Uses It and How They Shop for Care

Calls for transparency in healthcare prices are increasing, in an effort to encourage and enable patients to make value-based decisions. Yet there is very little evidence of whether and how patients use healthcare price-transparency tools.

The authors of this *Health Affairs* article evaluated the experiences, in the period 2011-2012, of an insured population of non-elderly adults with Aetna's Member Payment Estimator, a Web-based tool that provides real-time, personalized, episode-level price estimates. Overall, use of the tool increased during the study period but remained low. Nonetheless, for some procedures the number of people searching for prices of services (called *searchers*) was high relative to the number of people who received the service

(called *patients*). Among Aetna patients who had an imaging service, childbirth, or one of several outpatient procedures, searchers for price information were significantly more *likely to be younger and healthier and to have incurred higher annual deductible spending than patients who did not search for price information*. A campaign to deliver price information to consumers may be important to increase patients' engagement with price-transparency tools.

Source: *Health Affairs*, April 2016

HIPAA Penalties and a New Ruling

On January 28, 2014, the Department of Health and Human Services' Office for Civil Rights (OCR) sent Lincare, Inc., a medical supplies firm based in Connecticut, a letter of determination indicating that it was in violation of HIPAA. The reasons for the violation were:

- Failing to "implement written policies and procedures to safeguard records containing protected health information (PHI) that the employees in its 1200 operating centers use daily to provide in-home services;
- Failing "to implement reasonable safeguards containing PHI of 278 name patients against disclosure to unauthorized persons;" and
- "Impermissible disclosure of the PHI of these 278 patients to an unauthorized individual."

On January 13, 2016, an administrative law judge granted the motion for summary judgment and upheld the imposition of \$239,800 in Civil Monetary Penalty against Lincare. During the course of the investigation, OCR discovered that Lincare had woefully inadequate policies and procedures.

Medical practices should be mindful of the following considerations regarding HIPAA guidelines and PHI:

1. Make certain that policies and procedures are comprehensive and address remote workers, as well as paper and electronic PHI.

2. Perform an adequate risk analysis and risk assessment annually.
3. Implement adequate technical, administrative, and physical safeguards, in keeping with various rules and regulations.

Source: www.physicianspractice.com/articles/new-ruling-shows-inescapability-hipaa-penalties#sthash.tGiJHMxp.dpuf

PROFESSIONAL DEVELOPMENT

Nine Surprisingly Simple Ways to Get People to Respond to Your E-mail

According to a practical article in a recent issue of Fast Company, office workers get an average of 120 e-mails every day! So getting your e-mail read (and getting a response) can be tricky. Here's how to increase your chances of getting of a reply:

1. **Ask for a response in your subject line.** It sounds simple, but sometimes all you need to do is ask for a response. Put "response needed" at the end of the subject line.
2. **Change the subject line when the topic changes.** The topic can change, especially during a long back-and-forth thread, making the original subject line inappropriate. By updating the subject line on that thread, you re-engage all readers.
3. **Don't skip the greeting.** When an e-mail starts without addressing the recipient by name, he or she could easily assume it was sent *en masse* and doesn't require a response.
4. **Start your message with a clear request.** Don't bury the purpose of your e-mail; start it by describing the response you want and your deadline. For example: "Please let me know by the end of the day if you can meet for lunch on the 21st."
5. **Stay in the sweet spot when it comes to length.** To boost your response rate by half, keep your e-mail between 50 and 125 words, according to a study by e-mail-marketing platform

Boomerang. Response rates declined slowly from 50% for 125-word messages to about 44% for 500-word messages. After that, it stayed flat until about 2000 words and declined dramatically.

6. **Use third-grade language.** E-mails written at a third-grade reading level with simpler words and fewer words per sentence are considered optimal. Use ReadabilityScore.com to check readability level.
7. **Use emotion.** The Boomerang study found that using a moderate amount of positive or negative emotion words—such as great, wonderful, delighted, pleased, bad, hate, furious, and terrible—increased an e-mail's response rate by 10% to 15% over e-mails that were neutral or strongly emotional.
8. **Use rich text.** Use bold and color to highlight the response you'd like to get. You can use bullet points to increase readability, and use a different color text to draw attention to deadlines.
9. **Be strategic about when you send your message.** Send it in the morning. E-mails sent then get the highest open rates.

Source: www.fastcompany.com/3058316/how-to-be-a-success-at-everything/9-surprisingly-simple-ways-to-get-people-to-respond-to-you

PATIENT CARE

Most Doctors Unsure How to Discuss End-of-Life Care, Survey Finds

Doctors know it's important to talk with their patients about end-of-life care. But they're finding it tough to start those conversations—and when they do, they're not sure what to say, according to a national poll. Medicare now reimburses doctors \$86 to discuss end-of-life care in an office visit that covers topics such as hospice, living wills, and do-not-resuscitate orders. Known as "advance care planning," the conversations can also be held in a hospital.

The poll of 736 primary care doctors and specialists examined their views on advance care planning and end-of-life conversations with patients. Among the findings:

- While 75% of doctors said Medicare reimbursement makes it more likely they'd have advance care planning discussions, only about 14% said they had actually billed Medicare for those visits.
- Three quarters believe it's their responsibility to initiate end-of-life conversations.
- Fewer than one-third reported any formal training on end-of-life discussions with patients and their families.
- More than half said they had not discussed end-of-life care with their own physicians.

Kaiser Permanente uses physician extenders to work with patients on various stages of what the HMO calls "life care planning." The HMO also offers a website to guide people through the process. Kaiser views it as a routine part of care, "just like you'd get a mammogram or colon cancer screening."

Source: http://khn.org/news/most-doctors-unsure-how-to-discuss-end-of-life-care-survey-says/?utm_campaign=KHN%3A+Topic-based&utm_source=hs_email&utm_medium=email&utm_content=28753246&_hsenc=p2ANqtz-QUyHvCoQrSQv6T2tD5pznAxOKwJmXwzgfJFNstKbtIj-XygsQ3W5DhcJJEpEsKZpl-6ts5p5618_i5KqMJuKR6oAoA&_hsmi=28753246

PHYSICIAN ISSUES

Six Reasons Why Doctors Get Scammed

Unfortunately, the observation is true, doctors do get scammed frequently. This article by James M. Dahle, MD, FACEP, explains the reasons why:

1. **No training in business, finance, or investing:** Doctors for the most part simply lack the financial knowledge required to avoid bad investments and outright scams. When you don't know what a good investment or a good advisor looks like, it is difficult to spot a bad one.

2. **Being busy:** A doctor is more likely to simply go along with a recommended investment without doing the proper due diligence simply because he or she does not have the time or energy to do it.
3. **Overconfidence:** Some doctors make the mistake of assuming that because they are good at one thing, that knowledge and ability will bleed over into other fields.
4. **Trust in professionals:** As a general rule, physicians trust other professionals far too much.
5. **Accredited investor income without accredited investor experience:** An accredited investor is defined as an investor with an income of over \$200,000 per year (or \$300,000 combined income if married) or more than \$1 million in investable assets. Accredited investors are considered to need fewer protections from regulatory agencies because the assumption is that such wealthy investors are both more sophisticated and more tolerant of potential losses. But there is no way a brand-new attending, who despite having a negative net worth qualifies as an accredited investor, has the financial sophistication to properly evaluate these sorts of deals.
6. **Specifically targeted:** Physicians are frequently targeted due to their naivety, trust in professionals, lack of sophistication, and especially high incomes.

Source: www.hcplive.com/physicians-money-digest/investing/6-reasons-why-doctors-get-scammed?utm_source=Informz&utm_medium=PMD&utm_campaign=PMD_3-31-16#sthash.2EbxdI42.dpuf

HUMAN RESOURCES

Writing Notes on Hiring Documents?

Consider these two cases of hiring managers scribbling notes about candidates on employment applications or resumes. This practice can

create a dangerous paper trail, so make sure your managers refrain from doing such:

1. After a company gave applicants written tests, it noted the applicants' race and gender on the test. The well-meaning goal was to assess whether the test had a disparate impact on minorities. A group of applicants sued for hiring bias, saying the practice amounted to an illegal, pre-offer inquiry. The court agreed and allowed a class-action case. (*Modtland v. Mills Fleet Farm Inc.*)
2. A female candidate for a position cried sex discrimination when she didn't land the job. She pointed to notes such as "pink glasses" and "short brown hair" written by one evaluator on her application. The court tossed out her case, noting that all of the evaluators gave her a low score. It believed the manager's explanation that his notes were an attempt to remember the applicant. Still, the company had to waste time and money in court. (*Davis v. Chevron, USA, Inc.*)

Source: *Records Management Today*, April 2016

A Great Escape for Teams

An entire industry has grown up around corporate team-building programs, from ropes courses, wilderness programs, and paintball to ice breakers and trust exercises. Team-building activities should bolster the work employees complete together or provide a genuine opportunity to relax and unwind. Some medical practices find these types of team-building programs a way to connect the employees and to have them work toward a common goal.

The "Escape Room Challenge" is among the latest team-building activities created by the Disney Meetings Team in Florida. Participants are split into small teams and placed inside specially constructed "rooms" where they must work together to solve clues in order to escape the room and

move on to the next challenge. Upon arriving, participants are first greeted by four unique characters who explain the objective of the challenge.

Source: *Meetings & Conventions*, April 2016

LEGAL

Surgeon Pays \$75,000 to Settle Charges He Wouldn't Treat HIV Patient

In a case that has shocked AIDS activists, an otolaryngologist has agreed to pay \$75,000 and attend discrimination training to settle charges he refused to operate on a patient when he learned the patient was HIV-positive. The charges were brought under title III of the Americans with Disabilities Act (ADA).

The settlement was announced by Robert L. Capers, U.S. Attorney for the Eastern District of New York. It resolves a case brought against William Sher, MD, by a patient. Because about 80% of patients with HIV infections present with otolaryngologic symptoms, otolar-

ynologists are often the primary physician at the point of diagnosis.

According to court documents, the physician cancelled just minutes before performing a scheduled procedure, citing the patient's HIV status. About a month later, a routine neck biopsy was successfully completed by a different surgeon. The tissue sample tested turned out to be cancerous.

Source: www.hcplive.com/medical-news/surgeon-pays-75k-to-settle-charges-he-wouldnt-treat-hiv-patient?utm_source=Informz&utm_medium=HCPLive&utm_campaign=Trending_News_3-11-16#sthash.LvzxfgiG.dpuf

California Hospital Pays More than \$3.2 Million Over Potential Stark Violations

Tri-City Medical Center, a hospital located in Oceanside, California, has agreed to pay \$3,278,464 to resolve allegations that it violated the Stark Law and the False Claims Act by maintaining financial arrangements with community-based physicians and physician groups that violated the Medicare program's prohibition on financial relationships between hospitals

and referring physicians. The Stark Law forbids a hospital from billing Medicare for certain services referred by physicians who have a financial relationship with the hospital unless that relationship falls within an enumerated exception.

The settlement announced resolves allegations that Tri-City Medical Center maintained 97 financial arrangements with physicians and physician groups that did not comply with the Stark Law. The hospital identified five arrangements with its former chief of staff from 2008 until 2011 that, in the aggregate, appeared not to be commercially reasonable or for fair market value. The hospital also identified 92 financial arrangements with community-based physicians and practice groups that did not satisfy an exception to the Stark Law from 2009 until 2010 because, among other things, the written agreements were expired, were missing signatures, or could not be located.

Source: www.justice.gov/opa/pr/california-hospital-pay-more-32-million-settle-allegations-it-violated-physician-self-O

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Is Washington Finally Catching Up with the Volume-to-Value Shift in Regards to Paying Doctors?

Mark Reiboldt*

In late April, federal healthcare officials released a statement announcing that the Centers for Medicare & Medicaid Services (CMS) is preparing new plans that will entail significant changes in the current physician reimbursement model under Medicare and other federal healthcare reimbursement programs. According to Kaiser Health News, “Federal officials have unveiled their roadmap to a revamped Medicare physician payment system designed to reward doctors and other clinicians for the quality of care delivered, rather than the quantity.”¹ This statement came after much discussion over the past two years between CMS and industry representatives indicating that such changes were desperately needed, as the U.S. healthcare system as a whole continues to evolve, thus requiring new payment models for clinical services.

The need for updating the model in which clinicians and healthcare entities are reimbursed for services under various government-sponsored programs, such as Medicare, is no new trend within the industry. For more than a decade now, there have been extensive policy debate and legislation efforts around physician payment models under Medicare. Some of these efforts have seen varying levels of success; however, the majority of policy efforts on this subject have amounted essentially to temporary bandages aimed at preventing major cuts to Medicare reimbursement that would have dramatic negative results for clinicians and healthcare organizations.

With the general discussion around the need to change Medicare payment models not being very new to most people within the healthcare industry, the significant element to this recent announcement is the fact that CMS appears to finally be moving toward models that account for the bigger picture shift that is currently taking place across the healthcare system as a whole. But what is this shift exactly?

Over the last two to three years, an evolution has been occurring in the nature of the healthcare system’s core delivery models and related economic drivers. Some

of the key trends or drivers include clinical integration, hospital-physician alignment, Accountable Care Organizations, population health management, and other related trends. We generally refer to this macro-level evolution as the “volume-to-value shift,” which primarily refers to the fact that healthcare providers are moving toward centering their services and economic models on quality-based performance, as opposed to volume-based factors that the system has relied upon up to this point. Such a shift will ultimately allow for greater quality in services and improved outcomes, which are not only favorable results for the healthcare system, but critical necessities for healthcare consumers (i.e., patients) going forward.

But simply hoping for and wanting to move toward a system that is centered on quality over quantity is not enough. The system must support such a framework, which means we must develop and adopt the structures that allow such models to work in open market enterprise environments. Simply put, we must have an economic framework in place that allows clinicians and healthcare organizations to receive adequate and appropriate financial returns for centering their operations on things like quality, versus the current model that for the most part can be boiled down to a transaction-based, volume-driven payment model. And we have seen that when a clinician or organization is focused more on volume as the key to secure its individual and/or organizational financial viability, there is often a correlation to a decline in the quality of those services.

As such, there must be models in place that support a framework that is centered on quality as the driving value. And this ultimately means the payment models must be structured in a manner that incentivize those delivering health services to shift their focus from the current volume-based mindset to one that is centered on quality, outcomes, and generally improved results. With such a framework in place and this type of dramatically different mindset adopted, most clinicians and healthcare organizations have overwhelmingly agreed that we will then begin to see major shifts in quality and outcomes related to medical care and even the general health of the American patient population.

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Based on the recent statements from CMS, it now seems as though the federal government has finally come to the realization that in order to achieve success as ambitious as changing the overall health of the broader patient population (which is also a key component of the Obama administration's healthcare reform efforts), we will ultimately need to see significant changes to the antiquated CMS payment models. Moreover, despite the fact that the industry has been attempting to communicate this message to the administration and policymakers in Washington for some time now, the big question has remained whether the government would actually make the leap toward a shift of this scale.

The fact is that in the current healthcare marketplace, such frameworks that allow for physicians to shift their compensation models toward quality metrics versus the traditional productivity-based structures have been developed using a variety of specific approaches and deployment strategies. Further, such structures have been implemented and are currently in place within health systems across the country. However, all of these models have been restricted to private-based, managed care contracts and/or have been limited in scale (i.e., only within specific insurance carriers/plans, limited to designated patient populations, geographies, etc.). But if CMS is successful in shifting the Medicare reimbursement model toward such frameworks centered on quality and value, this would undoubtedly be the most dramatic step forward the industry could ultimately take toward achieving the broader-scale volume-to-value shift.

Undoubtedly there are still many questions that remain, and of course the devil with such matters is always found in the details, as well as the execution. There are still a number of barriers in place that have made this shift move slower than perhaps it could be otherwise moving. For instance, the standards for fair market value (FMV) and commercial reasonableness guidelines pertaining to physician compensation must also evolve in such a way that allows for compensation to be aligned more closely with quality-based drivers. Health systems across the country are including quality components in their compensation models for employed and/or aligned physicians. However, current FMV guidelines restrict the overall allocation of physician compensation that is tied to quality metrics, versus the

majority of their compensation models continuing under productivity standards.

The good news is that the market certainly does not have to start from scratch with developing and implementing such plans. Despite the fact that most health systems do not yet tie the majority of physician payments to quality and value metrics, we are now reaching a point where most health systems that have pursued physician alignment partnerships have integrated some quality elements within the overall physician compensation framework. Thus there are models currently in place, which have seen a great deal of success over the last 12 to 24 months in a wide range of healthcare delivery settings (meaning these are not working only in academic facilities, major acute care settings, or other limited-market constituencies). Overall, hospitals and physician-owned entities have found a number of ways that allow them to shift their focus toward quality and value while not having to sacrifice financial stability or compromise themselves legally.

Perhaps the most significant message here, however, is that *if* the government truly is finally willing to consider dramatic changes in Medicare reimbursement to account for such trends and *if* the government is flexible in terms of its parameters and willingness to work with private stakeholders, then the specifics around how this is ultimately achieved should not hold up the industry significantly. And while these are indeed big "ifs," they are not insurmountable barriers to success. Will it take time? Of course; everything in the U.S. healthcare system does, especially when it involves major shifts in government policy as this will. Will there be plenty of setbacks, likely originating from political jockeying and election cycles? Certainly, but again this is nothing new to the healthcare industry.

But if we are moving toward a goal that is ultimately shared by the government and industry players, and with a sufficient dose of compromise and collaboration between the government and all industry stakeholders, then this could legitimately mark one of the greatest steps forward our country will have made in this century. ■■

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Four Simple Steps to Conduct an Assessment of Your Practice

Valora S. Gurganious, MBA*

Medical practice management has never been more complex than it is today, with volumes of rapidly changing regulations, increasing cost pressures, and rising quality standards under the Affordable Care Act. These challenges have made it more critical for practices to assess their current position in order to determine how best to move the practice forward. A practice assessment begins with four simple steps: an evaluation of the long-term goals and motivation of the practice's owner; a review of key practice financials and how successfully the practice captures every dollar to which it is rightfully entitled; a measure of provider productivity and strategies to improve it; and an assessment of the talent and morale of the team of professionals at the practice.

KEY WORDS: Assessment; evaluation; operations; strategic plan; metrics; production; collections; patient satisfaction; growth.

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A generation ago, healthcare providers could count on having a stable, financially rewarding career by achieving a few straightforward objectives:

- Complete clinical training and attain requisite licenses/certifications;
- Deliver excellent patient care;
- Document, code, and collect payment efficiently;
- Control overhead and operating expenses; and
- Build and grow strong referral and patient relationships.

In the 21st century, the world of medical practice is no longer quite so simple. Providers now are subject to merit-based reimbursement models designed to pay for performance. They must report their compliance with treatment protocols, their outcomes for episodes of care, costs of care, and their activities in coordinating care with other members of a patient's care team. They must utilize electronic medical records in a "meaningful" way, all while complying with ICD-10 coding, new documentation requirements, and regulatory guidelines.

How can a practice leader establish a plan for success in light of all of these complex changes? Begin with a practice assessment. An assessment by the practice manager or consultant will help you evaluate your practice's current strengths and deficiencies, then set priorities that will drive its future success.

PRACTICE ASSESSMENT STEP 1: DETERMINE THE OWNER'S LONG-TERM GOALS AND MOTIVATION

Investigate the practice owner's strategic objectives and timeline. Is the provider at the beginning, plateau, or wind-down phase of his or her career? Regardless of the phase of the owner's career, financial success is essential to maintaining a practice's independence and sustainability, to growing the value of the enterprise, and to making it attractive and valuable to a prospective buyer at a strong multiple of EBITDA (earnings before interest, taxes, depreciation, and amortization).

A practice must make money for the owner, even if he or she elects to see fewer patients personally. The talent, facility, referral base, and operations of the practice should be successful enough to run smoothly and profitably with or without the owner as a full-time provider. If the owner has not yet achieved that, the practice manager or consultant must put the practice on course to build its "enterprise value," which can sustain and appreciate over time, and will be an asset that can be sold at an attractive future valuation.

The practice manager or consultant must consider strategies to develop referral relationships, improve operations, market the practice, grow revenues, and build cash flow

over time. Growth can be achieved by adding midlevel providers, specialty equipment, or service lines to distinguish the practice from its competitors and diversify its sources of income.

PRACTICE ASSESSMENT STEP 2: ASSESS PRACTICE FINANCIALS

How is the practice performing relative to its long-term objectives and relative to its peers? Pull the profit-and-loss statements and balance sheets for the last two or three years. Have practice profits and net assets grown, plateaued, or shrunk? What was the most significant category of that change? If the top line, or revenues, shrank, it is time to drill down to evaluate why.

Review patient volume and see whether fewer patients are visiting the practice than before. If so, are fewer calling to make appointments? Is the provider working fewer clinic days? Has a competing practice begun to lure away patients? Ask more questions of the front desk staff and even local sales reps to learn what your patients are saying, where they may be going, and why they are not continuing their care with this practice. Evaluate the causes of this negative trend by “mystery calling” former patients. Consider e-mail marketing to patients; get active on social media; and promote your practice’s unique services, specialties, or even extended hours on one day per week. Institute a patient recall program to get patients back in for annual visits. Your patients need to hear that you value their health and want to maintain their relationship with your practice.

The majority of outstanding insurance A/R should be 35 days or less.

Review insurance accounts receivable (A/R). If insurance A/R is increasing, take a closer look at the revenue cycle process. Confirm that patient demographics and insurance eligibility are confirmed with every visit. Be certain a certified coder (trained in ICD-10) is entering charges and confirming that the code(s) used have appropriate supporting documentation. Check that denials are worked and clean claims are resubmitted. Review electronic remittances and ensure that insurance payments are posted by a staff member *other than* the individual who entered the charge (to avoid inappropriate write-offs).

Review insurance aging. The majority of outstanding insurance A/R should be 35 days or less, according to Medical Group Management Association metrics. Payers such as Medicare typically process timely filed payments within 14 days, so the vast majority of outstanding payments should be less than one month. Table 1 shows metrics for the target aging distribution.

Table 1. Benchmark Percentages of Aged Accounts Receivable

A/R Aging Performance Metric for No. Days in A/R	Percentage of Total Insurance A/R
0–30	70–75
31–60	12–15
61–90	5–8
91–120	3
≥120	1

A/R, accounts receivable.

Source: MGMA 2014 Accounts Receivable and Aging Performance Metric.

If the practice’s A/R differs significantly from those metrics, a coding and documentation audit may be necessary. There may be a substantial number of denials due to coding errors, modifiers may have been missing, prior authorizations may not have been obtained, or certain codes may now be bundled that previously were paid separately. Make notes from each explanation of benefits by payer and by codes to monitor common themes, and, if a change is identified, communicate that change to providers and coding staff to avoid future errors.

Review patient A/R. With the proliferation of health insurance exchange plans and high-deductible plans, every patient’s eligibility and benefits must be checked at each visit. If a high copay or deductible is due, collect it at check-in.

Update your patient financial responsibility form to authorize the practice to maintain a credit card on file (encrypted to protect patient’s account number) through your merchant service card processor, and obtain the patient’s permission to charge any remaining patient responsibility that may remain after insurance adjudication. For patients who do not grant such authorization, reach out to them via your secure, private patient portal, inform them that they have a balance due with the practice and permit them to pay online via credit card. If balances remain unpaid, send statements of increasing intensity every two weeks for four statement cycles, and thereafter follow your practice’s standard debt collection protocols.

PRACTICE ASSESSMENT STEP 3: MEASURE PROVIDER PRODUCTIVITY

Estimate each provider’s current volume and productivity. Using a calendar spreadsheet, enter the initials of each provider scheduled to see patients in clinic each “AM” and “PM” for every day of the month. Count how many half-day clinic sessions each is available in the office each month. Review two or three months of past clinic schedules to calculate the average actual number of patients each provider has treated during each half-day session. You may observe very different levels of productivity among providers

because some providers work more quickly than others. This may be due to the nature of the patients that they treat (e.g., one provider may see more older patients with more complex illnesses than other providers), their speed with documentation, or even their use of midlevel providers. This report card will highlight their relative productivity, and encourage a careful reflection on their relative pace, patient mix, and efficiency, and enable all providers to open a dialogue on *how* each of them can work smarter and be more productive.

Calculate the financial impact of a moderate improvement in productivity. Compute the average payment (based on Medicare rates for, say, a Level 3 established patient office visit), and calculate the “opportunity cost” of the less productive provider’s lower volume, so providers have a sense of how their productivity has impacted their bottom line. View the most productive provider’s monthly volume and compare it to the monthly volume of the least productive. Multiply this difference by the average reimbursement per visit to compute how much practice revenues could grow if the lower producer’s output increased to a volume closer to that of the top producer.

Although achieving a productivity improvement that equals that of the top producer is hardly ever achieved or sustained, this will open the dialogue for providers to exchange tips to speed patient turnover, work-ups, conversation with the patient, evaluations, computer data entry, and so on. Top producers may be excellent mentors to help lower producers learn to practice good medicine more efficiently and more profitably.

PRACTICE ASSESSMENT STEP 4: ASSESS THE TALENT AND MORALE OF THE TEAM

Labor is the single largest expense category at the practice, totaling between 25% and 30% of total revenue. Your human resources, however, often are not regarded as the “asset” that they should be. In a service business such as healthcare, your staff is your “front line,” and staff members can make the patient experience either wonderful or horrible, which could taint an otherwise outstanding provider encounter. Your people matter, and can make an average practice great, or can bring down patient satisfaction scores of an otherwise extraordinary episode of care.

As a critical part of your practice assessment, interview every member of the medical practice’s staff to learn about their personal backgrounds and qualifications for their job, the adequacy of the resources that they use every day on the job, the culture of the organization, and what they identify as opportunities for improvement. They may be unhappy and frustrated or very optimistic about the practice as a place to work and deliver quality care. It is valuable to ask those on the practice’s front line how they feel

about the practice, because invariably their attitude shows through and is immediately transmitted to patients.

Evaluate team members’ skill sets and how well their role is matched with their own training and aptitudes. An employee who is not a “people person,” for example, is usually ill suited for the front desk or telephone clerk, and may be better suited for medical records, scheduling, or billing. If the culture of the organization is not conducive to learning, process improvement, or open communication among management and the staff, problems are not easily resolved, frustration builds, and poor customer service is the result.

Investment in your human assets almost always yields a positive return on investment.

Do the employees have suggestions or recommendations to improve patient flow, reduce wait times, raise patient satisfaction, and conserve expenses? They are often the best source of ideas, and many of their recommendations do not cost money or require major reorganization. They may be as simple as streamlining the patient registration process, shifting clinical tasks, or even relocating work spaces to another area to improve efficiency. Other suggestions would include enrolling staff in skill building classes or encouraging them to achieve certification in their area to “raise the bar” and invest in staff development. Investment in your human assets almost always yields a positive return on investment.

CONCLUSION

A practice assessment is an overall review of the practice’s effectiveness in delivering excellent patient care efficiently, professionally, and in a manner that permits sustained or improving profitability over time. The practice manager/consultant can use an assessment to drill down to evaluate the practice’s current deficiencies, and identify future opportunities to correct them and position the practice for future growth.

The steps to preparing a practice assessment are simple:

- Determine the long-term goal of the practice’s owner and his or her motivations.
- Thoroughly review the practice financials and understand the drivers of that performance.
- Measure provider productivity and develop strategies to improve it.
- Assess the talent and morale of the team of professionals working at the practice, and consider their input for ideas on process improvement and expense reduction.

With this foundation of information, the practice manager/consultant can get the practice on track and position it for both short- and long-term success! ■■

Modified Stage 2 and Stage 3 Meaningful Use for Eligible Providers: Performance Metrics, Reporting Period Lengths, and Hardship Exemptions

Richard Self* and Janis Coffin, DO, FAAFP, FACMPE†

In October 2015, the Centers for Medicare & Medicaid Services released its final rule on the new guidelines for alterations to the long-standing EHR Incentive Program. These Modified Stage 2 and upcoming Stage 3 Meaningful Use Rules were developed in response to provider and organizational feedback during the last few years. This article provides a comprehensive overview for the new rules as they relate to Medicare and Medicaid Eligible Providers. Reporting deadlines for previous calendar year compliance and the basic criteria for automatic provider hardship exemptions to avoid reimbursement penalties also are discussed.

KEY WORDS: EHR Incentive Program; Medicare; Medicaid; Meaningful Use; CMS; Stage 3; Modified Stage 2

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CHANGES TO MEANINGFUL USE CRITERIA

The recent Modified Stage 2 and Stage 3 Meaningful Use guidelines published in October 2015 are based predominantly on two previous proposed rule sets from March and April of that year, amended after Congressional testimonials and substantial physician and provider feedback during the interim.¹ In the 195-page report, the Centers for Medicare & Medicaid Services (CMS) outlined its primary overarching goals as: (1) providing an overall simplification of program requirements; (2) providing greater flexibility within certain Meaningful Use objectives; (3) providing optional participation in Stage 3 up to 2017 with the ability for current participants to use a “modified” set of Stage 2 rules; and (4) emphasizing new rules targeting improvements in interoperability between systems. CMS defined its mandatory rules for 2015–2017 as a continuation of 10 modified Stage 2 objectives spanning 15 discrete measures. This is a decrease from previous Stage 2 requirements due to removal of measures that CMS ruled as redundant or “topped out.” The years 2016 and 2017 will witness optional early adoption of eight final Stage 3 objectives spanning 21 measures, with the hard deadline for universal adoption among eligible providers set starting in 2018. Tables 1 and 2 summarize current measures with both exclusion criteria and alternative measures.

COMPLIANCE REPORTING DEADLINES AND PERIOD LENGTH

CMS has also overhauled its reporting period definitions to only 90 continuous days for both current program participants in 2015 and new participants in their first year in the program up to 2018. The period becomes 12 months, however, after this grace period. Attestation to avoid payment adjustments in following years for noncompliance to Meaningful Use standards also were listed in the report (Table 3).

HARDSHIP EXEMPTIONS FOR ELIGIBLE PROVIDERS

For providers who are having difficulty in meeting program requirements, CMS offers a hardship exemption application that becomes available after each reporting deadline.² The application is published only during this period, and specific information about the exemption can be found at the CMS website.³ The deadline for exemption applications from 2017 payment adjustments for noncompliance is July 1, 2016. These applications are evaluated on a case-by-case basis and must be resubmitted for each year of noncompliance. According to current CMS rules, no provider will be granted a hardship exemption for longer than five years. If a provider both fails to meet Meaningful

Table 1. List of Measures for Mandatory Modified Stage 2 (2015-2017)

	Modified Stage 2 Meaningful Use Measures	Exclusions/Alternate Measures
1.	Review EHR practices to ensure ongoing alignment with HIPAA security standards and provide necessary updates*	None
2.	Implement five clinical decision support interventions for at least four clinical quality measures related to scope of practice or high-priority health conditions	Stage 1 participants for 2015 only need to implement one clinical support intervention for a measure related to either specialty or high-priority health conditions
3.	Full implementation of drug interaction and drug allergy tools for entire reporting period	Excludes providers with <100 medication orders during the reporting period
4.	>60% of medication orders for period are through CPOE	Excludes providers with <100 medication orders during the reporting period. Stage 1 participants for 2015 only have a threshold of >30%
5.	>50% of lab orders for period are through CPOE	Excludes providers with <100 orders of this type during the reporting period
6.	>30% of radiology orders for period are through CPOE	Stage 1 participants for 2015 and 2016 are excluded from these requirements
7.	>50% of permissible medication scripts are transmitted to pharmacy electronically through EHR	Excludes providers with <100 medication orders during the reporting period and those without an in-house pharmacy or capable pharmacy within 10 miles of practice† Stage 1 participants for 2015 only have a threshold of >40%
8.	Transfers of care/referrals require use of EHR to generate a care summary; >10% of these must be electronically submitted	Excludes providers with <100 transfers during the reporting period Stage 1 participants for 2015 only are excluded from this requirement
9.	>10% of office visits receive clinically relevant patient special education materials identified through the EHR	Excludes providers with no office visits during the reporting period Stage 1 participants for 2015 only are excluded from this requirement if they did not intend to demonstrate the Stage 1 equivalent
10.	>50% of patients have medication reconciliation performed when transferred into the provider's care	Excludes providers who do not receive transitions of care during period Stage 1 participants for 2015 only are excluded from this requirement if they did not intend to demonstrate the Stage 1 equivalent
11.	>50% of patients provided access to view, download, or transmit electronic records to third party within four business days of patient visit‡	See additional footnotes below
12.	2015-2016: A single patient views, downloads, or transmits electronic records to third party‡ 2017: >5% of patients view, download, or transmit electronic records to third party‡ (Both requirements are subject to provider discretion to withhold certain information.)	Stage 1 participants for 2015 only are excluded from this requirement
13.	2015: Capability to send secure electronic messages from providers to patients/patient representatives is fully enabled through length of reporting period‡ 2016: One message sent via system‡ 2017: 5% of unique patients sent messages via system‡	Stage 1 participants for 2015 only are excluded from this requirement
Providers must meet ≥2 of the last three listed measures to satisfy requirements, with the immunization reporting measure not qualifying for optional exclusion. Stage 1 participants for 2015 only must meet just one of the last three listed measures. Providers will have the possibility to be exempt from any or all three if measure-specific exclusion criteria are met. All three measures below (items 14, 15, and 16) may exclude providers who practice in jurisdictions without capability or readiness to accept electronic records pertinent to the measure in the public health agency systems.†		
14.	Provider actively submits electronic immunization data to a public health agency	Excludes providers who do not provide immunizations to populations for which data is collected during the reporting period

(Continued on next page)

Table 1, continued

	Modified Stage 2 Meaningful Use Measures	Exclusions/Alternate Measures
15.	Provider actively submits electronic syndromic surveillance data to a public health agency	Excludes those who are not in a category of providers in which ambulatory syndromic surveillance data are collected in their jurisdiction
16.	Provider actively submits electronic specialized registry data to a public health agency	Excludes providers who do not either: (1) diagnose or treat any conditions relevant to specialized registries in their jurisdiction; or (2) collect data relevant to specialized registries in their jurisdiction during the reporting period

*Health information privacy: guidance on risk analysis. HHS.gov. www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html. Accessed December 13, 2015.

†Exclusion only valid if criteria are met at the beginning of the EHR reporting period chosen.

‡Excludes providers with >50% of their patient encounters in a county with >50% of households without 4Mbps broadband capability, as determined by the FCC at start of reporting period.

EHR, electronic health record; CPOE, computerized provider order entry.

Source: Reference 1.

Table 2. List of Final Measures for Stage 3 (2018 and Beyond)

	Final Stage 3 Meaningful Use Measures	Exclusions/Alternate Measures
1.	Review EHR practices to ensure ongoing alignment with HIPAA security standards and provide necessary updates*	None
2.	>60% of permissible medication scripts transmitted to pharmacy electronically through EHR	Excludes providers with < 100 medication orders during the reporting period and those without an in-house pharmacy or capable pharmacy within 10 miles of practice†
3.	Implement five clinical decision support interventions for ≥4 clinical quality measures related to scope of practice of high-priority health conditions	None
4.	Full implementation of drug interaction and drug allergy tools for entire reporting period	Excludes providers with <100 medication orders during the reporting period
5.	>60% of medication orders for period are through CPOE	Excludes providers with <100 orders of this type during the reporting period
6.	>60% of lab orders for period are through CPOE	
7.	>60% of radiology orders for period are through CPOE	
8.	>80% of patients allowed within four days to view, download, or transmit electronic records to third party and can view via a Web-interfaced program of their choice‡ (Subject to provider discretion to withhold certain information)	See additional footnotes below
9.	>35% of office visits receive clinically relevant patient special education materials identified through the EHR	Excludes providers with no office visits during the reporting period
10.	>10% of patients view, download, or transmit electronic records to a third party via a Web-interfaced program of their choice‡	
11.	>25% sent/received secure electronic messages between patients and providers based on total patients seen over the period‡	
12.	>5% of patients have nonclinical (e.g., self-generated) data entered into EHR‡	
13.	>80% of transfers of care/referrals/new patients have medication, medication allergy, and current problem list reconciliation performed when transferred into the provider's care	None
14.	>50% of transfers of care/referrals to other providers require use of EHR to generate care summary, and they must be electronically submitted‡	Excludes providers with <100 transfers during the reporting period
15.	>40% of transfers of care/referrals received require incorporation of the received summary of care into the EHR‡	
16.	Provider actively submits electronic immunization data to a public health agency**	Excludes providers who do not provide immunizations to populations for which data is collected during the reporting period
17.	Provider actively submits electronic syndromic surveillance data to a public health agency**	Excludes those who are not in a category of providers in which ambulatory syndromic surveillance data is collected in their jurisdiction

(Continued on next page)

Table 2, continued

	Final Stage 3 Meaningful Use Measures	Exclusions/Alternate Measures
18.	Provider actively submits electronic reportable case data to a public health agency**	Excludes providers who do not diagnose or treat any reportable conditions during the reporting period
19.	Provider actively submits electronic public health data to a public health registry**	Excludes providers who do not diagnose or treat any conditions associated with the public health registry during the reporting period
20.	Provider actively submits electronic clinical data to a clinical data registry**	Excludes providers who do not obtain any clinical data associated with the clinical data registry during the reporting period
21.	Provider actively submits reportable laboratory results to a public health agency**	Excludes providers who do not obtain any laboratory results considered reportable during the reporting period

*Health information privacy: guidance on risk analysis. HHS.gov. www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html. Accessed December 13, 2015.

†Exclusion valid only if criteria are met at the beginning of the EHR reporting period chosen.

‡Excludes providers with >50% of their patient encounters in a county with >50% of households without 4Mbps broadband capability, as determined by the FCC

**Excludes providers who practice in jurisdictions without capability or readiness to accept electronic records pertinent to the measure in the public health agency systems at least six months prior to the start of the reporting period.

EHR, electronic health record; CPOE, computerized provider order entry.

Source: Reference 1.

Table 3. Reporting Period Length and Attestation Deadlines by Year for Eligible Providers

First Year of Compliant Participation	Minimum Reporting Period Length	Attestation Deadline for Payment Adjustment Year*			
		PAY 2016†	PAY 2017	PAY 2018	PAY 2019
2015 and before	90 days (2015); 12 months onward	February 29, 2016	February 29, 2016	February 28, 2017	February 28, 2018
2016	90 days (first year); 12 months onward	–	October 1, 2016	February 28, 2017	February 28, 2018
2017	90 days (first year); 12 months onward	–	–	October 1, 2017	February 28, 2018
2018 and onward	12 months	–	–	–	October 1, 2018

*For all new participants or noncompliant providers, the reporting period for the first deadline is the most recent year of compliant participation. The reporting period for compliant returning participants is the full year prior to the deadline.

†2016 payment adjustments only apply to new participants or eligible providers who have not met Meaningful Use requirements in the previous year.

PAY, payment adjustment year.

Source: Reference 1.

Table 4. Providers Automatically Granted Hardship Exemptions

New providers practicing in their first year
Providers who have 90% of covered services or claims in either hospital-based inpatient units, outpatient observation services (based on a hospital campus), or hospital-based emergency departments. (Place of Service Codes 21, 22, and 23, respectively.)
PECOS specialties (05-Anesthesiology; 22-Pathology; 30-Diagnostic Radiology; 36-Nuclear Medicine; 94-Interventional Radiology) six months prior to the first day of the payment adjustments.

PECOS, Provider Enrollment, Chain and Ownership System.

Source: Reference 1.

Use requirements and is not granted hardship exemption, the Physician Fee Schedule will be decreased by 2% for payment adjustment year (PAY) 2016 and 3% for PAY 2017

and 2018, as the rules are currently written. Some providers are automatically granted hardship exemptions based on certain criteria (Table 4). ■■

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Leadership Strategies: Achieving Personal and Professional Success

Ronald Menaker, EdD, FACMPE*

Physicians and allied health staff in healthcare are finding themselves in situations characterized by uncertainty, chaos, and ambiguity, with high levels of burnout. A major influence is an aging U.S. population, resulting in increasing cost and reimbursement pressures. Medical group practices need leaders who have the capability to thrive in this environment. This article presents an integrated leadership model offering strategies and insights gained from keeping a journal for 40 years. Strategies to be shared include leading self through learning, leading others by developing relationships, leading organizations by achieving excellence, and achieving work–life integration and synergy.

KEY WORDS: Leadership strategies; leadership; work–life balance; interpersonal relationships; emotional intelligence; journaling; professional success.

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After completing graduate school and starting a career, it became clear that my formal schooling had provided a firm foundation to begin employment. There was, however, a need to develop my abilities in self-management, including stress management and building relationships with others. To help me improve these abilities, I started to journal my thoughts, inspirations, and frustrations. I carried this journal so I could capture important reflections and leadership concepts at the moment they occurred to me. Entries involved observations, stressors, concerns, successes, and failures. The journal provided me an immediate opportunity to capture the thought, emotion, or inspiration I was experiencing at that moment.

Writing these entries was also cathartic. As a manager, I was often confronted with high-conflict or high-risk situations. I was often tempted to act defensively or negatively, but I knew the release of negative emotion often causes damage. The journal allowed release of emotion in a positive and private way.

The journal also became a tool of lifelong learning. It helped me capture moments of creativity and inspiration so I could use them as intellectual capital to enrich my practice. I also recorded reflections that occurred during times of disappointment, rejection, or depression. A friend once told me that good judgment comes from experience, and experience sometimes stems from bad judgment. If I could

capture the wisdom gained from bad judgment, it would, I reasoned, help me improve my effectiveness as a leader.

As I gained experience, my focus and journal entries shifted from growing and self-learning to developing relationships and leading others. Over time I extended the learning to achieve organizational excellence. Although the early years were relatively stress free, the responsibilities of marriage, children, and home ownership combined with more stress and responsibilities at work led me to a fourth focus area: finding a healthy balance between work and life. As my responsibilities shifted, I felt a continuing need to maintain the leadership journal.

One of the questions that I asked throughout my journey is: Who are the leaders in the enterprise, and why are they the leaders? In my definition, leaders are not just the individuals in positions of leadership. Rather, they are the “go to” individuals who can be counted on, who are approachable, and who have developed and used their leadership strategies effectively. I recorded my insights and inspirations from observing these leaders.

During the process of reviewing my 2200 journal entries, I realized they were written as strategies in a logical sequence from which I developed an integrated leadership model. This model represents the four aspects in a leader’s career, with practical and specific behavioral strategies to achieve sustainable personal and professional success (Figure 1).

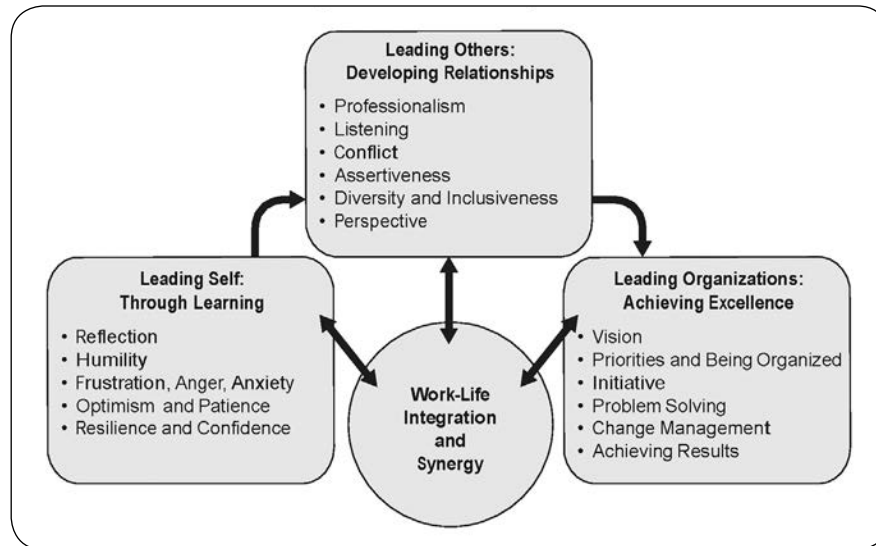


Figure 1. Integrated Leadership Model. The integrated leadership model provides an understanding of how one leads self through learning, leads others by developing relationships, and leads organizations by achieving excellence, all while maintaining work-life integration and synergy.

LEADING SELF THROUGH LEARNING

When considering self-leadership, how do we learn and reflect and address the anger, frustration, and anxiety that we all experience? How do we develop humility, optimism, patience, resilience, and confidence? Strategies for successful learning include learning by reading, learning from interactions with others, and learning from experiences (both good and bad). Learning involves overcoming the fear of the unknown, established habits, unplanned speed bumps and challenges, and a rapidly changing environment that has the potential to overwhelm:

- *Reflection* allows for a reevaluation and consideration of past actions through assessment of the current situation; absorption of new ideas; understanding of the relevance of the mission or vision strategies; weighing whether stated values are lived values; and evaluating the appropriateness of resource allocation.
- *Humility* is a powerful antidote for arrogance, a fatal characteristic that derails leaders. Maintaining a lower profile that recognizes and authentically appreciates the contributions of others will enhance effectiveness.
- *Frustration, anger, and anxiety* are a reality in the lives of all of us. Identifying the source, developing reacting and coping mechanisms, and understanding and managing the emotional intelligence capabilities of self-perception and self-confidence are critical.
- *Optimism and patience* are hallmarks of effective leadership, which also include being physically fit, being enthusiastic, understanding and living your values, having a positive attitude, and acquiring new knowledge. Both can guide leaders through the natural apprehension

and delays that normally occur in the development and implementation of operational and strategic plans.

- *Resilience and confidence* are important in accepting and adapting to setbacks, influencing emotional and cognitive reactions to develop new approaches with a learning orientation.

LEADING OTHERS THROUGH BUILDING RELATIONSHIPS

When leading others, do we display professionalism with empathetic listening to work through the inherent conflict found when working with others? Do we have capabilities in managing conflict, valuing diversity, being assertive, and maintaining a perspective on priorities and values?

Relationships are the core of leadership through which leaders have the opportunity to learn from others, to serve and listen, to build trust, to hear and respond to feedback, to discover the values of others which influence their choices, and to coach and mentor the leaders of tomorrow:

- *Professionalism* often is displayed with a tolerance for potential frustrations, a focus on priorities, and the ability to navigate challenges and obstacles with a calm, patient, mindful approach. Professionals self-regulate and set a standard of excellence, taking the long view with accountability for their actions.
- *Listening* is the most important leadership behavior, because it is the mechanism to enhance relationships. The empathetic listener provides an intense focus on the speaker, listening for his or her feelings

nonjudgmentally. Listening, and the silence that accompanies it, is how the voices of others are heard.

- *Conflict management* is the area where leaders often are tested. Resolution of conflict requires a display of effective communication, understanding differences in goals or objectives, understanding different personalities, appreciating variable work issues, and resisting the urge to blame or become defensive.
- *Assertiveness* is a delicate capability that involves empathetic listening, speaking up, minimizing defensive reactions, and an understanding of assertiveness, in contrast with aggressive, passive-aggressive, and passive behaviors. Assertiveness also can minimize unproductive interactions that can consume resources inefficiently.
- *Diversity and inclusiveness* recognize the business and human case for seeking the wisdom of the team to craft solutions for sustainable performance. Diversity and inclusiveness become a source of innovative ideas, building on the experiences of many stakeholders, especially during times of volatility, uncertainty, chaos, and ambiguity.
- *Perspective* is enhanced by reflecting on past experiences, understanding goals and strategies and putting them in context, learning from others, and maintaining a system-wide understanding of the industry and phenomena that one is living.

LEADING ORGANIZATIONS BY ACHIEVING ORGANIZATIONAL EXCELLENCE

Leading oneself and others serves as the foundation to what we as leaders are expected to do: achieve organizational excellence for long-term success. Strategies include having a vision, setting priorities and reducing noise, being organized, solving problems, taking initiative, and managing change. Achieving results, including being persistent and accountable, is the ultimate goal for attaining excellence:

- Having a *vision* is one of the most appreciated qualities of effective leaders. The vision is the overarching super ordinate goal that guides the alignment of all decisions and the allocation of resources.
- Setting *priorities and being organized* is the vital next step following the visioning process. Establishing priorities and organizing them appropriately identifies which vital initiatives will receive attention and resources. This maintains a focus on mission and vision critical plans, which will be the agenda for meetings and reports.
- Taking the *initiative* is enhanced when individuals are empowered to act on ideas without seeking unnecessary approval and share the vision with a passion and enthusiasm that generates high levels of discretionary engagement and effort.

- *Problem-solving* capabilities are higher when leaders can differentiate when extensive planning is required, know how to acquire the necessary resources, and have the ability to understand the larger problem, not just the symptoms, and the potential solutions that should be pursued.
- Leaders of successful *change management* efforts understand the presence of inertia, when a clear vision or sense of urgency is lacking. They can focus on communication, knowledge, and ability acquisition with appropriate reinforcement actions for sustainability. Understanding the emotions involved is paramount, especially in sensitive situations.
- *Achieving results* is the ultimate end game, a result of disciplined strategy, focus, and execution. Performance metrics need to be identified and shared for all people, processes and outcomes being monitored. Pulse checks to assure accountability are vital to avoid wasted efforts and to detect unplanned influences.

ACHIEVING A HEALTHY WORK-LIFE INTEGRATION AND SYNERGY

Personal sustainability is not possible without a vital fourth area, *work-life integration and synergy*. The pressures of self and relationship management and a career can easily cause damage to one's self, creating imbalances that result in poor health—emotional, physical, or both. Accordingly, as leaders, we need strategies, including relaxation and accepting reality, to achieve personal health and wealth in the leadership journey. The “wealth” referred to in this case is a “psychic” wealth—the wealth that comes from leading a meaningful life of contribution that is consistent with personal values.

Physicians and allied health professionals in medical group practices are experiencing very high levels of burnout. This burnout is substantial, affecting organizational performance and patient care. The drivers of burnout are coming from all directions: additional workloads; the need to change processes to increase efficiency; competing priorities from work-life demands; and increasing loss of autonomy and time challenges to do the work that is most meaningful.

Strategies to address burnout include being mindful of competing needs, recognizing signs of physician and emotional exhaustion, accepting mistakes as learning opportunities, seeking moderation and balance in work and personal efforts, and understanding and seeking the meaningful aspect of work. Also, it is important to recognize strategies for avoiding burnout by improving work-life integration and synergy will come from multiple sources, including the organization, the work unit, the leader, and the individual.

THE FUTURE

The unprecedented rate of change in the healthcare industry is resulting in enormous leadership challenges to improve the effectiveness and efficiency of our practices and our success at implementing changes. The industry needs leaders with the capabilities and strategies to successfully carry organizations through these challenging times. At the same time, leaders need to manage themselves as they manage their organizations to sustain a high level of effectiveness.

Four overarching themes, or “memos to self,” have emerged as I have studied the journal entries on my leadership journey:

- *Leading self* involves being positive, patient, and persistent. Successful change requires all three components. Develop a psychological capital by reading to develop your leadership capabilities, continually reflecting on what is and is not working as desired.
- *Leading others* involves listening, the key message in building relationships. My young daughter reminded me that the same letters that spell *listen*, spell *silent*. When we listen, and more importantly, hear the voices of others . . . when we take the time to be with others, we build the social capital we need.
- *Leading organizations* involves a focus on the vision. The research I did on transformational leadership identified very clearly the importance of visioning, to provide direction for where the organization is going. The vision becomes the anchor for priority management.
- *Work-life integration and synergy* involves a focus on your priorities. We all get to choose what is important to each of us. Like emotions, values are not right or wrong. If we understand our priorities, a product of our values, then our efforts should allow for a healthier integration and synergy between work and life. ■■

Editor’s Notes: Ronald Menaker is the author of *Leadership Strategies: Achieving Personal and Professional Success*, published by the Medical Group Management Association

and available at www.mgma.com. Also, Ronald Menaker retains the rights to the Integrated Leadership Model shown in Figure 1.

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Navigating the Shift to Value-Based Reimbursement: How Fast Is Too Fast, and How Slow Is Too Slow?

Aimee Greeter, MPH*

Providers are struggling to understand how the macro-level changes occurring in the healthcare industry will affect them on a micro-level, especially as they pertain to the shift toward value-based reimbursement. This article presents a guide to physicians and practice administration, in both the private and hospital-employed practice setting, on how to effectively manage this shift from fee-for-volume to fee-for-value. It analyzes new reimbursement models, population health management trends, and second-generation alignment and compensation models to help the reader understand practical tactics and overarching strategies to prepare for the changing method of reimbursement in the healthcare industry. The goal of this article is to provide clarity for decision-makers as they embrace the fee-for-value shift in a historically and predominantly fee-for-service environment.

KEY WORDS: Reimbursement; compensation; alignment; integration; value; fee-for-value; fee-for-service.

For over a decade, physicians have been under the threat that their world of reimbursement (and, accordingly, compensation) was approaching an end, yet very few practices have seen the change. However, with the passage of the Affordable Care Act, these perceived threats have become more imminent. Physicians and practice leaders continue to face the same two questions: Is change coming? And, if so, how quickly?

The U.S. Department of Health and Human Services (HHS) set a goal to have 30% of Medicare reimbursements tied to value-based care by 2016, with this percentage increasing to 50% by 2018.¹ Historically, commercial payers have followed the precedents set by the Centers for Medicare & Medicaid Services, which means that many will be looking to accelerate the migration of healthcare reimbursement from fee-for-service (FFS) to risk-based reimbursement or fee-for-value (FFV). In general, the volume to value transition will force physicians to retool their operations to focus more on population-based health initiatives, care management, cost reduction, effective data aggregation and utilization, and overall prevention and wellness.

Practices will likely have to enhance their current infrastructure and support staff to be able to measure and report

on certain metrics (e.g., quality and cost) to meet value-based goals and implement new strategies associated with FFV reimbursements. Moreover, this may result in reduced utilization and reduced office visits, which subsequently will reduce reimbursements. With the increase in additional costs and the decrease in reimbursements, physicians may experience reduced revenue if they are unable to capitalize on these new plans. Therefore, it is important to understand the evolving reimbursement models and additional pending market changes thoroughly to know the options and craft a strategy in response that best suits the individual practice.

Numerous approaches are available for transitioning from FFS to FFV, including aligning with a hospital to take advantage of economies of scale; participating in or building your own quality initiative, such as an Accountable Care Organization (ACO) or clinically integrated network (CIN); or tracking quality and cost metrics and offering incentives to providers to reduce overhead costs by tying incentives to such measures. Although these strategies are not direct reactions to the FFV reimbursement shift, they seek to align the practice as a whole to the core concepts of the changing healthcare industry before participating in a

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value-based reimbursement model, such as shared savings and losses or bundled payments. All of these alternatives have their pros and cons, which organizations will need to vet before they choose their go-forward strategy.

It is important to pursue these strategies proactively without *overreacting*. The tactics presented can be excellent avenues to mitigate numerous economic, strategic, and operational concerns; however, much of the market continues to follow the FFS model, and implementing an aggressive strategy too early could be detrimental to the long-term goals of the organization.

SECOND-GENERATION ALIGNMENT MODELS

The key to taking advantage of FFV reimbursements lies within alignment structures. These newer alignment structures vary significantly from previous alternatives, allowing more physician empowerment through a greater variety of integration strategies.

Alignment is essentially the first step in pursuing a comprehensive level of integration.

It may be critical for physicians to start aligning more closely, either with other physicians or hospitals, to capitalize fully on value-based reimbursement options. Unlike their predecessors of the 1990s, where employment was essentially the sole alignment strategy, these second-generation alignment models increasingly are focused on finding a happy medium between hospital and physician control, as healthcare leaders understand that physicians typically are the primary controllers of cost. When considering second-generation alignment models, two key areas are heavily negotiated to attain alignment with market characteristics and organizational cultures: compensation and governance.

Alignment is essentially the first step in pursuing a comprehensive level of integration, such as a CIN. A CIN is a network of interdependent providers, and potentially healthcare facilities, that collaborate to develop and sustain clinical initiatives and performance metrics and goals on an ongoing basis through a centralized, coordinated strategy and data transfer and sharing. For a CIN to be successful, the participants must be dedicated to developing a governance structure to monitor the adherence to set care guidelines and metrics as a way to hold the physicians accountable to the goals of the organization. As a CIN, the organization pursues centralized contracting that ostensibly benefits all participants. However, the ability of the CIN to negotiate collectively with payers is critical to its success, and requires the CIN to demonstrate a genuine level of

clinical integration (in both structure and implementation) so as to meet a “safe harbor” exception and other legal and compliance requirements.

An aggressive alignment strategy should not be pursued without careful consideration of the practice’s market position and current financial structure.

NEXT-GENERATION COMPENSATION STRUCTURES

If a physician organization or private practice has agreed to pursue one of the listed strategies, it becomes imperative to offer incentives to providers to support the effort. One of the main ways to use incentives is through the restructuring of provider compensation plans to align with the practice’s new measures and strategic initiatives. Restructuring is highly recommended, whether in conjunction with an alignment strategy or as a stand-alone initiative.

The landscape of physician compensation has changed dramatically over the past few years in response to the value-based reimbursement shift. Although there is a continued focus on productivity, many organizations have seen the benefits in including performance incentives (other than productivity) in their compensation plans. In numerous instances, historical compensation structures have led to an increase in costs, because the focus was on maximizing work relative value units (wRVUs) without any significant incentives related to cost control. Thus going forward, we will continue to see the increase of nonproductivity incentives such as patient satisfaction and attainment of quality metrics.

Changing reimbursement structures will demand that incentives be tied to something other than productivity.

The basic four-component model that is becoming common in the industry is made up of: (1) base compensation; (2) productivity incentives; (3) non-productivity incentives (e.g., quality and cost efficiency); and (4) other payments (e.g., pay for call, administrative service fees, medical directorships). Over time, productivity incentives and other payments are beginning to become less important in relation to quality and cost incentives and their weight in the determination of total compensation. This trend is expected to increase, as many organizations want to ensure they have aligned incentives between the way physicians are compensated and the way the organization is reimbursed for the services they provide.

Although these metrics may be harder to measure than wRVUs, changing reimbursement structures will demand

that incentives be tied to something other than productivity. Leadership must understand that although second-generation plans will need to reflect the new types of reimbursement, productivity-based incentives should not be excluded. Rather, compensation structures should be a hybrid of productivity- and non-productivity-based incentives, as described in the four-component model presented earlier. Moreover, the change in the total percentage of compensation tied to non-productivity-based incentives should be evident, but not drastic. It is also imperative that physicians feel included in the compensation structure update process and that they be educated on the impetus for the change. With the industry ultimately shifting toward population health management, physician behaviors and the overall organizational culture should shift to align with them.

Even if the practice decides not to pursue a FFV reimbursement contract at this time, it is important to begin considering alignment and compensation structures that reflect the new movement, because eventually these will be the basis for capitalizing on these incentives should it become necessary for the practice to do so.

VALUE-BASED REIMBURSEMENT MODELS

The two predominant value-based reimbursement models in the industry are shared savings/shared losses and bundled payments. Healthcare leaders should first prepare their organizations by applying the tactics mentioned above before contracting with a payer for a value-based reimbursement structure, because it will not be successful without the support of the physicians and internal infrastructure.

Shared savings and losses programs consist of an agreement made between providers and payers that includes payment for covered services and estimated medical costs, meaning the two entities prospectively agree on an established payment amount for a population base. This arrangement is typically contracted by an ACO or CIN (alignment models that are addressed in detail later in this article); however, it is possible for a private practice to participate. Providers submit claims as usual to the payers, as if it were a FFS contract. The payers and providers then review the metrics and analytics of the costs associated with providing care for the established population base. If the practice or group can provide care at a rate of savings to the payer, the organization is awarded a bonus based on these savings (typically between 40% and 60%). The provider organization then divides bonuses among the participating providers. Conversely, if the costs are not controlled effectively, and a loss is realized, the payer and providers split the loss in some mutually agreeable manner.

Alternatively, the provider organization can enter into a shared savings only model, which includes just the “upside risk” portion; however, most likely a smaller percentage of the shared savings will be awarded.

In a bundled payment model, providers deliver a set of services over a specified period within a single target price; often, physicians are only one segment of the providers delivering this care. Within the bundled payment, the fees are prospectively divided among all providers delivering care throughout the continuum of the service. If the physician can deliver the care for less than the stated price, he or she effectively shares in the savings. However, if complications occur and the patient requires more care than anticipated, the physician must absorb the extra cost. For example, if a patient receives an orthopedic procedure that requires anesthesia and an inpatient stay, the patient will pay one price that is divided among the physicians and hospital rather than paying each entity separately. In the new wave of healthcare, this bundle is often established within an ACO or CIN structure. However, it is certainly possible for the payer to distribute the payment to physicians independently under predefined rules, which has been the predominant methodology since bundled payments were first introduced.

Both the shared savings and bundled payment models have existed for several years now and are gaining in popularity. For example, the Bundled Payments for Care Improvement program (one of the most notable bundled payment programs) formalized its first cohort in January 2013, and by mid-2015, the program had more than 2100 participants.² Thus these models are solid examples of structures that practices are using as they step toward the FFV environment. Many practices find the shared savings model (where there is upside risk only) a particularly desirable model, since it minimizes risk but allows them to participate in a meaningful (and potentially lucrative) manner in this changing market.

The key to ensuring that the rewards of a value-based reimbursement model outweigh the risks associated with it is adequately structuring the practice to handle these changes before execution.

CONCLUSION

The accountable care era is ushering in a wave of changes, all of which pose unique challenges for private practice physicians. Private practices may lack the infrastructure or resources (e.g., IT, primary care base) necessary to respond optimally to these changes. Although risks and challenges exist, doing nothing will have detrimental impacts for independent physicians as traditional care delivery will prove to be more costly and unsustainable.

No one can be certain yet how long it will take to see a complete shift in the industry; therefore, different options to drive down cost must be analyzed. Before implementing

a strategy, physicians should consider the following points as they pertain to their specific situation and how each strategy will affect their individual practice:

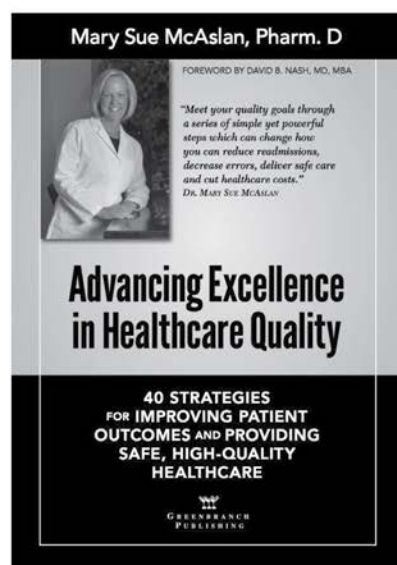
- **Physicians should understand their market.** Predominantly fee-for-service markets do not necessarily require a complete overhaul of existing systems. However, current strategies should be analyzed to prepare for when the market does shift.
- **Practices should analyze their patient populations and payer mix.** If a practice has a strong payer mix of predominantly private payers, it provides a very strong position when negotiating with prospective alignment partners. Moreover, if a practice currently has a strong payer mix and high reimbursements, it may be detrimental to renegotiate contracts preemptively. If the practice wishes to seek clinical integration, reimbursement contracts should be reviewed in light of potential collective bargaining. Providers should be cautious if their payer mix and current contracts are particularly high in reimbursement as compared to the market.
- **Physicians should fully understand their provider base.** Growing the network often is critical to long-term sustainability as an independent practice. Over the long term, when a practice enters into clinical integration or an ACO/CIN structure, it may start out with more of a specialty focus but will need to grow to incorporate primary care. Physicians should begin seeking potential partners and establish relationships with them, potentially through referral processes. Once these factors have been carefully examined, physicians should consider alignment opportunities in their market and identify potential approaches to clinical

integration. Physicians should then review different compensation models as a means to work toward compensating physicians through a structure that supports quality and cost savings. Finally, if physician leadership has determined the previous considerations and fully prepared their practice, both operationally and through technology requirements, the practice should seek a value-based reimbursement contract that best fits its specific practice and market.

Significant opportunities are on the horizon in the healthcare industry, particularly under the value-based reimbursement paradigm. Although many private practices are concerned about the growing cost of overhead, they should look to this concept of value-based reimbursement as an opportunity to recapture some of their previously lost reimbursements by capitalizing on these programs. The ultimate goal should be to develop a viable strategy that incorporates aspects of traditional and contemporary strategies to meet the needs of the shifting healthcare landscape after carefully reviewing market considerations and determining what best fits your individual practice. ■

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The Key Elements in Developing a Comprehensive Compliance Program

Debra Cascardo, MA, MPA, CFP*

With the ICD-10 implementation a task of the past year, practices can now turn from the key focuses of computer system upgrades, financial risk assessments, coding-specific education, and critical documents review to upgrading their compliance plan. However, they must continue to turn their attention to compliance issues and make sure all of the newly implemented policies are compliant with HIPAA regulations and the mandates of the many payers and the government. Compliance is an integral operational part of all medical practices. A compliance plan is not something to be written, implemented, and relegated to a bookshelf. It should be integrated into the practice's daily activities, used, reviewed, and tweaked as often as necessary. Remember that a well-written compliance program provides a roadmap for physicians and staff to follow and shows how a practice does its due diligence in monitoring, education and documentation.

Compliance is an expanding area of law, and one that is going to expose practices to more risks.

Just as you keep up with advances in the medicine you practice, you must also keep up with and adhere to the myriad changes in the compliance arena of the practice. It is important that physicians and their staff understand that compliance is an expanding area of law, and one that is going to expose practices to more risks. Your compliance plan should also include additional policies that address particular needs or risks relevant to your practice. Your practice should include human resources policies, finance policies, patient care policies, and OSHA policies.

The advent of federal and state Accountable Care Organizations, the expansion of Medicare and Medicaid managed care plans, and the implementation of other state Medicaid redesign initiatives, including Delivery System Reform Incentive Payment programs, are all dramatically expanding the breadth, scope, and magnitude of compliance programs.

Compliance obligations among healthcare providers and other entities entering into joint ventures and initiatives must be considered in your plan. Plans must be implemented among participants without duplicating efforts or expanding potential liability. They must figure out how to integrate new requirements with existing compliance efforts, as well as execute them across all partners and participants. States are implementing more specific and stringent compliance regulations.

As an example, following are the eight elements of the mandatory compliance requirements for the state of New York. The principles presented here should form the basis of your compliance plan.

Implement standards, policies, and procedures.

The compliance requirements state that policies and procedures must:

- Be modified and expanded in a template plan to meet your unique risks;
- Be easily accessible and regularly updated and maintained (If someone from the Office of Inspector General [OIG] comes in and finds two inches of dust on the document, it does not speak well of your practice.);
- Clearly communicate all rules, requirements, and processes.

Designate a qualified compliance officer.

The compliance officer must be empowered to educate other employees, update physicians, call meetings, and, when necessary, initiate corrective action in the event of a violation.

Open lines of communication.

To meet requirements, compliance programs must have communications initiatives in place that will:

- Notify individuals throughout your practice of the network of existing hotlines for reporting potential issues and problems;
- Explain which hotline or entity to contact for guidance on specific issues; and

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- Support the appropriate sharing of information among partners and participants to ensure that all relevant parties are fully informed of emerging issues and prepared to respond in a timely manner.

Provide training and education.

Your educational programs must be detailed and must be written to support compliance. You must develop training programs to ensure that staff members at every level are knowledgeable about compliance regulations, as well as their responsibilities in ensuring those regulations are strictly followed. You must have written processes in place to confirm training was provided for each position in your practice. The programs must include content specific to your policies and risks, and should be developed centrally and be compatible across entities to ensure consistency of content while avoiding duplication of efforts. Customized training and a written HIPAA test help ensure that staff members understand the key issues in compliance necessary to perform the specific tasks in their job descriptions. All new employees must be trained within the first 30 days of hire and be tested. I have customized all of my HIPAA tests for each client so that they are unique to their practice, specialty, and geographically area. I do not recommend a template plan because each practice is unique, and it makes a difference whether or not it participates in a physician network. You should also have annual refresher courses for all staff. Keep a file of the dates, content of each session Webinar, and other training that your employees have attended. Make sure that all of your employees have signed that they attended the course and/or read the material and understood its content. Your compliance plan should include a policy on the repercussions for failure to complete training as required.

Maintain discipline.

Discipline becomes more complicated and potentially politically sensitive as regulations broaden to include requirements that take into consideration non-employees and business associates. The most important features in any discipline plan are that it encourages good faith participation in the compliance program by all performing providers and that it is applied consistently. Staff must be held accountable for any compromises in their positions and roles in your practice.

Perform periodic chart audits.

Periodic chart audits should be done at least every six months and can help ensure that the documentation supports the level of service billed. This has been and will continue to be an issue that concerns the government

with auditing unnecessary medical services. Documenting auditing results is critical to your compliance efforts, as is documenting any corrective action and educational efforts taken as a result of your audit findings.

Traditionally, risk assessment has focused on four issues: medical necessity, documentation, coding, and billing. Your compliance officer also must have processes in place for meticulously and continually evaluating adherence to the implementation plan; the distribution, use and accounting of funds; and the completeness and accuracy of quality, cost, and other data that may need to be aggregated and delivered to the Centers for Medicare & Medicaid Services or the state.

Take corrective action.

The compliance officer is responsible for ensuring that effective corrective action is swiftly implemented for any identified issues. That officer's required role also includes communicating the corrective action plan and tracking progress against established goals. Document your findings so that anyone and/or any organization that investigates later sees that you took legitimate actions to deal with the issue and correct it on a timely basis.

Implement a nonintimidation and nonretaliation policy.

You must implement and enforce a policy of nonintimidation and nonretaliation. You have to monitor all disciplinary actions to ensure they can't be perceived as retaliatory. You also need to ensure that disciplinary actions are being applied equally across the entire network.

Now that you have appointed an individual to be responsible for your plan and program, you must have a code of conduct policy. This is the basic commitment to comply with federal, state, and local rules and regulations applicable to healthcare and your practice. Your compliance officer should have a job description of duties and powers.

We all know how much the rules and regulations in healthcare are changing. Your plan must include general topics, frequency of training, and how you will document completion of training. All policies should be reviewed annually and updated as necessary. Eliminate policies that are no longer appropriate or relevant and replace with new ones. Make sure that you have a template in place that permits you to document when a policy was last reviewed and when it was last changed.

Before starting your review, take a look at the OIG website at www.hhs.gov/oig. It will provide you with references and guidance. Remember that a well-written compliance program provides a roadmap for physicians and staff to follow and shows how a practice does its due diligence in monitoring, education, and documentation. ■■

The Patient-Centered Medical Home

Part I: A Primer

Steven Blubaugh, MBA, MHA*

The concept of the patient-centered medical home (PCMH) represents a shift in how healthcare is delivered as it shifts from reactive to proactive. The PCMH is a care transformation model with a number of studies demonstrating its effectiveness; becoming a PCMH can be a significant undertaking for primary care practices. This article presents a general overview of the PCMH model and briefly explains how it relates to the other healthcare reforms currently taking place.

KEY WORDS: Patient-centered medical home; PCMH; care transformation; NCQA; primary care practice; operations; reform.

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This article is the first of three parts.

The times they are a-changin'." That phrase is more than just a classic Bob Dylan song—in many ways it should be the official healthcare anthem. Just this year, the Sustainable Growth Rate has been repealed, Medicare payments are shifting to alternative payment models, ICD-10 is here whether you're ready or not, and providers need to make heads and tails of all kinds of acronyms: MU, PQRS, VBPM, QRUR, MIPS, PCMH, ACO, CI, CIN, NCQA, MACRA, PCSP, and APM. OMG! How can a medical practice administrator possibly keep up with all this change?

This article, the first of a three-part series discussing the Patient-Centered Medical Home (PCMH), primarily focuses on the National Committee for Quality Assurance (NCQA) model. However, it is important to note the best practices, recommendations, and action steps are applicable to all models. The second article in the series will describe how to evaluate a practice to determine the opportune time to begin the PCMH transition. And for those who decide the time is right for PCMH transformation, the third article will provide tactical information on how to become a PCMH—what pitfalls should be avoided and what actions must be taken to ensure success.

The PCMH model has proved to be effective at improving quality.

The NCQA has been one of the main proponents for the PCMH concept, and for the past 12 years has championed its growth and evolution into a key component of

the healthcare reformation taking place today. Contained within the details of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA), a 5% lump sum incentive payment for primary care practices participating in a PCMH model was announced. In addition to the lump sum, a 0.75% physician fee schedule increase will be offered starting in 2026, as opposed to a 0.25% increase for non-alternative payment models. Over 10,000 practices have already become NCQA-recognized PCMHs, but these represent only about 20% of all primary care clinics in the country. Fortunately for the remaining 80% of practices, incentives associated with MACRA do not start until 2019. Failure to act quickly, however, may result in practices lagging in adopting value-based care models and missing out on sizable revenue.

The PCMH model has proved to be effective at improving quality. Numerous studies outline the advantages for practices seeking to reduce emergency department (ED) visits, hospitalizations, readmissions, poorly controlled diabetes, and more. As an example, increasing access to primary care practices (a key staple of a PCMH), can reduce ED utilization by 56%.¹ This is very significant, considering the average ED visit costs \$580 more than an office visit.² These benefits will be addressed in greater detail later and throughout the series, with the hope that as a result of this series, practices will seek a complete transformation through adoption of the PCMH model.

HISTORY

The need for the PCMH care model is a direct result of the average person's approach to healthcare. As Toyosi

Morgan, MD, Director of Preventative Medicine at Emory Healthcare and one of the physician leaders in the practice's work in achieving NCQA Level 3 recognition (the highest level you can achieve) describes it, "[we] don't always think of our health until we develop a problem" (personal communication). Morgan likens patients' approach to their health to regular car maintenance—people tend to change their car's oil every 3000 miles because they know if they don't, their car could break down and the resulting cost will be exponentially higher. While it can be argued that patients should have more responsibility for their own health, physicians and practices should accelerate the transition from a reactive to proactive approach to healthcare delivery.

In 2003, the NCQA introduced a program called Physician Practice Connections (PPC), which emphasized the use of systematic processes and technology to begin managing patient populations to a greater extent. The desired outcome of this PPC program was to better understand a practice's patient population and, as a result, manage their health more appropriately.

Learning and growing from their experience, NCQA expanded the PPC model in 2008 with the release of their next version, the Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH). This version began implementing the joint principles developed through the collaborative efforts of the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association. Seeing positive results, the NCQA revised the model and name in 2011 to Patient-Centered Medical Home 2011, which further aligned itself with various government health initiatives (e.g., Meaningful Use).

The 2008 and 2011 models have been the subject of numerous research studies and analysis as the government and various insurance companies have begun closely monitoring the effectiveness of these programs. The 2013-2014 Annual Review of Evidence published by the Patient-Centered Primary Care Collaborative collected and summarized the various research on the PCMH programs and found great success in an overwhelming number of cases³:

- 89% of studies show an improvement with utilization;
- 71% of studies found cost improvements; and
- 56% of studies found improvements on access.

Specific findings include:

- 10.7% decrease in days in the hospital⁴;
- 7.6% savings measured against expected cost of care⁴;
- 8.5% reduction in readmissions⁴;
- 5% to 8% reduction in ED utilization⁵; and
- 7.4% Medical costs gross savings compared with control group reduction in readmissions.⁶

In addition to quality improvements, Medical Group Management Association analyses suggest that PCMH

practices have \$143.97 in total medical revenue after operating cost per patient compared with \$78.43 for non-PCMH practices.⁷ This significant increase in medical revenue after operating costs is due in part to the increased efficiency and increase in panel sizes that accompanies the PCMH transition. The Advisory Board projects a 43% increase in panel size.⁸

The NCQA PCMH model continues to evolve and most recently released the refined 2014 PCMH model, which includes five key changes:

1. Greater emphasis on team-based care;
2. Further integration with behavioral medicine;
3. Increased focus on intentional quality improvement, specifically aligned with the Triple Aim (who's goals include improving the patient experience of care, the health of populations, and reducing the per capita cost of healthcare);
4. Updated alignment with Meaningful Use Stage 2; and
5. Narrowed focus on the care management of high-risk patients.

The continued development and refinement of the PCMH model has cemented it as the foundation for healthcare reform moving forward. The expectation is that the number of practices with PCMH accreditation will continue to increase beyond the 10,000 recognized models today. In fact, Health and Human Services officials have called for fee-for-service payments through alternative payment models, such as the patient-centered medical home, to increase to 50% by the end of 2018.⁹

PHYSICIAN DRIVERS

The Triple Aim has the goal of providing the best care at the lowest cost for the whole population. The Centers for Medicare & Medicaid Services (CMS) has been putting increasing pressure on clinics to evolve through the use of programs that have significant payment adjustments for lack of participation or poor results. The Physician Quality Reporting System (PQRS) and Value Modifier go hand in hand, in that practices are required to participate or risk being penalized up to 6% in 2018 based on failure to submit in 2016; practices that do not submit receive a 2% penalty from PQRS and a 4% penalty for the Value Modifier.¹⁰ Because practices are required to submit more information, this gives them an opportunity to evaluate how they perform against the benchmark in various cost and quality measures in a report called the Quality and Resource Use Report (QRUR).

QRURs provide meaningful and actionable data from CMS on cost and quality outcomes (e.g., determining variance in per capita costs by diagnosis). This allows practices to have a firm understanding of how they perform compared with their peers. Due to the beneficiary allocation model that is used in the Value Modifier, primary care

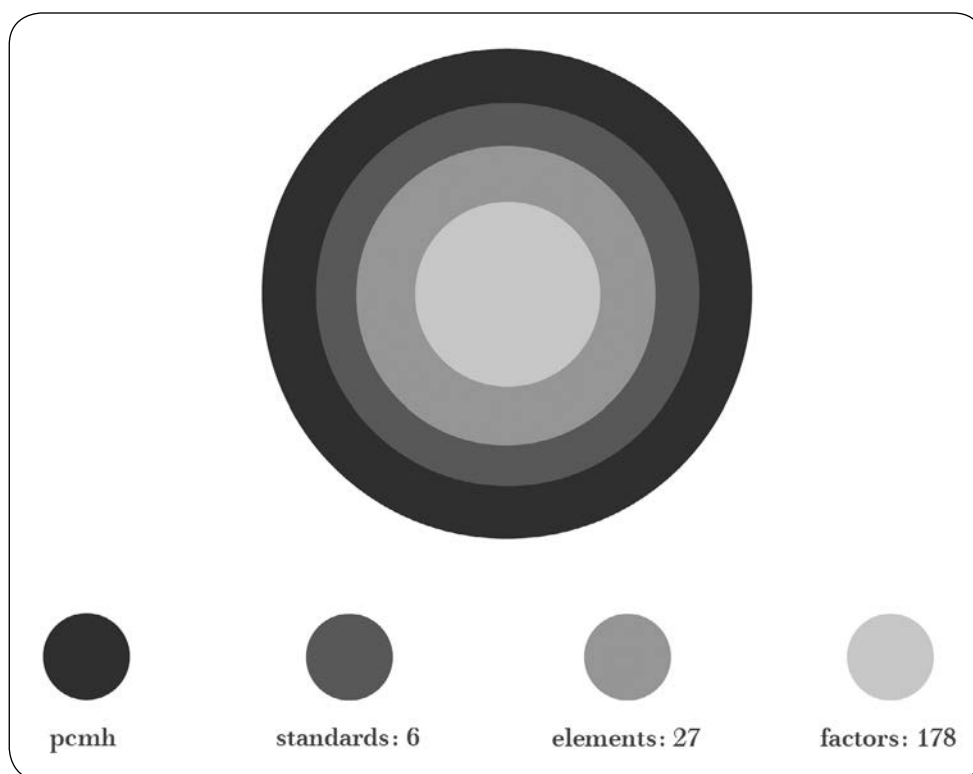


Figure 1. The ways in which the various components of a Patient-Centered Medical Home (PCMH) application build upon each other. Factors are the most detailed and specific components. These factors are combined to form elements, which are grouped into like segments to form standards. The six standards, together, form the foundation for a Patient-Centered Medical Home.

practices are allocated a large number of beneficiaries, and therefore have a great opportunity to truly evaluate how they perform. At the same time, with a large number of attributed beneficiaries there is greater risk for negative payment adjustments.

Details of the various quality programs go beyond the scope of this article, but the key takeaway is that the total revenue at risk for a practice and health system is rapidly on the rise. An organization must focus on three critical areas: enterprise intelligence; revenue transformation; and clinical enterprise maturity. Forward-thinking primary care practices that can quickly adopt care models proven to improve quality and reduce costs position themselves for success in the future.

WHAT IS A PATIENT-CENTERED MEDICAL HOME?

The effectiveness of a successfully implemented PCMH program is very well documented, with plenty of evidence demonstrating cost improvements, decreased ED utilization, improved quality outcomes, and even increased practice revenue. So what exactly is a PCMH, and what components make up a PCMH practice?

The NCQA PCMH model is like a Russian doll: you peel back one layer to reveal another and you peel back that next layer to reveal a third. Those layers are called Standards, Elements, and Factors. As you move from one layer to another, each layer gets more detailed and more specific about what a practice should be doing. Another way to imagine the PCMH model is to think of it as an architectural blueprint for clinical success. Each standard is a different floor in your house—each floor has its own purpose and the house cannot stand on its own without each floor—and the elements are the various rooms in that floor that make it complete. The factors are the details for each room—the furniture, paintings, their arrangement, and so on (Figure 1).

Six standards are designed to meet the specific goals of the triple aim:

- Patient-centered access;
- Team-based care;
- Population health management;
- Care management and support;
- Care coordination and care transitions; and
- Performance measurement and quality improvement.¹¹

Within the six standards are 27 associated elements. Six elements are designated “must-pass” elements, meaning



Figure 2. Summary of the key takeaways from the article. PCMH, Patient-Centered Medical Home; SGR, Sustainable Growth Rate.

you cannot receive recognition as a PCMH without the successful implementation and integration of that element. The NCQA has selected specific must-pass elements to direct a practice's focus and efforts to successfully implementing these very fundamental and essential concepts. An example of a must-pass element is Standard 1, Element A – Patient Centered Appointment Access. This element requires a practice to determine and define various workflows for providing routine and urgent same-day appointments, to determine how to provide care outside of regular business hours, to explore and implement alternative methods of conducting a patient visit, to put in place basic capacity management, and to implement access-focused process improvement.

Factors describe, in detail, what exactly a practice needs to do to receive recognition and designation as a PCMH. Factors may require a practice to submit written processes, reports, screenshots, example materials, and even blinded patient health records. There are 178 factors a practice may complete, and each set of factors earns a practice a certain percentage of the total points available within an element.

Tier 3 is the highest tier a practice can achieve.

But what happens if a practice cannot complete all 178 factors? PCMH tiers practices based on how well they implement the various standards, elements, and factors. Tier 3 is the highest tier a practice can achieve, and for that, a practice needs to earn 85 of the 100 possible points. Tier 2 is the 60- to 84-point range, and Tier 1 is from 35 to 59 points.

If you achieve Tier 1 or 2 but want to jump up a level, you have the opportunity to complete an add-on survey. This is an additional survey (and extra cost) in which you can submit new or adjusted data. Bumping up a level doesn't add any time to the three years you are recognized

as a PCMH, but instead allows you the opportunity to demonstrate continued effort to fully implement PCMH factors.

What if you are the administrator of a larger practice with three or more practice sites? In that case, you can fill out a multi-site application. To be eligible for a multi-site application you need three or more sites that use the same procedures and have the same electronic health record system. If this is the case, you will fill out an application that includes roughly half the factors. Those completed factors carry over to each site's individual application, meaning you will not need to duplicate efforts. Because PCMH recognition is granted at a site level, each practice must submit its own application. The multi-site survey will allow that group of factors to be applied across all sites, thereby reducing the work necessary on the applications for each site.

The multi-site survey is very valuable from a timing perspective, because the application itself takes quite a bit of time to complete. Most practices report requiring about 12 months to complete a PCMH application. This is due in part to the size of the application, but also because PCMH is more than just a form to fill out—it is a transformation in how practices work and function. Change takes time to accomplish, and during that time, competing interests vie for a practice's attention and focus. That is why, as will be described in great detail in coming articles, strong physician and staff leadership is a necessity to achieve recognition.

CONCLUSION

The PCMH is becoming a cornerstone of healthcare reform. MACRA specifically references medical homes, and the research findings are very promising.¹² Practices that position for the future through embracing these models will be positioned effectively for value-based reimbursement, meeting population health expectations and most importantly able to meet their patients' needs (Figure 2). There are distinct benefits for both patients and providers

from implementing the core concepts of medical homes, most evident in the government's backing of the program and commercial payers' development and support of medical homes.

As mentioned in the introduction, this is the first of three articles in the comprehensive PCMH series. The next article will explore whether your practice is ready for the journey. It will cover specific application details and discuss approaching the cultural transformation that must take place. ■■

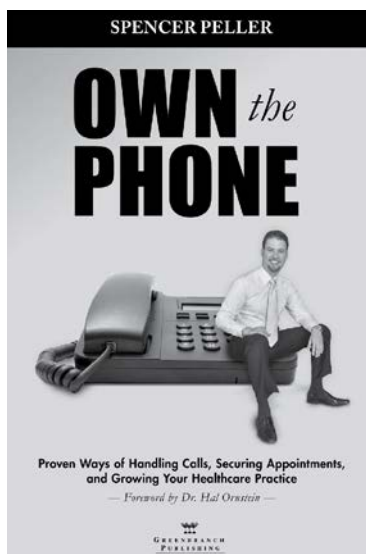
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To Be or Not to Be Certified

Kelley Suskie, FACMPE*

The pathway to professional development does not require a start or end date. Professional development is a perpetual process that is set into motion the day you first ask “why?” or “how?” Anyone who has spent time with a toddler knows that the endless pursuit of knowledge and, therefore, intellectual growth starts at a very young age. As we mature, we refine our questions beyond the whys and hows and start the professional development journey. Throughout each academic pursuit, we accomplish another rung on the ladder of our achievements. As we graduate from kindergarten, grade school, high school, and college, we easily point to the parchment most of these ceremonious events yield. Once we start our careers, though, what do we have to show for our professional development efforts? The mountains of literature provide a constant reminder of what you have left to learn. Most professions provide a formal pathway to aid in professional development, and medical practice management is no exception. The certification and fellowship program and process available from the Medical Group Management Association provides a system to map your journey of professional development—complete with its own version of parchment. This article explains why you would want to pursue professional development in the form of certification and Fellowship.

KEY WORDS: Professional development; certification; Fellowship; continuing education; career enhancement; medical practice executive; MGMA; ACMPE.

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WHAT DO YOU WANT TO BE WHEN YOU GROW UP?

When you ask children what they would like to be when they grow up, you may hear answers like a nurse, doctor, firefighter, or President of the United States. Rarely, if ever, would you hear a child utter the statement, “I want to be a medical group practice executive when I grow up.” So how is it that we find ourselves in this profession? Medical group practice management is not one of the majors you can choose in college. In fact, you must go out of your way to find this field of study; and, when you do, medical group management is likely an elective course or at best a small concentration in an overall business or health administration degree. Our profession is a hidden gem in the sea of available career options.

Even though becoming a medical group practice executive probably was not the dream job that immediately

popped into our minds the first time somebody asked what we would like to be when we grew up, we somehow found our way into the field of medical group management.

Some of us worked our way up through the ranks, whereas some pursued the degree after hearing and learning more about the discipline of healthcare management. I fall into the latter category. I knew I wanted a career in the healthcare field, but I had not settled on a specific area. That is, until I found myself passed out on the floor after witnessing a chest crack procedure during an emergency department observation. As I regained consciousness, I drew the conclusion that my particular choice of healthcare profession would need to be one that did not involve the presence of bodily fluids or invasive surgery.

Twenty years later, I find myself proudly saying that managing a medical group practice is my life’s work. My daily routine consists of ensuring the physicians and staff I serve have all the tools and resources they need to provide exceptional patient care. The tools and resources we use to

craft *our* trade come in the form of knowledge or access to find answers to questions. It is critical that medical group executives be well versed in the current rules and regulations regarding human resources management, regulatory compliance, and financial and operational management.

CAREER IN MEDICAL PRACTICE MANAGEMENT . . . CHECK. NOW WHAT?

A few years after securing my position as an academic medical practice executive, I began searching for even more validation in my career. In this pursuit, I sought to know more about the certification process of the American College of Medical Practice Executives (ACMPE), the standard-setting and certification division of Medical Group Management Association (MGMA). My interest in the certification and fellowship offerings of ACMPE helped me answer the question, "If I expect the physicians we employ to be board certified and thus documenting their knowledge through an external source then why shouldn't I expect the same of myself?"

THE ROAD OF PROFESSIONAL DEVELOPMENT

During my quest, I discovered that, since 1956, the ACMPE has answered this question while at the same time promoting professional growth of medical practice leaders. ACMPE board certification validates your knowledge and skills through the completion of three requirements: an objective examination; an essay examination; and continuing education. Becoming a Certified Medical Practice Executive (CMPE) served as more than a validation of my knowledge; it legitimized my existence in this profession. The continuing education requirement ensures that I remain current in my professional knowledge and skills. ACMPE grants continuing education hours to programs that feature relevant content aimed at improving participants' management competencies and medical practice management knowledge. The required continuing education portion of the ACMPE certification process was critical to me and my dedication to lifelong learning. This requirement made sense to me because of the many data sources vying for our limited time and attention. Just as the physicians we serve are often required to maintain their competency through the maintenance of [board] certification process, I think executives who manage the business of medical group practices should be expected to remain current in their field. The continuing education requirement of ACMPE ensures our relevancy.

Today, more than 6400 medical practice executives participate in the ACMPE. As of January 1, 2016, ACMPE has 2827 nominees, 2686 certified members, and 706 Fellows.

If you have a desire to promote your profession, then you should consider certification or fellowship in ACMPE.

DOES CERTIFICATION MAKE A DIFFERENCE?

Recently, I ventured out into the employment market and found that my credentials as a certified medical practice executive and a Fellow in the American College of Medical Practice Executive (FACMPE) did, in fact, make a difference. I was granted several invitations to interview based on this credential and accomplishment. Achieving Fellowship through ACMPE demonstrates an individual's willingness to embrace greater challenges and drive practice performance to new levels through the completion of a professional paper. As other Fellows in the program have stated, this achievement confirms our professional expertise and brings greater recognition from physicians, executives, industry professionals, and peers.

RESOURCES FOR PROFESSIONAL DEVELOPMENT

MGMA provides numerous resources for someone interested in pursuing certification and Fellowship, first among them your state MGMA affiliate, the ACMPE Forum Representative. The ACMPE Forum Representative serves as your personal guide through the certification and Fellowship process, providing information on professional development, certification, and Fellowship activities. Most ACMPE Forum Representatives are an integral part of the state MGMA executive leadership. Additional resources include an exam workbook, complete with practice questions; a Body of Knowledge (BOK) review series, a Knowledge Assessment book, and Body of Knowledge flash cards (all of which are available at mgma.com). The *Body of Knowledge for Medical Practice Management* provides the organizational foundation for the certification examination.

The BOK represents a network of knowledge and skills required to perform as a medical practice executive. The examination process is designed to attest to the knowledge and skills most medical practice executives have after two years of healthcare management experience. The board certification exam is experience-based. I admit that taking an exam after I had been out of college for a number of years did not sound pleasant. After some encouragement by a colleague who had recently completed her certification, I began to consider it. It took several months of psyching myself up for the challenge before I signed up for the exam. I was nervous, but six to eight weeks after completing the exam, I received the results in the mail and was able to celebrate that I had passed. I am encouraged to help others overcome their anxiety and realize their potential and receive validation of what they know.

The ACMPE certification exam is held four times a year at a testing center located near you. To help you prepare, MGMA offers a national study group Webinar series each year. These recorded weekly Webinar sessions are for those interested in board certification and for those preparing to take the board certification exams. The series consists of eight sessions: an overview of board certification and organizational governance; two sessions on Operations Management; two sessions on Human Resource Management; two sessions on Risk Management and Patient Centered Care; and two sessions on financial management, with an essay exam overview and critique.

The sessions are open to anyone interested in certification or planning to take the certification exams, and there is no registration fee. Interested individuals can register for the bundle of ALL eight sessions, or individual sessions. Those who register will also have access to a dedicated Board Certification Study Group Member Community where they can ask questions, post messages, and interact with the content experts/presenters.

The Fellowship resources are just as plentiful for those certified individuals who are looking to set themselves

apart or simply give back to their profession by authoring a professional paper on a relevant topic concerning medical practice management. ACMPE offers workshops and Fellow mentors to aid those actively pursuing this next step in their professional development.

CONCLUSION

Obtaining certification and fellowship gave me validation of my knowledge, skills, and abilities, and an avenue for professional development. The continuing education requirement keeps me on track to seek out educational opportunities to expand my knowledge and skill base. My commitment to my professional development helps me succeed by keeping me abreast of current knowledge and skills and makes me a better medical practice executive. ■■

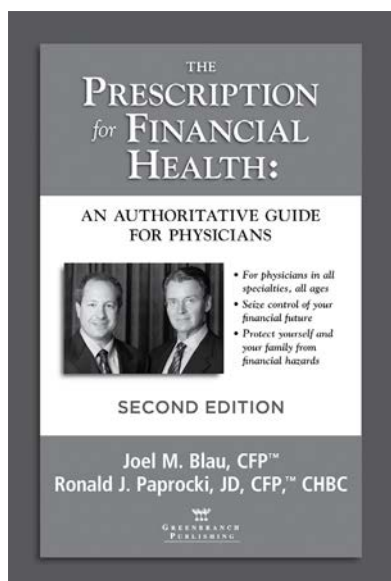
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THE PRESCRIPTION FOR FINANCIAL HEALTH: an Authoritative Guide for Physicians

Joel Blau, CFP™ and Ronald Paprocki, JD, CFP™ CHBC

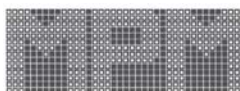


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Payer Negotiations in the New Healthcare Environment: How to Prepare for and Succeed in a Value-Based World

Ron Howrigan*

Because of their involvement with the Affordable Care exchanges, the national insurance companies have reported significant financial losses. As a result, there will soon be significant payer pressure to reduce medical expenses. To succeed in future negotiations with the payers, medical practices must understand the needs of the payers and then play to those needs. The author is a former managed care executive with more than 25 years of experience managing provider networks and implementing payer strategies for some of the largest payers in the United States. In this article, he outlines important things medical practices should be doing to prepare for the new world of value-based contracting. Medical practices that embrace this change and work hard to evolve with the future are the ones that are going to survive and succeed.

KEY WORDS: Payer negotiations; value-based contracting; pay for performance; Affordable Care Act; insurance exchanges.

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You may remember back in 2010 when Nancy Pelosi, referring to the Affordable Care Act, was famously quoted as saying: “But we have to pass the bill so that you can find out what’s in it.”¹ The insurance company executives completely understood and related to that statement. Many of them knew that they would have to wait and see what kind of members and risk they got once the Affordable Care Act was fully implemented. Then they would know its true impact. Well, here we are, a couple of years into this experiment, and the results are worse than anyone had predicted.

When the Affordable Care Act was passed, the payers expressed concern about the severity of illnesses in people who would be attracted into the exchanges. The national payers—Cigna, Aetna, United, and Humana—were very timid in their entry into this new market. These companies chose to offer their products in very few markets to limit their potential exposure. The fact that these for-profit companies did not flock to the opportunity to sell their product to a market of over 7 million customers should have been a major indication as to how bad this business was going to be for the insurance companies.

RESULTS OF THE AFFORDABLE CARE ACT

We now have two full years of ACA experience, and the results are staggering. Cigna, Aetna, and United have all issued earnings warnings because of their involvement in the ACA. Several of the national carriers have also indicated that they may withdraw from some or all of the ACA markets they participate in as soon as 2017. The results for the Blue Cross Blue Shield plans across the country are even worse. The combined financial statements for the 30 nonprofit Blue Cross Blue Shield plans are projected to show a net loss for 2015. That has not happened since the late 1980s. In my home state of North Carolina, Blue Cross Blue Shield has released some truly disturbing results. Blue Cross Blue Shield of North Carolina has around 250,000 members from the ACA exchange products. Those members, on average, cost 70% more than the non-ACA members they cover. Blue Cross Blue Shield is projecting a \$400 million loss on those members for 2014 and 2015. These kinds of losses are simply not sustainable. At some point, the carriers will either exit the market altogether or

be forced to figure out a way to stem the losses. Since politically it would be very difficult for Blue Cross Blue Shield plans around the country to exit the exchanges, the most likely outcome of all this will be significant payer pressure to reduce medical expenses. Remember, what they call “expense” is what you call “revenue.”

IMPACT ON PHYSICIANS AND MEDICAL PRACTICES

Unfortunately, the business of practicing medicine is going to get even harder. The payers have already started gearing up for the future with the recent rash of consolidations. Last year, Anthem agreed to buy Cigna, Aetna agreed to buy Humana, and Centene agreed to buy Health Net. If you look at the top four payers now as United, Anthem/Cigna, Aetna/Humana, and Centene/Health Net, these payers have combined revenue of \$367 billion. To put that in perspective, the entire Medicare budget is only \$505 billion. That means we will have four very large and very powerful national payers when all of these mergers are completed. The CEOs of these companies have been very candid about their reasons for consolidation; they want to be able to gain leverage on providers of care in order to reduce medical expenses. In light of all this, we know that it will become increasingly difficult to negotiate higher fee schedules in the future. Simply contacting the payers and demanding a raise when they are already losing money is not likely to be met with success. The market is shifting, and physician practices must change as well.

The bottom line is that the game has changed, and being able to routinely negotiate annual increases to your fee schedules will soon be a thing of the past. The payers are getting hurt financially, and they just do not have the appetite for fee schedule increases anymore. In many markets, large payers are significantly reducing fee schedules. I am not saying that contract negotiations will be impossible. I am just saying that negotiations will be more difficult than ever before. The environment is different, and a new approach is necessary. To succeed in future payer negotiations, physicians must understand the needs of the payers and then play to those needs.

THE FUTURE OF PAYER NEGOTIATIONS

The future of payer negotiations will involve showing the payers how you can reduce medical expenses and then negotiating for a portion of those savings to be returned to your practice. Although this may seem daunting, physician groups with the right negotiation and analytical expertise are uniquely positioned to do this work. It is my firm belief—and I think the data support this—that payers and the government have been minimally successful at controlling

healthcare costs. The only people who can truly bend the cost curve are physicians. Consequently, you are well positioned to do that work and then negotiate for a portion of the savings you are producing. This new approach is more complicated than simple fee schedule negotiations, but it is critical to your success in the new world and also produces the proverbial win-win.

Allow me to give you two real-life examples. One of my clients negotiated with a major payer an agreement to switch the specialty drug it was using to treat a specific condition. The drug it switched to is clinically equivalent and less expensive. In return, the payer agreed to remove all prior authorization requirements from the group. This reduced the group’s overall administrative costs and made the doctors much happier. Again, a win-win scenario. Another client negotiated a multiyear agreement with a payer where future year increases would be tied to four specific performance metrics. The group was confident that it could meet these metrics, which allowed for annual increases in the fee schedules. The payer was happy to know it had a partner in utilization management and cost control.

PREPARING FOR THIS NEW APPROACH

So how do medical practices prepare? The key is to get started now. The sooner you engage, the sooner you can execute new agreements. To be successful in the new world of value-based contract negotiations, there are several important things medical practices should be doing:

- **Data, data, data:** The need for data and analysis for this kind of negotiation is critical. You need to be able to analyze and track your utilization patterns by diagnosis, procedure, and payer. You will need to be able to run “what if” analyses to determine the amount of cost reductions produced if your physicians change the way they practice. In the example I gave earlier, the group that changed the drug it was using first ran the calculation on how much money the change would save the payer. This kind of data tracking and analysis is new and is critical for these types of payer negotiations.
- **Physician participation:** Unlike fee schedule negotiations, this new approach will require a much more active role by physicians. Physicians will play a key role in finding cost savings and making sure that any recommended initiatives are also good patient care. It is crucial that the physicians “buy in” to the programs or they just will not work. The worst outcome would be devoting precious time and resources to a shared savings program only to have it fail because the physicians weren’t engaged in the process.
- **Performance tracking:** Another new issue with value-based or pay-for-performance contracting is the ability

to continuously track performance. For the group that agreed to switch to a lower-cost drug, it is now imperative that it has a process to ensure compliance and track performance. For many practices, this will be a new function that will need to be developed.

- **Skilled and educated negotiator:** Before entering into these kinds of negotiations, the practice should make sure that its negotiator is equipped to succeed. Contracts of this nature can be incredibly complex; it is more than just negotiating a percentage of the Medicare fee schedule. Your negotiator will need to have a firm grasp on the analyses and the mechanisms necessary to finalize this type of agreement. He or she will also need to understand the potential system issues the payers face so that mutually beneficial common ground can be achieved. It does not do any good to negotiate a contract that the payer cannot implement in its systems. If you do not feel your negotiator is up to the task, make sure you either get him or her the necessary training or seek outside help.

Once you have completed these preparations and are ready to proceed, it's time to engage the payers. The best way to get their attention is to have a plan already in place. Right now, if you call payers and let them know you have a detailed plan on how you can save them money and you have already calculated the potential savings, they will be very interested in talking with you. The payers are under significant pressure, and they don't have time for concept meetings with no details. If you have specific ideas and data to share, it will help move things along.

CONCLUSION

Remember, you don't have to solve *all* the problems in the first discussion. You should walk first before you run. Do not rush out and try to negotiate a full risk capitation contract as your first foray into the new world. Pick something that is feasible and meaningful but is also easy to do, and work on that first. As you get more experience and the payers understand your abilities, then you can move on to broader agreements. The best way to do this is to look at your practice as a payer would. What diagnoses make up most of the money they spend with your group? What diagnoses or procedures do you think you can impact? In a recent analysis for one of my neurology clients, we discovered that almost 50% of all the money spent with the group was for multiple sclerosis, headaches, and sleep issues. We realized that if we focused on these three areas, we could make a huge impact on payers' costs.

Yes, the healthcare industry is in flux, and yes, everyone is facing challenges right now. But the future isn't all gloom and doom. Healthcare and the need for care are not going away. We are facing difficult times, but I firmly believe that physicians are the only true answer to the healthcare cost issues we face. The medical practices that embrace this change and work hard to change with the future are not only going to survive, they are going to succeed. ■■

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In Your Patients' Shoes

Timothy W. Boden, CMPE*

Doctor Jack McKee had it all—fame, fortune, and glory. He was a highly successful heart surgeon who functioned in his own sphere, aloof from the rest of us mortals. But a nagging cough turned out to be throat cancer; suddenly the doctor became the patient, and the entire healthcare system looked very different.

You may remember McKee from the plot of the 1991 film “The Doctor,” starring William Hurt. The movie was based on a memoir by rheumatologist Edward E. Rosenbaum, MD, originally titled *A Taste of My Own Medicine*. Twenty-five years ago, the story struck a familiar chord when it took a hard look at doctors who failed to make a connection with their patients.

Today we hear a lot about the importance of treating patients with empathy and compassion, but almost everything in “the system” seems to work against us. Under pressure to operate at maximum efficiency and productivity with fewer resources, physicians and support staff find it increasingly difficult to give patients the personal attention that keeps patients from feeling dehumanized: “*They treat me as if I were just a number!*”

Love it or hate it, the success of your medical practice will increasingly depend on a positive patient experience. The entire payer industry is trying to figure out how to effectively factor *patient satisfaction* into reimbursement schemes.

More importantly, patients who feel well served tend to be more compliant and conscientious in following treatment plans. Your clinical outcomes will likely be better when patients have a better relationship with their providers.

So what’s it like to be a patient at your medical practice?

“WALK A MILE IN MY SHOES . . .”

There’s nothing like being a patient (or a family member of a patient) to reveal the ordeals through which we put people every day. Sometimes the smallest errors can create significant hassles for the patients who depend on your clinicians and support staff for high-quality medical care **and** for help and guidance through the unfamiliar territory called “The U.S. Healthcare System.”

That point has been driven home for me over and over again in recent months as my wife and I have been dealing

with medical care arising from her cancer diagnosis almost a year ago. We have found ourselves on a pathway strewn with obstacles like claim forms, requests for information, preauthorizations, patient scheduling issues, delayed adjudications and payments, HIPAA privacy policies, provider-to-provider communication glitches—all without a map to help us find our way. *And considering my 30+ years in the industry, I should have some advantage over the average patient or family member!*

For example: A few weeks ago, my wife’s oncologist ordered a CT scan to check on the progress of my wife’s treatment. Simple—right? The check-out clerk at the doctor’s office phoned in the order to the imaging center, which gave us an appointment two days out. I began to make arrangements to take my wife in for the test. The imaging center is part of the hospital in a town some 22 miles away—part of the health system that employs her doctor.

The next day, the oncologist’s office called to let us know it ran into a precertification problem with the payer, and asked to reschedule the scan a week later. We adjusted our plans accordingly, and took time away from work to keep the appointment.

Upon our arrival at the hospital, the check-in desk apologetically informed us that my wife wasn’t on the schedule. Staff members looked in the electronic health record and saw the doctor’s note ordering the scan at the facility, but she wasn’t on the schedule. The staff members continued to dig until they discovered that the CT scan had been scheduled at the hospital in **our** town, about five miles from our home!

We had not only wasted our time and gasoline driving to the wrong facility, but we had simultaneously become a “no-show” at the correct facility. As it turned out, the person who rescheduled the appointment failed to notice the place of service in the original order. It was a simple mistake—a minor oversight—but it complicated our day; cost us time, effort, and money; and raised our blood pressure unnecessarily.

Happily, the staff at the “correct” imaging center cheerfully worked us into the schedule and made us feel welcome and well-served. No one showed the slightest sign that we were bothering them with our scheduling mix-up.

Thanks to my years inside the industry, I completely understand how this situation developed. Imagine what it feels like for the uninitiated! Our familiar, day-to-day environment is a confusing, almost hostile world to patients

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who are already frightened about their health and their medical bills.

A SECOND MILE

God forbid you or a loved one has to endure a major medical episode in order to get a patient's-eye-view of the American healthcare landscape! I wouldn't wish that on anyone. But my family's personal experience has helped me appreciate all the more how valuable it is for doctors, managers, and support staff to take time to observe closely the routine processes that patients endure day in and day out.

For example, take a bit of light paperwork or some reading material, and sit in your reception area for an hour or so. Watch and listen to what goes on at your check-in desk. Look at the furniture, the walls, and the ceiling. Look at the windows. Do things look clean and fresh, or shabby and worn?

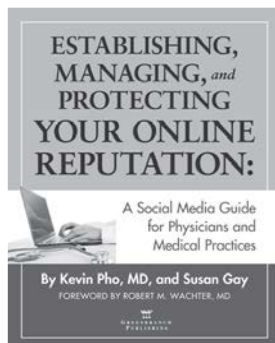
Watch the interactions between staffers and patients. Are your people cordial, welcoming, and helpful, or short and snippy? Listen to comments among patients. Do they

complain about long waits or confusing instructions? What's it like to *wait* in your waiting room?

Move on to subwaiting areas and nursing stations. Try to see everything from a patient's point of view. Spend some time near the check-out desk. Are instructions clear? How effectively do staffers ask for money? Do your employees portray openness to questions? Do they appear ready to serve?

You can use these techniques in nearly every phase of your practice operations. You might be amazed—*shocked*—at what you see and hear. (You might even be surprised at how *well* some of your employees and processes work, too!) But you will never see or hear anything if you don't stop, look, and listen.

Once you've walked a mile in your patients' shoes, you might find it a little easier to go that "second mile" to make sure each patient's needs and expectations are met or exceeded. And without exception, the best-run practices I've seen have placed *patient experience* among their highest priorities. ■■




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Provider Burnout and Patient Engagement: The Quadruple and Quintuple Aims

William Jackson Epperson, MD, MBA,* Susan Fink Childs, FACMPE,[†] and Gordon Wilhoit, MD[‡]

The Triple Aim has become the guiding light and benchmark by which healthcare organizations plan their future efforts. It has been adopted into healthcare policies with little regard for including the skill sets of compassion and emotional intelligence. The multiple increasing demands on providers of healthcare are unsustainable and will cripple the system, resulting in outcomes that are counter to the Triple Aim goals. Patient engagement with shared decision-making should become the primary focus of care delivery. New delivery models and care plans are unaffordable to far too many patients and payers, despite the efforts of futurists who seek to advance quality and lower costs. Clinical care delivery and patient engagement efforts must be drastically redirected to innovative and sustainable value-based delivery models that support the goals of the Triple Aim.

KEY WORDS: Triple Aim; patient engagement; provider burnout; delivery models; clinical research; insurance deductibles; seamless integration.

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The construct of the Triple Aim, as originally created and continually promoted by the Institute of Healthcare Improvement (IHI), outlines the foundational goals of what most view as the future of healthcare delivery in optimizing health system performance:

1. Payment—reduced per capita cost;
2. Population health improvement; and
3. Performance improvement in the patient experience.

MOLDING THE CLAY OF CHANGE

The IHI was founded in 1991 as an outgrowth from work that began in the late 1980s by a visionary group that was committed to redesigning healthcare through a move toward reduction in errors, waste, delay, and unsustainable costs. The idea was to move medical care into a more service-oriented delivery system than the current industrial factory/volume-based approach. The first decade of the IHI's efforts achieved corrections in care delivery defects and errors in areas such as the emergency department and intensive care unit. The second decade promoted efforts to find new solutions to old problems in the renowned 100,000 Lives Campaign and 5 Million Lives Campaign, which led to best practice changes within thousands of U.S. hospitals

and prompted international improvements in healthcare delivery. The third decade has ushered in the articulation of the Triple Aim, which summarizes a natural progression of the IHI's vision of improvements in health and healthcare delivery in many areas of the world.¹⁻³

The bold, visionary, innovative goals of the Triple Aim are proving to be the authoritative base against which decisions are means-tested for many healthcare delivery organizations, payers, and patients. The move to achieve these goals has prompted much needed change. What is seen as best practices now may be vastly different in the future due to realities of market forces that will direct changes that are well beyond the original vision.

THE BLINDING GLIMPSE OF THE OBVIOUS: PROVIDER BURNOUT AND PATIENT ENGAGEMENT

Two key cultural tenets are missing from the Triple Aim: physician/provider burnout and individual patient engagement. These could be considered the fourth (Quadruple) and fifth (Quintuple) Aims, respectively. The three elements of the Triple Aim must be supported by top-functioning physicians and providers. An authoritative veterinary model of healthcare delivery excludes the patients'

participation, and that model hurts the goals of the Triple Aim. Patients have choices and substantial control of their healthcare outcomes through their actions. It is impossible to improve population health without the patients' participation, ownership, responsibility, and engagement in shared decision-making.

A rising tide of concern centers on the reality that physicians and other healthcare providers are being pushed beyond human abilities to provide comprehensive care combined with significantly altering their delivery models (the Quadruple Aim). At the same time, pervasive regulatory documentation, which in many instances has nothing to do with the Triple Aim, has begun to negatively affect physician satisfaction. Those things that used to be expected and rewarded in physician/provider professional work are changing drastically. The problems with healthcare are system wide, delivery based, payer based, patient personal health behavior-related, and shared by all—not just the providers. Even the most perfectly designed delivery system will become dysfunctional if the leaders of the team lack the energy or desire to effectively carry out their responsibilities. Physician surveys indicate that as many as 60% of physicians have experienced or are experiencing multiple symptoms of burnout.

Patients rightfully own healthcare, and an authoritative veterinary delivery model is disrespectful to all involved. Patients deserve choice and quality, but they are poorly equipped to advance population health alone. Patients deserve complete information, effective coaching, individual monitoring, and educational support. Clinical decisions made together by providers and well-informed patients have been shown to improve satisfaction and outcomes, and reduce costs. Population health will always be best delivered one patient at a time.^{4,5}

Without physicians and providers, there would be no healthcare delivery, since healthcare is delivered by the provider and his or her licensed use of the pen or mouse click.⁶ As Bodenheimer says, we must make “the practice of primary care a joyful and sustainable job for clinicians and staff.”⁷

Provider satisfaction at all levels is a very serious problem that is overlooked by policy makers. Increased access demands coupled with the need to see more patients per day are compounded by the demands of satisfaction surveys and improved outcomes for cost and quality. The current stressful demands that patients be assured of the “Disney” experience during care delivery must be modified to meet more reasonable benchmarks. If those who create and implement these policies were held to the same standards in their work, it is likely they would realize the stress those demands create and would then institute more practical measurement standards. The patient satisfaction levels demanded on surveys do not provide a fair measurement of healthcare providers—in part because the level is unreasonably high. The intricacies and complexities of

healthcare delivery make assignment and attributions of patient judgment inherently undependable for accurate accountability. As Shore et al.⁸ point out, study bias is inherent when human behavior is being judged, and the validity of study outcomes is often questioned.

The *British Medical Journal* reported in 2015 that providing cultural freedom from physical and psychological harms is the right thing to do for providers of healthcare. It is smart economics, because toxic care delivery environments impose real costs on the organization, physicians, and, ultimately, all who need healthcare. The editorial further states that workforce provider burnout should be measured, and those associated metrics should direct efforts toward improved workforce engagement and safety.⁹

Spiegelman and Berrett¹⁰ state that patients are best served when providers are well supported and prepared to meet patient care delivery challenges. They propose that in any business, care must be taken of the employees, because they are the resource for taking care of customers. This is true in healthcare, too, as nurses, physicians, administrative staff, supervisors, switchboard operators, and housekeeping must be prepared and engaged so that they desire to provide great services to patients. Triple Aim goals are far more likely to be reached by systems that understand, engage, and support those who deliver care.¹¹

When patients trust their providers, compliance increases and outcomes improve.

There is a reason that “support staff” is called that. Each staff member should feel fully engaged in support of the healthcare organizational mission. This enhances continuity of care, adding to the momentum of patient engagement.

SUBSTANTIVE CHANGE REQUIRES DIVERSE APPROACHES

Movements to engage patients as responsible, accountable partners in their healthcare delivery are most successful when directly derived from patient-physician/provider relationships. When patients trust their providers, compliance increases and outcomes improve. Efforts to educate and coach providers with goal-directed incentives could greatly advance these goals. Finally, and very importantly, physician/provider coaching must also address the issues of physician/provider burnout.

When industry promotes the Triple Aim through employee programs, the forces of change come from very effective sources. For example, Hallmark, headquartered in Kansas City, Missouri, has been an innovator in employee health, a field that has long been ignored by other

large companies. Its innovation history includes the introduction of healthy onsite food service in 1923; an onsite medical department since 1956; the Healthworks wellness program, introduced in 1987; making it a priority to develop an integrated wellness plan in 2009; and introduction of the Hallmark Health Rewards Program in 2010.

The Hallmark workplace strategy has been to engage patients through financial rewards and monitoring of outcomes for actionable data to effect behavioral change. They offer an employee learning program with onsite health coaching and nutritional counseling as well as targeted health improvement workshops offered through the employee portal. Their programs, called “annual challenges,” include “Eat the Rainbow,” “Spring into Exercise,” and “Take the Pledge” to reduce sodium consumption. Hallmark-sponsored health improvement events and videos also are included as a more diverse approach to effectiveness. The top four risk conditions being addressed for Hallmark employees include: becoming “Healthy and Fit”; obesity; dyslipidemia; and back pain. Substantive employee participation with positive outcomes continues to prove that healthy behaviors will increase when patients are empowered with knowledge and health improvement coaching.¹²

Hallmark has implemented innovative sales opportunities as a spinoff of what is proven to work well within the company. Businesses can adopt the Hallmark employee health model and provide incentives to their employees using Hallmark products.

Hallmark is a well-known master of emotional intelligence, communicating to customers with ingeniously creative products. These employee health-directed efforts use the same approach to provide for recognition of successes obtained toward employee health goals.

Another approach to improve patient health through addressing patient behavior is an ongoing study at Roper St. Francis in Charleston, South Carolina, focused on employees with diabetes. In the My Diabetes Program, in just one year Hgb/A1c levels less than 8 have improved, from 61% of patients to more than 78%. During the same time, the percentage of employees with out-of-control diabetes (Hgb/A1c >9) decreased from 22% to less than 6%. The team approach to this success includes the patient’s primary care physician, nutrition coaching, personalized diabetes management training classes, and making sure that the patient has easy access to available medications.

Many companies provide bonuses to employees who participate in wellness programs. Increases in insurance premiums for smoking, elevated body mass index, and poor control of diabetes and hypertension have acted as incentives and greatly improved the health of employees across America. Patient responsibility can become a reality with health-promoting programs. This type of program is far less invasive than dealing with prior authorizations has become for patients and providers.

Many healthcare providers have been misguided toward responses that are actually detrimental to healthcare delivery by the chronic frustrations of providers in response to what is actually a small percentage of grossly noncompliant patients. Healthcare providers at many levels have long used cynicism, in reaction to professional fatigue, as a coping mechanism. Stress has always been high for healthcare workers, and it is steadily increasing in the face of so many encumbrances and distractions coming from outside of the exam room. Their stress-related cynicism must be recognized and managed through education in emotional intelligence techniques and coaching of providers and patients.

Athenahealth promotes that patient engagement is an essential strategy for achieving the Triple Aim of healthcare. They present true patient engagement as:

- The knowledge, skills, ability, and willingness of patients to manage their own and family members’ health and care;
- Healthcare organizational culture that prioritizes and supports patient engagement; and
- Active collaboration between patients and providers to design, manage, and achieve positive health outcomes.¹³

Most patients will improve their health behaviors and become motivated to engage with their care plans when presented a model of well-informed, shared decision-making. Best patient care delivery and outcomes happen when providers and patients embrace a new culture of seamless integration and shared benefits. The challenges are nearly insurmountable when payers and healthcare plans disrupt provider–patient relationships by forcing patients to choose new providers because of their ever-changing insurance plans. The insecure, forced transition to unknown providers will never lead to best outcomes.

In the past, healthcare delivery responded to market gains by “harvesting” the high-paying fee-for-service model. Market forces are directing change with new laws and payer contract agreements that place value on innovation that contains cost while maintaining quality. Nothing in healthcare will change until there is substantial change in the way we pay for it.

Although most healthcare providers have seen outstanding financial successes in the last three decades, it has come at great expense to patients and payers. Medical breakthroughs and healthcare availability have advanced, but costs are beyond what society can economically tolerate. Patients now see health insurance premiums and deductibles at levels that promote them to avoid care rather than seeking it when it is needed. Many patients are affected by near-poverty standards of living, and healthcare debt has become a major cause of personal bankruptcy.¹⁴

The use of electronic applications to bend the cost curve for healthcare will increase as patients become more technologically savvy. Smartphone application-based opportunities for electronic engagement are advancing. Apple

and others have been working on a wide range of very sophisticated applications for future patient engagement/empowerment. Many smartphone applications are available to monitor healthy activities for patients, and some are aligned with their healthcare delivery systems.

Healthcare providers must provide opportunities for patients to secure their future needs.

The realities of physical and financial health needs have motivated patients toward engagement with healthcare providers to stay healthy and minimize their personal healthcare costs. Healthcare providers must provide opportunities for patients to secure their future needs. Leading the way by example is Intermountain Healthcare in Salt Lake City. Their programs for engaging patients include personal primary care, shared patient-provider decision making, patient education, digital/mobile tools of care delivery, Live Well programs, and integrated care management for best outcomes to lower costs and achieve higher quality.¹⁵

An entire generation has grown up with copays and high deductibles of anywhere from \$2000 to \$10,000. Patients are experiencing severe sticker shock, and it is our role to assist them with understanding these new plans. Many—and likely most—patients will balance healthcare cost with total personal needs. Providers of healthcare are best suited to outline the risks of foregoing a prescribed treatment and guiding patients to choices that best accommodate their personal health and financial limitations.

Accountable Care Organizations (ACOs) such as Atlantic and Optimus Healthcare Partners ACOs in Northeastern New Jersey have proven outcomes data to document their care quality and patient engagement successes (personal interview with James Barr, MD, FFAFP, CMO Atlantic and Optimus Healthcare Partners). Patients' needs are recognized and met to ensure higher quality and reduced costs. These programs put the needs of patients first. Programs that empower patients with knowledge and long-term disease management support are being successfully carried out with programs such as home monitoring, self-management, virtual patient visits, telehealth, and personal health technology apps.¹⁶

NEW DELIVERY MODELS ARE NEEDED TO BEND THE CURVE OF HEALTHCARE COSTS

The overlooked and underreported moral dilemma in healthcare is that evidence-based medicine outlines many best management guidelines, but our healthcare economic structure does not allow for the delivery of the care that

would best advance the goals of the Triple Aim. This grave conflict is the bizarre dichotomy of discovery versus delivery in healthcare. Politically favored research is fanatically supported, while healthcare delivery for many common diseases is grossly underfunded or unavailable. Currently, the political and economic climate is favorable to the investment of millions of dollars to achieve advances in the treatment of many uncommon diseases. Over the last six decades, outstanding research discoveries have been made in healthcare for treating the millions of patients with common diseases, yet economic policies do not support the delivery of these services today. The focus of research must be drastically changed to concentrate primarily on the development of innovative delivery models for healthcare services that we already know are effective.

For example, the cost for renal dialysis is covered by the Centers for Medicare & Medicaid Services and represents over 20% of the Medicare budget. Every patient visit to the dialysis center costs around \$4000. With vascular surgery support and other management needs the yearly cost comes to around \$600,000 per dialysis patient per year. If an integrated, intensive outpatient care plan were implemented to prevent dialysis for a population, and the summary outcome was that 20 patients were delayed or prevented from dialysis for two years, then the dialysis cost savings could approach \$24 million. No one doubts that appropriate, comprehensive preventative treatment for diabetes, hypertension, and elevated cholesterol would greatly postpone and even prevent thousands of patients from needing dialysis treatment. We should educate our renal patients about the benefits of lower cost, more convenient home peritoneal dialysis when the kidney begins its inevitable course toward failure, and not when hemodialysis is an acute emergency. The improvement in the suffering of patients with renal failure would be immeasurable.¹⁷

Why does implementation research for healthcare delivery models receive so much less support than seeking new discoveries that may not be available for patients due to dysfunctional healthcare policy? Some research seems structured and motivated solely for financial gain within a funding system that is seriously damaged. A larger portion of future research should be focused on effective modern research toward achieving the goals of the Triple Aim.

Future success will only come to healthcare organizations that embrace the Triple Aim with careful attention to the issues of provider burnout and patient engagement. All five Aims can align and likely will become the common standards for all parties who purchase, deliver, and pay for healthcare. The American healthcare market currently is undergoing vast changes, but the most advantageous combinations of efforts are as yet unknown. Early experiences show that value-based payment alternatives to fee-for-service care delivery do advance the goals of the Triple Aim. The health of patients and the financial viability of entities that deliver healthcare will advance when the

right models are employed. The best models have yet to be determined and likely will vary based on location and market opportunities. The current fee-for-service model that drives volume care is unsustainable and fraught with poorly aligned incentives.

While it was originally anticipated by many experts that patients would be responsible for 33% of their healthcare dollars spent, the new reality is that the patient is responsible for 50% to 100% of their healthcare costs, depending upon the deductibility of the policy they have chosen. The typical employer mandate is a \$2000 deductible, whereas a typical Affordable Care Act mandate is a \$10,000 deductible. In reality, many patients present as self-paying patients. Patients have limited access to knowledge about healthcare utilization or costs. Providers and payers must transparently disclose costs so that patients can predict potential financial liabilities.

There is a very large healthcare “pie” in America, with costs exceeding \$3 trillion in 2015. Future policies are set not to cut spending, but to moderate growth in spending. It is hoped that early adopters of innovative, best practice, evidence-based models will see significant economic gains, as well as improvement in the health of the populations that they serve. Those with an entrepreneurial mindset that welcomes innovation and embraces substantive healthcare delivery changes will find themselves leading the field. All must change in this new model. Already many major carriers are developing new alternative payment models designed to promote a more value-oriented approach in keeping with the culture promoted by the Triple Aim. However, the intense addiction to fee-for-service models has most resisting the Triple Aim move to value changes. This obstinacy greatly slows preparations for future challenges in most healthcare organizations.

IMPROVING THE PATIENT-PROVIDER INTERFACE IS THE BEST OPPORTUNITY TO ACHIEVE MUTUAL BENEFITS

Tremendous opportunities exist to advance healthcare outcomes with population health measures based on evidence-based medicine. The challenges of physician/provider burnout and patient engagement will never be solved through government or payer policies alone. It is up to each healthcare delivery entity to invent, explore, implement, and monitor policies that substantively address efforts to reduce provider burnout and improve patient engagement. Best outcomes will be seen for those who effectively mold delivery systems that embrace patient engagement while mitigating provider burnout. Improving

the patient-provider interface should greatly advance the personal benefits of all by reducing provider burnout and advancing patient satisfactions. The greatest challenge is that this can only be achieved one provider and one patient at a time.

Healthcare economic forces will be driven by the needs of business, payers, policy makers, and, most importantly, patients. All in healthcare must follow the pathways outlined by the Triple Aim while embracing the challenges of provider burnout and the opportunities of innovative patient engagement. ■■

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Choosing a New Telephone System for Your Medical Practice

Brian Methereil*

E-mail may rule the world in other types of businesses, but for medical practices, the telephone remains the primary mode of communication with patients, specialists, and pharmacies. From making appointments to calling in prescriptions, telephones are essential to patient care. With technology changing very quickly and new capabilities coming into the medical practice, such as telemedicine and Skype, you need to know your options when choosing a new telephone system. The possibilities include on-site, cloud, and hybrid networked solutions. A wide variety of features and capabilities are available, from dozens of vendors. Of course, no matter what telephone solution you choose, you must meet regulatory compliance, particularly HIPAA, and Payment Card Industry Data Security Standard if you take credit cards. And it has to be affordable, reliable, and long lasting. This article explores what medical practices need to know when choosing a new business telephone system in order to find the right solutions for their businesses.

KEY WORDS: IP telephony; voice-over Internet protocol; VoIP; business telephone system; unified communications; cloud telephony; hybrid cloud networking; regulatory compliance.

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Just 20 years ago, hardly anyone gave a second thought to business telephones. You signed up with the phone company and got your telephones. But all of that has changed now. Telephone technology is changing very quickly, and new ways of providing patient care are coming into the medical practice, such as telemedicine and Skype. You have to understand the telecommunications landscape thoroughly to make an educated decision when choosing a new business telephone system.

You'll need to choose from an on-site or cloud solution, or even a hybrid of the two. You can choose from a voice-over Internet protocol (VoIP) solution or an Internet protocol (IP)/digital converged system. If your practice has multiple sites, you'll need to have a solution that connects all your offices, including your remote users.

If you have a contact center, your new solution must provide the latest features and capabilities to manage your agents, whether they are in one office, 20 offices, or working remotely from home. You'll also need to decide what features are important to you and all your employees, such as unified communications and unified messaging.

These days, virtually everyone uses a mobile phone, either as their primary phone or at the very least as an

emergency contact phone. You need a solution that will allow callers to dial your users' office numbers yet reach them on their mobile phones.

No matter what telephone solution you choose, you must meet regulatory compliance, particularly HIPAA and Payment Card Industry Data Security Standard (PCI-DSS) if you take credit cards. And the solution you choose has to be affordable, reliable, and long lasting.

To make it even more confusing, there are literally dozens of brands available and many different payment plans, from purchases and leases to service fees for cloud telephony. No wonder choosing a new business telephone system can be daunting.

VOICE-OVER-INTERNET PROTOCOL, CONVERGED, CLOUD, OR HYBRID?

Four main types of telephone systems are currently available.

- **Voice-over Internet protocol, commonly referred to as VoIP, or IP telephony:** VoIP systems send your voice conversations over your office's Ethernet local area network (LAN) so that one network does the work of two.

Four Tips for Choosing a New Business Telephone Solution

- Look for a brand that has a solid reputation, longevity in the marketplace, proven solutions, and a migration plan so you don't get left behind when new platforms are introduced.
- Choose a dealer that has experience in medical practice solutions and also has a solid reputation and longevity in the marketplace.
- Consider business telephone solutions that meet your need for system size, scalability (i.e., ability to increase users on demand), the features you need, and advanced technology to ensure reliability.
- Ensure that your solution provider will handle software updates, application licenses, warranties, and migration options.

This can be either an on-site system or a cloud-based solution. You must use IP telephones with these solutions.

- **IP/digital converged:** Combination solutions let you have it both ways and allow you to mix and match digital and IP telephones. This is an on-site system.
- **Cloud-based VoIP, also known as hosted telephony:** Cloud-based VoIP is similar to the old telephone service, in which you just have your telephones and the service and applications are provided to you remotely. However, with current cloud technology, you are able to receive all of the features of even the most sophisticated on-site systems. This option requires IP telephones.
- **Hybrid cloud networked solutions:** Hybrid solutions are a combination of cloud or hosted telephony networked with on-site VoIP or IP/digital converged systems. You can use digital and IP telephones, although IP telephones are the better choice to access the full range of features.

ADVANTAGES OF AN ON-SITE BUSINESS TELEPHONE SYSTEM

With an on-site system, such as a VoIP or IP/digital converged system, you can buy or lease the telephone system. This puts the system in your environment and gives you complete management. In most cases, you have to make a capital investment or engage in a lease.

If your system needs to support more than 500 users, or a cadre of serious power-users, such as a contact center, then an on-site system is often the best choice. It also makes sense if you simply prefer the idea of having complete on-site accountability and control for your mission-critical communications, because you can have the phone system server securely locked in your own equipment room or data center.

WHAT IS A CLOUD-BASED BUSINESS TELEPHONE SOLUTION?

A cloud-based VoIP solution delivers the benefits of IP business communications as a monthly service, without requiring you to buy, install, or maintain an on-site communications server.

This service is said to be “in the cloud.” With cloud-based VoIP, the central intelligence of the phone system resides in a service provider's secure data center off site.

All you need to have on site are the end-user devices, such as telephones, softphones on a computer or tablet, or mobile phones, plus the local network gear to connect those devices to the provider's managed IP network.

How to Know When It's Time to Move to the Cloud

It makes sense to move to the cloud in any of the following situations:

- **You've outgrown your current system's capacity.** With cloud communications, just add seats as needed by turning on a license for a modest monthly fee.
- **Your legacy system is too expensive to maintain.** Forget aging hardware and expensive trunk lines to the phone company. With cloud communications, you do not have to own your own server, because business communications run on the same data network you use for Internet.
- **Your legacy system lacks the modern features you need.** Cloud services can offer IP features that legacy digital phone systems often cannot perform, such as unified communications and mobility.
- **You're moving or adding new locations.** It is not necessary to buy, install, and maintain a phone system for each location. Just add users to the cloud network as needed, wherever they are, and have the dispersed network operate as a single integrated system.
- **You're merging with another company and need a new telephone solution.** With the cloud, it is easy to bring multiple locations into one unified network.

Business Benefits of Cloud Telephony

- **Enterprise-class communications:** Gain new productivity and convenient features you would expect from a much larger organization, such as:
 - One-number reach and the ability to manage voice-mail from a PC or tablet;
 - The ability to have calls follow you across desktop and mobile devices;
 - The use of your smartphone as a business phone system extension; and
 - The capacity to converge your phone and PC into a multimedia call management device.

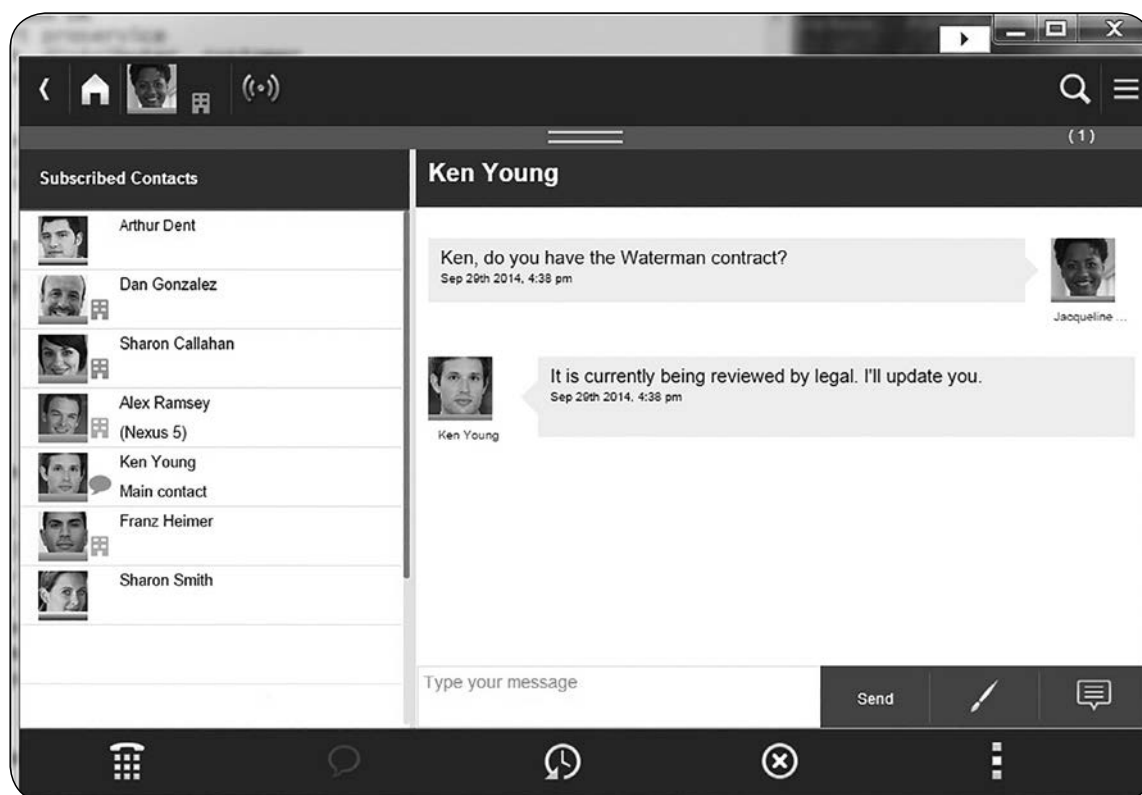


Figure 1. Using Toshiba's UCedge application, users can instant message from their computer desktops. When they step away from their computers, they can continue instant messaging using UCedge on their smartphones.

- **Scalability and agility:** Pay only for what you need today, and expand on demand. Start with a handful of users and expand to hundreds, on *your* schedule. It is easy to open a new location or add and remove seats to meet short-term or unexpected requirements.
- **Flexibility:** New applications are efficiently deployed and managed in the cloud rather than on individual devices. With this flexibility, the business can respond rapidly to new opportunities and changing market conditions.
- **User control:** Users have full control to personalize their own phones, call handling, messages (e.g., voicemail, e-mail, instant messaging) and more, just as they would if the server were in the office. Figure 1 illustrates desktop instant messaging, and Figure 2 shows smartphone avatars for Presence (the person's status based on his or her phone status [i.e., "busy"]).
- **Budget-friendly fixed monthly costs:** Because there is no server to buy, cloud telephony is an easy-to-budget monthly operating expense. Since costs are based on the number of users and the selected calling plan, you know exactly how much to budget each month for the duration of your contract. There are no added costs for annual maintenance contracts or software upgrades.
- **Zero upfront cost:** If you prefer to use capital for other purposes, lease the on-site telephone equipment you

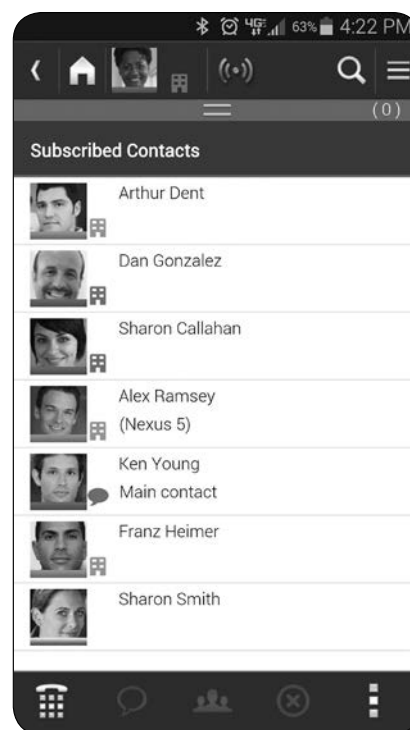


Figure 2. Using Toshiba's UCedge application on a smartphone, users can view subscribed contacts' avatars to determine the presence status (to see if they are available or busy) and then click to call or instant message.

formerly would have purchased, such as desktop and wireless phones.

- **Lower total cost of ownership:** With affordable monthly rates and lease options, you can create a sophisticated business phone system at a remarkably low cost—ideal for new and fast-changing organizations.
- **No system obsolescence:** You always benefit from the latest firmware, software, and features.
- **Premium performance:** For assured uptime, the servers that host your company's cloud communications are protected by power conditioning, redundancy and disaster recovery resources far beyond what a typical medical practice can provide.

A cloud communication solution is ideal for medical practices that:

- Want to preserve working capital instead of spending it on office infrastructure;
- Have ambitious growth plans and could outgrow a purchased phone system; or
- Prefer to focus on core business rather than the capital cost and ongoing management of a sophisticated on-site phone system.

Figure 3 presents 10 ways telecommunications in the cloud can help your business.

BEST OF BOTH WORLDS—A HYBRID CLOUD TELEPHONY SOLUTION

Hybrid cloud networking enables you to create a company-wide network across town or across the country using a combination of on-site and cloud solutions from the same vendor. This type of system enables you to:

- **Open up new options:** Expand using capital expenditures (CAPEX) or operational expenditures (OPEX), depending on your current business needs. Support new users and locations with little or no upfront expense by adding lines of cloud service to network with existing on-site systems.
- **Mix and match the right platform for each location:** For example, you could deploy an on-site IP private branch exchange (PBX) at larger sites, a digital/IP PBX for sites that still use analog and digital trunks and phones, cloud service to bring remote locations into the company network—and converge them as one.
- **Enjoy feature transparency across the network:** Hybrid networking is an affordable way to integrate multiple small or remote locations—even one-person offices—into a single network that presents a unified and professional company image. Advanced features and applications work across the hybrid network for a seamless user and caller experience.
- **Support a mobile and remote workforce:** Users can work from anywhere and enjoy the same direct-extension

10 WAYS TELECOM IN THE CLOUD CAN HELP YOUR BUSINESS

1 REDUCE CAPITAL EXPENDITURE

- // Reduce in-house telephone system hardware investment
- // Purchase VoIP-Ready telephones
- // Save on managing both phone/data lines

2 MINIMAL IT SUPPORT

- // Free your IT staff
- // System management occurs in the Cloud

3 SPACE-SAVING OPTION

- // No need for an in-house server room
- // Ideal for remote locations

4 BUSINESS CONTINUITY

- // Resides in redundant and secure data centers
- // Forward calls to mobile phones utilizing LAN/WAN

5 SCALE UP/SCALE DOWN

- // Highly flexible
- // Quick to deploy

6 COMPREHENSIVE FEATURES

- // Advanced features and functionality
- // Appear as a call from the main office from anywhere

7 AUTOMATIC UPGRADES

- // Software changes happen automatically in the background
- // Keep informed with notifications of new capabilities

8 PRODUCTIVITY ANYWHERE

- // Constant connectivity—anywhere, anytime
- // Business can get done no matter where you are

9 MOBILE SOLUTIONS

- // Use your smartphone as your office telephone
- // Place outbound calls while displaying your office number instead of the mobile number

10 FOCUS ON WHAT MATTERS

- // Enables you to concentrate on your core business
- // Stay competitive with advanced features and productivity tools

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Figure 3. This Infographic displays the 10 ways telecom in the cloud can help your business.

dialing, auto attendant, unified communications, and other features as their colleagues in the office.

The beauty of a hybrid network is that you can deploy an on-site server where it makes sense to own the phone system and expand as needed—in the same location or elsewhere—one line at a time.

COMMUNICATION APPLICATIONS GIVE YOU MORE CONTROL THAN EVER BEFORE

Today's telephones do a lot more than just allow you to make and answer calls. Advanced features include:

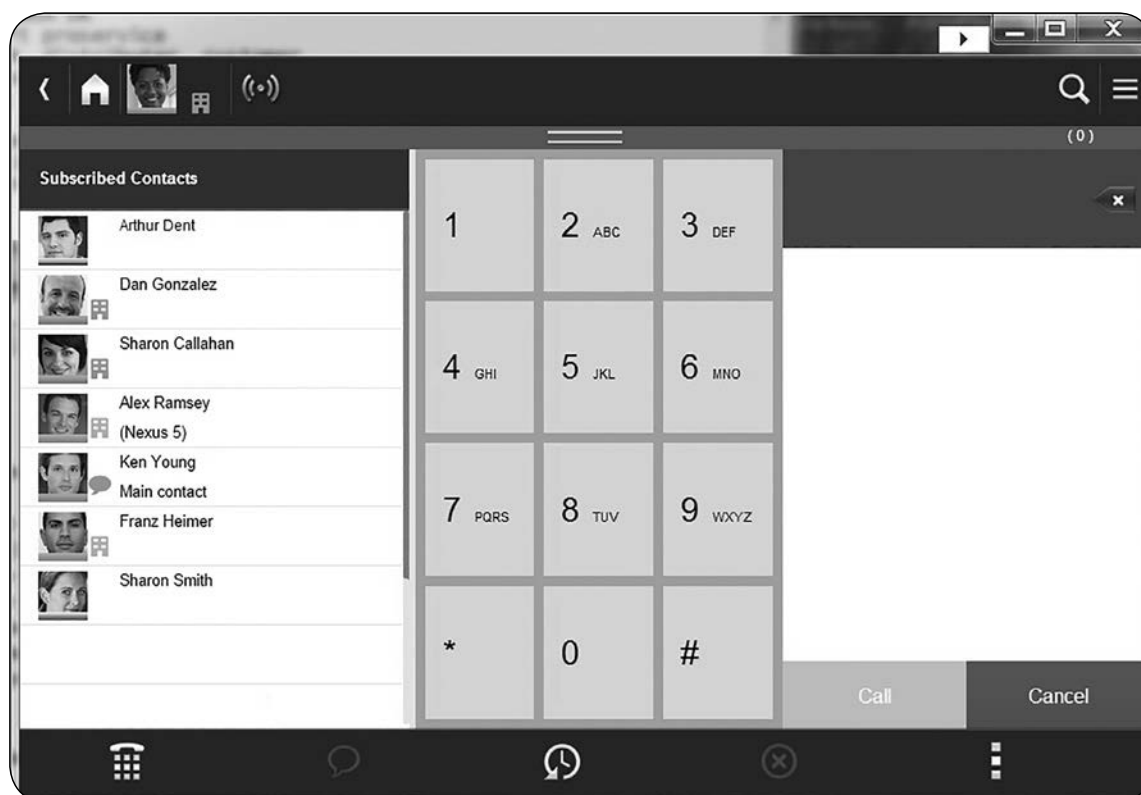


Figure 4. Toshiba's UCedge application enables desktop dialing either by keypad or by clicking to dial subscribed contacts.

- **Unified communications**, enabling users to exchange ideas and do their jobs more effectively by integrating communication tools, such as IP telephony, presence technology, instant messaging, and more.¹
- **Unified messaging**, which allows the handling of voice-mail, fax messages, and e-mail as objects in a single mailbox.²
- **Mobility**, which supports the trend of having more employees working out of the office and using mobile devices to perform business tasks, essentially using your mobile devices to do most or all of your work.³
- **Centralized, browser-based administration**, allowing the IT manager to control multisite systems and hybrid cloud solutions from the Web.

WHAT IS YOUR (END)POINT?

Today, you can be on your business telephone without even touching your business telephone. How is that possible? Today's users can choose from a variety of endpoints, including:

- Softphone on the computer or laptop (see Figure 4 for desktop dialing from your computer or laptop);
- Softphone on a tablet;
- Mobile phone that acts as an extension of your business telephone; and
- Even the reliable, traditional business telephone.

MAXIMIZING YOUR CONTACT CENTER

Whether your contact center has 2 agents or 40, using an automated call distribution (ACD) solution can help ensure that calls get through, are handled appropriately and are compliant with regulations including HIPAA and PCI-DSS.

Benefits of ACD solutions include:

- **Skill-based routing:** Incoming calls can be routed to the specific agent or department based on predetermined criteria, such as specific skill sets.
- **Immediate response to important callers:** Callers who are identified as of high value to your practice, based on predetermined info, are immediately routed to the most appropriate agent, or, if no agent is available, they can be given priority in the queue.
- **Integration with computer-telephony integration (CTI) technology:** ACD along with CTI integration and skill-based routing allows agents to view the patient's information, such as past communications history, before they answer a call.
- **Connect multiple locations:** ACD can easily route calls to agents sitting at different or remote locations yet still have all the agents functioning as a single team.

FAQs: Cloud Versus On-site Telephone Solutions

Choosing the Right Communications Solution for Your Practice

Cloud- or network-based services are familiar concepts to most of us. Think of sharing digital photos via Shutterfly or Facebook instead of on DVDs or glossy prints—or voicemail instead of an answering machine.

Why not apply the same concept, with all its benefits, to your business phone system? With cloud-based VoIP service from a trusted service provider, you can get advanced IP business communications as a pay-as-you-go service.

How Do Cloud-Based Business Communications Work?

Instead of having an IP PBX on site at your business, the server—the central intelligence of the phone system—resides in a service provider's secure data center. All you have to buy or lease are the end-user devices—such as phones and attendant consoles—and the network gear to connect those devices to the provider's IP network.

What Advantages Does Cloud-Based Telephony Offer Over an On-Site PBX?

- **Little or no upfront capital expense:** Instead of upfront capital acquisition for the communications server, you simply pay a monthly service fee based on the number of seats and the calling plan—for up to 500 users in one or more locations.
- **Fewer communications-related costs:** No annual maintenance contracts, software upgrades, or other system maintenance. No cost for the office space and energy to power and protect a PBX. And you reduce network costs by running voice and data on the same LAN and outside connection (trunk) to the service provider.
- **Access to enterprise-class phone features:** Access to advanced call processing, mobility, voicemail with unified messaging, unified communications, and the ability to use a PC as a phone and a smartphone as a business system extension. You can present a big-business persona, whether your organization has a handful of employees or hundreds.
- **Better phone system performance:** The core of your phone system is managed by IT specialists in a remote data center ("the cloud") that has power protection, redundancy and disaster recovery resources far beyond what any small business could provide. Furthermore, you always benefit from the latest firmware, software, and features without having to upgrade your system yourself.
- **Greater business agility:** With cloud-based service, you pay only for what you need today, and you can expand on demand. It is easy to open a new location or add seats to meet short-term or unexpected requirements.

- **Call-back:** ACD allows callers to opt for a call back instead of waiting on hold. The system dials the caller back to connect with the next available agent.
- **Coaching of agents through live call monitoring:** ACD enables call center managers to implement live call monitoring and can whisper or instant message with the agent to assist with the call.
- **Recording:** Recording of contact center calls can aid in dispute resolution, reduced legal liability, and training for improved customer service.
- **Reporting.** Supervisors can access reports on schedule or on demand to determine the call center's efficiency and that of all or specific agents.⁴

ENSURING REGULATORY COMPLIANCE

No matter what telephone solution you choose, you must meet regulatory compliance, particularly HIPAA, which requires extensive compliance as outlined in its Privacy, Security, Breach Notification and Patient Safety rules. If you accept credit cards, you must also adhere to the PCI-DSS, which includes specific requirements for masking credit card numbers and other sensitive information, as well as specific rules for call recording storage, security and encryption, and record-purging capabilities.

Your new business telephone solution must support compliance by providing recording solutions to meet your specific needs.

Your new business telephone solution must support compliance by providing recording solutions to meet your specific needs. If you are using Skype for Business, you must record video. If all your patient communication is conducted by traditional telephone calls, then call recording will suffice. As the ways you connect with your patients expand, it is important to ensure you are still within compliance.

WAYS TO SAVE MONEY ON YOUR PHONE SYSTEM

- Select VoIP to utilize your office network;
- Employ session initiation protocol trunks, the use of VoIP to facilitate the connection of a phone system to the Internet;
- Use direct extension dialing between your offices to avoid long-distance charges;
- Choose the cloud for OPEX rather than CAPEX;
- Lease rather than buy an on-site system;

- Take advantage of extended warranties; and
- Eliminate costly maintenance of older systems, helping pay for a new solution. In some cases, it can cover the entire cost of a new solution.

PREPARE FOR THE FUTURE: TELEMEDICINE/TELEHEALTH APPLICATIONS

As you choose your new business telephone solution, keep in mind that the future is upon us: telemedicine, also known as telehealth.

Telemedicine is the use of electronic communications to exchange medical information from one site to another to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, e-mail, smartphones, wireless tools, and other forms of telecommunications technology.⁵ In fact, telemedicine is already being adopted and used by major healthcare organizations, including United Healthcare, Oscar, WellPoint, and some BlueCross and BlueShield plans.⁶

As you choose your business telephone system, choose wisely. Make sure it works with every endpoint you may ever use, including your smartphone, computer screen, and tablet. After all, someday soon, you may be dispensing medical advice to your patients over these platforms. ■

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Strategic Planning: A Practical Primer for the Healthcare Provider: Part I

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Entrepreneurs are known for opportunity recognition—that is, “How can I start a business to make money from this opportunity?” However, once a commercial entity is formed to take advantage of an opportunity, the leadership priority shifts from entrepreneurial to strategic. A strategic perspective leverages limited resources to position a business for future success relative to rivals in a competitive environment. Often, the talents needed for one priority are not the same as those needed for the other. This article, the first part of a two-part article, intends to simplify the transition from an entrepreneurial to a strategic focus. It walks an entrepreneur through the strategic management planning process using a fictional business. The various tasks in the process (i.e., mission, vision, internal analysis, external analysis) are illustrated with examples from a typical primary physician’s private practice. The examples show how the strategic management tasks are interrelated and ultimately lead to a philosophical approach to managing a business.

KEY WORDS: Strategic planning; strategic management; mission statement; internal evaluation.

This article is the first of two parts.

Entrepreneurs are primarily concerned with recognizing profitable opportunities and seizing the initiative to take advantage of that opportunity.¹ Once seized, success without competition is relatively easy. However, success breeds competitors and requires a different skill set for further survival and ultimate economic success. To survive in today’s fast-changing healthcare environment, the primary care physician needs management skills in addition to entrepreneurial skills already held.² This article provides primary care physicians with a practical primer to strategic management. We present the strategic management process using a fictional private medical practice located in an urban environment.

PURPOSE

Entrepreneurs pour their hearts and souls into new ventures for years hoping for that elusive pay-off.³ Perhaps they have heard of strategic management but haven’t really had

time to pursue it as a process. Few know much about strategic management, and fewer still have ever participated in the process. And unlike in larger organizations that may have strategic management departments, the onus for everything in smaller, start-up organizations falls to the owner/manager/physician.

Therein lies the purpose of this article—to remove some of the mystery associated with strategic management. And we hope we’ll be able to provide some practical guidance toward taking the next step in managing an ongoing business. A summary of the strategic planning process and a list of suggestions for conducting the process are provided. We think you will find that the process is pretty much common sense and easier to accomplish than originally perceived.

The importance of strategic management to a business can be summed up with the old saying, “If you don’t know where you are going, any road will take you there.” Prudent use of the information contained in this article will help ensure that you and your company will find the road to success and will continue to follow it year after year.

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THE STRATEGIC MANAGEMENT PROCESS

Your first step in learning the strategic management process should be to put yourself at ease. Although the term “strategic management” invokes a grandiose technique that may seem larger than life, it is, in fact, little more than an exercise in proactive time management. It’s all about how to achieve what’s important when faced with conflicting demands and limited resources. Second, don’t get caught up in the hype of strategic management. Too many organizations go through the motions but lose sight of the intent. These companies are ridiculed in mainstream culture such as in the Dilbert comic strip—often, when you want a plan bad enough, you get a bad plan. Remember that the intent of strategic management is to set up your company for future success.

Your mission is your starting point.

Planning is the first phase of strategic management, followed by the implementation phase. We concentrate on the planning process here by showing how things *should* progress while giving some practical examples.

Mission

Your mission is your starting point. Just as important as knowing where you are going, you need to know where you are starting from—where you are today.⁴ A good mission statement provides an introduction to your company and tells readers what you’re doing and how you’re conducting business. Clearly state your company’s name, location, major product/service offering, major customer(s), and source of competitive advantage. Think of yourself trying to answer the following questions: Why am I in business? What am I doing? How am I going to make any money?

For illustration, assume a fictitious single physician, Dr. Smith, who opened his own general practice, The Smith Clinic. Smith provides general clinical services in an urban downtown office and provides surgical procedures in a major hospital located across the street from his practice. A good mission statement would be:

The Smith Clinic provides a nonthreatening, comfortable setting for patients in the uptown area who desire preventative and acute treatment of medical discomfort or concerns. We will see you at your scheduled appointment time or quickly as a walk-in. By the time you leave our office, you will know what you need to do to address your condition. If further treatment is necessary, it will be arranged prior to your departure. Our success rests on our ability to provide all patients with accurate and

timely diagnoses and treatments better than our competitors.

After reading this mission statement, one can easily picture what the business does. It would be difficult to develop a similar understanding if the mission was simply “To make money” or “Keep people healthy.” In a capitalist economy, it’s a goal of most businesses to make money. The issue at hand is to structure and position your company so that it has the best possibility to make more money than the competitors.

Vision

Once you have defined the current state of your business with your mission statement, you then need to define where you’re going. Your destination will be described in your vision statement. We can all remember President John F. Kennedy’s vision of “A man on the moon by the end of the decade” and Martin Luther King’s vision of “I have a dream.” Both are simple yet extremely powerful.

A good vision statement need not be as powerful as those above, but it should be useful. The business’s vision statement should paint a clear picture of the company in the distant future—one that can easily be visualized. In general, vision development should be easy for an entrepreneur. After all, the vision is simply a representation of the opportunity that was recognized and led to the formation of the business in the first place.

A good vision should inspire and motivate everyone at the company.

A vision is often less defined than the mission and more goal-oriented. Visions provide a unifying motivation for the organization. The time frame is flexible, but three to five years is a reasonable goal. A good vision should inspire and motivate everyone at the company. Building on Smith’s example, a decent vision could be, “When experiencing or even thinking about medical concerns, The Smith Clinic is the first choice that comes to a mind for how to answer questions quickly and accurately.” This vision provides sufficient direction for managers at Smith’s to use when setting priorities.

Now that we know where we are (i.e., the mission) and where we want to go (i.e., the vision), it’s time for a reality check. The owner/manager needs to evaluate his or her company relative to competitors to see what needs to be done to make sure that the company will reach the desired future. This issue is addressed in the next part of the process and has two steps. We start by looking inside the business with an *internal* evaluation of what the company has and then look outside at the *external* environment to see how the company compares to competitors in ways that are useful in attracting customers (i.e., be competitive).

Internal Evaluation

Internal evaluation involves some serious soul-searching. You need to look around and take inventory of everything that you have at your disposal. Put yourself in Smith's shoes, and the inventory should include everything he has: people, buildings, desks, chairs, waiting rooms, examination rooms, consultation rooms, computers for electronic health records, and so on—these are resources. Now look at what's being done with those resources: greeting patients, registering patients, examining patients, maintaining records, consulting, cleaning, and sterilizing—these are activities.

The internal evaluation process should provide a very detailed description of the business—what it has and what it does. The more detail the better. In fact, the soul-searching session will be more effective if you can remain objective and refrain from assigning adjectives during this identification phase. To illustrate by building on Smith's example, one resource could be the clinic's address/location. Although the location may be a reason for success (e.g., ease of access, close to hospital, good parking), avoid any claims of "prime" location for the moment. Simply list everything; the list will be pared down and prioritized later.

Smith's resources would include: a physician with credentials from a particular medical institute; two nurses; a receptionist; 100 square feet each for a waiting area and two examination rooms (each with appropriate medical instruments and a computer with Internet access); a combination consulting space and general office for the owner; a lease on the property; and so on. Smith's activities would

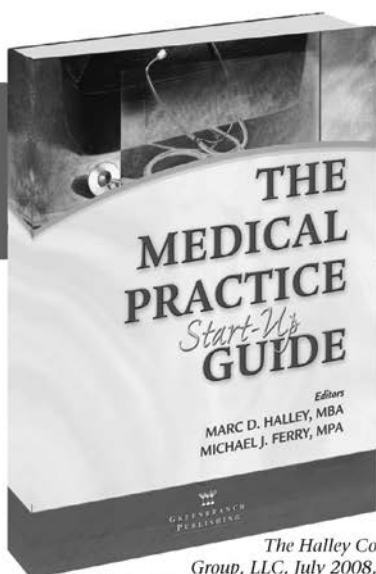
include: meeting and greeting patients; making appointments; examining patients; running tests; documenting results; communicating results to patients; preparing the examining room for the next patient; disposing of waste; paying the employees; paying the bills; and so forth.

The more detail you can provide, the better—because you have to evaluate each of these activities to see where you rank relative to competitors. We want to find out what Smith does better than his competitors. Furthermore, why should potential patients choose Smith over Brown, Jones, or Williams? This is the question we want to answer next, and the more activities we have in our description, the more options we have in our next step—external evaluation.

Bottom Line: Every practice, regardless of size, location, or specialty, needs to create a strategic plan. Getting started requires creating a mission, followed by creating a vision. In Part II, we will connect the internal analysis to the external analysis and show how everything fits together into your strategic plan. ■■

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Managing a Team of Former Peers

Laura Hills, DA*

Becoming a manager of former peers is a common occurrence in medical practice management, but it can be awkward and challenging. This article describes the specific staff management challenges that recently promoted practice managers encounter. It urges promoted managers to seek support outside the practice through new friendships, mentoring, and leadership networks. This article also describes how best to announce the promotion and suggests that new managers hold one-on-one meetings with each employee. It offers the agenda for those meetings and for the manager's first whole-team leadership kickoff meeting. This article also describes smart first tasks for a promoted practice manager and considers the possibility that some employees may not come on board with the changing social and leadership structures in the practice, and what to do about them. Finally, this article suggests that preparation to become a medical practice manager should start early. It offers a strategy for handling former peers who continue to overshare personal information with the manager. It describes how to handle four common authority challenges newly promoted practice managers may face, with sample dialogue. And it suggests a social media strategy medical practice managers can use when they are connected electronically to their former peers.

KEY WORDS: Peer; coworker; favoritism; authority; promotion; mentor; leadership; vision.

Many medical practice managers are promoted from within the practice. They are individuals who have worked hard as a member of the medical practice staff for many years and have demonstrated their talents, value, loyalty, and management capabilities. Ultimately, their contributions and abilities are recognized and they earn the promotion to management. If this is your story, congratulations! You have landed a big promotion, and you deserved it.

However, over those same years that you worked so hard and developed your skills, you also established friendships with the other members of your medical practice team. No doubt, you participated in a variety of staff social events over the years, such as lunch outings, birthday celebrations, picnics, holiday parties, and baby showers. You may remember times when you chatted happily with your coworkers over lunch or a cup of coffee in your breakroom or when you offered support to a coworker who was going through a bad time. Perhaps you relished feeling part of such a wonderful team and considered one or

more of your coworkers to be among your closest friends and confidantes.

Once a staff member is promoted, the social climate in the practice almost invariably changes.

Things are probably different now that you're the practice manager. Once a staff member is promoted, the social climate in the practice almost invariably changes. According to Salemi,¹ "Even if others in your group weren't going for it [the promotion], they may inevitably feel resentment that you're rising through the ranks and they're not. After all, isn't their hard work noticeable and rewardable, too? And if they were vying for the same role you pursued, that's another issue. They didn't get it and you did, end of story. Resentment, anyone?" Gallo² agrees, adding that promoted managers are the subject of extra scrutiny. She says, "The dynamics completely change. People start to watch you

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Prepare to be a Practice Manager from the Start

According to Miller,¹ the most successful transitions start long before a promotion takes place. If you want fewer challenges after you get promoted, establish a high level of character and integrity early in your career and keep it consistent, Miller says.

Imagine how hard your job as practice manager will be if you have voiced your frustrations about your most difficult patients to your former peers, shared gossip, or cut corners. It will be doubly hard if you showed yourself as uncaring toward other members of your team. As Miller suggests, “If you’ve shown your peers that you aren’t supportive of their success and team cohesion, they will brace for the worst when they find out you’re becoming their boss—rather than showing you their best. Their reluctance to trust you in the new role, and your inability to regain their respect, could quickly derail your transition.”

Therefore, if you’re not already promoted to the practice management position you want, consider the management style you’d like to be known for and demonstrate those skills while you are still working side-by-side with your peers. That way, when you are promoted, there will be no surprises. Your team will already know what to expect from you, based upon their experience of your planning, decision-making, communication, and collaboration skills.

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more than ever before . . . You need to establish your credibility and authority, without acting like the promotion’s gone to your head.”

Some promoted practice managers experience a profound sense of loss.

Medical practice managers who are promoted from within the practice must therefore combine the challenge of the promotion with the additional challenge of having to recalibrate their relationships with their coworkers. It is common to feel isolated, or even purposefully excluded socially, from the rest of your team. Some promoted practice managers experience a profound sense of loss, as they have, in fact, lost their place in the practice’s social structure. As Davey³ puts it, “Your good fortune means disappointment for your coworkers who didn’t get the job. When you’re promoted over people who have always been friends (or rivals), the power relationship is inevitably altered . . .

How to Handle Oversharing

Part of the process of growing out of your old role and into a new one as practice manager involves detaching yourself from the old day-to-day routines and conversations. Of course, your door should remain open, and members of your team may stop by to say hello. But you should do what you can to avoid conversations that are too personal, unless they are relevant to work. For example, if a staff member’s child has a health issue and he or she needs a flexible work arrangement, that’s an example of when to listen and to show continued compassion and support. But, as Salemi¹ suggests, “Knowing how they unknowingly butchered their tuna casserole recipe at the latest block party? Too much information.”

You’ll need to walk a fine line when a team member tries to continue sharing the intimate details of his or her personal life with you that are not relevant to the job. Of course, you won’t want to be perceived as rude or uncaring. But be mindful that as the practice manager your relationship has changed, and that the individual may be trying to curry favor with you. Gently bring the conversation back to work. As Salemi¹ suggests, you can do this by saying something like, “That’s an interesting story! I hate to cut it short but we have a very tight schedule until noon today. How’s that coming along?”

Be mindful of how much time you spend engaging in light conversation with each staff member, and the quality of that conversation. All eyes will be on you and if you are inequitable, you may be perceived as playing favorites. Avoid inside jokes and banter to which only some of your employees are privy. For more information on keeping your relationships equitable, see the sidebar, “Don’t be Perceived as Playing Favorites.”

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The one thing I can almost guarantee is that there will be awkward moments as you transition from team member to team leader.”

EXPECT THINGS TO CHANGE

The very first thing that you must do when promoted to practice manager is to anticipate and accept that things will be different now. It will do you no good to cling to or pine for your previous social position with the members of your team. As Quast⁴ suggests, “Realize that your previous personal relationships with coworkers will need to be moved to a different level because you’re no longer a

Handling Four Common Challenges to Your Leadership

Some of your former peers are likely to test your authority and leadership. Davey¹ describes four common challenges you may face and how you can handle them:

Leadership Challenge	Leadership Strategy
A decision is made without your knowledge, though you should have been privy to it.	Talk with the person/people who made the decision and make your displeasure clear. "I just learned that you authorized _____. That's a decision I should have been involved in. Let's go over the types of decisions you can make autonomously and the ones I need to be part of."
An issue that has been closed is reopened.	Resistant team members will often attempt to reopen a decision as a way to test your authority. You can discourage that behavior with this approach: "We made a decision on that issue last week. What's leading you to raise it again now? Let me reinforce that we need to move efficiently and that my expectation is that once a decision is made, everyone is on board and executing it. Dissent is welcome, but only before the decision is made."
A team member resists your leadership passive-aggressively.	Often, resistant team members don't have the courage to challenge you directly. Instead, they show irreverence with subtle and not-so-subtle body language such as turning away from you in meetings, rolling eyes, or disengaging from the conversation. When that happens, start with a subtle response such as sitting directly beside or across from the person in the next meeting or walking behind the person while you're talking. If resistance persists, provide direct feedback in a one-on-one session: "In the last couple of meetings, you've been sitting at the back of the room and providing only one-word answers to my questions. I'm concerned that you're not making the transition to me being the leader of our team. What are you willing to do differently to show that you're on board?"
A group of employees gangs up on you.	Don't try to turn things around in that moment. Diffuse the tense atmosphere by repeating the process of meeting with everyone individually. Then, bring everyone back together and address the issues in a team meeting. Be direct and don't be afraid to make people a little uncomfortable: "I'm concerned that some of you have challenged my decisions/authority and that your pushback is encouraging others to do the same. How do we get things back on track?" If there are things you've been doing that have contributed to the resistance, take responsibility for them. Then, reinforce the ground rules you established at the beginning. State clearly that in the future that you expect members of the team to address any issues they have with you directly, and to do so respectfully and constructively.

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peer—you are now the person who assigns work, analyzes productivity and provides performance appraisals." Gallo says that no matter what you do, the change is inevitable. She says, "You can no longer have close, personal friendships with your former peers. You can't continue to have relationships in the way you did before. This is a loss for everybody but it's part of the deal." In fact, if you try to maintain the status quo socially, you may appear to be playing favorites. Instead, Gallo suggests that you remove yourself from many of your usual social interactions with your former peers. If team members go out for happy hour, for example, it may be better for you to stay behind. You don't need to become aloof and unavailable, but you may want to attend fewer social gatherings, Gallo says. Quast agrees, urging newly promoted managers to "eliminate

any water-cooler or break-room gossip and venting sessions with employees."

If your personal support and social activities to this point have come mostly or entirely from your coworkers, now is the time for you to strengthen supportive relationships outside of your practice. Think about the people you already know who can be better friends to you as you move forward. Put more effort into those relationships. Have lunch with those friends; seek their insights and support. And build and foster relationships with new friends, especially with individuals who can relate well to what you're going through and support you. You will need a new social network to replace the one that's about to change.

Finally, Adenle⁵ urges you to seek a mentor who can coach you to manage your former peers effectively. She

suggests, “Find another manager with lots of experience and ask the manager to help you transition by coaching and mentoring you. Set up a reoccurring meeting with your mentor and be proactive at managing the relationship. This will gain you considerable esteem and boost your confidence in the new role.” Adenle suggests that you also join a good leadership networking group. There are lots of leadership groups and courses available online that can give you the tools you need to manage your peers, she says. Through any of these groups, you can connect with thought leaders, learn best practices, and have access to useful tools and information. In a leadership network, you can ask experienced managers how they deal with the complicated leadership issues you are likely to face now that you’re managing your former peers.

ANNOUNCE THE TRANSITION

In most medical practices, it is someone else’s responsibility to announce your promotion, but occasionally the task of making the announcement falls to the promoted practice manager. Either way, it usually is best to gather everyone together for the announcement and to do it face-to-face. That way everyone will hear the news the same way and at the same time. Schedule the announcement at the end of the day so everyone has a chance to process the news without the demands of the workday in front of them.

The exception to the general announcement approach is if you know that you have one or more staff members who may find the news particularly challenging. For example, if you won the promotion over another team member, it will be best to tell him or her in private that the job went to you, before your general announcement. That way, the individual will have time and space to process his or her disappointment privately, not in front of the rest of your staff. Just be sure that the individual has no opportunity to share the news with the other members of your team before your general announcement.

Prepare a very brief response to the announcement. Express your gratitude and excitement, but focus mostly on how much you’re looking forward to working with everyone. Accept the inevitable congratulations you receive graciously, but be mindful that all eyes will be on you from now on. A short, modest, and humble response will be best.

DISCUSS YOUR EXPECTATIONS

You will need to make it clear right away that you own your new role, especially if your new direct reports include peers who feel slighted or were passed over for the job. Step decisively into the role from the first day by letting the team know that things have changed, and that you are now their manager. A great way to do this is to schedule a one-on-one conversation with each member of your team the day after the announcement.

Rethink Your Social Media Settings

Are you connected to your former peers through Facebook and other social media? If so, you may not want to share your personal life with your staff as you’ve done before. As Salemi suggests, “Start thinking if you really want your team to know you caught up with a college buddy last night at the local watering hole.”¹

If you were vigilant about your social media all along, you won’t need to backtrack to change access to photos and more. But if you shared more than you want your staff to know in light of your new role, change your privacy settings. And from this time forward, be extra mindful about everything you post.

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Salemi suggests that you can begin your discussion by acknowledging the elephant in the room, saying something like this: “I know this can be a little awkward and feel unfamiliar because we were so close and now I’m your boss.” Use this opportunity to discuss how expectations have changed and what this new relationship will look like. Talk through what you expect of your former peers and what they expect of you. Negotiate and, if necessary, re-negotiate those expectations. Ask: “What can I do to help you be more successful?” If you do this with openness and professionalism and show that you’re sincere, quickly backing up your words with action, you’ll be well on your way to gaining your staff’s trust and respect. That said, your former peers may go through more growing pains than you do as they see you step up to the challenge of your new role. As Salemi cautions, “The need to get over it is more *their* issue than it is yours.”

At the end of each one-on-one meeting, enlist the support of each employee by asking for specific help in areas where he or she can add value. As Davey says, “Everyone knows that you went from being a peer to being the boss overnight, and pretending that you suddenly have all the answers will damage your credibility.” Ask for assistance in a genuine way that makes your direct reports feel valued and engaged.

Your transition to management will probably be a lot more complicated when a former peer is also an extremely close friend. It makes sense to honor that friendship by devoting extra care, openness, and time to your discussion of how the relationship will be changing, and to talk through the implications both inside and outside of work. Be candid about how your own responsibilities and

Don't be Perceived as Playing Favorites

If you worked in a medical practice that has 20 or more employees, you'd typically associate closely with only a handful of them. That's not necessarily because you have a dislike for everyone else. Rather, there are simply some people to whom we more naturally gravitate than others. As a member of the staff, you no doubt had coworkers you knew and liked better than others.

Now, as the practice manager, you'll still have some employees you prefer over others. However, you'll need to make a concerted effort to spread your attention more evenly among your entire staff. Continuing to have a closer relationship with some employees could potentially make others feel as though you value them less. That can fuel a host of problems, not only for your leadership but for your team overall. Employees who believe that they are valued less may make life more difficult for those they perceive as having the boss's favor.

If you have an employee you'd prefer to avoid, fight that inclination and give him or her a fair share of your attention. Also do your best to be equitable with everyone on your staff in your tone, facial expressions, and body language.

priorities have changed and ask how your friend sees his or hers changing as well. Tell your friend that you have valued your friendship and that you want him or her to be happy and successful. Let your friend know he or she can count on your continued support. Ask for your friend's loyalty in return. But make it clear that there won't be and cannot be any special treatment.

You may be able to keep your special friendship intact. But you may not be able to, at least not in the same way. Be very careful that you are not perceived by others as playing favorites. Accept that you will not be able to share everything you know with your friend as perhaps you did. And accept that even if you can maintain the friendship, the nature of that friendship will change if for no other reason than that you are now your friend's boss.

Finally, if one of your peers was in competition for the job, you will have an added layer of complexity to address. He or she has suffered a loss and is most likely disappointed. In some cases, you may need to give the person some space and time to let him or her adjust to the new situation. But it's important that you do what you can to keep him or her from sabotaging you in your new role. Make it clear that you value him or her as an employee and that you plan to advocate for his or her development. Gallo suggests that you say something like: "I understand you're disappointed. You're an important part of this team, and I'm going to make sure you have what you need to succeed."

HOLD YOUR FIRST TEAM MEETING

Once you've completed your one-on-one meeting, schedule your first team meeting. Create a special format for that event. Ideally, make your leadership kickoff meeting longer than your usual staff meeting, preferably in a unique setting such as a conference center in your community. The event can work even better if you can plan to spend an afternoon meeting with your team and then go out with them socially afterwards.

Start by discussing the purpose of your team. Of course, you'll have your own take on this because you've been a part of the team. But seek your staff's input, too. Bring in some of the ideas you collected from your one-on-one conversations. Engage in a discussion about where you need to continue on the same path and where you need to make changes. This will demonstrate that you're not just a steward of the former practice manager's plan, but a leader in your own right.

Next, share your early vision for your team and any priorities that you will tackle right away. Leave room for comments and questions so your team members feel like coauthors of the plan. Then discuss the ideal meeting schedule for your team. What are the different types of meetings you'll need and how frequently and how long do you need them to be? This is another good way to usher in a new era under your leadership.

Finally, spend some time explaining how you like to operate and what your rules of the road are going to be. Davey suggests that it will be most useful if you can distill your philosophies into two or three guiding principles or ground rules. For example, if you know that some of the members of your team tend to be passive-aggressive, be explicit about your expectation that they address their concerns directly. For example, Davey suggests that you say something like this: "I want to be very clear that all issues need to be shared openly so they can be resolved. Please don't come to me with an issue you haven't addressed directly with one another first." By stating your ground rules, you'll manage your team's expectations and establish how you're going to handle things.

Be sure to end your meeting on a high note. For example, this would be a good time to initiate a new ritual for your team and to tell them what it means to you to have their support.

TREAD LIGHTLY AT FIRST

You probably have tons of ideas about how to lead your team, and you may be chomping at the bit to make sweeping changes in your practice. But don't introduce any major overhauls right away. You'll need to demonstrate your new authority without stepping on toes or damaging relationships. Gallo suggests that you make a few small decisions fairly quickly, but that you defer bigger ones if at

all possible until you've been in the role longer and have time to gather input.

In the meantime, seek volunteer opportunities that will demonstrate your leadership. For example, volunteer for a committee for your professional organization and become more actively involved. As Salemi suggests, "As you take on leadership roles [outside your medical practice], former peers begin to see you as just that – a leader. An added bonus? You'll start seeing yourself as a leader, too."

CLEAN HOUSE IF YOU NEED TO

Your medical practice has demonstrated confidence in you by making you its manager. Continue to deserve that confidence by balancing the humility to listen and learn and serve your team with the courage you will need to assert your role as a leader.

Your former peers will have to accept and support your leadership, or they will have to go.

Make the best effort you can, but recognize that you and each member of your staff have a two-way relationship. Your former peers must be willing to come around, too. If they're not meeting you halfway despite your best

efforts over time, tell them. And if resistance continues after you've addressed the issue directly with your former peers and given them opportunities to come on board, handle the matter as you would any serious performance issue. Clearly state your expectations, explain where they're falling short, and warn them what the consequences will be if you don't see improvement. Then follow through. Ultimately, your former peers will have to accept and support your leadership, or they will have to go. As Davey suggests, "Valuable team members will adapt. Those who don't may need to find another place to contribute." ■■

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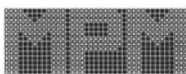
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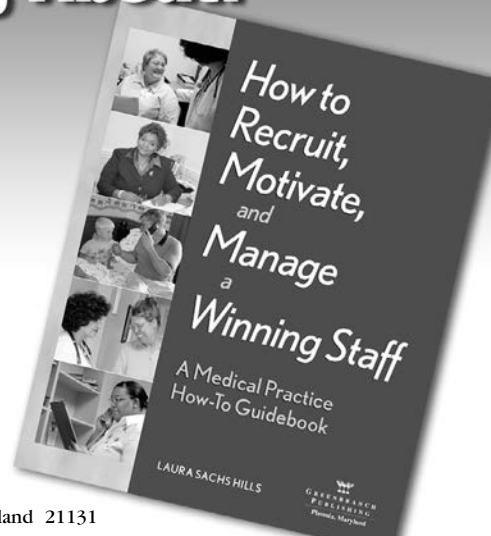


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Thirty Cost Savings for the Medical Practice

Michael O'Connell, MHA, FACMPE, FACHE*

Cleveland Clinic has used a collaborative approach in seeking ways to make care more affordable by identifying approaches to create better value by improving quality and decreasing costs. It is possible to achieve cost savings and create better value without compromising quality. By engaging caregivers and creating multidisciplinary teams to evaluate cost savings, over \$500 million was saved, and hundreds of ideas were implemented. This article reviews 30 cost-saving ideas that any medical practice could use. The ultimate goal is to reposition costs and make care more affordable.

KEY WORDS: Care affordability; cost savings; value; quality; innovation; teamwork.

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As a medical practice administrator, it is critical to constantly investigate ways to improve value and reduce cost in the medical practice. The challenge is to do it in a way that does not compromise quality, outcomes, or service. Whether one is leading a hospital-based or independent medical practice, the challenge is the same. Value equals cost over quality. At Cleveland Clinic, we live our mission by providing better care of the sick, investigating their problems, and educating those who serve. We live the mantra of "Patients First" and welcome change, encourage innovation, and always look for ways to seek better, more efficient ways to achieve our goals. We achieve that innovation through teamwork, where we all share our knowledge to benefit our patients and caregivers with the goal of advancing our mission.

In the current healthcare landscape of care affordability, we must be excellent stewards of our resources.

In the current healthcare landscape of care affordability, we must be excellent stewards of our resources. We cannot assume that the current way of caring for patients will continue to work in the future, and we must investigate every service, program, and cost to determine whether it provides value to our patients.

As a multispecialty academic health system, we have phenomenal opportunities to explore our systems and practices, with over 6.6 million outpatient visits in 2015, 165,000 hospital admissions, and over 1.9 million unique patients to serve. Yet regardless of size or scope of the

service, investigation of costs involves collaboration, teamwork, and problem solving with a "patients first" orientation.

Everyone was challenged with a system-wide goal of investigating all costs and reducing them by \$498 million over a two-year period while improving outcomes and quality and working to ensure that "Every Life Deserves World Class Care." The organization assembled eight teams, all chaired by physician champions, and explored all costs throughout the health system, including supplies, staff and benefits, energy, and anything else that made the list. All areas of the enterprise needed to be looked at from a fresh perspective.

Parallel to this effort, several years ago, the system implemented a program called "My Two Cents" that asked all caregivers to submit their suggestions, ideas, and recommendations on ways to improve patient experience, quality and safety, employee engagement, and marketing/growth. This effort invited employees to be creative, innovative, and forward-thinking and provide fresh perspectives and insight into doing things differently, better, and more efficiently. The program has collected over 1000 ideas and has resulted in \$7 million in savings.

Some ideas could be implemented easily, whereas others took much time, effort, and energy to address. Regardless of the idea, implementation required a team effort with effective communication and problem solving. Approaching the solutions with care affordability in mind, the ideas generated more ideas and ways to save money and create better value. Of the more than 1000 ideas that were chosen, this article lists 30 ideas that were implemented. The intent of the article is to challenge the reader to consider at least

one of these ideas to consider in his or her practice, if that has not already been done, and explore additional ways to create solutions that can save money and improve value.

In addition, cost repositioning and care affordability was approached through creation of eight teams with a long-term, enterprise-wide effort in which every clinical and administrative employee assesses everything he or she does to provide service more effectively and efficiently. The eight teams are:

- **Clinical Program and Asset Optimization:** reviews clinical programs, assets, and services to optimize locations and capacity;
- **Indirect Program and Asset Management:** examines non-billable operational support, corporate shared services, administrative overhead;
- **Non-Staff Workforce and Productivity:** focuses on non-physician employees, including hiring patterns, productivity, span of control, pay/benefit policies;
- **Staff Workforce and Productivity:** investigates physician recruitment, practice, and retention;
- **Stewardship:** looks at managing system resources, discretionary spending, sustainability, and waste;
- **Education:** examines educational services including graduate medical education, continuing medical education (CME), and health sciences;
- **Research:** looks at performance of basic, translational, and clinical research; and
- **Value-Based Care:** assesses care paths, care coordination, contracting.

Through these eight teams and the My Two Cents Program, a small sample of ideas is shared for consideration:

1. **Consider more electronic options.** By eliminating sending employees' communication or information via regular mail, send the information electronically. Cleveland Clinic no longer mails paper checks, W-2 forms, or open-enrollment packages to employees. All are available online. By not mailing employees paychecks, the total one-year savings was \$640,000 (figuring 44,000 employees and 26 pay periods).
2. **Standardize product use.** The organization went from using five wound-cleansing products to one, with a cost savings of \$10,000.
3. **Default printers to double-sided printing.** When sending a document to print, default printing to a double-sided option reduces paper costs by 50%.
4. **Replace expensive markers with less expensive ones.** We were using \$3 brand-name markers to mark surgical patients' body parts and throwing away the marker after use. By using a generic marker instead, at \$1 each, the cost savings was \$20,000 for 10,000 surgeries performed.
5. **Eliminate exam-room phones.** Many offices use iPhones or portable phones in their offices. Having an exam room phone is redundant and unnecessary; removing exam room phones can save over \$1500 for six exam rooms.
6. **Decrease overtime.** Many offices do not flex staff when staff gets close to working more than 40 hours per week. Explore creative ways to prevent inappropriate use of overtime. Examples include scheduling staff for a 36-hour work week so that if extra hours are worked, they are not overtime. Another way is to reduce the use of what we call the 15-minute creep, by communicating with employees that they can't work past their shift unless approved by management. This discourages employees who consistently punch out several minutes after their scheduled end of shift and get paid for time not approved.
7. **Consolidate computer software resources.** We found that we were using redundant technology and software. By eliminating one software, we saved \$1 million.
8. **Provide in-house computer training.** Outside computer training can be expensive and adds up. By offering some desktop computer training in-house, we avoided \$200,000 of outside vendor fees.
9. **Reduce par levels kept on supply carts.** By looking at clinical cart par levels, we were able to go from 700 to 330, items saving \$69,000 annually.
10. **Switch supply vendors.** We were using alcohol pads from one vendor and found that we could switch to another vendor, get alcohol pads of comparable quality, and save \$17,000.
11. **Convert to unit-dose medication packaging.** By converting to unit-dose packaging instead of using 28-g tubes, we reduced the amount of wasted product by \$8000.
12. **Consolidate courier services.** By reevaluating schedules and pickup times, we were able to leverage the courier and save \$35,000 in annual charges.
13. **Default to E-prescribing option.** By switching from paper scripts to electronic prescribing, we saved 1¢ per page, resulting in thousands of dollars in savings.
14. **Eliminate desktop printers.** In one building we eliminated individual office desktop printers and saved \$12,000 in maintenance, toner, and electricity by moving to centralized printers.
15. **Reduce lotion size.** We were providing patients with 20-ounce bottles of lotion when they were normally only using 10 ounces. By switching to 10-ounce bottles, we saved money per unit and reduced amount of wasted product.
16. **Restock and reuse supplies still sealed.** It's a cost-saving alternative to throwing away such supplies that normally were thrown away in a patient room.
17. **Standardize Bivalirudin (blood thinner) concentration.** When we standardized the concentration from 5 mg/mL to 1 mg/mL, the amount of medication wasted was reduced, saving about \$200 per drug dispensed.

- 18. Replace foam cradle for patients' arms at ambulatory surgery center.** We reduced the price for each cradle from \$6.19 to \$2.57 by working with a vendor to settle on a comparable product. The result was over \$10,000 in savings for 3000 surgeries.
- 19. Implement programs and incentives for healthy lifestyle choices for employees.** These incentives included a tiered premium health plan, no-smoking policy, and chronic care programs. We reduced employee health costs by 50 percent.
- 20. Change sterile gloves.** By switching the type of sterile glove used in one department, cost per box dropped by \$78 to \$20, for a savings of \$5000.
- 21. Reprocess single-use devices.** We use a third-party company to reprocess single-use devices, including arthroscopic shavers, blood pressure cuffs, catheter introducer sheaths, endoscopic trocars, and electrophysiology catheters and cables. This resulted in a 12-month savings of \$3.3 million and 95,101 pounds of waste diverted!
- 22. Power off computer monitors at night.** This provided an annual cost savings of \$6100.
- 23. Deactivate telephone and fax lines no longer in use.** Thousands of dollars can be saved this way.
- 24. Create a "Green Team" to reduce, reuse, and recycle waste.** One site has saved over \$15,000 annually by eliminating the use of one dumpster weekly.
- 25. Evaluate medication formulary approvals.** By enlisting the support of physician committees and based on evidence-based medicine, we saved \$750,000 on an oncology formulary.
- 26. Evaluate pagers and on-call schedules.** One area reduced its on-call pagers from three to one, saving \$8500 annually by eliminating on-call pay and monthly pager fees.
- 27. Create multifunctional devices.** By combining printing, faxing, and scanning functions into one unit, thousands of dollars were saved.
- 28. Create an energy committee.** In one location, the energy committee accounted for \$100,000 of savings in projects in its first year by such steps as replacing light bulbs with more efficient bulbs, decreasing temperature settings, and turning off lights.
- 29. Remove rapid sequence intubation kits.** By placing needed medication into crash code carts, annual savings resulted in \$1200.
- 30. Evaluate alternate waste options.** By using purple waste bags for recyclable surgical items, we reduced garbage bin fees and achieved \$230,000 in annual cost savings.

CONCLUSION

The key takeaways are to:

- Engage with caregivers and professional staff to encourage them to submit their ideas;
- Encourage a culture of innovation and creativity;
- Encourage everyone to submit ideas, with the more the better;
- Explain to the idea submitter the reason why his or her idea was not considered;
- Thank everyone for submitting ideas;
- Let staff know when a cost-saving idea has been implemented; and
- Celebrate ideas that are implemented.

By embracing this collaborative approach, greater value can be provided to patients through cost reductions that do not compromise quality. It's an approach that has worked for the Cleveland Clinic and will continue for years to come with a "Patients First" focus. ■■



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Using a Radiofrequency Identification System for Improving the Patient Discharge Process: A Simulation Study

Sung J. Shim,* PhD, Arun Kumar, PhD,[†] and Roger Jiao, PhD[‡]

A hospital is considering deploying a radiofrequency identification (RFID) system and setting up a new “discharge lounge” to improve the patient discharge process. This study uses computer simulation to model and compare the current process and the new process, and it assesses the impact of the RFID system and the discharge lounge on the process in terms of resource utilization and time taken in the process. The simulation results regarding resource utilization suggest that the RFID system can slightly relieve the burden on all resources, whereas the RFID system and the discharge lounge together can significantly mitigate the nurses’ tasks. The simulation results in terms of the time taken demonstrate that the RFID system can shorten patient wait times, staff busy times, and bed occupation times. The results of the study could prove helpful to others who are considering the use of an RFID system in the patient discharge process in hospitals or similar processes.

KEY WORDS: Hospital; RFID; computer simulation; patient discharge process; patient tracking; process modeling; process reengineering.

Organizations reengineer their business processes to improve efficiency, to contain costs, and to stay competitive in the marketplace. With escalating healthcare costs, hospitals also seek ways to provide quality healthcare services while containing costs. Hospitals traditionally have emphasized breakthroughs in healthcare technology to stay competitive. However, as competition among hospitals continues to intensify, patients may perceive little difference in the healthcare technology used by different hospitals. Consequently, hospitals are beginning to understand that process reengineering can be a better way to achieve competitive advantage. Just as many businesses successfully reduce costs and gain competitive advantage by reengineering their business processes, hospitals can reengineer the way certain healthcare processes are carried out to achieve efficiency and cost containment. Computer simulation that has proven successful in improving various business processes can also serve as an effective tool in the search for more efficient processes in hospitals.

This article describes a case study undertaken at a hospital in Southeast Asia (referred to as “the Hospital”

hereafter for brevity and anonymity). The Hospital has about 1400 beds and also runs more than a dozen specialty clinics for outpatients. To improve the patient discharge process, the Hospital management considered implementing some changes with an RFID system that can keep track of movement of patients in the process. Using computer simulation, the study modeled the patient discharge process and assessed its efficiency in terms of time taken and utilization of resources in the process. The results of the study will prove helpful to those who are considering reengineering and improving the patient discharge process or other similar processes with RFID systems.

RADIOFREQUENCY IDENTIFICATION TECHNOLOGY IN HEALTHCARE

RFID is emerging as a viable technology solution for hospitals to identify and track various mobile assets in medical facilities, identify and locate patients, and manage healthcare staff.¹ In the case of patient tracking, for example, a patient can wear a wristband with an RFID tag and then the location of the patient can be tracked by the RFID

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system. An RFID system usually consists of a reader and a tag that communicate with each other over a certain radio frequency. An RFID tag is made up of integrated circuit and antenna. The antenna enables the integrated circuit to receive power and communicate, enabling the RFID tag to exchange data with the reader. A recent study reported that the global market for RFID systems in the healthcare industry will increase steadily, from \$90 million in 2006 to \$2.1 billion by 2016,² and it seems that this prediction has been fulfilled.

Although most studies on RFID technology in healthcare have focused on the tracking of physical assets, only a few studies have reported on the use of RFID technology for identifying and tracking patients. Bacheldor³ reports on a hospital group in Florida that planned to use RFID technology to keep tabs on its patients. Bacheldor,⁴ Cangialosi et al.,⁵ and Hancox⁶ also report on systems using RFID-enabled wristbands to identify patients and surgical procedures that they need. Amini et al.⁷ report on a simulation study conducted at a regional hospital where an RFID-based system was used to collect data related to the movement of trauma patients in the hospital. Few, however, have studied any specific use of RFID for tracking patients in the discharge process or its impact on the process.

COMPUTER SIMULATION IN HEALTHCARE

Computer simulation involves modeling processes that enable analysts to study how a system reacts to conditions that are not easily or safely applied in real-world situations and to examine how the working of an entire system can be altered by changing individual parts of the system.⁸ The real power of simulation is fully realized when it is used to study complex systems.⁹ Healthcare encompasses a dynamic system with complex interactions among various components and processes. Furthermore, healthcare management operates in an environment of aggressive pricing, tough competition, and rapidly changing guidelines. To meet these challenges, healthcare management must respond quickly to identify critical system processes, recognize all relevant resources, access real-time information and analyze “what if” cases.¹⁰

Although many applications of computer simulation to healthcare management and operations are possible,¹¹ we may classify them into two groups: (1) applications to healthcare systems at the various levels of communities, regions, or the nation; and (2) applications to specific operations, processes, or services in healthcare institutions. The first group includes applications intended to study the provision of mental health, public health, health reform, or healthcare workforce, often with policy implications. For example, Anderson et al.,¹² Jacobson and Sewell,¹³ Rauner,¹⁴ and Zaric¹⁵ illustrate the use of simulation for

various health policy analyses. The second group includes applications intended to improve facility design, staffing, and scheduling, and the reduction of patient wait times and operating costs.¹⁶ The case study described in the following sections attempts to extend this line of study by considering the patient discharge process with an RFID system implemented in a hospital.

MODELING THE PATIENT DISCHARGE PROCESS

The main objective of the simulation in this study is to model the patient discharge process in three scenarios: (1) the current process; (2) the new process with the RFID system; and (3) the new process with the RFID system combined with the discharge lounge. The process is assessed in terms of two efficiency measures: (1) time taken and (2) utilization of resources in the process. The patient discharge process consists of six stages, as described in the remainder of this section

Verification

The nurse (or the patient service associate) verifies the doctor's authorization for discharge of the patient by checking the patient's medical notes and treatment sheet.

Notification

The nurse informs the patient (or the patient's caregiver or family members) of the impending discharge. The nurse also notifies the relevant departments in the hospital (e.g., the business office) and external institutions (e.g., nursing home, police station, and medical social workers) of the discharge if necessary. The patient and relatives are advised that the official discharge time is 1:00 PM and that an additional day's rate will be charged for any discharge that occurs after 1:00 PM. If necessary, transportation from the hospital is also arranged for the patient by the patient and relatives.

Preparation and Coordination

The nurse arranges outpatient follow-up appointments if necessary, either on the computer system or by calling the respective specialty clinics. However, the details on follow-up appointments can only be retrieved from the computer system after 30 minutes, and only after the appointment details are ready can the referral memo be printed out and the discharge advice form be filled out. Before the paperwork is printed, the nurse also reminds the doctor to take the patient's existing home medications into consideration when the doctor prescribes discharge medications for the patient. Once the doctor has completed the medical certificate and prescription form, the prescription form is dispatched to the satellite pharmacy before noon. Afterward, the patient and relatives are advised to collect

the patient's belongings from the admission office. If the patient is a foreigner, the patient is referred to the business office for discharge clearance. The nurse liaises with the transport officer for ambulance services if the patient is being discharged to another hospital, as specified by the doctor in charge. If the patient is a public assistance card holder or has financial difficulties, the medical social worker assists the patient in arranging for transportation from the hospital.

Patient Education

Before the patient is discharged, the nurse goes over, once again, health education to the patient and relatives, as recorded in the discharge planning of the nursing assessment record. The health education usually includes providing the patient with information and instructions on medication management such as injections, wound management, physical therapy, medical equipment and techniques, personal care and household care.

Discharging the Patient

Before discharging the patient, the nurse checks the patient for any signs of physical discomfort and makes sure that the patient is ready and healthy enough for discharge. The nurse provides the patient and relatives with all necessary discharge documents as indicated on the discharge checklist. When the patient's relatives or caregivers are not able to adhere to the official discharge time at 1:00 PM, the patient is discharged after office hours. If the discharge takes place after office hours and no follow-up appointment can be arranged, the patient and relatives are kept informed by phone or mail on the next working day with regard to the follow-up appointment details. Then the nurse prints out a blank copy of the referral memo for outpatient appointments and passes it to the patient and relatives. Once informed by the nurse over the phone about the outpatient appointment details, they fill in the appointment details in the referral memo, which is then brought along for subsequent appointments. The nurse records the particulars of the patient in the outpatient appointments in the late discharge cases and checks this record daily for any patients who have not been informed and followed up accordingly. The record is updated once the patient and relatives have been notified. In the event that the patient has no contact number or cannot be reached for two consecutive days, a notice of appointment details is mailed to the registered address of the patient.

Administration

The patient service associate (PSA) keys in any outstanding charges in the database. PSAs are non-nursing staff that help patients in the registration and discharge processes. The nurse also returns any balance of medications, wound products, and enteral feeds back to the pharmacy, using the drug adjustment form. Then the nurse prints out and

gives the provisional bill to the patient before the patient leaves the ward. When the patient leaves the ward, the discharge data are entered into the computer system, and the census board is updated. Data such as patient name, identification number, gender, time and date of discharge, bed occupied, and contact number are updated in the patient register. If the patient is a direct access case from a primary physician's office, a discharge summary is faxed to the referring physician. The PSA checks that the doctor has summarized the case notes and ensures that the case notes are ready for collection by the medical record office staff within the next 72 hours. The case notes are removed from the ward and then updated in the medical record management system.

PROBLEMS IN THE CURRENT PROCESS

The Hospital management is concerned about the lengthy and inefficient process for discharging patients. Data from the Hospital show that the whole discharge process in each ward can take at least two hours. This not only causes frustration and dissatisfaction on the part of the patients but also leads to delays in processing incoming patients and low ratios of bed turnovers. The Hospital management has identified two major bottlenecks in the current patient discharge process.

The first bottleneck is at the stage of arranging follow-up appointments for the patient. The nurse or PSA cannot check the follow-up appointment details in the computer system immediately after making the appointment, because it can typically take about 30 minutes for the specialty clinic to confirm the request for a follow-up appointment. The Hospital management recognizes that it is important to improve efficiency at this stage, which depends on how fast an appropriate follow-up appointment is arranged and confirmed by the respective clinic.

The second impediment comes at the stage of completing the medical certificate and prescription form by the doctor. This drawback results from the delay in waiting for the doctor to complete the medical certificate and prescription form. That delay occurs because the doctor often has to deal with demands from other sources at the same time. For example, after authorizing the patient for discharge, the doctor in charge may have to attend to other duties and responsibilities in the specialty clinic, leaving little or no time to complete the medical certificate and prescription form. The doctor usually is not available to complete the forms until after his or her other commitments have been taken care of, which causes a disruption to the patient discharge process, inadvertently forming a queue with waits and delays.

Another potential problem that can lead to a delay in the patient discharge process occurs when the patient does not adhere to the official time for discharge (e.g., by 1:00 PM).

For example, even after the discharge is authorized, the patient may still occupy the bed because no caregiver is present to complete the discharge process. As “hidden beds” are not being eliminated, this results in unnecessary holdups, reducing the bed turnover ratio, which may then cause the hospital to lose potential income.

THE NEW PROCESS WITH THE RADIOFREQUENCY IDENTIFICATION SYSTEM

The changes that the hospital management considers in order to improve the patient discharge process include: (1) setting up a new “discharge lounge” where patients can stay after they are authorized for discharge but before they leave the hospital; and (2) using the RFID system with RFID tags on the wristbands of patients to keep track of movement of patients in the process. The discharge lounge is planned to be furnished with wheelchairs, recliner beds, television, reading materials, and toilet facilities.

The current patient discharge process is carried out while the patient waits in bed. This results in delay in the patient discharge process, a shortage of beds available for new patients, and slow turnover of bed occupancies. To resolve these problems, the Hospital management considers adding a discharge lounge in the patient discharge process. Once the doctor has authorized the patient to be discharged, the patient is transferred to the discharge lounge, where the patient can wait for all administrative and paper work to be completed, for prescription medications to be prepared, for follow-up appointments with specialty clinics to be arranged, and for transport services or family members or relatives to pick them up. Patients can be examined by a doctor or nurse for their suitability for the discharge lounge before being transferred to the discharge lounge. Some patients may feel uncomfortable with staying in the discharge lounge with other patients, and those patients can stay and wait in their bed. The Hospital management expects that the discharge lounge will improve the overall patient discharge process, make more beds available for new patients to be admitted, and utilize staff resources more efficiently.

The Hospital management expects the RFID system to keep track of the patient, with particular emphasis on when the patient enters and exits the new discharge lounge, and when the patient leaves the hospital. When the patient is transferred to the new discharge lounge, the RFID reader at the entrance/exit of the lounge scans the patient’s RFID tag, initiating the following notifications: letting the attending physician know that the patient is waiting in the discharge lounge for prescriptions and the medical certificate; informing the housekeeping department that the patient’s bed has been vacated and is ready for cleaning; informing the bed management unit that the patient’s bed

has been freed up for a new admission; and requesting outpatient follow-up appointments. When the patient exits the discharge lounge, the RFID reader at the entrance/exit of the lounge scans the patient’s RFID tag and initiates tasks such as faxing a copy of the patient’s discharge summary to the general practitioner, entering the discharge data into the computer system and updating the census board, and reminding the consultant to summarize the patient’s case notes. The Hospital management expects that the RFID system will enhance the usability of the discharge lounge by allowing patients to be tracked with less staff and discouraging any patient from leaving the Hospital before completing the discharge procedures. The RFID system can trigger an alarm if patients attempt to leave the Hospital before completing the discharge procedures.

RESULTS AND DISCUSSION

For the simulation in this study we used data obtained from the Hospital. When necessary data for the simulation model were unavailable, we used the best estimates provided by the Hospital staff familiar with the patient discharge process. Using Arena software, we constructed a simulation model for the patient discharge process at the Hospital and ran the simulation model in the following three scenarios: (1) the current process; (2) the new process with the RFID system; and (3) the new process with the RFID system and the new discharge lounge.

The three scenarios were built on a common foundation or base model in which all variables were held constant. The simulations run in the three scenarios used data with 30 patients discharged per week on average. In the simulation model, 100 trial runs were used to reduce any variability in the results. During the simulation, the model ran for a period of 182 days (26 weeks) or 182 replications of daily discharges of patients. The patient discharge process was assumed to commence at 9:00 AM and end by 2:00 PM from Monday to Sunday.

Table 1 shows the simulation results on the time taken in the three scenarios of the patient discharge process. Patients experienced the longest wait time in scenario 1—117.04 minutes. Scenario 2 shortens patient wait time by 8.85 minutes, while scenario 3 shortens patient wait times by 3.07 minutes. The Hospital staff, including doctors, nurses, PSAs, and orderlies, spent about 140.70 minutes in scenario 1. Scenario 2 shortens staff busy times by 18.32 minutes, while scenario 3 shortens staff busy times by 12.34

Table 1. Times Taken in the Patient Discharge Process

	Scenario		
	(1)	(2)	(3)
Patient wait time	117.04	108.19	113.97
Staff busy time	140.70	122.38	128.36
Bed occupation time	117.04	108.19	6.01

Table 2. Utilization of Resources in the Patient Discharge Process

	Scenario		
	(1)	(2)	(3)
Doctor 1	0.3211	0.2793	0.2811
Doctor 2	0.3208	0.2779	0.2817
Doctor 3	0.2645	0.2350	0.2351
Doctor 4	0.2644	0.2365	0.2314
Average of doctors	0.2927	0.2572	0.2573
Medical orderly 1	0.0200	0.0201	0.0569
Medical orderly 2	0.0199	0.0201	0.0585
Medical orderly 3	0.0167	0.0167	NA
Medical orderly 4	0.0168	0.0167	NA
Average of medical orderlies	0.0183	0.0184	0.0577
PSA 1	0.3028	0.2426	0.4882
PSA 2	0.2952	0.2366	0.4810
PSA 3	0.2552	0.2020	NA
PSA 4	0.2531	0.2017	NA
Average of PSAs	0.2766	0.2207	0.4846
Ward nurse 1	0.0333	0.0333	0.0153
Ward nurse 2	0.0329	0.0329	0.0159
Ward nurse 3	0.0279	0.0277	0.0130
Ward nurse 4	0.0278	0.0278	0.0127
Average of ward nurses	0.0305	0.0304	0.0142
Lounge nurse	NA	NA	0.0521
Average of all	0.1545	0.1317	0.1710

PSA, patient service associate.

minutes. The new discharge lounge significantly helped reduce the bed occupation time.

Table 2 shows the simulation results on utilization of resources, including four doctors, four medical orderlies, four PSAs, and four nurses involved in the patient discharge process. The utilization level of doctors decreases slightly, from about 29% in scenario 1 to about 26% in both scenarios 2 and 3. The utilization level of medical orderlies in scenario 3 is more than twice as high as that in the other two scenarios. Similarly, the utilization level of PSAs in scenario 3 is much higher than that in the other two scenarios. Also, the utilization level of PSAs in scenario 2 is about 5% to 6% lower than that in scenario 1. This result suggests that the RFID system can relieve some of their tasks in the patient discharge process. The Hospital management also wanted to test the simulation model for utilization of two medical orderlies and two PSAs in scenario 3. The utilization level of nurses is about the same in scenarios 1 and 2, but it decreases significantly in scenario 3. This result suggests that the RFID system and the discharge lounge together can relieve as much as half of the nurses' tasks in the patient discharge process.

CONCLUSION

The hospital management is considering using the RFID system and setting up a new discharge lounge in order to improve the patient discharge process. This computer simulation study models the patient discharge process and evaluates the effects the changes would have on the time taken in the process and the utilization of resources involved in the process. The simulation results on the time taken in the process demonstrate that the RFID system can shorten patient wait times, staff busy times, and bed occupation times, while the discharge lounge can significantly shorten bed occupation times. The simulation results on utilization of resources suggest that the RFID system can slightly relieve the tasks of all resources involved in the process, whereas the RFID system and the discharge lounge together can significantly mitigate the nurses' tasks in the process. Based on the simulation results, we support the implementation of the RFID system and the discharge lounge to improve the patient discharge process in the hospital. ■■

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Economic Benefits of Enhanced Recovery After Surgery

Jeffrey Huang, MD*

Enhanced recovery after surgery (ERAS) consists of standardized, coordinated, interdisciplinary perioperative care plans. An increasing body of evidence supports the clinical effectiveness of ERAS for a wide range of procedures. ERAS plans have been implemented worldwide. Evidence from randomized controlled trials, systematic reviews, and meta-analyses has demonstrated the economic benefits of ERAS.

KEY WORDS: Enhanced recovery after surgery; cost; economic benefits; surgeries; clinical outcomes; quality.

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Enhanced recovery after surgery (ERAS) consists of standardized, coordinated, interdisciplinary perioperative care plans that incorporate evidence-based interventions to minimize surgical stress, improve physiologic and functional recovery, reduce complications, and thereby facilitate earlier discharge from the hospital.¹

Initially, this approach was named “fast-track surgery.” The term “fast track,” however, caused confusion about the goal of the approach. The goal is not just reduction in length of hospital stay; the primary aims are to hasten recovery time, decrease morbidity, improve efficiency, and decrease variability, which will be reflected in a reduction in hospital stay.^{2,3}

An increasing body of evidence supports the clinical effectiveness of ERAS for a wide range of procedures.

Since the early 1990s, ERAS has gradually become the standard of care in colorectal surgery.⁴ ERAS has been investigated and implemented worldwide.⁵⁻¹⁰ An ERAS protocol includes more than 20 elements.^{11,12}

An increasing body of evidence supports the clinical effectiveness of ERAS for a wide range of procedures. In addition to colorectal surgery, the benefits of ERAS also have been demonstrated in patients undergoing urologic, gynecologic, orthopedic, upper gastrointestinal, hepatobiliary, cardiac, and vascular surgery.

CLINICAL OUTCOMES

Meta-analyses of randomized trials comparing an enhanced recovery pathway with traditional perioperative care in colorectal surgery have reported that the ERAS program is associated with earlier recovery and discharge after colonic resection.

Two systematic reviews^{13,14} demonstrated that ERAS reduced hospital length of stay (LOS) after colon resection. However, the mortality rate and readmission rate stayed the same.

A Cochrane review¹³ included four randomized controlled trials (RCTs) with 237 patients (119 ERAS vs. 118 conventional). The primary LOS was shorter for the ERAS-treated patients (mean difference -2.94 days; 95% CI, -3.69 to -2.19). There was a significant risk reduction for all complications (RR 0.50; 95% CI, 0.35-0.72). Readmission rates were the same in both groups.

ERAS programs can improve clinical outcomes and may also be associated with a reduction in cost.

Varadhan et al.¹⁴ reported on six RCTs with 452 patients, 226 in each group. Patients undergoing major open colonic or colorectal surgery and managed with a perioperative ERAS pathway had a primary hospital stay 2.5 days shorter than those managed with a traditional care pathway [weighted mean difference (random, 95% CI), -2.51 (-3.54, -1.47)]. Management with an ERAS plan resulted in significantly fewer postoperative complications [RR (95%

CI): 0.53 (0.41, 0.69)]; there were no statistically significant differences in readmission [RR (95% CI): 0.80 (0.32, 1.98)] and mortality rates [RR (95% CI): 0.53 (0.09, 3.15)].

ECONOMIC BENEFITS

Because of rising healthcare costs, clinical protocols that both improve clinical outcomes and decrease costs are increasingly attractive. Economic evaluations are an essential part of assessments of new health technologies and are important for funding decisions made by hospital administrators, insurers, governments, and policy developers.¹⁵

ERAS programs can improve clinical outcomes and may also be associated with a reduction in costs as a result of the reduction in LOS and morbidity. A recent systemic review describes economic evaluations in a wide variety of abdominal surgical procedures conducted in an ERAS program. Almost all studies showed decreases in LOS and costs, and none of the included studies found a significant increase in the incidence of either readmission or morbidity.¹⁵

Colorectal Surgery

The cost reductions following implementation of ERAS programs for patients undergoing elective colorectal surgery are well documented.¹⁶⁻¹⁸ Lemanu et al.¹⁹ reported on seven studies in colorectal surgery, all of which demonstrated cost reductions. Lee et al.²⁰ reported on 10 studies. Five of those studies provided enough information to calculate incremental cost-effectiveness ratios, and all 10 studies showed ERAS programs were less costly and more effective for reducing LOS. Roulin et al.²¹ demonstrated that ERPs have resulted in a mean savings of €1651 (\$2245) per colorectal surgical patient.

Bariatric Surgery

Lemanu et al.²² conducted an RCT comparing patients undergoing laparoscopic sleeve gastrectomy in an ERAS protocol with those receiving conventional care. The LOS was significantly shorter in the ERAS group than in the control and historical groups. There was no difference in readmission rates or postoperative complications, and the mean cost per patient was significantly lower in the ERAS group than in the historical group.

Gastric Surgery

A systematic review assessed ERAS in gastric surgery.²³ Five studies with a total of 400 patients were included in the meta-analysis. All included studies reported that postoperative hospital stay was significantly lower for the ERAS group in comparison with the conventional perioperative care group. There was no significant difference in readmission rates between the two groups. ERAS did not increase postoperative complications compared with the

conventional group. The LOS was significantly shorter in the ERAS group than in the control group. Mortality, morbidity, and readmissions were similar between groups, and hospital costs were significantly less in the ERAS group than in the conventional group. Total costs were significantly decreased with ERAS.

Gynecology

Yoong et al.²⁴ described implementation of an ERAS protocol in vaginal hysterectomy. Fifty patients who underwent vaginal hysterectomy after implementation of ERAS were compared with 50 control patients before ERAS. The LOS was reduced by 51.6%, and the percentage of patients discharged within 24 hours was increased five-fold. A cost savings of 9.25% per patient was realized with an ERAS protocol.

In a case-control study, Relph et al.²⁵ reported on similar cost data in their study of 100 patients undergoing vaginal hysterectomy (50 ERAS and 50 control patients). The inpatient readmission rate was similar in both groups. Establishing the program incurred additional expenditures, including delivering a patient-orientated gynecology "school" and employing a specialist enhanced recovery nurse, but despite these, they demonstrated a saving of 15.2% (or £164.86) per patient.

Kalogera et al.²⁶ reported on 241 patients who underwent a variety of different types of gynecologic surgery after implementation of an ERP protocol compared with 235 historic controls from one year earlier matched by procedure type. The ERAS program resulted in a 4-day reduction in LOS, with stable readmission rates and a 30-day cost savings of more than \$7600 per patient (18.8% reduction).

Gerardi²⁷ studied the patients with advanced ovarian and primary peritoneal cancers who required rectosigmoid colectomy as part of cytoreductive surgery. Nineteen patients had their postoperative management prescribed by an ERAS pathway, whereas 45 patients were cared for by individual surgeon preference (conventional). Patients in the ERAS group had a shorter median LOS. The median total hospital cost of postoperative care for patients in the ERAS group was \$19,700, compared with a median total cost of \$25,110 for patients in the conventional group. Overall, clinical pathway-directed management was associated with a median reduction in total direct and indirect hospital cost of postoperative care of \$5410 per patient.

Pancreatic Surgery

Coolsen et al.²⁸ systematically reviewed ERAS programs in pancreaticoduodenectomies. They included five case-control studies, two retrospective studies, and one prospective study, with a total of 1558 patients. Meta-analysis of four studies focusing on pancreaticoduodenectomies showed that complication rates were significantly lower in the ERAS group. Neither mortality nor readmissions increased after

introduction of an ERAS protocol. All studies reported a decrease in total hospital costs after introduction of their ERAS pathways, and this decrease was significant in the three studies focusing on pancreaticoduodenectomy.

Esophageal Surgery

Lee et al.²⁹ investigated the clinical and economic outcomes of an ERAS program in esophagectomy. A total of 106 patients were included (47 traditional care, 59 ERAS). The LOS was lower in the ERAS group than in the traditional care group, and there was no difference in 30-day complication rates between the two groups. Costs were significantly lower after implementation of the ERAS. The ERAS pathway resulted in €2013 overall cost saving per patient.

Vascular Surgery

Tatsuishi et al.³⁰ reported on the clinical and economic outcomes in patients undergoing open aortic aneurysm repair. The postoperative LOS was significantly shorter for the ERAS group, and in-hospital medical costs for the ERAS group decreased by 8% compared with those for the conventionally managed group.

SETUP COSTS

ERAS programs require significant time and money to implement and maintain. Sammour et al.¹⁷ reported on establishing an ERAS program in New Zealand. Setup costs included salaries for research personnel, ERAS patient materials, supplemental nutrition drinks, preoperative carbohydrate drink, resource supplements, preoperative patient education, and time for establishing ERAS protocols. Although the ERAS program required an additional cost of approximately 2000 NZD per patient to implement, these costs were paid off after only 15 patients had participated in the program, with an overall saving per patient of just under 7000 NZD.¹⁷ Successful implementation of ERAS pathways has been reported following a brief preparatory period, including the requirements for staff and patient education.^{31,32}

CONCLUSION

Evidence from clinical and economic evaluations indicates that ERAS protocols across many abdominal surgical specialties are clinically efficacious and cost effective. Evidence from RCTs, systematic reviews, and meta-analyses has demonstrated that ERAS can improve healthcare quality with lower cost.

When performing an economic evaluation of an intervention, the costs are determined by payer costs directly or indirect societal costs indirectly.³³ The costs (and effectiveness) of an intervention often are evaluated by the amount

of in-hospital resource utilization or the costs incurred during readmissions.¹⁵ Measurement of such direct costs may not represent the costs/benefits to the welfare of the population as a whole.¹⁵ From a societal perspective, the influence of return to work, mood, and quality of life should be included in the costs of an intervention.¹⁵ Therefore, these results must be interpreted with caution, as there is significant study heterogeneity and limited generalizability across countries and institutions.²⁰ ■■

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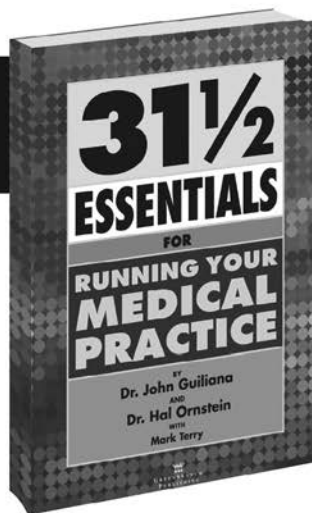
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Effective Scheduling Using Sacred Time

Neil Baum, MD*

Doctors need to become more efficient in order to become more productive. One of the best ways to enhance efficiency is effective scheduling. Every practice has several urgencies or emergencies every day that have to be worked into the schedule, and these few additional patients can wreak havoc with the schedule. This article will discuss how to use "sacred time" in order to enhance efficiency in the practice.

KEY WORDS: Scheduling; efficiency; productivity; sacred time.

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According to Tom Peters, the guru of excellence,¹ there are two secrets for success:

1. Find out what the patient wants and give him or her more of it; and
2. Find out what the patient doesn't want and avoid it.

Patients' number one complaint regarding healthcare is the delays they experience waiting to be seen by their physician. Languishing in the waiting room has been reported to cause more patient dissatisfaction than any other aspect of medical care, including fees.

One of the easiest ways to manage your schedule is look at what is currently taking place in your practice. This can be easily accomplished using a time and motion study (Figure 1). I suggest you conduct this study for just a few days once or twice a year. The time and motion sheet can be placed on the paper chart or added as a template to the electronic medical record. Doctors will be amazed at how much time patients are spending in their offices and how little of that time is spent with physicians. Sometimes patients are in the office for two hours and only get to spend five minutes with the physician. This most definitely does not leave them with a warm fuzzy feeling when they leave the office. This disparity between time spent in the office and time spent with the physician does not result in a positive experience for the patient and has the end result of tarnishing the reputation of the entire profession.

SACRED TIME

What are some solutions for dealing with the inevitable delays that will take place in any office? Nearly every medical practice has one or two urgent situations or emergencies that must be worked in every day. Most of the time, patients with an emergency are just told to come to the office and that they will be worked into the schedule. This wreaks

Time and Motion Study	
	Time patient arrived in the office
	Time patient taken to the exam room
	Amount of time spent with the provider
	Time patient left the office
	Total time in office / total time with MD

Figure 1. Time and motion study.

havoc with the schedule and delays patients who have designated appointments at the end of the day, because when the worked-in patient is fit in ahead of them, they often experience a significant delay in seeing the doctor. Another scenario occurs when a referring doctor calls a specialist and asks if his or her patient can be seen on the same day. Again, these patients often are told to just come to the office and that they will be worked into the schedule. There also are times when the need to see additional patients quickly can be anticipated: for example, flu season; back-to-school physicals at a pediatrician's office; or end-of-year requests for appointments so patients won't have to pay deductibles so quickly in January. Finally, most doctors can anticipate additional patients on a Monday morning when patients who developed problems over the weekend and went to the emergency department are requesting follow-up appointments on Monday morning.

To avoid the problems that arise with emergencies, urgencies, or work-ins, you can create a few 15-minute time slots. In my practice these slots are at 10:30 AM and 2:45 PM. Patients with urgencies or emergencies are told

to come at those designated times or at the very end of the day. These slots are referred to as “sacred time” and cannot be filled until after 8:30 AM on that day. I have yet to encounter a patient or referring doctor who won’t accept that scheduling option. Now the patient with a scheduled late morning or late afternoon appointment can be seen in a timely fashion.

Make an effort to be an on-time physician.

I rarely have a day that those sacred time slots are not filled with urgencies or emergencies. On the odd occasion where the time slots are not used, the time can be spent returning phone calls to patients, completing patient charts, or dictating notes.

Finally, if you want to make your schedule effective, make an effort to be an on-time physician. This means

starting every day on time, not arriving 10 to 15 minutes late for the office clinic and hoping to catch up later in the morning. So many physicians arrive a few minutes late, look at their e-mail, or do a few minutes of paper work, and as a result start 15 or 20 minutes late. This is the surest way to have significant delays in the office from which you can never recover. If you want to see patients on time, then you also have to be on time for your staff.

Bottom Line: The reality is that few physicians have the ability to make changes to healthcare policy. However all of us have the ability to be an on-time physician and solve the problem of patients waiting to see the physician. One solution is to provide sacred time slots time each day to see urgencies and emergencies. ■■

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INTEGRATING BEHAVIORAL HEALTH INTO THE MEDICAL HOME: A Rapid Implementation Guide

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AUTHORS:

Kent A. Corso, PsyD, BCBA-D • Chris Hunter, PhD, ABPP
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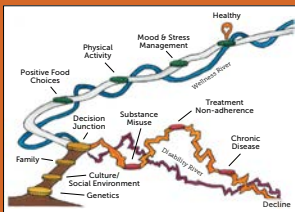
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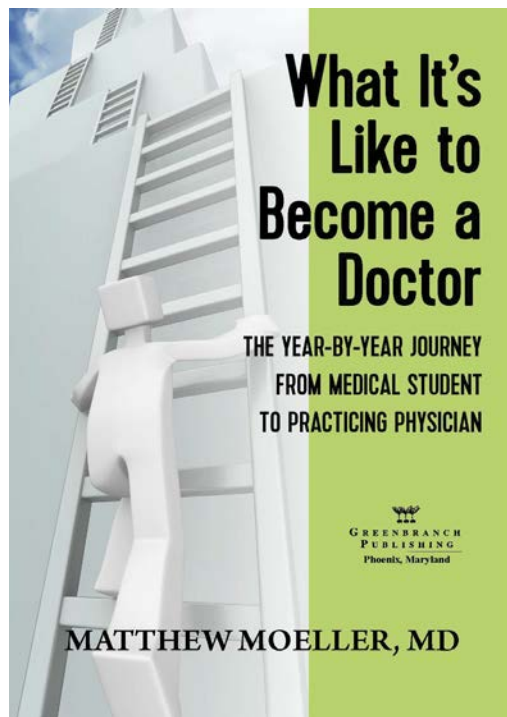
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Matthew Moeller, MD, is a double board certified physician in Internal Medicine and Gastroenterology. He is the author of several peer reviewed scientific articles in Gastroenterology and Hepatology and has spoken on topics of liver and gastroenterology diseases in national and international forums. He trained at the University of Michigan and at Henry Ford in Detroit and currently practices Gastroenterology in Michigan.

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