The bottom line in healthcare marketing

Collect copays and deductibles up front to reduce bad debt and enhance your hospital’s margins

by Eben Fetters and Ron Luke

The suggestion that hospitals should collect copayments and deductibles before providing service may seem like a lesson from Hospital Management 101. In theory, it’s a given that hospitals would have processes and procedures in place to ensure that such payments are handled at the time of registration for scheduled procedures. In reality, however, many hospitals could improve up-front collections and, in doing so, would significantly reduce bad debt and improve margins.

Such collections should happen at registration if for no other reason than that it’s easier to collect these funds up front, prior to service, than it is to balance bill the patient 30–90 days after providing the service. Turning over late payments to a collection agency is a waste of time and money. What’s worse, collection letters and phone calls to patients—especially those getting over serious illnesses or injuries—is bad public relations.

Take a lesson from docs

Perhaps hospitals should embrace the same culture, training, and systems that have been in place for years in physician offices. Patients are almost always asked and expected to pay their copayments and deductibles at the time of their office visits. Patients are accustomed to this, and it’s not considered poor patient relations. So why shouldn’t hospitals do it, too?

Our experience suggests that failure to collect copays and deductibles up front is a more significant factor in hospital bad debt than is the number of uninsured patients. This part of the revenue cycle will become more important as more patients move to insurance plans with high deductibles. For example, if the percentage of payment that comes directly from the commercial patient rises from 7% to 21% and you don’t collect it, bad debt can triple with no change in the percentage of uninsured.

Develop rigorous payment policies

When done properly, up-front collections can go a long way toward improving patient relations and customer service.

When done properly, up-front collections can go a long way toward improving patient relations and customer service. How many times have patients arrived at the department on time for their procedure, only to be told to go to patient registration to complete their paperwork and financial arrangements? This not only adds to the patient’s anxiety, but also disrupts the patient’s and the hospital’s schedule.

So where should hospitals begin? First, put in place policies, procedures, and training to collect copayments and deductibles at the time of patient registration for nonemergency services. This includes the ability to process registration...
and make financial arrangements over the phone in the days prior to the scheduled procedure.

Don’t wait until the morning the patient shows up for a procedure to obtain payment information, particularly if your hospital recommends that patients not bring valuables with them on the day of a procedure. There is nothing wrong with taking credit card information over the telephone. Advance registration and financial arrangements, including payment of copayments and deductibles, keeps the hospital or outpatient center schedule working smoothly.

Talk up your policies

Once you have policies in place, communicate to all stakeholders (i.e., board members, medical staff, hospital staff, your patients, and the general public) the difference between routine, scheduled elective patient encounters and emergency cases. Failure to communicate on a regular basis will result in poor community and customer relations and will affect the measurement of a hospital’s value to the community.

Also educate all stakeholders on your collection systems and procedures. This communication is important so that key constituents are aware of pending policy changes or enforcement of existing policy.

Finally, train patient registration and business office staff to collect copays and deductibles at the time of registration. Explanations of these policy and procedure changes need to be automatic for staff and monitored for effectiveness. Too frequently frontline staff do not receive adequate training or scripting.

Proper training and communication is a customer service issue—if hospital staff know the rationale behind the policy, they can better respond to patients who have questions or complaints about collections.

It’s also a physician-relations issue. Referring doctors should not hear about the policy for the first time from a disgruntled patient or office staffer after the hospital declines to schedule a procedure until the copayment is collected.

Focus training broadly

It seems likely that the responsibility for implementing these payment policy changes would go to the chief financial officer.

But in reality, these types of changes involve significant communications and customer service training that require a broader organizational focus and commitment.

Because these policies are likely to generate a significant interaction with the board and the medical staff, the CEO and his or her team should direct this change with a coordinated effort to plan and implement the changes through advanced communication and education.

Hospitals need to understand the effect that missed financial opportunities of copayments and deductibles have on their finances.

But establishing procedures to implement appropriate customer service training and communications to collect these funds without negative public relations is just as important.

Editor’s note: Fetters is a principal with and Luke is president of Research & Planning Consultants in Austin, TX. Contact them at efetters@rpcconsulting.com or rluke@rpcconsulting.com.
Hospitals buy new equipment to care for obese patients

More hospitals are changing to accommodate the rising number of morbidly obese patients, offering bariatric surgery, and other obesity-related procedures and tests, according to a report by the Toronto, ON–based healthcare strategic information firm Millennium Research Group (MRG).

“Bariatric equipment such as wheelchairs, beds, scales, and longer-length devices are often required when surgery or other procedures are performed on very obese individuals,” said MRG senior analyst Lexie Code, in a statement.

There are currently more than 11 million obese people nationwide, a number that is expected to grow by 3% per year, bringing the number to 13 million by 2010. The U.S. bariatric equipment market will generate more than $1 billion in annual revenue by 2010, according to an MRG release.

New line of hospital garb offers patients more dignity

To boost patient satisfaction, hospitals have tried a range of initiatives, from improving physicians’ bedside manner to improving food at the facility. The latest trend is to offer patients plush pajamas that provide full coverage in the back.

Designed and marketed by the fashion and home merchandise company KN Ltd./Karen Neuberger, the new line of hospital wear is made of cotton-poly blend fabric designed to become softer with each washing. The line initially launched in 2005 as part of a partnership with Stanford (CA) hospitals and clinics. Products include pajama tops, drawstring pants, onesies for infants, and unisex hospital gowns that cover the derriere. The garments also have tie closures along the sleeves.

U.S. trails other countries in tools to provide patient care

Primary care doctors in the United States are less likely than those in several other countries to offer patients access to care outside of regular office hours or to have systems that alert them to potentially harmful drug interactions, according to a survey conducted by the New York City–based healthcare research firm The Commonwealth Fund.

U.S. physicians are also less likely than those in other countries to receive financial incentives for improving quality of care, according to the survey, which targeted more than 6,000 doctors in the United States, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom.

“In an era of advanced computer systems, it’s disturbing that the vast majority of primary care doctors in the [United States] don’t have the tools to electronically prescribe medications, access patients’ test results, or know when patients are overdue for essential care,” said Commonwealth Fund Senior Vice President Cathy Schoen, in a statement.

“The data show that U.S. primary care doctors find it difficult or impossible to perform tasks that doctors in other countries find easy; they also practice without basic decision sup-

ports that could improve health outcomes and reduce costs.”

Portable system connects patients to interpreters

Miami’s Mercy Hospital recently installed a system that allows physicians to communicate around the clock with non-English-speaking patients. The Language Access Network allows live, one-on-one communication with interpreters using a portable flat-screen device that can be installed in any healthcare setting. Patients connect with an interpreter via two-way video.

The Language Access Network call center provides interpretation services in 160 languages. For more, go to www.languageaccessnetwork.com.

New service aims to ease appointment-making process

A new online service lets consumers book and pay for medical appointments online. DoctorsDirect.com claims to simplify the process of scheduling medical appointments for consumers, and reduce insurance and billing paperwork for doctors without the need for software or training, according to a release.

The service is being tested in select markets. A launch date has not been announced. Go to http://doctorsdirect.com/consumerIndex.dd to find out more.

Medicare final rule sets physician payment rates and policies

In an effort to encourage increased communication, the Centers for

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The computer programs search claims data for suspicious patterns by comparing practitioners’ claims with their peers’ claims and larger claims databases.

Using the technology, Medicare investigators uncovered a group of diagnostic testing companies that had been using improperly obtained Medicare identification numbers to bill for exams that were likely never performed.

As a result, 83 diagnostic centers lost their billing privileges in 2006, and $163 million in payments were denied, according to the article.

**AHA calls for medical device identification system**

The American Hospital Association (AHA) is urging the U.S. Food and Drug Administration to develop a mandatory unique device identifier (UDI) system for medical devices, similar to the National Drug Code used for pharmaceuticals.

A UDI system would improve patient safety and reduce medical errors while increasing efficiency in the management of the roughly 600 medical-device recalls issued each year, according to the AHA.

With a UDI, users can conduct searches electronically—rather than manually as they are currently—and hospitals could more quickly and accurately notify and, if necessary, treat patients who have used a recalled device, according to a release from the AHA.

**Safer MRI scans for pacemaker and defibrillator users**

Currently, hospitals do not allow pacemakers and defibrillators in magnetic resonance imaging (MRI) machines, because they can cause serious problems such as burnt tissue and implant malfunction.

According to an Associated Press article, doctors at hospitals such as Johns Hopkins Hospital in Baltimore are experimenting with using MRIs that shield heart devices from melt-downs or misfires.

In addition, the article notes that by the end of 2006, hospitals will begin the first human study of a pacemaker designed to withstand MRIs.

**Medical centers to pool information about HIV therapies**

Using a $2.45 million grant from the National Institute of Allergy and Infectious Diseases, and the National Heart, Lung, and Blood Institute, seven U.S. medical centers will create the first electronic network to pool information about HIV therapy, according to an article in The New York Times.

The goal of the project is to determine the effectiveness of therapies for patients in everyday practice compared with about 100 patients selected for clinical trials.

The network will be the first formal way to track HIV and AIDS treatments and outcomes. The University of Alabama at Birmingham is managing the project.
Hospitals named to first-ever ‘Leapfrog Top Hospitals’ list

Fifty-nine U.S. hospitals have been named to the “Leapfrog Top Hospitals” list based on their positive responses to a survey asking about their awareness of and action on the 30 safe practices for better healthcare endorsed by the National Quality Forum.

The survey of 1,200 hospitals was conducted by The Leapfrog Group, a Washington, DC–based organization that aims to promote healthcare quality and safety.

Although 60% of the hospitals surveyed have fully implemented at least one of the four quality and safety categories outlined by The Leapfrog Group, the organization also found that

- more than 90% haven’t implemented computerized physician order entry under Leapfrog’s standards
- half do not have an explicit protocol to ensure adequate nursing staff or a policy to check with patients to find out whether they understand the risks of their procedures
- 30% lack procedures for preventing malnutrition in patients and do not vaccinate healthcare workers against the flu

Few adults check for source of online health information

Just 15% of 113 million American adults who search the Internet for information on health topics always check the source and date of the information they find to assess its quality, according to a survey released by the Washington, DC–based Pew Internet Project.

Three-quarters of health seekers said they check the source and date “only sometimes,” “hardly ever,” or “never.” This translates into about 85 million Americans gathering health advice online without examining the quality indicators of the information they find.

EHRs still not routine part of medical practice

In the most comprehensive study to date to reliably measure the state of electronic health record (EHR) use by doctors and hospitals, researchers from Boston-based Massachusetts General Hospital and Washington, DC–based George Washington University estimate that about one in four doctors (24.9%) use EHRs to improve delivery of care to patients. However, fewer than one in 10 uses what experts define as a “fully operational” system that collects patient information, displays test results, allows providers to enter medical orders and prescriptions, and helps doctors make treatment decisions.

The study, Health Information Technology in the United States: The Information Base for Progress, is a joint effort by the Robert Wood Johnson Foundation and the federal government’s National Coordinator for Health Information Technology. It shows that EHR-adoption rates remain low due to financial, technical, and legal barriers.

The authors of the report write that the barriers will prevent the health sector from meeting President George W. Bush’s desired goal of ensuring that most Americans have their medical information collected, stored, and organized in an EHR by 2014.

Meanwhile, the American Hospital Association (AHA) has sent a survey to community hospitals in an effort to gather information on their use of health information technology (HIT) and the barriers that prevent adoption. The AHA will use the survey findings to educate Congress about HIT and facilitate its adoption in the field.

Some specialists’ compensation shows double-digit increases

Data show a double-digit increase in the average total cash compensation levels paid between 2004 and 2006 for nine specialty practices, according to a survey of 264 healthcare organizations by the Chicago-based human resource management firm Sullivan, Cotter and Associates, Inc. The specialties showing the largest increases were neurosurgery (28%), pathology (25%), anesthesiology (18%), dermatology (18%), and radiology (16%).

The survey also revealed that 42% of participants provide hiring bonuses to physicians, with the average annual bonus for a specialist at $17,239, and the average for a primary care physician at $10,093.

Two-thirds of survey participants reported having an incentive compensation program for their physicians. In addition, 15% of survey participants plan on decreasing cash compensation levels for at least some physicians in 2006, primarily due to productivity levels, according to a release.

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Healthcare industry lags in supervision of employees

Already facing significant workforce shortages, U.S. healthcare companies must drastically improve both leadership and employee supervision, according to a study by Chicago-based employee research and consulting firm ISR.

In the survey, leadership effectiveness and staff supervision at U.S. healthcare companies lagged slightly behind the norm.

But when compared to ISR’s “Global High-Performance Companies Norm,” which comprises survey scores from companies that both perform financially at the highest levels for their industry and demonstrate excellent people practices, there was a statistically significant decline.

Leadership effectiveness was rated 12% lower and staff supervision 8% lower at U.S. healthcare companies when compared to the high-performance companies, according to an ISR release.

Survey: U.S. doctors discouraged, have low morale

Doctor fatigue and emotional burnout have led to family discord, depression, and even suicidal thoughts, according to a recent survey conducted by the American College of Physician Executives. The survey of 1,205 U.S. physicians found that

» nearly 60% have considered leaving the practice of medicine because they are discouraged about the state of U.S. healthcare

» almost 70% said they knew of at least one doctor who stopped practicing medicine due to low morale

Respondents identified low reimbursement, loss of autonomy, bureaucratic red tape, patient overload, and loss of respect as the top five factors contributing to low morale.

Physicians polled on ‘pill splitting’

Physicians are split on the practice of pill-splitting, according to a recent survey by Medical Economics.

Physicians were given a scenario in which a patient requests a prescription for twice the actual dose he needs so that he can split the pills and save money.

This is a practice frowned upon by health insurers.

In the scenario, the patient’s prescription copay had increased from $25 to $50 for 90 tablets.

According to the survey, which was published in the October 20 Medical Economics,

» 38% said they would write the prescription as the patient requested

» 36% said they would compromise by writing a prescription for a generic drug

» 24% said they would follow insurance company regulations

Respondents justified their choices in a variety of ways, citing issues of autonomy, fraud, health concerns, medical record accuracy, and the fact that insurance company executives are overpaid.
Scarborough Research to better
gauge health ad effectiveness

Scarborough Research, a media research and pattern agency in New York City, is teaming with Evanston, IL–based healthcare data information company Solucient to help advertisers better gauge the effectiveness of healthcare advertising. Scarborough maintains a database of consumer buying patterns and media usage to help media buyers, ad agencies, and networks better target and track their advertising by zeroing in on demographic groups.

Under the agreement, Scarborough is embedding Solucient’s HouseholdView™ proprietary life-stage segmentation system and HealthView Plus®, Solucient’s proprietary national research on consumer attitudes and behaviors about healthcare services, into Scarborough’s databases on consumer shopping habits, media patterns, demographics, and lifestyles.

This will allow healthcare marketers to examine local consumer media utilization to create more efficient media plans targeting specific segments, based on healthcare needs. Marketers can also use segmentation information when planning other marketing programs, such as co-marketing initiatives.

Developed specifically for the healthcare market, the HouseholdView segmentation system identifies 56 types of healthcare households. Combined with HealthView Plus research on 20,000 households annually and the Scarborough local research of 210,000 consumers specific to each market, the Scarborough-Solucient partnership will enable marketers to understand the attitudes, behaviors, and decision-making patterns of healthcare consumers.

Study: Consumer-driven plans have mixed results

Consumer-driven health (CDH) plans can reduce healthcare use and lower costs, but may also deter consumers from seeking needed care, according to a study by the Santa Monica, CA–based research firm the RAND Corporation. The researchers estimate that if all privately insured, nonelderly Americans switched from low-deductible plans to consumer-driven ones, the result would be a one-time healthcare cost reduction of 4%–15%.

However, the study’s authors note that people who have to pay more out of pocket for healthcare through CDH plans may hesitate to seek care, according to a RAND release. In addition, CDH plans may attract only healthy individuals and families, as the results of the study show that those in CDH plans tend to have higher incomes and are in better health, according to the release.

Employers’ enthusiasm for consumer-driven options cooling

The growth of consumer-driven health (CDH) plans has cooled, although it will remain strong during this fall’s open-enrollment period, according to a survey conducted by the International Society of Certified Employee Benefit Specialists (ISCEBS).

In the previous survey, released in fall 2005, benefit specialists who responded predicted that 23% of companies with more than 10,000 employees would offer CDH plans in 2006. That prediction fell short—this year’s survey respondents reported that only 13% of these large companies offered CDH plans in 2006.

Respondents to the latest survey predicted that 18% of large companies will offer CDH plans next year, according to an ISCEBS release.

Uninsured among Americans’ top health concerns

Rising costs and the problems of the uninsured are among Americans’ top concerns, according to a Health Affairs study published online on October 17 (www.healthaffairs.org). The biggest perceived health threats are cancer, HIV/AIDS, and avian flu, the researchers found.

Although most Americans do not think that the health system is in crisis, the public remains dissatisfied with both the country’s healthcare and public health systems, the researchers said. These attitudes are likely to create a climate that is supportive of increased health spending and substantial policy changes, they concluded.

Overall, however, healthcare is a “second-tier issue” for the American public, ranking behind the situation in Iraq, the economy, and gasoline prices as a priority for government action, according to the report, which was sponsored by the Harvard School of Public Health in Boston and is based

Research notes

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The hospital medical board at Valley Baptist Medical Center (VBMC) in Harlingen, TX, suffered from a lack of continuity. New board members struggled to learn and assume their responsibilities.

Some took up to nine months to feel comfortable in their roles, says Christopher Hansen, MD, chief medical officer at VBMC.

Unfortunately, just as these important leaders got up to speed, it was time for a new election.

The challenge to recruit capable leaders was not limited to VBMC’s governing board. Not unlike the situation at hospitals nationwide, maintaining physicians in positions of leadership posed a challenge throughout the organization.

To overcome this obstacle, VBMC introduced in 2004 a leadership fellowship program that participants have a maximum of two years to complete.

The goal of the program is to develop a pipeline of new leaders, Hansen explains.

That’s a worthy goal for healthcare organizations of any size—a successful leadership development initiative provides new leaders with tasks and responsibilities to gain leadership experience and trains them for the roles that they will assume, thus making the business run more efficiently and insuring quality.

A good leadership development program can do the following:

- **Identify potential leaders when they are hired.** To develop new leaders, focus on new medical staff and those who demonstrate the potential to take on leadership roles, says Barbara LeTourneau, MD, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Physicians who regularly attend meetings, ask questions, and provide feedback to current leaders typically make excellent leaders themselves, she says.

- **Provide new staff with opportunities to demonstrate their leadership qualities.** Giving potential new leaders specific tasks such as reviewing a policy or getting feedback from other medical staff, allows you to rate them and assess how they respond to leadership tasks, says LeTourneau. Ask a potential leader who succeeds at these tasks to take on more challenging projects.

### Challenges of recruiting leaders

Many physicians are reluctant to step into leadership roles because of time constraints and other pressures, says Rick Sheff, MD, chair and executive director of The Greeley Company. Therefore, you must invest in ways to continuously develop leaders.

“If you want to have physicians prepared for and willing to accept leadership positions, you need to invest in it,” he says. “You must invest in it year in and year out. It’s not a one-shot deal.”

Failure to recruit and develop physician leaders puts at risk the relationship between the hospital and physicians, Sheff adds.

Strong physician leadership is necessary to ensure that physicians play a role in discussions between the medical staff and the hospital about issues that relate to patient care and physician livelihood.

“We need physician leaders who are committed, well-trained and competent to do what they do, and [are] willing to put in the time and effort,” Sheff says.

However, to secure strong physician leadership, medical staffs must confront the following changes in the relationship between hospitals and physicians that make recruiting leaders a challenge:

- **A smaller pool of potential candidates.** The number of physicians who see the hospital as the primary focus of their practice is rapidly shrinking.

- **Physicians with less time.** Making a living practicing medicine has become more difficult and more demanding—physicians need to spend more time in their offices to make the same amount of money. As overhead costs have gone up and reimbursements have gone down, the
stresses of practice give physicians less energy and less
discretionary time for leadership roles.

» An eroded sense of citizenship. The former promise of
a medical career to provide a high social status, high stan-
dard of living, and professional autonomy has changed.
Younger physicians are often less willing and able to make
personal sacrifices to benefit the hospital when they see
fewer or reduced returns.

By submitting an application, the
medical staffer is demonstrating a
commitment to the hospital and the
medical staff—a commitment that is
essential to becoming a successful leader.

» A rise in performance expectations. As accountability
for patient care quality increases, physicians are concerned
about dedicating all of their time and energy to taking
care of patients rather than handling administrative tasks
or attending meetings.

Recruit candidates
To overcome leadership recruitment challenges, physician
leaders at VBMC took on the task of recruiting program
participants.

The leaders sent out to the entire medical staff announce-
ments explaining the components of the fellowship program.

Here’s how it works—physicians on the hospital’s med-
ical staff leadership development committee interview inter-
ested candidates.

The interviewers then each pass on to the entire commit-
tee their recommendations about whether to accept the
physician into the fellowship program.

Potential leadership fellowship candidates must meet the
following prerequisites to apply:
» Be an active medical staffer at VBMC
» Express a desire to assume a leadership position in
the future
» Interview with and receive approval from the medical
staff leadership development committee

To graduate from the fellowship, physicians must fill out
an application (including confidentiality statements) and
attend, at a minimum,
» 75% of department meetings
» 75% of full staff meetings
» at least one committee in addition to the department
committee
» one medical board meeting (by invitation or
appointment)
» one credentials committee meeting (by invitation or
appointment)
» one leadership meeting or retreat with the medical
board or board of trustees
» one board of trustees meeting (by invitation or
appointment)
» one senior management meeting (by invitation or
appointment)
» one leadership seminar

Note: The medical staff leadership development committee
rarely turns down fellowship program applicants, says Hansen.
By submitting an application, the medical staffer is demon-
strating a commitment to the hospital and the medical staff—
a commitment that is essential to becoming a successful leader.

Program kick-off
The leadership fellowship program begins with a ses-
son at which the hospital’s CEO and other leaders at the
organization discuss VBMC’s vision, values, and strategic
initiatives.

The initial seminar also includes discussion of physician
expectations, the peer-review process, medical staff bylaws,
sentinel events, and root-cause analysis. Hansen gives a pres-
entation on medical board responsibilities.

The program also includes several videos about conflict
resolution, credentialing, and other leadership roles and
responsibilities.

If you want to start a program such as the one at VBMC,
make your potential physician leaders aware of the upside of
accepting a leadership role, says LeTourneau.

This includes the ability to make a difference and provide
substantial input into the management of the hospital, the
ability to affect patient care at a broader level rather than one
patient at a time, and the opportunity to meet new challenges
and expand professionally and personally. ♦
Mentor programs help create leaders of tomorrow

by Edward Marx

Across all industries, healthcare included, the practice of mentoring appears to be at an all-time low. We see this reflected specifically in the graying of existing leadership combined with the symptomatic high-profile lack of succession planning.

The art of mentoring, a time-honored method of conveying skills, culture, and values between two individuals and an ongoing, planned partnership focused on helping a person reach specific goals over a period of time, was lost at some point after the apprenticeships of the preindustrial age and has been replaced with short-term, focused leadership programs. These programs attempt to turbocharge management education, cramming years of collective wisdom into a one-week synopsis.

The College of Healthcare Information Management Executives has a leadership development program, “The CIO Boot Camp,” that cannot keep up with the demand for enrollment. One reason for the popularity of such program is that they fill the mentoring void that exists in most organizations today.

The benefits of mentoring

Formal and informal mentoring programs offer several benefits, not only for the people who participate in them, but also for the organization.

Better your employees: A mentor offers educational tools that a person cannot normally get directly from his or her supervisor—broader experience, organizational perspective, and new skills. Learning how to perform the technical aspects of a position and career (i.e., cross-training) is different from observing the actions and hearing the lessons-learned of an authority figure (i.e., mentoring).

Valuable experience outside the realms in which an employee operates each day—such as an information technology (IT) professional being mentored by someone in financial or clinical areas—gives professionals a more well-rounded view of the organization. An employee who only enters into mentoring relationships with others in his or her department risks becoming overly focused on one area and failing to see the larger picture.

Mentors themselves benefit from the satisfaction of performing a selfless act of service, subordinating their precious time and focus for the sake of the profession and the future of healthcare.

Better your organization: Formal organizational mentoring programs may also help in recruiting and developing a healthy corporate culture. Job candidates respond favorably to organizations that care for their professional development and will facilitate mentoring to enable them to achieve career success. Such programs lead to improved recruitment and retention.

Over time, as prospective employees learn that your organization actively seeks to encourage and enable the career success of its employees, a formal mentoring program can evolve into a major differentiator in recruitment efforts, positioning your organization as an employer of choice.

A more engaged work force is another potential byproduct of a mentoring program because the program allows employees to address critical questions about their organization and leadership. The Gallup organization has statistically demonstrated that organizations with greater numbers of engaged employees significantly outperform those with non-engaged work forces in areas such as customer satisfaction and financial results.

Finally, mentoring improves patient safety and helps make it easier to implement changes in the clinical process. It is essential to building alliances in an organization and is a key factor to ensuring that we grow a new generation of trained leadership.

Better the profession: Mentoring can also have a positive effect on the healthcare community at large. Organizations that adopt mentoring programs make an investment in the collective long-term success of the industry. They actively demonstrate dedication to the future of the profession and, ultimately, to an improvement in the quality of our leaders.

The IT example

Most leaders in healthcare IT clearly understand their responsibility to leverage technology to enable clinical and financial success. However, much of this understanding results from knowledge, not transformative experience.
Mentoring can address that shortfall by giving IT leaders hands-on experience in the clinical setting. They can see what they had only heard or read about previously. Partnering IT leaders with a chief medical officer (CMO) or chief nursing officer (CNO) in a mentor relationship exposes them to new insights and understanding.

At my organization, University Hospitals in Cleveland, all employees in the IT department are required to have an annual informal mentoring experience. They work with a variety of leaders and departments, including the emergency department, radiology, lab, and patient care units. Additionally, all IT leaders participate in an active formal mentoring relationship and serve as mentors.

As University’s CIO, I lead by example. I have an active mentor and also serve as a mentor to an up-and-coming leader. I have had the privilege of being mentored by my organization’s CEO, chief financial officer, and chief operating officer. I receive informal mentoring by rounding with physicians and by shadowing nurses.

Mentorships such as these allow IT leaders to experience specific clinical care settings, answer questions, and discuss the critical intersection of IT and quality patient care. Besides experiencing professional growth, leaders return to the IT department with a new sense of purpose and motivation to ensure that clinicians are well supported in their delivery of care. Because the IT leaders witnessed how clinicians put to use the technology that the IT department delivers, they made changes to IT systems and support to help ensure a higher quality of care.

Starting points
To determine which leaders within your organization might make appropriate mentors, look inward and examine your employees’ strengths and weaknesses. A professional who lacks a strong clinical background should be paired with his or her CNO, CMO, or another well-respected clinician.

Conversely, someone who already has a strong clinical background might be paired with a CFO to gain key insights into the healthcare financial world. Just as mentoring from a CFO develops financial acumen, pairing with the CEO allows an emerging leader to understand the importance of executive presence and ways to handle organizational politics without losing momentum and direction.

Arranging mentor relationships within your own organization gives you the advantage of proximity and familiarity.

Further, the development of such relationships assists in creating a strong sense of teamwork and connectedness. Mentors from outside of the organization or the healthcare industry can offer a level of anonymity and broad perspective but may lack the context for key elements of discussions.

No time like the present
Given the limited pool of emerging leaders, mentoring is more critical than ever. It is imperative that we identify and grow talent within our organizations. Our leadership effectiveness is not so much based on formal education and rigorous reading, but real, on-the-job experience. Partnering up-and-coming leaders with members of executive leadership allows this real-life experience to occur and can accelerate growth, as well as ensure critical succession planning.

To determine which leaders within your organization might make appropriate mentors, look inward and examine your employees’ strengths and weaknesses.

The purpose of the mentorship is to allow the student to get an inside look at the mentor’s daily routine and learn to navigate the organization to facilitate success. Senior executives with differing backgrounds can identify the strengths and weaknesses of the understudy and stimulate required growth.

Many fine resources are available online and through various associations to assist an organization or individual in establishing a quality mentoring program. When executed correctly, the art of mentoring can propel one’s career and skill set to a higher level.

Mentoring serves as a catalyst to allow future leaders to leapfrog others who are making the journey alone. Often, mentors will learn just as much from the relationship as the subordinate. Therefore, the collaborative relationship has positive benefits for all parties and for the organization as a whole. When done correctly, mentoring can help drive organizational and personal success. 

Editor’s note: Marx is CIO at University Hospitals, an integrated health system based in Cleveland. Contact him at Edward.Marx@UHhospitals.org.
on opinion surveys conducted in 2006. Of the Americans surveyed, the top four health concerns were

- high costs (43%)
- lack of insurance and access (34%)
- Medicare and the drug benefit (15%)
- low-quality care (11%)

Hospital liability claims stabilizing

Insurance claims against doctors, nurses, and other medical professionals have stabilized for the second consecutive year, although the average size of malpractice claims rose 6%, according to an annual study by the Chicago-based risk-management firm AON.

The study measured 47,735 claims representing more than $4.4 billion of incurred losses, according to a release. The study also found that the average amount paid to compensate claimants rose 3% and the amounts paid to defend against liability claims grew 17% as more hospitals invest in claims management, according to the release.

Study: Education boosts mammography appointments

One-quarter of female patients in emergency departments (ED) who were educated about mammography screening for breast cancer received or scheduled a mammogram within one month of their ED visits, according to a study presented during the annual meeting of the American College of Emergency Physicians (ACEP), held in October in New Orleans.

The research shows that a little education can do a lot of good, said Elizabeth Bascom, MD, lead author of the study. “Because many women who visit the [ED] have no other sources of medical care, we have a great opportunity to teach them about the necessity of breast cancer screening and resources that are available, including free mammograms.”

HIPAA security compliance low

Only 56% of providers have implemented standards to comply with the Health Insurance Portability and Accountability Act of 1996 security rule despite the deadline passing more than a year ago, according to a study by the Chicago-based Healthcare Information and Management Systems Society and healthcare consultant Phoenix Health Systems in Montgomery, MD.

In response to questions about their incomplete security rule compliance, 15% of healthcare organizations cited among the top three obstacles, the fact that their organizations place higher priorities on other projects.

Providers’ greatest roadblocks, however, were reportedly budgeting constraints (20%) and difficulties in achieving successful integration of new systems and procedures across their organizations (20%), according to a release. The study also found that 22% of healthcare providers remain noncompliant with HIPAA privacy regulations.

Numbers of retiring nurse leaders to escalate within four years

A new survey by the New York City–based employment recruitment firm Bernard Hodes Group shows that the number of retiring nurse leaders will begin to escalate in four years, with 75% of current leaders planning to retire by 2020. According to the study, although nurses are retiring at a rapid rate, only a small percentage of healthcare organizations surveyed have implemented solutions to assist in the recruitment and retention of nurses, such as

- implementation of lift teams (22%)
- redesigned roles for older nurses (24%)
- formal succession planning (9%)

Hospital costs for children with flu higher than previous estimates

A new study conducted by researchers at The Children’s Hospital of Philadelphia reports that hospitalizing children for influenza may cost three or four times more than previous estimates.

The researchers analyzed billing data for 727 patients admitted to Children’s Hospital with laboratory-confirmed influenza during four consecutive flu seasons.

Researchers found that the cost for influenza-related hospitalizations in children was about $13,000 each, compared to previous studies that estimated the cost at $3,000–$4,000 per patient.

“This suggests that annual influenza vaccinations for children, especially those with certain high-risk conditions, may be more cost-effective than previously thought,” said study leader Ron Keren, in a statement.
The quality equation

by Gary Baldwin

Even providers who can afford expensive electronic medical record (EMR) systems discover that adapting them to improve care quality is a difficult undertaking.

Members of the Concord (NH) Hospital Physician Group participated in a diabetes quality-improvement program sponsored by the National Committee for Quality Assurance, winning recognition for outstanding care in September 2004 after a yearlong effort.

But even with the EMR tools in place, getting those improvements took concerted effort, largely because of one variable—patients. If pay-for-performance (P4P) programs overlook one factor, it is that improved outcomes depend on patient compliance.

The financial incentives that many health plans offer in their P4P programs are inadequate to entice medical groups to participate given the high cost of purchasing an EMR—a virtual prerequisite to measure and uphold quality, according to representatives from the Concord Hospital Physician Group.

Ultimately, the EMR is adept at prompting physicians to order tests and helping them keep tabs on results, but the effort can be for naught without active patient management.

Improved clinical outcomes may depend on altering patient behavior, but caregivers still must take the lead. And EMR technology, by capturing performance data, can be a reminder to healthcare providers who fail to do basic interventions for patients with chronic diseases.

For the Concord Hospital Physician Group, the EMR’s ability to trap collective data was a real eye-opener, said some of the group’s representatives. After doing its initial analysis of physician performance, the group found that it lagged in several areas other than ordering eye exams.

“We popped our superiority bubble,” said Joel C. Berman, one of the group’s physicians. “The more you measure, the more you realize how you overestimate how well you were doing.”

In April, Dartmouth Hitchcock Health System in New Hampshire finished its first year of a P4P project funded by Medicare. Cheshire Medical Center in Keene, NH, is one of three group practices joining the effort at Dartmouth, which could receive up to $4 million in bonus payments from Medicare if Dartmouth upholds quality measures for diabetes, congestive heart failure, and coronary disease during the three-year program.

Mike House, chief information officer at Cheshire, said he wants to expand Cheshire’s capacity to analyze physician-performance data. Cheshire can extract collective performance data by writing its own database queries, a time-consuming effort. Allscripts offers a module that can streamline report writing against its clinical database for about $250,000. Still, the investment might be a good bet, House said.

“Once you shine a light on your performance, it is amazing the results you get. We created some friendly competition among our physicians, and it was amazing how fast the numbers improved,” he said.


Market your practice by mailing a patient newsletter

Patient newsletters provide a valuable community service, informing readers of potential health threats and possible medical treatments, said Scott Hartman, director of communications and marketing at Burlington, MA–based Lahey Clinic. But they can also serve another function: to help healthcare organizations market services and communicate with patients.

Lahey’s patient newsletter includes educational health articles, a calendar of events, and contact information for the clinic’s support groups, medical centers, and group practices. A patient who begins reading the newsletter to learn about a common health problem may end up using it to schedule an appointment or to follow up for more information.

If the ultimate goal is to garner new business, a newsletter can help in several ways. For starters, branding the newsletter reminds existing patients about your organization, keeping you

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top-of-mind when it comes time to book an appointment. It can also help recruit new patients if the newsletter goes out to the entire community (not just to existing patients).

Further, if sent to area physicians, a newsletter can help increase referrals.

Avoid publishing pitfalls

As enticing as a patient newsletter may sound, reaping the rewards is not always an easy task. If your newsletter isn’t filled with quality content, and the layout doesn’t catch the reader’s eye, it won’t be very successful. Patients will judge your organization based on their impressions from your newsletter, so it must look professional. It also must contain information that educates the patient and should avoid appearing like a marketing ploy.

You can outsource the job to a company that will help design the newsletter and write most of the content. But if you decide to produce your patient newsletter internally, keep the following tips in mind to ensure that your newsletter is used as an effective tool:

» Publish regularly. Patients who look forward to the newsletter will notice if you miss a printing, so try to stick to a publication schedule.

» Assume the patient’s viewpoint. Critique your newsletter from the patient’s perspective, writing about what the patient would think is important and interesting.

» Distinguish your newsletter from junk mail. If your newsletter looks like other advertisements that patients receive every day, they may simply throw it away, or worse, resent you for adding to the clutter.

See: The Doctor’s Office, November 2006, online (www.hcpro.com).

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Atlanta’s Emory Healthcare initiates multiple advertising efforts to maximize exposure

To reach three separate audiences, maximize exposure to their brand, and tout two specialty services with one overall image, Emory Healthcare in Georgia launched an aggressive multi-integrated campaign that advertised the women’s care and plastic surgery centers and branded one of the system’s hospitals as a leading healthcare provider in the region.

Emory’s vice president of brand marketing, Mark Swilley, chose an integrated approach so the hospital’s image would be seen in multiple mediums promoting different specialties offered at the hospital. By using this approach, the hospital can reach multiple target audiences at once.

“Our goal in this campaign was to not only promote specific service lines . . . but to also generate more awareness of the Emory brand in Atlanta by positioning our hospital as the premiere destination for medical attention in the region,” Swilley said.

To market Emory’s women’s center, the hospital created a direct-mail campaign targeted to women aged 25–35 in the Atlanta area who are expectant mothers, caregivers, or future moms. The direct-mail piece, which featured an infant mid-yawn, asked, “Do you know a good OB/GYN? Come meet one!” and offered a free luncheon and symposium during which women could meet potential doctors and nurses or other women going through the same experiences and ask questions.

The luncheons were well-attended. One local woman who was hesitant to choose a doctor she’d never met noted that the meet-and-greet luncheon “made the whole experience really comfortable.” The women’s center had a 40% increase in calls over the course of the four months following the campaign, Swilley added.

A second campaign, this one for Emory’s aesthetic surgery center, skewed to an older female demographic—age 45-plus with a higher income. The direct-mail campaign was sleek and colorful, featuring older women with a youthful glow. The tagline reads, “Look younger. Feel younger. Think of it as a lifestyle upgrade.”

The direct-mail pieces flirt with the audience, saying, “Get carded more often,” and “Make the bag boys fight over who’s going to carry your groceries.”
The back of the pieces spotlight four plastic surgery residents. Highlighting the doctors also brands the hospital as a confident academic facility and one that touts the education and experience of its physicians. Swilley said the facility experienced a 30% increase in calls in August and September to the aesthetic center and an increase in overall admission.

Finally, Emory launched a high-end print campaign branding Emory’s Crawford Long Hospital as the premiere hospital in midtown Atlanta. The ads position the hospital as a destination, even going as far as to compare it to a hotel. One ad shows the hospital from an aerial view, comparing its looks to a luxury high-rise apartment building. The second ad shows the inside lobby of the hospital, which looks distinctly like the lobby of a five-star hotel. “Our top priority is to make patients feel comfortable here at Emory,” Swilley said. “Nobody wants to be in a hospital, but if you have to go, why not feel at home?”


‘Incubate’ physicians to boost recruitment, success

When a hospital wants to recruit a physician to practice in its community, it generally faces two problems. First, the Stark self-referral laws limit the means that the hospital can use to recruit a physician, such as paying for only certain recruitment costs.

Second, a physician who is new to private practice likely will be unprepared to practice independently, causing the new practice to struggle.

However, hospitals now have a tool to address both of these problems in the form of a new “incubator” compensation model, which allows a hospital to grow a practice and bypass certain recruitment restrictions, said Craig Hunter, associate partner with Alpharetta, GA–based practice management consulting firm The Coker Group.

“The doctor comes in, often under an employment arm, and you grow the practice until it can stand on its own,” Hunter said. “Then you release it into the wild, and it goes into the private sector.”

The initial incubation period, which typically lasts one or two years, can take two forms.

Most commonly, the hospital employs and helps the physician set up the practice by leasing space and personnel services from a larger group in the area.

Alternatively, the hospital provides an income guarantee—covering overhead expenses of the new recruit who, in turn, purchases support from the group practice—and treats the physician like a solo practitioner.

Whether the physician works under hospital employment or an income guarantee, the incubator model is essentially a practice within a practice, explained Michael Blau, partner with Boston-based Foley & Lardner, LLP.

Whether the physician works under hospital employment or an income guarantee, the incubator model is essentially a practice within a practice.

In other words, the physician recruit can work with the local group practice and use its equipment and services, as long the two remain completely separate, independent operations.

If this is the case, the hospital can help the physician lease equipment, space, and support services such as information services and front-and-back office personnel from the group.

“The important distinguishing characteristic is that the physician embedded within the group cannot join the group,” Blau said. The physician must

» bill for services under a separate provider number
» obtain patient registration separate from group registration
» keep a separate set of medical records
» be treated as a wholly separate, independent practice
» remain a self-contained practice within the context of that group

Stark law exceptions

The first regulatory concern when setting up an incubator arrangement should be recruitment limitations under Stark.

When the Centers for Medicare & Medicaid Services

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published the Stark II Phase II final rule in 2004, it included new rules for hospitals to follow when recruiting a physician to an existing group practice.

Because the physician does not technically join the group under an incubator arrangement, the financial transactions between the hospital and group are not limited to recruitment costs and incremental expenses.

The hospital can pay for all costs associated with bringing in the additional physician, as long as the hospital pays a fixed, fair market value for those items and services.

The hospital must have a contract describing the services with specificity, and the arrangement must be locked in for at least one year.

For example, if the fair market value for the physician recruit’s overhead is $220,000, the hospital can pay that entire amount to the medical group as long as the physician remains a separate entity.

However, if the physician joins the group, the hospital can pay only for incremental additional expenses or new costs to the group, which may be as low as $50,000 or $60,000.

An incubator arrangement may also be subject to anti-kickback statute violations if it does not meet specific safe harbors that govern financial transactions between hospitals and groups.

“The question is whether . . . lease payments to the group or the recruitment package is somehow intended by the hospital to induce referrals, either from the new recruit or the medical group,” Blau said.

The Office of Inspector General has established safe harbors that apply to a physician recruit’s overhead expenses such as leasing space and equipment as well as management contracts.

Because the physician does not technically join the group under an incubator arrangement, the financial transactions between the hospital and group are not limited to recruitment costs and incremental expenses.

To fall under the safe harbor, a financial arrangement typically must satisfy the following conditions:

» Must be explicitly stated in writing
» The contract must last at least one year and specify the length of the agreement
» Charges must be set in advance, consistent with fair market value in arms-length transactions (i.e., the parties involved are independent of one another)
» Payments cannot take into account the volume or value of referrals or other business generated between the group and the hospital


Worth reading

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