

VitalSigns

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We can't escape the fact that health care is becoming more and more competitive. In response, practices, hospitals and health systems are having to become more creative to ensure their viability. Even if you think you're working as hard as you can at being successful, you may still be overlooking some simple, easy-to-implement ways to get better.

This issue of *VitalSigns* addresses the ways in which a practice can differentiate itself through delivering exceptional patient service and increasing quality of care. We also talk about how a hospital can alleviate issues with referring physicians, and we discuss the impending Medicare cuts and what they'll mean to practices over the next few years. Plus, we present a handy practice assessment checklist addressing billing and collections.

Paying attention to and staying on top of issues such as these, as well as nurturing mutually beneficial relationships between hospitals, physicians and patients, are critical to staying competitive and profitable.

PRIDE and the 4 C's of quality care A winning combination

Given the current competitive state of the health care industry, with an increasing number of alternative providers (including urgent care centers, minute clinics, and teledoctors), paying attention to existing patients' and their families' needs is critical not only for the viability of the practice, but also for ensuring opportunities for future referrals.

These alternative providers have tuned in to the needs of patients and are finding creative ways to meet them. Physician practices that fail to properly attend to the needs of their patients are likely to see a leveling in their volumes — or even a decline.

The solution appears to be simple: Provide quality care and patients will be satisfied, right? Not so. To be successful in today's practice environment, physician offices must address two aspects of quality — patient service and medical care. Although most practices provide quality medical care, many fall short in their delivery of quality patient service.

True quality cannot be achieved without attention to both. Practices excel by finding out what the patient wants and delivering it to them. Unfortunately, many patients cannot distinguish between the subtle differences in medical care and patient service that separate private practice from the other models. So your practice must be proactive in distinguishing itself.

Bringing PRIDE to your practice

How do you achieve the desired quality of service needed to maintain and grow your practice? Physicians and staff alike need to take responsibility and truly demonstrate that they care about their patients. Every individual involved with the patient and the patient's family, whether by phone or in person, needs to be accountable for his or her relationship with the patient.

To achieve this goal, one method that some practices have adopted is called Personal Responsibility In Delivering Excellence,



or PRIDE®. Developed by Businessballs (businessballs.com), a free ethical learning and development resource for people and organizations that juggle balls of management, training, and development, PRIDE is a concept that begins with committed physicians who "walk the walk."

That is, physicians need to set a standard of patient service excellence for staff to follow. After all, how the billing clerk interacts with patients is just as important as how the front desk staff answer the phone. Both have ample opportunity to either strengthen patient loyalty or weaken it. And when a problem arises, staff will follow the path they observe the physicians take — whether good or bad!

Attention to providing quality service should begin as early as the interview for new staff members. Are they on time or, ideally, early? Are they friendly and polite when interacting with the staff? Are they clean and neat? Is their CV free of errors and omissions?

If a candidate doesn't go the extra mile during the interview, you can be assured that going the extra mile will not be one of his or her value-added services to patients. Every staff member's annual review should include a review of their initiative to deliver excellent patient service. Staff should be complimented on an ongoing basis for successes in meeting patient service goals and counseled on needed improvements.

Fulfilling the 4 C's of quality care

Along with incorporating PRIDE, or some other patient service improvement program, successful physician practices need to incorporate the four C's of quality care:

1. **Compassion for patients.** Patients want compassion from a physician and staff who are genuinely kind and understand their concerns. They want someone to listen and not rush them.

A 2007 study, "Physician's Office and Outpatient Pulse Report: Patient Perspectives on American Health Care," conducted by health care researchers Press Ganey, reinforces this point. Surveying more than 4.6 million patients treated in over 6,000 physician offices and 2,500 outpatient facilities nationwide, the study identified "our [the physician office's] sensitivity to your [the patients'] needs" as

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Assess your billing/collections process by asking the right questions

Many physicians and managers are so busy with the day-to-day operations of their practices that they don't take the time to conduct regular diagnostic check-ups of the business. Whether you're guilty of this oversight or simply sense something may be wrong, a practice assessment is a good idea.

Your staff and physicians are a good place to start. By surveying them about the state of your practice, you can gain great insight into any problems that may be brewing or discover issues that you need to address immediately.

One area that every medical practice should regularly assess is billing/collections. Asking the right questions, and investigating the responses if necessary, should help you decide whether there's an issue you need to address. Here's a handy checklist to get you started:

___ Is your computer system current and capable of handling the practice's needs?

___ Are all patient charges and payments posted each business day?

___ Are all co-payments, deductibles, and patient balances collected before the patient is seen, and are patients instructed to be prepared to pay these balances when appointments are scheduled?

___ Does the staff verify insurance benefits for all patients?

___ Does your charge ticket have current CPT and ICD-9 codes for the high-use codes specific to your practice?

___ Are CPT and ICD-9 codes updated with the new codes by October 1 of each year?

___ Are charge tickets tracked to find potential missed charges, deleted codes, inadequate codes (always bill to the farthest digit for ICD-9 codes to avoid denials), and inaccurate procedures or descriptions?

___ Does the staff get updated information (address, phone number, insurance coverage, etc.) from established patients each visit? (Asking if anything has changed is not getting updated information.)

___ Are patient statements sent out on a 30-day cycle?

___ Are too many statements sent out for co-payments that should have been collected at the time of service, costing the practice money?

___ Do you have a good way to capture hospital and/or surgery charges?

___ Is there a separate hospital charge slip (pocket-size index card) or a separate surgery charge slip to capture potential missed billing opportunities and to avoid billing errors?

___ Does the provider of service code its own services or is a certified coder used?

___ Is your outstanding accounts receivable (A/R) comparable to industry standards? (As a rule, better performing practices have less than 12% of A/R more than 120 days old.)



___ Do insurance claims get filed within two to three days from the date of service, and are all possible claims sent out electronically?

___ Is there any reason that claims are held, such as providers not dictating in a timely manner or problems getting hospital registration for inpatients?

___ Is the practice's fee schedule reviewed annually and compared to a standard (for example, a percentage of the Medicare fee schedule or a published fee analyzer by locale and specialty)?

___ Do global periods display for the provider when to charge for a visit?

___ Are all denials or zero pays investigated for items, such as improper bundling and coding and registration errors, in a timely manner?

___ Are good appeal and adjustment procedures in place, and does the staff follow these procedures in a timely manner?

___ Are insurance payments reviewed to ensure the practice is receiving the contracted rate, and are underpayments challenged?

___ Are refunds reviewed, posted to patients' accounts and sent out regularly?

___ Are noncontractual adjustments (including professional courtesy, bad debt, financial hardship, etc.) approved and reviewed? (Many times embezzlement will be hidden in this type of write-off.)

___ Are charges for all appropriate ancillary services captured?

___ Does the practice have written collection policies? (The staff should have a timeline for collection steps for final letters, along with guidelines for when and if an account should be turned over to a collection agency and whether the patient should be terminated from the practice.)

___ Is the staff properly trained in collections to adhere to state regulations?

___ Does the staff work the outstanding A/R in a timely manner? (The staff must be aware of timely filing deadlines or valuable revenue will be lost. Accounts should be followed up no later than 30 days after nonpayment.)

___ Do you have an adequate number of staff dedicated to outstanding A/R?

___ Are credit card payments accepted by the practice, and do staff and patient statements offer this payment method?

___ Are realistic payment plan arrangements set up or are the staff allowing \$5 per month payments on large balances? (Note: It will take a patient five years to pay off a \$300 balance if he or she pays \$5 per month, costing the practice more than \$120 in the end.)

A periodic diagnostic check-up like this will give you a feel for whether your practice is in good or poor financial health. If this all seems like too much work, or if you want a neutral opinion, you may want to consider hiring an expert to perform this important task for you.

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the greatest opportunity for improvement in patient service. Thus, it may be the best use of your time to demonstrate your sensitivity by spending time listening to patient concerns.

2. Convenience with prompt access to care (appointments/phone advice).

Convenience is crucial, and alternative providers often offer a wider variety of options than those available in physician offices, especially for working patients and parents. Staff must demonstrate their desire to meet the patients' needs when they call.

Even loyal patients who attempt to schedule a visit with their physician's office might seek out another care provider if they cannot get an appointment or resolution by phone in a timely manner. Consider staggering your office hours to

accommodate patients with less flexible schedules.

3. Consideration for patient's privacy and time.

This can be demonstrated in many ways, but few are more important than privacy. Patients must be able to trust that their personal information, both financial and medical, will remain confidential.

Many of the steps you can take are fairly simple — for example, eliminating conversations about patients in open office areas. Doing so will keep patients from wondering what staff might say about them after they leave the office. Another consideration is time: Respect for patients' schedules will likely earn your practice high satisfaction ratings, as you're validating that their time is just as valuable as yours.

4. Contentment in your work.

Visiting a physician office should make patients feel

better — even if it's only emotionally. The Press Ganey study also noted that the second largest opportunity for improvement in physician offices was "overall cheerfulness."

Staff should be upbeat and positive, not discussing their personal problems in front of the patients, for example. Something as simple as getting to know patients and using their names frequently will promote positive feelings.

Discovering what your patients want

It's an important point that bears repeating: Physician offices need to discover what patients want and be able to provide it for them. Clearly, quality is the answer, but you cannot address quality of care at the expense of quality of patient service.

Impending Medicare cuts offer options, opportunities and obstacles

Over the past five years, Medicare has proposed cuts to professional fees and technical fees for physician services. Each year these cuts have been stopped or delayed, but they're inevitable at some point in the near future.

The federal government budgets a fixed dollar amount for Medicare spending annually — \$454 billion in 2008. However, the current plan is to decrease Medicare spending by \$76 billion over the next five years. Current market dynamics pose a problem for the success of this plan. At a time when proposed budget cuts in excess of 10% have likely already taken effect (as this issue went to press, such a cut appeared probable but not certain), the Medicare population is increasing as a result of the baby boomer generation entering its golden years.

The Centers for Medicare and Medicaid Services (CMS) predicts that, by the year 2030, the Medicare-eligible population will have progressively doubled and, as such, the costs of health care services will accelerate accordingly. In addition, the pool of those who contribute to the Medicare program, primarily through payroll tax funding, will diminish, rendering demand greater than resources available.

Even if the proposed budget cuts don't go into effect this year, the professional and technical fee cuts are likely to occur as a result of the increased demand. In any case, physicians and health care organizations need to begin preparing for cuts of one kind or another.

The PQRI program

CMS has developed a program to begin to transition payor methodology from a cost/utilization basis to more of a quality/resource basis. This program, the Physician Quality Reporting Initiative (PQRI), allows physicians to recoup a portion of the proposed cuts by meeting and reporting on an array of quality measures.

If a practice successfully identifies, reports and validates specific quality measures with Medicare, the practice can earn up to an additional 1.5% of total allowed charges. The program is geared toward using technology to maximize both quality and operational excellence. The two structural measures that the program currently concentrates on are Electronic Medical Records (EMR) and E-scribing. (We discuss these in more detail later in this article.)

The PQRI program requires a significant administrative effort in which EMR can significantly facilitate the identification and reporting process. The program is predicated on having appropriate documentation of every health record to validate that quality measures are being achieved.

Because of the lack of practices that currently use EMR, however, the administrative effort required to fulfill the PQRI requirements is often overwhelming. In fact, many practices choose not to participate, as the cost outweighs any of the gains.

The potential upside gain is up to 1.5% of the total Medicare-allowed charges for the reporting period. Nevertheless, the percent granted is discretionary to the Medicare intermediary and will be capped at a maximum level.

Effect on other payors

The impact of the federal cuts on the other payors is unknown at this time. According to a study conducted by the AMA, roughly 60% of physicians surveyed indicated that they would limit the number of Medicare patients that they would be willing to see in their practices. This would create a significant access issue for the increasing Medicare population.

If the cuts have a more widespread impact, affecting the insurance industry, physicians will have to position their practices for a decrease in total practice cash flow. Most physician groups run their practices efficiently and close to the margin in terms of overhead, with little expense to be cut.

What's worse, the cost of running the average physician practice continues to escalate. Supply and staff costs are rising; staff workloads are becoming more demanding because of increased administrative requirements; and equipment replacement/acquisition expenses are going up as well.

The advantages of automation

Operational efficiencies achieved through investment in technology and automation of processes is one way to prepare for the cuts. Whereas the initial investment in EMR, and perhaps new billing software, may be significant, savings can be achieved and sustained through:

- Reduced patient charting time allowing for increased patient access,
- Reduced patient intake time by support staff,

- Eliminated charge entry function,
- Improved coding practices,
- Reduced pharmacy callbacks,
- Reduced chart pulling (searching) time, and
- Reduced referral time and reporting.

Implementation of EMR, however, takes comprehensive support and dedication from the practice staff in its entirety and, above all, by the physicians. The initial time and resource commitment is significant.

Yet, if planned thoughtfully and thoroughly, the transition can be smooth. A decrease in practice production during implementation and transition will need to be planned for, both operationally and financially. Finding a way to minimize the financial impact is essential. Various options merit consideration, including implementation on a per provider basis, a patient type basis (new patients, every third patient, well visits, etc.), or a system module basis (E-scribing, referrals, medication and problem list, etc.).

Regardless of the methodology, a comprehensive implementation plan and progress tracking system need to be developed to ensure the project stays on track to meet its financial objectives.

4 other technologies

Other types of technology are also available to assist in enhanced productivity and operations. Four examples include:

- 1. E-scribing.** Submitting prescriptions electronically allows for less administrative time in filling prescriptions and reduces duplicate/contradictory prescribing.
- 2. Voice recognition dictation.** This technology enables the physician to directly dictate progress notes into a word processing document, which eliminates the need for a dictation service and allows for organized and legible progress notes.

3. Practice management systems.

These solutions track patient workflow throughout the patient encounter as well as during the billing process.

4. Health informatics. This data-gathering system brings all types of information together in a central reporting/monitoring environment that helps practices work more efficiently and effectively.

An opportunity for uplift

When the impending Medicare cuts are considered in their entirety, not all is doom and gloom. This is an opportunity to give health care an operational uplift by adding ways to enhance quality of care and the efficiency in providing it. It's time to bring health care into the new age of technology and transform outdated manual processes into state-of-the-art best practices.



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Fostering successful physician-hospital relations

Successful physician-hospital relations begin with a strategy built around listening. Many hospitals develop physician-relations departments to promote good relationships with their referring physicians. These departments have bright people who are happy to visit physicians and discuss the hospital's latest services and programs. But the true test of success in the relationship is whether hospitals enable these managers to facilitate better relations. Do these relations managers take the time to really listen? Can they act upon what physicians are telling them?

Avoid common mistakes

Some hospitals and health systems make the mistake of believing that their physician staff only come to them for some sort of financial assistance. For many if not most private-practice physicians, this isn't the case.

It's also a common misconception that the proliferation of physician-owned surgery and diagnostic centers arose from the investment profits available to physicians. Many physicians, however, made their investments solely on the ability to improve their efficiency and quality of life, with any profit gained coming as a pleasant surprise.

Another major mistake that hospitals and health systems make is that they cater to the physicians who are "squeaky wheels"; in other words, those who complain the loudest and openly threaten to send their referrals to the competition. Unfortunately, hospitals tend to accommodate these physicians, as well as those from other hospitals who promise to bring referrals and cases to their institution, while forgetting the silent majority of physicians on staff who are loyal supporters of the hospital's programs and services. The silent majority never asks for much and doesn't complain, yet is the most vulnerable part of the medical staff.

So what do physicians really want? Simply put, they want a hospital that is easy for them and their patients to use. Private-practice physicians want to be able to access hospital services quickly and easily. They want laboratory and test results returned promptly and accurately. They want their patients to be able to obtain referred testing swiftly and without hassle.

They don't want to have to make excuses to their patients about lost tests, poor quality services or rude, uncooperative staff. For example, physicians can become unhappy when they cannot schedule a patient for a new MRI service — highlighted by the physician-relations staff — sooner than 14 days. Frustrated surgeons often speak of the unreasonable length of operating room turnaround time and being late for their office appointments because of operating room inefficiencies. Patients often complain of searching for parking at a facility to get a simple laboratory test.

Develop a strategy

Visionary hospital leaders understand that many areas of the country are experiencing physician shortages in numerous specialties. You need to

develop strategies to differentiate your health system from hospitals that are competing for the same physicians, both locally and in other geographic regions.

The first step is to develop a comprehensive physician strategy that includes support for independent physician practitioners and that explores the employment of physicians. When beginning to develop the plan, carefully listen to the physicians — not just the squeaky wheels but the silent majority as well. The strategy cannot only be a sales strategy; it must be tied into the hospital's operations plan.

When exploring the employment of physicians, the plan must also consider the impact of the hospital funding competition on its own medical staff. The health system must evaluate the impact that employing physicians will have on private practitioners, because the revenue to employ the physicians may be coming from the private physician's referrals to the hospital.

As part of the strategy, a comprehensive medical staff plan should be developed outlining specific staffing needs. Share this plan with the medical staff and revise it based on their input.

Think collaboratively

Health systems and physicians are more likely to succeed through collaboration rather than competition. The physician is at the very heart of the hospital's survival. The CEO and other high-level staff should be the primary contacts in managing referral relationships.

The relationship of a hospital's senior leadership to a referring physician is similar to that of a consulting partner of a law firm managing a key client relationship. As a law firm would never send a first-year attorney to manage a key client relationship, neither should a hospital rely on a staff member who is without authority to be the physician-relations manager.

Get healthy

Both the hospital and physician are interested in helping patients get healthy through shared services. Creating a solid plan is only a start. Implementing that plan and listening to the real needs of the physician is the hard work — and where the rewards lie.