[VIDEO] Shattering the Stereotype: Honoring Our Nurses

To get our readers ready for National Nurses Week, we wanted to share a great new video from the Robert Wood Johnson Foundation that asks the question “What is a Nurse?”

The traditional view of the nurse as direct caregiver and bedside attendant to patients is really a limited view of the expansive and critical role nurses play in our healthcare system. As more and more change arrives in our system, nurses have taken on a myriad of other roles in the care process: research, community outreach, education, counseling – all of these represent departures from a “stereotypical” view of the role of nursing, and the video highlights the growth in these and other areas.

At Manage My Practice, we would like to thank all of our readers in nursing for delivering quality patient care in so many of our
healthcare settings. Happy National Nurses day on May 6th, 2013!

Start PQRS Now! It’s Not As Hard As You Think

• NOTE: CMS has just added additional presentations of the webinar below — please check the end of the article for added dates. MPW

What is PQRS?

The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a CMS reporting program that uses a combination of incentive payments (carrots) and payment adjustments (sticks) to promote reporting of quality information by eligible professionals.

Program Points:

• How: Eligible professionals submit data.
• What: Quality measures for covered Physician Fee Schedule (PFS) services
What are the 2013 Deadlines for PQRS?

October 15, 2013 – Last day to elect Administrative Claims option to avoid the 2015 payment adjustment!

- A reporting mechanism under which an EP or group practice elects to have CMS analyze claims data to determine which measures an EP or group practice reports
- Deadline for group practices to submit a self-nomination statement via a CMS-developed website
- Group practices consisting of 100+ EPs, beginning in 2015, will be subject to the Value Based Modifier based on PQRS reporting in 2013
- Deadline for groups consisting of 100+ EPs to elect quality tiering approach to VBM

Why Should I Care About Participating in PQRS in 2013?

Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. The 2015 PQRS payment adjustment will be based on 2013 program year data, so if you do not participate in 2013, you will receive less payment for Medicare services in 2015.

STEP 1: Are You Eligible?

Determine if you are eligible to participate for purposes of the PQRS incentive payment and payment adjustment. A list of medical care professionals considered eligible to participate
in PQRS is available in here. Read this list carefully, as not all entities are considered “eligible professionals” because they are reimbursed by Medicare under other fee schedule methods than the Physician Fee Schedule (PFS).

Individual eligible professionals do not need to sign-up or pre-register in order to participate in the Physician Quality Reporting.

**STEP 2: What Reporting Method Will You Use?**

Determine which PQRS reporting method best fits your practice. PQRS has several methods in which measure data can be reported –

- to CMS on Medicare Part B claims *(more details here and claim sample here)*
- to a qualified Physician Quality Reporting registry *(more details here)*
- to CMS via a qualified electronic health record (EHR) product *(more details here)*
- to a qualified Physician Quality Reporting data submission vendor – Group Practice Reporting Option (GPRO) only *(more details here)*

In order to satisfactorily report, it is important to review each method’s specific reporting criteria. For additional guidance, refer to the [2013 Physician Quality Reporting System (PQRS) Implementation Guide here](#) and view the 2013 Physician Quality Reporting System Participation Decision Tree starting on [page 19](#).

**STEP 3: Will You Report Individual**
Measures or a Measures Group?

If the chosen method to report is claims-based or registry-based, determine which measure reporting option (individual measures or measures group) best fits your practice. Review the specific criteria for the chosen reporting option in order to satisfactorily report.

STEP 4: Choose Three Individual Measures or One Measure Group

If already participating in PQRS, there is no requirement to select new/different measures for the 2013 PQRS.

All PQRS measures and their available reporting methods can be reviewed in the 2013 Physician Quality Reporting System (PQRS) Measures List here.

Notice that each measure or measure group has a reporting frequency or timeframe requirement for each eligible patient seen during the reporting period by each individual eligible professional (NPI). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the instructions section of each measure specification or in the Measure Group Overview section. Ensure that all members of the team understand and capture this information in the patients’ medical record to facilitate reporting.

Upcoming CMS Webinars

For more information about PQRS and the other ways you can increase your Medicare payments in 2013, or in the years ahead, attend one of two upcoming webinars on “CMS 2013 Medicare Incentives Programs.” I’ve posted the handout from
this webinar below.

Wednesday, May 1, 12:30 PM – 2:00 PM EDT
http://www.eventbrite.com/event/6060470029#

Friday, May 3, 1:30 PM – 3:00 PM EDT
http://www.eventbrite.com/event/6060698713#

Tuesday, May 7, 2:30 PM – 4:00 PM EDT
http://www.eventbrite.com/event/6534552021

Wednesday, May 8, 11:30 AM – 1:00 PM EDT
http://www.eventbrite.com/event/6534951215

Thursday, May 9, 7:00 PM – 8:30 PM EDT
http://www.eventbrite.com/event/6535252115

A recording of the CMS 2013 Medicare Incentives Webinar is available in the Adobe webinar room linked below:
https://webinar.cms.hhs.gov/p15399995/

2013 Incentive National Handout from CMS from ManageMyPractice

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**EHR Documentation Compliance: Preventing Fraud (Slide Deck)**

Our recent webinar on EHR Compliance was a big hit and we’ve had lots of requests for the slides, so we decided to make
them available to everyone.

EHR Compliance: What You Need to Know from ManageMyPractice

Register Now for “Starting a Credit Card on File Program in Your Practice – May, 2013”

Register Now!

Our next Credit Card on File Webinar will be Thursday, May 9th at 1 p.m. EST. If you want to improve your practice’s cash flow in just one hour, sign up now as seats are going fast!

We’ve had such a great response to our Credit Card on File Webinars that we are running another session. We hope you will join us! Click here to register!

How to Cut Your Medical Practice’s A/R and Collection Costs in Just 60 Minutes.

We know patients are bearing more of the financial burden for healthcare, particularly in the form of High Deductible Health Plans (HDHPs), so it falls to the provider to collect the deductibles. How can you collect deductibles, co-pays and co-insurance, as well as electronically manage patient payment
plans while reducing the associated labor and resource expense? Register for the Manage My Practice webinar that teaches you everything you need to know to spend less and collect more at time of service by implementing a Credit Card on File Program in your practice.

What is a Credit Card on File Program?

A Credit Card on File (CCOF) Program facilitates the collection of a credit or debit card from each patient and requires this card to be used for co-pays, co-insurance and deductibles. You have the option of collecting an estimate of what is due at time of service, and/or charging the credit card when the payer pays the claim.

What are the benefits of a Credit Card on File Program?

- Reduced days in accounts receivable.
- Improved cash flow.
- Elimination of statements.
- Electronic management of payment plans.
- Elimination of bounced checks.
- Elimination of the manual refund process and refund check expense.
- Reduced labor in daily reconciliation process.
- Elimination of cash drawers and change issues.
- Reduction or elimination of deposits.
- Facilitate faster check-in and check-out.
- Elimination of paper receipts.
- Elimination of collections expense.
This one-hour webcourse with accompanying materials is an incredible value at $59.95

What will I learn if I take this webinar?

1. Understand how a credit card on file program differs from traditional payment options offered by practices.
2. Learn the terminology and protocols of credit card processing – it’s not as mysterious as it seems!
3. Compare credit card processing fees and choose a vendor based on an informed analysis.
4. Utilize handouts to train staff and educate patients on the credit card on file program.
5. Successfully implement a credit card on file program.

What does the program include?

Purchase of this program for only $59.95 includes the live webinar, slide handouts, and a complete Action Pack of forms and templates in Word, including:
1. Worksheet for Credit Card on File Program Return on Investment (ROI)
2. Staff Script & Role Playing Suggestions for Staff Training
3. Sample Security Policy to Comply With PCI Guidelines
4. Credit Card on File Program Timeline Worksheet
5. Credit Card Program Comparison Worksheet
6. Patient Handout #1: Information About Our Credit Card on File Program & Discontinuation of Statements
7. Patient Handout #2: What is a Deductible and How Does It Affect Me?
8. Sample Patient Agreement for the Credit Card on File Program
Register Now!

- May, 9th 2013 at 1:00 p.m. Eastern/ 12:00 p.m. Central/ 11:00 a.m. Mountain/ 10:00 a.m. Pacific – Click here to register!

URGENT! Attest Now to Get Paid Medicare Rates for Medicaid Patients

- On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) released the final regulation implementing Section 1202 of the Affordable Care Act, which increases Medicaid payments for specified primary care services to 100% of Medicare levels in 2013 and 2014. (Medicaid.gov)

What primary care services are eligible for Medicare rates?

E&M codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474 (or successor codes, where applicable) are eligible for higher payment.

E&M codes not paid by Medicare are also included:

- New Patient/Initial Comprehensive Preventive Medicine—codes 99381 – 99387;
- Established Patient/Periodic Comprehensive Preventive Medicine—codes 99391 – 99397;
- Counseling Risk Factor Reduction and Behavior Change
Intervention—codes 99401 – 99404, 99408, 99409, 99411, 99412, 99420 and 99429;

- E&M/Non Face-to-Face physician service—codes 99441 – 99444.

**NOTE:** Services billed using local codes will be eligible for higher payment if the state Medicaid agency submits, as part of the required state plan amendment, a crosswalk of those codes to the specified E&M codes. Inclusion of a code on this list does not require a state to pay for the service if it is not already covered under the state’s Medicaid program; it only requires the state to pay for the service at the Medicare rate if covered. All other state coverage and payment policy rules related to the service also remain in effect.

**How do I get the Medicare rate of payment for Medicaid services?**

The final rule provides for higher payment in both the fee for service and managed care settings for specific primary care services furnished by:

- Practicing physicians who self-attest that they are **board certified** with a specialty designation of family medicine, general internal medicine and pediatric medicine, or
- Subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association, or the American Board of Physician Specialties who also self-attest that they are board certified, or
- Physicians related to the specialty categories of family medicine, internal medicine and pediatrics who self-attest that at least **60 percent of all Medicaid services**
they bill or provide in a managed care environment are for the specified Evaluation & Management (E&M) and vaccine administration codes.

- **Advanced practice clinicians** when the services are furnished under a physician’s personal supervision.
- This increase is not limited to office based primary care services, but will also include hospital observation and consultation for inpatient services provided by non-admitting physicians, emergency department services, and critical care services.
- Eligible services provided by all advanced practice clinicians providing services within their state scope of practice will receive the higher payment. Non-physician practitioners may use their own Medicaid number when billing for these services, however, it requires that an eligible physician have professional oversight or responsibility for the services provided by the practitioners under his or her supervision. If the state reimburses for services rendered by supervised advanced practice clinicians at a percentage of the physician fee schedule rate, it will continue to do so in 2013 and 2014.
- NOTE: Higher payment is **not** available for physicians who are reimbursed through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or health department/clinic encounter or visit rate or as part of a nursing facility per diem rate.

**Will this payment come automatically or do providers have to sign up?**

Check on your state’s provisions here or check with your State Medicaid Agency. State Medicaid agencies may pay physicians based on self-attestation alone or in conjunction with any
other state level provider enrollment requirements that currently exist. However, if a state relies on self-attestation, it must annually review a statistically valid sample of physicians who have self-attested that they are eligible primary care physicians to ensure that the physician is either **board certified in an eligible specialty or subspecialty** or that **60 percent of claims are eligible codes**.

**Is this in effect already?**

The statute requires that states make higher payments for services provided on or after January 1, 2013. CMS policy dictates that federal financial participation (FFP) is not available for services provided pursuant to an unapproved State Plan Amendment (SPA) and states have until March 31, 2013 to submit a SPA that is effective on January 1, 2013.

Therefore, states can either make the higher payments to physicians or wait to submit claims for FFP until the SPA is approved. If a state chooses to wait, it can pay physicians at the 2012 Medicaid state plan rates and make supplemental payments once the SPA is approved.

Theoretically, this means that a state could delay action until March 31 before submitting a SPA to CMS. CMS may then take another 90 days to review and approve the SPA, which means could be six months or longer before eligible physicians and practitioners receive the higher payments. CMS is requiring states to make the higher payments as either add-ons to existing rates or as lump sum payments. To ensure that physicians receive the benefit of higher payments in a timely manner, the final rule indicates that “lump sum payments should be made no less frequently than quarterly”.
What will the increase in payment equate to?

Though the pay increase will vary because Medicaid rates differ from state to state, the average pay increase will be about 73 percent given Medicare last year paid on average 66 percent of what Medicare pays for certain primary care services, according to a Henry J. Kaiser Family Foundation study. Doctors in some states could see payment increases of 100 percent or more. (Forbes)

How to Dispose of Unwanted Prescriptions and Sample Medications

Information for patients about drug disposal is a great item to post to your practice website, and for you to use for your
own practice medications (samples or otherwise) that are outdated or unusable.

Saturday, April 27 is **National Prescription Drug Take-Back Day**. The event runs from 10:00am until 2:00pm at sites across the nation.

If you have unwanted prescription drugs or over-the-counter medicines, this is a great opportunity to safely discard them.

**Enter your ZIP code to find a collection site near you.**

Properly disposing of medicines is important to human health and environmental protection.

Don’t flush medicines down the toilet or drain. Doing so could affect drinking water sources.

Don’t throw medicines directly in the trash. Doing so could lead to the poisoning of a child or pet, or drug abuse by a teen or adult.

Do find out how to **properly dispose of medicines (PDF)**.

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**Special Notes for Practices**

Pharmaceuticals and/or their packaging **should not** be placed into your medical red bag waste or sharps containers as these wastes may be treated by methods other than incineration!

If you have drug samples that you routinely discard because they expire before they can be used, you might want to **read this article** about donating drug samples to charity.
DreamIt Health Startup Medlio Has a Virtual Insurance Card: An Interview With David Brooks

We first met David Brooks last year when we interviewed him about his work at the start-up qliqsof. David contacted us recently to tell us about a new company he started called Medlio.

Disclosure: Based on our belief in this product (you’ll see why!) we are proud to be advisors to Medlio.

Mary Pat: Medlio is called a “virtual health insurance card,” which is pretty intriguing right off the bat. Give us the back story on Medlio and tell us what it does for patients and for physicians.

David: I guess the back story of Medlio stems from my involvement in the mobile and digital health space, combined with my first-hand experience starting and running a primary care medical practice. On one hand, I’ve worked in an industry that has been desperately searching for new and innovative ways to improve outcomes while driving down costs. Last year alone, $1.2B was invested in digital and mobile health start-ups. Despite all this investment, there have been very few success stories. On the other hand, I’ve spent countless hours on the front-lines of care, trying to help a primary care office remain financially viable while delivering high-quality, personalized care. There is a tragic divide between
what we are trying to accomplish with technology and where we are today in the practice of medicine.

At some level, I believe much of the efforts of new technology initiatives have lost touch with what is happening in the field. Technology solutions frequently presume a base level of engagement by patients that simply does not yet exist. Other solutions promise to help physicians be better providers, with somehow the implication being that they are not doing enough today.

My partners and I started with the very simple question: how do we get patients to download a smartphone application that begins the process of participation at the absolute most basic level? Furthermore, how do we get the same application to provide meaningful value to patients, providers and payers? Right or wrong, these are the major stakeholders of our current healthcare system, and if we cannot create value for each, we will almost certainly incentivize resistance.

Medlio is creating a virtual health insurance card. For patients, the application provides current, up-to-date benefits information, and eliminates the frustration of paper forms. For providers, the application accurately estimates the cost of encounters so that patient balances can be collected prior to service. The goal is to enhance the patient experience, while creating greater transparency at the point of transaction.

We believe payers will be very interested in supporting our effort. As their business model changes from risk-shifting to risk-management, they are increasingly focused on finding new, effective ways to reach their customers.

*Mary Pat: Does Medlio eliminate the need for healthcare organizations to copy or scan the patient’s insurance card?*

*David: Absolutely. It also eliminates the need for patients to carry the card in their wallet, and the payer to print and*
mail the cards in the first place. Insurance cards are nothing more than a means of conveying an identification number from patient to provider. Cards may also list basic benefits information, but that information is continuously subject to change. As a result, regardless of what a card says, the office rendering care should always confirm insurance status and benefit levels every time they see the patient. In other words, the information is not static. Additionally, with the growing prevalence of high-deductible plans, patients have a growing need to confirm specific service line benefits (i.e., physician office visit, urgent care, ER, etc...), as well as current deductible balances. Medlio can provide that. A printed card cannot.

Mary Pat: What form does the virtual insurance card take? Does it look like an insurance card as we see it today?

David: For patients, Medlio offers a smartphone application where a user enters their insurance card information. Medlio looks up the user’s benefits information and presents it in an easy-to-read format on the user’s smartphone. When a patient visits their physician, they can either check-in directly from their phone if the provider uses Medlio’s desktop application, or they can securely send the insurance card information (along with a real-time eligibility verification) directly to the provider. The provider sees a combination of the basic insurance identification card, as well as a current snapshot of the patient’s benefits as verified by the insurance provider.

Medlio for patients will be available on iOS, Android and tablet devices (both iPad and Android tablets.) Medlio for providers is a web application.

Mary Pat: Can you describe the scenario you envision with Medlio for a patient checking in for a doctor’s appointment?

David: In a perfect world, a patient will log into their
Medlio smartphone application after they park at their provider’s office. Once the patient is within a specified distance of the provider’s office, the application will ask the patient if they would like to check in. The patient will simply tap “Check-In”, and Medlio will notify the front-office person that the patient has arrived. The notice will also provide links for the front-office person to view insurance eligibility as well as forms data. If the patient has been seen before using Medlio, the application will notify the front-office person if any data has changed since the last visit. As the patient arrives at the front-desk, the front-office person will confirm the reason for the visit. They will then create an estimate of the encounter, which they will then push straight to the patient’s smartphone application. The estimate will provide a detailed explanation of how the costs were calculated and the patient will have the option to pay directly from the app.

Mary Pat: Much of what a patient will be responsible to pay at time of service relies upon the allowable that the doctor has agreed to accept from the insurance company. This is particularly critical for patients with high-deductible health plans (HDHPs.) How does Medlio know what those allowables are?

David: There are a couple of ways to determine allowable rates. Some clearinghouses offer estimation tools where they determine the allowable rate by evaluating prior claims data, including remittance advices, to determine what a given payer allows a given provider for a given procedure. This removes the burden from the provider of having to do anything to calculate an estimate, but it’s also a bit like putting the fox in charge of the hen house.

In my view, providers should absolutely know what their contracted fee schedules are with every payer. We are building in a simple tool for providers to input their allowed rates for each payer, and will most likely help providers gather that information if they do not have it readily available.
This requires a bit more effort, but it also ensures that the correct rates are being used.

Mary Pat: Many patients experience frustration when the physician office staff cannot tell them how much a visit will cost when they are deciding whether or not to come to the doctor, or if they are doctor shopping. Can Medlio check eligibility and benefits at the time a patient calls to potentially schedule an appointment?

David: Absolutely. As long as the provider performs an eligibility look-up in Medlio at the time they are scheduling the appointment, the only thing needed to estimate the cost is the reason for the visit.

Mary Pat: Many practices are already paying for eligibility through their practice management system or their clearinghouse. Will using Medlio eliminate the need for other eligibility and benefits products? How about other payment estimator products? What does Medlio cost the provider? What does the smartphone app cost the patient?

David: Yes, Medlio eliminates the need for any other eligibility, benefits and payment estimator products. In our view, while most clearinghouses offer eligibility verification, few if any are well integrated into practice management systems, and none integrate the patient into the experience. We are completely focused on creating an exceptional user-experience that empowers patients and front-office personnel alike.

We are evaluating provider pricing now, and are committed to keeping cost down so that it does not become a barrier to adoption. The smartphone application will be free to patients, though we may have to limit the number of free look-ups a user can perform over a given period of time.

Mary Pat: Are there other things Medlio can do besides check eligibility and benefits and calculate an estimated out-of-
pocket for the patient? Does it interface with practice management systems?

David: In the process of creating a touchless check-in experience for patients and providing cost transparency, we are creating a highly extensible secure communication channel. We can then interface with both practice management and electronic medical record systems to support the delivery of any number of messages, from appointment reminders, to lab results, to care plan recommendations. While there is no question that interfacing to these core systems will eventually become essential, our first goal is to make sure we are providing something that patients care about today.

Mary Pat: Is Medlio available today?

David: It’s a work in progress. We’re developing Medlio in several phases and have already begun field-testing our web-based real-time eligibility verification solution.

We were recently selected to DreamIt Health’s four-month accelerator program, based in Philadelphia and co-sponsored by Independence Blue Cross and Penn Medicine. Our goal is to complete as much of the solution as possible during the program, but we are going about it much more deliberately than we would have in the past. Rather than locking ourselves up in a room for 6 to 12 months, we are investing a lot more time on the front-end collaborating with patients and providers to identify and solve their biggest problems.

Mary Pat: What are you doing to engage providers?

David: We are about to open up our private beta to 50 additional provider participants. Beta participants are testing our web-based real-time eligibility verification solution and providing feedback to help us identify additional ways Medlio can create an exceptional user-experience for both providers and their patients. If anyone reading this interview would like to be considered for the private beta, please visit
History is full of marketing disasters, and some are funnier than others. One addition to the ranks is the recent “Cheat Death” campaign created by North Carolina’s Caromont Regional Medical Center in Gastonia. Intended to promote healthy eating and increased exercise, the medical marketing campaign backfired badly when local government leaders had to step in and ask the hospital to “reconsider” the slogan. Apparently community members’ responses ranged from amusement to outrage, with some thinking it was silly while others considered it blasphemous. We have no way of knowing how much the failed campaign cost the hospital but one thing is certain: the money would have been better spent on market research and testing ahead of time.

**Step #1: Conduct Market Research**

There’s very seldom such a thing as “one size fits all,” particularly in the healthcare service environment. If Caromont had taken the time to survey their current and prospective patients, partners and suppliers, they might have been clued in to the conservative values held by a majority of
their community.

**Takeaway: When in doubt, ask. Survey your target audience to find out what they want to see, what sort of messaging works for them and what turns them off.**

### Step #2: Create Patient Personas

Knowing who your potential patients are is helpful, but it doesn’t benefit you as much as it does to understand their mindsets. Boiling it down to demographic profiles doesn’t cut it, either. To really get to grips with who your medical marketing is talking to, you need to create patient personas that will bring your audience to life.

- **Start by humanizing your patients.** Choose 4 to 6 personas to create, based on the most common denominators in your database.
- **Give your personas names,** dates of birth and home addresses. Determine what they “look” like – what they do, what ailments they suffer from, how many children they have, what their income levels are.
- **Identify what drives them:** this could be health and wellbeing, finances, time pressures or future opportunities.
- **Find out what media channels they consume,** where they purchase their medicines, whether they have insurance and how likely they are to make use of your facilities.

Let’s be clear here: we aren’t suggesting that you gather specific information from anyone. These personas are simply a word sketch of the “typical” patient and all the information is gathered from anonymous surveys or based on unnamed, statistical analysis of your records.

**Takeaway: Without a clear picture of who you are speaking with, it’s much easier to get it wrong.**
Step #3: Develop Campaign Options

Armed with a clear vision of who your practice is targeting with your medical marketing campaign, develop several options. A good rule of thumb is to develop possible slogans and branding aimed at each of the patient personas and then look at where they overlap. You can either choose one persona to target specifically with a niche campaign, or you can use the overlap or “sweet spot” to create a campaign designed to appeal to those prospective patients who fit within two or more of the personas. These are the people most likely to take notice of the campaign and respond to it, anyway.

*Takeaway: By developing a range of campaign options before you finalize it you avoid overlooking aspects that might be critical to any specific group.*

Step #4: Test the Options

Test, test and test again. It sounds expensive, but it’s not as much as you might think and *definitely* not as much as putting a medical marketing campaign in place only to pull it a week or two later. Most comprehensive business marketing has a test phase, during which the marketer does some or all of the following:

- **Runs focus groups** where the various campaigns are shown to respondents and their feedback is obtained.
- **Implements a pilot project** with a small sample of the target market before going large.
- **Gets feedback** from industry partners such as physicians and vendors that they work closely with.

*Takeaway: Analyze the results of the tests, and keep in mind that one dissatisfied voice is 100 times louder than multiple satisfied ones. Unless your aim is to shock your audience into submission, you’re better off following the majority vote in*
About the Author: Greg Fawcett is President of leading North Carolina medical marketing firm Precision Marketing Partners. In this capacity Greg helps healthcare service entities to research their target markets, build their brands and develop creative strategies to reach patients.

Join Us for a Free Webinar on Leveraging your EHR for Fraud Prevention

Thanks to HelloHealth for sponsoring

“Adding to Your Compliance Toolbelt: Fraud Prevention in Your EHR/Clinical Documentation”

Recent changes to the Health Information Portability and Accountability Act (HIPAA) have brought stiffer penalties for fraud prevention, with new levels of enforcement among smaller and independent medical practices. Electronic medical record users should be aware of issues that pertain to electronic documentation compliance, including patient identification and demographic accuracy; and documentation, auditing
and authorship integrity. This webinar reviews these and other concepts, including:

- Are you “gaming” the EMR?
- Locking the record before billing
- Cut and paste rules
- Macro/template rules
- Using a scribe
- Choosing the E/M Code
- Closing the order to bill
- Rules for split/shared visits
- Rules for documentation by medical students and residents
- Providing a well visit and a sick visit at the same time

Join us Tuesday, April 23rd from 2:00 to 3:00 pm EST!

Click Here to Register

About the Speaker

Mary Pat Whaley, FACMPE, CPC of manageypractice.com is an industry recognized medical practice management consultant and blogger with more than 25 years of experience working with physician practices of all sizes and specialties in the private and public sectors. She is board certified in medical practice management and a fellow in the American College of Medical Practice Executives, and has worked with many of the leading medical billing and electronic medical record (EMR) solutions. Her company’s emphasis is on getting solo and small practices paid what is due to them more quickly.
Everyone Is Essential: Guest Author Bob Cooper

Some organizations will use the terms essential and non-essential workers as a way to distinguish between who needs to be on site in the event of an emergency, and who does not. I do understand the purpose of this distinction, however, it’s very important that businesses not give the impression that some employees are more important or valuable than others.

Have you ever thought about the importance of the Bank Teller’s role? Is this individual given the requisite respect they deserve? I once overheard a bank manager say the following – “She’s only a teller, you can’t expect her to know better.” Think about the responsibility of this role. The Teller helps to build the customer experience and is responsible for very important transactions. I don’t know about you, but I want the Tellers in my bank to be satisfied and maintain a good focus on their work.

How do you view each and every member of your team? Do you respect everyone as an important member of the team? How does each person on your team impact the internal and external customer experience?

Your employees are your most important asset, and you need to serve them. If you expect them to deliver exceptional service to others, you need to serve them first.

The following are a few suggestions to demonstrate that you view every member of your team as essential:

1) Show Respect at all Times – Never make the same mistake that the Bank Manager made by saying “She’s only a Teller, or clerk, or aide, or any other position. Sometimes the best ideas come from your front-line staff. They have dreams and aspirations and want to know that you value them for their
contributions. They have feelings and want to know that you value them as professionals.

2) Engage their Hearts and Minds – Give every member of your team the opportunity to become involved in all aspects of the business. Show your staff how their work is integrated with other members of the team and is critical to the organization’s success. Find out what motivates team members, and wherever possible, allow them to become involved in initiatives that ignite their passion. They should become engaged in offering ideas to build the business and drive strategy.

3) Say Thank You – Show your gratitude for individual efforts by expressing sincere thanks for a job well done. The key is your sincerity. If your thank you is half-hearted, don’t be shocked when one of your best performers leaves the organization because they don’t feel appreciated. You can’t fake sincerity.

4) Care About Them – Have you ever experienced a personal problem only to find your boss is only concerned with the project you are working on? I have heard bosses say – “Leave your personal issues at home.” Oh really? What if a staff member has a loved one who is very ill? Should this not matter? I have witnessed throughout my career many top performers change jobs because they felt their boss was totally insensitive to their personal concerns. When people come to work, they bring their whole selves to the office. Of course they need to perform their duties responsibly. As a leader, part of your job is to help staff keep their head in the game. You need to show empathy and assist the employee to effectively deal with their issues.

5) Bring Them Coffee – In my book “Heart and Soul in the Boardroom” I discuss a former boss named Warren. Although I have not seen Warren in over 25 years, I remember him as if it was yesterday. Warren would say – “Bob, can I bring you a cup
of coffee back from the cafeteria?” He would make the same offer to every member of the team. Warren treated every member of the team with respect. What about the boss who asks his or her assistant to bring back a cup of coffee and never offers to do the same? What’s the message? This individual believes that others are there to serve them – WRONG! You are there to serve others. In turn, they will reciprocate and go the extra yard to help you win.

6) Care About Their Careers – Take the time to listen and understand your employee’s goals. Make every effort to help them to achieve their goals. The key here is to show the effort and desire to assist them to reach their full potential.

Great leaders treat every member of the team as essential. They realize that the receptionist or janitor make a huge impact on the customer experience. I will never forget what a former boss named Harry said many years ago during a meeting. Harry said – “Remember, the janitor may be at the bottom of our organization's hierarchy, but is the CEO to his family.” I can still hear Harry’s voice. He was so right. Every human being deserves to be respected.

If you treat every member of your team as essential, and truly care about them, they will perform beyond your expectations. We must make sure the financial compensation is fair and competitive, but the differentiating factor is that staff know you care, and see them as essential to the organization’s success.

For a complete listing of our services, please visit us at www.rlcooperassoc.com or call (845) 639-1741.

RL Cooper Associates’ book “Heart and Soul in the Boardroom” outlines suggestions for leaders to develop highly respectful and ethical work cultures and is available in the Manage My Practice Store. For additional information about their
services, please visit www.rlcooperassoc.com.