Executive Decisions in DERMATOLOGY

ADAM

November/December 2013

Health Information Exchanges have opened, are you ready for what's next?

BENCHMARKING

By Tony Davis, CPA, CMPE

A common business management proverb is, "What gets measured gets managed." The concept is fairly simple in that it requires a manager to collect information or data or metrics (measurements) and then apply a point of comparison to that measurement in order to evaluate whether the measurement is favorable or unfavorable. Once the evaluation has been made as to favorability, action is then determined (management). A key component to the evaluation of a measurement especially as it applies to financial data is comparative data, otherwise known as benchmarking.

In my experience in the health care accounting and consulting world, finding good benchmarking data can be difficult. There are several excellent health care benchmarking resources available particularly through the Medical Group Management Association (MGMA). Unfortunately, however, industry resources are often very general in nature and the level of data available for dermatology is limited.

If, as dermatology business managers, we are to accurately (measure) our financial data in order to appropriately (manage) our businesses, we must have confidence that the data we are comparing to (benchmarks) has been tailored to suit the needs of dermatology managers.

Recently I posted the following question on the ADAM LinkedIn page, "What level of interest is there from ADAM members about creating a confidential Financial Benchmarking survey that would cover very broad data sets like Work RVUs, Collection %, Overhead etc.?" I received several positive responses from ADAM members indicating we might be ready as an organization to undertake such an endeavor.

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In conjunction with CareCredit, ADAM is proud to announce the

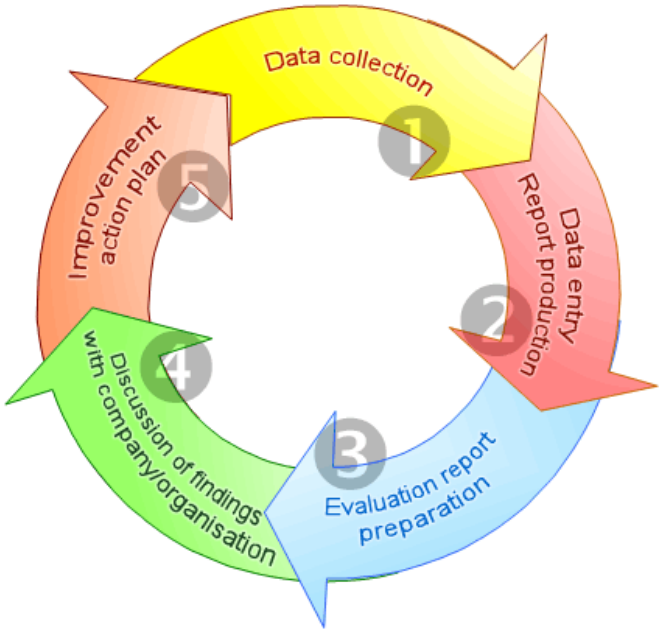
ADAM Practice Manager of the Year Award

Created to recognize an outstanding Practice Manager, this award will be presented at the 2014 Annual Meeting in Denver. The winner will receive a **Grand Prize** of $1,000 and free conference registration to the 2015 Annual Meeting in San Francisco all courtesy of CareCredit.

Stay tuned for more details!

In this issue:

As a precursor to creating a dermatology-specific financial benchmark study, it would be vital to define the key metrics of the study so as to ensure that we collate financial data in a common way. This would make the study very usable for the membership.



Some of these key terms that we would use in an independently owned general dermatology practice include:

Gross Charges – sometimes called Gross Billings. These are the amounts billed to insurance based on a fee schedule set at a pre-determined "higher" rate above your highest paying insurance contract.

Contractual Adjustments and Allowances – these are the adjustments to the clinic's fee schedule by insurance companies to bring the charged fee down to the particular contract fee of the insurance company.

Net Collectible Charges – this is net amount calculated by subtracting the Contractual Adjustment from the Gross Charge. The result of this is the amount to be collected from insurance (or the patient if they haven't met their deductible).

Medical Collections – The actual cash collected from the insurance company or the patient.

Net Collection Percentage – this is calculated by dividing the Medical Collections by the Net Collectible Charges. The goal would be to be as close to 100% as possible!

Cosmetic Collections – this is usually the cash collected from elective "cash" cosmetic procedures. Example procedures would be injectables, chemical peels, microdermabrasions, laser hair removal, product sales etc.

Human Resource Costs – All staff members' salaries and benefits, training etc. Does **NOT** include physicians.

Physical Resource Costs – Facility and equipment costs including items such as rent, leases, repairs and maintenance, telephone, cosmetic supplies and inventory.

Purchased Services Costs – Includes items such as outside professional fees – legal, accounting, payroll, and billing services.

General and Administrative Costs – All other office related costs like supplies, marketing, advertising, printing and copying.

Clinic Overhead – A combination of Human Resource, Physical Resource, Purchased Services and General and Administrative. Another definition would be all the costs to run the clinic **EXCLUDING** the doctor's costs.

Relative Value Units (RVU) - are a measure of value used in the United States Medicare reimbursement formula for physician services. Most CPT codes have been assigned a RVU. It is a combination of 3 values. They are a value for the work expense of the provider, an office expense value and a malpractice value.

Work Relative Value Units (wRVU) – This is one component of the Total RVU. It is a value assigned for the provider expense only.

The above list is by no means all encompassing. Other factors such as group size, geography, use of mid-level providers and insurance mix definitely can influence the financial results of a practice. It is, however, a good start. I do believe that if we were able to collect the financial data above from a substantial sample size of the ADAM, we would, for the first time, have relevant and comparative data that would allow us to "manage what we measure".

Be on the lookout for Benchmarking information in the future.

President's Corner

A series about the state of the Association and what's new with ADAM. Do you have a question for Jayne? Email us at ADAMinfo@shcare.net

Fall is upon us and the Annual Meeting is four months away. From the Healthcare Information Exchanges to ICD-10, our goal to provide the best tools and information to allow your practice to thrive during the year of change. Over the next several months, we will be previewing sessions from the Annual Meeting, so please stay tuned.

Sincerely,

Jayne M Kresinske

Member Spotlight

Would you like to nominate someone for the Member Spotlight? Email us at ADAMinfo@shcare.net

ADAM: *What is your name and where do you work?*

Sarah: Sarah H. Lopez. I work for Dr. Christopher Hubbell at Acadiana Dermatology. We also have a Medical Spa, a Jeuné (pronounced ah-jhuh-Nay) Advanced Medical Skincare. We are located in Lafayette, LA.

ADAM: *When did you join ADAM?*

Sarah: I joined ADAM when I started with Dr. Hubbell in 2006.

ADAM: *How long have you been a practice manager?*

Sarah: I began my career as Dr. Hubbell's practice manager in 2006. Prior to that I managed the Louisiana State University Medical School ENT residents who were relocated to Lafayette, Louisiana after Hurricane Katrina decimated the New Orleans campus. My MBA/HCA (Health Care Administration) degree led me to my career in healthcare.

ADAM: *As a practice manager, what do you find to be the most challenging part of your job?*

Sarah: There are many aspects of the job that I find challenging. Leading and supervising 12 employees while simultaneously working on my specific tasks and projects assigned by my physician certainly would be my biggest challenge. In addition, I am always trying to find innovative ways to get the employees motivated and excited about their jobs. Another challenge is staying up-to-date with the numerous regulatory and legislative changes occurring every day in healthcare. The financial health of the practice rests, in part, on my shoulders and this can be daunting. The least pleasant part of my job is having to enforce the rules and regulations of the practice which often results in discipline issues or unwelcome changes for the employees.

ADAM: *What has been your best experience being an ADAM member?*

Sarah: My two favorite things about ADAM are:

1) The annual meetings: I love our annual meetings! The speakers and classes provide very worthwhile information; the networking and best practices opportunities are priceless.

2) The LinkedIn Group: I am a huge fan of the LinkedIn Group! The help I receive from posts and the satisfaction I receive from helping others is truly unbeatable. I have found so much useful information through this group. The "light bulb" is constantly going on when reading these posts. I have found the posts on making the workplace fun just invaluable.

ADAM: *What would you recommend to a member who is looking to be more involved?*

Sarah: I would definitely recommend going to the annual meetings and joining the dinner groups. As I learned at my very first ADAM meeting in San Antonio, "you should never eat alone." Also, it was recommended to me to join an ADAM committee. I haven't had the opportunity to do so yet, but it is definitely on my list of things to do!

Avoiding Hazards on the Road to the Health Information Exchange (HIE)

By Mike Meikle

The news in recent weeks has not been "optimal" in regard to the rollout of the Affordable Care Act (ACA) website, Healthcare.gov. We read and hear stories of a multiplicity of technology failures with a development price tag that rises to nearly $700 million.

However, when you look under the hood of the Federal Health Insurance Exchange, you can see why this has been such a difficult undertaking. The system collects and sends data to multiple interconnected systems every time an enrollee attempts to comparison shop for coverage. Multiple federal and state systems swap data back and forth, while the results are being displayed for the user.

This architecture is very similar in design to Health Information Exchanges (HIE or HIX). In this article we'll briefly touch on what a provider should know about HIEs at the local, state and federal levels.

Why is this topic so important? In the scale of software development and database integration, few projects like the Nationwide Health Information Network (NwHIN) have been so sweeping in scope; no matter the industry.

One facet that defines this massive effort is the dollars spent. The Affordable Care Act (ACA) mandates (Meaningful Use) that healthcare providers shift to Electronic Medical Records (EMR). Without EMRs, a NwHIN would not be possible. In order to facilitate this, the Federal government has doled out $12.6 billion in subsidies to providers since 2012. For the first two months of 2013, $425 million was handed out for EMR Meaningful Use. These large numbers do not take into account the vast sums that will be spent on local, state and federal HIE/HIX promotions, setup and operations (currently estimated at $5 billion).

Another facet is the business integration effort of such an undertaking. Currently, just for Medicare and Medicaid there are over 50 programs at the state level. Some states have multiple Medicaid programs with many divergent rules on eligibility and reimbursement. When you add in private health plans, both employer and individual, you have a mountain of business process integration.

The technological wrinkles are substantial as well. Hundreds of legacy applications, EMRs, state and federal systems all have either integrated or sent their data in a recognizable format that will eventually end up at NwHIN. When you look at the state of failed Federal IT projects (i.e. FAA[1] and FBI[2]) that are 1/10 the scope of the NwHIN you can see the herculean effort that is being undertaken.

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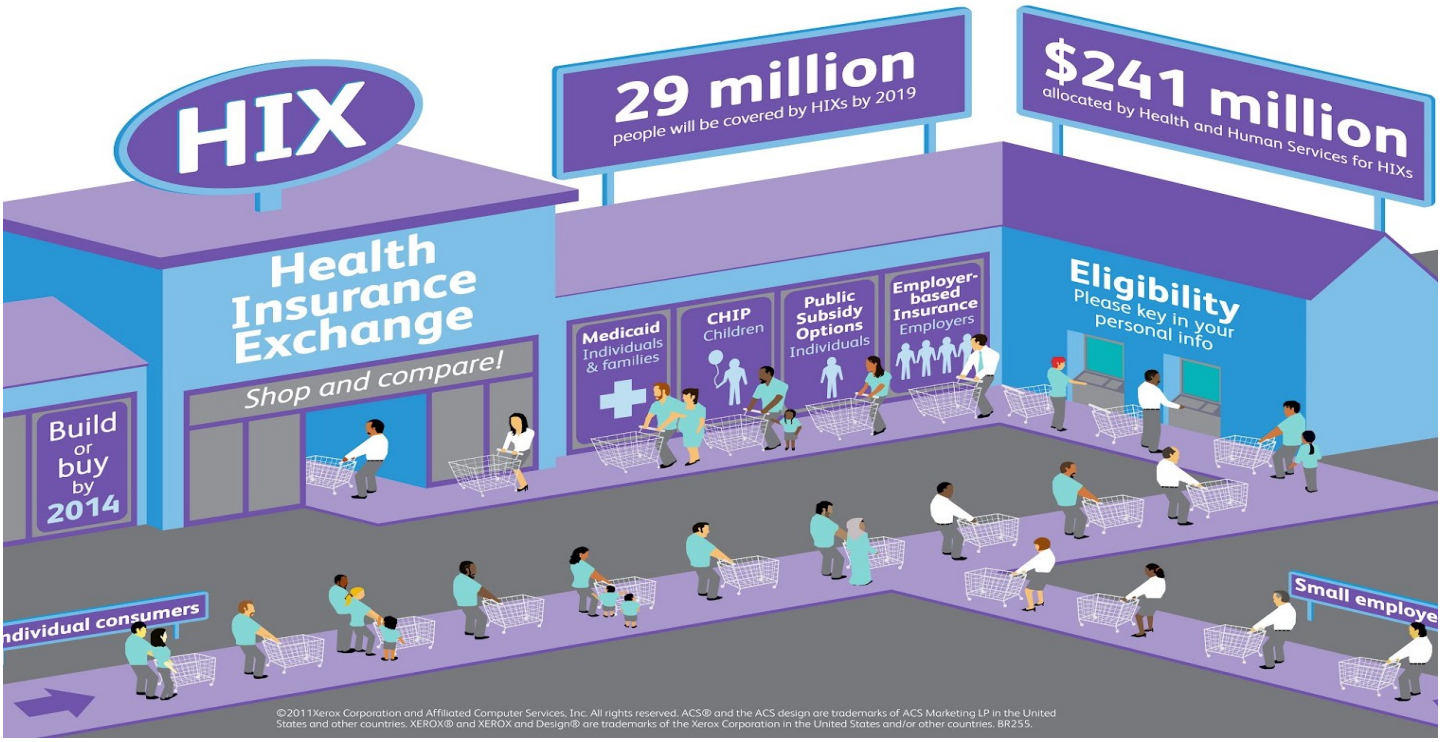


Project morale also takes a hit when one of the key stakeholders stated "Let's just make sure it's not a third-world experience."[3]

For all this churn and uncertainty, one thing is for certain, all the money and political capital that has been spent by private and public entities ensures that all these initiatives will move forward, even with the latest ACA employer mandate delays and uncertainty about the Health Insurance Marketplace.

So, the healthcare provider is going to have to understand this rocky environment since their organization will be integrating with a state or private HIE or they will be involved at the governmental HIE projects.

There are four types of exchange models:

- Private: used by a healthcare provider's organization to share patient data to a variety of business associates. These include healthcare clearinghouses (billing), insurers, pharmacies, clinics and primary care physicians.
- Centralized: link multiple healthcare providers in a region. Often private exchanges are joined together at the centralized level.
- Federated: a rollup of private and centralized exchanges at the state level. This is where the NwHIN comes into play. These Federated exchanges are then supposed to plug into the NwHIN which also plugs into multiple Federal agencies. Currently 35 states are relying on the Federal government to provide their State-level (Federated) exchange.
- National (Hybrid): cross between centralized and decentralized architecture. A hybrid model provides the interface engine for which organizational entities in the HIE communicate. "For example, the eHealth Volunteer Initiative in Tennessee uses a system where the data is physically stored and managed in a central location, but the data is logically separated into "vaults" controlled by each organization that contributes data."[4]

HIEs are a very complex and daunting topic that cannot be adequately explained in a short article. However, if you are a healthcare provider, chances are you are exposed to projects based on exchange creation or integration such as EMR/EHR, Meaningful Use and ICD-10.

There are a few of options open for providers to prepare for or participate in HIEs, depending on organizational size. First, create a stand alone private HIE using best practices gleaned from your state's HIE technology framework. Second, find a state or private exchange in which you can participate. Third, delay a decision until state or federal officials mandate a direction.

My recommendation would be to partner with an organization that already has their private or local HIE in production. This reduces out of pocket costs for the organization, plus spreads the business process and technology risks inherent in solo HIE initiative.

For more information on this topic or to answer your questions, please feel free to drop me a line at mmeikle@securehim.com.

[1] Cone, Edward. Crash-Landing Ahead?. 1998. http://www.informationweek.com/664/64iufaa.htm. Accessed October 8, 2013.

[2] Greenemeier, Larry. FBI Looks To Redeem Itself With Sentinel After Virtual Case File Snafu. 2006. http://www.informationweek.com/fbi-looks-to-redeem-itself-with-sentinel/192500844. Accessed October 8, 2013.

[3] Roy, Avik. CMS on Obamacare's Health Insurance Exchanges: 'Let's Just Make Sure It's Not a Third-World Experience'. 2013. http://www.forbes.com/sites/theapothecary/2013/03/22/cms-on-obamacares-health-insurance-exchanges-lets-just-make-sure-its-not-a-third-world-

[4] A HIMSS Guide to Participating in a Health Information Exchange. 2009. http://www.himss.org/files/HIMSSorg/Content/files/HIE/HIE_GuideWhitePaper.pdf. Accessed October 20, 2013.

Member Feature

MODIFIER 25

The ADAM Communications Committee strives to provide ADAM Members with notable topics and research. We would like to present the Modifier 25 survey, which we hope to ADAM is identifying the "norm" among the dermatology community as to the average percent of E/M services billed with modifier 25. We plan to make this one in many data collecting surveys in the future.

If you have not completed the survey, please click here. We want to hear from you by November 20, 2013.

2014 Annual Meeting

By Gabi Brockelsby

The final details of the 2014 ADAM conference are being finalized as I write this article. Watching the conference develop based on *your* ideas has been a very rich and rewarding process.

What can members look forward to in Denver? Well, there is always the time to network with your fellow ADAM members and this year we've built a little extra time specifically for networking on specific subjects such as marketing, technology, academic hot topics, and one for new managers. We have experts who will guide us through Human Resources, changes in compliance statutes, bench-marking dermatology practices, developments in technology for derm practices, chart audits, embezzlement, and even a primer on dermatology diseases. And that's just a snapshot!

Added to that, Faith McNicholas and Peggy Eiden of AAD will make a full-day presentation on dermatology coding including dermatology-specific ICD-10 education.

I know we will have succeeded if you have a hard time choosing your sessions!

I hope you'll be able to join us in beautiful Denver for the 2014 ADAM conference!

Gabi Brockelsby
2014 Annual Meeting Chair

Book your room for the 22nd Annual ADAM Meeting today!

New Member Pricing - Available for New Members Only!

Do you have a friend, coworker, or colleague who would love to join the only association for dermatology practice managers? You're in luck! Beginning November 1, new members can join ADAM for $350 and be covered through December 31, **2014**! This prorated membership offer will continue through the end of the year.

Month	Price
November	$350
December	$325

Remember, this is for new members only. Their dues will be paid for the reminder of 2013 *and* all of 2014!

Tell your colleagues to join the nation's resource for dermatology practice managers!

Don't miss out on member pricing for webinars, the Annual Meeting, and more. Members can also take advantage of the members-only LinkedIn group, My ADAM, and ADAM-Edge.

For more information, email **ADAMinfo@shcare.net today!**

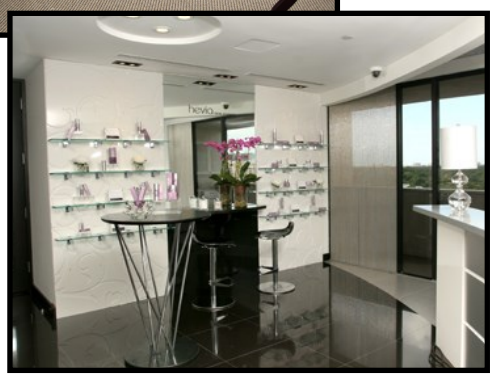
Going Cosmetic: Keep Patients for Life!

By Glenn Morley

This is Part 3 in a 3-part series exploring the integration of cosmetic services into a dermatology practice.

You've made the strategic shift toward increasing cosmetic lines of service. You've developed a solid infrastructure to support your vision. The final and most important philosophy to adopt as you build a cosmetic dermatology practice is this: when you acquire a cosmetic patient, ***make it your goal to keep them for life.***

Unlike general dermatology, medical necessity is not driving a cosmetic patient's decision to see you. For the majority of cosmetic patients, emotions, thoughts, and feelings about the visible signs of aging drive their decision. And because there are many options available for patients to have their cosmetic service needs met, never take patient loyalty for granted.



Cosmetic patients visit the practice more frequently than medical patients. This is a critical difference for practices shifting from medical to cosmetic to understand. These frequent visitors must receive a consistently positive experience in order for them to develop a deep loyalty to you. Success requires team buy-in and may take time to achieve, but it's well worth the effort.

The Value of Loyalty

Every patient relationship has an economic value. Generally speaking, it costs the practice less to retain an established, loyal patient than it does to attract and acquire a new one. Think about the marketing, communication, and staff resources needed to motivate a new patient to call or email, schedule a consultation, and actually arrive in the office. If you dazzle them once they are there, if you build a loyal relationship and develop a skincare and rejuvenation plan that is aligned with their needs, these patients will return again and again and continue to spend money in your practice. But if you don't, that new patient you spent so much money and time to get into the exam room will essentially become a 'one and done' episode of care.

That's why cultivating the loyal patient is so critical. Loyal patients can spend thousands each year in your practice, with very little financial effort on your part. For instance, if every year a loyal patient comes in for a few injectable treatments and a peel series, perhaps your yearly revenue from that patient is $2,500. If that patient is loyal to your practice for 10 years, that's $25,000 in revenue – plus the potential revenue from the 1, 2, 5 or more patients he or she refers over those 10 years. In fact, the "Lifetime Value" of a loyal patient can become hundreds of thousands of dollars.

But let's say that same patient begins to have less than optimal experiences with the practice after only two years of treatments. Maybe a new staff person was rude, or she felt rushed during her last visit. If she flees to a competitor, you've potentially lost $20,000 in easy, opportunistic revenue dollars over the next 8 years. To say nothing of the referrals you missed out on.

Understanding this value is good business management, and in no way diminishes the important and mutually satisfying patient-doctor relationship or patient-staff relationship. Strive to develop the philosophy that every cosmetic patient will be a "frequent flier" lifetime customer. You and the patient will reap long-term rewards by implementing a sustainable retention strategy that includes the review and potential expansion of the patient's personal treatment plan at every visit.

Create a "Patient for Life" Protocol

Adapt a loyal, lifetime patient philosophy for every cosmetic patient. Establish these protocols, train staff, and make sure everyone in the practice becomes an ardent disciple:

1. Develop a plan for every patient. During an initial cosmetic consultation you may discuss a

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myriad of options. By the end of the visit, deliver the patient a written plan that aligns each patient need and interest with products or services you confidently recommend. Ideally this plan can be reviewed, financing options presented, and decisions made in the same visit. Few dermatologists provide this ideal scenario. It will be a strategic advantage if you do.

2. Articulate and schedule the "next step" for every patient, for every treatment. Educate patients who believe there is a 'silver bullet' for achieving their desired result immediately. Most services and treatments must be repeated at predictable intervals in order to maintain results, so dispel the myth that one little Botox® Cosmetic (or filler, or laser) treatment is all it will take. These services are 'annuities' and making a variety of payment options available can build patient loyalty over time. If you accept a healthcare credit card that can be used at your practice again and again*, patients may be more likely to feel comfortable scheduling and returning for their next procedure or treatment. Your ability to communicate options, and make each "next step" in the process clear and manageable will separate you from the majority of practices that take a laissez faire attitude to the patient's treatment plan follow through.

*Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.

Glenn Morley, practice management consultant with Karen Zupko & Associates analyzes practices and advises physicians and managers on operational, financial, personnel and marketing strategy and tactics.

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If you are not a member of the ADAM LinkedIn Group become one today and join the discussion.

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