Making Third Party Payers Pay!

Agenda

Monday, November 22, 2010

Time	Title	Presenter
9:00 – 9:30	Registration	Pat
9:30-10:00	Welcome and Simulation Exercise	Eric/Jeanne
10:00 – 10:30	Leadership Vision for this project Why NIATx? Why Now? Where to go to keep up to date on health care reform.	Pat
10:30-11:15	PI 101	Bobbi
11:15-12:15	Resource Allocation -Who does what? -Dedicated Staff -Change Leader -Project Charters -Staffing	Pat/Eric
12:15-1:15 Lunch and Patient Flow	Patient Flow -Breakdown of bottle necks and barriers -Hand offs -Is the right decision maker doing the right steps? -Why do claims get denied?	Gervean Gervean will prepare slides Gervean's dashboard
1:15-1:45	IT - Maximizing system capability	Eric
1:45-2:45	EDI HIPPA Paper Billing How to Buy/procurement	Gervean
2:45-3:30	Design/Change Project Charter	All

Overall Goal: Improve Billing and Increase Revenues from Third Party Payers

NIATx Business Improvement
Making Third Party Pay

Ohio Kick-Off
November 22, 2010
Pat Bridgman
The Ohio Council of Behavioral Health & Family Services Providers

The Current Environment

Slide 2

Why This: Why Now

- Budget Realities
  - State Budget - Medicaid
  - Federal Budget
- Managed Care Looming
- Health Care Reform

Slide 3

Budget

- 8,000,000,000 State Budget Deficit
- Talk of State and County Consolidation
- Growing Public Concern Re: Federal Budget Deficit

Slide 4

Ohio Medicaid

- Continued Overall Growth – primarily in Covered Families and Children benefit
- Managed Care Expansion
- Pharmacy increases – $8 million in six months just for Buprenorphine!

Slide 5

BH Medicaid

- Also growing and "unmanaged"!

	ODADAS	ODMH
2007 Actual Match need	$25,000,000	$150 million
2012 Projected Match need	$32,985,463	$212.5 Million

Slide 6

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What State Can Do to Limit Medicaid

- Get rid of optional services
- Change Rates
- Change Amount, Duration and Scope
- Increase Managed Care Penetration

Slide 7

Managed Care

- They want our benefits!
- Strong lobby
- Integration trends
- Health Care reform

Slide 8

Health Care Reform

- Requires AoD Benefits
  - SA Block Grant will change
- Increases Medicaid Coverage to more people
- Requires Parity for new Medicaid Eligibles
- May see employers dropping coverage – fine is less than cost
- Huge Medicaid Liability for States

Slide 9

Health Care Reform

- 2014 - Medicaid for up to 133% Federal Poverty

current Medicaid enrollment	uninsured & Medicaid eligible in 2014	currently insured, potentially Medicaid eligible in 2014
1,653,560	667,767	929,320

Slide 10

Private Sector Market

- Uncertain because of healthcare reform
- Pre-existing conditions now must be covered – what does this do to market?

Slide 11

Private Sector Market

- Ohio requires non ERISA plans to at least have a $550 minimum “alcohol” benefit
- Plans with more than 50 employees fall under federal parity
  - Qualitative regs
  - Quantitative regs
- Ohio parity is only for SMD diagnosis

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So Why This Project……

- Better Skills that Transcends Public/Private Sector Markets
- Potential New Revenue Streams – Parity and Health Care Reform Implementation
- Increases Competitive Edge

Slide 13

Resources

- Health care reform:
  - State - www.healthcarereform.ohio.gov/
  - Federal - www.healthreform.gov
  - Federal - http://healthreform.kff.org/
- Parity Implementation
  - State - http://www.insurance.ohio.gov/consumer/pages/mhparity.aspx
  - *Federal* - http://www.saasnet.org/drupal-6.6/node/125
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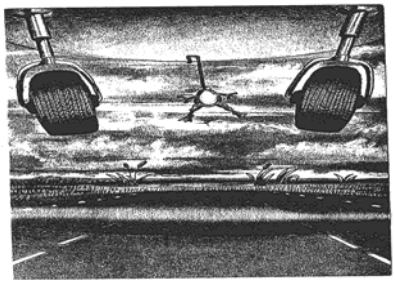
Slide 14

Be the Jet.....Not the Frog!



NIATx
The Network for the Improvement of Addiction Treatment

Improving Client Engagement & Retention: A process improvement primer

Kim Johnson, MSEd, MBA NIATx

Reduce Waiting & No-Shows • Increase Admissions & Continuation

Overview

Topics to be addressed:

- Understanding and documenting the patient flow
- Understanding and documenting the revenue cycle
- Creating a maximizing reimbursement environment

Slide 17

Agenda

- What is process improvement
- Why use process improvement
- PI 101
- Map out system from client perspective
- Solidify Walk through plans
- Measuring improvement
- Next steps/Assignments

Slide 18

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W. Edwards Deming

85 percent of the problems that organizations have in serving customers are caused by their processes

*A **process** is a collection of interrelated tasks, which accomplish a particular goal.*

Three types: management
operational
supporting

*All **processes** have inputs, steps, and outcomes, for which data can be collected, measurements can be made, and changes can be developed and tested to lead to improvement.*

*In organizational Development (OD), **Process improvement** is a series of actions taken to identify, analyze and improve existing processes within an organization to meet new goals and objectives. These actions often follow a specific methodology or strategy to create successful results.*

Wikipedia definition

Some methodologies for process improvement that you may have heard of:

- TQM
- Six Sigma
- ISO 9000
- NIATx

Process improvement is one way of making change. It uses an incremental improvement process that leads to gradual improvement over time.

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Every system is perfectly designed to achieve exactly the results it gets.

Paul Batalden

Four NIATx Project Aims

- Reduce Waiting Times
- Reduce No-Shows
- Increase Admissions
- Increase Continuation Rates

Slide 26

NIATx Results

- Reduce Waiting Times: **51%** reduction
  (37 agencies reporting)
- Reduce No-Shows: **41%** reduction
  (28 agencies reporting)
- Increase Admissions: **56%** increase
  (23 agencies reporting)
- Increase Continuation: **39%** increase
  (39 agencies reporting)

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Defining Quality, Delivering Quality

- W Edwards Deming, the "father of process improvement," explains that the "behavior of an individual can only contribute to meeting a specified goal insofar as the system makes reaching the goal possible."
- "If the person succeeds, it is because the system is designed to generate success."

Defining Quality, Delivering Quality
By Tim smith, Executive Director
Daybreak, Spokane , WA

Slide 28

Why Process Improvement?

- Customers are served by *processes*
- 85% of customer related *problems* are caused by organizational processes
- To better serve customers, organizations must improve processes

Slide 29

Five Key Principles

Evidence-based predictors of change

- Understand & Involve the Customer
- Focus on Key Problems
- Select the Right Change Agent
- Seek Ideas from Outside the Field and Organization
- Do Rapid-Cycle Testing

Slide 30

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1. Understand and Involve the Customer

- Most important of all the Principles
- What is it like to be a customer? Staff are customers, too!
- Walk-through, focus groups…

Slide 31

How to do a Walk Through

1. Agency director or executive sponsor plays the role of client and or family member
2. Inform staff and clients if needed, in advance that you will be doing the walk through
3. Encourage staff to treat you as they would a client; no special treatment
4. Think, feel, observe
5. Record observations and feelings
6. Involve staff, get their feedback

Slide 32

2. Focus on Key Problems

- What is keeping senior management awake at night?
- What processes have staff and customers identified as barriers to excellent service?

Slide 33

3. Select a Powerful Change Leader

Who has:

- influence, respect and authority across levels of the organization
- a direct line to the CEO
- empathy for the staff
- time available to lead change projects
- no fear of data

Slide 34

4. Seek Ideas Outside the Organization and Field

- Provides a new way to look at the problem
- Real creativity in problem solving comes from looking outside the familiar

Slide 35

5. Do Rapid-Cycle Testing

- Start by asking 3 questions
  - What are we trying to accomplish?
  - How will we know the change is an improvement?
  - What changes can we test that will result in an improvement?

Langley, Nolan, Nolan, Norman, & Provost. *The Improvement Guide,* San Francisco, Jossey-Bass Publishers, 1996

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Rapid-Cycle Testing

Rapid-Cycle changes
- Are quick; do-able in 2 weeks

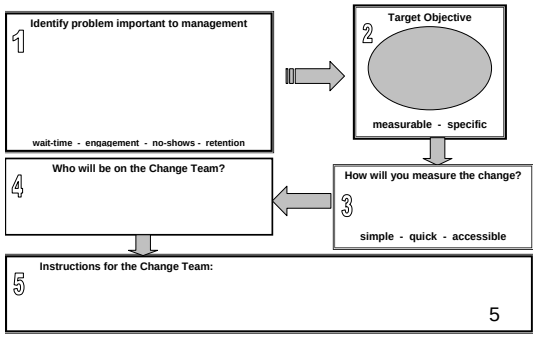
PDSA cycles
- **P**lan the change
- **D**o the plan
- **S**tudy the results
- **A**ct on the new knowledge

Planning a Service Improvement

Or, now that we have the theory, what do we actually do

Quick Start Road Map

- A graphic series of steps to make it easier to plan and implement a change
- Steps divided into leadership and change team responsibilities
- Assures that critical steps in the process will not be skipped



Role of the Executive Sponsor

- Senior leader in the organization
- Must see change/improvement as a priority
- Identifies the problem and articulates the vision
- Demonstrates commitment to the process (time, resources)
- Empowers the change leader

Quick Start Road Map

Leadership responsibilities:

1. Do a needs assessment and identify a problem important to management
   - Walk-Through
   - Focus Groups
   - Existing Data
2. Establish a target objective
   - Achievable
   - Specific
   - Measurable

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Quick Start Road Map

Leadership responsibilities:

3. How will the change be measured?
   - Simple
   - Quick
   - Accessible
   - Who can record the data?
   - How frequently can it be gathered and summarized?

TIP: Data driven decisions are more objective and more readily accepted

TIP: Without data you have no way to gauge the success or effectiveness of a new practice

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Quick Start Road Map

Leadership responsibilities:

4. Who will be on the Change Team?
   - Change Leader
   - 3-5 Members
   - Work together until success is achieved
5. Instructions for the Team
   - Clear statement of problem with data
   - Priority for improvement
   - Clear objective
   - Promise of support and commitment

Slide 44

Selecting a Change Leader

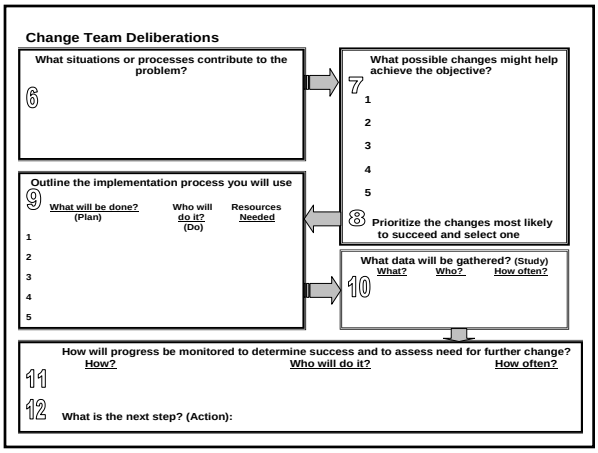
- Person has sufficient power and respect to influence others at all levels of the organization.
- Person has the ability to: instill optimism, has big picture thinking, focused, goal oriented, a good sense of humor.

Slide 45

Change Leader Responsibilities

- Serves as a catalyst to develop ideas
- Successful communicator: facilitates change team meetings, consistent, concise (data), creative and engaging (incentives), skilled listener.
- Minimizes resistance to change
- Keeps the executive sponsor updated on change leader activities.

Slide 46



Quick Start Road Map

Change Team responsibilities:

6. Collaborate on what contributes to the maintenance of the problem
   - Agency processes
   - Unclear Interagency communication
   - Service design
   - Unclear expectations
   - Lack of knowledge or skill
   - Organizational policy
   - Others?

Slide 48

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Frequent start-up issues

1. **Measuring** the impact of change
   - What measures to use
   - Documenting the change process
   - Recording data daily; reviewing data weekly
2. **Having the right people** in key roles
   - Executive Champion or Sponsor
   - Change Leader with time to do the job
   - Small enough Team to be effective
3. **Assuring key participants understand** the service improvement model and process
4. **Lack of customer involvement** in establishing a change objective

Communication: Key to Success

- Frequent meetings
- Consistent, concise (data)
- Creative, engaging (incentives)
- Truthful, authentic, real
- Authentic listening
- Continuous feedback to the organization

Other Keys to successful change and spread

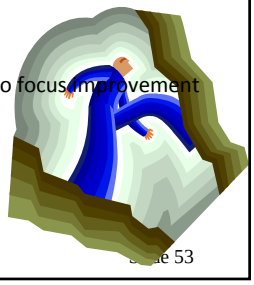
- Align with the vision and values of the target audience (staff, client, community)
- Adopt a results orientation model of improvement
- Use skits, stories, analogies and metaphors
- "Engage, engage, engage, retain, retain, retain"

Questions
Comments

Process Mapping

What does the current system look like from a client perspective?

This can help identify places to focus improvement efforts



Measuring Change

An essential step in assuring the success of any process improvement

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Financial and Operations Management

Measuring Change

1. Define the measures you will use
2. Collect baseline data before you begin
3. Establish a clear aim or objective
4. Consistently collect data
5. Chart your progress and share the info
6. Ask questions about what the data is telling you

Slide 55

1. Define measures

- Clarify the project objective: What specifically are you working to improve?
- What is the target?
- How will you know if the target is being achieved?

TIP: Clear definitions are critically to successfully measure change

Slide 56

2. Gather baseline data

- Using agreed upon measures, gather data for 2-3 weeks prior to beginning a change project
- Keys:
  - Does the data provide the info you need?
  - How accurate is the data?
  - Does the process assure consistent data collection?

TIP: Never start a change project without gathering baseline data

Slide 57

3. Establish a clear aim

- Make sure the target objective is specific, realistic and clear
- Make the objective challenging but achievable
- If the target is reached easily, increase the objective

TIP: The aim should challenge the organization

Slide 58

4. Consistently collect data

- If the data is not already being gathered, manual collection may be necessary
- Important to have quick and accurate measures of progress
- Can be gathered over a short period of time to assess initial success or failure

TIP: Consistently collect measures related to the change

Slide 59

5. Chart your progress

- Important to track progress daily or weekly
- Track progress for a long enough period to have confidence in the results
- Communicate progress with change team, management and others
- Graphs are the most powerful way to illustrate progress

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6. Ask questions

- "What is the information we are gathering telling me?"
- When a change is not having the expected impact, ask "Why?"
- Continue asking questions about how you can improve…continuous improvement is the goal

TIP: Do not accept your results at face value; keep probing and you will find other ways to improve

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Thank-you for coming!

Reduce Waiting & No-Shows • Increase Admissions & Continuation

Patient Flow and the Patient Experience

Slide 63

Overview

Topics to be addressed:

- Understanding and documenting the patient flow
- Understanding and documenting the revenue cycle
- Creating a maximizing reimbursement environment

Slide 64

Patient Flow

It all begins when the patient needs services from the behavioral health center

Slide 65

The Patient Experience

- What is it like to be your patient?
  - Perform a detailed walk-through and document your patients' experience
  - Evaluate your findings and improve on the process
  - Tie in the ultimate patient experience with the ultimate revenue cycle

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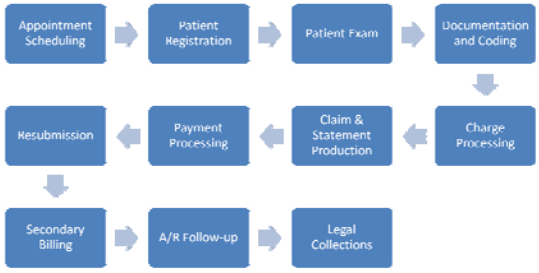
The Revenue Cycle



Slide 67

Appointment Scheduling: Goals

What should be the goals of the **Clinical Department** and **Patient Services**?

- Schedule the appointment within time desired by patient
- Inform patient of the sliding fee process
- Inform patient to bring insurance card and co-payment

Slide 68

Appointment Scheduling Process

- Pre-registration
- Begin the revenue cycle
- Verify insurance
- Authorize and certify insurance
- Sliding fees policy

Slide 69

Patient Registration: Goals

- Make sure that:
  - You've received pre-authorization
  - Insurance is verified and PCP validated
  - Patient has completed sliding fee application completely
- For all appropriate patients, collect co-pay and verify demographic information

Slide 70

Patient Registration Process

– **Revenue Cycle (For Appointments)**

- Verification of insurance
- Authorization and certifications
- Registration gathering demographics
- Initial review of financial requirements
- Co-pay collection for all appropriate patients

Slide 71

Patient Visit: Goals

- Reasonable/timely access
- Complete clinical service
- Informative to patient
- Appropriate documentation for patient care and for correct billing to third party

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Patient Visit

- Patient identifies concern/problem
- Treatment provided
- Service documentation initially recorded

Slide 73

Documentation & Coding Process

Where it can go wrong!

- Clinician documenting service
- Service coding

Slide 74

Documentation & Coding Process

- Clinician documents services
- Services coded by clinician and/or coders:
  - CPT codes (procedures)
  - ICD-9 (diagnosis)

Slide 75

Documentation & Coding: Goals

- Documentation complete and signed by provider
- Codes accurately reflect patient service(s)
- Coding reviewed to insure it reflects documentation

Slide 76

Ensuring Proper Coding: High-level Overview

- Collect data on provider visits (E&M Codes)
  - By individual provider
  - In the aggregate for the health center
- Prepare graphs to show frequency of codes used
  - Show increasing intensity of visit from left to right
- Overlay health center providers and aggregate data on national averages
  - Include payor-source specific graphs

Slide 77

Charge Processing

- Data entry and coders enter data into practice management system
- Fee entered automatically or manually
- Claims Manager software scrubs entries for correctness
- Problems sent to department work file for processing
- Reconciliation performed to ensure all entries received and entered into practice management system

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Charge Processing: Goals

- Accuracy of service and charge
- Appropriate edits to scrub data
- Charges entered timely for prompt payment

Slide 79

Claim & Statement Production

- Claims edited to ensure completeness and correctness
- Claims sent regularly to carriers for processing
- Claims flow electronic and paper
- Billing statements sent to patients for self-pay balances

Slide 80

Claim & Statement: Goals

- Get accurate claims out daily
- Increase % of electronic claims
- Keep average cost per claim better than benchmark
- Get statements out to patients for self-pay balances every Monday within the current billing cycle (30 days)

Slide 81

Payment Processing

- Electronically or manually post remittances from payers and patients
  - Payments
  - Denials or rejections
  - Adjustments
- Refunds
- Reconciliation of charges, payments and adjustments

Slide 82

Payment Processing

- All payments and denials processed within 24 hours of receipt
- Process all refunds in a timely manner

Slide 83

Resubmission, Appeals, & Secondary Claims

- Invalid registration
- Medical documentation required
- Correct coding /charge corrections
- Missing referral/pre-authorizations
- Secondary claims and patient statement produced

Slide 84

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Resubmission & Appeals: Goals

- All invoices requiring an appeal processed are completed within one week of receiving rejection
- Process all responses from clinical departments within one day of receiving information
- All secondary claims submitted within a week of receiving primary payment

Slide 85

A/R Follow-up

Follow-up on...

- Payment arrangements (budget plans)
- Red flag rules
- http://www.nachc.com/client/documents/FTC_Red_Flag_ITPP_IB_4_8_09%5b1%5d.pdf
- Improve claim edits as an outcome
- Bad debt transfer

Slide 86

A/R Follow-up: Goals

- Process all denials requiring departmental involvement within one week of receipt of reject
- Follow up on all outstanding requests with clinical departments within one week of initial request
- Follow-up on all "no response" invoices within 45 days of submission of claim

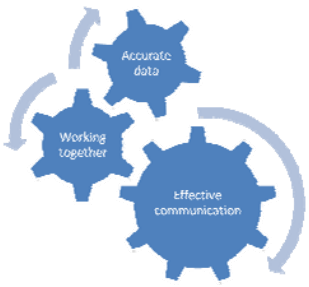
Slide 87

Legal Collections

- Actions if any to be determined by Executive Staff & Board

Slide 88

A successful revenue cycle depends on…



Slide 89

Common Reasons Claims are Denied

- The patient is not enrolled
- The service/procedure is not covered
- No pre-certification/authorization is on file
- Demographic mistakes on the claim
- Claim not timely filed

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Strategies to Avoid Denials

- Select Implementation Tasks:
  - Incorporate standards and policies that guide personnel.
  - Establish analysis for denials
  - Coordinate training of clinical staff and billing personnel.
  - Develop a standard feedback mechanism for professional employees.
  - Institute regular chart/billing reviews to assess compliance and to identify issues requiring further education.
- Measure performance at the front desk
  - Select standard measurements for accuracy of data collection
  - Establish minimum thresholds for staff to meet

Slide 91

Billing and Revenue Strategies

Billing and revenue strategies are intended to improve the billing and collections process in the health center and encourage the effective use of staff who perform these functions.

Common goals and objectives achieved through billing and revenue strategies:

- Increased patient revenue.
- Improved collections rates.
- Reduced medical coding errors.
- Cost savings of doing it right the first time.

Slide 92

Board and Executive Management Steps

to Ensure the Health Center has a Maximizing Revenue Culture:

- Establishing a culture of revenue maximization with board, staff, patients, and community
- Setting the health center up for success – operationally
- Regular reports and monitoring
- Intervening when necessary

Slide 93

IT Maximizing System Capability-Efficiency

- Technology is being used to address the ever increasing complexities in billing, payment and collections
- Technology is automating many of the manual processes
- Technology is helping both providers and payers by proactively identifying potential errors or mistakes and avoiding them

Slide 95

IT - Maximizing System Capability - Efficiency

- Technology is simultaneously reducing the need for paper and time spent looking for missing charts, lost claims, etc.
- Technology is reducing payment and transaction turnaround times

Slide 96

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IT - Maximizing System Capability – Quality

- Software solutions are designed to improve the quality of care through the use of care management protocols, identification of potential drug-drug/drug-allergy interactions, identification of or reminders for services that the patient needs to receive at the point of care, etc.
- Electronic charts such as those found in EMRs provide ready access to patient data without the need to leaf through lengthy charts or decipher handwriting.
- Improved patient compliance is achieved through automated appointment reminders, recall of patients with missed appointments, specific conditions, etc.

Slide 97

IT - Maximizing System Capability - Quality

- Governmental requirements around interoperability (HIE) will allow organizations to share clinical data electronically, improving continuity of patient care
- Evidenced based medicine will provide clinicians with access to knowledge bases that identify various courses of treatment and the expected outcome for each treatment

Slide 98

IT - Maximizing System Capability - Reporting

- Reporting of clinical data will be a key component in the transformation of healthcare. Reporting will lead to:
  - Consumerism in healthcare – unlike most purchases made (e.g. buying an automobile), patients have way of understanding the cost of care or how to evaluate the value and quality of the care they receive. Availability of data is quickly changing this dynamic
  - Transparency – data will allow clinicians, insurers, employers and patients to compare clinical outcomes, morbidity rates, etc., of one practice or care center to another
  - Greater accountability – with transparency, we will see greater accountability as comparative data begins to illustrate aberrant variations in care provided

Slide 99

Summary – Maximizing IT

- Reengineer business processes
- Automate
- Assure quality, accuracy, reliability and timeliness
- Reduce cycle time and improve cash flow
- Add functionality and enhance productivity
- Achieve Interoperability
- Share knowledge
- Data analysis, reporting and business intelligence
- Achieve Meaningful Use

Slide 100

IT Basics – what is EDI?

- EDI (Electronic Data Interchange) is a standard format for exchanging business data. The standard is ANSI X12 and it was developed by the Data Interchange Standards Association.
- ANSI X12 is either closely coordinated with or is being merged with an international standard, EDIFACT. An EDI message contains a string of *data elements*, each of which represents a singular fact, such as a price, product model number, and so forth, separated by delimiter. The entire string is called a *data segment*. One or more data segments framed by a header and trailer form a *transaction set*, which is the EDI unit of transmission (equivalent to a *message*).
- A transaction set often consists of what would usually be contained in a typical business document or form.
- The parties who exchange EDI transmissions are referred to as *trading partners*.

Slide 102

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IT Basics – what is EDI?

- EDI transactions will significantly reduce administrative and operating costs, gain efficiency in processing time and improve data quality.
- Under HIPAA, as EDI transactions gradually replace paper-based transactions, the risk of losing documents, encountering delays, and paper chasing is minimized. Trading Partners benefit immensely using EDI as it involves little if any human touch in highly routine process.
- EDI supports
  - 837 Health Care Claims
  - 835 Payment Advice
  - 270/271 Health Care Benefit Inquiry and Response
  - 276/277 Claim Status Request and Response
  - 278 Health Care Services Request for Review
- Two basic methods are available to generate EDI claims transactions:
  - Direct Submission by Provider
  - Submission by Clearinghouse or Billing Service

Slide 103

IT Basics – Choosing a Clearinghouse

What is a clearinghouse and what does it have to do with medical billing?

- A clearinghouse is responsible for ensuring the accuracy of your billing.
- It is responsible for reformatting your data to a format that is acceptable to the various insurance carriers. Namely, programs such as Medicaid, Medicare, Blue Cross, and a host of others require their medical billing records to be in a certain format such as the EDI standard format.

Slide 104

IT Basics – what is HIPAA?

- The **Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191)** [**HIPAA**] was enacted by the U.S. Congress in 1996.
- According to the Centers for Medicare and Medicaid Services (CMS) website, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

Slide 105

IT Basics – what is HIPAA?

- While electronic records and mobile computing are enhancing patient care, carrying unencrypted protected health information (PHI) can place your organization at significant risk. State data breach notification laws and federal HITECH rules require notification in the event of loss or theft of data.
- HITECH, organizations can now be fined up to $1.5 million per incident.
- To meet data protection and safe harbor requirements, healthcare data must be encrypted and its protection reported.
- Enforcing policies, auditing device usage, and the ability to remotely wipe data are the differences between having to report a breach or not.

Slide 106

IT Basics – What is an EMR?

- Typically, the "EMR" (electronic medical record) portion of the EHR is the clinical portion of the patient's data and can include:
  - Progress notes
  - Problem list
  - Patient Allergies
  - Patient Risk factors
  - Medications and medication history
  - Chief complaint
  - Vital signs
  - Past medical history
  - Immunizations
  - Laboratory data
  - Radiology reports
  - Flow sheets (e.g. growth charts)

Slide 107

IT Basics – what is a PM?

- Typically, the "PM" or practice management portion of the EHR is the administrative portion of the patient's data and can include:
  - Patient Registration (e.g. demographics and insurance coverage information)
  - Appointment Scheduling and Case-Load Mgmt
  - Eligibility Verification/Management
  - Service Capture (online super bill or charge ticket)
  - Billing and Accounts Receivable
  - Contact Tracking /Communication Logs (e.g. document patient follow-up attempts)
  - Document storage (e.g. copies of ID card, forms, etc.)

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IT - Purchase of a System or Procurement

- There are no right or wrong answers…it is dependent on your preference.
- It is important to note that there are inherent limitations to both types of systems

IT - Purchase of a System or Procurement

- There are specific things that you will need in order to perform your daily functions efficiently.
- The most important consideration should be in choosing the right IT system to meet the demands of your clientele base.
- Research whether or not you prefer to purchase an actual software program or use a web-based internet program.

IT - Purchase of a System or Procurement

Examples of Limitations to Medical Billing Systems:

- If you purchase a license to use a medical billing software system from a larger vendor, you should understand that you do not own the program.
- These companies are only allowing you access to their program, which is strategically designed to process medical billing claims effectively.

IIT - Purchase of a System or Procurement

- On the plus side, there are smaller vendors you can find who will sell you the actual medical billing software system
- As with any purchase, make sure an ample amount of research is conducted before buying.

IT - Purchase of a Software System

Internet-Based Medical Billing Software:

- A limitation to internet medical billing programs is that you will not have control over your own back-up data.
- If you decide to cancel your internet billing service, you will not be entitled to keep your own medical billing records.
- Most importantly, you have to pay a monthly fee to utilize this service, as opposed to paying one total cost to buy the actual software program itself.

Ready to Buy?

- More than 6/10 implementations fail
- Adoption and implementation take time – more than a year and there is no rushing the process
- Do not automate poor processes and workflow. Fix them first
- Find systems that suit you as precisely as possible. Do not try to twist your business and clinical operations around software. Identifying "cool" vendors is nowhere near the top of the to-do list…that comes later
- Understand that Total Cost of Ownership involves hardware, software, networking, consultants, staff time, training, implementation involving disruptions to work in progress (billable time)
- Interoperability, standards, certification, and compliance are essential

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Learn From Others

- Productivity will be impacted by as much as 50% during the first few months following implementation; some practices never return to 100% of original pre-EHR levels
- Don't assume that implementation of the EHR will lead to immediate usage and adoption. Have a process to ensure all staff, not just the physicians, are not "backsliding" to the old paper chart.
- Keep changes to a minimum for the first 3 to 6 months. Focus users on giving the process a chance rather than making ad hoc changes to appease staff
- Conduct staff assessment, consider training tiers. Consider computer 101 training for staff that have never used a computer before.
- Onsite, post implementation training is as important if not more important than intensive upfront training

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Learn from Others

- Have a plan for your paper charts. Are you going to scan them into your new EHR, or will you abstract key data or patient synopsis information.
- Some groups use the chart abstraction process as an opportunity to train the clinicians – while abstracting data, the clinician is also becoming more familiar with the EHR
- Paper charts should be "retired" after no more than three patient visits. Retaining paper charts onsite indefinitely impedes your ability to implement a truly paperless environment and enables backsliding for those who prefer using the paper chart vs. the EHR
- Don't go overboard when designing your clinical templates. It is very easy to get caught up in the powerful data collection and documenting capabilities an EHR has to offer. Too many fields, drop list choices, and forms to complete result in a cumbersome system that will impede patient throughput.
- Similarly, pop-up messages and reminders can be overwhelming if too many are setup. Consider setting reminders for key items or events only; or important items that are regularly overlooked or missed.

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