Getting to Know Obamacare’s New Standard Insurance Application

Last month the Obama Administration released the standard application form that will be used to apply to the Affordable Care Act’s new health insurance exchanges. Applications will be accepted starting October 1, 2013 for coverage through the exchanges that will begin January 1, 2014. The first things you’ll notice about the forms – they’re short. Traditionally forms for health insurance coverage have averaged around 20 pages or so – the new individual short form is only 3 pages (plus a cover sheet and an appendix if you get a preparer’s help). If you are also seeking coverage for family members, the form balloons to 7 pages – still 2/3 less paper work than usual. The forms are designed to be a one-stop entry to not only the insurance exchange marketplaces but also to tax credits for eligible enrollees and to Medicaid and Children’s Health Insurance Program (CHIP) programs for those who qualify. From the Centers for Medicare and Medicaid Services press release:

“Consumers will have a simple, easy-to-understand way to apply for health coverage later this year,” said CMS Acting Administrator Marilyn Tavenner. “The application for individuals is now three pages, making it easier to use and significantly shorter than industry standards. This is another step complete as we get ready for a consumer-friendly marketplace that will be open for business later this year.”

In the three years since the Affordable Care Act was passed a lot has been written about what “will happen” under Obamacare, but actually seeing the rubber meet the road in the release of the paperwork to apply for coverage means the prediction is
giving way to implementation. If your practice does not offer coverage to your employees, these are the forms they will use to apply for coverage under the new system.

The same goes for your patients: if they lose coverage or do not have enough coverage, these forms will give them access to all of their options in one place. More than ever, providers need to be partners in their patients’ health, but also in assisting them in understanding their health coverage. Making sure stakeholders know all the options means making sure they can achieve the best outcomes.

Check out the new standard Insurance Applications:

- Individual Short Form
- Family
- Individual without Financial Assistance

A Success Story: Using Lean to Reduce Pressure Ulcers at Toronto Western Hospital
We had a great response to our interview with Lean Expert Mark Graban so we know Lean in healthcare is of interest to many. Here’s a short video explaining how Toronto Western Hospital reduced pressure ulcers (sometimes referred to as bedsores) in their Intensive Care Unit (ICU.) Pressure ulcers are injuries to the skin and underlying tissue caused by prolonged and consistent pressure to the skin, and are most often experienced by the elderly and people with a medical condition that limits their mobility and ability to change positions. Pressure ulcers can lead to fatalities according to a UCLA study published last fall.

Photo Credit: Pollobarba via Compfight cc

10 Reasons Why Your Doctor Won’t See Medicare Patients

Many patients are panicked that their physician will stop seeing Medicare patients, and that is not without cause. Physicians that care for Medicare patients do so at a loss to their practice which they can only hope to make up for from other payers. As money gets tighter and tighter, physicians are forced to decide if they can continue to see any patient at a loss.

Although a number of surveys indicate that few Medicare patients (less than 18% nationally) have difficulty finding primary care physicians, much has been written criticizing the methodology of these surveys. A survey in North Carolina in August 2012 revealed that of 200 family physicians called by “mystery shoppers”, only 100 offices indicated they accept new
Medicare patients.

Here are 10 reasons why physicians might consider not seeing new Medicare patients, not participating with Medicare or opting completely out of the Medicare program.

#1: Medicare does not pay enough to cover the expenses associated with the services provided.

Physicians are doing everything they can to reduce their expenses while keeping the quality of their care high. No matter what they do, it does not change the fact that the fees Medicare pays physicians — especially primary care physicians — are not enough to cover the overhead of rent, utilities, staff, benefits, malpractice, and technology.

Each year for the past 10 years, physicians have faced the possibility of a cut in their Medicare payments. Prior to the freeze on the accumulated 27% cut slated for 2013, many physicians said they would throw in the towel and opt out of Medicare. Just as physicians breathed a sigh of relief, the sequester kicked in and a 2% cut took affect.

According to a 2013 survey by Deloitte, a quarter of physicians would place new or additional limits on the acceptance of Medicare patients if there were potential payment changes to the Medicare program, such as lower payments or a switch to vouchers (Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform and the future of the medical profession.)

A July 2012 survey by the Texas Medical Association found only 58% of Texas physicians would accept any new Medicare patients.
#2: Filing Medicare insurance is more complex than any other insurance. Medicare billing codes and rules are different than the codes and rules that every other payer uses. Due to the lack of standardization physicians must employ qualified staff or purchase sophisticated technology to file Medicare claims. If incorrect codes are used, Medicare may see this as a “red flag” – in other words, an attempt to gain more payment from Medicare.

#3: Medicare does not pay for an annual physical. Most Medicare patients want a head-to-toe annual visit, but Medicare is geared toward “sick care” not “well care.” Medicare did introduce new wellness visits in 2011, but these visits are counseling visits only, and do not include a physical exam. Physicians are stuck between a rock and a hard place as they try to give patient the care they are asking for without having the patient pay 100% out-of-pocket for it.

#4: Medicare patient care often involves taking more time to deal with the same issues. This includes more time for patients to ambulate, more time to undress and dress, extra time for communication due to hearing issues or memory issues, extra time for blood draws or getting urine samples, and in general more time needed to discuss complex or multiple problems.

The 2013 MedPac Report noted that 20% of Medicare patients age
65 to 74 have 4-5 chronic conditions (Report to Congress: Medicare Payment Policy, March 2013.)

#5: Medicare patients are the least tech-savvy of the patients, so they may not take advantage of the patient portal.

One of the ways physician practices can offer efficient service and communication is via the patient portal. The patient portal allows physicians to communicate securely with patients about test results and allows patients to receive automated appointment reminders, schedule appointments and request refills or records. This automation can reduce the amount of staff needed to accomplish these important tasks.

#6: Medicare patients often have more emotional needs dealing with end-of-life discussions, loss and depression.

The National Institute for Mental Health estimates that as many as five million elderly people in the U.S. suffer from subsyndromal depression, which can lead to major depression if left untreated. Depressed elderly are at high risk for suicide. Although senior citizens comprise only 12 percent of the U.S. population, they accounted for 16 percent of all suicides in 2004 (NIMH, 2007.) Helping patients with these types of issues often falls to the primary care physician, who may have a long-standing relationship with the patient. Although it is not condoned by Medicare, we know that many physicians do not charge adequately for counseling-type visits.
#7: Medicare patients often have adult children in other states who want to call and speak to the physician about their parent’s condition.

Medicare does not reimburse for phone calls from loved ones.

#8: Regional Medicare carriers (MACs) create their own local rules for Medicare patients in specific states.

This is another level of guidelines and codes to adhere to in addition to having specific rules for Medicare nationally.

#9: Medicare requires physicians to adhere to a number of specific program requirements or lose anywhere from .05% to 2% of their payment.

These include prescribing electronically, reporting quality measures related to patient care, and using an electronic medical record system. These are all good things, but most physician practices are overwhelmed with all the requirements of participation in Medicare.

Why are physicians hanging in there with the Medicare program? Because they care deeply for their patients and find it almost impossible to decide they cannot care for them any longer.
#10: Medicare has 6 – 8 different audit programs in place at any given time looking for fraud and abuse.

Physician offices are kept busy with a constant flow of paperwork in answering audit requests, supplying medical records, and tracking medical record disclosures to adhere to HIPAA, the privacy law. Auditors include:

- Medicare Administrative Contractors (MACs)
- Recovery Auditors (RACs)
- Program Safeguard Contractors
- Zone Program Integrity Contractors (ZPICs)
- Comprehensive Error Rate Testing (CERT) Review Contractor
- Office of Inspector General (OIG) Annual Work Plan

This quote from family physician Su Zan Carpenter, MD, of Texas, who opted out of Medicare almost a year ago says it all:

“Every time you turn around someone has a new rule or a new regulation or a new audit or a new inspection or a new something,” she said. “There’s a point where enough is enough. You need to see the patient, talk to the patient, examine the patient, and actually do something with your patients for your patients. All that stuff is starting to get in the way of practicing medicine and helping people.” (Texas Medical Association website)
(Video) Turnkey Ancillary for Physician Practice Bracing: An Interview With Ron De Santo of SelectOrtho DME

Mary Pat and I had the pleasure recently of being introduced to Ron De Santo and his team at SelectOrtho DME. We are always excited to hear about new products and services bringing win-win solutions to physician practices and patients. SelectOrtho’s turnkey solution for in-office brace fitting is a way for the physician practice to add ancillary services while providing quality service to patients. As a changeup from our regular “10 Question” format, we thought it might be fun to do a video interview and Ron De Santo graciously agreed.

Mary Pat’s Interview with Ron De Santo of SelectOrtho DME Part 1 of 2

Click below for the second part of the interview!

Mary Pat’s Interview with Ron De Santo of SelectOrtho DME Part 2 of 2

Disclosure: Manage My Practice receives no compensation for any “10 Question” interview.
Register Now for “Starting a Credit Card on File Program in Your Practice – June, 2013”

Register Now!

Our next Credit Card on File Webinar will be Thursday, June 6th at 3 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!

- June, 6th 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!
Get Your 10 Electronic Prescriptions (eRx) Done Before June 30th to Avoid a 2% Cut in Medicare Payments in 2014

The deadline is fast approaching for both individual eligible professionals (EPs) and group practices participating in the Group Practice Reporting Option (GPRO) to complete their required number of electronic prescriptions. If you are an EP or an eRx GPRO participant, you must successfully report as an electronic prescriber before June 30, 2013 or you will experience a payment adjustment in 2014 for professional services covered under Medicare Part B’s Physician Fee Schedule (PFS.)

The 2013 eRx Incentive Program 6-month reporting period (January 1, 2013 to June 30, 2013) is the final reporting period available to you if you wish to avoid the 2014 eRx payment adjustment.

If you do not successfully report, a payment adjustment of 2.0% will be applied, and you will receive only 98.0% of your Medicare Part B PFS amount for covered professional services in 2014.
Avoiding the 2014 eRx Payment Adjustment

Individual EPs and eRx GPRO participants who were not successful electronic prescribers in 2012 can avoid 2014 eRx payment adjustment by meeting specified reporting requirements between **January 1, 2013 and June 30, 2013**. Below are the 6-month reporting requirements:

- Individual EPs – 10 eRx events via claims
- eRx GPRO of 2-24 EPs – 75 eRx events via claims
- eRx GPRO of 25-99 EPs – 625 eRx events via claims
- eRx GPRO of 100+ EPs – 2,500 eRx events via claims

Exclusions and Hardships Exemptions

Exclusions from the 2014 eRx payment adjustment only apply to certain individual EPs and group practices, and CMS will automatically exclude those individual EPs and group practices who meet the criteria.

Here are the reasons you **would not** have to ePrescribe in 2013:

- You successfully ePrescribed in 2012.
- You are NOT an **eligible professional** such as a MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by 6/30/13 based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES.)
- You do NOT have not have at least **100 Medicare Part B PFS cases** containing an encounter code in the measure’s denominator for dates of service from 1/1/13-6/30/13.
- You do not have **10% or more of your Medicare Part B PFS allowable charges** (per TIN) for encounter codes in the measure’s denominator for dates of service from 1/1/13-6/30/13.
You’ve already done at least 10 electronic prescriptions and reported the G-code (G8553) via claims during the 2013 eRx 6-month reporting period 1/1/13-6/30/13.

You’ve achieved Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the 12-month eRx reporting period (1/1/12-12/31/12) or the 6-month eRx reporting period (1/1/13-6/30/13) and you attested during the 6-month reporting period (1/1/13-6/30/13.)

You’ve demonstrated intent to participate in the Medicare or Medicaid EHR Incentive Program by registering (providing EHR certification ID) during the 6-month reporting period (1/1/13-6/30/13) and adopting certified EHR technology.

You’ve submitted one of the hardship exemption G-codes via any payable Medicare Part B PFS claim with a date of service during the 6-month eRx reporting period (1/1/13-6/30/13.)

You’ve requested and CMS has approved a hardship exemption via the Physician Quality Reporting Communication Support Page (Communication Support Page.)

More information on exclusion criteria and hardship exception categories can be found in this pdf: Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Show and Tell: Take Advantage of These Great Medical Practice Management Resources

The only thing better than finding a great report, tool, or piece of information on the web is sharing it with our
readers so that they can put it to work themselves. Here are some of the “treasures” that I’ve been pointed towards recently that have found places in my bookmarks folder. We hope you’ll find them useful too!

**Barton Associates’ State Physicians Licensing Guide**

Locum Tenens staffing service Barton Associates has a fantastic tool for anyone who deals with licensing physicians. Their State Physicians Licensing Guide is an animated, state-by-state guide to the licensing requirements, physician abilities and regulations for Locum Tenens (temporary fill-in physicians) licensing in each state. The tool is also tremendously useful to providers who may be considering accepting a positions in various states or in doing locums work in a specific state to have an understanding of how the landscape varies from state to state.


**RSG Health Services’ 2012 – 2013 Allied Health Jobs & Compensation Report**

Salary information is always highly sought after in the healthcare field. Groups are always trying to compete for top talent in the provider and allied health world, and data is critical. Healthcare staffers RSG Health Services have put together a fantastic report that aggregates all of the offers that were made to allied health candidates through their system for the past year. The information is broken down into categories for medical imaging, ultrasound, cardiology, laboratory and rehabilitation. While the report might not be a
definitive statement on the market in your area or specialty, the data is a great place to start.


Health Security Solutions’ HIPAA Omnibus Rule Webinar Series

With so much focus on Meaningful Use and changes under the Affordable Care Act, it can be easy to forget that the recent release of the HIPAA Omnibus rule has also meant change for how practices and their compliance plans must operate. Not to worry though, consultants Health Security Solutions have developed a three-part webinar series about the new rules and what they mean. All three videos are available on their site free of charge, and provide a great overview of what you need to be doing now.

http://www.healthsecuritysolutions.com/2013/04/hipaa-omnibus-rule-ep-1/

What about you? What are your favorite “go-to” resources for medical practice management? Share in the comments!

Cloud File Sharing Service Box Makes a Big Investment in Healthcare
We use and believe in Box at Manage My Practice and we are Certified Box Resellers. More information here.

Box, a California cloud file sharing and content management service has announced new partners and investments in the healthcare industry. Makers of software for clinical documentation, care coordination, interoperability and access to care will integrate tightly with Box’s existing platform to make sharing data from their software even easier. The platform partners announced were: EHR DrChrono, dental PM system Umbie Dentalcare, secure messaging apps TigerText and Medigram, provider social network Doximity, telehealth platform Healthtap, image viewers iMedViewer and iPaxera, record release app Medi-Copy and finally posture analysis app Posture Screen Mobile. In addition to announcing the new platform partners, Box also announced an early-seed investment in DrChrono to help the software make medical data viewable in Box. Box also added former Google Health director Missy Krasner to help their push into healthcare. Krasner sees her work with Box as “picking up where Google Health left off“.

Box’s software-as-a-service offering lets individuals and companies store and access their data on all of their computers and mobile devices, as well as securely share files with colleagues, friends and family. For the healthcare arena, Box is both HIPAA and HITECH compliant, and signs Business Associate Agreements with its covered entity partners – so you can count on Box to be a part of your storage solution.

Our customers use Box to:

- **store** all their critical documents like contracts, credentialing documents and policies
- **share** their patients’ data with other stakeholders like billing, coding and outsourced benefits policies
- have a **HIPAA and HITECH compliant way to work** in different locations
- **share patient information** between locations and
Into The Fray: A Medical Practice Manager Shops for Health Insurance

I have been on the management side of the healthcare industry for more than twenty-five years, so I know how health insurance works and how it is sold. Many times in my career I have been the administrator entrusted with evaluating health insurance for the entire practice. So when my husband and I recently found ourselves in the market for coverage I was confident about navigating the market, even though this would be the first time we had ever funded our own premiums 100%. The process was pretty eye-opening.

My hope was to pay no more (or less if possible) than I was currently paying for COBRA through a former employer. We are 54 and 58 years old, overweight and on blood pressure medication, but in generally good health. No heart attacks, no diabetes, no cancer. In all my years of enrollment, we had never met our deductible – even when it was as low as $500! Our annual premiums through COBRA totaled around $10,000.

Starting, as always, with the internet, I went to an insurance aggregate site for the policies sold in my state. After four hours of reviewing plans, I chose two that I thought would be a good fit. I couldn’t help but wonder how much time other people spend researching plans – or if they realized how much
information is now at their fingertips.

Plan A was a high-deductible plan (HDHP) with a health savings account (HSA.) This type of plan was much cheaper ($300 per month for both of us) as it would only cover catastrophic care. We would pay for our basic care from our HSA, into which we would deposit the difference between what we had been paying and what we now would pay (a difference of $500.) This plan really appealed to me because I could potentially make good healthcare choices and use my HSA money carefully. Plan B was more traditional with a deductible and co-pays, but it would be comparably priced to the COBRA plan expiring in 30 days. My husband really liked this plan because it was just like our current plan – he could understand it! To have something to compare to the plans I chose, I joined AARP, which requires membership to get a quote. Their rates were not at all comparable to the other plans, so I gave up on them immediately.

We decided to go ahead and apply to Plan B. Although we were supposed to be notified within 24 hours, we did not hear back for about a week that we had been turned down! There was no explanation, no phone call, just a stock letter mailed to us. I would think as a potential customer who was getting ready to spend $10,000 over the next 12 months, someone might have called and gone over the application with me. Maybe I had filled the form out incorrectly, or checked a box wrong? With time running out, I went back to the internet and researched a state plan that I had heard about that would insure you if you had been turned down for insurance or your COBRA had run out. I found the site and looked at plans that would keep us spending no more than $10,000 per year. With a lump in my throat, I applied for the plan with a $5,000 deductible for each of us. I had no idea what our next option would be if we were turned down by our state plan.

We were accepted by the state plan in very short order and so the $5,000 deductible became a reality. We now are the true
gatekeepers of our own health and health spending. With no first-dollar coverage except preventive care mandated by the Affordable Care Act, we started thinking about the medications and routine services that we had previously all but taken for granted for the cost of a co-pay.

Even with my background the process of shopping for coverage was both confusing and impersonal. It will be interesting to see how the state health insurance marketplaces of the Affordable Care Act change the process starting October 1st, 2013 – I’ll be shopping again when it opens!

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Guest Author Bob Cooper: Reaching Your Full Potential

Have you ever wondered why some individuals with average talent achieve great success while others with exceptional talent see their careers derail? In sports we witness this all the time. Players with great talent often find themselves on the bench or out of the game. It may be a lack of commitment, desire or emotional intelligence. I have always appreciated the dedication and commitment of New York Yankee shortstop Derek Jeter. He clearly has talent, but his desire to continuously improve, his love of the sport, and his respect for all is why he will always be admired for his achievements.

What about the world of business? Do you feel that you have reached your full potential? If not, why not?

The following are a few suggestions to assist you to reach your full potential:
Don’t Blame Anyone for Where You Are

If you are not satisfied, then take an honest look in the mirror. When working with professionals, I often need to spend some time helping them to stop blaming everyone for their inability to achieve their goals. I hear things like “If only I got lucky”, “My boss isn’t willing to give me the opportunity”, “I just can’t catch a break.” If you are surrounded by people in your life who are willing to listen to this and say “you’re right, you can’t catch a break” or “It’s your bosses fault”, I encourage you to stop listening. You can either be the victim, or you can take control of the situation. It’s not too late. Hope is not a strategy – passion and focused commitment is.

Find Your Passion & Purpose

When you feel passionate about your work, and it has great meaning to you, it doesn’t feel like work. Why did you choose your profession? Do you love your work? If not, why not? If your environment has taken your breath away, you probably need a change. The starting point in this journey is to connect with your work in a meaningful way. How have you made a difference for the business and those whom you serve? What can you do going forward?

Keep Your Energy Up

This has a connection to the first two points. Blaming others or not finding joy in your work takes away your energy. Focus on your goals and develop a plan to achieve them. Don’t let anyone say you can’t do it. Be careful not to buy into other’s stories. People in your life will try to convince you that you will not be able to accomplish big goals – don’t believe them. You must believe in yourself, see the
possibilities and go for it. I recall a conversation I had with a colleague where he spent a tremendous amount of time telling me why he couldn’t make a change. “You see Bob, I have 4 weeks vacation. I have been in this industry for over 20 years, I can’t do anything else.” This went on for months. I listened, offered empathy and some guidance, but he was stuck. He had finally reached a point of desperation. I said the following – “If you believe you are stuck, then you are stuck. If you believe in yourself, then you are free.” He switched careers and is extremely happy. His energy is high and he feels a sense of peacefulness. Surround yourself with people who will fuel your energy tank, and try to minimize contact with people who want to fill your tank up with negative thoughts. It might just be that they are not happy and are looking for company.

**Build Talents into Sustainable Strengths**

I highly recommend the book “Strengths Finder 2.0 by Tom Rath.” Based on the work of the Gallup organization, you take an online assessment to learn about your top 5 talent themes. The main message is we need to spend our time building on our talents and turning them into sustainable strengths. When you combine talent with passion you can achieve greatness.

**Find Great Mentors**

I was very fortunate to find great mentors throughout my career. These are individuals who are excellent role models and teachers. They take the time to listen and understand. They build up your competence and confidence, and assist you to reach your full potential. They tell you the truth (even if it hurts), and care about you and your success. Thank you Bill, Harry, Warren & Susan as I will always be grateful to you. You attract great mentors when you show passion and
desire. I remember a conversation I had with Harry on our way back from a trip to Boston. I said “Harry, I want to train every employee throughout the country on our new Distribution Resource Planning Program.” He said, “Bob, have you done much training in your career?” I said, “No Harry, but I love it and will not let you down.” Harry smiled and said “It’s yours.” If you want others to believe in you, you must believe in yourself. They will want to see you win and will take great pride in helping you to succeed. Harry helped me develop the curriculum and gave me several important suggestions. I was only 24 years old at the time and greatly appreciated Harry’s belief in me and his willingness to help me succeed.

If you lead others, I encourage you to assist members of your team to reach their full potential. Find out about their professional goals. Provide the guidance and mentoring support to build competence and confidence. As a leader, your most important role is the developer of champions. You will build a team capable of executing the business strategy because they believe in the direction, believe in the strategy and most importantly believe in themselves. They will trust you and go the extra mile for you.

Are you willing to provide the opportunity to let others reach their full potential? If yes, thank you. I thank you on behalf of your entire team. You are living the principles found in my book “Heart and Soul in the Boardroom.”

Reaching your full potential is much more than a nice saying – it can be your destiny!

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.