Compensation models - Compensation is a key issue that any practice must address. It must be established to reduce a practice’s losses over time but also provide incentives and opportunities for the practicing physicians.

Compensation methodologies - Most compensation plans are derived from some combination of the methodologies. Create a landscape of a doctor’s office that visually reinforces how each of these models affects the practice. Each section breaks down the key pieces of what should be considered in the methodology:

- Leadership and compensation
- Committees and physician leadership
  - No two medical group practices are alike. Size, composition and location determine much of what the group requires with regard to governance.
  - In addition to the right agreements, the practice must have strong physician leadership that works in partnership with the administrator. Physician leadership is not about “who holds what title” but rather what the individuals in those roles do to establish a viable culture and lead the group. True physician leaders think and act on behalf of the group and work hand in hand with the stakeholders. True physician leaders are also visionary and strategic; they understand that their role is to guide the group and plan for the future. In addition to the bottom line, they have to understand the relationships among members of the group.
  - Once a year, at budget time, all salaries should be reviewed for equity.
- Ancillary revenue - Another important consideration for medical practices is how the ancillary revenue (lab, radiology, etc.) will be distributed or allocated within the practice. Under the Stark Law there are specific regulations as to how this is handled. Failure to understand and comply with these and other regulations could result in substantial fines, significant legal expense, public relations issues and/or prison for individuals involved. Attorneys experienced in health care law, specifically Stark and Anti-Kickback regulations, should be consulted regarding the medical practices agreements and compensation plans.
- Allocation of expenses - Another aspect of the compensation plan concerns how expenses in the group are allocated back to the physicians. As with the revenue component of the compensation plan, there are a number of different ways the expenses can be allocated. This table provides a brief overview.
- Fixed – Examples
  - Facility lease expense or depreciation
  - Equipment depreciation
  - Service contracts
  - Utilities
Description - The expenses are not dependent on volume. They are reoccurring and are often related to the facility and equipment utilized by the practice.
Allocation methodology - Each physician is allocated some percent of the fixed overhead. This percent will vary by practice, but many groups divide these expenses by the number of physicians in the group, with each being allocated an equal amount.
- Variable – Examples
  - Staff expenses
  - Supply
  - Expenses
Description - These expenses will fluctuate based on the activity or volume within the practice.
Note: Some groups may consider staff as a fixed expense.
Allocation methodology - Many practices will allocate these based on the individual physician’s production as a percent of the practice’s total production such as an individual’s professional charges as a percent of the group’s total professional charges.

- Direct – Examples
  - Physician benefits
  - Continuing medical education (CME) expense
  - Transcription
  - Cell phone
  - Malpractice

Description - These expenses can be directly attributed to the physician.
Allocation methodology - These expenses are incurred by each physician and are directly allocated back to the individual.

Compensation and production reports - On a monthly basis, each physician in the practice should receive a compensation/production report. This should include data regarding the physician’s charges, collections, adjustments and allocated expenses. The report should also incorporate RVU and/or visit data. This document should enable the physician to determine earnings and compensation to date through draws and previous bonus payments.

Buy-in/buy-out provisions - For practices that are owned by the physicians, the governance structure and documents should define how physicians become partners or conversely how partners can leave the practice. Elements of this would include:
  - Requirements to become a partner/owner
    - The cost of becoming a partner, for example, how shares in the practice are to be valued
  - How the buy-in process works.
    - Over what time frame the buy-in can occur
    - During these times of transition there can be considerable consternation or discord within the group. The better defined this process is, the more comfortable the physicians will be during these times of change.

Responsibilities
  - Agreements and contracts - Whether the practice is owned by the physicians or a larger entity, the governance structure should be established and documented in the form of by-laws, organizational charts, shareholder agreements and physician employment contracts. These vehicles establish the basis for practice leadership and reporting relationships, and determine the various parties’ responsibilities, obligations and expectations.
  - Agreements and their elements
    - Shareholder agreement
      - Ownership
        - Initial investment
        - Additional investments
      - Directors and officers
      - Voting
      - Decision-making and control
      - Rights and duties
      - Conditions of change of composition
      - Share transfers
      - Salaries and draws
      - Employment
      - Exit clauses
Conduct and expectations - Regardless of size or structure, physicians in every medical group should have an understanding of expected standards of conduct and behavior. In larger groups, such policies become even more important as there are more physicians, more relationships and more behaviors to manage. Policies should be created, approved and ultimately enforced by the governing board. The list below represents some of the key policies that the group should have in place:

- Code of conduct
- Disruptive behavior policy
- Compliance policy
- Conflicts of interest
- Disruptive behavior
- Sexual harassment
- Harassment and intimidation

Advocacy

Civic and community responsibilities

Planning - Planning is a process by which management visualizes the future and develops specific courses of action to achieve organizational goals. The strategic framework requires the development of an organization’s mission, vision- and values.

- The mission statement describes the purpose of the organization. It should be brief, concise- and to the point. It describes now. An organization’s mission statement should encompass its core purpose. It should follow the core ideologies (reasons for being) of the organization and should answer the question, “Who are we?”
- The vision statement, on the other hand, outlines where the company wants to be and focuses on the future. An organization’s vision statement should answer the question: “Where do we want to go?” It should be succinct, compelling- and easy to communicate.
- The values statement highlights the culture of the organization. I conjunction with the mission and vision statements, this framework is used to build a strategic plan.
- The strategic plan is a long-term plan that encompasses five to 10 years into the future. It is a dynamic document that should be reviewed and updated periodically. The purpose of a strategic
plan is to help an organization fulfill its mission and vision and to provide a road map to reach the goals outlined in these statements.

**Strategic Planning Phases**

- **Phase 1: Environmental Assessment** - It is important to understand the external and internal environments of an organization. The environmental assessment serves as the foundation of the strategic plan. It is important for an organization to determine “where it is” before it can begin to work on “where it wants to go.”

  Review existing documents, including financial statements, board minutes, patient/referring physician satisfaction survey results, and any previously developed plans as a starting point. Gather and organize as much information as possible. Consider interviewing and surveying staff and physicians. It may also be helpful to interview colleagues from noncompeting medical practices in your market to receive an outside perspective.

- **Phase 2: Planning for Uncertainties** - There are several methods of planning for uncertainties. In the ideal planning process, the group incorporates a mixture of components.

  Scenario planning is a systematic approach of imagining all possible scenarios that will impact the organization’s strategic plan. It is most effective when there are a wide range of uncertainties.

  Incorporate the competitive environment in your service area as a part of scenario planning.

- **Phase 3: Current vs. Future State** - The third phase is for organizational introspection. This is where the organization captures what it is, where it wants to go, and how it is going to get there.

- **Phase 4: Goals, Strategies, and Measures of Success** - Specific strategic goals must be established, strategies developed, and periods measured. Benchmarking is very useful during this phase of strategic-plan development.

- **Phase 5: Implementation** - Simply stated, the implementation phase is the enactment of the organization’s strategy. Make sure that the strategic plan is in an easy-to-understand written format. Get formal approval of the strategic plan from the governing body and make sure there is support for the strategic plan.

  Benchmarking data can be very useful in determining an organization’s starting place and providing quantifiable data to include in its goals.

**Operational Planning** - Like the strategic plan, the operational plan must be aligned with the organization’s overall mission, vision, and values.

Be prepared to create monthly, quarterly and annual reports comparing operations plan measurement criteria with actual results, as appropriate. As part of operational planning:

- Identify and define the problem or issue to be addressed
- Identify the goal that will define the completion of this plan as a success
- Identify the resources needed to complete the plan
- Determine the timeline for completing the plan
- Identify the potential interactions with other stakeholders and affected parties

**Costs and Services**

- **Billable and Non-billable**
  - Non-billable supplies are consumables that are used as part of normal, everyday operations but cannot be charged to the patient and/or third-party payer.
  - Billable supplies, on the other hand, are consumables that can be billed to the patient and/or third-party payer.

- **Process for ordering**
  - Practice guidelines and procedures are necessary to ensure efficient and effective ordering, usage, and monitoring of non-billable and billable materials.
  - Establish a schedule for ordering different groupings or categories of supplies (e.g., clinical, office, pharmaceutical.)
• Use standardized order forms with a list of specific items that can be ordered.
  • Determine minimum and maximum reorder points.
  • Quantity used versus quantity purchased (to avoid unnecessary inventory.)
  • Supplies to minimize maintaining multiple brands of the same item.
  • Check prices among various suppliers.

- Equipment is considered a fixed asset that can be reused and appear on the balance sheet. Like any technology, its value depreciates over time.
  • Costs
    ▪ Equipment cost
    ▪ Acquisition costs
    ▪ Supplies needed to maintain equipment
    ▪ Construction/renovation costs
    ▪ Maintenance contracts
    ▪ Disposal of waste products/bio hazardous waste (typically handled through contracts with licensed companies)
  • Vendor/manufacturer references
  • Ability to negotiate for the best offer
  • Periodically evaluate the equipment to ensure that it continues to meet the practice’s needs

Vendor relations and records
  - How to select a vendor
  - The minimal contact information required in each vendor file is:
    • Name
    • Address
    • Telephone number
    • Facsimile number
    • Contact name and direct telephone and fax numbers
    • Email address
    • Tax ID number
    • Entity type (corporation, partnership, LLC, sole proprietorship)
    • Payment terms
  - A policy that spells out vendor access to the group

Using experts - These experts include services such as human resources, information technology, transcription services, and housekeeping. We routinely review how well they provide a support function and at what cost. Smaller practices have less ability to spread fixed costs.
  - Process
    • Conduct a business and technical analysis of current and future requirements.
    • Develop a project scope and charter, to include what is to be provided.
    • Identify vendors who can provide the service(s).
    • Create a request for proposal (RFP) to include services needed and specific requirements.
    • Develop a matrix to compare vendor proposals, focusing on the most critical needs in order of priority.
    • Evaluate proposals and reduce to two to three vendors.
    • Select companies to present and provide a demonstration of the product or service.
    • Make site visits to other practices using the service.
    • Develop a complete matrix chart as to specifics by vendor.
    • Justify costs and evaluate return on investment (ROI).
    • Select vendor based on the specific criteria and requirements.
    • Negotiate agreement and terms.
    • Establish time frame for implementation.
• Implement outsourced service.
• Monitor for compliance with agreement and to pre-negotiated levels of service.
• Ask questions:
  ▪ Does the company have a credible reputation and experience with the service being provided?
  ▪ Does the company have the financial resources, staffing and technology to provide the services?
  ▪ What are the company’s long-term plans and direction?
• Consider cultural compatibility

Professional/Advisors – advice/expertise
- Attorney
  • Legal structure
  • Joint ventures
  • Acquisitions
- Human resources and employment
  • Agreements
  • Contracts
- Financial advisor
  • Tax planning
  • Retirement planning
  • Investment planning
- Accountant
  • Taxes
  • Financial reporting
  • Compensation plans
- Architect
  • Facility design
  • Zoning and building codes
  • Compliance with federal laws

Facility Planning - Facility planning begins with understanding the needs of the practice and its operations. Considerations for current and future needs are critical in the development of a successful project.
- Planning - A couple of key facility planning concepts to consider:
  • Format follows function: Establish workflow and patient flow before decisions are made about appearance. Design the facility from the inside out when possible, rather than the outside in.
  • A rule of thumb: Planning space for physician clinics is 1,200 to 1,500 square feet per physician. Of course this will vary by specialty and will depend on what types of ancillary services the practice offers.

The architect will also design the facility to meet federal American with Disabilities Act (ADA) requirements and local zoning and building codes.
Depending on the services that are offered in the facility there may be other design elements that are required by other federal agencies such as the Occupational Safety and Health Administration (OSHA).
- Maintenance - Once the facility is operational, you should expect numerous expenses associated with maintenance and repair.
These will encompass a broad range of items, including general housekeeping, major facility maintenance (roof), equipment (air conditioning) and landscaping/lawn care.
Marketing
- Marketing and communications plans
- Definition of marketing - Marketing plants a seed indicating why they, their friends and their family should seek care at your practice.

For a marketing program to succeed, it must support and align with your practice’s strategic plan. In addition, you need to clearly understand and determine the specific customer base your practice is focused on attracting.

- Why engage in marketing?
- Is marketing expensive?
- Key characteristics include:
  - Training staff and physicians on the importance of customer service, for example, ensuring that staff make eye contact when patients near the registration area
  - Making customer satisfaction a practice priority
  - Using an answering service that properly represents the service values of the practice
  - Creating a reception room culture that doesn’t make patients feel like a number and doesn’t make them wait longer than an established amount of time. If delays occur, make sure there is communication with the patient
  - Ensuring that facility conditions such as cleanliness, room temperature, up-to-date magazines, etc., meet patient expectations
  - Offering help and assistance

Patient Satisfaction
- Several methods of monitoring patient satisfaction include:
  - Frequent patient satisfaction surveys to ensure that you are meeting their needs.
  - Digital photo mapping of the facility from patients’ perspective to ensure that a patient-focused environment is maintained.
  - Mystery shopper program in which “mystery” patients are hired to contact your practice, make an appointment, and record the details of their experiences.

Branding
- Some key service identity elements that you’ll want your customers to know include:
  - Offer evening/weekend appointments
  - Use the latest technology
  - Have a friendly staff
  - Offer easy parking/access
  - Be responsive to patient needs
- Board certified physicians

Logos and Slogans
- What about logos? Logos and slogans are essential for enhancing brand identity. Logos enhance a professional image, help establish customer recognition, and can be used for:
  - Business cards/stationary
  - Publications/advertising
  - Signs
  - On vehicles
  - Other promotional materials

Some logos can be encased in memorable graphics. Think about Johnson & Johnson, IBM, Coca-Cola, and Crest.

- What about slogans? Slogans complement logos and can be used to fight advertising sensory overload. A genuine, unique, and creative slogan will:
  - Link words and emotions
• Hook the reader, leaving a key brand message in mind
The following example shows how a physician recruitment and marketing firm used a catchy slogan to cut through a large number of physician “want-ads:"
• "We are Career Evolutionists!"
• Practice promotion
• The channels and strategies you use to promote your practice depend on the audience you’re targeting.

Managing Information - Medical practice leaders should develop a plan that provides a 1-3 year roadmap and establishes the basis for the group’s information technology (IT) requirements. This plan should reflect:
- The alignment between IT and the group’s strategic goals and objectives
- A review of the practice’s internal and external environment
- Incorporation of future IT needs
- Responsibility for tasks and action items
- A timetable for milestones and targets
- Specific information requirements, priorities, and any needed infrastructure
- The budget and identified resources for any projects in the plan
- The communication plan for staff and physicians

• Needs Assessment
  ▪ To begin your information systems needs assessment, first examine your internal computer systems. List all of the information systems you own, as well as features you use. Ask yourself the following questions:
    ▪ Do you have a practice management system?
    ▪ Do you have an electronic medical record system?
    ▪ Do you have a lab information system?
    ▪ Do you have a radiology (PAC) system?
    ▪ Do you have a website?
    ▪ Do you have an email system?
    ▪ Do you have Internet access?
    ▪ Do you use all components of all systems efficiently and effectively?
    ▪ Are your various systems interfaced or do they require entering the same data in more than once?
    ▪ Does the telephone system meet the needs and the call volume of the clinic?
    ▪ What are the needs of the groups patients?
  ▪ Answers to these questions will show gaps where integration might be needed. Other questions to consider should include:
    ▪ What level of computer skills and experience do the staff and physicians have?
    ▪ Is there more than one location to consider when implementing and integrating the technology?
    ▪ Is there a need to interface or integrate with organizations outside of the practice?

• Information System Goals
• To procure the appropriate information technology for a practice, the first step is to identify possible systems. Information about technology and companies in the field can be found through:
  ▪ Networking with other medical group practice leaders
  ▪ Participating in trade association events
  ▪ Attending trade shows/conferences, shows and conferences, including those of MGMA
  ▪ Healthcare IT journals or association listserves
• List of Vendors - Develop and send to those vendors in whose services you are interested a standard request for information (RFI) and cover letter with a deadline for responding. The RFI should include:
  - Descriptions of products and features
  - Current hardware configurations required
  - Operating system required
  - Database manager solutions
  - System costs

• The next step is for the steering committee is to develop a request for proposal (RFP). This step is time-consuming and should include the departments that will later be involved in system implementation. Each department should submit features that it must have and features that it would like to have. It is at this point in the process that you should create the specifications that you are seeking.

• The committee assembles these and creates a questionnaire to submit to each vendor with a deadline for completion. The vendors need not know which features are mandatory. Possible questions that could be included are outlined below by category:
  - **EHR features**
    - Does the EHR system have a database capable of recording and reporting when a patient checks in at the registration desk and when he or she is seen by a physician?
    - Does the EHR system screen for potential drug interactions by checking medications prescribed against over-the-counter medications that the patient takes?
    - Does the EHR system check medications against all insurance plan formularies?
    - Can the EHR send prescriptions electronically?
  - **Practice profile**
    - Does the EHR handle multispecialty physician documentation templates?
    - For physicians who do not use the computer, what options are available for recording or transcribing information into the system?
  - **Practice goals/constraints**
    - Does the EHR allow the practice to scan existing medical records into the system?
    - Is your EHR health level 7 (HL7) compatible with other EHRs (including those used by hospitals) to send/receive patient information?
    - Does the EHR system have an HL7 interface capability to accept appointment data from the practice management system (PMS) in real time?
  - **Hardware/platform questions**
    - Does the EHR software work on personal digital assistants, tablets and/or desktops?
    - What hardware platform configuration is recommended based on the number of physicians in the practice and the number of appointments they have each month?
  - **Software/application service provider**
    - Does the software reside on the practices server(s)?
    - Is the application provided via a web-based service?
    - What is the frequency of software upgrades?
    - How long will software be supported?
- **Service**
  - Is there a help desk and what are its hours of service?
  - What is the cost of the service agreement?
  - What does the service agreement cover?

- **Security compliance**
  - Does the EHR accept electronic signatures? If so, explain issues related to compliance.
  - Does the EHR have two levels of user authentication? If so, what are they?
  - To what degree can users be given view-only, update or full-access capabilities for features or modules?

- **References**
- **Implementation and maintenance** - The selection committee will have to transition to or establish an implementation team. These individuals should represent a cross section of the practice’s staff and physicians. This group will be charged with a significant amount of pre-work, including evaluating workflows and designing processes that can be supported by the newly acquired technology. This is a critical step. Failure to redesign current work processes at the very least will result in not receiving the full benefits of the new system. Much more likely is a worst-case scenario in which practice productivity comes to a halt. Time spent at the beginning on this step will determine the success of the implementation and the satisfaction level of using the product.
  
  The implementation team will also establish the schedule of events and milestones that will eventually lead up to going live with the product. The steps encompass:
  - Acquisition and implementation of the hardware
  - Facility requirements that must occur
  - Identifying project champions, super users and trainers
  - Migrating data from existing systems
  - Staff training

- **Training and support** - To analyze your training and support needs, first examine your physician and staff expertise. Conduct a survey focused on measuring the skills needed to perform certain tasks on the information technology system.
  
  The next step is to evaluate survey responses to determine how many physicians and staff members need basic, intermediate and advanced training. Training for common tasks such as word processing, spreadsheets and email can be handled in groups and should be offered periodically. These can even be done without an instructor, but the interaction with an instructor is much better and mandatory for physicians in most cases.

  If you have a group with 10 or more new hires each month, you might want to have monthly or biweekly trainings after orientation to go through job-specific modules. For a smaller number of new hires, one-on-one on-the-job training, along with a quarterly update to confirm competencies, may suffice. For specific applications such the prescription-writing module of an EHR, you should identify users of the module and those who benefit from it to set up a training class. For prescription writing, be sure to train every physician, then confirm competency after training.

  **Confidential physician survey**
  - Do you have a computer at your desk?
  - Do you have a computer at your home?
  - Do you use MS Word, Excel or Outlook (email)?
  - Do you have an email address?

  On what level would you place your computer skills: Beginner/Intermediate/Advanced
  - When could you attend a class? 7 a.m./noon/5 p.m./weekends/by appointment only
Security

- There are many threats to a medical group’s information systems. Applications must be protected by policies as well as technology. There are significant penalties for failure to protect medical data, not to mention the impact on operations should data be lost or stolen.
- The practice must establish policies with regard to who has access to the systems. Access may vary with different levels of security. Staff may be limited in what records they can see.
- The software should have the ability to identify who accessed what records and when, and should provide reports with this information. The practice should have policies with regard to the frequency with which the reports are reviewed; privacy audits must also be performed.
- The hardware and IT infrastructure should be secured by firewalls, software encrypted and updated on a regular basis. The practice should have in-house experts or contract with IT consultants and companies that specialize in data and IT security.
- As a precaution, all data and systems should be backed up nightly.

Privacy Standards - The main purposes of The Health Insurance Portability and Accountability Act (HIPAA) are to improve efficiency and create security and privacy standards. Another purpose is to adopt standards for health identifiers. HIPAA covers not only providers in your practice, but health plans and clearinghouses as well. A covered entity may not use or disclose Protected Health Information (PHI) except as permitted by the privacy regulations. PHI is defined as individually identifiable health information. The communications can be oral, written or electronic. Practices must adhere to privacy standards since they are a covered entity. HIPAA affects not only physicians, but also every member of the office staff. Individually identifiable health information can be created or received by a covered entity or an employer. It identifies an individual directly. Individually identifiable health information pertains to the physical or mental condition of an individual, provision of healthcare services to an individual and payment for services. The designated record is any item, collection or group of PHI maintained, collected, used or disseminated.

This information is used to make decisions affecting an individual. The decisions are not just medical but also relate to billing and administrative matters.

Disclosures - Recognizing that information is required to care for a patient, HIPAA permits various uses and disclosure of information. PHI may be disclosed for treatment, payment and healthcare operations. When considering HIPAA, it’s important to take a common-sense approach to patient privacy. Good judgment should always be used when dealing with patients and their records.

You may have discussions about a patient only with persons involved in the patient’s care and treatment. The practice should always treat patient records with care, away from the eyes of the public. There are times when the law requires disclosure of information. For example, a practice need not have authorization or agreement for release of records in response to public health activities, judicial and administrative processes, criminal reports or organ donation.

Patient Records - Under HIPAA, access to records must be kept to a minimum. The decision to allow access should be based on roles. That is, you must determine what level of access to patient records, if any, an employee’s role in the practice requires. Keep in mind that there are instances when the minimum necessary standard does not apply, such as for patient treatment or patient-authorized disclosures made to the government, or as required by law.
Under HIPAA, patients must be informed of privacy practices. A notice of privacy practices must be presented on the first date of service for new patients. The notice of privacy practices describes policies governing the use and disclosure of patients’ health information. A copy of the notice should be posted in the waiting area.

Practices require assistance from a variety of business associates. A business associate is defined as a person or entity that provides certain functions, activities or services for or to a covered entity involving the use and/or disclosure of PHI. Associates use PHI on behalf of a covered entity. All business associates must sign an agreement with the healthcare provider or practice, stipulating that PHI will be used only for specific purposes, and that the associates will protect the information. The practice is responsible for identifying, issuing and maintaining contracts with all business associates.

PHI may be used and accessed for the following purposes:

- To carry out treatment, payment or healthcare operations
- To the individual patient or to the patient’s representative
- To family members or others involved in patient care, or to notify the next of kin
- With prior patient authorization and released to life insurance application, a lawyer’s request for records, etc.

Further protection of PHI should be incorporated into the development of polices that stipulate how patient records are to be maintained, stored, and secured. Policies should also be developed in conjunction with state law as to the requirements for how long they must be kept and at what point they may be destroyed.

• Privacy Officer - Every practice should designate a privacy officer. The main duty of the privacy officer is to serve as a staff and patient resource on office privacy issues. He or she should orient new staff members to office privacy policy and procedures, administer and update policy and procedure manuals, and ensure that office staff, vendors and service providers comply with privacy policies and procedures.

  - The privacy officer should perform a periodic self-audit focusing on patient consents and authorizations, employee training, security issues and complaints and sanctions for violations.
  - The privacy officer must ensure that access to medical records, the office computer system, files and storage areas is limited to authorized personnel only. He or she must also develop and implement procedures for the disposal of records (paper and electronic) that ensure that all PHI is properly destroyed.
  - A deceased patient’s PHI is entitled to the same protection as that of a living patient. However, the executor/administrator of the estate may authorize the release of PHI. If a person has legal authority to make healthcare decisions on behalf of an adult or emancipated minor, the office must treat that “personal representative” as the patient.
  - If a parent or guardian has the authority to make healthcare decisions on behalf of a minor, then the practice must treat the parent or guardian as the personal representative of the minor patient. That individual is entitled to the minor patient’s entire PHI.
  - If a patient wishes to review his or her records, it is recommended that he or she request the records in writing and submit the request to the privacy officer. The office may deny access if the information is likely to endanger the life or physical safety of, or cause harm to, another person, or if the request made by a personal representative may cause harm to the patient or another individual.
• The patient has a right to request an amendment to his or her PHI to ensure that the information is accurate and complete. Requests from patients must be made in writing to the attention of the privacy officer.
  - The request must include the information that the patient deems inaccurate or incomplete and also must specify what information he or she wants to include to make the record complete and accurate. The patient has a right to receive a record of all PHI disclosures made over a period of six years prior to the request.
• Training in privacy policy and procedures is required for all employees. This is the privacy officer’s responsibility. Employees are expected to read and be familiar with the policy and procedure manual and any revisions. They must attend compliance training and specialized training when required. Attendance at required training sessions must be documented.
• All employees must strictly adhere to the policies and procedures of the office, as well as applicable laws and regulations governing patient information. Violations are a serious matter that must be reported to the privacy officer and should result in disciplinary action.
  • Reporting - Various government agencies have mandated reporting requirements. These are at both the federal and state levels. Depending on the type of practice, there are certain reportable medical conditions, disease, vaccine, and other registries to which each medical group must submit. In addition, medical groups must comply with federal and state requirements for biohazard and epidemics. Suggestions for compliance:
    ▪ Develop a planning calendar for regulatory agency report submission deadlines.
    ▪ Document methods of reporting for future years to ensure accuracy and time savings.

Quality Management - The goal is to reduce the outcome variability of key processes, thus reducing waste, increasing efficiency and increasing overall customer satisfaction and profitability. A basic understanding of statistical measurements is very important in any successful quality management program. Practices must appropriately measure variability before they can manage and reduce it.
  - Total Quality Management (TQM) - TQM seeks to integrate an organization’s functions with respect to meeting customer needs and organizational objectives. TQM prescribes to the principal of “Do the right thing, the first and every time,” and “Quality is a constantly moving target.”
  - Continuous Quality Improvement (CQI) - CQI is similar in many aspects to TQM. However, it has historically been more popular in healthcare settings. It is focuses on:
    ▪ Quality planning: What does the customer want or need?
    ▪ Quality measurement and control: Were the processes done well?
    ▪ Quality improvement: How can we improve the services or products?
  - Six Sigma - The roots of Six Sigma are heavily grounded in the manufacturing industries. Six Sigma was primarily pioneered by Motorola in the mid 1980s. The goal of Six Sigma performance is to reduce the number of errors (or variances) to an extremely low number (six standard deviations from the mean). This level of error reduction reduces the “defects per million” to less than one.
  ▪ Measuring Data - The goal of quality management is to reduce variability in a key process. Therefore, measurement is very important. Numerous quality tools – including histograms and Pareto charts – are available to help you analyze and improve quality. You can access the American Society for Quality’s website to review these in more detail.
  ▪ Flowcharting - In this course, we will focus on flowcharting in more detail. Flowcharting is a fundamental quality improvement method. A flow chart is a pictorial
representation of the various steps involved in a process. It is an exact way of describing a process and goes beyond simply listing the steps. The flow chart allows for decisions and intermediate results to occur throughout the entire process. It also allows for different paths to be taken at different steps. Flow charts provide stakeholders with an easily identifiable, common language by using various shapes and lines, each with a distinct meaning.

- Clinical Pathways - Clinical pathways are frequently used to improve healthcare delivery and ensure patient safety. A clinical pathway is a guideline of a care or treatment plan for a specific condition. A clinical pathway also outlines preventative and self-care for patients with this condition.
  - Define and Develop Clinical Pathway Structures - A structured approach to patient care lends itself well to a clinical pathway. The purpose is to encapsulate a care or treatment plan for a specific condition or preventative care for patients in a particular situation or condition. It identifies care activities and the caregiver workflow needed for a patient with a specific condition or disease. It can be adjusted for the particular patient’s needs.
  - A clinical pathway may also be used for:
    - Identifying a standard of care for patients with a particular problem or condition that considers risk adjustments based on a patient’s psychological health and social factors, family/genetic history, age, race and gender.
    - Treating illnesses or managing health and wellness.
  - A clinical pathway consists of a template, which is a diagram of network structure or a flow chart identifying recommended alternative paths of care based on intermediate goals and outcomes. Network diagram paths can lead to final outcomes that identify the conclusion of the care path (e.g. discharge from the hospital), or paths may be ongoing.
  - A care activity may consist of:
    - Text identifying care to be given
    - A goal
    - An order or appointment to be automatically scheduled
    - A protocol defined elsewhere in the system
    - Another clinical pathway
  - Keys for Successful Clinical Pathways - Successful clinical pathways focus on satisfying customer’s expectations, identifying problems, building commitment, and promoting open decision making among workers. They also provide the identification of an issue having significant monetary, clinical or outcome impact if improved or modified.
    - In order to be successfully implemented, the development of the pathway must account for the practice patterns of physicians and other members of the healthcare provider team. The entire care team must be allowed input to ensure buy in and improve adherence to the pathway.
    - The pathway should be written in short, easy-to-understand sentences.
    - Measure the effect of the pathway on outcomes, cost and patient satisfaction.
    - Incentives do not have to be monetary. Recognition and demonstrated appreciation for a job well done can serve as good incentives.
    - Consider clinical flexibility. When necessary, physicians need to be able to circumvent the guideline in a way that is not too time consuming or inconvenient. Monitor the frequency of divergences from the clinical
pathway and review repeated episodes to determine if the pathway needs to be revised or expanded.
• Monitor compliance and provide performance measures to encourage discussion of best practices.

Credentialing and Certification
- Credentialing - To be successful in the credentialing process, it is essential to:
  • Be organized
  • Invest in a computerized tracking system
  • Know the rules
  • Invest in staff and training
  • Be proactive and persistent
- External credentialing/certification organizations - Most small- to medium-sized medical groups have a system of internal controls and quality-assurance programs centered on clinical practices and do not necessarily seek credentialing from outside organizations. However, many larger groups seek the expertise of an independent credentialing verification organization (CVO) to validate internal processes, screen potential providers, and provide the group with verification of credentials.

Accreditation
- The two most recognized accreditation organizations are the Accreditation Association for Ambulatory Health Care (AAAHC) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). AAAHC focuses on medical groups and JCAHO focuses primarily on hospitals. However, because many hospitals employ physicians or own medical groups, physicians are often required to meet JCAHO criteria for the hospital to pass the hospital accreditation.
- Each of these organizations has very thorough and extensive processes to earn accreditation. The evaluation is based on clinical quality, documentation, confidentiality, patient safety, practice protocols, error prevention and physician certification. Both organizations provide the practice and/or hospital with detailed information on the requirements. Criteria from AAAHC and JCAHO can be used as a roadmap for internal quality assurance efforts.

Peer Review - All healthcare organizations require peer review for initial and periodic renewal of privileges. For hospital credentialing, peers are asked to evaluate potential candidates on both personal and professional criteria.
- If patient or staff complaints are received about a practitioner, peer review may again be invoked. Examples of concerns include clinical skills, decision-making ability, reliability and medical necessity.
- Informal evaluation systems are based on:
  • Patient complaints
  • Patient attitudes
  • Professional work patterns
- Peer review is also used in Quality Assurance Committee meetings. These meetings use measures to access clinical outcomes and processes. These meetings typically include an examination of random or specific patient medical records.
- Health plans, state medical boards or outside agencies investigating fraud or abuse allegations or malpractice situations can request or demand external, independent reviews.

Credentialing - The Centers for Medicare & Medicaid (CMS) website details Medicare and Medicaid licensure and credentialing processes. Websites for payers explain the process and have online applications on their websites. The websites have sections that allow practice representatives to enroll their physicians, nurse practitioners and physician assistants as providers.
- Medicaid Credentialing
• Each state has its own Medicaid program that includes specific instructions on becoming a contracted provider, filing claims and navigating the state’s unique appeals process.
• States may have multiple programs (traditional Medicaid and Medicaid managed care organizations, as example) that may require multiple provider numbers and separate contracts.

Medicare Credentialing
• Medicare provider enrollment is online. The application is standardized and the progress can be tracked online. Individual providers must reassign their benefits to the group in order for the group to receive payments for their services.
• You must treat Medicare patients the same as other patients from a financial and business perspective.
• Detailed instructions are available in the online Medicare provider manuals and through the contracted vendors (designated intermediaries) who adjudicate claims and administer payments for Medicare.
• You will need to determine the intermediary payer for your state and follow its credentialing, provider enrollment and claims-filing processes.

Third-party Credentialing - Third-party payers are straightforward in terms of credentialing. In fact, as the industry has moved away from closed panels in favor of open networks, most of the focus has been on financial arrangements, customer service and meeting certain minimum clinical standards (e.g., childhood immunizations, mammograms). As part of the credentialing process, your provider must:
• Have a license to practice medicine
• Have the requisite malpractice insurance
• Be willing to accept new patients
• Agree to the fee schedule/contract terms and conditions stated in the provider manual
• Have call arrangements for after-hours and emergency care

Commercial carriers may have additional requirements such as proof of CPR and advanced life support training, tuberculin skin testing, letters of reference from peers or hospital privileges. Although third-party payers may accept the tax identification as part of the claims-filing process, claims will be rejected without an National Provider Identifier (NPI) number for the provider and for the group, if the group is receiving payment for the provider’s services.

Be aware that even if you file claims with payers as a convenience for your patients when you are not contracted as a provider, you are not automatically under contract. You may get paid at a lower out-of-network rate, your services may not be covered or the payment may go directly to the patient.

Your group should file claims electronically. You can do this directly with the payer or through an intermediary, an electronic data interchange (EDI). The intermediary services can be free of charge without fees for each transaction. They may have specific filing requirements or work only with designated practice management software.

Internal Focus and Priorities - When considering what is required for certification and credentialing, the practice must look at its medical specialty service area, budget and market conditions. In other words, what does the practice need to do to optimize its revenue cycle and provide the appropriate level of patient care? Many groups do not invest enough in staff, systems or time to be completely successful. To ensure a minimum level of success, the group should:
• Make sure your equipment meets industry standards. If a portion of your revenue is attributed to laboratory, radiology, outpatient surgery, or procedures, you must have licenses and certification up to industry standards and current regulations. You must also have a quality-assurance program to track maintenance and compliance on a real-time and ongoing basis.
• Make sure that clinical support staff have the appropriate licenses and training and their scope of practice is closely monitored. Verification of licensure and training should be confirmed annually.
- Keep a detailed list of credentialing requirements including expirations and renewal criteria. The practice should establish a reminder system for renewing credentials in a timely manner. It is critical to maintain and renew licensure, malpractice coverage, and certification before it expires.
- Maintenance of board certification and proof of continuing education are often requirements for medical license renewal.
- Research possible rate reductions for malpractice insurance coverage from completing risk management or other certification training programs.

Objectives (Self check):

- Sketch out an organization’s strategic plan
- Identify the importance of legal compliance requirements in governance
- Discuss the advantages and disadvantages of the compensation modules
- List key policies that the group should have in place
- Identify some options for agreements and contracts that can be used
- Describe civic responsibilities of the practice
- Practice laying out an operational plan
- Discuss how physicians and administrators are key to the operation plan
- Explain the steps for an operational plan
- List the steps for developing an operational plan
- Explain the five phases of strategic planning
- Define planning
- Define mission statement
- Define vision statement
- Define values statement
- Define strategic plan
- Assess how you would determine which process or service that could be outsourced
- Describe the process of selecting business partners
- Identify types of advisors for the practice
- Identify times when a practice should outsource expertise
- Recognize ideal vendor relationship criteria
- Identify the minimal information that must be kept for vendor records
- Read an example of a safety policy
- Identify the difference between non-billable, billable and fixed assets for operation costs
- List examples of non-billable, billable and fixed assets
- View an example of a purchase order
- Outline what needs to be done in the next three years at your practice
- Produce an overview on the current status
- Explain how the facility plan gives an overview of the practice and its needs
- List activities that require maintenance services
- View and example of an inventory table
- Tell how the architect is key to the facility plan
- Relate how programming works in the facility plan
- Outline the steps of the facility plan
- Construct ways to implement a marketing plan
- Express the importance of knowing your customer and market
- Identify different channels that can be used for advertising
- Relate ways to establish customer recognition techniques
- Identify key service identity elements
- Explain ways to gauge patient satisfaction
Identify the groups that help with marketing
Explain the elements of a successful marketing plan
Identify way to develop and maintain appropriate internal communication pathways for staff
Develop a needs assessment and goals for a plan
Identify the need for an RFP
Discuss technology security process to protect patient and practice data systems
Discuss implementation and maintenance of systems
Identify medical information systems including medical records, medication administration and healthcare related document storage
Describe processes to comply with mandated reports of specified patient issues to regulatory agencies
Describe a quality improvement tool to develop a clinical pathway.
Identify quality management programs.
Review the peer review process for clinical staff.
Identify patient satisfaction and customer service programs.
Identify and maintain benchmarks for establishing practice performance standards.
Give examples of internal processes and systems to participate in pay-for-performance programs to enhance healthcare quality.
Identify programs for staff, business and equipment credentialing and licensure.