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TRENDING: Chronic Obstructive Pulmonary Disorder Meaningful Use 2 Oncology: Practice Management Preparing for ICD-10

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Top 15 challenges facing physicians in 2015

Master challenges by maximizing efficiency



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By Ken Terry, Alison Ritchie, Donna Marbury, Lisa Smith, Elaine Pofeldt

Solo practitioner Paul Sueno, MD, had a good idea of the challenges he would face when he opened his private practice in Tacoma, Washington, in 2012. His late father, also a physician, had practiced in the same community, and Sueno grew up helping his father and learning about medicine.

ALSO READ: [Top 10 challenges facing physicians in 2014](#)

Immersing himself in every detail, from filing insurance claims to selecting equipment, Sueno has built the four-employee practice from the ground up. But now that he's gotten a handle on the business side it through some "nerve wracking" moments, Sueno says the practice is doing well—and he is glad he didn't become an employee of a giant organization.

"I want to go to work every day enjoying what I do," Sueno says. "I don't want to go in thinking I have a little more money in my pocket but dreading the work experience, knowing I'd have to work for a

certain bottom line.”

As Sueno has found, it is possible to maintain your independence without going broke, even in an environment that is increasingly challenging for physicians who own their own practice. But we won't kid you: You've got to become the equivalent of a mixed-martial arts champion in practice management.

As our list of the top 15 challenges for 2015 underlines, physicians will need to navigate some tough obstacles in the coming year. These include the increased costs of operating a practice, time-consuming regulatory burdens, and hassles with getting paid by insurance companies.

The pressures are not likely to abate any time soon, thanks to a trifecta of regulatory changes impacting physicians. Starting January 1, 2015, physicians' payments will be increasingly tied to providing higher-value care under the Affordable Care Act. In February, financial penalties kick in for practices that could not attest to meaningful use. Then in October, the ICD-10 transition deadline finally arrives.

Perhaps it shouldn't be surprising that, in this constantly changing ecosystem, more practices are struggling to maintain financial homeostasis.

“It used to be that physicians made enough money that they could let a lot of things slide,” says Cindy Ackrill, a non-practicing physician based in Alexandria, Virginia, who coaches physicians in areas such as leadership and stress management and sees some suffering from burnout. “It used to be that physicians made enough money that they could let a lot of things slide. The margin is so much thinner now. You do have to micromanage the money. No one taught us to do that.”

That's the bad news. The good is that it's possible to maintain a viable, even thriving practice if physicians confront challenges and identify fixes that can improve their lives and the health of their patients.

There are concrete steps physicians can take to minimize the burdens of these challenges. When it comes to ICD-10, for example, physicians can engage their staff now to build training, testing, and documentation protocols that will best serve the practice when the transition occurs.

As Sueno has found, it is possible to learn—and still take good care of patients. The following coverage details the 15 challenges every primary care physician needs to master to succeed in 2015.

Next: Challenge #1

Challenge 1: ICD-10 implementation

Physicians should not expect another delay

Practices should be updating systems and training their staffs for ICD-10. But even with an extra year to prepare, will doctors be ready to go live with ICD-10 in October 2015?

“I guarantee there will be one large payer or a few small payers, or both, that won't be ready to process ICD-10 claims on October 1, 2015,” says Joshua Berman, director of business analytics and ICD-10 lead at Relay Health Financial.

The ICD-10 delay helped and hurt practitioners, depending on who you ask. According to a Medical Group Management Association survey in February 2014, 79% of practices had not yet started implementation or were only somewhat ready. A survey by Part B News says that the delay will cost practices more money in training, and that 34% of practitioners would have been ready for the October 2014 deadline.

No matter where practices are in their preparation for ICD-10, the new coding system will cost a considerable amount of money. The American Medical Association estimates that small practices could spend between \$56,639 and \$226,215 to implement the coding system.

Pam Jodock, senior director of health business solutions for Healthcare Information and Management Systems Society (HIMSS), suggests that practitioners allot time for end-to-end testing with clearinghouses to ensure coding is working properly. “HIMSS recommends that practitioners follow the 80/20 rule to determine which health plans process the highest volume and highest value claims,” Jodock says, adding that HIMSS has an “ICD-10 Playbook” on its website to assist practices of all sizes. She suggests that practices take advantage of the Centers for Medicare and Medicaid Services ICD-10 testing on March 2-6, 2015, and June 1-5, 2015.

ICD-10 preparation 101

- ☐ **Continue training** Conduct high-level training on ICD-10 for providers and coders to prepare for eventual testing.
- ☐ **Take a financial snapshot** Begin analyzing the financial health of your practice. Evaluate your payer mix, determine your typical accounts receivable cycle and examine denied claims, both for coding and documentation reasons. Determine what you need to do to survive financially if you encounter a major problem with reimbursements after October 2015.
- ☐ **Gather coding data and identify diagnostic patterns** Analyze your practice's coding patterns to determine which codes you use most frequently, which ones make up the largest portion of your revenue, and which ones are denied most frequently. This should be done for each payer you work with, going back about one year.
- ☐ **Contact vendors and health plans** Ask all your payers and vendors—electronic health records, billing services, clearinghouses—about their ICD-10 readiness. Monitor the preparedness of your vendors and payers and work with them to identify and address gaps.
- ☐ **Beef up your documentation** Providers should begin documenting patient encounters as if ICD-10 is already in place. The goal is to be ready, from a documentation standpoint, for testing and eventually going live with ICD-10.
- ☐ **Begin testing** Testing ICD-10 claims to ensure that your coding and documentation are working properly is vital, and should begin as soon as possible. CMS is holding testing weeks prior to the October 2015 transition, but waiting for those events is not necessary. Testing is important both within your practice and with the clearinghouses and payers you will be working with. One key: Test using records that reflect the patient encounters you will commonly deal with.

Berman says that practices will have to be ready to send both ICD-9 and ICD-10 claims during a period of transition to ensure payment. "The dual coding process that will need to take place at that point will prove to be very time consuming and resource intensive while at the same time may be difficult to do via their current health information system and/or practice management system."

Having extra cash on hand during ICD-10 implementation will help practices in the event of increased denials and delayed payments. "Denials from miscoding or other process glitches could significantly slow down payment," says Berman. "That being said, physicians need to have a financial plan in place in case payments are slowed down/delayed for a significant length of time."

Jodock says now is the time to make ICD-10 training a priority. "Practitioners who take the time to prepare in the months between now and October 1, 2015 will have fewer challenges than those who choose to wait, especially if they participate in end-to-end testing. Those who delay

their preparations or who choose not to test may experience a higher number than usual of claims that are rejected or pended for additional information, which could lead to a delay in payment," says Jodock. "Even the most well-executed implementation effort could experience challenges."

Next: Challenge #2

Challenge 2: HIPAA

Staying compliant in a fast-moving, digital world

Mitigate security risks to your medical practice

The security infrastructure of a medical practice should have five components, according to the HIPAA security rule. The following table briefly outlines each component and provides examples.

5 SECURITY COMPONENTS FOR RISK MANAGEMENT		
Security Components	Examples	Examples of Security Measures
Physical Safeguards	- Your facility and other places where patient data is accessed - Computer equipment - Portable devices	- Building alarm systems - Locked offices - Screens shielded from secondary viewers
Administrative Safeguards	- Designated security officer - Workforce training and oversight - Controlling information access - Periodic security reassessment	- Staff training - Monthly review of user activities - Policy enforcement
Technical Safeguards	- Controls on access to EHR - Use of audit logs to monitor users and other EHR activities - Measures that keep electronic patient data from improper changes - Secure, authorized electronic exchanges of patient information	- Secure passwords - Backing up data - Virus checks - Data encryption
Policies & Procedures	- Written policies and procedures to assure HIPAA security compliance - Documentation of security measures	- Written protocols on authorizing users - Record retention
Organizational Requirements	- Beach notification and associated policies - Business associate agreements	Agreement review and updates

Source: The Office of the National Coordinator for Health Information Technology

Though the chances your practice will be audited for [Health Insurance Portability and Accountability Act \(HIPAA\)](#) violations are slim, keeping patient information secure is growing more complicated. Since 2009, there have been more than 800 patient data breaches and 29 million patient records affected by [HIPAA violations](#), according to the 2013 Redspin Breach Report.

The Office of Civil Rights began its second phase of HIPAA audits in October, and will continue until June 2015. Of the 350 healthcare organizations that will be asked to submit information on patient health data security, approximately 150 will be audited. Fines for HIPAA violations can start at \$100 and can go as high as \$50,000, capping at \$1.5 million annually, depending on the scale of the breach. Fines aren't the only consequence practitioners face—a HIPAA violation can break the trust that patients have with their physicians.

HIPAA violations may seem like a large-organization problem, but considering that many breaches are a result of employee theft and carelessness, smaller practices are at risk. One issue practitioners face: It becomes harder to keep track of electronic communication within the practice when patients and staff often have mobile devices and can be unaware of how easily HIPAA rules can be violated.

“While there are certainly threats from outsiders, insider threat (employees accessing information inappropriately) is also a serious threat for practices,” says Lisa A. Gallagher, BSSE, CISM, vice president of technology solutions at the Health Information and Management Systems Society.

Practices must consider mobile technology as a threat to patient security. Create a ‘bring your own device’ policy that allows the practice to access an employee’s device if there is a potential breach. Also be aware of smartphones and other portable devices that have audio and video capabilities that employees and patients bring to the practice.

Employees who use social media at work can also be a threat to HIPAA rules. “For example, an employee may think nothing of posting about an irritating patient with sufficient detail as to identify the patient. Even well-meaning employees can make such a disclosure without realizing it. If a practice employee takes a picture with their favorite patient and posts it to their social media account, the post is a PHI (patient health information) disclosure,” says Daniel F. Shay, JD, an attorney who focuses on HIPAA at Alice G. Gosfield & Associates in Philadelphia, Pennsylvania and contributor to Medical Economics.

In addition, Shay adds that “employees may post photos of seemingly innocuous content, such as a picture of their lunch...which happens to be sitting on top of a patient chart or order sheet.”

One major issue that many physicians are not aware of is the requirement, both for HIPAA and meaningful use, to complete and keep updated a security risk analysis, intended to identify risks to record security. Many physicians are not aware of this requirement, and it is a primary reason why practices fail meaningful use audits, says Mark Norris, a consultant who specializes in privacy, security

Next: Challenge #3

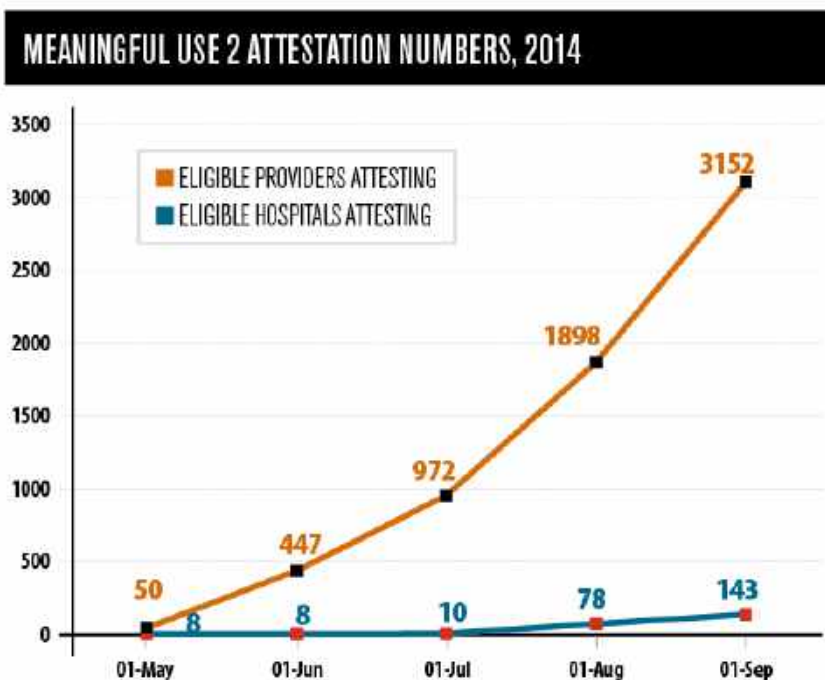
Challenge 3: Meaningful use 2

Penalties for not attesting start in 2015

[Meaningful use 2 \(MU2\)](#), which has been a challenge for physicians, is unlikely to get easier in 2015, according to Bethany Jones and Naomi Levinthal, health IT consultants for The Advisory Board Company.

Starting in 2015, eligible professionals (EPs) will see a 1% decrease in Medicare reimbursements for each year they don't meet meaningful use requirements. The penalty will change by 1% point each year to a maximum of 5%. EPs have until the end of February 2015 to [attest for MU2](#). As of November 1, 11,478, or 2% of EPs have attested to MU2.

and meaningful use attestation.



The Centers for Medicare and Medicaid Services (CMS) has not made things any easier with its frequent rule changes, which require practices to stay up to date on the agency's latest FAQs, Jones points out. To start with, Levinthal notes, some electronic health record (EHR) vendors continue to struggle to obtain 2014 certification, which is required for use in MU2. Other vendors have elected not to pursue this certification at all. That means their customers will have to switch to other EHRs to show they have met the MU2 requirements.

In August, CMS finalized a "flexibility rule" that allows EPs to use 2011- or 2014-certified EHRs or a combination of them if their vendors have been slow in delivering upgrades to the 2014 edition. But next year, they will have to use 2014-certified EHRs, and EPs who are scheduled to attest to MU2 will have to do so.

The American Medical Association (AMA) has requested a stop to MU2 penalties due to interoperability challenges between EHR systems. "The whole point of the meaningful use incentive program was to allow for the secure exchange of information across settings and providers and right now that type of sharing and coordination is not happening on a wide scale for reasons outside physicians' control," says AMA President-elect Steven J. Stack, MD. "Physicians want to improve the quality of care and usable, interoperable electronic health records are a pathway to achieving that goal."

Moreover, Jones points out, the reporting period next year is 12 months for all physicians who have gone through at least one year of the meaningful use program. Until now, the reporting period has been only 90 days—and it remains that for doctors who will be in their first year of the program in 2015. The full-year reporting requirement will be challenging for many doctors, Jones says.

In MU2, one of the most difficult criteria is persuading 5% of a practice's patients to view, download or transmit their electronic health information, typically through the use of a patient portal attached to an EHR. When physicians reach out to patients themselves, they're more likely to get them to use a portal, Jones notes. But many doctors—particularly specialists who receive mostly episodic visits—are not ready to educate patients about portals, she says.

Portals are also "brand new territory" for most practices, Levinthal adds. So for this requirement, as well as for the requirement that EPs exchange care summaries in transitions of care, mastering the technology is the biggest hurdle in many practices.

In the MU2 attestation data that CMS has released to-date, she says, 70% of attesting EPs have qualified for exclusions from the transitions of care requirements, including at least one exchange of a care summary with the user of an EHR that's different from the attester's system. CMS allows EPs to exclude these criteria if they have referred fewer than 100 patients to another physician or have ordered them to be transferred to another care setting, such as home care or a skilled nursing facility, during the reporting period.

Many EPs, particularly specialists, have fewer than 100 transitions of care within a 90-day period, she notes. But next year, when the reporting period increases to 365 days, a far smaller percentage of EPs are likely to meet the exclusion criteria.

Meanwhile, direct secure messaging—the main method that physicians are using to exchange care summaries—continues to be plagued by difficulties. Jones believes this situation is improving, but cautions: “Providers have to be really creative in the way they approach transitions of care.”

Jones doesn’t expect most EPs to abandon meaningful use and accept the Medicare penalties for failing to attest. As of July, CMS had received more than 44,000 hardship applications from practitioners requesting an extension for MU2 attestation. CMS stopped accepting hardship applications in November.

“Some stuff is out of their control and they’re having trouble meeting objectives, but they’re charting their own course,” she says. “We don’t see them giving up, but they’re asking for more time.”

Next: Challenge #4

Challenge 4: Getting paid

The ACA's impact on physician reimbursement

Physicians find themselves under constant pressure to get paid for the work they do. Increasingly, those challenges will be tied to impact from the [Affordable Care Act \(ACA\)](#) and the how reimbursement models are shifting from the fee-for-service model to value-based payment models.

The challenges are likely to grow in 2015 for some of those who work with Medicare patients. Under the ACA, penalties for physicians who don’t participate in the Physician Quality Reporting System (PQRS) or aren’t deemed successful participants for the 2013 program year will face a 1.5 % penalty in Medicare payments in 2015 and 2% thereafter. In 2014, Medicare proposed that physicians not

participating in PQRS in 2014 would face penalties in 2016.

Private insurers are also increasingly adopting value-based payment models. An October 2014 study by the Analysis Group showed that private insurers are quickly shifting to value-based payments and risk sharing. In 2011, 46% of respondents’ beneficiaries were involved in such payment programs. That figure rose to 62% in 2014 and was projected to increase to 75% by 2017.

Avoiding claim denials

While claim denials have been decreasing in the past few years, some experts believe the ACA will usher in an era of increased frequency of denied claims, so physicians are taking steps to avoid losing money from denials.

To avoid denied claims, practice owners find they need to immerse themselves in every minute detail to submit a “clean” claim. When Paul Sueno, MD, opened his practice, he discovered how quickly insurance companies would deny a submission based on even a small data entry error or a tiny discrepancy between his records and the insurer’s.

“These are simple things that seem so unbelievable—things like a hyphenated last name,” he says. “If the patient gives you an ID and says their last name is hyphenated and it’s not with the insurance company, that’s ground for denial. It’s an unbelievable amount of work that has to go in beforehand.”

Sueno’s practice now relies on a pre-billing checklist to prevent errors and has created a proprietary manual documenting the nuances of completing claims from every insurer its patients use. “Once a denial happens, your staff has to take up to 30 minutes to hours on end in a day to deal with that aspect,” Sueno says.

5 COMMON REASONS FOR CLAIM DENIALS

- 1 The patient isn’t eligible for services because his or her health plan coverage ended, and the patient hasn’t shown proof of new insurance.
- 2 The claim form is missing a modifier or modifiers, or the modifier(s) are invalid for the procedure code (as in the case of bilateral codes billed on both sides).
- 3 A particular service isn’t covered under the plan’s benefits, or there appears to be a lack of medical necessity. In another example, there could be a mismatch between the actual diagnosis and the service performed.
- 4 The claim is deficient in certain information. It may be missing prior authorization or the effective period of time within which the pre-approved service must be provided for reimbursement to occur.
- 5 Errors or typos were made while collecting pertinent information from the patient or during the data entry process for a claim.

Despite his proactive approach, Sueno is now dealing with an appeal on a claim he filed about a month ago. "It's time taken out of treating patients and trying to grow the practice," he says.

In another case, the denial and appeals process became so frustrating that the patient asked Sueno if the treatment was worth it. "I had to call the medical staff at the insurance company to get a peer-to-peer authorization," he says.

Leaving insurance behind

Some physicians have [opted out of accepting insurance](#) altogether to avoid the hassles and changes resulting from healthcare reform. Mary Ann Block, MD, a general practitioner in the Dallas-Fort Worth, Texas, area, accepted insurance during her first year in private practice but didn't like having a third-party making decisions that affected her patients' care. So 21 years ago, after returning from a one-year teaching stint, she decided not to accept insurance. She doesn't work with Medicare and Medicaid patients, but says not all of her patients are wealthy. Patients often have insurance and submit claims on their own.

"People ask me why I don't take insurance," she says. "If I'm going to help you I need the freedom to spend time and do the testing that will help me find out what's really wrong with you and not just give you a drug to cover up symptoms."

Now, as she looks back at her decision, she has no regrets about a decision that has helped her avoid the insurance hassles with which many of her peers contend. "I'm as busy as I would want to be," Block says. "In fact I'd like to find another doctor to come in with me. I need more help."

Alexander J. Cummings, MD, a clinical assistant professor of surgery at the University of Illinois-Chicago and president-elect of his county medical society, spent two decades as an emergency department physician before opening an aesthetic and regenerative medicine practice in Peoria in 2014. While he does not accept insurance, some of his colleagues at the Peoria Medical Society face obstacles to getting paid. Some physicians he knows are living paycheck to paycheck.

"If the federal government was interested in bringing down the cost of health, it should have focused on regulations, bureaucracy, paperwork and tort reform," he says. "That would help cut back healthcare costs where we can safely cut back."

Next: Challenge #5

Challenge 5: Maintenance of certification

Why the MOC debate is just beginning

The controversy surrounding the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program is extensive, and it's a challenge that will certainly follow physicians into 2015.

ABIM has faced significant backlash from physicians and advocate groups over MOC's cost and time requirements. For family physicians, the application fee alone can range from \$1,300 to \$1,500.

The ABIM and other MOC proponents say that the program is necessary to ensure that physicians maintain their medical knowledge. However, some primary care physicians argue that the test material often is not applicable to typical occurrences within their specialty.

"It is essentially a sub-specialist created test that quizzes generalists by repeatedly asking them to make decisions after reviewing cardiac catheter data or viewing renal biopsies. These are responsibilities and decisions that simply do not exist in the real medical world of the primary care physician," David C. Sobel, MD, FACP, wrote in a letter to Medical Economics. "It not only makes the entire experience useless but in reality for an office-based generalist invalidates any conclusions regarding physician competence or quality of care."

The ABIM released changes to the accreditation process at the beginning of 2014, and nearly 20,000 physicians signed a petition calling for those changes to be rescinded.

"Board certification is intended to serve both the public and our diplomates. Physicians rightly have expectations for a credential that recognizes their ongoing efforts to keep up in the specialty, but they also want it to be relevant and reflect what they do in practice," said Richard J. Baron, MD, ABIM president and chief executive officer. "We are listening to the feedback we have received from the community about changes to our program, but at the same time the public is seeking a way to know that their doctor is 'keeping up in their field'. Maintaining one's certification is one means by which that need can be fulfilled."

Another point of contention is that the ABIM publishes physician certification statuses on its website as either "meeting" or "not meeting" MOC requirements. The ABIM said it would revisit this policy.

"The [ABIM] agreed that the current language used for reporting whether or not ABIM Board Certified physicians are meeting requirements in ABIM's new [MOC] program is causing legitimate confusion because many physicians hold some certificates which are grandfathered, or "lifetime" certificates. These physicians are encouraged but not required to participate in MOC for those certifications," the ABIM announced.

In June, the American Medical Association's House of Delegates voted to assess the feasibility of conducting an impact study on MOC's impact on the medical professional and patient outcomes.

The American College of Physicians' (ACP) Board of Regents issued this MOC policy statement in October:

"ACP does not support using participation in MOC as an absolute prerequisite for state licensure, hospital credentialing, or insurer credentialing. Instead, decisions about licensure and credentialing should be based on the physician's performance in his or her practice setting and a broader set of criteria for assessing competence, professionalism, commitment to continuous professional development, and quality of care provided."

To help physicians understand the program's requirements and prepare for their examinations, the ACP has developed an interactive tool called the ACP MOC Navigator, which is available on the ACP website.

Breaking down examination costs

American Board of Internal Medicine	
Internal Medicine certification exam:	\$1,365
Subspecialty certification exams:	\$2,200 (except for Adult Congenital Heart Disease, Advanced Heart Failure & Transplant Cardiology, Transplant Hepatology, Cardiovascular Disease, Interventional Cardiology and Clinical Cardiac Electrophysiology)
Subspecialty certification exam in cardiovascular Disease:	\$2,345
Subspecialty certification exams:	\$2,830 for Adult Congenital Heart Disease, Advanced Heart Failure & Transplant Cardiology, Transplant Hepatology, Interventional Cardiology and Clinical Cardiac Electrophysiology
Non-refundable late registration fee:	\$400
International test center fee:	\$500 (This fee is waived for active members of the military)
American Board of Family Physicians	
Application fee:	\$1,300-\$1,500
Late filing fee:	\$200

MOC requirements FOR INTERNISTS

Lifelong learning and self-assessment (part II):
Earn a total of 100 self-evaluation points every five years

- 20 points in self-evaluation of medical knowledge
- 20 points in self-evaluation of practice performance
- 60 points from either self-evaluation of medical knowledge, self-evaluation of practice performance or a combination of both

Practice performance assessment (part IV):
Earn a total of 100 self-evaluation points every five years

- 20 points in self-evaluation of medical knowledge
- 20 points in self-evaluation of practice performance
- 60 points from either self-evaluation of medical knowledge, self-evaluation of practice performance or a combination of both.

FOR FAMILY PHYSICIANS

Lifelong learning and self-assessment (part II):

- Must complete a minimum of one Self-Assessment Module (SAM) comprised of a 60-question Knowledge Assessment and a clinical simulation in a specific health care topic per each three-year stage.
- An average of 50 CME credits per year or 150 CME credits per stage.

Practice performance assessment (part IV):

- Diplomates must complete either a Performance in Practice Module (PPM) or an approved alternative module in each 3-year stage.

Next: Challenge #6

Challenge 6: Collecting co-pays and deductibles

ACA exchange plans place financial stress on physicians

Collecting on co-pays and deductibles has always been a challenge for physicians, but new plans created under the Affordable Care Act (ACA) have the potential to add to that burden in 2015.

Patients who sign up for plans under the ACA have a 90-day window within which to pay premiums. The American Medical Association (AMA) and other physician advocate groups warn that physicians can get stuck with bills from enrollees who take advantage of medical services during that time but then fail to pay premiums.

About eight million Americans purchased new health insurance plans through state exchanges or the federal marketplace site, Healthcare.gov, during the ACA's first enrollment period, which ended March 31, 2014, according to The Commonwealth Fund. About 67% of those enrollees had paid their premiums by April 15, 2014, according to responses from insurance companies gathered by the U.S. House of Representatives Energy and Commerce committee.

Many ACA plans have [higher deductibles](#) and co-pays than existing commercial plans. As a result, those plans could increase the provider collection burden as more patients purchase and use them. The AMA, which opposes the 90-day grace period provision, has developed resources to help physicians avoid getting stuck with unpaid bills.

It offers a step-by-step guide to the ACA grace period as well as a grace period collections policy checklist, model financial agreement language for patients receiving Advance Premium Tax Credits, and a sample letter for patients about the grace period. The AMA also encourages providers to verify insurance eligibility before a patient's visit and to document the information.

Physicians also should collect co-payments at the time of service and widen the window for payment options to include online and mobile payment processing, and to schedule automated and recurring payment plans that collect from credit/debit cards or directly from bank accounts.

The talk about cost needs to happen as early as possible in the patient-contact process, at pre-registration and maybe before they set foot in the office, says Nate Davis, MBA, product manager with ZirMed, a healthcare information technology and management company in Louisville, Kentucky.

"There needs to be internal training and education with staff about how to communicate upfront payments. Plus, there are plenty of payment plans possible that will work with patients with high-deductible plans," says Davis.

The fear among physicians, Davis adds, is that patients will spend more time talking about money than healthcare, and doctors just don't want to be the ones to have the conversation.

"Remind your patients to keep all of their paperwork and receipts from all of their doctor's appointments and from the pharmacy as well," Reed Tinsley, CPA, a healthcare consultant in Houston, Texas, told Medical Economics.

"They may need them for their insurer. Remind them they should carry their card at all times. If they don't have a card, they can contact their plan to get a card," he adds.

While claim denials have the potential to disrupt payments and strain physician practices, AMA research shows that claims denials have been dropping in recent years, down 47% in 2013 after a sharp increase in 2012 among most commercial health insurers. Some industry analysts speculate that claim denials may increase in the future because of ACA influence, but that trend has yet to materialize.

Physicians also face payer challenges from government agencies, including Medicaid. Medicaid often takes the longest to pay claims, and the federal/state program also has the highest claims denial rate. Medicaid has historically performed worse than commercial health plans and Medicare on key metrics such as days in accounts receivable, denial rates, and electronic remittance advice transparency. With large numbers of newly-insured Medicaid patients entering the market, physicians must be careful to safeguard themselves against Medicaid claim denials, notes the report.

Denials due to ICD-10 coding errors are also a concern for 2015. Laura Palmer, a senior industry analyst with the Medical Group Management Association, predicts a spike in claims denials after ICD-10 is implemented on Oct. 1, 2015.

"I would expect to see a multitude of denied charges for coding and billing errors when the industry changes to ICD-10," she says. "When diagnosis codes change to more specific coding, there may be mismatches with medical necessity and provider payment guidelines. Payers have not changed or may not have released their payment determinations for the new codes."

4 tips for addressing healthcare costs with patients

Start with their name Money and health are personal subjects. Addressing patients by name, and letting them know they are valuable to the practice is the first step in showing patients that you are looking for solutions and not blame.

Ask for payments the right way Don't ask patients if they will pay—ask them how they are going to pay. Don't make delaying payment an option right away, but be sure to mention payment plans if on-the-spot payment is an issue.

All staff members should be prepared

Every member of the staff should know about your practice's payment options and procedure costs. Patients may be more comfortable talking about finances with a nurse or physician.

Reminders are important When contacting patients for appointments, remind them that a copay will be due when they arrive, and have an estimate of costs available. Be sure to remind patients about payment plans, other options, and online portals if available.

Source: Nate Davis, ZirMed

The Centers for Medicare and Medicaid Services has warned that denial rates could increase 100% to 200% in the early stages of ICD-10 implementation unless practices get proper training.

Next: Challenge #7

Challenge 7: Administrative burdens

The link between busy work and burnout

If you feel like you're glued to your computer or tablet for much of the day, it's not your imagination. Many physicians say mounting paperwork is keeping them from spending enough time with patients. In The Practice Profitability Index, the percentage of physicians who spend more than one day per week on paperwork increased from 58% in 2013 to 70% in 2014.

This trend is eroding physicians' on-the-job happiness. "The physicians I know truly enjoy spending time with patients and teaching, and anything that takes them away from that is a negative," says Henry Borkowski, MD. In one sign of how squeezed many feel, 81% said they were overextended or at full capacity, according to The Physicians Foundation survey.

Prior authorizations are a major, and growing, source of physicians paperwork burden. More and more payers are requiring prior authorizations for more drugs and procedures. Consider, for example, that in 2013 21% of the brand-name medications covered under Medicare Part D required prior authorization, and 35% were subject to some form of utilization management. By contrast, in 2006 when Medicare Part D began, those numbers were 8% and 18%, respectively, according to a Kaiser Family Foundation study.

Another Kaiser study, from 2012, estimated that the nation's physicians spend more than 868 million hours annually on prior authorization activities. Payers say prior authorizations hold down costs, improve treatment efficacy and ensure patient safety. To physicians, however, they are an obstacle to providing the best care for their patients.

Technology-driven changes, from meaningful use to ICD-10, are one key administrative task that's taking up time. In a survey earlier this year by Deloitte, three quarters of physicians said despite increasing costs, electronic health record (EHR) systems do not save time.

From prior authorizations to struggles with implementing and operating EHR systems, physicians are increasingly struggling to squeeze patient encounters in between bouts of paperwork and other red tape.

"I can't stand saying it—and can't believe physicians say this—but patient care has almost gotten in the way of documentation and charting," says Michael Murphy, MD, who gave up medical practice recently to become chief executive officer of ScribeAmerica.

"Obviously, if you're in front of a computer and have all these different mandates of quality and ICD-10, you're going to see fewer patients and have less financial return," Murphy says. "That's what's driving a lot of physicians to sell their practice. On average, you're seeing 25% sustained productivity losses around the country. That makes it hard to keep a practice open and hard to give your staff raises."

Next: Challenge #8

Challenge 8: Rising operational costs

Why practice costs keep climbing

Strategies to increase revenue

Maximize your people
This means ensuring the highest and best use of all personnel, and ensuring the practice is taking advantage of the skills of their administrative staff and that clinical staff are working at the top of their license. High-performing practices emphasize communication, education, flexibility, and understanding of the practice's need to provide access.

Grow revenue through extended hours
With a growing emphasis on patient-centeredness and convenience, many primary care practices are adding office hours during early mornings, evenings, weekends, or some combination thereof.
Make sure you have or can build enough volume to fill the extra slots. "If we're just taking our 20 patients today and spreading them over nine hours instead of six, we're not doing ourselves a whole lot of good," says Marc D. Halley, MBA, president and chief executive officer of Halley Consulting Group. "But if you want to talk about cost control, getting more patients per square foot by adding another three hours in the day is a good strategy."

Choose technology wisely
Technology is supposed to help a practice, not hinder it. Identify what you want technology to do for you—increase ease of patient scheduling, eliminate phone calls, identify patients who need to be reached out to because of chronic conditions, etc.—and choose solutions that work. Patient portals are often included in EHR systems, tablets can often be a good investment to help staff engage patients, and a check-in kiosk can streamline flow through the office.

There is no denying the cost of running a practice is going up. Climbing overhead has hurt profits. Perhaps it shouldn't be surprising that, in this constantly changing ecosystem, more practices are struggling to maintain financial homeostasis. More than 84% of physicians surveyed by Medical Economics said their practices are doing the same or worse financially than a year ago, according to the 2014 Medical Economics Physician Practice Survey.

Dealing with rising costs was also the top daily challenge for medical practice executives in an August 2013 survey by the Medical Group Management Association (MGMA). Research by the group showed that the cost of running a practice had increased twice as fast as the consumer price index during the previous 11 years.

Staff and technology costs

Complaints about mounting overhead come as no surprise to Los Angeles, California-based healthcare attorney Mark Weiss, who represents both hospital-based and office-based physicians' practices. He often helps owners sell their medical practices.

"In general terms, my clients are seeing increasing operating costs," says Weiss. "The office practice doctors are seeing increasing rent, increasing rates for malpractice insurance and for directors and officers liability coverage, and higher health insurance costs in connection with their own staff."

Personnel costs, which have increased in recent years, are likely to keep rising. Competition with hospitals for employees has driven up wages, according to MGMA. "It is not so much with physician staff but with non-physician staff, with nurses, that they are seeing higher compensation expectations," says Weiss. Statistics back this up. The Clinical Advisor, a trade publication, found that the average salary among nurse practitioners was \$94,881 for 2014. In 2011, by comparison, average nurse practitioners' salaries ranged from \$75,556 to \$90,114.

Florence Comite, MD, the sole physician in a 16-employee endocrinology practice in New York, New York, is feeling the pinch of higher overhead in her practice. "The cost of employees has gone up. The cost of coverage for healthcare has gone up," she says.

Steeper regulatory challenges have also added to physicians' overhead:

Challenge 1: Because of requirements of the Affordable Care Act, 49% of physicians reported seeing profits at their practice dip, according to the Practice Profitability Index.

Challenge 2: ICD-10, the new, more complex medical coding system, is resulting in more software and training costs to practices. In a September 2014 survey conducted on behalf of The Physicians Foundation by physician research and consulting firm Merritt Hawkins, 50.1% of respondents said ICD-10 would cause severe administrative problems for their practices, and 38.3% said it would expose physicians to liabilities and penalties.

Challenge 3: Most physicians (85%) have transitioned to electronic health records to comply with meaningful use, according to The Physicians Foundation survey, compared with 69% in 2012. This isn't cheap. Published statistics from the Michigan Center for Effective IT Adoption says the average five-year total cost of an in-office system is \$48,000. For a cloud-based system, it's \$58,000. These costs are in addition to the bite into productivity that many physicians cite. In a recent survey by Medical Economics and market research firm MPI Group, nearly 70% of physicians said the transition to EHRs was not worth it and they would not purchase their systems again because of poor functionality and higher costs.

The Health Insurance Portability and Accountability Act (HIPAA), designed to safeguard patients' privacy, poses increasing challenges—and costs—for practices as more records are digitalized. Weiss represents several large practices that need to draft HIPAA business associate agreements with vendors—which means additional and higher legal bills.

"It's a much bigger job for their lawyers and own compliance people than it ever was before," Weiss says. "It's a whole level of compliance expenses. These aren't investments—they are really expenses."

And more old-fashioned paperwork for physicians, too. "We are bombarded with requests for record release," says Comite, whose team spends considerable time copying, collating and checking these files. "This is a cost you could impose on a patient, but you don't want to."

Make overhead costs work for you

When faced with this assortment of escalating costs, a common reaction is to slash overhead expenses, but there is only so far a practice can cut and still achieve the aims of quality patient care.

There are strategies that physicians and practice managers can use to put overhead expenses to work generating revenue, including better use of non-physician providers, expanding hours to increase productivity by providing greater convenience to patients, and leveraging technology to reduce inefficiencies and time waste.

"So if you're looking to save the world or save a practice by cutting costs, pretty soon you're cutting muscle, and then you're reducing productivity," says Marc D. Halley, MBA, president and chief executive officer of Halley Consulting Group. "Where you win or lose the game in a medical practice is on the revenue side of the balance sheet."

Next: Challenge #9

Challenge 9: Pay for performance

The shift to value-based payment continues

The drive to shift the nation's healthcare system away from fee-for-service and towards rewarding quality and outcomes will pick up steam in 2015, posing challenges for primary care physicians.

The latest phase of the push to reward quality will be the imposition of payment adjustments—financial penalties—for not reporting Physician Quality Reporting System (PQRS) data to the Centers for Medicare and Medicaid Services (CMS). Beginning next year, practices that had not reported PQRS data in 2013 will be docked 1.5% in their Medicare reimbursements. That amount rises to 2% in 2016.

In addition, under CMS' Value-based Modifier Program, Medicare reimbursements for group practices consisting of 100 or more eligible professionals (EPs) by 2013 will decrease by an additional 1%. The adjustments will extend to practices with EPs of 10 or more, then to all EPs, in 2016 and 2017, respectively.

Meanwhile, public and private payers alike continue to look for, and experiment with, alternatives to fee-for-service medicine—largely in the form of shared savings programs. Under such a program, providers band together to form an accountable care organization (ACO) and contract with a payer to provide care to a designated patient population during a set time period while meeting agreed-upon quality and cost benchmarks.

The problem for independent practitioners is that participating in, and benefitting from, alternatives to the standard fee-for-service payment model generally requires spending money upfront. Being part of an ACO, for example, often requires adding staff, such as case managers and care coordinators.

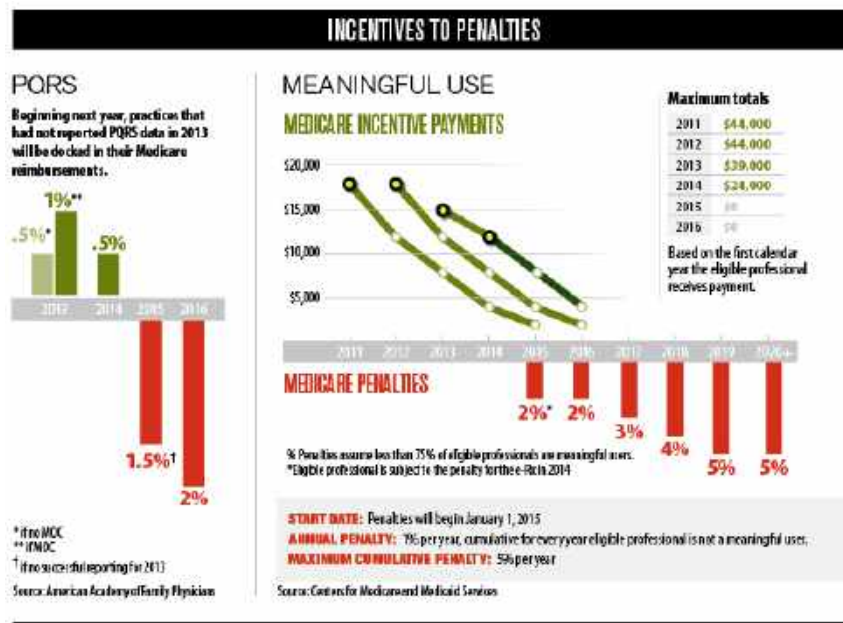
"In order to be part of an ACO you've got to have the wherewithal...and know what this is all about in the first place," says David Zetter, PHR, CHBC, principal of Zetter HealthCare Management Consultants. "And most smaller practices these days are struggling just to keep their doors open."

It's also unclear whether being part of an ACO is the right move, especially since the performance of many of the ACOs in various government initiatives has been lackluster. For example, the Pioneer ACO program's results from its first two years show that while some of the participating ACOs have saved money, others have actually increased their costs. Meanwhile, participants in the program continue to drop out. One recent dropout called the Pioneer program "financially detrimental."

Benefitting from a pay-for-performance model also requires the ability to collect patient data so that the provider can monitor outcomes, notes Reed Tinsley, CPA, a Houston-based practice consultant. "There is always more money behind knowing the clinical outcomes and data," he says. "A lot of doctors are saving payers money and not getting a piece of the pie."

Some health policy analysts believe that the first step in moving away from fee-for-service will come in the form of hybrid, or blended, payment methods that combine fee-for-service with some type of pay for performance method. And while hybrid approaches sound good in theory, they have yet to show that they can help doctors transition to a reimbursement system based only on quality.

"The resistance is because most of these models are really not designed to provide the capabilities for physicians to actually succeed," says Harold Miller, president and chief executive officer of the Center for Healthcare Quality and Payment Reform. "It has to be the right amount of money, delivered in the right way, with the right information, and the right accountability standards."



Next: Challenge #10

Challenge 10: Independence vs. employment

Physicians chafe at pressures to give up independent practice

For some physicians, joining a large hospital system offers a haven from the rising administrative burdens of staying independent and from competitive pressures that can drive a small practice into insolvency. But joining a hospital system is not a panacea for the challenges facing physicians.

Heena Rajdeo, MD, for example, joined a hospital system in 2011 after 30 years of being a partner in a two-physician surgical practice. But she soon found that she preferred independence to being someone else's employee. "Now I am going to have to invest everything," Rajdeo says.

Some physicians are returning to private practice because their compensation from hospitals became less attractive after the expiration of their initial contract, says Divan Dave, chief executive officer of OmniMD. During an initial "honeymoon period," he says, their pay was based on the previous three years of tax returns. However, after the contracts were up, the hospitals switched to performance-based pay, which ended up being lower.

Omni is helping three physicians, including Rajdeo, return to independent practice after being employed by hospital systems. "They got so upset at the hospital they are now converting their private practices back," Dave says. "One of the doctors said, 'I didn't go to medical school to work for someone. I went to be independent.'"

Indeed, for all the talk of the demise of private practice, the American Medical Association's 2012 Physician Practice Benchmark Survey found that 60% of physicians were working in physician-owned

practices compared with 29% who worked in a practice that was either partially- or wholly-owned by a hospital system. While the trend towards consolidation and hospital employment is continuing, the AMA data suggests it has not happened as quickly as many analysts expected.

Still, the pressures on independent physicians are such that more physicians are likely to seek to join a hospital in the coming years.

"As large networks acquire more and more physicians, they direct patients to their physicians," says Henry Borkowski, MD, a Waterbury, Connecticut cardiologist and member of the board of MPS ACO Physicians in nearby Middletown. "If you are outside of the network in most communities, that means the hospital systems or national networks will hire people to compete with you and take the losses up-front that are involved to ultimately get the patient base."

It is not a theoretical issue for him. Borkowski and his colleagues ran their Connecticut-based practice, Cardiology Associates of Greater Waterbury, independently for 37 years before affiliating with Waterbury Hospital two years ago. Lower reimbursements were a key motivating factor. "It was purely a financial decision," he says.

Survival tips for independent practice and employment

INDEPENDENT PRACTICE

- 1. Join forces:** Consider joining an independent physician association (IPA) to align with other physicians. Some physicians have found that membership helps them negotiate tricky situations where they might not otherwise get reimbursed.
- 2. Look for high-impact savings:** The major expense items that practices need to get right are occupancy and personnel costs. Find ways to save property costs and get the most from your employees.
- 3. Revamp billing practices:** Make sure that someone in the practice has clear accountability for checking that all services get billed can help eliminate work that isn't reimbursed through better claims management.
- 4. Ensure collections:** Check on referrals and insurance authorizations before providing services and ask patients for co-pays at the time of check-in.
- 5. Re-examine fee schedules:** If you are not part of a group that negotiates for you, you may discover that you're losing money in ways you may not be aware of. Regular re-calibration of your fee schedule could help.

Source: Medical Economics

EMPLOYMENT

- 1. Get it all in writing:** No matter how minor it seems, delineate responsibilities in writing.
- 2. Learn about compensation details:** It is to your advantage to be an expert on your compensation package and method. Knowing RVUs and quality-based compensation will be important.
- 3. Find out who to call:** Going from a private practice to a large corporation is a big change in culture, and finding out who to call when something goes wrong can be a problem. Make a flow sheet showing to contact and how to do so depending on the problem.
- 4. It's OK to make some noise:** It is better to fix a problem than worry about how you will be perceived.
- 5. Know your limitations:** Sometimes, other people do know their stuff and can teach you quite a bit. Get ready to listen when you find these people.

Source: David Nelson, MD

Next: Challenge #11

Challenge 11: Payers dictating healthcare

Why payer interference is increasing

Paul Sueno, MD, knew it would happen eventually, because his mentors told him it would. And sure enough it did: "I received my first request for an audit a few weeks ago for a Medicare chart," he says.

Fortunately, his staff has been scrupulous about record-keeping. "We document everything, within reason," he says. "We know if it's not documented, it didn't happen." Nonetheless, he doesn't know what to expect. "How this all is going to happen is still unclear to me," he says.

Physicians have to deal with a range of audits tied to meaningful use and other programs. The federal government can audit Medicare patients' charts, while individual states can audit records for Medicaid patients, since they fund Medicaid, up to 10 years after a patient's treatment, notes Tatiana Melnik, JD, an attorney specializing in technology and healthcare IT in Tampa, Florida.

"It's very important that they print out the information and keep it in a binder," Melnik says. "If the audit takes place six years from now they are still going to have to produce that information."

The audits are just one sign of a trend toward payers influencing—or some would say dictating—patient care that, for many medical professionals, can erode their satisfaction with their profession. In a RAND study that the American Medical Association released in October 2013, being able to provide quality care was a top driver of physicians' satisfaction—and factors that blocked this, such as payers' refusal to cover necessary services—eroded this.

It isn't just Medicaid and Medicare that are dictating patient care. According to the 2014 National

Scorecard on Payment Reform issued by Catalyst for Payment Reform, a San Francisco nonprofit that works on behalf of large healthcare purchasers, 40% of payments to hospitals and providers are designed to nudge them toward what the insurers consider better care. In some cases, payments reward more affordable care.

Factors like these remind Mary Ann Block, MD, a general practitioner in the Dallas-Fort Worth, Texas, area, of how prescient her decision to stay independent of these outside payers really was.

"I believe in the sanctity of the doctor-patient relationship," says Block. "That third-party—whoever it is—should not be in the middle of it."

Audits are not the only way payers are inserting themselves into the physician-patient relationship. Prior authorizations are another ways payers attempt to take decision-making out of the hands of physicians.

In addition, more payers are tightening their provider networks in an attempt to reign in costs. This move toward narrow networks means many physicians are being evaluated.

DROPPED BY A PAYER? WHAT TO DO NEXT

Notify patients While payers are legally obligated to contact patients to inform them that their physician is no longer in the network, physicians should call patients themselves to inform them of their options. "You should take it upon yourself to notify the patients yourself, especially if they are on the schedule for the next three to four weeks. You need to know whether the patient still wants to see you," says David Zetter, consultant with Zetter Healthcare Management Consultants in Mechanicsburg, Pennsylvania. Zetter also suggests writing a script to explain the situation and the options for patients, so whoever is calling patients will be prepared for their questions.	Get answers Contact provider and contract representatives in the payer organization to get concrete answers on why you were dropped. "If you find out a few other doctors you know were dropped, you can try to call the payer and get answers," Zetter says. "But you may not get far." Reach out An untapped resource for many physicians is local medical societies and organizations. County medical associations have led the charge in the fight against UnitedHealthcare in Connecticut, and have won legal victories for physicians. Physicians should use these groups as a way to make their voices heard.	Create payment policies Decide on a standard self-pay policy to offer to patients who still want to see a physician who is no longer in their insurance network. Your fees should be equal to the highest reimbursement you received from your third-party payers. "I don't recommend a standard percentage cash discount," Zetter says. "Your cash policy should be in writing because if you are charging people different prices, it could raise some issues with payers."
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Next: Challenge #12

Challenge 12: Patients dictating healthcare

The problem with patient satisfaction

Balancing the desire to practice quality medicine with the need to obtain positive feedback from patients promises to be a growing challenge for primary care physicians (PCPs) in 2015 and the years beyond.

As with anyone else providing services to customers, physicians have always wanted their patients to be satisfied. But government programs such as the Physician Quality Reporting System—which indirectly ties Medicare reimbursements to patient satisfaction scores—as well as the growth of websites devoted to evaluating doctors, the need to keep patients satisfied has taken on new urgency. But is that need affecting PCPs medical decision-making?

The answer is "yes," according to many practitioners. "Physicians are judged by their performance grade card, so to protect their livelihood they tend to modify their practice patterns, to be more productive and improve their scores," says David Fleming, MD, MACP, president of the American College of Physicians. "In all too many practices medicine is devolving into a metrics-centered business, rather than a patient-centered profession."

"The challenge for clinicians is that the goal of patient satisfaction isn't always aligned with the goal of providing high-value care," says Joshua J. Fenton, MD, MPH, associate professor of family and community medicine at the University of California, Davis. "I assume this is true in other specialties, but in primary care, there can be tension between what a patient wants and expects and what the provider believes to be clinically important and evidence-based."

William Sonnenberg, MD, FAAFP, board chair and a past president of the Pennsylvania Academy of Family Physicians, made the point even more forcefully in a 2013 editorial in *Keystone Physician*, the academy's journal: "The mandate is simple: Never deny a request for an antibiotic, an opioid pain medication, a scan, or an admission," he wrote. "And doctors face the reality that uncomfortable discussions on behavioral topics—say, smoking or obesity—come with the risk of a pay cut. Satisfied patients are not healthy patients."

Sonnenberg goes on to recount anecdotes such as an emergency department that dispenses Vicodin "goody bags" to all discharged patients so as to improve their Press Ganey patient satisfaction ratings, and a physician who reported upping his satisfaction scores by 7% by prescribing an antibiotic for any patient with complaint of a cough, sore throat, or sinus headache.

Sonnenberg's conclusion is supported by results of a 2012 study of patient satisfaction, healthcare utilization, expenditures, and mortality published in the *Archives of Internal Medicine*.

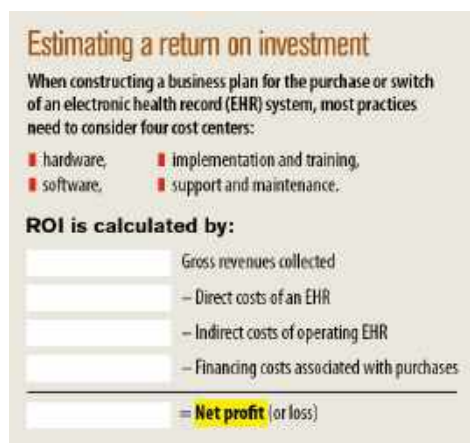
The authors found that "higher patient satisfaction was associated with less emergency department use, but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality."

While the measurement and reporting of patient satisfaction scores likely will continue, it doesn't mean doctors have to give in to every patient demand, notes Sonnenberg. "We should try to be kind to our patients and take time to understand them, but...sometimes patients have to be told 'no,' and the leadership in healthcare must understand this."

Next: Challenge #13

Challenge 13: Keeping pace with technology

Technology burdens and the medical practice



Information technology costs have soared in physician practices in recent years, and they're not expected to drop in the foreseeable future. Even if meaningful use went away tomorrow, notes David Zetter, PHR, CHBC, a practice management consultant in Mechanicsburg, Pennsylvania, there would be additional IT costs for Medicare programs such as the Physicians Quality Reporting System (PQRS) and the Value-Based Payment (VBP) Modifier Program.

The Medical Group Management Association (MGMA) also blames IT for much of the rise in group practices' administrative costs. The 2014 MGMA Cost Survey finds that the

median cost of business operations staff—including IT staff—is now about \$52,000 per full-time-equivalent physician. MGMA attributes much of this expense to meaningful use and the other government programs that Zetter cites.

Nearly every practice has computers, even if it only has a practice management system, Zetter notes. The cost and complexity of both hardware and software increase substantially when the practice adds an EHR. In addition, he points out, support and maintenance of these systems are expensive. To start with, practices must either pay their EHR vendor an annual maintenance fee (typically, 18% of the software cost) or pay for each new upgrade.

Technical support presents additional challenges, especially for smaller practices. Since they can't afford an IT department or even a staff member dedicated to IT, these practices usually hire a local computer service company to support their EHRs. Such firms can be skilled at maintaining computer networks, but they don't necessarily understand the intricacies of

EHR software or how to perform the kind of security assessments that meaningful use requires.

"There are plenty of people who know how to do IT and networking, but they may not know about the healthcare industry," Zetter says.

To keep costs down, many practices have selected low-cost or free EHRs. Those products work well for some physicians, depending on their circumstances, Zetter says. But some practices have found that such EHRs fall short of their expectations, he notes.

Experts are divided over whether the five-year cost of cloud-based EHRs is higher or lower than that of on-premises, client-server systems. Yet more and more practices are moving to cloud-based EHRs and billing systems, especially if they're seeking replacements for current products. This is partly about avoiding the upfront cost of new software and computer.

Next: Challenge #14

Challenge 14: Staff retention

How to keep your staff superstars happy

Ask any consultant, and they will tell you that a practice is only as good as its employees.

As more payers gravitate toward value-based payment models and increased emphasis is placed on effective team-based medicine, maintaining staff will be critical to practice success.

Yet, recruiting and retaining top talent continues to be a challenge for many medical practices.

Staff turnover can be a significant drain on both practice revenue and resources. The

Center for American Progress estimates that for workers earning less than \$50,000 annually, it will cost employers approximately 20% of that employee's salary to find a replacement. As some practices face shrinking revenue under fee-for-service models, Deborah Walker Keegan, PhD, FACMPE, a healthcare consultant for Medical Practice Dimensions and Woodcock & Walker Consulting, says they may look at reducing their staffing size. "At some point, unless other changes are made to recognize these staff in terms of both tangible and intangible rewards, staff feel overworked and underpaid," she says.

3 strategies to retain quality employees

- 1 Staff engagement**
where employees work with managers to improve processes;
- 2 Care teams**
where work is delegated to the appropriate level and everyone plays an important role; and
- 3 Get paid for the work**
Recognition, which may extend beyond wages, including flexible hours and educational rewards.

Source: Deborah Walker Keegan, PhD, FACMPE

"These practices recognize that each member of the care team is vital to the success of the whole," Keegan says. "They expect high engagement and performance, while at the same time creating a practice where staff feel their work is valued and makes a difference in patients' lives."

Complexity is impacting practices both clinically and administratively, she says. When staff members are faced with additional workload, often it is without first being provided with the necessary tools and education. Also, uncertainty has some staffers feeling insecure in their employment as healthcare continues to change, Keegan says.

"Faced with this challenge, some staff go about their day racing from one task to another, feeling increasing stress as they try to accomplish multiple, often competing demands," Keegan says. "They feel they cannot get out from under the weight of the work and are not able to do their very best work. As a consequence, some staff members are seeking jobs that are more defined (and less chaotic)."

Successful practice managers must walk in their staff's shoes in order to keep them happy at work. Addressing workplace issues that seem minimal to you can go a long way. Also, pay must remain competitive.

"Your employees can reach superstar status only if their lower-order needs are met: The paycheck is good and working conditions are fair," says Judy Bee, practice management consultant with Performance Practice Group in La Jolla, California, and a Medical Economics editorial board member. "Good employees may leave because they are lured away (someone else promises something missing in your practice) or because they are driven out (something in your practice is intolerable)."

Bee says to reward employees in meaningful and creative ways. Extra paid time off, gas and other gift cards and tuition assistance for dependent children can solve employees' problems that may hinder workplace performance.

"In today's world of declining reimbursements, lower revenue means budget pressure on staff

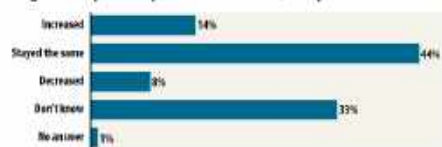
compensation. But that is the employer's problem to deal with," Bee says. "Physicians and managers should never talk about such matters in the presence of the staff because it can cause anxiety about job security, which can lead to distracted job performance and behavior."

Next: Challenge #15

Challenge 15: Avoiding liability

The ACA'S impact on malpractice

Change in malpractice premiums for 2013, compared with 2012



The influx of patients stemming from the Affordable Care Act (ACA), could be contributing to added medical malpractice claims.

A 2014 report from Aon Risk Solutions projects the frequency of claims per class 1 (internal

medicine) physician in 2014 to be 3.37%, and the severity of claims to be \$185,000 per claim. The projected frequency of claims by Aon in 2014 was 2.97% per class 1 physician, with a price tag of \$203,000 per claim.

Aon projects the loss rate for physician professional liability to be \$6,230 per class 1 physician for incidents occurring in 2015, up from \$6,030 in 2014.

The 2015 projected loss rate for hospital general liability is \$125 per occupied bed versus \$119 in 2014, while the average general liability claim is expected to be \$38,000 for claims occurring in 2015, up from 2014's projection of \$36,000. The report draws on data from all U.S. states and provides specific benchmarks for 27 states and the District of Columbia.

According to the report, Florida (\$7,920) has the highest projected loss rates for 2015 at \$7,920, while Indiana, (\$800) and Minnesota (\$770) have the lowest. While the expanded market might increase claims, premium prices have been holding steady for several years. The median level of annual premiums paid by family/general practitioners in 2013 was \$11,900, unchanged from the prior two years.

Since 2009, median annual premiums for family/general physicians have dropped by 5.8%, and premiums for internal medicine practitioners have come down by 11.7%, driven largely by greater competition.

As a way to avoid potential liability, some physicians report practicing defensive medicine. Erring on the side of caution, physicians order more diagnostic procedures than might be necessary to head off litigation.

But a new study suggests that the overuse of resources might have less to do with avoiding liability than with routine. RAND Health and RAND Institute for Civil Justice looked at emergency department data from Medicare patients from 1997 to 2011 in three states that raised standards for malpractice liability. The new standards essentially required patients to prove that physicians consciously disregarded the need to use "reasonable care."

The study found that "legislation that substantially changed the malpractice standard for emergency physicians in three states had little effect on the intensity of practice, as measured by imaging rates, average charges, or hospital admission rates."