# **10 IN 10:** TAKE 10 MINUTES OUT OF YOUR BUSY DAY FOR THE INSIGHTS YOU NEED MOST

10 Trends that Every Practice Executive Must Understand to be Successful

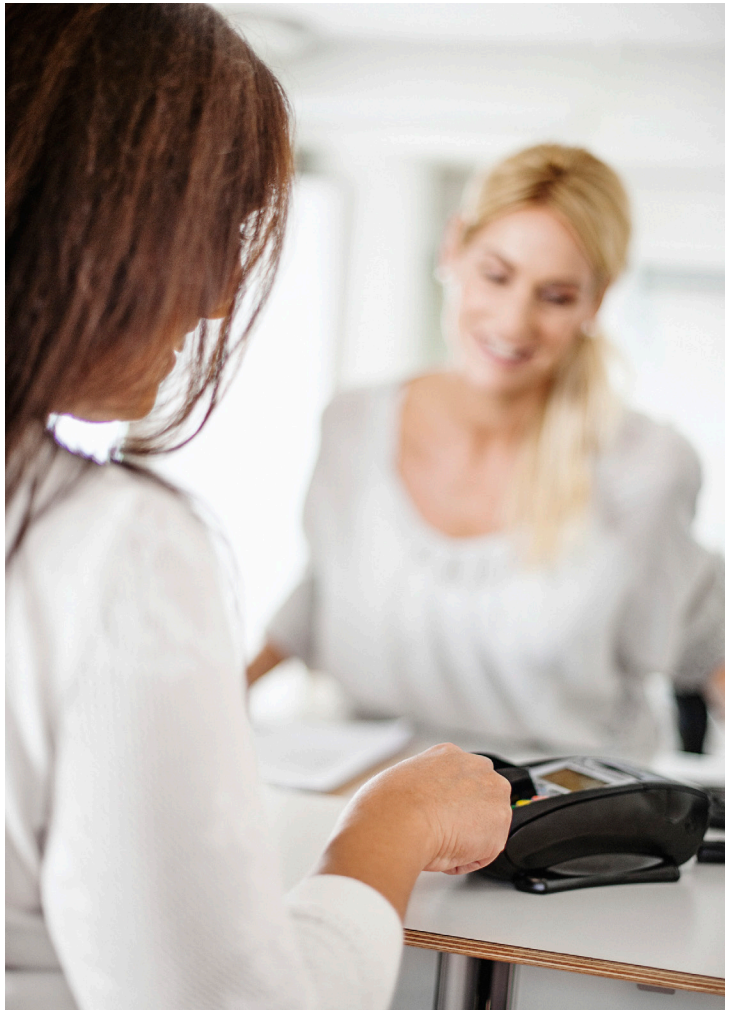
By Elizabeth W. Woodcock, MBA, FACMPE, CPC

# 1 THE EVOLUTION OF THE PATIENT INTAKE EXPERIENCE

When a patient presents to your practice, consider what he sees: a closed window, crowded with taped up signs, and a clipboard perched on a ledge. We seem to have all but forgotten the art, and yes, the science of receiving patients. But it doesn't have to be this way. A successful practice takes an adept, multi-step approach that engages patients and leverages technology to collect demographic information, insurance eligibility, medical history and payments. Patients today want an arrival process that includes a warm greeting and attentive professionalism—not a redundant stack of paperwork. To meet those expectations, the intake process should be managed by a "director of first impressions," an employee who has the skills and the time to welcome each patient and devote extra attention to those who need it.

## 2 THE GROWING PREVALENCE OF HIGH-DEDUCTIBLE PLANS

Financial accountability for medical care has shifted rapidly from third-party payers into the hands of patients. Nearly a quarter of American workers were enrolled in high-deductible plans in 2014, up sharply from 8% of workers in 2009, according to data from the Kaiser Family Foundation. Practices unprepared for this change will find themselves challenged to be effective resources for patients and, in turn, will suffer financially. In contrast, successful practices recognize that many—if not most—of their patients covered by commercial insurance now have high-deductible plans. Adjusting collection processes to align with this new reality means asking important questions: Do your employees know what they are allowed to collect at the time of service? Do you? The design and administration of a system to collect copayments and balances is a minimum business necessity. To accomplish this task, successful practices have moved much more of their collections effort, including requests for unmet deductibles and coinsurance, to the front-end of the revenue cycle.



# 3 MOBILE PATIENTS WHO DEMAND THE PERSONAL TOUCH

Nearly two-thirds of Americans own a smartphone, and that number is growing every day, according to a recent Pew Research Center report. Indeed, smartphones and other mobile devices, such as tablets, are the go-to tools that millions of people use to perform a multitude of everyday tasks. Today's successful practices recognize their role as leaders in mobile patient engagement. Even patient portals—a recent innovation in the health care industry—are migrating to mobile-friendly platforms that offer patients more functionality than ever before. Requesting prescription renewals, making payments, checking-in for their appointment or looking up information about a health condition (as 62% of smartphone owners did in 2014[1]) are functions that patients appreciate and expect.

# 4 WORD-OF-MOUTH MARKETING

Satisfied patients are the best marketing tools a practice can have and their word-of-mouth referrals trump even the most elaborate (and expensive) marketing efforts. Too many practices seem to view effective word-of-mouth marketing as merely a result of providing good medical care (which it is), but not as an approach to aggressively pursue. Successful practices, on the other hand, look for every opportunity to capture patient opinions and they recognize that such feedback is necessary tool for improvement. The typical post-encounter survey remains a solid foundation for assessing the patient experience but forward-thinking practices also look for other methods to understand their successes and shortfalls, including carefully monitoring online patient reviews and seeking guidance from the practice's most engaged patients.

# 5 USING ICD-10 TO IMPROVE THE REVENUE CYCLE

After 40 years of use, the familiar ICD-9 scheme made its final farewell in 2015. The transition to the new classification system, ICD-10, with quadruple the number of codes, began October 1st, 2015. Even though there are more of them, codes are still codes. Successful practices recognize the impact that this deeper drill-down will have on reimbursement. With so much depending on using the new coding system correctly, practices must develop business processes that immediately identify denials. Using data from payers, practices can monitor for denial trends and, most importantly, establish feedback loops through which their business offices share critical information with all points in the practice. The ultimate goal is to ensure that denials are prevented, not just managed. Successful transition to ICD-10 is not easy, but by monitoring eligibility and utilization trends, managing billing and reimbursement processes more adeptly, carefully assessing clinical documentation processes and, importantly, training employees and providers, ICD-10 can improve billing and cash flow, as well as clinical and financial results.

# 6 POPULATION HEALTH

As the healthcare system moves from volume- to value-based models of reimbursement, successful practices recognize the importance of identifying and managing their patient panels. Historically, practices focused on accommodating patients when they called for appointments or advice but left many of the responsibilities for ongoing care management and coordination in the hands of patients. With the shift to a population health approach, providers are now encouraged to proactively manage and coordinate care across settings. Practices can use a variety of approaches to detect gaps in care and identify high-risk patients, including implementing physician dashboards, analyzing referral patterns and incorporating evidence-based guidelines at the point of care. The evolution to population health management may require practices to redesign business processes, develop new protocols and ultimately rebuild some—or perhaps all—of their infrastructure. By taking these important steps, practices will be ready to succeed in emerging at-risk arrangements.

# 7 ACCESS TO CARE

Recognizing that traditional methods of appointment management often introduce barriers to care, successful practices have focused attention on improving patient access. They carefully monitor no-shows, cancellations and provider-initiated bumps, and they encourage patients to avoid them. They redesign workflow to assure that canceled appointment slots are swiftly refilled, waitlists are maintained and patients are contacted to schedule follow-up appointments. Successful practices also put careful thought into assuring that physician time—a medical practice's most precious and easily eroded asset—is managed wisely. That means carefully managing designated leave and setting clear expectations for the number and timing of clinical sessions each physician handles per week. Practices are also making investments to extend the time available to patients by enhancing the care team with advanced practice providers, health coaches, behavioral health specialists and other healthcare professionals. This attention to detail allows a practice to understand its capacity and, when necessary, add to it so as to ensure that patient demand is met.

# 8 TRANSPARENCY

There's much to find fault with in the federal government's meaningful use incentive program but one of the notable positive outcomes of this drive to upgrade information technology has been to make healthcare transparency a top priority. The program's focus on providing patients access to their visit summaries, test results and other health information helps patients to engage with their physicians and actively participate in managing their own healthcare. Marrying transparency in health information with better information about the costs of care (still a work in progress) will bring the patient more fully into the decision-making process. Successful practices know that transparency can work to deliver greater value and ultimately better outcomes for the patient. For example, test results can be trended over time accompanied by meaningful commentary and suggested resources for the patient. As this happens, the medical record becomes a coordinated assessment and plan of care instead of merely a series of disconnected notes.

# 9 EMPLOYEE ENGAGEMENT

Saddled with turnover that averages as high as 30 percent among administrative support positions, it's a wonder that many medical practices have survived at all, let alone thrived. The practices that do succeed recognize the importance of employee engagement and they work to create an environment where their staff can flourish. That involves searching out employees who best assimilate with the practice's culture, making meaningful improvements to training and orientation practices, and understanding that positions that require frequent patient contact are best held by people who have a natural affinity for service. Progressive medical practices also seek out new ways to provide internal mobility to employees who want to advance, whether through expanding job roles, cross-training in new responsibilities, taking continuing education or serving in temporary developmental assignments

# 10 NETWORK IN – NOT OUT

Given the recent mergers involving many major third-party payers, reimbursement pressures will continue on a downward trend for medical practices for the foreseeable future. To avoid being marginalized, practices are positioning themselves for success by focusing on gathering evidence of the quality of care they provide, as well as their efforts to coordinate care across the continuum, engage patients, enhance access and minimize costs. Successful practices are compiling data to create scorecards highlighting what they do best and proactively reporting self-defined quality and resource scores to payers, as well as to patients and the public at large. Instead of being pushed out of networks, practices are assessing and developing partnerships that will position them to be value-added companions in contracts featuring risk and bundled payments, as well as other alternative payment models.

# ABOUT THE AUTHOR

Principal of Woodcock & Associates, Elizabeth Woodcock, MBA, FACMPE, CPC, has focused on medical group operations and revenue cycle management for over 20 years. She has led educational sessions for the Medical Group Management Association, the American Congress of Obstetricians & Gynecologists and the American Medical Association. She has also consulted for diverse clients ranging from a solo orthopedic surgeon in rural Georgia to The Mayo Clinic. Educated at Duke University and The Wharton School of Business, she is the co-author of *The Physician Billing Process: Potholes in the Road to Getting Paid*.

## END NOTES

[1]US Smartphone Use in 2015 by Pew Research Center. http://www.pewinternet.org/files/2015/03/PI_Smartphones_0401151.pdf

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