

Journals Reviewed for This Issue

- *Journal of Medical Practice Management*
- *New England Journal of Medicine*

Web Sites Reviewed for This Issue

- *American College of Physicians*
- *Bloomberg*
- *Fast Company*
- *Forbes*
- *HealthcareDive*
- *Health IT Buzz*
- *Healthcare IT Today*
- *Healthcare Success*
- *HealthLeaders*
- *HFMA News*
- *MGMA Insight*
- *Physicians Practice*
- *SmartBrief*
- *U.S. News and World Report*

PRACTICE OPERATIONS

1. Data Mine: Quo Vadis? 20 Years of Cost and Revenue Data Help Point to What's to Come

David N. Gans, *MGMA Insight*, June 10, 2020; <https://www.mgma.com/resources/financial-management/data-mine-quo-vadis-20-years-of-cost-and-revenue>

ABSTRACT

Medical Group Management Association (MGMA) has gathered, classified, and reported physician practice-management data through its process of annual surveys for nearly 50 years. Other organizations have offered similar catalogs of benchmarking data, but MGMA has the most extensive datasets, as well as one of the largest followings out there.

Thousands of medical practices, representing tens of thousands of physicians and other providers, self-report survey responses covering production and compensation, costs and revenues, and more. Critics point out the fact that self-selection skews the numbers, but no one can say that the sheer amount of data is less than robust.

David N. Gans, senior fellow at MGMA's Industry Affairs, demonstrates the value of data analysis in predicting the future of a business. This article looks at a 20-year trend in revenue and costs at physician-owned multispecialty practices as reported in the annual surveys.

It may surprise some readers that physician-generated revenue (on a full-time-equivalent physician basis) has increased steadily over the past two decades. It should surprise no one that expenses have also risen. In terms of dollars,

- medical revenue was up 191.07%, and
- operating expense was up 207.0%.

That means the profit-margin ratio has shrunk somewhat (still, it's up some 159.0%). But to get a fuller picture, you must look at the Consumer Price Index (CPI) over the same period. The CPI is a common way to measure inflation. The CPI rose 51.0% over the same period.

Comparing costs—particularly major categories of operating expenses—to the CPI reveals that physicians have to generate more gross revenue (measured in dollars or wRVUs) to stay ahead of inflation and grow their businesses.

EXPERT COMMENTARY

Trend analysis is absolutely essential for projecting the future financial health of your practice. Fundamental business-management principles tell us that we must understand the past if we hope to predict the future. Data analysts such as David

Gans of MGMA spend untold hours gathering, organizing, and analyzing performance data. They recap the data based on factors that have proven highly influential on the outcome.

Through the years, survey data have demonstrated very different benchmarks for practices in different settings. Physician-owned practices perform differently than hospital-system-owned ones. Academic practices report very different numbers than do private practices. Other factors, such as geographic setting, practice size and specialty, compensation schemes, and many others, show marked differences.

Finding relevant data for your practice can prove challenging, but if you can compare “apples to apples,” you can develop an understanding of how your performance stacks up against national averages. It can help you develop more realistic expectations.

But understand this: benchmarks are *not* performance targets. They simply point you to practice-management issues that may need your attention. When your performance varies greatly (for better or worse), you need to figure out why you differ. Does something need to be corrected? Has something been neglected?

As you analyze these differences, look at your own data to discover trends in your practice. Is productivity growing? Shrinking? Are average days in receivables increasing? Decreasing? Again, figure out *why*. Look for both long-term and short-term trends. The shorter the trend, the more likely it’s an aberration—an interruption caused by one of the following:

- Practice growth (adding providers, locations, services)
- Practice consolidation
- Shifts in compensation (new contracts, new methods such as pay-for-performance)
- A so-called “black swan” event (pandemic, natural disaster, major disruption)

Trend analysis is a critical component of your annual budgeting process. You always start with historical data (revenue and expense), then factor in inflation, business plans, projected acquisitions

or investments, and so forth. Like mythical Janus, you have to keep one face turned toward the past and one face turned toward the future.

2. Scribes and Efficiency in the Medical Workplace

Callista Eckert, Ashkon Nehzati, Janis Coffin, DO, FAAFP, FACMPE, *Journal of Medical Practice Management*, May–June 2020

ABSTRACT

Mounting evidence draws a direct line between physician burnout and electronic health record (EHR) documentation overload. Physicians report spending more time than ever on charting—in the exam room, in their offices, and now (thanks to 24/7 Internet access) at home. To ease this burden, some physician practices have deployed medical scribes. Scribes shadow physicians, keeping detailed notes of what goes on in the treatment room—what was done, what was said, and what was reported. They create chart notes that the physician finally reviews and signs.

Physicians have reported that scribes improve their perceived quality of life, allowing them to focus on the patient, not the record. Patients report greater satisfaction, feeling that the doctor spent more time listening to and caring for them—that they were more attentive.

Of course, one of the most-cited drawbacks to utilizing medical scribes is cost. They have to be trained and be paid for their technical skills. But evidence is rapidly emerging that indicates significantly increased productivity—doctors can see more patients when using scribes.

Determining a scribe’s scope of work can be complicated as well. Generally, scribes are just notetakers and are prevented from touching a patient (even in emergencies), and often they are not qualified for order entry. Depending on specialty and practice policies, that can severely limit their usefulness.

Finally, there tends to be a higher turnover rate among medical scribes. Often, a medical scribe is using the position as a “stepping stone” on his

or her way to a career in medicine. An effective scribe program should factor in the turnover rate in how it operates, developing new scribes to replace those who leave for other opportunities.

EXPERT COMMENTARY

A study published late last year by the *Journal of the American Medical Informatics Association* examining the relationship between health-IT-related stress and burnout found that about 70% of physicians reporting burnout cited EHR overload and related IT factors as major sources of professional frustration and fatigue. Electronic charting leads many physicians to perceive that face-to-face time with patients has decreased—that tapping on a computer distracts and impedes communication in the exam room.

Even more onerous is the sense that the “convenient” EHR access online has intruded into family and personal time at home. Everyone touted electronic records as providing all the data a provider needs at his or her fingertips—but not many champions of the medium discussed how all that data would get *into* the record in the first place. It turns out the provider is responsible for the lion’s share of the data.

If your practice has invested in the latest and greatest EHR on the market, the sales rep probably made a point to the effect of “This system will pay for itself by making you more efficient and reducing your workforce head count.” That makes it hard to consider adding medical scribes as a strategy to address growing cyber-fatigue. It seems counterintuitive when struggling to keep the practice profitable.

However, if deploying scribes can allow a physician to see just one more patient per clinic session (based on half-day sessions), the additional revenue should at least pay for the scribe’s salary and benefits. Depending on specialty, revenue per visit (RPV) can exceed \$200. Six additional patient visits per week (\$1,200) multiplied by 46 weeks (assuming six weeks off per year) should yield over \$55,000.

And if a scribe strategy helps relieve burnout, the practice will save hundreds of thousands of dollars by reducing physician turnover.

FINANCIAL MANAGEMENT


1. Medical Center Improves Collections and Patient Experience with Upfront Payment Program

Alexandra Wilson Pecci, *HealthLeaders*, July 27, 2020; <https://www.healthleaders-media.com/finance/medical-center-improves-collections-and-patient-experience-upfront-payment-program>

ABSTRACT

Semirural Floyd Medical Center in Rome, Georgia, has revised its strategy for collecting patient balances and has seen a significant improvement in patient revenue—and a decrease in patient complaints about their balances due. The medical center has accomplished these results by adopting the services of Nashville-based CarePayment, a medical finance company that offers interest-free financing for patients who can’t pay their balances in one lump sum.

CarePayment’s program is a full-recourse plan; that means the finance company pays the



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patient's balance up front, but Floyd has to pay back any balances if the patients fail to keep up their payments. There's no credit check nor credit reporting, and the plan doesn't charge patients any interest. Financing fees are borne by the medical center as a discount. (The up-front payment is the patient balance less the fees.)

The center's financial director says the improvement in cash flow and the reduction in billing and collection costs justify paying the fees. Patient collections are up some 123%, and among patients who choose CarePayment as an option, only about 6% default on their plans. Patient complaints are nearly nonexistent: somewhere around a half percent.

EXPERT COMMENTARY

Historically, many hospital systems have struggled with the challenge of collecting patient balances. In this country, patients have a hard time viewing their residual balances as *their* responsibility. There's a general feeling that it's someone else's obligation to pay for their care—usually the payer, whether government or private. People don't understand the copayment system, and the breathtaking rise in deductibles and copayments in recent years caught almost everyone off guard.

The old days of deductibles between \$100 and \$500 and of 10% copayments allowed providers the luxury of accepting “insurance-only” reimbursement. And it was often easier to write off old balances than to pursue them doggedly. But today's insured patient bears a much higher percentage of the overall costs of care. And providers can't really afford to write off the thousands of dollars appearing in the patient-balance column on the aged accounts-receivable report.

About 15 years ago, a few creative-minded businesses saw opportunity in the trends toward greater patient balances due. Companies like CareCredit (now part of giant Synchrony Financial) had been offering health-related credit services since the late 1980s in industries where insurance benefits are low (or nonexistent). Dentists, optometrists, chiropractors, and even

veterinarians offered CareCredit services before most medical practices had even heard of them.

These days, CareCredit and similar programs have become commonplace in doctors' offices. Other companies such as CarePayment, Medifinancial, ClearOne, and many more offer variations on the theme of patient-balance financing. Some are full-recourse, and some have limited- or no-recourse options. Some charge patients a very high interest rate, and some have no-interest options. (Of course, the no-interest plans depend on charging the practice a hefty discount. *Somebody* has to pay the debt service!)

We recall how medical practices reluctantly adopted credit-card payments, so it wouldn't surprise us if smaller practices prove reluctant to partner with credit companies. Ignoring such a strategy, however, could lead you to be “penny wise and pound foolish.” Find the right partner for you and your patients, and you will likely see a significant increase in revenue.

2. How the Johns Hopkins Hospital Uses Financial, Operational and Clinical Collaboration to Achieve Cost Savings

Eric C. Reese, PhD, *HFMA News*, July 15, 2020; <https://www.hfma.org/topics/news/2020/07/how-the-johns-hopkins-hospital-uses-financial--operational-and-c.html>

ABSTRACT

The 1,145-acute-bed, \$2.5 billion Johns Hopkins Hospital developed an effective framework to manage performance improvement and identify cost savings across its enterprise several years back. By cultivating a collaboration among its finance, operations, and clinical areas, the hospital has thrived in Maryland's unique approach to reimbursement—and most recently, in the face of the COVID-19 pandemic.

Maryland received a waiver from CMS that exempts it from participating in Medicare's prospective payment system. Its reimbursement system includes a policy of global budget revenue, under which a hospital's regulated revenue is

subject to a fixed revenue cap. That ensures that the hospital has a predictable annual revenue, but it shifts the focus to cost control rather than revenue growth to improve profit margins.

Careful planning in a collaborative environment has produced remarkable results. The eight-month, annual planning process begins on the financial side, focusing on budgeting and determining institution-wide performance targets. Three months in, department heads receive the annual targets and begin their processes for analysis, cost-cutting, and projections. Team members share information and insights, trying to predict obstacles and devising strategies for overcoming them.

This strategy has resulted in interdisciplinary initiatives, such as a clinically integrated supply chain that examines “value analysis,” which have clearly benefited the bottom line without compromising clinical care. The administration emphasizes optimizing the value of every expense—getting the most bang for each buck.

EXPERT COMMENTARY

The venerable Johns Hopkins system finds itself in the unenviable position of revenue control that severely limits its ability to grow income. Hence the focus on cost control and value analysis. These disciplines will profit (both literally and figuratively) any healthcare-provider business, but we’ve found that too many practices labor under a mindset that emphasizes cost-cutting rather than revenue growth.

Small and medium-sized practices often neglect the tedious work of developing (and sticking to) an annual budget. Not having a budget wastes a tremendous amount of time and energy—not to mention the fact that such neglect usually leads to missed opportunities for substantial cost control.

Imagine life in your practice day by day and month to month in which the physicians or partners don’t have to be interrupted with requests for requisition approvals or special meetings to hash out an unplanned expenditure. A few

months of hard work before the beginning of your fiscal year can provide that.

With good budgeting, your executive leaders, administration, committees, department heads, and managers will have carefully planned spending limits. Approvals will only be needed for expenses exceeding budgeted amounts. As a bonus, every year you enter into the budgeting process, the work gets easier. Experience and data will make the planners more efficient (and more accurate) in predicting the future and strategizing your financial management.

Learn from this major-league player: Johns Hopkins uses a highly collaborative approach to its budgeting process. Not only will you get the collective knowledge and wisdom of your organization, but you will also have broad (emotional) ownership in the final budget. And that will almost guarantee success.

PHYSICIAN ISSUES

1. Working in a Male-Dominated Medical Practice Can Cost Female Physicians \$90,000—or More

Maggie McGrath, *Forbes*, July 30, 2020; <https://www.forbes.com/sites/maggiemcgrath/2020/07/30/working-in-a-male-dominated-medical-practice-can-cost-female-physicians-90000-or-more/>

ABSTRACT

The fact that women physicians draw less pay than their male counterparts has become common knowledge across the entire spectrum of American healthcare. Medscape’s annual salary survey reported a 25% wage gap between male and female primary-care doctors. With specialists, the gap grows to about 31%. A new study out of Harvard Medical School reports that the gaps widen when the medical staff has a higher men-to-women ratio.

In nonsurgical practices staffed equally by male and female doctors, the men average 12% more in compensation. Where the males number in the 90% range, the gap increases to 20%. Using

the average reported earnings from the nearly 10,000 groups surveyed, that means women get paid about \$90,000 less per year than their male counterparts.

For surgical practices, the men and women endure a 10% differential when they are equally represented on the staff, and it grows to 27% (or \$149,460 per year) when the staff is 90% male.

EXPERT COMMENTARY

People who don't understand the U.S. healthcare delivery system—especially the professional component—tend to see (and report on) statistics like this as outrageous examples of sexism that needs immediate correction. Veteran medical-practice leaders read an article like this and immediately think of a dozen or more questions:

- How were responding physicians grouped?
- How did practice structure and ownership impact the wage gap?
- How was experience factored in?
- Did group size affect the gap?
- Did compensation type affect the gap? (For example, was the gap the same in practices relying heavily on productivity to set incomes? How was productivity measured?)

How a practice measures a physician's value—male or female—greatly impacts his or her earning potential. And not only does measuring that value range widely from organization to organization, but the dynamics of today's shifting reimbursement schemes make the future of medical revenue very hard to predict. A traditional private practice, using the classic model of compensation (meaning pay received by the physician is based on how much business they personally bring to the practice) would appear to offer the fairest compensation for men and women. After the bills are paid, the physician receives the money collected for his or her actual work.

And yet, you'll often find a wage gap there as well. How can this be? Perhaps it's a by-product of our culture—women are expected (and often carry self-expectations) to manage the home, including a large part of child-rearing. Despite

the advancements of the past 30 years or so, male physicians feel freer to stay longer, take on “one more” surgical case, work an extra on-call time slot. Right or wrong, nature or nurture, it's one of the differences between working men and women—even in the 21st century.

The complexity of why wage gaps persist prevents any of us from coming up with a simple solution. But those challenges shouldn't keep you from taking a serious look at how physicians are compensated in your practice. There may be a number of subtle factors that work against you when trying to level the playing field. Eliminate what you can, and think creatively to lessen the impact of what you can't change.

2. ACP Professional Accountability Principles

Board of Regents, American College of Physicians, March 2018

ABSTRACT

Accountability, according to the American College of Physicians (ACP), “refers to the obligation of one party to justify its actions and be held responsible for those actions by another interested party and encompasses three main components”:

- The accountable parties (Who is accountable to whom?)
- The domain of actions (What are the parties responsible for?)
- The procedures of accountability (What are the processes to evaluate compliance?)

When it comes to “professional accountability,” the ACP Board of Regents adopted a definition of *professionalism* as a defined common belief in a common set of standards and values. Therefore, *professional accountability* can be viewed as both internal and external. *Internal* focuses on the physician's responsibility to patients, colleagues, and society to accept and meet clinical and ethical standards. *External* focuses on obligations to the public, to regulatory agencies, and to the marketplace in which the physician operates.

These underlying definitions serve as a sort of “preamble” to a number of principles the ACP adopted a couple of years ago in a somewhat contentious effort to create a transparent and rigorous (but not unreasonably burdensome) system of continuous education, ongoing quality assurance, and maintenance of certification for its member physicians.

The ACP document concludes with several principle statements that prioritize clinical performance over maintenance of certification, explicitly affirming that maintenance of licensure should not compromise patient care nor create barriers to physician practice.

EXPERT COMMENTARY

Official documentation that delineates ethical principles often requires more than one reading to comprehend fully what the governing body is really getting at. This paper from the ACP Board of Regents is no exception. In fact, it would take a little background research to understand some of the statements in this document. Many internal-medicine specialists have expressed strong opinions about requirements to maintain board certification.

We don’t intend to address the controversy. Rather, these principles serve as a strong reminder of society’s stronger-than-ever demand for medical professionals to be accountable for their actions. It wasn’t that long ago that the physician community functioned as a closed system that seemed more interested in protecting one another than in protecting patients. Accountability to payers, health systems, government entities, regulating bodies, and the like was viewed as interference from the outside.

Physicians are more accountable than ever—to the point that many (especially veteran) doctors feel they have lost all control of their lives and livelihood. The profession as a whole has been accused of being more self-protective than self-policing for a long time—and sometimes with good reason. But credentialing and certification, risk prevention, and cost control have all brought more reporting requirements into the

practice—to the point of hampering our ability to do business!

Ironically, physicians in group practice have not been terribly effective at holding one another accountable. You will hear partners talk *about* one another—about weaknesses, irritations, or mistakes—but when it comes to *confronting* disruptive behavior, those same partners fall eerily silent. The reluctance to confront may be motivated by a gracious, forgiving spirit, but more often it comes from their own fear of scrutiny.

Honest, responsible accountability is actually a good thing. When properly administered, it contributes to quality improvement and safety. And an organization with a conscientious commitment to accountability will tend to be more honest, more open, and more “human” in other aspects as well.

MARKETING/PUBLIC RELATIONS

1. How Email Marketing Can Help Collect Delinquent Medical Payments

Hoala Greevy, *Physicians Practice*, July 22, 2020; <https://www.physicianspractice.com/view/how-email-marketing-can-help-collect-delinquent-medical-payments?eKey=bmNvbGxpbnNAZ3JlZW5icmFuY2guY29t>

ABSTRACT

Thanks to the higher-than-ever financial burden borne by patients—including those with “good” health insurance—medical practices struggle with collecting those patient balances. According to a study conducted by athenahealth, providers are abysmal at collecting time-of-service payments.

It’s more important than ever for you to use all the tools in your kit to collect patient balances. One oft-neglected channel for communicating medical bills—HIPAA-compliant e-mail—can make a positive impact on your patient-balance collections. Adding e-mail to the traditional channels of phone calls and paper statements broadens your reach and closes possible gaps.

For very little additional cost, for example, you can send a prestatement e-mail to patients, informing them that the bill is coming. It will help them plan ahead. Once the statements go out, follow-up calls by an automated system and automatic e-mail reminders will deliver your message more effectively for much less money than “snail mail.”

Be as transparent as possible when it comes to medical billing. Have your financial policies in writing. Use signs, e-mails, paper handouts, and your Web site to explain financial obligations. Take an objective look at your bills and reminders. Can the average person understand them? Use plain language and spell out obligations and options clearly.

Make sure patients have an accurate picture of what anticipated care will cost them out of pocket—*well before the scheduled service*. Create as many effective patient payment options as possible, and monitor multiple communication channels for them to ask questions or raise concerns.

Use collection services only as a last resort. And don't do it without clear warning: give them a date and dollar amount due to avoid going to collections.

Finally, include financial topics in your marketing. Don't dodge the issue—consider strategies such as including a satisfaction survey with an e-mailed bill reminder. Help all staff understand how good patient relationships improve balance collection. People who owe you money will respond much more quickly if they like you.

EXPERT COMMENTARY

The typical patient coming to your practice can prove pretty resistant when it comes time for him or her to pay their share of the bill. Consider these common patient characteristics:

- Not prepared for healthcare costs (most people don't save for rainy days)
- Expects insurance to pay the bill (most do not understand the insurance they pay for)
- Doesn't understand how deductible and copayments work

- Doesn't understand the language used around a medical office
- Feels somewhat resentful that he or she experienced the bad luck of needing medical care
- Thinks that medical offices can't do much legally to collect payment
- Thinks doctors make plenty of money already

Collecting patient balances has always been a tough assignment, but in these days of high deductibles and copays, it can seem nearly impossible. But it's not impossible at all if you approach it correctly and keep in mind these principles:

- **Provide education, information, and transparency.** Give patients down-to-earth, plain-language information about the billing process and your financial policies.
- **Manage expectations.** From the outset, begin the information process. Outline what the patient can expect from his or her insurance company and from you.
- **Shift gears from “debt collector” to “financial resource.”** In every communication and conversation, steer clear of the “you owe us” message. Replace it with “Let us help you get this bill settled.”
- Within reason, be as flexible and patient with people as possible. Offer lots of options. Stay up-to-date on assistance programs that might be available.

If you convince patients that you are on *their* side from the very beginning, you will find them much more happy and willing to pay your balance due first.

2. All-Time First and Best Healthcare Marketing Tips and Techniques

Peter Do, blog post on *Healthcare Success*; <https://healthcaresuccess.com/blog/doctor-marketing/first-best-healthcare-marketing-tips.html>

ABSTRACT

Marketing strategist Peter Do reminds healthcare organizations not to neglect some seemingly

elementary marketing tools readily available. These fundamental, time-tested strategies still work today, and often without the high price tag associated with the “latest and greatest” marketing ploys out there.

He offers, as it were, a checklist for healthcare marketers to be sure they haven’t overlooked some simple tactics:

- **Use external signs.** Well-placed, highly visible signs work for you 24/7.
- **Create effective referral systems.** You can’t optimize referrals without an effective system. Your referral processes (both in and out) need to run smoothly and efficiently.
- **Happiness is your “product.”** People don’t shop for a surgery. They are seeking relief and restoration. Promoting your skills with a knife or endoscope won’t draw patients. But promising quick recovery, effective conservative treatment, and restoration to normal activity will.
- **Differentiate your practice.** Develop a market presence as *the* place to go when people are seeking the services you offer.
- **Give something to get something.** Freebies do more than generate interest and brand recognition. There’s a psychological tendency to feel a bit more obligated to someone who already gave you something. The gift can be anything from accessible, rich information on your Web site to a handy doodad emblazoned with your logo.
- **Digital front door.** Nearly every patient’s journey with you involves an Internet search early on—perhaps as the first step. Search-engine optimization and online reputation management are critical for keeping your digital front door open and active.
- **Internet presence must be local, mobile, and convenient.** Everyone (it seems) uses a smartphone these days. That’s why everything you post on the Web must be “small-screen friendly.” It has to look good and be easy to use on a telephone screen. Use tools such as

Google My Business (free) to develop and manage your *local* presence on the Web.

EXPERT COMMENTARY

Even though most of us are exploring new digital-media channels for marketing our practices, the underlying principles of a good marketing strategy remain the same. Certainly, you must recognize and leverage your “digital front door.” You must have an attractive Web site and a lively social-media presence. But those tools only reflect the age-old principle of taking your message to where your target audience will see and hear it. Your target market lives a large percentage of their lives online. It’s an old concept in a new format.

Physicians have been making the same mistake ever since the American Medical Association relaxed its canon of ethics to allow commercial marketing: selling the wrong “product.” No one shops for surgery—not even cosmetic surgery. Surgery is something you endure to acquire the results. Those results are your product. Salesmen used to say, “You don’t sell the steak; you sell the sizzle.”

Optimizing your referral system recognizes that you have more than one marketing target. It’s one thing to make your practice attractive to patients, but referring physicians, employers, allied healthcare services, and anyone in position to send a patient to you can make up a significant portion of your marketing target. The more specialized your practice, the more important it is to attract referrers.

The concept of “giving something to get something” might cause some practices a little heartburn. Physician-owned practices in particular have a reputation for avoiding spending money on advertising. That comes from seeing marketing as an expense rather than as an investment. Without thoughtful strategy, marketing might not produce a very high return on investment (ROI), but a well-planned and carefully executed marketing plan will produce practice growth and a healthy ROI.

HUMAN RESOURCES

1. Four Ways to Spot a Potentially Toxic Hire over Video Interview

Aytekin Tank, *Fast Company*, July 17, 2020; <https://www.fastcompany.com/90528856/4-ways-to-spot-a-potentially-toxic-hire-over-a-video-interview>

ABSTRACT

Toxic employees are more than just workers who appear to be miserable all the time—they're the ones who infect everyone around them, bringing coworkers, bosses, and direct reports down with them. They suck the energy out of the workplace and destroy company morale.

One study reported that while a “superstar” employee can add \$5,000 per year to the company's profit, a toxic employee can erode productivity to the point where he or she *reduces* profits by more than twice that amount—around \$12,000 per year!

Spotting a toxic personality type during the interview process is very difficult; after all, even the worst people can behave themselves long enough to get hired. And with many companies relying on remote interviews, the task can feel nearly impossible.

Therefore, develop proven strategies such as the following to identify (and eliminate) those applicants who will likely prove detrimental to your office:

- **Ask the difficult questions.** Don't ask hypothetical or theoretical questions. Ask specifically about past experiences. For example, ask questions such as these: “Describe a time when you've dealt with stress in the office,” or “Tell me how you handled working with a particularly difficult person.”
- **Look for honesty and vulnerability.** Asking, “What about yourself would you most like to improve?” can reveal if a candidate leans toward humility or arrogance.
- **Focus on the “how” over the “what.”** You can look at a résumé to determine the “what” information about a candidate. Instead of

asking what they've accomplished, ask how they did it.

- **Get your team involved.** As appropriate, try not to interview alone. A second or third set of eyes and ears can help you pick up on subtleties that you might otherwise miss.
- **Speak with former coworkers.** Often underutilized, reference checks should play an important role in your vetting process. Ask former colleagues, supervisors, and direct reports what it's like to work with the candidate. If their answers are short and colorless, that may be a red flag—what are they afraid to tell you?

EXPERT COMMENTARY

Some managers seem to have a special gift for hiring excellent employees—but it's not simply a special talent. You can learn the same techniques used by the superstars of recruiting. Although video interviews are much better than, say, telephone interviews, the medium makes it difficult to pick up on some subtleties of face-to-face communication.

More importantly, the best methods for spotting a potentially toxic employee remain the same whether you conduct your interviews by telephone or computer, or in person. The tips in this article add up to a good recipe for screening out the “bad apples.” The “trick” (if any) is using your boldness, persistence, and alertness as an interviewer.

Notice the emphasis on asking tough questions designed to get behind the image every candidate tries to project. It's easy to present oneself as a true professional as long as you talk about theory and concepts, but asking for real examples of conflict resolution or problem-solving can catch the interviewee off guard. Instead of asking, “What's your greatest weakness?” ask, “What would you like to improve?” The latter version is more positive and may even reveal whether the candidate can honestly self-critique.

Finally, admit to yourself that you can be fooled. Avoid interviewing applicants alone. Not only do you help protect yourself from later

misrepresentations of what transpired, but you get the observations and input from another person. Similarly, don't neglect or minimize reference calls. It's sometimes discouraging to make these calls in today's "name, rank, and serial number" HR departments, but with a little creativity and friendliness you can elicit more information than simple facts of employment, pay rates, and eligibility for rehire.

2. Managing Anger in Controversial Times

Marlene Chism, *SmartBrief*, June 1, 2020;
<https://www.smartbrief.com/original/2020/06/managing-anger-controversial-times>

ABSTRACT

Workplace-behavior expert Marlene Chism points out that a second pandemic has broken out alongside COVID-19: *anger*. From road rage to social-media posts to outright terrorism, anger has been on the rise, and escalating rapidly. While we can't cure the world, we can take control in our areas of influence as leaders and in our personal lives. Chism offers four specific strategies in pursuit of control:

1. **Increase self-awareness.** We often become disconnected from our "inner landscape" created by our feelings and emotions. We don't notice mounting frustration, and our emotions begin to color our assessment of—and responses to—difficult situations. Chism suggests setting your watch to beep at one-hour intervals to remind yourself to pause and look inward for a moment.
2. **Identify triggers.** Triggers are personal and often embedded in our subconscious minds. What sets you off may go unnoticed by someone sitting next to you. Try making a list of situations in which you have been accused of "overreacting" or misunderstanding someone's intentions. Analyze your thoughts and reactions for defensiveness, aggression, or rage. See if you can uncover what actually triggered your anger and why. Bringing that awareness to mind will help you control how

you respond when someone presses your "buttons."

3. **Align anger with purpose.** When anger arises inside you, it may not be "bad." Anger about an unjust situation can provide energy to do something about it. Uncontrolled anger, on the other hand, will usually prove destructive. Stop and ask yourself, "Will my expression of anger build or destroy?" If it serves your purpose and leads to bridge-building (as opposed to bridge-burning), you could help others find the energy to act as well.
4. **Master your energy.** Sometimes anger is "just energy that wants to go somewhere." Simply suppressing it can be destructive emotionally, organizationally, and even physically. To master this energy, create some space. Don't act immediately—take some time to breathe and think. Figure out how to channel the energy creatively. Once you've calmed down, you can reapproach the situation logically.

EXPERT COMMENTARY

Whether you're scrolling Facebook or standing in a six-foot-spaced line at a retail store, you will find it difficult to ignore the anger that seethes just below the surface nearly everywhere. Tempers are short, reactions are exaggerated, and anger flares out of control more easily than usual.

People on both sides of every issue have one thing in common: they are angry at the people on "the other side." Some people give vent to that anger directly, but most still suppress the urge to engage in debate.

All that suppressed rage exacts a toll that can be even more destructive than getting caught up in another pointless argument. It stresses every part of you—mentally, spiritually, and physically. Some very disturbing statistics are now emerging regarding depression, suicide, and substance-abuse recidivism. The pandemic all but halted our booming economy, and its effects will be felt in the market for a long time. It appears that its adverse effects on public health reach far beyond

COVID-19 cases, and those effects will echo for months—perhaps years.

Marlene Chism offers some positive, practical steps you can take to address the anger trying to hijack your mind, soul, and body. In general, these tactics come from the currently popular behavioral-health concept called “mindfulness.”

Mindfulness covers a range of techniques and philosophies, but in therapy it generally refers to focusing your awareness on the present moment, while calmly acknowledging and accepting your feelings, thoughts, and bodily sensations. It requires significant emotional intelligence and self-control, and it takes a lot of practice.

RISK MANAGEMENT/MEDICAL/LLEGAL

1. U.S. Doctors on Coronavirus Frontline Seek Protection from Malpractice Suits

Tom Hals, *U.S. News and World Report*, April 2, 2020; <https://www.usnews.com/news/us/articles/2020-04-02/us-doctors-on-coronavirus-frontline-seek-protection-from-malpractice-suits>

ABSTRACT

Both state and federal legislators have felt tremendous pressure since the early days of the coronavirus outbreak to provide legal cover for decisions made in crisis-stricken emergency rooms. Overworked staff—some practicing outside their normal areas of expertise—serving overcrowded hospitals justifiably fear malpractice accusations from patients and family members experiencing tragic outcomes. Avaricious tort attorneys are already planting seeds with ads like “What you should know about medical negligence during the COVID-19 crisis.”

Plaintiff attorneys have publicly claimed that some providers are following untested treatment plans or use hastily designed and manufactured patient-care equipment. Physicians worry about patients presenting with symptoms (such as cardiac or stroke symptoms) who normally would

be admitted overnight and tested extensively, as they’ve had to send them home to make room for patients with COVID-19.

Lawyers argue that the legal system already protects medical professionals from frivolous suits. They maintain that attempts to control the special circumstances of COVID-19 could spill over into relaxing standards for unrelated cases.

The question revolves around the legal requirement to prove that a physician operated at the “standard of care” established by the profession and the industry. This (hopefully) once-in-a-lifetime crisis makes it hard to define that standard. What is truly a “reasonable” expectation?

EXPERT COMMENTARY

This article, written early in the COVID-19 crisis, discusses legislation introduced by Senator Ben Sasse (R-NE) to protect doctors practicing outside their areas of specialty or using a modified medical device. His Health Care Workforce Protection Act of 2020 (S.3372) was referred to committee months ago, and many of the concerns addressed therein were included in the Coronavirus Aid, Relief, and Economic Security (CARES) Act and other measures.

The CARES Act focuses on *volunteer* care, but compensated providers have protection in extraordinary circumstances (public-health emergencies) under the Public Readiness and Emergency Preparedness (PREP) Act. Individual states have enacted similar legislation as well.

Situations involving gross neglect or wanton disregard will not be protected, but emergency circumstances will be taken into account whenever a complaint is being evaluated for “standard of care.”

Both houses of Congress and both political parties have expressed concerns over these issues, and for once it appears governing entities agree that a public-health emergency is not to be considered fertile ground for rainmaking attorneys seeking new revenue sources.

2. Detroit Nurses Sue Tenet for Alleged Retaliatory Firings over COVID-19 Safety Concerns

Hailey Mensik, *HealthcareDive*, June 12, 2020; <https://www.healthcarediver.com/news/detroit-nurses-sue-tenet-for-alleged-retaliatory-firings/579704/>

ABSTRACT

A lawsuit filed in June alleges that Tenet's Detroit Medical Center's Sinai-Grace hospital fired employees in retaliation for bringing attention to patient and employee safety concerns during the coronavirus pandemic. While not commenting directly on the case, the hospital did acknowledge that employees were dismissed for taking inappropriate photographs of deceased patients.

Seeking \$25 million each in damages, the four plaintiffs of the suit accuse the hospital of not only violating Michigan's Whistleblower Protection Act, but also intentionally inflicting emotional distress on the plaintiffs. Two of the terminated nurses complain of inhumanly long shifts (25+ hours) and inadequate personal protective equipment (PPE). They claim to have raised their concerns with management in late March and early April and only went to the media when management failed to act.

In mid-April, a photo depicting bodies of deceased patients who had COVID-19 went viral. The four plaintiffs deny having taken or sent the photos, and they allege that another employee admitted to taking the pictures.

EXPERT COMMENTARY

We expect to see a growing number of legal cases involving COVID-19 in the months (perhaps even years) to come. And while federal and state governments have put some rules in place designed to rein in potential malpractice claims, personal injury attorneys will likely find some fertile revenue fields in the realm of employment law.

Nearly every employer was caught flat-footed by the chaos caused by a pandemic, government intervention, shutdowns, and quarantines. We watched the Internet daily (several times a day!)

as new rules were created, released, revised, and revised again. Medical science changed its mind regarding contagion, safety, and PPE.

In the end, a lot of people took financial hits—some were devastatingly serious. You can expect employers to be sued for discrimination, lack of safety, harsh or draconian interpretations of rules, and more.

As an employer, your best bet is transparency and support for your employees. Avoid falling into an adversarial position with staffers. Bend over backward to show that you care about them. In doing so, you may never know what future trouble you have avoided once this mess is over.

LEADERSHIP/PROFESSIONAL DEVELOPMENT

1. "Is It Safe for Me to Go to Work?" Risk Stratification for Workers during the Covid-19 Pandemic

Marc R. Larochelle, MD, MPH, *New England Journal of Medicine*, May 26, 2020; <https://www.nejm.org/doi/full/10.1056/NEJMp2013413>

ABSTRACT

Marc Larochelle, MD, internist and researcher at Boston University School of Medicine, studied emerging data early in the COVID-19 pandemic regarding occupational risk—especially for workers designated “essential” amid stay-at-home orders and other social-distancing measures. Healthcare workers—especially in hospital settings wherein patients with coronavirus were being treated—showed significant infection rates. Workers in transit, grocery, and corrections also showed higher rates due to difficulty of maintaining safe physical distance in these settings.

He proposes a three-component strategy for physicians counseling patients regarding risk factors at work:

1. **A framework to help clinicians counsel patients about continuing to work during the pandemic.** He offers a grid with two axes: “Risk of death from COVID” and “Occupational

risk of contracting COVID.” The intersections of these risk levels help quantify how safe or risky it will be for the patient to go to work.

2. **Urgent policy changes to ensure financial protections for people kept out of work.** A large number of workers in high-risk situations (healthcare support services, for example) are among the lowest paid. They can ill afford to miss work.
3. **A data-driven plan for safe reentry into the workforce.** Such a plan will have to be flexible to accommodate the emerging data.

EXPERT COMMENTARY

Dr. Larochelle introduces his thesis with a compelling story of the tragic death of one of his patients, an older, high-risk diabetic who worked in support services at a nursing home. There’s no way to tell whether she contracted the disease at the facility (there were no cases of which she was aware), but he mourns the lack of guidance for having a conversation about workplace risk. “It’s too late for [her],” he says, but we have the means and the moral obligation to protect the thousands who must decide whether to go to work or stay home.

Now that the pandemic has dragged on for months, much of the public is very tired of the situation. Despite the CARES Act and similar initiatives by federal agencies and state governments, many workers are hurting financially and feel the need to return to work. Even those who have been telecommuting in order to “shelter in place” want to get back to the office and interact with real people face-to-face. So the question “Is it safe to return to work?” continues to hang over most of the nation.

As a leader, you have to reconcile what could seem to be conflicting issues. Decisions about bringing your employees back to work must reasonably balance the following:

- **Employee safety.** What measures can you put in place to decrease chances of exposure and infection?

- **Patient service.** How soon can we get back to “normal” regarding patient volumes, range of services, freedom to bring family members, and more?
- **Practice profitability.** In the end, we are running a for-profit enterprise; how can that best be accomplished?

Emphasizing one priority over the others could result in failure on multiple fronts.

2. The World’s Supply Chain Isn’t Ready for a Covid-19 Vaccine

Brendan Murray and Riley Griffin, *Bloomberg*, July 25, 2020; <https://www.bloomberg.com/news/articles/2020-07-25/the-supply-chain-to-save-the-world-is-unprepared-for-a-vaccine>

ABSTRACT

Government agencies, big pharma companies, and independent researchers continue to race toward developing an effective vaccine for COVID-19. The typical seven (+/-) years to develop a drug in this country must be shortened to *months*, not years. And the most optimistic estimates predict a workable vaccine in the 2020–2021 winter months. But experts in the worldwide shipping industry admit that they are simply not ready to handle the rapid distribution of the drug to billions of people worldwide.

Freight companies have been seriously stretched by the pandemic, and some air carriers have pressed otherwise idle passenger planes into service as cargo planes. Satisfying the demand for PPE demonstrated bottlenecks throughout the supply chain, and shipping pharmaceuticals is far more complex. Refrigeration requirements alone create vulnerabilities that could result in airplanes full of ruined shots.

Using, say, wide-body Boeing 777s, it would require about 8,000 planes to safely deliver vaccines to just one-half of the world’s population! And that barely addresses the additional challenges of getting refrigerated vaccines to third-world and remote areas that currently rely on

surface transportation or aerial drones to deliver drug supplies. Vaccines might not survive those conditions.

EXPERT COMMENTARY

One or two big pharma companies have boasted of their expectation to deliver a COVID-19 vaccine before December. They are in Phase 3 human trials now, but more conservative experts believe midwinter will be a more likely release date. But how will the companies manufacture and distribute billions of doses rapidly?

Assuming they can churn out safe vaccines (without skirting safety protocols), where will they come up with the 8,000 wide-body planes needed to deliver to half of the world? How will they get doses to remote areas? How will they move rapidly enough to avoid spoilage due to lack of refrigeration?

Granted, humans have come up with amazing, creative solutions to impossible problems during crises in the past. But from our current viewpoint, it looks as if it will take a large part of 2021 to deliver enough vaccine to achieve the worldwide immunity we envision.

Expect a prioritization that includes health-care workers and other essential workers. But don't expect to see a lot of immunized people walking around anytime soon.

HEALTH INFORMATION TECHNOLOGY

1. Better Management of High Utilizers and the Impact on the Overall Costs of Care

Manjula Julka, MD, MBA, *Healthcare IT Today*, December 18, 2019; <https://www.healthcareittoday.com/2019/12/18/better-management-of-high-utilizers-and-the-impact-on-the-overall-costs-of-care/>

ABSTRACT

Many, if not most, safety-net hospitals do very little to address “social determinants of health” among the economically and socially challenged populations they serve. It's hard to make a business

case for providing services that lie well outside the traditional lines of medical- and health-related care. Administrators see such services as costs—while recognizing that a return is hard to perceive, let alone predict.

Clinician and researcher Manjula Julka, MD, sees a clear connection between “upstream social and economic issues” in the lives of high utilizers that prevent them from developing healthy lifestyles and habits. “High utilizers” are those patients with multiple chronic conditions and multiple social/economic challenges; they generally require intensive primary care and often have problems with access to care.

High utilizers often struggle with transportation problems, contributing to higher-than-average no-show rates. No-shows cost an estimated \$125 to \$350 each according to researchers. Health systems that have implemented various ride-share programs have seen reductions in no-show rates.

Housing and transitional-care problems pose a different set of challenges. Having no place to send discharged patients can increase average lengths of stay. A few systems across the country partner with other agencies and community-based organizations to connect people with resources to address housing and related problems.

Dr. Julka proposes that safety-net hospitals analyze claims data to discover which social determinates are most affecting their populations. Housing, food insecurity, transportation, and non-acute care often lead the list. The hospitals should then pursue ways to partner with local resources and connect people according to their needs.

As a data analyst, she presses the need to analyze the outcomes of initiatives and to be ready to adjust services and interventions as indicated.

EXPERT COMMENTARY

Despite all the talk about population health management in these times of evolving health-care reform, no one has quite figured out how to practically and economically accomplish its lofty goals. Much of the discussion has focused on underserved patients and groups living with

chronic health problems while having very limited access to care. Social and economic “determinants of health”—such as housing and food, culturally engrained attitudes and beliefs, and family support systems (or lack thereof)—fall outside healthcare’s normal purview. But these factors affect health-system resource utilization and medical outcomes, so health systems become stakeholders in the dilemma of how to address these nonmedical health issues.

It seems reasonable to project cost savings for a health system if it invests in social programs designed to improve these determinants. But it’s difficult to incorporate such projections in a business plan. How do you estimate an expected return on such an investment? Therefore, how do you develop a reasonable project budget?

Obviously, a health system should focus on partnering with programs and resources already in place. Agencies and community-based organizations will benefit, the hospital will create and increase goodwill in the community, and its public image will improve. A strategy that invests in the community might stand a better chance of getting off the ground if the leadership approaches it as a public-relations or marketing concept to begin with. Improved outcomes in the targeted population might create a rationale (and data) to expand the program as part of the institution’s population health management initiative.

2. What You Need to Know about the Conditions and Maintenance of Certification

Rob Anthony, *Health IT Buzz*, April 21, 2020; <https://www.healthit.gov/buzz-blog/healthit-certification/what-you-need-to-know-about-the-conditions-and-maintenance-of-certification>,

ABSTRACT

Robert Anthony, the director of the Certification & Testing Division in the Office of the National Coordinator (ONC) for Health Information Technology, offered a blog post to provide an

overview of the Cures Act final rule (published May 1 of this year) regarding the “Conditions and Maintenance of Certification” required in Section 4002 of the act. The final rule lists seven conditions that must be met for an information system to be certified:

1. **Information blocking.** Any vendor participating in the program is prohibited from any activity that constitutes *information blocking*.
2. **Assurances.** IT developers must report that they do not inhibit the appropriate exchange, access, and use of electronic health information.
3. **Communications.** Developers may not restrict or prohibit communication with their clients regarding health IT’s usability, interoperability, and security, nor about business practices, user experiences, or even the manner of use among their clientele.
4. **Application Program Interfaces (APIs)** . Most rules about APIs require transparency and cooperation for interfacing applications—including controls to prohibit price gouging.
5. **Real-world testing.** IT modules without testing (both in development and ongoing) in real-world settings will not be certified.
6. **Attestations.** The burden of attesting to an IT module’s certification conditions rests with the developer, and it must be kept current through attestation every six months.
7. **Future EHR reporting criteria submission.** The reporting criteria weren’t completed in time for the final rule, so a condition to comply with future requirements for EHR reporting was included.

EXPERT COMMENTARY

Since the early days of Meaningful Use, CMS programs designed to incentivize providers to transition to EHRs have been developing standards for eligibility to receive those incentive payments (and later to avoid financial penalties). Eventually we were required to use “certified” products with demonstrated (compliant) utilization. As software continues to develop, the

ONC has continued to refine the certification standards.

The final rule issued this year lays out the conditions of certification and the requirements to maintain certification. The primary burden rests on the software developers and vendors, but the consequences of uncertified systems could hit the practices using the products—either in denial of incentive payments or in penalties levied later.

We observed the ONC and Department of Justice making examples out of some large IT developers in recent years for their failures to comply with certification criteria *to which they had attested*. It put thousands of providers at risk for penalties and recoups of incentives because their failure invalidated providers' attestations for Meaningful Use and similar programs. The substantial financial penalties imposed on the IT vendors essentially recouped those incentives so the Fed could forego pursuing the providers for them.

For better or worse, incentive programs like MU, MIPS and MACRA accomplished something the market itself proved incapable of producing: virtually ubiquitous EHR deployment. For over ten years we watched reluctant practices unimpressed with inadequate (but expensive)

software offerings drag their collective feet into the world of electronic recordkeeping. At the end of the 1990s, EHR usage was somewhere in the 12% range. By 2017, almost nine out of ten (86%) physician offices were using EHRs (most of them certified).

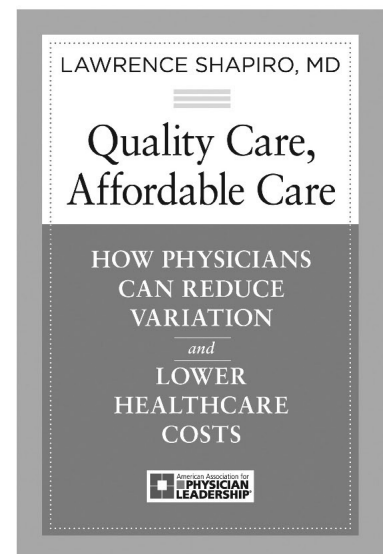
Lest you think that the Cures Act final rule is the exclusive problem of IT developers, think again. The certification process is designed to impact clinicians as well. Another article published by ONC (“What ONC’s Cures Act Final Rule Means for Clinicians and Hospitals,” <https://www.healthit.gov/curesrule/what-it-means-for-me/clinicians>) outlines the intention behind the certification conditions:

- Making patient data requests easy and inexpensive
- Allowing choice of apps (integrated add-ons using open APIs)
- Commonsense rules regarding information blocking that allow reasonable and necessary actions that protect patient privacy while handling data that is technically impossible to move
- Balancing protecting patient safety and access while protecting intellectual property rights of IT developers

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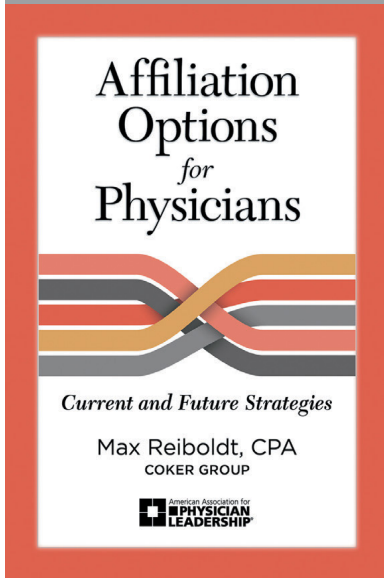
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- Physician to physician
- Private group to private group
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- Private group to private equity/outside investors, and more

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