Natural Language Processing, First Steps Towards Telehealth, and a Single App to Read any EHR in another edition of Manage My Practice's 2.0 Tuesday!

As managers, providers and employees, we always have to be looking ahead at how the technology on our horizon will affect how our organizations administer health care. In the spirit of looking forward to the future, we present "2.0 Tuesday", a feature on Manage My Practice about how technology is impacting our practices, and our patient and population outcomes.

We hope you enjoy looking ahead with us, and share your ideas, reactions and comments below!

- ## Natural Language Processing Advances Allow for Improved Insight into Public Health

Writing for KevinMD, Jaan Sidorov, author of the Disease Management Care Blog highlights several examples of how Natural Language Processing- the idea of teaching computer programs to understand the relationship between words in human speech (teaching them to not just hear us, but understand us- like Watson understood the clues on Jeopardy) is being be applied to the Electronic Health Record to predict and prepare for public health trends, as well as to correct mistakes present in the electronic record due to human error. Recent

developments like the CDC's Biosense program allow public health officials at local, state and federal levels to monitor big picture trends in public health by the words and diagnoses reported in medical documentation- keeping an ear on health trends, by "listening" to data about reported health incidents.

- ## 10 Best Practices for Implementing Telemedicine in Hospitals

Sabrina Rodak at Becker Orthopedic, Spine and Pain Management has put together a fantastic list of the steps and assessments involved in implementing a telemedicine program in a hospital setting. Although written with Orthopods in mind, the questions that need to be answered, and the steps that need to be taken to develop a strong, lasting program are similar across many different programs and specialties. With so much excitement in the field, it is very nice to see someone talk about the process of taking these technologies from drawing board excitement to nuts-and-bolts execution.

(via FierceHealthIT)

- ## San Diego Health System Seeks to Develop Single App to Access Any EMR

Presenting at a Toronto Mobile Healthcare Summit Last Week, Dr. Benjamin Kanter, CIO of Palomar Pomerado Health presented the two-hospital system's plans to develop their own native mobile application to view as many different Electronic Medical Records as possible from a single mobile interface. In other words, this fairly small health system, who has only devoted three employees to the project, is taking on one of

the biggest, and toughest challenges in HIT by simply saying "We can do it ourselves!", and from some of the reactions from the conference attendees who saw the presentation, they are off to quite a strong start. The first version of the program should launch for Android in March, and the system already has a deal in place with vendor Cerner to access their systems. Stay tuned!

(via ITWorldCanada)

Be sure to check back soon for another 2.0 Tuesday!

Managed IT Services, HIPAA/HITECH Compliance and Changing IT Providers: Ed Garay from Lutrum Answers Your IT Questions.

Mary Pat: ***Where does the name of your company, Lutrum, come from?***

Ed Garay: When I was developing a name for this company, I didn't want to be like every other healthcare IT services company with health, md, medical, etc. as part of their name. I wanted it to represent something deeper about what we do and who we are as an IT organization. Although we are IT specialists, I realized that one of the things that I am always working with my team on is to listen and understand our client's needs. Which lead me to creating the name, Lutrum. Lutrum is a slight variant of the Latin word Lutra. Lutra means otter in English. And the otter symbolizes empathy.

Mary Pat: ***What led up to you starting your own business?***

Ed Garay: In late 2000, I worked as an IT Director for an organization that continued to downsize. I came to a career crossroad. With starting to support under 100 systems, and the network running in tip-top shape, there was really no need for me to be there full-time in the long run. So, do I look for another job that can't possibly be as fulfilling as where I was, or do I take a leap of faith and start up my own business and share my knowledge with the masses? Through the feedback of mentors and other resources that knew me personally and professionally, I was highly motivated to take the leap of faith and have never looked back. My business career has evolved over the years and has naturally lead me to Lutrum.

Mary Pat: ***What are Managed IT Services?***

Ed Garay: Managed IT Services is a proactive approach to IT support. It's a flat fee service that provides virtually unlimited support. And in our case, it also includes virtually unlimited **Clinical Application Support**, which is Managed IT Services includes proactive measures such as Anti-virus/Anti-malware software, Anti-spam services, backup services and other services that help prevent certain issues. It's intended to be a Win-Win-Win scenario. If we are doing

our job correctly, then it’s a Win for us since we have less reactive ‘fires’ to put out, a Win for our client as their entire organization remains productive (and there are less jokes made by their staff about their technology), and a Win for our client’s client as one of the results of properly leveraged technology is responsive customer service.

Mary Pat: ***Can you expand on what you mean by Clinical Application Support?***

Ed Garay: We assist you with your use and management of your practice management and EMR software by helping you create or update templates, helping you manage and train staff on system upgrades, helping you create training materials and cheat sheets, and are available to help you however we can to improve your use of the software.

Mary Pat: ***How can you manage practices nationally?***

Ed Garay: With our Managed IT Services support platform, we are able to do at least 80% of IT support remotely. The newer the client’s hardware, the higher the percentage. When in need of someone onsite, or ‘remote hands,’ outside of our area for a short amount of time, we reach out to our network of IT Partners to help. In some cases we work with internal client staff if they are made available to us. But because we can do so much remotely, and we work well as a team with our clients staff and their vendors, all management of our clients is done out of our main office. We do make site visits from time to time as necessary.

Mary Pat: ***What sets you apart from other companies offering IT services?***

Ed Garay: First, I have the most memorable personal tag line “When your computer is dead, call Ed!” Second, Lutrum has a culture of personable IT people. Although we work hard, we definitely appreciate a good humor and enjoy working closely with our clients. Third, unlike most IT companies, we won’t

just install your EMR/PM application and leave. We will also provide you a Clinical Application Manager to help you leverage your technology and work towards a Return On Investment. Lastly, we continue to modify our Managed IT Service offerings so that they are turnkey. For example, we include many services and hardware that most IT providers would prefer to charge separately.

Mary Pat: ***You recently had a booth at the MGMA annual meeting in Las Vegas and had a lot of interest in your Compliance product.***

Ed Garay: *Practices are looking for help with HIPAA/HITECH compliance and we had a number of managers who told us they came to the exhibit hall specifically looking for our solution.*

Mary Pat: ***What is your HIPAA/HITECH solution?***

Ed Garay: The HIPAA/HITECH Report on Compliance is generated by a **ROC (Report on Compliance)** cloud-based tool that we provide. Three key features to it are: It meets the Meaningful Use Stage 1 Security Risk Analysis requirement, it's a system that is continuously updating regulations so that a Practice's Compliance Officer doesn't have to keep track on their own, and Covered Entities can better manage and track their Business Associate's compliance documentation. Since it is built in a Yes/No question format, it becomes easier to figure out where your organization stands with compliance. As a Managed Compliance Provider, I originally started offering the ROC tool so that our clients can hold us accountable for keeping them HIPAA/HITECH compliant. But we soon found out that with our expertise on the HITECH side of compliance, we can assist practices even with existing internal or external IT support as well. MMP readers can request a sample ROC (see a small section below) by emailing me at ed.garay@lutrum.com.

Mary Pat: ***One of the most nerve-wracking projects a manager can undertake is moving from one IT vendor to another. Can you talk about how that process can be successful?***

Ed Garay: It is possible to achieve success during an IT Vendor Transition. If you follow a steps outlined here, you will feel more confident about making an IT Vendor change and can start expecting better results from your current (or future) IT Vendor.

- Start with understanding the agreement terms with your current IT vendor. Some may have an early termination fee. You'll want to have 15-60 days of availability from your current IT Vendor before fully cutting over to your new IT vendor
- Determine timeline of transition that works best for your medical practice. Is it a transition that needs to be expedited, or is it one that needs detailed consideration?
- If you do not have network documentation provided to you by your IT Vendor, have them provide you electronic documentation of the following:
    - Computer Inventory
    - Administrator username and passwords for networked devices, your domain, online providers, website hosting, etc.
    - Medical Practice's top three HIGH RISK areas
    - List of open support requests especially if they are known security concerns and high priority requests
    - List of 3rd party service partners such as Internet Service Providers, Online Backup Providers, and Website Hosting Providers, etc.
    - Backup configuration(s) and devices
    - Endpoint Security configuration(s) such as Anti-

    - virus and Anti-spyware software
    - Anti-spam configuration(s)
    - Network configuration(s) and layout to include wireless connectivity, VPN's, and networked devices
- Provide this documentation to your new IT Vendor and allow them 3-5 business days to comb through the information and document questions they may have for your current IT Vendor
- Initiate a conference call or face-to-face meeting between your medical practice (key individual(s)), your current IT Vendor and new IT Vendor. This is a very critical step.
    - All great IT Vendors exit their client's organizations smoothly
    - With your network documentation in hand, the new IT Vendor can talk more specifics with your current IT Vendor.
    - If certain software and services are specific to your current IT vendor, the current and new IT vendor will need to coordinate the swapping out of the software and services within your timeline.
- Encourage current and new IT vendors to communicate with each other regularly during the identified timeline
- Have both IT Vendors regularly report to you updates on the transition
- Have your new IT vendor engage with your medical practice's end users during the transition before Go Live
- Go Live of your new IT Vendor's services!

Mary Pat: As a takeaway for MMP readers, Ed has put together a <u>Top 10 List</u> of steps that practices can take to ensure they are mitigating HIPAA/HITECH risks. For your copy, send an email to ed.garay@lutrum.com

Ed Garay is the CEO of **Lutrum**, a managed IT services company that provides medical practices with a turnkey IT solution. He is certified in Management of Clinical Information Technology. Ed says "Through state-of-the-art technology, strategic planning, quick response time, and open communications, we create a winning partnership between your team and ours so that your IT worries disappear, leaving you more time to run your business." You can contact Ed at 480.745.3091 or ed.garay@lutrum.com.

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mHealth Gives Home Health a Whole New Meaning

One of the most exciting trends in modern healthcare can be found at the intersection of two larger societal changes: the shifting demographics of an aging Baby-Boomer population, and the fast adoption of smart mobile devices and mobile application platforms. As robust, secure and intuitive mHealth applications are adopted, patients are more empowered to monitor and share their health data outside of a traditional medical office or hospital setting. As healthcare delivery system already short on providers becomes even more taxed, mHealth applications will allow the system as a whole (patients, caregivers, loved ones, and payers) to navigate health decisions in a more efficient and informed way.

This quote from the Deloitte Center for Health Solutions 2010 Survey of Health Care Consumers says it all:

> *"Boomers view tech-enabled health products as a way to foster control and ongoing independence for themselves, especially*

> *in light of the rise in incidence in chronic disease with aging, and their desire to reduce costs. Nearly 56% of boomers show a high willingness to use in-home health monitoring devices in tandem with care of their primary physician."*

What are the advantages of pushing home health medical data from the source to the care provider?

- Minimum lag time between data collection and the clinician's ability to review it.
- Reduction in errors associated with human intervention in data entry.
- Intuitive and simple interfaces promote active patient involvement and caregiver communication in healthcare management.
- Secure sharing of PHI (Protected Health Information) with patient, family members, and approved internal and external stakeholders in health.

Here are just a few of the companies and products available now (or in the near future) that might change your mind about where and how health data is captured and shared. Each of these products automates the capture of health data and the transfer of the data in a usable format to an Electronic Health Record.

Near Field Communications

NFC (Near Field Communications) is a wireless technology that allows for quick transfer of data between two sensors that are fairly close (an inch or two) together. The secure transfer allows for seamless data tracking inside caregivers' workflow. For example: medical supplies, drugs, injectables and fluids can be fitted with low cost sensors that are swiped past a patient's sensor to indicate they will be administered to the patient, and then again past the provider's sensor to indicate a finished procedure, capturing time of administration,

dosage, and patient information without slowing down the care to enter this critical data by writing them down, typing them in, or just resolving to remember them for later entry.

Gentag makes the data sensors and applications that manufacturers can use to send data via cell phone to the hospital or physician for seamless inclusion in the electronic medical record (EMR). Monitoring of blood pressure, fever, weight management and urinalysis are just a few of the ways Gentag has improved data capture in healthcare.

iMPak Health makes a cholesterol monitor the size of a credit card that accepts a small blood sample to process for triglyceride levels. The data is uploaded wirelessly to a cell phone that transmits it to a health provider.

Smart Fabrics and Wearable Monitors

Researchers at the Universidad Carlos III de Madrid in Spain developed a fascinating concept for an "**Intelligent T-Shirt**" that uses sensors woven into a washable fabric to create a hospital garment that does more than preserve the patient's modesty. The sensors in the fabric can detect and record temperature, bioelectric impulses (for ECG monitoring), as well as the patients location, current resting position, and level of physical activity.

Copenhagen Institute of Interaction Design graduate Pedro Nakazato Andrade has designed a dynamic cast called **Bones** that collects muscle activity data around a fracture area by using electromyographic (EMG) sensors to report the patient's progress to physicians automatically. This could reduce the need for follow-up visits and imaging, or change the specifics of rehabilitation.

The **Basis Band** is a wristwatch-type accessory that monitors heart rate by directing light into the skin to image blood flow. It also uses a heat sensor for skin temperature changes, an accelerometer for recording movement and activity, and

sensors for galvanic skin response. The band also gives customers access to a free, web-based health dashboard to oversee the data the device collects and transmits.

There are still some considerable hurdles to full adoption of mobile home health monitoring. Very few patients use only one medical device, so not only do monitoring devices need to work with networked EHR technologies, they have to be integrated with each other to present a comprehensive picture of health to providers and Health Information Exchanges (HIEs). Also, as patients navigate the system of generalists, specialists, and emergency care providers, the possibility of encountering multiple software and hardware platforms will require flexible, integrated solutions that can run on any device. As with any networked application of sensitive data, security and availability are major factors in a success deployment. Unless patients can count on the privacy of their data, and providers can count on the uptime of their software, healthcare systems won't be able to realize the full benefit of mHealth installations. On top of that, more monitoring of patient health means that there will be even more data to be collected on each patient, and on the population as a whole. While more data means more opportunity for large scale research and analysis for the public benefit, it also means more data has to be secured and protected as a part of the health record, requiring even more security and storage resources. And finally, the Food and Drug Administration will have a large say in the future of mHealth application development through industry regulation. Device makers and application developers will certainly have to work within a governmental framework which will have a large say in the time-to-market of many possible products.

With all that being said, the opportunity to meet the demographic challenges of an already stressed healthcare system with mobile home health monitoring and Electronic Health Records will be one of the major themes of the future

of both the heath and technology industries.

The Best of Manage My Practice – November, 2011 Edition

In between polishing off leftover turkey and stuffing, we're looking back over some of our most popular posts from the month in case you might've missed them the first go round. Thankfully Presenting, **The Best of Manage My Practice, November 2011**!

- Compliance: a critical issue for all practices, but a subject so expansive, where do you even begin? Learn the "Big Three" with Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare
- Are your record retention policies up to date? Can you say with confidence that you have hard copies of everything you should? Find out with Record Retention Simplified – The Ultimate Guideline
- Are you or someone you know thinking about Medical Coding as a a possible career? Follow along with Coder Bob in Tales of a Coder Part III: School Begins
- Are you the kind of leader that can see your group through the toughest of times? Bob Cooper asks practice managers in Are You a Resilient Leader?

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your favorite posts and discussions this month? Did we skip over

your favorite from November? Let us know in the comments!

Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare

In health care, we are "*blessed*" with an abundance of rules, policies, standards and laws. In Health Care Regulation in America: Complexity, Confrontation, and Compromise, **Robert I. Field**, professor of health management and policy at Drexel University School of Public Health, observes the following:

> *"**Regulation shapes all aspects** of America's fragmented health care industry, from the flow of dollars to the communication between physicians and patients. It is the engine that translates public policy into action. While the health and lives of patients, as well as almost one-sixth of the national economy depend on its effectiveness, health care regulation in America is bewilderingly complex."*

Here are some of the most important regulations in health care that you should not only know about, but should be actively managing with a robust compliance plan.

Stark Law (Physician Self-Referral)

When: Section 1877 of the Social Security Act, also known as the physician self-referral law, is commonly referred to as

the Stark Law. When enacted in 1989, it applied only to physician referrals for clinical laboratory services. In 1993 and 1994, Congress expanded the prohibition to the additional designated health services listed below.

What: Stark Law "prohibits physicians from making referrals for designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies," according to the Centers of Medicare & Medicaid Services (CMS). Specifically covered designated health services include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Penalties: Penalties for violating the Stark Law include denial of payment, refund of payment, imposition of a $15,000 per service civil monetary penalty, and imposition of a $100,000 civil monetary penalty for each arrangement considered to be a circumvention scheme.

*The following will help you **remain compliant with the Stark Law:***

1. Offer all patients a written list of choices for obtaining

the care your physicians are recommending.

2. Disclose any financial relationship with any entity that is on the list offered to patients.

False Claims Act

When: Originally enacted during the Civil War, and sometimes known as the Lincoln Law, the False Claims Act (FCA) as we know it today was signed by President Reagan in 1986.

What: Under the FCA, those who knowingly submit – or cause another person or entity to submit – false claims for payment of government funds will be subject to liability. The FCA contains qui tam, or "whistleblower," provisions.

Penalties: Medicare and Medicaid fraud and abuse prohibit the knowing and willful making of a false statement that affects reimbursement under a federal health program. That provision imposes felony penalties of up to five years' imprisonment and/or fines up to $250,000 for an individual and $500,000 for an organization.

In addition to criminal penalties, the Office of Inspector General (OIG) may impose civil penalties under the Civil Monetary Penalties Act for submitting false claims. Civil penalties can be up to $11,000, plus three times the amount claimed. According to the Telehealth Resource Center, "The Civil Monetary Claims Act prohibits claims for services not provided as claimed; false or fraudulent claims; claims for physician services not furnished by physicians; or claims for services provided by an excluded physician or provider. The False Claims Act gives the federal government, as well as any person, a cause of action against any person who submits false claims to the government."

To help your practice ***remain compliant with the False Claims***

***Act**, keep the following in mind:*

1. Perform background checks and obtain references on all potential employees, making sure they are not sanctioned by the OIG.

2. Have an audit performed by a third-party biannually to make sure that your billing department is following your compliance policy to the letter.

Anti-Kickback Statute

When: Congress enacted the anti-kickback statute, 42 U.S.C. § 1320a-7b(b), in 1977 as a prohibition against the payment of kickbacks in any form.

What: The anti-kickback statute states that criminal penalties will be issued for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration intended to induce or reward referral of business reimbursable under any of the federal health care programs (Medicare, Medicaid, etc.)

Penalties: The anti-kickback statute is a criminal statute, the violation of which constitutes a felony punishable by a fine of not more than $25,000 per offense and/or imprisonment for up to five years. A conviction also will lead to mandatory exclusion from participation in federal health care programs. The OIG also may impose civil monetary penalties of up to $50,000 for each violation, plus damages of three times the amount of the remuneration.

*To help you **remain compliant the anti-kickback statute**:*

1. Seek the advice of an experienced health care attorney before entering into any agreements with parties to pay or receive payment for goods or services where a kickback might

be construed.

2. Make sure your compliance plan addresses the acceptance of gifts by physicians and staff.

Put It All Together: Your Compliance Plan

A compliance plan does not have to be long or overly complex. The federal government recommends a **seven-component compliance plan** that covers the critical points in a simple and easy-to-understand way:

1. **Designate a compliance officer**, which can be the manager or a staff member.

2. **Implement compliance and practice standards**, and have all employees sign an agreement to comply with the standards. Make compliance training a part of new employee orientation and conduct annual re-training for all staff.

3. **Conduct initial compliance training** and education for physician and staff. Training can be outsourced, and is also available online. Document all training.

4. **Oversee internal monitoring and auditing**, and document the results.

5. **Respond appropriately to detected offenses** and develop corrective action plans. Document offenses and responses.

6. **Develop open lines of communication** and encourage employees to discuss compliance at staff meetings, or in one-on-one meetings.

7. **Enforce disciplinary standards** through well-publicized guidelines.

Make sure that your compliance plan is not just a binder on

***the shelf!** All employees must understand the seriousness of the penalties (There are lots of examples online to illustrate this.) and the importance of compliance to the success of your practice.*

Common Sense Billing and Coding Compliance

Compliance can be a little tricky to define, but in the context of health care billing and coding, compliance is all about what we don't do, rather than what we do. Here are 16 common sense and simply-worded rules:

1. Don't bill what wasn't documented.

2. Don't bill what wasn't done, thinking it probably was or will be.

3. Don't provide unnecessary services.

4. Don't name someone in the medical record or on the claim who wasn't there.

5. Don't double bill the payer.

6. Don't change the place of service to maximize payment.

7. Don't unbundle services that are part of a single service.

8. Don't charge for related services during the global period.

9. Don't upcode or downcode services.

10. Don't neglect or misuse modifiers that would change the payment.

11. Don't discount care to patients for referring other patients.

12. Don’t waive patient balances unless a financial need is documented.

13. Don’t keep the money if a patient or payer overpays.

14. Don’t change the diagnosis to achieve payment if the payer denies payment based on the diagnosis.

15. Don’t accept money or gifts to prescribe drugs, refer patients, or order procedures or tests.

16. Don’t direct patients to the facility that you own for a necessary test or procedure without disclosing that you own part or all of the facility.

Do you have any compliance tips, guidelines, or maxims that help keep your group on track? Share them in the comments below!

Steve Jobs, Social Media and iPad enabled voting: Welcome to 2.0 Tuesday! A look at what’s next in technology and healthcare.

At Manage My Practice, we have always been fascinated by the opportunities created when innovation and technical advancements are applied to the Healthcare system. The intersection of technology and medical practice has always

been one of the most exciting spaces in research and development because the challenges of the Human Body are some of the most daunting and emotionally charged of our endeavors. Curing diseases, diagnosing symptoms and improving and saving lives are among our most noble callings, so naturally they inspire some of our brightest thinkers and industry leaders.

As managers, providers and employees, we always have to be looking ahead at how the technology on our horizon will affect how our organizations administer health care. In the spirit of looking forward to the future, we present "2.0 Tuesday", a weekly feature on Manage My Practice about how technology is impacting our practices, and our patient and group outcomes.

We hope you enjoy looking ahead with us, and share your ideas, reactions and comments below!

- ## Steve Jobs thought iCloud had the potential to store Medical Data

Apple's recently announced iCloud service let's you store pictures, movies, music, and documents in Apple's "cloud", or Internet storage system, and retrieve them with your iPhones, iPods, iPads, and Mac computers. Dr. Iltifat Husain, writing for the IMedicalApps blog notes that in the new biography of the Apple founder, Jobs mentioned that he thought even personal medical data would one day be stored in Apple's iCloud. Cloud storage is all the rage right now in a lot of different areas of technology, but Jobs saying that medical data would be stored on the consumer end next to vacation photos and favorite songs represents a very bold vision of the future of patient data.

Researchers using Social Media to study attitudes about Public Health

A team led by Marcel Salathé, PhD at Pennsylvania State University published a study last month in *PLoS Computational Biology* that used "tweets" gathered from the social network Twitter to analyze how the public felt about the H1N1 influenza vaccine in 2009. Although Social Media research has limitations, Christine S. Moyer, writing for the American Medical Association's Amednews.com notes that the results were similar to traditional phone surveys conducted by the Centers for Disease Control, and provides some other examples of how Social Media has been used to understand public health trends.

- ## Interesting EHR/EMR data from the Soliant Health Blog

Medical staffing specialist Soliant Health had very eye-opening list of statistics about EHR/EMR implementations on their blog last week. My personal favorite: *Hospitals using EHR/EMR systems have a **3 to 4% lower mortality rate** than those that don't*. Very interesting numbers.

- ## HealthWorks Collective predicts changes in healthcare communications after ACA

Healthworks Collective's Susan Gosselin makes some predictions about how the communications between and among providers and patients are going to be changed by the Affordable Care Act (or Healthcare Reform)- and what both groups will demand from a changing system. Great stuff!

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- ### Oregon to help disabled voters cast ballots using iPads

In today’s local and congressional elections, five counties in the state of Oregon are going to be equipping local officials with iPads preloaded with special touch-interface software to accompany people with physical or visual impairments, or who would otherwise have a hard time making it to the polls. The 9 to 5 Mac blog is reporting that the pilot program features hardware donated by Apple, and could soon spread statewide by the next election.

Be sure to check back next week for another 2.0 Tuesday!

The Best of Manage My Practice – October, 2011 Edition

As we finish off another month here at MMP, we wanted to go back over some of our most popular posts from the month and get ready for another busy, productive, and meaningful month. Presenting, **The Best of Manage My Practice, October 2011**!

- Are you ready for the holidays? How about the New Year? Even though it's still a few months off, make sure you don't see an interruption in your practice's cashflow by getting ready for the January 1st 5010 deadline!
- CMS has released the Premiums and Deductibles for Medicare patients for 2012, so you can start informing staff and patients now. More importantly, will 2012 be the year that you get serious about collecting deductibles at the time of service?
- Mary Pat's "Collection Basics"series about the fundamentals of Revenue Cycle Management in Physician offices is now at part three! Check out Patient Collections Basics: Developing a Financial Assistance Program.
- One of Healthcare's most misunderstood and underutilized documents– the Medicare Advance Beneficiary Notice- is changing for 2012. Make sure you're ready.
- And finally, the Office of the Inspector General (OIG) of he department of Health and Human services has released its 2012 Work Plan for areas it will concentrate on investigating. Better safe than sorry! Mary Pat goes over the highlights here.

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your favorite posts and discussions this month? Did we skip over your favorite from October? Let us know in the comments!

How Much Do Medical Practice

Managers Make?

Read the 2011 update to this article **here.**

You've heard that healthcare is one of the few job markets that is still growing in a down economy and you think you might like to be a medical office manager. The question is: how much do medical practice managers make?

The real answer to this question is "it depends." Two people in different parts of the United States could have the same job description and one could make $50,000 and another could make $100,00. Most experienced, capable medical practice managers make a good living somewhere in the middle.

What differentiates medical practice managers (and I use this term in a generic sense to cover the variety of titles used in the healthcare field) from other office managers is that they are expected to know something about almost everything. A typical day in the life of a medical manager might well include tasks in the areas of:

- human resources
- risk management
- coding and billing
- credentialing
- accounting
- information technology
- facilities management
- conflict resolution
- physician compensation plans
- marketing
- physician/provider recruiting
- and more! **(see my post on what managers do here**.)

The medical practice manager is often in the unique position of both answering to the owners (physicians) and managing them – a phenomenon not seen in other industries.

What a medical practice manager earns relates to:

- what the decision maker(s) believes the job is worth, or what they're willing to pay
- what a consultant or financial adviser has said the job is worth
- what other local practices are paying their managers
- what the previous manager made

Factors influencing the posted salary for a position are:

- the specialty or specialties (single-specialty vs multi-specialty and primary care vs. sub-specialty care)
- the number of physicians/providers
- the number of sites or ancillary services (imaging, physical therapy , medical spa, ambulatory surgery center)
- hospital-owned vs. non-hospital-owned
- if hospital-owned, how the position is graded, or where it fits in the management structure
- billing in-house or outsourced
- financial soundness of the entity
- the entity's competition in the community
- cost of living factor for region

Factors that might influence the salary ultimately offered YOU for a position are:

- Years of experience in healthcare management
- Years of experience managing the same or similar specialty
- Years of experience managing the same or similar # of physicians
- Stability of jobs over the past 10-15 years
- Special degrees: Master's, CPA, CPC, Compliance, RN, Lean, Black Belt (Six Sigma)
- Having installed an EMR (electronic medical record)
- References

Where does one look for specific information on what managers make?

The Bureau of Labor Statistics' (BLS) most recent information reports:

> *Median annual wages of wage and salary medical and health services managers were $80,240 in May 2008. The middle 50 percent earned between $62,170 and $104,120. The lowest 10 percent earned less than $48,300, and the highest 10 percent earned more than $137,800. Median annual wages in the industries employing the largest numbers of medical and health services managers in May 2008 were:*

General medical and surgical hospitals	$87,040
Outpatient care centers	74,130
Offices of physicians	74,060
Home health care services	71,450
Nursing care facilities	71,190

According to a 2009 survey by the **Professional Association of Health Care Office Management** (PAHCOM), the median salary for health administrators in small group practices is $56,000; for those in larger group practices with 7 or more physicians the median is $77,000.

The silver-back of healthcare salary surveys comes from the Medical Group Management Association (MGMA). The Management Compensation Survey is one of the "golden trio" of surveys that I've used throughout most of my professional life. You can view a sample page here: **Sample Table** (pdf). The survey information is free if you are a MGMA member and participate in the survey yourself. **You can purchase the Compensation Survey here.**

Many state MGMA groups also sponsor state salary surveys and sell them to non-members. In addition, some local manager

groups do limited surveys and make the information available for a fee.

Job descriptions for medical managers can be found under the Library tab at the top of the page.

More articles on medical management can be found under the category of "A Career in Medical Management" on the right-hand side of the page, including **"A Day in the Life of a Practice Administrator"** and **"The 5 IT Skillsets Every Physician Practice Manager Needs to Succeed in 2009 and Beyond."**

A Memo to the Staff: The Preciousness of Patients

Sometimes in the midst of making changes to improve things, we inadvertently lose the patient.

Sometimes we literally lose the patient because they say "Everything is changing and I don't like it. I'm taking my business elsewhere."

Sometimes we figuratively lose the patient because they feel a distance in not connecting with the staff, or not understanding why things are changing.

How do we hold on to our patients when all around us the world is changing, healthcare is changing and we are changing to stay alive financially and competitively?

- Focus on each patient you come in contact with and look into their eyes. We forget to look into people's eyes. If you find yourself not connecting with a patient, **ask yourself what color eyes the patient has**. In checking,

you will connect.

- Remind yourself of the preciousness of life and of each life you come in contact with. The job is do are not just “any” job. We are fortunate to do jobs where we are entrusted with people’s most precious possession – their health and their lives. We are not telemarketers, we are not selling widgets, and we are making a difference in this world. Don’t forget that **YOU are making a difference.** No matter how your job touches a life directly or indirectly, you are in healthcare, one of the most challenging and meaningful jobs out there.
- Even though we sometimes shake our heads over patient expectations, we can still do our best to let patients know that we are sorry when we cannot do what they are asking. We can’t always see everyone who wants to be seen today. We can’t always get their forms completed, or their medical records copied, or their test results reported back to them immediately, but we can express the understanding that **their needs are important to us.**
- Give everyone the benefit of the doubt. **Believe they are human and doing the best they can.**
- Do not think I expect perfection. I don’t. I expect each of you to **do the best you can,** but I do not expect perfection of myself and I don’t expect it of you.

Thank you for being in healthcare with me.

Mary Pat

What Does a Medical Practice Manager Do?

Whether the title is manager, medical practice manager, physician practice manager, administrator, practice administrator, executive director, office manager, CEO, COO, director, division manager, department manager, or any combination thereof, with some exceptions, people who manage physician practices do some combination of the responsibilities listed here or manage people who do.

Human Resources: Hire, fire, counsel, discipline, evaluate, train, orient, coach, mentor and schedule staff. Shop, negotiate and administer benefits. Develop, maintain and administer personnel policies, wellness programs, pay scales, and job descriptions. Resolve conflicts. Maintain personnel files. Document Worker's Compensation injuries. Address unemployment inquiries. Acknowledge joyful events and sorrowful events in the practice and the lives of employees. Stay late to listen to someone who needs to talk.

Facilities and Machines: Shop for, negotiate, recommend, and maintain buildings or suites, telephones, hand-held dictation devices, copiers, computers, pagers, furniture, scanners, postage machines, specimen refrigerators, injection refrigerators, patient refreshment refrigerators, staff lunch refrigerators, medical equipment, printers, coffee machines, alarm systems, signage and cell phones.

Ordering and Expense Management: Shop for, negotiate and recommend suppliers for medical consumables, office supplies, kitchen supplies, magazines, printed forms, business insurance, and malpractice insurance as well as services such as transcription, x-ray reads/over-reads, consultants, CPAs, lawyers, lawn and snow service, benefit administrators, answering service, water service, courier service, plant

service, housekeeping, aquarium service, linen service, bio-hazardous waste removal, shredding service, off-site storage and caterers.

Legal: Comply with all local, state and federal laws and guidelines including OSHA, ADA, EOE, FMLA, CLIA, COLA, JCAHO, FACTA, HIPAA, Stark I, II & III, fire safety, crash carts and defibrillators, disaster communication, sexual harrassment, universal precautions, MSDS hazards, confidentiality, security and privacy, and provide staff with documentation and training in same. Make sure all clinical staff are current on licenses and CPR. Have downtime procedures for loss of computer accessibility. Make sure risk management policies are being followed. Alert malpractice carrier to any potential liability issues immediately. Make sure medical records are being stored and released appropriately.

Accounting: Pay bills, produce payroll, prepare compensation schedules for physicians, prepare and pay taxes, prepare budget and monthly variance reports, make deposits, reconcile bank statements, reconcile merchant accounts, prepare Profit & Loss statements, prepare refunds to payers and patients, and file lots and lots of paperwork.

Billing, Claims and Accounts Receivable: Perform eligibility searches on all scheduled patients. Ensure that all dictation is complete and all encounters (office, hospital, nursing home, ASC, satellite office, home visits and legal work (depositions, etc.) are charged and all payments, denials and adjustments are posted within pre-determined amount of time. Transmit electronic claims daily. Send patient statements daily or weekly. Negotiate payer contracts and ensure payers are complying with contract terms. Appeal denials. Have staff collect deductibles, co-pays and co-insurance and have financial counselors meet with patients scheduling surgery, those with an outstanding balance, or those patients with high deductibles or healthcare savings plans. Make sure scheduling staff know which payers the

practice does not contract with. Liaison with billing service if billing is outsourced. Credential care providers with all payers. Perform internal compliance audits. Load new RBRVS values, new CPTs and new ICD-9s annually. Run monthly reports for physician production, aged accounts receivable, net collection percentage and cost and collections per RVU. Attach appropriate codes to claims for e-prescribing and PQRI. Have plan in place for receipt of Recovery Audit Contractor (RAC) letters. Make friends and meet regularly with the provider reps for your largest payers.

Marketing: Introduce new physicians, new locations and new services to the community. Recommend sponsorship of appropriate charities, sports and events in the community. Recommend sponsorship of patient support groups and keep physicians giving talks and appearing at events. Thank patients for referring other patients. Track referral sources. Recommend use of Yellow Pages, billboards, radio, television, newspaper, magazine, direct mail, newsletters, email, website, blog, and other social media. Prepare press releases on practice events and physicians awards and activities. Recommend practice physicians for television health spots.

Strategic Planning: Prepare ROIs (Return on Investment) and pro formas for new physicians, new services, and new locations. Forecast potential effect of Medicare cuts, contracts in negotiation or over-dependence on one payer. Discuss 5-year plans for capital expenditures such as EMR, ancillary services, physician recruitment, and replacement equipment. Explore outsourcing office functions or having staff telecommute. Always look for technology that can make the practice more efficient or productive.

Day-to-day Operations: Make the rounds of the practice at least twice a day to observe and be available for questions. Arrange for temporary staff or rearrange staff schedules for shortages, meet or speak with patients with complaints, and

meet with vendors, physicians and staff. Open mail and recycle most of it. Unplug toilet(s).

Stay Current in Healthcare: Attend continuing education sessions via face-to-face conferences, webinars, podcasts and online classes. Maintain membership in professional organizations. Pursue certification in medical practice management. Network with community and same specialty colleagues. Participate in listservs, LinkedIn and Twitter.

What did I leave out? Take a lunch?

Read my post on "How Much Do Medical Practice Managers Make?" **here.**