



April 2014
Issue 14-02

MGMA
Medical Group Management Association
Colorado

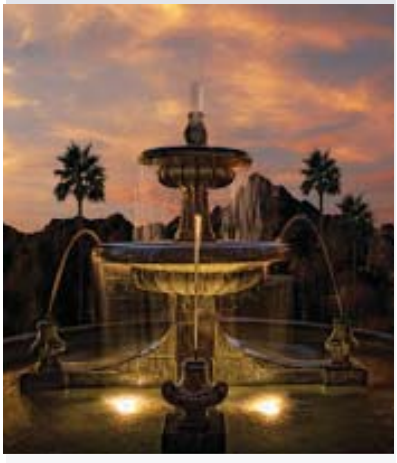
Colorado Connection

The Official Newsletter of Colorado MGMA

Upcoming Conference Schedule

4 Corners Conference

April 23-25, 2014
Hilton Pointe Tapatio Cliffs
Phoenix, AZ



For more information, visit www.cmgma.com.

2014 Challenges (Carrots & Sticks)

By Judy Boesen
President, CMGMA

How are you meeting the challenges of the year? There are many; EHR, PQRS, "credentialed" medical assistants, e-prescribing not to mention the biggest of all ICD-10.

Let's take a look at each of them and how to avoid them.

e-prescribing: It is too late to avoid the penalty in 2014 because e-prescribing reporting concluded 3/31/2014. If you did not file 10 claims with the (G8553) or file a hardship exemption between January 1, 2013 and June 30, 2013 you may be experiencing a 2% reduction in Medicare FFS payments. This is in addition to the 2% sequester adjustment that appears on all Medicare FFS payments. However, if you did report 12 months of e-prescribing, either by EMR, registry, or claims activity in 2013 you may be eligible for a 0.5% incentive payment. This payment will be paid in one lump sum probably sometime around October 2014.
Can I avoid this penalty? None, however the good news is that 2014 is that last year a penalty will be assessed.

EMR/EHR: Hopefully everyone has done a cost benefit analysis regarding implementation of an EMR/EHR for their practice. If the practice has not implemented and successfully demonstrated meaningful use of a certified electronic health record by 2015, the practice will see a 1% decrease in Medicare FFS reimbursement beginning January 1, 2015. The penalty increases by 1% per year up to a maximum of 5% by 2018. Remember this penalty is on top of the 2% sequester penalty. Implementation of an EHR may be expensive and painful but it may be necessary to maintain the financial viability of the practice.
Can I avoid this penalty? Implement a certified electronic record and successfully demonstrate meaningful use as soon as possible. If you implement an EMR/EHR in 2014 you are still eligible for $24,000/doctor in Medicare incentive payments. If you qualify for Medicaid incentive that amount is $63,750/doctor. Once you have implemented an EMR/EHR you will continue to demonstrate meaningful use every year. If you miss a year (unless there is an exception declared) you will be penalized.

PQRS: Beginning in 2015 if a practice did not report to the **P**hysician **Q**uality **R**eporting **S**ystem in2013, a 1.5% penalty will be assessed to Medicare FFS payments. The deadline for reporting was March 31, 2014 for 2013. Some of you may have missed reporting in 2013 thinking it was too much of a hassle. There are a 5 ways to report PQRS data in 2014 and some are painless. Reporting by certified EHR, registry, claims, PQRS data submission vendor, and qualified clinical data registry (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/).

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The transition from ICD-9 to ICD-10, Part 3

Eric J. Chappell, CMPE
President Elect, CMGMA

This is the third and final newsletter article in the series on how my practice keeps moving forward with the conversion from ICD-9 to ICD-10. The first two parts focused on the plan for implementation and also the necessary infrastructure needed. This article will focus on improved physician documentation. As we all know by now, the ICD-10 implementation date of October 1, 2014 has been delayed till 2015. That doesn't mean you should stop moving forward with your preparation. Physician documentation is a continued necessity regardless of billing.

Just to summarize, our group has installed the required software upgrade to allow for the ICD-10 code set to be loaded into our practice management and EMR. With the practice management system, we have internally tested input and transmission of claims data. Our certified coders have all gone through a one or two day coder specific boot camp and some webinar training. In addition, the coders have begun to create online and paper cheat sheets with the most commonly used diagnosis codes from ICD-9 and the best matched ICD-10 to help the administrative and clinical staff.

Once the infrastructure is in place, the next step will be to train all the staff and physicians. The documentation specificity requirements from ICD-9 to ICD-10 are significant. Whether we transition to ICD-10 in 2015 or later, the following documentation guidelines could be implemented.

Some general documentation guidelines:

- Use Standard terms to describe severity and time course of clinical conditions. Acute vs. Chronic
- Describe conditions according to standard categories.
- Use qualifiers such as "possible", "suspected", or "Likely" to describe your thought process.
- Use a symptom as a diagnosis only when all possible diagnoses are excluded.
- Make sure that every lab, radiology test and medication has a diagnosis code.
- For Surgical Patients, document all postoperative conditions and events.

"PACCS" your documentation for best practices:

- P - Principle Diagnosis
- A – Acuity (Acute, Acute on Chronic, Chronic)
- C – Capture all Complications and Co-Morbidities
- C – Causes (Etiology)
- S - Specificity and Stage

Obviously there was a whole host of seminars, conferences and webinars to attend related to ICD-10. I am sure those will slow down for the next year and pick up again around this time next year. We have found them the boot camps to be very helpful with our coders. I decided to keep the rest of this article to share with our members even after the legislative action; it may be of help to you in the future.

We will still use this method if and when we make the change:

In our office, the physician selects the diagnosis code and CPT code that they feel best describes the service rendered. We have billing in house, and our coders review each and every billable service prior to sending the claim to the insurance company. A few years ago, we created what we refer to as "The Down Coding List". In the event the doctor selects a CPT code but fails to document everything required to meet that codes requirements, we let the physician know what else needs to be documented in order to bill that requested code. We are going to use this concept to training our physicians in real time. Starting in June, we are going to select a few notes each day and code both in ICD-9 and ICD-10. This has been extremely successful in training the physicians on the necessary documentation. Obviously, this has duel intent, to train the coders and keep their training up prior to October 1st, but also to start to encourage the physicians to document all the required additional specifics.

We will have some of our physicians do additional documentation training as well. If your physician works out of a hospital system, most hospitals are doing documentation training sessions at different times to encourage physician involvement.

Some other friendly things to consider as we move closer and closer to the deadline:

Cash Flow: It is highly recommended to have a line of credit with a bank prior to October 1st or maintain enough cash on hand to cover expenses in the event that there are delays in payment due to this transition.

Staffing: Expect significant increased staff demands placed on your billing and clinical staff as we get closer to the transition. If you use an outsourced billing company, find out the plans to handle the changes. I am projecting at least one to two additional FTE's in the business office. We are still assessing the impact on the clinical and administrative staff. Some experts predict a 50% reduction per FTE in productivity.

Claims: Any claims for date of Service September 30th or prior must be billed with ICD-9 diagnosis codes. Any claims for date of service October 1st must be billed on a separate claim form using the ICD-10 codes. So if you are in the situation like my group will where a physician will be rounding on a patient on 9/30 and 10/1, make sure you make the necessary changes and bill the claims correctly.

Prior Authorizations: Make sure that your authorizations are completed based on when the date of service or admission is. I have heard that some insurance companies will be ready as early as June 1st for authorizations under ICD-10, while others will not be ready until late September, possibly later.

Insurance Carriers: Watch and stay up to date on how they are doing. Test if possible. Watch you're accounts receivables closely. I love this term from a webinar a few weeks ago; "Bilingual Coding" meaning you will still need to have your staff or physicians code in ICD-9 after October 1st. Auto and Workers Compensation are not required to make the transition.

We all have an additional year to get ready, which is not a lot of time for a project of this magnitude. If you have any questions on ICD-10 or how our practice has continued to plug away at this project, you can reach me by email at echappell@ssoc.com.

From the CMGMA Secretary

To Text or Not to Text

By Paula Aston
CMGMA Secretary

Texting is instantaneous, convenient, and direct. It makes pagers seem as outdated as carrier pigeons. Without appropriate safeguards, however, texting can lead to violations of the Health Insurance Portability and Accountability Act (HIPAA).

Physicians are smartphone "super-users." According to Manhattan Research, over 81 percent of physicians use a smartphone to communicate and access medical information. The attractions are obvious: Phone applications put libraries full of information at your fingertips, and drug alerts (such as PDR.net) are just a click away. Texting reduces the time waiting for colleagues to call back and may expedite patient care by sending and receiving critical lab results and other necessary patient data.

Safeguard against HIPAA violations.
The very convenience that makes texting so inviting may create privacy and security violations if messages containing protected health information (PHI) are not properly safeguarded. Text messages among colleagues should be encrypted and exchanged in a closed, secure network.

However, according to a member survey conducted by the College of Healthcare Information Management Executives, 96.7 percent of those surveyed allowed physicians to text, and 57.6 percent of those surveyed did not use encryption software. The underlying reasons for poor compliance with encryption could be due to lack of technical knowledge or to avoid the inconvenience of sending a message to someone who may not be able to unencrypt it.

With penalties starting at $50,000 per HIPAA violation, safeguarding texts should be of utmost priority. In addition to encrypting texts, consider installing autolock and remote wiping programs. Autolock will lock the device when it is not in use, and it requires a password to unlock it. Wiping programs can erase data, texts, and e-mail remotely. Both types of safeguards provide additional protection in the event a device is lost or stolen. Do not text orders.

On November 10, 2011, The Joint Commission noted that texting is not the same as a verbal order. Texting provides no method for recipients to verify the sender's identity and no reasonable method for preserving or incorporating the original message into the medical record.

Ensure accuracy to avoid liability concerns.
A cavalier attitude when composing a text message can also pose a legal risk. The informal nature of text messages may at times lead to using shorthand, which can increase miscommunication. Additionally, a deleted text is never fully deleted, and metadata (the "data behind the data") is also producible in a lawsuit. It's important to ensure accuracy, particularly when patient information is exchanged over text.

Finally, texting cannot substitute for a dialogue with a colleague concerning a patient. If there is a critical matter or any doubt about the communication, pick up the phone.

Take steps to protect your practice.
Consider the following steps to safeguard your practice:

- Enable encryption on your mobile device.
- Have a texting policy that outlines the acceptable types of text communication and situations when a phone call is warranted.
- Report to the practice's privacy officer any incidents of lost devices or data breaches.
- Install autolock and remote wiping programs to prevent lost devices from becoming data breaches.
- Know your recipient, and double check the "send" field to prevent sending confidential information to the wrong person.
- Avoid identifying patient details in texts.
- Assume that your text can be viewed by anyone in close proximity to you.
- Ensure the metadata retention policy of the device is consistent with the medical record retention policy, and/or in accordance with a legal preservation order.
- Ensure that your system has a secure method to verify provider authorization.
- When conducting your HIPAA risk analysis, include text message content and capability.

- Julie Song, MPH, Patient Safety/Risk Management Account Executive, and Susan Shepard, MSN, RN, Director, Patient Safety Education. The Doctors Company
www.thedoctors.com

Legislative Updates

By Janet McIntyre, FACMPE
Legislative Liaison

On March 31, 2014, The US Senate agreed to legislation passed by the House of Representatives, that delays for one year the 24% cut to Medicare physician payments that was slated to take effect April 1st. Once again, the sustainable growth rate (SGR) formula has been "the can kicked down the road" by Congress. Expected to be signed by the President, this legislation has other significant provisions as well:

- Extends the 1.0 work Geographic Practice Cost Index (GPCI) floor and therapy cap exceptions process for one year
- Delays the transition to ICD-10 for at least one year
- Creates new Medicare policies for clinical diagnostic laboratory tests
- Puts in place "appropriate use" criteria for certain imaging services
- Creates a new process for identifying "misvalued codes" in the Medicare Physician Fee Schedule

This is disappointing and frustrating for physicians and their practices. It appeared that Congress might actually do something permanent this time, but once again, they simply put another one year Band-Aid on the sore.

In Colorado, the General Assembly is bearing down on its final weeks of the session that ends May 8, 2014. Close to 500 bills were introduced this year. Compared to the 2013 session, however, this one has been fairly quiet. Between a tightly split Senate and 2014 being an election year, few complex or controversial bills have been introduced.

One interesting bit for practice managers is that the **Medical Clean Claims Task Force** is slowly, but surely making progress. Senate Bill 14-159 gives the task force an additional year to accomplish their task. The initiative convenes a large group of experts to develop a uniform set of "medical claim edits". The task force is led by Barry Keane, a concerned citizen, and Marilyn Rissmiller, of the Colorado Medical Society. These two individuals have directed a prodigious effort over the past three years. Their process has been transparent and inclusive—convening any interested party including national representatives from many health plans, vendors of software, and providers. The goal is to develop a uniform set of claim edits that would subsequently be adopted by all payers contracting with providers in Colorado. Such a uniform set of medical claim edits and payment rules is estimated to save Colorado more than $80 billion per year. Another great effort towards administrative simplification--stay tuned!

Thank you.

Thank you to those who attended our 2014 Legislative Reception

2014 Challenges (Carrots & Sticks)

Continued from page 1

I prefer registry reporting because I know immediately whether I met criteria. If you did not report PQRS data in 2013 be sure you do in 2014 to avoid the 2016 penalty of 2% and 2% each year thereafter that you don't report. Remember this is in addition to the 2% sequester reduction. There is a 0.5% incentive for reporting PQRS data in 2014 in addition to avoiding the 2016 penalty. This incentive is usually paid in one lump sum about October of the following year. (The 2013 incentive should appear in October of 2014.)

Can I avoid this penalty? There is no way to avoid 2015 penalty if reporting was not done in 2013. Review the PQRS requirements for 2014 to avoid 2016 penalty. Visit the CMS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html?gclid=CP6wgaXaur0CFa5DMgodFWoAqA) and review your options. The complete 2014 individual claims registry documentation can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html , individual measures 2014 PQRS Individual Claims Registry Measure Specification Supporting Document.

For 2015, you could have Medicare reimbursement penalties of 2% for not using EHR, 1.5% PQRS and 2% sequester for a total of 5.5%. This is beginning to be real money.

Credentialed Medical Assistant: In October of 2012 congress passed a regulation that required anyone who orders CPOE services through the EMR/EHR be licensed. CPOE includes entering prescription refills, lab, and radiology orders into EMR/EHR. Licensed professional includes a physician, RN, LPN, CMA, RMA etc. Most physician office have MA's that do a lot of order entry into the EMR/EHR such as scheduling surgeries with standing lab an imaging orders, and prescription refills per office standards. Many of the MA's in our offices have learned on the job, or have not taken the CMA or RMA exams after completion of a formal course, or have let the CMA or RMA status lapse. It is important that the practice get the staff "credentialed". There are several options that have become available. The schools such as PIMA and Everest College are including the cost of the test in their tuition. These same schools are offering refresher courses

to alumni for free in many cases and many employers are paying the cost of the test. AAMA, the organization who provides CMA certification has developed a limited "Assessment Based Recognition" certification for those people who have learned on the job. It includes 5 modules which are completed on line. Another resource for credentialing current staff is NHA (National Healthcareer Association). Check out their website's information about certification http://www.nhanow.com/Libraries/pdf/Meaningful_Use_Provider.sflb.ashx .

CMGMA and PAHCOM (Professional Association of Health Care Office Managers) are co-sponsoring an educational collaborative with the propriety schools, and community colleges in Colorado Springs on April 16. Check the CMGMA website for details.

Is there a penalty? If an auditor requests proof of licensure, CMS can take back all the audit year money.

If our day to day challenges are not enough this is a short list of critical issues we need to address this year. CMGMA is constantly striving to provide educational opportunities to address these issues and well as networking opportunities for everyday support.

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From the Featured Speaker at 4 Corners Conference

Manage Message Flow

By Elizabeth W. Woodcock, MBA, FACMPE, CPC

In an automated environment, recognizing the importance of managing the flow of inbound messages, high-performing medical practices spend extra time training employees how to handle them. It may seem like common sense, but you can leave nothing to chance to make sure the act of taking a message is done consistently. Tell your employees that when taking messages, they should respond to patients who ask to speak with physicians or advanced practice providers by asking if there is something they can do to assist the patient: "Is there anything that I can do to help you?" Make this question a requirement before a message is ever taken. The patient may just need to schedule an appointment!

Ask the patient for the information the physicians and advanced practice providers say is needed. Physicians must establish protocols about what information they want to see in patient messages. To ensure inclusion of the appropriate information, consider developing a message template that can be used to guarantee comprehensive data capture. When you integrate this template within your secure message system, it allows the patient to assist you with capturing comprehensive information upfront.

Make sure that your EHR system incorporates the identification of the user who took the message when the call occurred, the name of the patient or caller, the nature of the call, the urgency of the situation, and if there is permission for the provider to leave a voicemail, text message, or secure electronic message, if applicable.

Keep messages on active status until the issue is resolved. Don't delete the electronic message or file it in the patient's record (or elsewhere if about a non-medical issue) until the matter is handled. Assign responsibility for responding to messages, and hold employees accountable. Develop standards regarding the timeframe for message resolution. Measure and monitor responses, and the timeliness of them, by assigned employee and team. Incorporate your findings in performance evaluations for employees.

Appointment Recalls

Appointment recall systems prove valuable in facilitating timely and appropriate care management. Appointment recalls are a method of tracking the next visit(s) that the physician has recommended for the patient's follow-up care. Unlike an appointment *reminder*, a recall communicates an alert to physicians, employees, and/or patients regarding recommended tests, preventive services, or other care based on the patient's medical condition, age, gender, and other factors related to clinical guidelines. Once the recall is communicated, an appointment can be made for the patient. For example, if a patient receives a physical in November and a follow-up visit is recommended in March, the practice should record, track, and communicate with the patient in February to schedule the follow-up appointment needed in March.

Recalls can also be an effective alternative to giving patients appointments in the distant future. When the physician asks a patient to return in 12 months, don't make an appointment; instead, record the request in your recall system. Proactively reach out to the patient in 10 months to schedule the appointment. Use your patient population and their history of cancellations and no-shows to determine when to start recalling. If your patients tend to forget – or cancel or fail to keep – appointments made three or more months in advance, set the recall process to cover 12 weeks and out.

Most PM and EHR systems can conduct the recall process by automatically sending appointment notices to patients via secure electronic messaging, by telephone, or in writing. Alternatively, a recall list can be generated to prompt a physician to review a patient's medical records to decide if a recall is appropriate. Or develop manual recall logs, in which employees record all appointments or other reminders in date order to prompt the recall. If your practice is looking at starting or revising your recall systems, consider the following proven methods.

Computerization: Recall functions are built into many PM and EHR systems. Recall is one of the most powerful tools these systems offer. Check with your vendor if you do not know how to use your system's recall functions.

Registries: An automated patient registry can be a standalone system, part of an EHR system, or built into your patient portal. Most are structured to "register" and monitor patients by chronic disease. Patients with diabetes, for example, would be entered into the registry, and the registry would provide alerts for those patients for whom care is due. Many registries come pre-populated with standards related to clinical guidelines for recommended care by disease.

Logs: Keep a log (electronically or on paper) of patients who need follow-up care, tests, and other interventions. Organize the entries by the month in which the patient needs to return, and call the patient four to six weeks in advance to schedule.

Calendar: Develop a paper or electronic calendar to record recalls. If, for example, a patient visits in May and needs to

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return for a six-month follow-up visit in November, record the patient's account number and a note or task that will appear on the calendar in late September or early October. This gives your employees four to six weeks before the appointment to send a recall notice or make a reminder telephone call.

Card system: When a patient completes his or her visit, write out a card that records the recommended care as well as the date in the future it will be needed. File the cards by date going up to 12 months into the future. Query the cards once weekly, contacting patients due for care in the next four to six weeks.

Envelopes: Ask the patient to write his or her name and address on a blank envelope. Put the envelope in a filing system organized by month. Go through the files weekly. Four to six weeks before the care is needed, put a request to schedule an appointment, get the test, and so on, into the appropriate envelope and mail it to the patient.

You can also take the concept of generating reminders one step further – if the patient hasn't been in the office for a long time, most recall systems won't pick up on the need for a follow-up appointment. Query your database for patients who haven't been seen in one – or more – years or are otherwise due for an appointment. Send those patients a postcard or letter, call them on the telephone, or send them a secure message through your patient portal. Invite them back to your practice. Speaking of finding missed opportunities, be sure to follow through on your appointment reminders by contacting any patients who missed – or cancelled and never rescheduled – their recommended follow-up appointments.

Regardless of the nature of the recommended return visit, don't leave the recall solely up to the patient. Ensuring that patients are notified about the care you recommend helps improve their health – and can boost your bottom line. Recalling patients for follow-up care within your office means you'll get their business next time, and communicating with patients about necessary preventive care or the need to obtain other services outside of your office creates loyal patients who know that you're keeping an eye out for them, a cornerstone of population health management.


DUST OFF YOUR GOLF BAGS

CMGMA Golf Tournament

Monday, July 28th

Mark your calendars! The annual CMGMA Golf Tournament has been set for Monday, July 28th at The Ranch Country Club. We looked at golf courses all over the metro Denver area this year, considering many different options. In the end, we decided to return to the The Ranch Country Club in Thornton, as they continue to offer our organization the best value and flexibility as well as a challenging and enjoyable course.

We will have an afternoon shotgun start, followed by an enjoyable awards dinner. Cost for Active members and Vendors will be approximately $80, which includes greens fees, golf cart and dinner.

Our corporate affiliates are encouraged to arrange and sponsor foursomes with CMGMA members and clients. Corporate affiliates are also welcome to contribute or sponsor prizes for the awards dinner. Additional sponsorship opportunities will also be available.

More details and specifics will be announced in the coming months, but be sure to mark your calendars now and start planning your foursomes. Please contact our executive director, Kristina Romero, with questions.

ACMPE Workshop at the 4-Corners Conference

By Mike Fisher, DBA, FACMPE,
CMGMA College Forum Representative

Laura Inlow, FACMPE (Director, Practice Development, John C. Lincoln Health Network) and I are presenting a pre-conference session for those thinking about or in the pursuit of the MGMA Certification and Fellowship credentials. Don't forget to sign up for our interactive discussion on Wed, April 23, 2014 from 10 am – 12:30 pm.

Earning Certification as a Medical Practice Executive (CMPE)

2014 exam dates have been announced! Exams will be offered:

- May 19-31…Registration will be available March 17–April 18
- August 18-30 . . . Registration open June 16 - July 18
- December 1-13 . . . Registration open Sept 29 - Oct 31
- Exam sites can be found at https://www.castleworldwide.com/castleweb/clients/testing-services/ibt-testing-sites.aspx#uslocations.
  - Please note that only using US sites are used by MGMA (please disregard international sites).
- Registration information is located on www.mgma.com/exams.

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Keep the 2014 deadlines in mind:

- May 16 – recommended outline deadline
- Aug. 22 – final manuscript deadline
- Oct. 26-29 –New Fellow Recognition at MGMA Annual Conference in Las Vegas
- Find Fellowship information and resources at www.mgma.com/fellowship.

Apply for ACMPE scholarships and grants

The ACMPE Scholarship Fund Program, operated by ACMPE Scholarship Fund, Inc., supports individuals who, by virtue of experience, current position and plans demonstrate potential for contributing to the medical practice management profession.

Apply for scholarships and Richardson-Sargent grants that assist with expenses related to continuing education required for certification and Fellowship at http://www.mgma.com/education-certification/education-resources/acmpe-scholarship-fund-program .

Scholarships will open March 31, and the deadline to apply will be June, 1, 2014.

To apply for undergraduate/graduate scholarships, select the "Apply for SFI scholarships" button. To apply for certification and Fellowship grants, select the "Apply for Richardson-Sargent grants" button.

An extra incentive offered to CMGMA members only

CMGMA will pay **one** year of annual CMGMA dues for all members who achieve their CMPE certification, payable in January of the upcoming year.

Better yet! CMGMA will pay **one** year annual dues to MGMA for all those members who complete their fellowship for ACMPE. Those fees will be reimbursed upon their renewal date.

Don't let your CMGMA membership lapse! Both incentives are available only to active members of CMGMA.

I'm always available to discuss items related to CMPE and FACMPE preparation. Just contact me mfisher@regis.edu or on my cell phone at 303.870.3214.

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MU2, MH, and XLS: How to get the most out of your EHR

Most administrators are very familiar with seeing financial data that comes from the practice management system in the form of an Excel spreadsheet (xls). This data is very informative as it tells a story of the health of your revenue cycle. It can also tell you who is the hardest to collect money from and how many days the practice can expect to collect on a procedure performed today.

With the paring of both your practice management system and your EHR, you now have the ability to see the practice's strength in the quality of care. For example, the xls spreadsheet can now tell you who your most compliant patients are and allow the practice to target specific panels with the ease of a few mouse clicks. This type of data mining is essential to meet medical home (MH) standards. And, it can be performed relatively cheaply and quickly.

Meaningful use (MU) compliance can also be quickly downloaded from your EHR. You can export an xls table that shows whether a physician collected the smoking status on a patient. Or, check to see which patients received educational material on their office visits. These types of tables are easy for a medical assistant to utilize for patient outreach and wellness visit reminders.

To get more from your data, a practice administrator should understand how pivot tables in Excel can help tabulate information and filter out extraneous data. This will assist personnel in targeting necessary improvements and enhancing the quality of care.

If your EHR is more cumbersome, Crystal Reports can allow you to customize data downloads and pick out specific information in a multi relational database such as SQL. Most EHRs employ SQL to store and index protected health information (PHI). Crystal Reports can help organize important information into a spreadsheet.

Understanding how to retrieve information from your EHR is critical to meeting the future needs of your patients and other stakeholders. Whether it is finding new opportunities to grow the practice or identifying more meaningful ways to increase the quality of care, spreadsheet analysis will help you achieve your practice's goals.

Eric W. Speer, MBAHA, CMPE
Salary Survey Chair

SAVE THE DATE

LEAN WEBINARS

SERIES II – April 16
SERIES III – May 14
from 12:00-1:00 pm

Make Your Plans to Attend the 2014 Colorado MGMA Fall Conference!

Don't miss Colorado MGMA's Fall conference that will be held at the Sheraton Denver West Hotel in Lakewood, September 11& 12, 2014. We are planning a terrific lineup of nationally-known speakers as well as networking opportunities with fellow practice administrators from across our state. In the ever-changing field of healthcare, you are faced with demanding business decisions, increasing governmental pressure and more. Being able to exchange information with others who face similar responsibilities and challenges is one of Colorado MGMA's most valuable assets. With the ICD-10 implementation only weeks following the conference, we will discuss how to *Know Your Numbers!* Don't miss this excellent educational opportunity, mark your calendars now!

Registration will be available in June.

Hotel reservations may be made until August 20, 2014.

Sheraton Denver West Hotel
360 Union Blvd., Lakewood, CO 80226

Reservations can be made directly by calling the hotel at: (303) 987-2000 and referencing group CMGMA

Or reserve you room online by typing the following into your browser: https://www.starwoodmeeting.com/StarGroupsWeb/booking/reservation?id=1311225036&key=A48DC

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What does the new HHS lab result rule mean to your patients and your practice?

By Jennifer Souders, FACMPE
Immediate Past President

On February 3rd the US Department of Health & Human Services (HHS) issued a final rule that eliminates exceptions under the Health Insurance Portability and Accountability Act (HIPAA) and the Clinical Laboratory Improvement Amendments (CLIA) that allows labs to withhold information from patients and their personal representatives. Currently, 13 states require labs to give results only to health care providers. The rule supersedes the state laws that prohibit patients from getting results directly from a lab.

Beginning April 4th, your patients will be allowed to call the lab and get their test results directly, without having to interact with their health care professional. In a statement, HHS Secretary Kathleen Sebelius said "Information like lab results can empower patients to track their health progress, make decisions with their health care professionals and adhere to important treatment plans". I'm sure we can all agree with that statement.

According to Dr. Reid Blackwelder, president of the American Academy of Family Physicians, "Patients have a right to access their records and notes" but since physicians treat patients, not numbers, there is a need to explain why tests are being done and to put the results into context. "If you just have numbers out there without that context, it can create anxiety". I'm sure we can all agree with Dr. Blackwelder's statement as well.

Perhaps the rule will not make that much of an impact after all - the final rule notes that labs will not be required to interpret the results and that they are given 30 days to respond to an individual's request. With that time frame, physicians should be able to get the results before patients do and in turn, provide context.

HOW DO YOU MEASURE SUCCESS

By Peter Howell, Member At Large CMGMA

Recently a reporter asked the Sec. of Health and Human Services "what does success look like with enrollment in the Affordable Care Act"? She answered that "somewhere around 7 million enrollees". For the Sec. of HHS she measured success with the "total" number of enrollments; not the number of "uninsured" enrolled or the number of "young-healthy" adult's enrolled or other measure.

So, if this reporter came to your practice to interview you and asked, "how do you measure success"? Your answer could be one or a combination of the following:

- Financial performance: You anxiously await your financial report each at the close of each month and that your collections exceed expenses and you're able to meet accounts payable requirements, meet payroll, and a nice distribution to your owners.
- Clinic metrics: This includes total visits, charge per visit, collections per visit, and so on. You set a goal each month that your trends report will demonstrate and positive increase in metrics.
- Staff retention: Replacing and training staff is expensive. In addition, it impacts patient relationships. Patients like the comfort of a familiar face when coming to the doctor's office. If you lose an employee that is "familiar" to the patient that relationship is disrupted and the patients measure of quality may by impacted.
- Patient satisfaction: We all want to know how our patients measure quality; i.e. cleanliness, wait time, parking, and perhaps outcome "did I get better" and now have a sense of well-being.

There are other ways to measure success and how you determine what the success of your practice looks like. Hopefully, you're looking at all the above measures to help you determine success.