



3rd Quarter 2021
Issue 16-059

MGMA COLORADO

Colorado Connection

The Official Newsletter of Colorado MGMA

Upcoming Events

WEBINAR

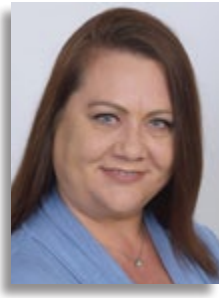
Preparing for the Future of Value-Based Care
Tuesday, November 9
11am

• • • •

Getting Ready for 2022: Reimbursement & Coding Changes
Wednesday, Dec 15
11am

THURSDAY, NOVEMBER 18

For more information, visit www.cmgma.com



From the President

Tawnya Wartell, FACMPE
Practice Administrator Colorado Cardiovascular Surgical Associates, PC

Dear CMGMA Membership,

It is an honor and privilege to be your new CMGMA President. I look forward to leading the association for the next year. However, I know that I do not stand here alone. I am a member of a fantastic board who will help carry me successfully through my tenure. I recently attended the MGMA State Leaders conference in San Diego and it just reiterated what I already know–Colorado has one of the top performing and engaged boards compared to many other associations. I walked away proud to be able to represent Colorado and discuss all of what our state should be proud of. Top of the list is the commitment our 2019-2020 board made to stay in our roles to get us through the pandemic. Past President Bonny Brill lead us through 2 years with her extended presidency and devotion to CMGMA. At the conference I heard over and over how many presidents stepped down and boards dissolved due to the Pandemic. Colorado stood strong allowing CMGMA to be able to continue to provide great content to our members. Thank you to Bonny for handing over your strong presidency to me. I promise to carry on your hard work and dedication.

Our Colorado chapter has always been driven by our members. We strive to provide educational content and opportunities to make managing medicine that much more successful. In addition, we are always working to expand our membership to bring in more thought thinkers and networking opportunities. The bigger we are the better we are. I encourage everyone to take advantage of all we have to offer and hopefully meet some new colleagues along the way. I have met so many great people over the years and that is not only what makes MGMA extraordinary but makes me more successful in my day-to-day job. Over the next year, please take advantage of our lunch and learns, webinars and social events. Bring a friend or coworker and let them experience CMGMA along with you.

I look forward to seeing many of you in person this year and hoping to see some new faces. I feel great momentum as I begin my presidency and excited to see what the year brings us.

Welcome to the 2021-2022 CMGMA year.

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MGMA® COLORADO

From the Past President

Bonny L. Brill, CMPE, CMRS
Practice Manager, Colorado Colon & Rectal Specialists

Healthcare Superheroes – Going Above and Beyond the Call of Duty. What a befitting theme for Colorado MGMA's 2021 Fall Conference held September 23-24! It was great to see familiar faces—and great to see so many new ones. This year we offered two pre-conference workshops the afternoon before. *Building a High-Performance Culture,* co-sponsored with Colorado Medical Society, was facilitated by nationally recognized speaker Matt Griswold. He focused on the 'why' and 'how' leaders drive positive cultures. Concurrently, Cristian Lieneck, PhD, FACMPE, FACHE, FAHM, CPHIMS, led a study group and offered practice exams for those pursuing CMPE certification. Dr. Lieneck is Associate Professor—School of Healthcare Administration at Texas State University. We hope to invite him back to lead future CMPE study sessions.

For those who attended the conference, I hope there were many takeaways for you. Merit's '*Are you open to…*' and Avish's '*Yes, and…*' are two simple phrases that can effectively change the temper of our conversations; Kyle's storytelling session closed the conference and inspired us all. It was a dynamic line up of speakers; they gave us tools to help us improve, and delivered important topics including updates on new laws and regulations, emerging technology, and revenue cycle management. I was especially impressed by how interactive the sessions were and how engaged everyone was. You can find speaker handouts at www.CMGMA.com under Events/Fall Conference. For those who could not attend, I hope you join us next year.

Thank you to CMGMA 2021 Fall Conference sponsors, exhibitors, and speakers

CMGMA 2021 Fall Conference highlights:

- Here I come to Save the Day: Why Mighty Mouse Must Have Been in Healthcare – Merit Kahn, CSP
- Building a High-Performance Culture – Matt Griswold and Diana Royalty
- Developing an Inspired Leader: How to Get People Out of Their Cave and Into the Sun – Aimee Greeter, MPH, FACHE
- Presenting Financial Information to Physicians – Maddox Casey, CPA
- Legislative Update – Eric Speer, FACMPE
- Effective Listening and Your Personal Brand: How to Build and Enhance It – Maddox Casey, CPA
- Managing HR Decisions in Post Pandemic Times – Jacqueline Guesno, JD
- Leveraging Technology to Grow Your Practice – James Capps
- Breaking Down the Silos – Matt Griswold
- Communication Styles – Matt Griswold
- The Super Power of Effective Listening – Kyle Dyer West

In closing, it has been an extraordinary honor to serve as CMGMA president these past two years. I have met many wonderful people and made special friendships along the way. As I said at the conference, most challenging has been how best to lead and inspire my peers—you are far more qualified than me in many aspects. Thank you for teaching me how to listen, learn, and lead better. Above all, special congratulations to my friend Eric Speer, FACMPE, and CMGMA past president for being awarded the prestigious 2021 CMGMA Lifetime Achievement Award. Eric, you exemplify the best of CMGMA.

We are what we repeatedly do.
Excellence is not an act, but a habit.
~Aristotle

Conference 2022
Save the Date
September 14-16
Embassy Suites
Loveland, CO

It's time to break the mold: Healthcare operations and technology are due for an extreme makeover

By Marion Jenkins PhD, FHIMSS

You can order a pizza, groceries, school supplies and even make an airline or hotel reservation, just by using any connected device in your home, including smart speakers, your TV and beyond. You can track the progress of your pizza being prepared or your product being shipped down to a few minutes or a few meters. Security is handled painlessly with your choice of authentication method using your fingerprint, your voice pattern, a facial scan or a QR code. Need to modify a reservation or exchange an item? That's equally easy for the end user.

But healthcare? Welcome to a world still heavily consisting of clipboards and paper forms, with many onerous and manual processes that still rely heavily on printing, scanning and faxing. This creates duplicative data entry, which is not only time-consuming but prone to errors as well. In a recent study, up to 20% of patients surveyed reported errors in their EHR records, with a substantial number of those errors deemed serious.[1]

Where technology does exist, the systems are cumbersome and siloed, requiring patients and staff to maintain disparate login information for dozens of different URLs and applications, which frequently work on one kind of platform (e.g., browser, operating system or smartphone) but not another. Every user interface is different, and for most users–especially healthcare providers–the technology experience frequently detracts from good patient care.

The COVID-19 pandemic severely strained all businesses, as they were forced to deal with drastically altered service delivery models, disrupted workflows and supply chains, along with mandatory social distancing. Most businesses quickly pivoted to modify processes and adapt technology to minimize contact and wait times and generally improve operations, such as implementing automated texts and just-in-time curbside delivery, direct messages and instant updates on wait times and product availability, and using web tools to provide more extensive and more timely information to their customers. In other words, the crisis forced businesses to streamline operations to gain much-needed efficiencies and improve the user experience. Whole new paradigms emerged in delivering better service, and most businesses have pivoted away from legacy processes that no longer fit the mold.

Healthcare, however, merely did what it has always done in the face of new compliance requirements or workflow changes: It added more layers of processes and forms. Even in cases in which the added processes were digital, it was usually not integrated into a seamless user experience and integrated data flow, and it certainly did not create any efficiencies. New ad hoc processes to quickly incorporate telehealth visits and support a remote, virtual workforce created additional pressure on what were essentially brittle and poorly designed systems and processes in healthcare.

This forced medical practices into a precarious middle ground, caught between virtual and physical worlds of healthcare delivery.

Now that things are returning (somewhat) to pre-pandemic routines, many practices unfortunately seem to be returning to the "old way," bringing back processes that should have been eliminated long ago or keeping old legacy processes and the new pandemic-prompted processes in parallel, exacerbating the inefficiencies.

The pandemic is merely the latest example of compliance issues increasing the burden on systems and processes in healthcare. MIPS, MACRA, sexual orientation/identity, financial policies, HIPAA disclosures and permissions to treat are just a few additional recent examples where more layers were added instead of finding streamlined ways to comply with new requirements.

Healthcare has always lagged behind other industries in automating processes, despite tremendous spending under the American Recovery and Reinvestment Act (ARRA) and the HITECH Act, not to mention the spending by providers themselves. This spawned hundreds of EHRs[2]. Sadly, providers soon discovered these EHRs were just glorified billing systems and electronic medical record repositories, lacking basic automation features they needed to run their clinics more efficiently, such as patient intake, patient payments, messaging, reminders and patient education. This, in turn, spawned hundreds more "add-on" products to fill the gap. This patchwork technology is one of the reasons CMS has mandated increased interoperability and data sharing[3], though with limited positive impact.

The back-office staff has jerry-rigged the use of technologies such as printing, scanning and faxing to replicate their highly manual

Continued on page 5

workflows. In most cases, old processes have not been optimized or killed off to take advantage of truly game-changing technologies–sometimes new technologies were selected precisely because they replicated existing processes. The battle cry seemed to be, "Give us technology that requires the least change."

Despite all this money and effort and new products, the healthcare technology landscape is a wasteland. This is indeed unfortunate, given that many measures show healthcare to be the most consequential part of the U.S. economy[4].

Patient experience

Patients are asked to arrive 30 minutes early for appointments, only to find out (after they arrive) that their provider is running an hour late. Patients are usually still presented with a clipboard containing some paperwork, even if a kiosk, tablet or online forms platform is also involved. And now because of COVID-19, they still have to sit in a half-roped-off waiting room or in their cars.

These inefficiencies are frustrating to all concerned and make it harder to practice social distancing, which increases the risk of infection. This isn't just a recent COVID-19 issue–there has always been a problem with potentially infected people sitting in waiting rooms.

Patients are barraged with different technology systems and different processes, even within a single practice, with disparate interfaces, logins and security protocols. Most practices have multiple different systems for the patient to deal with, including appointment reminders, patient portals, insurance verification, check-in, medications, X-rays, labs, compliance matters, satisfaction surveys and many others.

And when you think of a patient's experience going from one practice to another, one can easily see how frustrations mount exponentially.

John Hughes, chief financial officer of Ventura Orthopedic Medical Group, recently reflected on his experiencing getting a new driver's license after moving to a new state. "Even the DMV now has better technology than healthcare," Hughes said. "I can sign in on my smartphone and see what the wait times are, schedule an appointment, and I can magically see how I move up in the queue before I even leave my house."

Staff experience

Patient-facing staff are already buried in a jumbled mix of legacy paperwork and different electronic devices and systems, and then they have to deal with frustrated patients and family members, repeatedly explaining (and apologizing for) the delays and lack of clarity and the sheer difficulty in just getting an appointment.

Now because of COVID-19, the staff must juggle additional manual phone calls to shepherd patients from waiting in their cars to entering the clinic. It's no wonder staff burnout and turnover are high.
Despite automation, nearly every patient encounter still involves some physical paperwork. It is safe to say that, not only has healthcare not gone paperless–there's more paper than ever. Massive and expensive multifunction printers, along with a huge proliferation of desktop printers and scanners, are the norm in healthcare; whereas in most businesses the use of these technologies have vastly diminished.

Provider experience

Providers have an ever-increasing burden to document everything, and the automation tools that were supposed to reduce or even eliminate this drudgery has instead forced them to contend with cumbersome and often quirky technologies and systems, requiring them to click through dozens of screens and drop-down lists. Physician burnout and dissatisfaction are at an all-time high, and "technology fatigue" and dissatisfaction with EHRs are at the top of most surveys in the literature[5].

Fee-for-service payment models have forced doctors to maintain large waiting rooms and fill them with patients stacked like raw materials in a factory setting. Hoping patients won't notice this too much, there is virtually a waiting room "arms race" for more creature comforts. The ubiquitous lobby fish tank and worn copies of Highlights magazine have been replaced with coffee bars, aromatherapy units and giant flat panel monitors with hundreds of channels. In fact, grand opening announcements of a new medical office typically feature pictures of the fabulously attractive new waiting room.

Amid COVID-19, the waiting room density must be sharply reduced, leading to the prospect of having to devote even more nonclinical space to waiting rooms in the future.

Solution

So how can we dig out of this mess? How can we get rid of or sharply reduce duplicative paper forms, fax machines, scanners, waiting rooms, check-in front desks and clipboards?

Stop buying more products and systems, especially add-on systems that create more interfaces to your EHR. This is costly and inefficient, as maintaining all the separate systems and interfaces impact the clinic. If you have 12 add-on systems (we typically see twice that amount and more), and each system has an update once a year, then you will be continuously upgrading every month of the year.

Look closely at your workflows and operations and stop looking for products and systems that merely automate what are in essence inferior processes in the first place. Processes should be reengineered before they are automated[6].

What if Amazon merely decided to design tech to speed the flow of shopping carts up and down the aisles of megamalls? What if Uber had merely created a massive, centralized call center with thousands of agents and a single, easy-to-remember 1-800 number so you could get a cab anywhere in the country with shorter phone wait times? What if Google just stopped at making a web search engine for all the books in the Library of Congress? Think of all the innovations that occurred because smart people worked together to think beyond merely making existing processes faster and/or digital?

As Jeremy Ealand, chief operations and technology officer, Sierra Pacific Orthopedics, notes, healthcare delivery largely has gone unchanged in the past 100 years, from the days of house calls to the traditional patient visits in a clinic.

"We can no longer continue to grow by increasing patient volumes and relying on existing processes, putting even more stress on providers, staff and patients. We have to find efficiencies in all areas –staffing, real estate, patient flows, etc.," Ealand said. "We need new ways of thinking to figure out how to incorporate technology beyond just supporting billing and compliance. We have to have a better patient/provider experience."

Continued on page 6

Work with technology vendors to demand change. Refuse to accept the infrequent once-or-twice yearly software updates. Don't continue to pay for bug fixes that should never have been there in the first place. Get much more involved with EHR and other user groups and make them more than just a booster section for their corporate leadership. This isn't about being adversarial; it's about collaborating with your technology partners and demanding consolidation of systems, breaking down silos and creating more user-friendly interfaces. Drop vendors who only want to sell you some new product or system; instead, seek out and work with technology partners who want to help you solve operational problems, regardless of whether it helps them sell a product or consulting service.

Many practices and providers seem to hate their current EHR and want to change, and the depth and breadth of this dissatisfaction is borne out in numerous industry surveys[7]. What these surveys clearly show is that there is no good EHR, because if there was a good EHR, everyone would be on it. In the end, almost every "top-ranked" EHR is top ranked in some highly selective category. Why change from something that is terrible to something that, at best, is merely less terrible?

The time, expense and impact of selecting and implementing a new EHR is extremely significant. Consider spending that time and money working with your current EHR provider to make it better. An old version might need upgrading, and your team likely could benefit from more training and optimization. It will require work and spending, but it will likely be a fraction of what would be involved in a rip-and-replace action. Unless your EHR is at risk of being sunsetted or decertified, or your EHR vendor has lost a significant part of its core brain trust of critical engineering and/or customer-facing talent (which frequently happens after an acquisition), there is little rational justification for changing EHRs.

Stop designing and building new medical offices with elaborate and wasteful waiting rooms. Instead, spend the time and money on creating ways to change your processes and utilize technology to sharply reduce the waiting process. Then partner with the right design team–one focused on making the physical space support better processes, rather than making your waiting room look like the Ritz.

Bruce Cohen, MD, practicing surgeon and chief executive officer of OrthoCarolina, echoes the need to avoid adding more real estate for clinics.

"I don't want more and bigger and fancier waiting rooms. I may not even need a front desk," Cohen said. "We need to figure out how to design new processes and new technologies to reduce or even eliminate those constructs. We need to use our resources more efficiently, whether it's people or space. It will require a completely different way of thinking, because what has worked in the past won't work in the future."

One of those people working to make those types of design changes is David Baker, director of Health Facility Advisors. "We are doing everything possible on the facility design side to work with practices to maximize useful clinic space and support more efficient workflows that take advantage of newer technologies," Baker said.

"Much less space is needed for large waiting areas, check in/check out desks, space for printers, copiers and fax machines, plus associated supply storage," Baker added. "Clinics can be more open and more productive, resulting in a better experience for patients, providers and staff, with lower overhead and better profitability."

It is well past time for physician practices to stop complaining about poor technology and operations, and instead do something about them. Look to where you can optimize workflows and streamline operations, and partner with the right type of healthcare technology firms and space planners to improve the process.

By working together, we can bring real and lasting change–including lower costs and a better experience–to patients, providers and staff.

Notes:

1 Bell SK, Delbanco T, Elmore JG, et al. "Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes." JAMA Network Open. 2020;3(6):e205867. doi:10.1001/jamanetworkopen.2020.5867

2 ONC. "Certified Health IT Product List." Available from: bit.ly/2Z2FAgA.

3 Gans DN, Jenkins M. "21st Century Cures Act: After 10 years of broken promises, is EHR interoperability finally at hand?" MGMA Connection, September 2019. Available from: mgma.com/21stcenturycures.

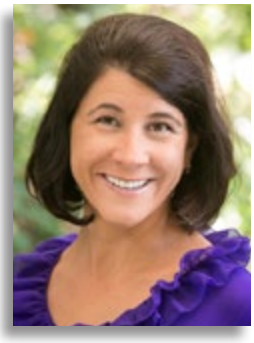
4 Nunn R, Parsons J, Shambaugh J. "A dozen facts about the economics of the US healthcare system." Brookings Institute. March 10, 2020. Available from: brook.gs/3zGC36A.

5 O'Reilly KB. "New research links hard-to-use EHRs and physician burnout." AMA. Nov. 14, 2019. Available from: bit.ly/3DH8h48.

6 Enginess. "Why You Should Improve Business Processes Before Automating Them." Oct. 10, 2018. Available from: bit.ly/3BBqRIZ.

7 Sukel K. "Switching EHRs." Medical Economics. Jan. 5, 2020. Available from: bit.ly/2WHzAe0.

Your guide to ACMPE credentialing opportunities



Gena Weir, FACMPE
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MGMA offers professional accreditations from the American College of Medical Practice Executives (ACMPE) ranging from Certificates to Board Certification and Fellowship to help you in any stage of your career.

Certificates: After completing an online seminar, you will receive a verified certificate and credential through MGMA's certifying body proving completion and understanding of a topic or specific skill set. No membership, education, or experience required to complete a Certificate.

Board Certification: The Certified Medical Practice Executive (CMPE) promotes professionals who possess the standard knowledge based on the Body of Knowledge (BOK) to lead each aspect of a practice. MGMA membership required.

Fellowship: After obtaining your CMPE, demonstrate your mastery of the healthcare practice industry and become a Fellow in the American College of Medical Practice Executives (FACMPE). Fellows are the thought leaders within healthcare organizations and demonstrate the ability to execute on dynamic solutions to business problems and contribute to the advancement of medical practice leadership.

Find the best fit for you and get started today!

Your Digital Front Door

Elizabeth Woodcock, MBA, FACMPE, CPC

By Elizabeth Woodcock, MBA, FACMPE, CPC

Open the (Digital) Door

It will be many years before we determine the long-lasting impacts of the pandemic on medical practices, but there is one effect that is already crystal clear–patients' expectations for a digital front door to their physicians. The migration to a digital interface for your patients need not be frightening, as it can be accomplished without significant investment. There are third party vendors that can handle the function for you, for a price. Alternatively, you can set up a basic interface to allow your patients to request an appointment online, but then manually process it on the back end by keying it into your scheduling system. To your patients, this looks like a digital front door, but it can easily be merged into your current workflow. Of course, there are advanced options as well, with many vendors ready to serve the market. To get a sense of the options, reach out to your EHR vendor to seek their advice–or do a quick Web search using key words like "patient self-scheduling."

As technology evolves, it's important to recognize that you're not going to hear patients asking for this function–it's an expectation. When you log onto Amazon to order a product or when you do an online search for a restaurant your friend told you about, and you can't find what you're looking for, you don't report your frustration–you just move on to the next option. That's exactly what's happening in health care right now; by making a small investment in some digital entry points for your patients, you can make sure they have the access they expect. Plus, you'll enjoy some direct benefits–opening a digital front door results in fewer incoming phone calls and more patient arrivals (as self-scheduling is associated with a reduction in no-shows).

Virtual Care Assistant

If you determine that virtual care will be a permanent component of your medical practice, it's essential to have the resources to execute the workflow effectively. This includes a staff member(s) who can support the effort. Preparing for virtual visits, conducting patient outreach, providing support during care transitions, interpreting test data from mobile health devices, and other related tasks expands the work scope of traditional staffing models. Although some practices have attempted to assign current staff the additional responsibilities of remote care, others have created a staffing model that is separate and distinct from the traditional face-to-face visit, with one person (or team) dedicated to remote care and another to in-person care. (See the sample Task Distribution guide below.) The virtual care assistant may be a permanent position–or may be rotated between medical assistants. The latter is a terrific way to boost staff morale as the role can be performed from home.

Regardless of how the responsibilities are structured, the key is to ensure that there is a proactive approach to understanding what tasks are involved with virtual care–and who's going to do them. Otherwise, the virtual care tasks get swept aside as the in-person care is prioritized. This leads to challenges that may have implications for patient quality and safety. Take the opportunity now to define and design a virtual care assistant.

Sample Task Distribution: Virtual vs. In-Person

Virtual	In-Person
• Pre-encounter scrub	• Clinical intake/rooming
• Virtual patient communication	• Clinical support
• Care monitoring	• Medication preparation & administration
• Virtual clinical intake/rooming	• Training, education, & instructions
• Result communication	• Orders; referrals for care
• Preventive care management	• Phlebotomy; office testing
• Other	• Other

UPCOMING WEBINARS

MGMA STATE AFFILIATE MEMBER WEBINARS

Preparing for the Future of Value-Based Care & Increasing Your Quality Performance Bonus

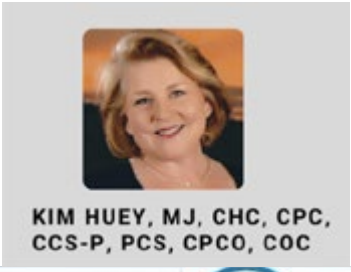
Tuesday, November 9
11am MST

ACMPE CREDIT AAPC Advancing the Business of Healthcare

Click here to register

Getting Ready for 2022: Reimbursement & Coding Changes

Wednesday, December 15
11am MST



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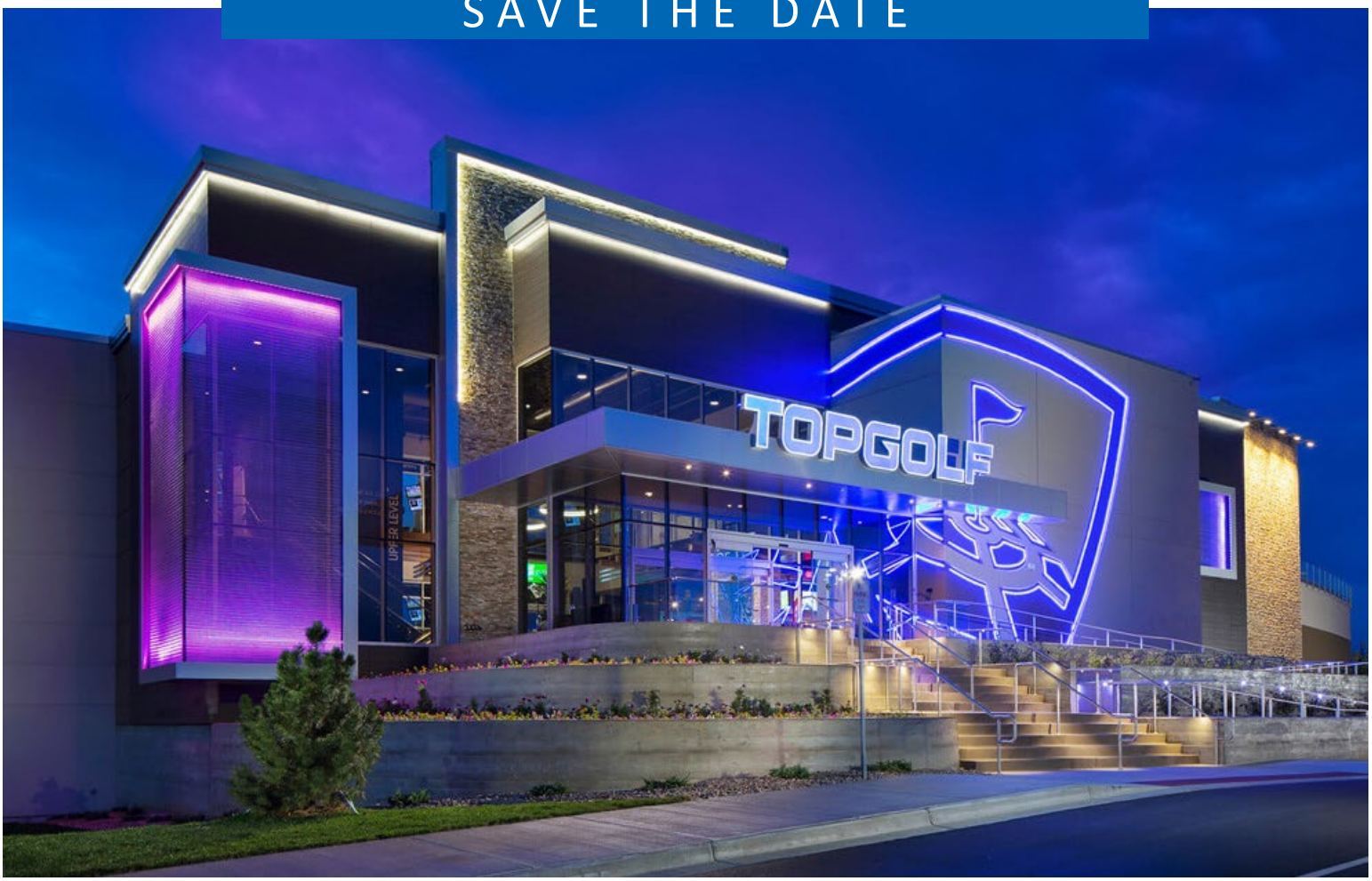
CMGMA Webinars are FREE for members!

SAVE THE DATE



TOPGOLF

THURSDAY, NOVEMBER 18

MGMA COLORADO CAHE COLORADO ASSOCIATION OF HEALTHCARE EXECUTIVES

CMGMA and CAHE are teaming up! Join us at Topgolf Centennial for a night of networking, food and fun. You do not have to be golfer to enjoy the evening!

We are excited to be collecting donations for the Denver Santa Claus Shop and we would love for you to please bring an unwrapped toy to contribute to our annual toy drive.

Space is limited, register today!

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COLORADO
Department of Health Care Policy & Financing

Dear Provider,

Pursuant to Section 6032 of the Deficit Reduction Act of 2005 (DRA) any entity that receives or makes payments totaling at least $5,000,000 annually must have certain written policies and procedures in place that are readily available to all employees, contractors, or agents.

An entity includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), for-profit **or** not-for profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of the DRA apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies when the entity submits claims for payments using one **or** more provider identification or tax identification numbers.

If identified as an entity subject to the requirements of the DRA, providers must:

- Establish, disseminate and maintain written policies for all employees, including management and the employees of any contractors or agents, that include detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)).
- Include in those written policies detailed information about policies and procedures for detecting and preventing waste, fraud, and abuse.
- Include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of policies and procedures for detecting and preventing fraud, waste, and abuse. **Note**: An employee handbook does not need to be created if one does not already exist.

Entities subject to the DRA must complete and return to the Department the DRA Declaration. Entities with multiple identified locations must send one DRA Declaration with an attachment listing all NPIs and service location IDs covered by the DRA Declaration. The DRA Declaration is located on the Deficit Reduction Act of 2005 web page.

The completed **DRA Declaration** must be emailed to hcpf_draact2005@state.co.us no later than **November 1, 2021**.

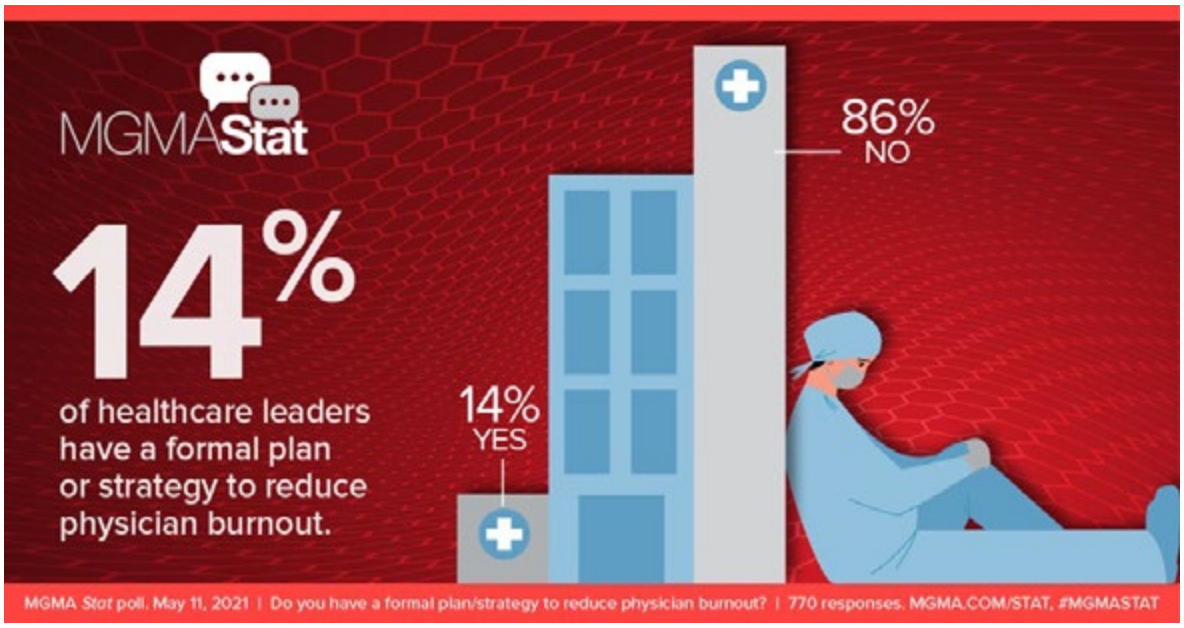
Contact Eileen Sandoval, Recovery Officer, Program Integrity Contract Oversight Section, at 303-866-3133 or email hcpf_draact2005@state.co.us with any questions regarding the DRA.

Sincerely,

Bart Armstrong - Manager, Program Integrity Contract Oversight Section
Medicaid Operations Office
Department of Health Care Policy & Financing

HEALING MORAL INJURY: WHAT SHOULD YOUR STRATEGY TO REDUCE PHYSICIAN BURNOUT LOOK LIKE?

By: MGMA Staff Members



Medical practice leaders face a tall task in working to turn the tide on an epidemic of physician burnout in the United States. At the core of healthcare leaders' work is the need to balance financial expectations with the well-being of clinicians and staff.

According to a May 11 MGMA *Stat* poll, **only 14% of healthcare leaders say they have a formal plan or strategy to reduce physician burnout**, compared to 86% who do not. The poll had 770 applicable responses.

Responses varied whether it was about the causes of burnout or potential solutions:

- In many cases, respondents who said they had no formal strategy or plan pointed to **lots of discussion and informal efforts to monitor burnout** among physicians and staff.
- One practice leader pointed to pain points in the EHR for clinicians: "All the extra clicks suck the life out of everyone."
- Other respondents noted they **invested in specialty-specific EHRs that are more intuitive for clinicians to use**, as well as more functionality to help the team follow up on outstanding labs and other items that can prove stressful if left unchecked.
- Many healthcare leaders say they have adopted **formal physician wellness committees** to inquire about key issues and provide guidance in efforts to address them.

- Developing a **one-on-one coaching/mentoring system** is another common strategy many healthcare leaders have adopted, sometimes as part of a provider leadership academy. A March 30, 2021, MGMA *Stat* poll found almost half of practice leaders say they provide leadership coaching or mentor-ing to clinicians.
- To assess physicians' well-being, one respondent said the practice takes a **weekly pulse survey** to find out how to help providers to alleviate various types of stress they encounter, especially if it can be addressed via staff training or knowledge sharing.

Addressing the causes of burnout

In a recent article for *Physicians Practice*, MGMA's Andy Swanson, MPA, CMPE, vice president, industry insights, pointed out that **burnout levels were startling for healthcare workers prior to the pandemic, especially physician-owners**–"The pressure to achieve ever-higher patient volumes, relentlessly long work hours, obstacles that prevent spending more time with each patient, daily battles with insurance companies, and Medicare, the downward pressure on small practices coming from competing healthcare providers, and … the stress of being a business owner on top of everything else."

Other recent MGMA *Stat* polls point to the necessity to find burnout mitigation strategies to retain talented physicians: A March 2 poll found that 28% of healthcare leaders said a physician unexpectedly retired in the past year.

Swanson recommends healthcare leaders shift away from treating symptoms and instead "address the underlying issue" that poses chronic frustration for healthcare providers and contributes to burnout, including:

- **Technology**: Swanson recommends forming a working group to achieve EHR customizations that can streamline processes and address issues in other areas related to the practice's EHR, such as patient portals and scheduling software.
- **Payment processing**: Swanson recommends improvement in insurance verification, prior authorization, collections or timeliness of payment, which "may seem minor, but in total they will lessen the kind of chronic stress that wears down doctors."
- **Patient care access**: Swanson recommends a five-step methodology, similar to how clinicians diagnose and care for patients, to make small gains in areas such as time spent with those patients or medication and treatment adherence.

INSIGHTS FROM #MPE21

The need to address burnout was a major topic throughout many of the sessions at the Medical Practice Excellence: Pathways Conference this week.

- Practice leaders need to find "incremental" ways to get more time and resources for addressing physician well-being, according to Laurie Baedke, MHA, FACHE, FACMPE, director of healthcare leadership programs, Creighton University, during her keynote presentation, "Resilient Leadership: The Role of Well-Being in Individual and Organizational Performance." (Listen to Baedke's recent appearance on the MGMA Insights podcast for more.)
- MGMA consultant Adrienne Lloyd, MHA, FACHE, chief executive officer and founder of Optimize Healthcare, said that healthcare leaders leading teams that have embraced remote work need to "draw boundaries to prevent burnout while maintaining communication and productivity," by setting a clear vision for yourself and your team, with clear expectations and alignment between your team and the organization's goals.
- In a discussion group focused on strategic leadership, many practice leaders noted that building psychological safety within the organization can address many of the elements needed in physician's work lives that mitigate burnout, such as trust and willingness to share feedback. (Read more about steps for cultivating psychological safety in healthcare settings.)

Do you have any best practices or success stories to share on this topic? Please let us know by emailing us at connection@mgma.com**.**

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Our ability at MGMA to provide great resources, education and advocacy depends on a strong feedback loop with healthcare leaders. To be part of this effort, sign up for MGMA *Stat* and make your voice heard in our weekly polls. **Sign up by texting "STAT" to 33550 or visit** mgma.com/stat**.** Polls will be sent to your phone via text message.

OTHER RESOURCES

- MGMA *Stat*: COVID-19 polls — Get a comprehensive look at MGMA *Stat*'s data since the beginning of the pandemic
- "How eliminating the 'stupid stuff' can reduce clinician stress and physician burnout" — In this episode of the MGMA Insights podcast, Jay Anders, MD, chief medical officer, Medicomp Systems, addresses EHR pain points such as usability and how eliminating the "stupid stuff" can help decrease clinician stress and physician burnout.
- "Limit physician burnout risk by analyzing company culture, contract criteria" (*Physicians Practice*)
- "Guide to physician mental health and disability" (*Physicians Practice*)
- MGMA Consulting — With a collective 400+ years in healthcare experience, there isn't a challenge they haven't already thought of a solution for, and in a way that is tailored for your organization.

Source: MGMA *Stat* - May 13, 2021
https://mgma.com/data/data-stories/healing-moral-injury-what-should-your-strategy-to

COLORADO LEGAL CORNER

Information Blocking and HIPAA's Right to Access: Compliance Burdens for Healthcare Providers

Jacqueline R. Guesno, Of Counsel

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule became effective in 2003, it generally required covered entities to provide patients timely access to their medical records. Of course, state health laws also have provided similar rights to patients regarding their records, some more and some less stringent than HIPAA.

However, concerns over the level of patient access to records are driving increased emphasis, heightened enforcement activity, and new laws to ensure individuals have easy access to their health information. This includes the two-year-old Office for Civil Rights Right to Access Enforcement Initiative and the new information blocking rules under the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program.

A critical goal of these efforts is to empower patients to be more in control of decisions regarding their health and well-being. By helping individuals have ready access to their health records, according to OCR, they are better positioned "to monitor chronic conditions, adhere to treatment plans, find and fix errors in their health records, track progress in wellness or disease management programs, and directly contribute their information to research." During the nearly 20 years since the HIPAA Privacy Rule became effective, technological changes now support even greater access rights, including enabling access in real time and on demand.

Questions received over the years from providers inspire this summary of requirements and some best practices for ensuring patients have access to their records and avoiding enforcement actions, headaches, and penalties.

What is the "Right to Access" under HIPAA?

The HIPAA Privacy Rule generally requires HIPAA-covered entities (health plans and most healthcare providers) to provide individuals, upon request, with access to protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect, obtain, or both, a copy, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. This right applies for as long as the covered entity (or its business associate) maintains the information, regardless of the date the information was created, and whether the information is maintained in paper or electronic systems onsite, remotely, or is archived.

When implementing this rule, covered entities and their business associates have several issues to consider, such as:

- What information is subject to the right and what information is not, such as psychotherapy notes.
- Confirming the authority of "personal representative" to act on behalf of an individual.
- Procedures for receiving and responding to requests, such as written request requirements, verifying the authority of requesting parties, timeliness of response, whether and on what grounds requests may be denied, and fees that can be charged for approved requests.

Are certain categories excluded from the Right to Access?

Yes. Categories of information that are excluded from the Right to Access under HIPAA include:

- Information not used to make decisions about the individual
- Psychotherapy notes
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding

An example of information that is not used to make decisions about the individual is information maintained as part of providers' peer review process.

While the Right to Access under HIPAA may exclude certain information, patients may have broader rights under state law that are not preempted by HIPAA. Accordingly, when responding to requests for access, providers must also be aware of the applicable state law requirements.

When must records be provided?

In general, HIPAA requires records to be provided within 30 calendar days from receipt of the re-

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quest. As with many such timeframes (including the breach notification rule), 30 days is an outer limit. This means that covered entities should endeavor to respond to a Right to Access request sooner if possible.

If the covered entity cannot respond within the initial 30-day period, such as when the information requested is maintained in offsite storage, an extension of up to 30 calendar days is permitted. To take advantage of this extension, the provider must inform the individual in writing during the initial 30-day period of the reasons for the delay and the date by which it will respond. State law also may shorten the time to respond and may not permit an extension. Further, regulations have been proposed to shorten the current 30-day rule to 15 days.

Can requests for access be denied?

Yes, in limited circumstances. Providers must consider the reason for denying access, because the individual may have a right to appeal in some cases.

Examples of circumstances in which a covered entity may deny a request for the Right to Access *without* also being subject to having that decision reviewed include: (i) a request for psychotherapy notes; (ii) a request for information compiled in anticipation of a legal proceeding; (iii) requests in connection with certain research studies; and (iv) a request relating to information obtained by someone other than the provider (*e.g.,* family member) under promise of confidentiality.

In certain other cases, the decision to deny access to an individual is subject to review by a licensed healthcare processional not involved in the original decision to deny access. These cases include denials based on determinations that (i) access is reasonably likely to endanger the life or physical safety of the individual, or (ii) access to the individual's personal representative is reasonably likely to cause substantial harm to the individual or another person.

Can a fee be charged?

The OCR would prefer covered entities do not impose fees on individuals to access their records. According to the OCR:

> While the Privacy Rule permits the limited fee described above, covered entities should provide individuals who request access to their information with copies of their PHI free of charge.

However, the law permits fees to be charged, provided they are *reasonable, cost-based fees when* individuals request copies of records (or a summary of explanation). Additionally, the following items may be taken into account:

- Labor for copying the PHI, whether in paper or electronic form;
- Supplies for creating the paper copy or electronic media (*e.g.,* CD or USB drive) if the individual requests the electronic copy be provided on portable media;
- Postage, when the individual requests the copies or summary be mailed; and
- Preparation of an explanation or summary of the PHI, if agreed to by the individual.

Covered entities that want to charge a fee will need to think carefully about the calculation of those fees and when they are assessed. State law also may need to be considered.

How is the Right to Access being enforced?

In 2019, the OCR commenced its Right of Access Initiative, an enforcement priority to support individuals' right to timely access to their health records at a reasonable cost. At least one study found providers are struggling to fully comply. Nonetheless, the OCR has announced nearly 20 enforcement actions under its Right of Access Initiative – a full list of enforcement actions is available on the OCR website.

The OCR's enforcement actions have typically resulted in resolution agreements with covered entities. About half of the entities investigated are small providers, including solo practitioners. Monetary settlements to date have ranged from $3,500 to $200,000. In addition, the OCR resolution agreements require the covered entities to develop a corrective action plans to prevent further violations. Examples of required actions covered entities agree to under a Right of Access corrective action plan include:

- Two years of monitoring by the OCR;
- Revise its right of access policies;
- Submit its right of access policies to OCR review;
- Obtain written confirmation from staff that they read and understand the new right of access policies;
- Train staff on the new policies; and
- Every 90 days submit to OCR a list of requests for access from patients and the covered entity's responses.

Taking steps to get compliant with the HIPAA Right to Access rule can enhance greatly the chance of avoiding an OCR investigation and a covered entity's ability to negotiate a more favorable result.

What is information blocking?

The Cures Act included provisions intended to minimize the interference with the ability of authorized persons or entities to access, exchange, or use electronic health information – in general, "information blocking." The Cures Act authorized the Secretary of Health and Human Services (HHS) to identify, through rulemaking, reasonable and necessary activities that do not constitute information blocking.

The law also empowers the HHS Office of Inspector General (OIG) to investigate claims of information blocking and to provide referral processes to facilitate coordination with the OCR. The goal of these provisions is to support seamless, secure access, exchange, and use of electronic health information (EHI).

The Cures Act defines information blocking as business, technical, and organizational practices that prevent or materially discourage the access, exchange, or use of EHI when an actor knows, or (for some actors like electronic health record vendors) should know, that these practices are likely to interfere with access, exchange, or use of EHI. If conducted by a healthcare provider, the focus here, there must also be knowledge that the practice is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.

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Which healthcare providers are subject to the information blocking rules?

The Cures Act specifies three categories of entities or "actors" that must comply with information blocking requirements: (i) healthcare providers; (ii) health IT developers of certified health IT; and (iii) health information networks and health information exchange.

"Healthcare providers" is defined broadly:

hospital; skilled nursing facility; nursing facility; home health entity or other long term care facility; health care clinic; community mental health center; renal dialysis facility; blood center; ambulatory surgical center; emergency medical services provider; federally qualified health center; group practice; pharmacist; pharmacy; laboratory; physician; practitioner; provider operated by or under contract with the Indian Health Service or by an Indian tribe, tribal organization, or urban Indian organization; rural health clinic; covered entity under 42 U.S.C. 256b; ambulatory surgical center; therapist; and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the HHS Secretary. Readers can examine the full definition at 42 U.S.C. 300jj.

The rules apply to healthcare providers even if they do not use certified health IT. Moreover, the definition if not limited by size of business or to healthcare providers that are covered entities under HIPAA.

What health information is subject to the information blocking rules?

The information blocking rules apply to EHI regardless of when it was generated.

Until October 6, 2022, EHI is limited to information represented by data classes and elements within the United States Core Data for Interoperability (USCDI). For example, this would include eight types of "Clinical Notes" (*e.g.,* history, Review of Systems, physical data, diagnosis, and plan of care): (1) Consultation Note; (2) Discharge Summary Note; (3) History & Physical; (4) Imaging Narrative; (5) Laboratory Report Narrative; (6) Pathology Report Narrative; (7) Procedure Note; and (8) Progress Note. None of these eight types of clinical notes are limited based on the type or specialty of the professional who authors them.

What are some examples of prohibited information blocking activity?

Whether an activity violates the information blocking rules generally requires a fact-based, case-by-case assessment of the circumstances. The assessment would address whether the interference is with the legally permissible access, exchange, or use of EHI; whether the actor engaged in the practice with the requisite intent; and whether the practice satisfied the conditions of an exception.

Examples of activities that could constitute a violation of the information blocking rules include:

- **Restrictive policies:** A physician's office requires written patient consent (as opposed to electronic consent) before sharing any EHI with unaffiliated providers for treatment purposes.
- **Technology Related Limitations**: A physician disables the use of an electronic health record capability that would enable staff to share EHI with users at other systems.
- **Unreasonable delays**: A physician is able to provide same-day EHI access in the format requested by their patient or an unaffiliated provider, but instead takes several days to respond. However, if the release of EHI is delayed in order to ensure the release complies with state law, it is unlikely to be considered an interference if the delay is no longer than necessary.

Are there exceptions to the information blocking requirements?

There are eight types of "reasonable and necessary activities" that have been identified as exceptions to information blocking. Those eight activities are grouped into two categories

Exceptions when an actor does not fulfill requests to access, exchange, or use EHI:

- Preventing harm exception
- Privacy exception
- Security exception
- Infeasibility exception
- Health IT performance exception

Exceptions that involve the actors' procedures for fulfilling requests:

- Content and manner exception
- Fees exception
- Licensing exception

Importantly, satisfaction of one or more exceptions requires the actor to have met certain conditions. A discussion of the conditions for each of these exceptions is beyond the scope of this summary, but provider should review those conditions carefully and implement them where possible. However, a provider's practice that does not meet the conditions of an exception will not automatically constitute information blocking. Instead, such practices will be evaluated on a case-by-case basis to determine whether information blocking has occurred.

If a provider meets the HIPAA timeframe under the Right of Access requirement, will it satisfy the information blocking rule?

Not necessarily. The information blocking regulations have their own standalone provisions. An actor's meeting obligations under another law will not automatically demonstrate the actor's practice does not implicate the information blocking definition.

What are the penalties for violating the information blocking rule?

Under the Cures Act, actors found to have committed information blocking are subject to penalties issued by the OIG:

- *Health IT developers of certified health IT, health information networks, and health information exchanges:* Civil monetary penalties up to $1 million per violation.
- *Healthcare providers:* Appropriate disincentives to be established by the Secretary of HHS.

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At this point, additional rulemaking from HHS is needed to outline what "appropriate disincentives" could apply.

When are the information blocking rules for healthcare providers effective?

The final rule on information blocking was set to apply on November 20, 2020, but was delayed to April 5, 2021, due to the COVID-19 pandemic.

What should we be doing?

Providers receive all kinds of requests for medical and other records in the course of running their businesses. Reviewing and responding to these requests no doubt creates administrative burdens. However, buying forms online might not get the practice all it needs, and could put the practice at additional risk if those materials, if compliant, are followed without considering state law or are not implemented properly.

Putting in place relatively simple policies, carefully developing template forms, assigning responsibility, training, and documenting responses can go a long way toward substantially minimizing the risk of OCR enforcement actions or Cures Act penalties. Providers also should consider sanctions under state law that also might flow from failing to provide patients access to their records in a compliant time and manner.

Here are some key takeaways:

- Assess whether the fees being charged for Right to Access are permissible
- Review policies and procedures and modify those that unreasonably delay or prohibit data sharing or access
- Develop written policies to address the information blocking exceptions, including preventing harm, privacy, and security exceptions
- Review business associate agreements to ensure you will be able to comply. Such agreements cannot be used to limit disclosures
- Know your state law

Please contact a Jackson Lewis attorney if you have questions or need assistance.

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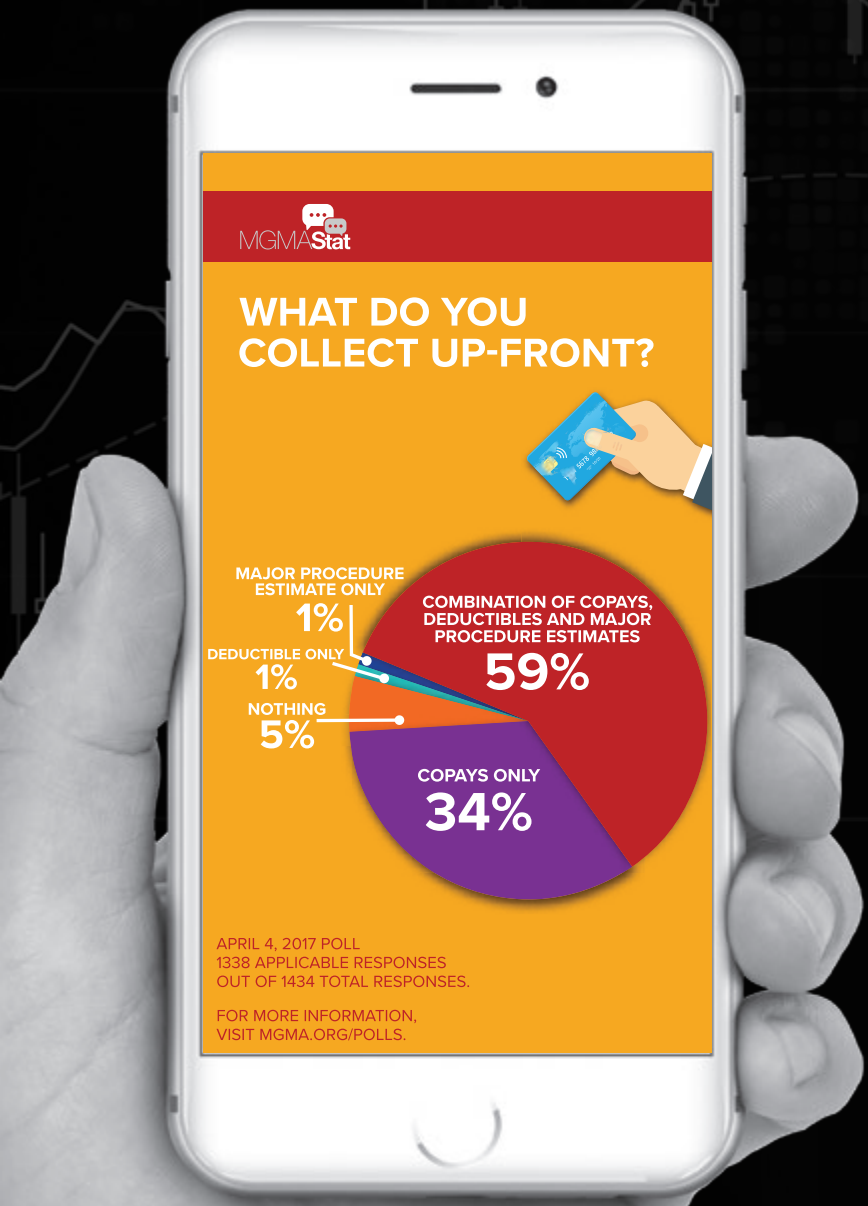

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