

Periodicals Reviewed for This Issue

- *Family Practice Management*
- *Journal of Medical Practice Management*

Web Sites Reviewed for This Issue

- *FierceHealthcare*
- *Harvard Business Review*
- *Health Affairs*
- *Healthcare Finance News*
- *HealthLeaders Media*
- *HITECH Answers*
- *Inc.*
- *Medical Economics*
- *Modern Healthcare*
- *Physicians Practice*
- *The Telegraph*

PRACTICE OPERATIONS

1. Four Reasons for a Physician Rights and Responsibilities Document

Karen Zupko, *Physicians Practice*, May 24, 2017; <http://www.physicianspractice.com/patients/4-reasons-physician-rights-responsibilities-document>

ABSTRACT

Practices often create a patient “rights and responsibilities document” (RnR) that describes how patients will be treated and what is expected of them in return. While it isn’t done as often, there are good reasons to define physician rights and responsibilities clearly as well. The reasons include the following:

- The RnR document ensures that all physicians know their role, purpose, and place in the organization. It should include the following rights and responsibilities:

- Rights typically include being trusted, getting the benefit of colleagues’ help on cases, getting respectful and courteous treatment from staff, and having access to financial reports that illustrate their performance.
- Responsibilities typically include treating business and clinical staffers with respect and courtesy, maintaining professionalism with patients and their families, and arriving on time.
- The document codifies the practice culture, including shared values and accepted practice principles. Cultural expectations may include showing up for meetings, respecting referring physicians, avoiding name-calling based on ethnicity, and adhering to a specific dress code outlined in the text.
- Also, this document offers guidance to junior partners and new physicians. The RnR spells out what physicians must do to meet expectations, including participating in the development of clinical protocols and outcome reviews, abiding by documentation guidelines, and completing charge slips every day.
- The RnR document also clarifies workflow expectations, addressing questions such as whether physicians must submit hospital charges within 48 hours or when to follow the practice’s policy on discounted and charity care. Workflow expectations may include completing chart notes accurately and dictating procedure reports within 24 hours, or only scheduling elective cases when precertification and determination of benefits have been completed.

EXPERT COMMENTARY

Virtually any business could benefit from having clearly stated expectations articulated in a single, well-thought-out document. The problem comes when the business, in this case your practice, isn't sure what it should be requiring from physicians.

If you decide to create a physician RnR document, you'll end up asking yourself what you really want to see physicians do rather than adhering to whatever norms exist at the moment. Don't be surprised if you aren't sure what the answers are. In fact, if they're really good questions, it's more likely than not that you'll need to give them some thought.

If you're a practice manager, be sure to involve your senior practice members in this process. You may know what works administratively, but they of course should have the final word on clinical issues.

Go about the RnR development process thoroughly, and you'll learn a great deal in addition to giving physicians something concrete to which they can refer if they're uncertain about process issues. If you develop the RnR with care, you'll get extra benefits from an already-worthwhile effort.

2. Learn to Maximize Your Success in CMS' Quality Payment Program

Sheri Porter, *Family Practice Management*, August 9, 2017; <http://www.aafp.org/news/macra-ready/20170809fpmqpp.html>

ABSTRACT

Under the Merit-based Incentive Payment System (MIPS), CMS adjusts physicians' Medicare Part B fee-for-service payments depending on their performance on quality, cost, and improvement categories as well as advancing care information.

As part of MIPS, physicians must report data on at least six quality measures. According to Sandy Pogones, senior strategist for healthcare quality with the American Academy of Family Physicians, practices should learn about quality measurement benchmarks to see how performance on specific measures will affect their MIPS quality score.

She also reminds practices that there are certain high-priority measures and end-to-end reporting techniques that confer bonus points and could raise quality scores by up to 20%. She also calls on physicians to start collecting data no later than October 2 to capture a full 90 days of data before then reporting at the year's end on January 1, 2018.

EXPERT COMMENTARY

The article above offers some worthwhile insights into how to succeed under MIPS. It's worth noting, however, that selecting which quality data to submit is particularly complicated. It seems that doing so may call for getting a good education in what's required, and not just going with your gut.

Unfortunately, such is the nature of the countless quality-management requirements that practices are facing of late. While some of the programs foster behavior that may be beneficial for your practice over the long run, getting familiar—and then comfortable—with any quality data effort is likely to take more work than you'd originally expect.

If they have any common element to consider, perhaps ironically, it's that the organizations measuring care quality are hoping to get a sense of the big picture. Rather than simply selecting a bunch of metrics willy-nilly, the better quality-measurement programs are instead hoping to put those pieces together into a greater whole. While

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it may not come out this way, CMS and private insurers are hoping to capture the essence of your quality-improvement measures by painting a portrait of your work.

That being said, there's no guarantee that your best performance will meet their expectations, as CMS's view of quality may be counterintuitive, as Pogones notes. Just bear that in mind, and study up carefully.

FINANCIAL MANAGEMENT

1. Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction

Aaron Sojourner and Ezra Golberstein, *Health Affairs*, July 24, 2017; <http://healthaffairs.org/blog/2017/07/24/medicaid-expansion-reduced-unpaid-medical-debt-and-increased-financial-satisfaction/>

ABSTRACT

New research suggests that the Medicaid expansion enabled by the Affordable Care Act has lowered the number of low-income Americans with unpaid medical debt while improving their satisfaction with their financial situation.

Previous studies have found that the Medicaid expansion lowered uninsurance rates for adults with low incomes, increased access to care, and may have improved measures of self-assessed health.

Other research has concluded that low-income areas in Medicaid expansion states had significant reductions in unpaid nonmedical bills and in the amount of nonmedical debt sent to third-party collection agencies as compared with those areas in nonexpansion states.

The new study, which surveyed 25,000 people, uses data from 2012 and 2015, which correspond to time periods before and after the Medicaid expansion. Researchers compared this data with data from 2012 and 2015 for states that didn't expand Medicaid.

They found that by 2015, states that expanded Medicaid saw the uninsurance rate fall by 27 percentage points. Also, in the expansion states,

the share of medical debt fell 13 percentage points, as compared with 7% in the nonexpansion states. The researchers also found that those in expansion states saw greater satisfaction with their current financial state.

EXPERT COMMENTARY

Many practices aren't thrilled about accepting fee-for-service Medicaid payments, as they tend to be a bit on the low side, to put it charitably. In many cases, in fact, practice leaders complain that Medicaid doesn't even pay enough to cover the practice's actual costs for delivering care. It's not a pretty picture.

Obviously, there are good reasons to refuse patients with Medicaid. In fact, looked at one way, it's a no-brainer. No business can afford to give care away for long, much less offer services that effectively impose extra costs, so why treat patients with Medicaid? If you're trying to make a profit, the answer may be that "there's no reason." In fact, you might even wonder whether the whole Medicaid program works as currently constituted.

On the other hand, it may make sense to look at Medicaid coverage in the context of the larger system. As you know, patients who don't have good (or any) insurance tend to show up later and sicker, and not just in the emergency department. Even if they get insurance and enter your practice, managing their cases can be complicated, with outcomes that may reflect badly on you regardless of your skills.

In other words, wherever you stand on the issue of Medicaid and its benefits, you may want to consider whether you're willing to absorb the extra costs that arise from treating a sicker population or willing to deliver first-line care. Either way, you have an investment in solving the problem of gaps in care.

2. MACRA: Easing Physician-Practice Pain Points

Christopher Cheney, *HealthLeaders Media*, May 30, 2017; <http://www.healthleaders-media.com/finance/macra-easing-physician-practice-pain-points#>

ABSTRACT

With the Medicare Quality Payment Program (QPP) leveling up in January, practices are working to overcome obstacles undermining their ability to prepare for the new value-based payment system. Characteristics of practices that are likely to succeed with QPP include those with the following qualities:

- Their EHR offers population health management tools, such as the ability to track patients who are chronically ill.
- They have experience with reporting metrics to Medicare under programs like Meaningful Use or the Physician Quality Reporting System (PQRS).

One example of a practice meeting these criteria is DuPage Medical Group of Downers Grove, Illinois, which has more than 560 primary-care and specialty physicians on board, and sees more than a million patient visits each year.

DuPage had already been reporting data to CMS for the PQRS program, Meaningful Use, and the Medicare Shared Savings Program ACO, which helped it prepare for MACRA, according to Krishna Ramachandran, the group's chief administrative officer.

Because it had these experiences, DuPage had put an internal dashboard in place that tracks Medicare payment-system metrics, even before QPP became a concern. Having access to these payment metrics has, in turn, helped shape the group's annual physician incentive bonus criteria.

EXPERT COMMENTARY

DuPage's experience with quality metric tracking is instructive. As the story illustrates, it's not ideal simply to submit the metrics that programs like these require to Medicare. If you want to get the most out of your investment of time and money, you need to institutionalize the data management skills you pick up along the way and use them to improve your practice.

Hopefully, you've already got your hands-on data that helps you manage quality-improvement processes within the practice. Meanwhile, it's

almost certain that you track physician compensation and bonuses in a sophisticated way as well. However, it's possible that you may not have integrated the two sufficiently.

Even if you and your physicians are happy with the payment scheme you've used in the past, it probably won't work in the future if it doesn't take Medicare quality metrics into account sufficiently. It's critical that both your physician compensation scheme and your incentive payments are designed to help you meet the goals of initiatives like QPP. After all, it hardly needs to be said that you won't meet your goals unless your physicians know what those are and are paid for meeting them.

GROUP DYNAMICS

1. Google's CEO Doesn't Use Bullet Points and Neither Should You

Carmine Gallo, *Inc.*, May 23, 2017; <https://www.inc.com/carmine-gallo/how-googles-ceo-creates-brain-friendly-presentations.html>

ABSTRACT

Lately, Google CEO Sundar Pichai has focused on making himself easily understood when he gives presentations. "Since stories are best told with pictures, bullet points and text-heavy slides are increasingly avoided at Google," he said at a conference.

At the conference, Pichai did use a PowerPoint deck, but he kept it stripped-down and simple. His slides used fewer words and more photos and animations than most corporate presenters. This approach is in sync with research on how the brain processes information, which has concluded that people retain 65% of the information contained in pictures.

In addition to including photos and animation in presentations, experts suggest that you subject any slides you prepare to the "three-second rule." If you don't think viewers will understand your slide in three seconds, it's too complicated.

EXPERT COMMENTARY

Most of us see the benefit of communicating clearly. If we have an idea in our head, we know instinctively that our approach to presenting it must be organized and relatively simple. We know that overloading people doesn't work. Unfortunately, though, it's one thing to understand a concept clearly and quite another to get the idea across to someone else.

Luckily, there are some basic steps you might want to take to make a presentation easier to digest:

- Make sure every slide answers just one question the audience might have. If it answers more questions, it can create confusion.
- Be ruthless in cutting out needless information. Provide just enough detail to address your core concerns.
- Consider starting your presentation with a short, pithy statement summarizing what you are about to say.
- Include slides that provoke good questions, but don't try to anticipate all questions. If you intrigue people, they will do their own follow-up research.
- To avoid getting caught up in your own mental clutter, keep the big idea behind your presentation in front of you as you write. If your content doesn't support the idea, you don't need it.

Finally, one of the fundamental paradoxes of communicative writing is that if your details are overwhelming your core ideas, you may not know enough to proceed. Oddly, while it may be counterintuitive, people often overwrite when they're not sure what they're trying to say. When you've hashed things out further, the right words will come, clutter-free.

2. Ten Ways to Reduce Workplace Drama

Laura Hills, *Journal of Medical Practice Management*, July–August 2017

ABSTRACT

Workplace drama can turn even the best medical practice into a tense and miserable place to work. Many of us have experienced firsthand the discomfort that comes from working where rumor mills, office cliques, tattling, gossiping, backstabbing, shouting, crying, shunning, blatant histrionics, and other workplace drama are common. Insight Management Consulting warns that U.S. employees spend an average of 2.8 hours per week dealing with workplace drama, or the equivalent of 385 million working days annually. This article suggests strategies that medical practice managers can use to discourage workplace drama, or keep it to a minimum.

EXPERT COMMENTARY

According to Marlene Chism, author of “7 Ways to Stop Drama in Your Healthcare Practice,” the question to pose is, “Where is the resistance, and who is resisting what?” Only by identifying the drama can you begin to change it, she says.

Here are several strategies for medical practice managers to reduce drama in your practice.

1. **Become fully present for your employees.** As much as you may be tempted to multitask when an employee is talking to you, put everything aside for the moment, and give the employee your full attention. Make eye contact, and squarely face your body toward the employee. Ask clarifying questions. If you are busy, schedule an appointment for a time when you can be fully present, and honor that commitment.
2. **Model a no-drama approach.** If you model drama for your employees, you'll be much more likely to see drama in your medical practice. Be sure that you are not overreacting when the chips are down. Don't raise your voice. And when you must correct behavior, do so when you are in control of your emotions, preferably in private. What not to do: Lecture employees. Overreact. Panic. Make more of the situation than it really is. Go on a tirade.

3. **Become more transparent.** Employees who suspect that you are concealing information from them may invent things that aren't there. According to Chism, "Drama increases in direct proportion to the amount of uncertainty."
4. **Establish and implement personnel policies.** A medical practice that does not establish clear personnel policies can find it challenging for managers to stay out of coworker drama, even when they don't want to be involved in it. Should you avoid an office drama instigator altogether? Try to defend yourself? Do your best to ignore the flying gossip? Or, should you stand up for yourself and intervene? Set your own limits.
5. **Be clear about how you want your employees to communicate.** Your job as a medical practice executive is not to listen every time an employee wants to gripe, vent, and tattle. But there are certainly times when one employee should blow the whistle on another, particularly when safety or the quality of patient care is at stake.
6. **Tweak your open-door policy.** Open your door to employees who want to share helpful and productive information and ideas. But close it to those who come to you with unproductive griping, venting, and tattling.
7. **Look for teachable moments.** You may encounter times when members of your team get so caught up in workplace drama that the drama spins out of control. When everything finally calms down, you may be able to bring your staff together to talk about what happened, and to explore with your employees how they might have handled things more productively.
8. **Be consistent and fair.** Nothing contributes to workplace drama more than the feeling that the boss is unpredictable and unfair. As Chism says, "Letting your star performer break the rules or ignore policy contributes to negativity and a lack of trust." Stick to

your rules. As Chism suggests, "Let policy be the bad guy."

9. **Reinforce the behavior you want.** Medical practice managers may inadvertently reinforce workplace drama when they pay more attention to the drama and to those who cause it than to employees who are focused and engaged in their work. Instead of allowing drama to rule the day, ask those involved: "Do you have a suggestion for how to solve this issue?" or "I am worried that you are seeing this as a much bigger problem than I do. Let's talk through what we know for sure and determine the best path forward."
10. **Link workplace drama to employee performance.** Begin documenting specific drama instances, and issue warnings. Be clear with the employee that drama-making can ultimately be cause for dismissal. Then follow through. You can't afford to have anyone on your team whose drama consistently undermines morale, derails others from their work, and/or spills over to your patients.

HUMAN RESOURCES

1. OB-GYN Shortage Predicted for U.S. in Face of Coming Retirement Wave

Joanne Finnegan, *FierceHealthcare*, July 20, 2017; <http://www.fiercehealthcare.com/practices/ob-gyn-shortage-predicted-face-coming-retirement-wave>

ABSTRACT

New research has concluded that the United States may soon face a shortage of OB-GYNs as existing practitioners retire from the workforce.

The study, which was completed by clinician social network Doximity, notes that one-third of all OB-GYNs in 38 major metropolitan areas are 55 years or older, and that in many areas of the country, a large portion of OB-GYNs are poised to retire. According to the research, areas most likely to see a shortage include Las Vegas, Orlando, Los Angeles, and Miami.

Such a shortage would be dire because practicing OB-GYNs deliver an average of 105 babies each year, and others have an even larger workload, making it difficult for still-practicing colleagues to meet the excess demand when these OB-GYNs retire.

The situation is made worse by the fact that there are not enough younger physicians coming through the ranks to replace them. The research found that only 14% of all OB-GYNs in the United States are 40 years of age or younger, and the average age is 51. Most OB-GYNs begin to retire at age 59.

EXPERT COMMENTARY

The above-described report is far from the only research spelling out how bad an OB-GYN shortage the United States could be facing.

For example, data from the American College of Nurse-Midwives shows that we already have a problem with maternal healthcare provider access. The group reported last year that about 50% of U.S. counties lack an OB-GYN, and that 56% don't have a nurse-midwife.

Meanwhile, the American Congress of Obstetricians and Gynecologists is projecting that there could be a shortfall of 6,000 to 8,000 OB-GYNs by the year 2020, which could grow to a shortage of 22,000 by the year 2050.

Perhaps, though, evolving care models will help address this shortfall. As medical practices steadily work together, and the joint efforts roll up into Accountable Care Organizations, it may be possible to extend the reach of maternal health providers who are available.

As things stand right now, a certain amount of duplication is inevitable when practices compete, including OB-GYN practices. However, with payers increasingly looking at care models that address all the patient's healthcare needs, there may be opportunities to make better use of OB-GYNs' time.

With any luck, maternal health practices will have both financial and practical incentives to work together more effectively—and take more advantage of support from, for example, primary

health providers—and be able to maintain the same quality of care and outcomes.

That being said, the extent to which retiring OB-GYNs aren't counterbalanced by incoming practitioners is worrisome. Let's hope that population-level approaches to patient care, which emphasize smart resource sharing, will help win some ground back.

2. The Omissions That Make So Many Sexual Harassment Policies Ineffective

Debbie S. Dougherty, *Harvard Business Review*, May 31, 2017; <https://hbr.org/2017/05/the-omissions-that-make-so-many-sexual-harassment-policies-ineffective>

ABSTRACT

The author's research began with a simple question: If 98% of organizations in the United States have a sexual harassment policy, why does sexual harassment continue to be such a persistent and devastating problem in the American workplace? As evidenced by recent headlines regarding ongoing sexual harassment at Uber and Fox News, it seems clear that sexual harassment policies have not stopped the problem they were designed to address.

Scholars convincingly argue that sexual harassment is embedded in organizational culture. In other words, sexual harassment serves an important cultural function for some organizations. And organizational cultures are embedded in a larger national culture in which men have traditionally been granted privileges over women.

To see how employees interpret policies, the authors gave 24 employees of a large government organization a copy of the organization's sexual harassment policy, asking them to read it and then explain the policy. They asked them to talk about the policy in groups, and then were interviewed individually.

They found that the actual words of the sexual harassment policy bore little resemblance to the employees' interpretations of the policy. Although the policy clearly focused on behaviors of sexual harassment, the participants almost

universally claimed that the policy focused on perceptions of behaviors. For the participants, the policy was perceived as threatening, because any behavior could be sexual harassment if an irrational (typically female) employee perceived it as such. In this somewhat paranoid scenario, a simple touch on the arm or a nonsexual comment on appearance (“I like your hairstyle”) could subject “innocent” employees (usually heterosexual males) to persecution as stipulated by the policy. As a result, the organization’s sexual harassment policy was perceived as both highly irrational and as targeting heterosexual male employees. The employees shifted the meaning of the policy such that female targets of sexual harassment were framed as the perpetrators and male perpetrators were framed as innocent victims.

EXPERT COMMENTARY

The findings from the study suggest very specific language that may be useful in sexual harassment policies:

- 1. Include culturally appropriate, emotion-laden language in sexual harassment policies.** Our findings suggest that if you don’t add this language, organizational members will include their own. For example, adding language such as “Sexual harassment is a form of predatory sexual behavior in which a person targets other employees” frames the behavior such that alternative interpretations may be difficult to make. Using terms such as “predatory” instead of “perpetrator” and “target” instead of “victim” can shape how organizational members interpret the policy.
- 2. Sexual harassment policies should include bystander interventions as a required response to predatory sexual behavior.** Most policies place responsibility for reporting harassment exclusively on the target, which puts them in a vulnerable position. If they report the behavior, then they are likely to be viewed with suspicion by their colleagues, often becoming socially isolated from their coworkers. On the other hand, if they do not report the sexual harassment, then it is likely to

continue unabated, creating harm for the targeted employee, and wider organizational ills, too. Mandating bystander intervention can relieve the target of their sole responsibility for reporting and stopping predatory sexual behavior, and rightly puts the responsibility of creating a healthier organizational culture on all members of the organization.

RISK MANAGEMENT/MED MAL

1. SC Hospital to Pay \$1.3 Million for Not Properly Treating Emergency Psych Patients

Harris Meyer, *Modern Healthcare*, July 5, 2017; <http://www.modernhealthcare.com/article/20170705/NEWS/170709977>

ABSTRACT

AnMed Health in South Carolina has agreed to pay the largest-ever settlement in a case brought under the federal law that requires hospitals to care for patients in emergency situations. The not-for-profit system will pay nearly \$1.3 million to settle federal allegations that in 2012 and 2013 it held patients with unstable psychiatric conditions in its emergency department (ED) without providing appropriate psychiatric treatment. Instead of being examined and treated by on-call psychiatrists, patients were involuntarily committed and kept in AnMed’s ED for days or weeks. The patients, most of whom suffered from serious mental illness, were held in the ED from 6 to 38 days and did not receive any examination, even while on-call psychiatrists were available.

AnMed did not admit to liability under the settlement deal. In a written statement, AnMed said it had a long-standing policy to accept only voluntarily admitted patients, while patients who were to be involuntarily admitted were held in the ED until they could be transported to the state mental hospital. The shortage of space in that facility often prolonged the stays of patients needing psychiatric care in the AnMed ED, the statement said. Sandra Sands, a senior attorney with the HHS Office of Inspector General, said

in an interview that AnMed has engaged in significant corrective action, including expanding its psychiatric inpatient unit from 15 to 34 beds by the end of this year. AnMed said that they had also launched a corrective plan in 2015 to make their own behavioral health unit appropriate for involuntarily committed patients.

EXPERT COMMENTARY

Many hospitals are suffering from similar problems of needing to hold patients who require psychiatric care in their EDs because of insufficient space. A study published in *Health Affairs* last year found a 55% jump nationally in ED visits related to mental health from 2002 to 2011, from 4.4 million to 6.8 million. Meanwhile, the number of beds available nationally to serve these patients plummeted nearly 80% from the 1970s to 2010, from about 500,000 to 114,000.

AnMed's situation was different, however, because the hospital determined that the 35 patients cited in the settlement were involuntarily admitted, and therefore fell under their policy that if a patient should be involuntarily committed and did not have financial resources, the attending physician could write an order for the local mental health center to evaluate the patient for commitment to the state mental health system after the patient is medically stable. Frankie Berger, director of advocacy at the Treatment Advocacy Center, said the policy sounded like "a convoluted method of triaging that this hospital system came up with to save expense and try to get around EMTALA so they can transfer these patients to a different system." Sands agreed that it was unusual, saying, "I'm not sure we've ever had anything like that, where the hospital makes a distinction between who they treated and who they didn't treat." In 2013, AnMed's director of emergency services told *Bloomberg News* that the reason his system had to hold patients who were mentally ill for long periods in the ED was that state budget cuts had led to a severe shortage of available beds for inpatients needing psychiatric care.

2. Texas Doctor Slapped with 35-Year Sentence and \$269M in Restitution for Massive Fraud Scheme

Beth Jones Sanborn, *Healthcare Finance News*, August 14, 2017; <http://www.healthcarefinancenews.com/news/texas-doctor-slapped-35-year-sentence-and-268m-restitution-massive-fraud-scheme>

ABSTRACT

A Dallas-area doctor has been convicted of conspiracy, obstruction of justice, and healthcare fraud for bilking Medicare and Medicaid of hundreds of millions of dollars. The doctor, 60-year-old Jacques Roy, will spend 35 years in prison and pay \$268 million in restitution penalties.

Roy was convicted of conspiring with several codefendants using companies they owned, including Medistat Group Associates, Apple of Your Eye Health Care Services, and Charry Home Care Services. Some of the codefendants recruited individuals to sign up for Medicare, then submitted falsified claims to make it appear as though these individuals were qualified for such services.

Medistat alone processed and approved portable oxygen concentrators for 11,000 beneficiaries for more than 500 different home health agencies. It also submitted fraudulent claims for POC certifications, recertifications, and unnecessary medical services.

EXPERT COMMENTARY

Medicare has always taken false claims seriously. While the case above appears to be an example of completely egregious wrongdoing—one could almost imagine Dr. Roy and his associates daring the government to catch them—the feds have never voluntarily let one dollar go to fraudsters.

Of late, however, it seems as if they may be stepping up the fraud busting even further. CMS is ratcheting up scrutiny of both hospitals and physicians, and while no program can completely eliminate fraud, it seems to be making a big impact.

Since 2010, HHS, the HHS Office of Inspector General, CMS, and the U.S. Department of Justice have been working together to fight fraud and abuse. During this period, the task force (known as the Health Care Fraud Prevention and Enforcement Action Team, or HEAT) has shifted away from what it calls a “pay and chase” approach to a more proactive stance.

One of HEAT’s key components is the Medicare Fraud Strike Force, which brings together Office of Inspector General and Department of Justice analysts, investigators, and prosecutors targeting emerging or migrating fraud schemes. These efforts seem to be working. During fiscal year 2016 alone, the government recovered more than \$3.3 billion to healthcare fraud judgments, settlements, and additional administrative fees.

None of this is to suggest that the average practice is at risk for having antifraud cops break down their door. Nonetheless, it never hurts to know when government regulators are stepping up their game.

MARKETING/PUBLIC RELATIONS

1. How to Bridge the Health Literacy Gap

Barry Weiss, MD, *Family Practice Management*, January–February 2014; <http://www.aafp.org/fpm/2014/0100/p14.html>

ABSTRACT

Large national studies have demonstrated that about one-third of American adults have limited health literacy, and among some racial/ethnic minorities and older adults, the rate exceeds 50%. This is true even among professionals with strong reading, writing, research, and functional skills.

To address this gap, health communication experts, trade groups such as the American Medical Association, and government organizations like the Agency for Healthcare Research and Quality are recommending that providers adopt universal health literacy precautions when

seeing patients. This includes taking the following steps:

- Explain things without using medical terms, and tailor these explanations to the patient’s level of past understanding and motivation to participate in health decisions.
- Focus on just two to three key messages rather than bombarding patients with information. This includes telling the patient what the main problem being treated is, what they need to do about it, and why it is important to proceed, whether the patient asks specifically or not.
- Speak at a slower pace, especially when discussing topics that might be unfamiliar to the patient.
- Have patients repeat instructions in their own words to be sure they understood their provider’s instructions.
- Use easy-to-understand written materials that, like verbal instructions, focus on the key things the patient needs to understand and do. They should also be free of medical jargon.

EXPERT COMMENTARY

To address health literacy among your patients, it is important to take a systematic approach. It’s important to increase awareness of the need to address health literacy when training staff, and then to follow up with research and resources.

Health literacy training should extend to a staff member’s first day in the office. Include information on health literacy in staff orientation meetings, and encourage attendees to ask questions. They need to absorb this information on both an intellectual and an intuitive level, and be able to bring this understanding to bear when interacting with patients.

Also, take a broader look at specific programs or projects you may have and the way they could be affected by low health literacy. Consider whether addressing health literacy directly might improve the effectiveness of these programs.

Take stock of whether any existing activities contribute to improvement of health literacy, as well as how you can recognize and support

these activities. It's easier to fan a flame than try to strike a spark.

To further bolster health literacy awareness and action, brief your senior staff and key decision-makers in the practice on the importance of health literacy. As specifically as possible, articulate how health literacy supports your practice's mission, goals, and strategic plan.

Finally, include specific goals and objectives related to improving health literacy in your planning, including strategic plans, performance plans, and educational initiatives. This could extend to population-based goals or objectives specific to the mission of your practice. Your goals may need to be adjusted, but even if they change from quarter to quarter, the act of revisiting them will pay dividends.

2. Here's the Ultimate Cold Email Template to Help You Land a Meeting with Anyone, No Matter How Busy or Successful

Libby Kane, *Inc.*; <https://www.inc.com/business-insider/how-to-write-the-ultimate-cold-email-and-get-responses.html>

ABSTRACT

Here's an exact template that you can use for landing a meeting with anyone, no matter how busy or successful they may be:

To: Jane

From: Samantha

Subject: Recent health administration grad—would love to chat about your work at Deloitte.

Hi Jane,

My name is Samantha Kerritt. I'm a 2016 grad from the University of Pennsylvania, and I came across your name on our alumni site. [*Tell them how you came across their name so you don't seem like a creep.*]

I'd love to get your career advice for 15–20 minutes. I'm currently working at Acme Healthcare Company, but many of my

friends work in consulting, and each time they tell me how much they love their job, I get more interested. [*The first sentence says what she wants. Most people are flattered that people want/value their advice.*]

Most of them have told me that if I'm interested in consulting, I have to talk to someone at Deloitte. Do you think I could ask you about your job and what motivated you to choose Deloitte? I'd especially love to know how you made your choices after graduating from the University of Pennsylvania. [*“University of Pennsylvania” reinforces the shared bond.*]

I can meet you for coffee or at your office . . . or wherever it's convenient. I can work around you! [*The busy person is more important than you. Treat them accordingly.*]

Would it be possible for us to meet? [*A busy person can simply reply to this with a “yes”—perfect. Note that she didn't ask for the time/location, as that's too much information in the first e-mail.*]

Thanks,
Samantha

EXPERT COMMENTARY

Remember to keep your e-mail short and concise. In an ideal world, high-powered people would be dying to talk to you. In reality, however, it can be hard to get busy, successful people on the phone, much less sitting across from you in a cafe. In a post on his Web site, GrowthLab CEO Ramit Sethi says that your initial e-mail is crucial to getting a meeting—and he describes exactly what to write.

“This is a simple thing that signals to your expert that you are competent, won't waste their time, and you're capable of actually USING the advice they give,” he writes. “One of the best things about this email is its brevity,” writes Sethi. “There's zero fat in the message and it just tells the recipient what she needs to know.”

CODING/COMPLIANCE

1. How to Choose Your HIPAA Security Officer

Dava Stewart, *Medical Economics*, May 25, 2017; <http://medicaleconomics.modern-medicine.com/medical-economics/news/how-choose-your-hipaa-security-officer-0>

ABSTRACT

Under HIPAA rules, your practice is required to name a security officer. Particularly in smaller practices, that security officer may turn out to be whomever agrees to fill the role, but that doesn't need to be the case. By considering the talents and skills of each staff member, you may be able to find a security officer who is genuinely interested in getting the job done.

To begin with, consider separating security and privacy officer positions. While both roles are required by HIPAA, they are often filled by the same person. That being said, having separate people fill them can benefit the practice, as the role of security officer calls for technical skills not needed in the privacy role.

In some cases, it may be beneficial to retain an outside firm to audit your security practices and patch any technical holes they find. On the other hand, small-to-medium-sized practices should avoid turning the security officer role over completely to an outside organization, as that may not help to generate the level of awareness your staff must have.

Also, practices should look for an individual who is willing to take a proactive role in safeguarding security. Ideally, groups should choose someone who will seek out educational options, read healthcare technology news, and research emerging issues.

EXPERT COMMENTARY

Unless you're a professional nerd, it is likely that you know little about what practices should do to protect their data. You probably know what you need to do to maintain HIPAA compliance, but you may not know how to implement compliance policies effectively. You may not understand how

computer and data security works on a technical level, either.

However, as the article above notes, you don't need to be a technical or security practices expert to help your practice do better with these issues. Even better, the person who takes on this role can learn and grow on the job and bring their colleagues up to speed.

How can you tell who is likely to follow through and do well in this role? Look for staff members or clinicians who have shown a willingness to navigate change processes within your organization. For example, you may remember someone who stood out during your EMR roll-out process. It's just as good if they demonstrated their capabilities on a nontechnical initiative. The key is to find interest and enthusiasm.

Also, it doesn't hurt if you find somebody who brings natural teaching skills to the table. Not only do you want someone who cares about the subject of security, but also it would be great if they know how to share what they are learning and why it matters. That way, you'll get not only improved security but a better security culture as well.

2. Final ICD-10-CM Codes for 2018 Contain a Few Surprises

Decision Health, *HealthLeaders Media*, June 15, 2017; <http://www.healthleadersmedia.com/technology/final-icd-10-cm-codes-2018-contain-few-surprises>

ABSTRACT

The latest update to the ICD-10-CM codes includes 360 new codes, revises 226 diagnostic codes, and deletes 142 codes. The final 2018 codes include 322 more that changed from the hospital IPPS rule in April. The changes will go into effect on October 1.

One notable change makes it possible for coders to use specific codes when a patient is in remission from using various substances, including alcohol, opioids, cannabis, and nicotine. The codes also clarify the severity of the use as mild, moderate, or severe, which serves

to better coordinate ICD-10-CM coding with the American Psychiatric Association's DSM-5 classification manual.

In addition, the final code set includes more than 100 deletions not in the proposed set.

EXPERT COMMENTARY

As with prior updates, the current set of ICD-10-CM code updates demands attention. In addition, practices must be sure that coders understand the significance of these changes and can establish new workflows needed to make sure these codes are applied correctly.

For example, in addition to becoming aware of the changes to the 2018 code set, see to it that your coders can explain the payment impact of the new and revised codes. Simple mechanical knowledge isn't enough; your coders should understand how the correct application of the 2018 updates can have an effect on the financial well-being of your practice.

As part of this grounding, coders should be able to demonstrate that they recognize codes for conditions that have been updated or revised. While they are unlikely to be able to memorize every code change, they could certainly be aware of changes most likely to affect your specialty and become especially familiar with how they should be applied.

Also, the coding staff must be able to apply correct coding sequences for relevant conditions such as COPD. That's where workflow changes come into play. Ultimately, they'll figure out how sequences should work, but that will take time. In the meantime, make sure that their existing workflow doesn't prevent them from spending enough time to get the sequences right.

HEALTH INFORMATION TECHNOLOGY

1. Four Things to Do before Jumping into Your Software Build

Laura Alabed-Olsson, *HITECH Answers*, August 16, 2017; <https://www.hitechanswers.net/4-things-jumping-next-software-build/>

ABSTRACT

When your practice decides to create a digital health tool, you may wish to move quickly and get tangible results in hand. However, if you plan your next software build carefully, your practice is likely to save time, money, and frustration over the long term.

To prepare properly, take the following steps:

1. Before you begin your technology development project, define its scope clearly, and make sure all major stakeholders and project team members are on board with the plan. Your project overview should include a one-to three-year plan for how to use the technology once it's ready.
2. In addition to executive management, designate a project manager who can stay on top of project timelines, budget, needs, resources, communications, and deliverables. Also, include subject-matter experts (such as financial leaders when building a payment app) to make sure that the final tool meets their needs.
3. Make sure the tool will meet users' needs, or you'll have trouble maintaining their interest. To do so, research user habits and develop user personas that help you model how they interact with the tool. This will make sure you are clearly aware of your users' goals, behaviors, pain points, and typical tasks.
4. Once you've developed a project model that meets everyone's needs, determine what technology and structure you'll need to support the tool. This includes decisions on how to support security, performance, and the ability to scale up your software over time.

EXPERT COMMENTARY

Unless your practice is particularly large, or part of a larger overarching health system or hospital, your organization probably doesn't have much experience with building larger technology projects. You may have been through the process of evaluating and selecting someone else's software, but you might never have seen development of, for instance, an app from start to finish.

Fortunately, there are commonsense principles that underlie both technical and nontechnical projects. Having doubtless been through the latter, you may be better prepared to manage development of a digital health tool than you might expect.

One commonsense preparation for both non-IT and IT projects is to make sure that you're solving the right problem with the right process. For example, there's no point in adding e-mail functionality to your portal if your patients respond far better to phone conversations. Sometimes, throwing technology at a problem seems like an obvious response, especially if the budget is already in place, but doing so can sometimes create additional problems.

Another common constraint is the amount of time you have to execute the project. In fact, it never hurts to double- or triple-check the time estimates to make sure you can get everything done on schedule. If IT is new to you, estimating the amount of time and effort it takes to execute these projects may be more difficult, but in any case, the key is to get plenty of input on how things go.

The bottom line here is that while building digital health tools may be a stretch for your organization, delivering care isn't. You already know what your business needs. If you keep focused on your high-level objectives, you'll be fine.

2. Password Guru Who Told the World to Make Them Complicated Admits: I Got It Completely Wrong

James Titcomb, *The Telegraph*, August 8, 2017; <http://www.telegraph.co.uk/technology/2017/08/08/man-wrote-password-bible-admits-advice-completely-wrong/>

ABSTRACT

Fourteen years ago, a man named Bill Burr wrote a book on password security on behalf of the U.S. government. In the book, Burr suggested that to keep passwords from being guessable, they should include capital letters, numbers, and nonalphabetic symbols such as question marks.

He also advised that computer users change their passwords often.

Since then, corporate security watchdogs have insisted that is the best way to protect access to computer networks and files. But this year, Burr admitted that he made a mistake. Instead of protecting access to systems, complex passwords actually made them less secure.

In reality, when people are forced to use long, complex passwords, they tend to write them down and post them in places others can find. Meanwhile, these numbers and symbols weren't helpful in preventing other computers from guessing these combinations. Also, asking users to change the password often backfired, as people generally change the original password by one character, which doesn't discourage hackers.

Today, corporate security advisers recommend that people use long but easy-to-remember passphrases, ideally one that captures a memorable visual (such as "rabbiteatingcarrot"). Such combinations might take up to one trillion years for an automated cyber attacker to crack, compared with one minute for "P@55w0rd."

EXPERT COMMENTARY

Unfortunately, trends in technical security evolve, and as the article notes, standards that were considered gospel at one point may fall out of favor over time. Not only that, but as new technologies emerge, they'll call for new security approaches. Even those who work full-time in the healthcare IT security field can barely keep up.

That being said, if your practice keeps up with the most basic of security practices—those that stood the test of time—you may already be better off than your peers. Good security hygiene can go a long way toward protecting your data and devices.

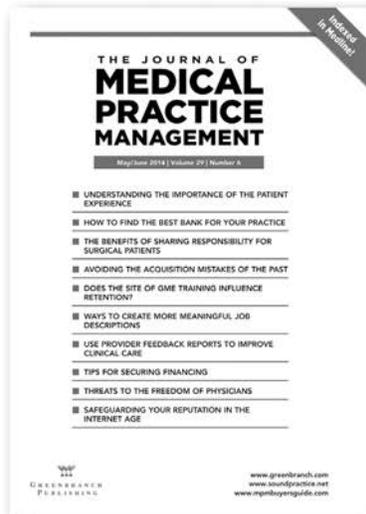
For example, teach staffers and clinicians that, when in doubt, they should not click on attachments to e-mail messages sent by people they don't know. Ban the use of outside flash drives on practice systems, as they can contain viruses or other malware. Instruct staffers never to write down their passwords, much less share

them with others (a task that could be made much easier by using the memorable password styles described above).

In addition, review your practice's security basics regularly to see if people are making obvious mistakes. When doing so, research any possible threats you hadn't heard of before. If you're not a techie, this may seem intimidating, but take the time, as a serious security incident can harm your reputation or even damage your practice permanently.

The key here isn't to become a cutting-edge security wizard. If you need such a person's expertise, one is usually available for a manageable consulting fee, and most are happy to coach you on the basics as well. It is a good idea, however, to become as informed as you can. Though it may seem unfair, if you have computers, security is one of your responsibilities, and you can't afford to let it slide.

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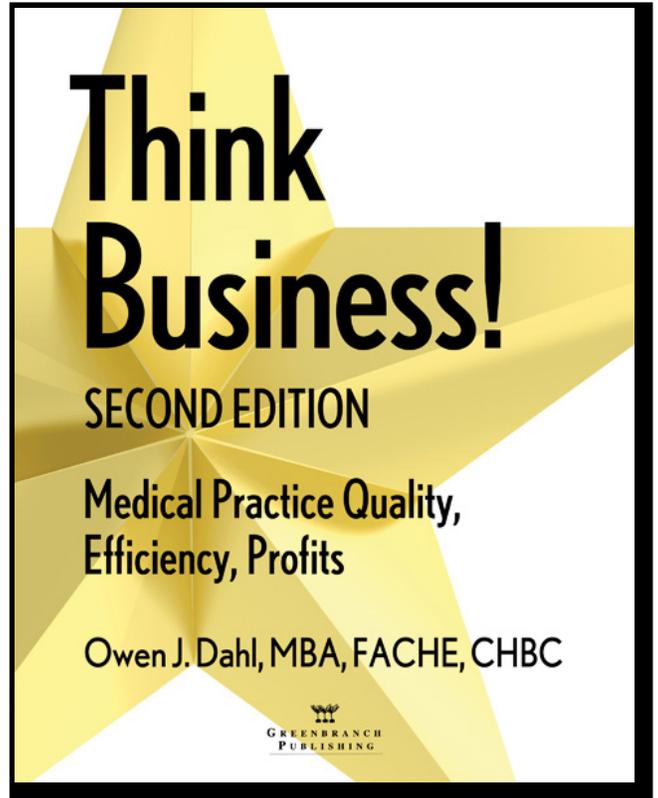
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