Orthopaedic Administration - A recipe for success!

by Jennifer Ale-Ebrahim, Administrator
Orthopaedic & Sports Medicine at Cypress, Wichita, KS

Begin with a group of physicians and their employees, add the following ingredients: hiring, firing, training, coaching, mentoring, negotiating, developing, administering, conflict resolving, injury preventing, and lastly, but probably the most important ingredient is your ability to listen when someone needs to talk.

Mix in a smidgen of repairing and maintaining equipment as well as property.

Add a pinch of, ordering, negotiating, recommending medical and office supplies, medical malpractice insurance, employee health benefits, housekeeping, shredding, coffee, linens, and IT services.

Sprinkle in some payroll, budgeting, reconciling bank statements, preparing P & L statements, filing, and preparing refunds and expense reports.

Blend with scheduling, collecting co-pays & deductibles, financial counseling, pre-certing procedures, and loading in fee schedules, ICD-9(10), CPT and HCPCS codes.

Add a dash of coding, billing, posting, transmitting claims, and sending statements.

Mix with marketing, sponsoring, advertising, tracking referrals, writing articles & press releases, updating websites, and best of all social networking.

Squeeze in some compliance regulations, such as OSHA, ADA, EOE, FMLA, CLIA, COLA, JCAHO, FACTA, HIPAA, STARK I, II, III.

Mix in some strategic planning and disaster preparedness.

Now blend in e-RX, PQRI, MUE as well as pending decreased reimbursements.

Bake in a hot oven or a cold icebox, depending on which staff is in that day or what side of the building your office is on.
Orthopaedic Administration - A recipe for success continued...

While baking or cooling, spend time reading, maintaining education, and networking in and outside of your specialty. Use the List Serv, Webinars, blogs, and face-to-face conferences to ensure you are not alone!

Relish in the laughter from your employees, and the wonderful stories of patient outcomes.

Fold in lots of patience and understanding, blended with some experience and a pinch of humility.

Eat your slice of mistakes with joy at the knowledge gained.

Enjoy that you are now a seasoned Orthopaedic Manager/Administrator.

Now sit back for a moment, cause that's all you will get, and begin planning this year’s Christmas Party entertainment! Happy Holidays!

How to Optimize Your Staff Talent to Prepare for Healthcare Reform
by George D. Trantow, FACHE, Executive Director, Aspen Orthopaedic Associates - Aspen, CO; Jim P. Kidd, CMPE, Executive Director, St. Peters Bone & Joint Surgery - St. Louis, MO; Moderator: Patricia Brewster, FACHE, CEO/Partner, IntraHealth Group - Atlanta, GA

Executive Summary of a Presentation made at the AAOS Fall Symposium, October 28, 2011.

We believe there are four keys to optimizing staff talent in preparation for healthcare reform. The key principles are Delegation, Optimization, Automation and Regulation.

Delegation is the assignment of authority and responsibility to another person. As most physicians can attest only 55% or less of their time is spent on face-to-face patient care. The balance of their time is spent on care coordination (20%), paperwork (6.5%) or other tasks. The goal is to move the 55% to 60-65% therefore...continued on next page
How to Optimize Your Staff Talent continued...

increasing physician productivity. In order to make the physician more productive more tasks must be delegated to physician extenders, nurses, x-ray techs and administrative staff. Remember physicians only have (3) types of time: wasted, delegated and billable. We need to increase the billable time by delegating duties to staff and reducing wasted time.

**Optimization** is the act, process or methodology of making something as fully perfect or effective as possible. This includes identifying those tasks that provide the most beneficial results to the practice. For our purposes we are stretching our expectations for our staff in order to challenge and reward them simultaneously. For example, high performing orthopaedic executives are using their passion and expertise to “ferret out” data that is transformed into information for sound decision making.

**Automation** is the technique, method or system of operating or controlling a process using electronic devices and reducing human intervention to a minimum. Most medical groups use a Practice Management (PM) system and most are moving to an Electronic Medical Record (EMR), but healthcare reform is going to demand sophisticated reporting and analysis of data. We will be required to demonstrate both quality and the “Value” of the services we provide. Additionally, the downward pressure on reimbursement will force us to adopt technology that can lower our cost to provide care. Orthopaedic groups with an advanced information technology infrastructure are in a competitive position.

**Government regulations** are a growing burden upon many industries, including medicine. If you are highly automated you can improve your regulatory compliance. Every orthopaedic practice that accepts Federal funds is required to have a compliance plan in writing and comply with the seven elements. Today, we can use online compliance programs that are inexpensive, easily scheduled and comprehensive. If you have not evaluated an online compliance plan against your current training plans we recommend you do so. The Recovery Audit Contractors (RACs), OSHA, Medicare/CMS and other regulatory bodies will be less of a threat if you have a solid compliance plan.

In summary, we all need a plan to prepare our staff and practice for healthcare reform. We believe that focusing on Delegation, Optimization, Automation and Regulation compliance will move you in the right direction. A full copy of the presentation can be found here.
The “Ah-Ha” Moment: The Six, and Only Six, Ways to Market an Orthopaedic Practice
By Lonnie Hirsch and Stewart Gandolf, MBA

Marketing and advertising for orthopaedic practices have gone from 0 to 60 almost overnight. Change is the order of the day. Practitioner groups are forming or morphing, hospitals are aligning or integrating orthopaedic practices, and the competitive landscape is as stable as quicksand. And what was once a reliable stream of patients and referrals into the practice has changed course.

For many practices, if not most, it’s a turbulent time. Newly formed groups as well as well-seasoned practitioners ask our advice about how to build an effective marketing plan. The mix of branding, marketing, advertising and public relations can appear to be complex, confusing and daunting.

We’ve met surgeons and orthopaedic practice executives who lose business opportunities because they hold back on their marketing potential. But we also see clients relax with an understanding that the road to marketing success is grounded in only six fundamental building blocks.

We call it an “ah-ha moment.” It’s that highly gratifying instant in our consulting work when the veil drops, the mystery disappears, the light bulb ignites—and a big idea is understood in a flash. That’s rewarding for us as instructors. And the greater reward is in opening the door to increased revenue for the orthopaedic practice and practitioners.

So here it is. In only 14 words, the sentence that frequently ignites an “ah-ha” moment:

“There are only six ways to market an orthopaedic practice. Six and only six.”

Admittedly, the broad topic of healthcare marketing can be complex. There are hundreds of strategies and thousands of tactics, but understanding this six-point outline provides a manageable starting point for bringing it all together.

These core components are the framework for every client marketing plan and for our marketing seminar presentations. If this is a back-to-basics list for you, take it as a useful refresher. (Consider sharing it with others in your organization.) And if this is an eye-opener, we’re pleased.

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The “Ah-Ha” Moment continued...

For any given situation, the order and the emphasis of these elements will vary, but grasping the essential building blocks often demystifies healthcare marketing.

The Six Fundamental Elements

Professional Referral Marketing: A reliable and continuing flow of inbound patient referrals from other medical or professional sources is the lifeblood of many orthopaedic practices. And whether it’s a primary or secondary channel, referral sources can’t be taken for granted. Doctor referrals do not happen by magic or simply because you are a surgeon or resource. Success requires a written plan and an unfailing system to preserve and grow the flow of inbound referrals.

Internet Marketing: From websites and social media tools, to patient portals and mobile apps, online marketing is a mainstream channel for branding, marketing, advertising and public relations. Exactly how you use the considerable muscle of the digital freeway can turn out to be highly effective and profitable, or a huge waste of time and money.

Branding: This is all about standing out from the crowd in a positive way, and it includes virtually everything you say and do. A powerful, differentiating brand for the practice is an important part of reputation building and the ability to attract referrals and new business. Meaningful and effective branding does not occur without a deliberate effort to shape and express the right message at the right time.

Internal Marketing: This heading includes all the ways and means that you communicate with people who already know you, including present referral sources and previous patients. Depending on the nature of your situation, this influential audience can be a rich resource for referrals, additional services, testimonials and/or word-of-mouth advertising.

External Marketing: These are the media messages that reach prospective patients and referral sources that don’t know you. Advertising in newspapers, radio, television, billboards and other media speaks to the target audience that needs to know that you provide an answer for their need. An external media budget—if this tool is right for you—is expected to produce quantifiable results.

Public Relations: This heading includes, among other things, planning and generating publicity and free press exposure, such as newspaper articles or broadcast interviews. The end results look easy, and it can be a positive and powerful influence. But “free press” typically results from careful planning, good...continued on next page
The “Ah-Ha” Moment continued...

timing, a clear message and a deliberate effort. PR is free (sort of), but not always easy to get or to control.

Return-on-Investment is the yardstick of success...

Every successful marketing plan recognizes these six (and only six) components. Some will have greater or lesser emphasis, but an orthopaedic marketing program is an investment, not an expense. Like many other aspects of business, the yardstick of success is the Return-on-Investment. And in the right combination for your situation, will return measurable success.

ABOUT THE AUTHORS
Lonnie Hirsch and Stewart Gandolf, MBA are two of America’s most experienced healthcare marketers. They have a combined 30 years experience, have written hundreds of articles and have consulted with over 3,500 healthcare clients, including orthopedic surgeons, medical groups, hospitals, doctors and corporations. Additionally, Lonnie and Stewart have spoken at hundreds of venues across North America to tens of thousands of healthcare executives and doctors. As Co-Founders of Healthcare Success Strategies, they lead our team of over 40 Healthcare Marketing All-Stars. You may reach either of them directly by calling 800-656-0907, through their website at www.HealthcareSuccess.com or via email at info@healthcaresuccess.com.


by Jeanetta Lawrence

Health spending per capita in the United States is much higher than in other countries, according to the Organization for Economic Co-operation and Development (2010) report. Healthcare spending grew at a rate of 6% from 2005-2007. Health spending has outpaced the rate of growth in the Gross Domestic Product (GDP) for over a decade. The economic environment has slowed the growth of health spending down from 6% to 4.4% in 2009 and to 3.8% in 2010. The Center for Medicare and Medicaid Services (CMS) projects that between 2011 and 2013 health spending will grow faster due to expected improvements...continued on next page
in the economy reaching a rate of 5.5 percent by 2013. CMS also forecast that by 2020, national health spending is expected to reach $4.6 trillion and comprise 19.8 percent of the GDP. As practice leaders, we understand that the healthcare industry cannot sustain that rate of growth. A change was inevitable. Meaningful Use (MU) was finalized in 2009 and we had until the end of 2011 to attest to receive the first payment of $18,000. The problem with the MU concept is it is designed for primary care physicians and not specialists. Orthopaedic physicians were faced with having to change their practicing style to the point and click methodology. As we are all aware, orthopaedic surgeons are production-driven physicians and the manner in which the system was created would slow them down capturing information that is not relevant to orthopedics.

Meaningful use is upon us whether we like it or not. One of the challenging aspects of this program is getting the physicians to buy in. This is quite a difficult task, especially when attempting to convince a specialist to adapt to a primary care practice style. It is a painful process and, as one of my physicians always says, “When have you fought with the government and won?” A good working relationship with your vendor paves the road for as much as a smooth transition as possible. Also, having the physician involved with selecting the measures to report is critical.

I will lead you down my journey and hopefully it will provide you some insight and help pave the way. Look within your organization and determine who will be your champion physician. Having someone that is computer savvy is always a plus, but not a necessity. In my opinion, desire is 90% of the challenge. We are a group of 25 physicians and only one of them is on the full-blown certified Electronic Medical Record (EHR). My thought was at the time, if I can get one through the process, he will pave the way for the others. Also, the workflow issues will be resolved and staff trained allowing a smooth transition for the others.

The first four months on the system was spent perfecting the templates making slight system changes to our Point of Care (POC) module. Then our attention shifted to the MU process. Our vendor, Pulse, and our team had a kickoff call so that we were all on the same page and outlined the time frame. We then set up weekly conference calls through Outlook, created a project status report and an MU tool in order to stay on task. It took two weeks working with the physician to determine our reporting measures. The reporting measures we selected outside of the 15 Core measures were 1, 3, 6, 7 and excluding 9 (menu set); 1, 2, 3, 6, 7 and 8 (Clinical Quality).

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Meaningful Use continued...

Once the measures were selected, Pulse went to work on system changes to capture the elements, and we began staff training to collect the data. The changes to our workflow were as follows:

**Front Desk**

1. Patients were resistant in providing Race, Ethnicity and Preferred Language over the telephone. We customized our face sheet to capture that data, satisfy our patients and meet the Core measure 7.

2. Prior to the patient’s appointment, we call if the pharmacy information is not on file. This process saves time on the clinical side for Core measure 4.

3. The ability to encrypt messages was added to our server in order to process medical records electronic request for Core measure 12.

4. The Continuous Care Document (CCD) was created in our EHR to provide the summary note on demand. We have a signs posted in all waiting areas and checkout desks informing the patient that we will print out the summary of their visit at their request for Core measure 13.

5. Provide the patient the History forms to update their information prior to being taken to the clinical area, assisting in Core measure 1, 5, 6, 9; Clinical measures 3(a), and 8.

**Clinical Area**

1. We added blood pressure to our vital signs for Core measure 8 and Clinical Quality measures 1 and 2.

2. Update the system with new medications, allergies, smoking status, mammogram information and any new problems for Core measures 3, 5, 6, 9; Clinical Quality measure 3(a), 8; Menu Set measure 7.

3. Hand patient appropriate education material from Krames or the American Cancer Society (ACS). The ACS provides educational material for smoking, hypertension, breast cancer screening and weight. Clinical Quality measures 3(b), 6, 7 and 8; Menu Set measure 6.

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Meaningful Use continued...

4. Generate prescriptions through the system on behalf of the physician, Core measure 4.

**Physician**

1. Review BMI, medications, problem list, allergies, smoking status, and mammogram with patients. Reiterate the need to follow up with primary care physician if the responses require follow up, quantify the work completed by the assistant and discuss the information with the patient, Menu Set 7.

**System**

1. The RX module performs a check after the nurse enters the information, Core measure 2, Menu Set 1 and 7.

2. A rule is loaded into the system to run once the data is entered, Core measure 9 and 11.

3. The creation of the CCD accomplishes Core measure 14.

**IT**

1. IT staff to conduct risk assessment analysis through our server software, Core Measure 15.

**Patient Account**

1. Generate list of patients by diagnosis upon request, Menu Set 3.

Meaningful use is a difficult task to implement within the Orthopaedic space. As practice leaders, we have to refresh our change agent skills in order to move our practices forward. Remember, you are not alone. CMS has reported as of September 30, 2011 that 357 million has been paid in the Medicare EHR incentive program, and 514 million in the Medicaid EHR incentive program. [http://www.CMS.gov/EHR/incentive programs/50_spotlight.asp#TopOffPage](http://www.CMS.gov/EHR/incentive programs/50_spotlight.asp#TopOffPage)

The MU program was designed to save lives, coordinate care and reduce cost of care. At the end of the day, let's all hope that we achieve the results intended.
How One Solo Practice Member Utilizes the Benchmarking Survey and More!

by Allan A. Fentner, Chair

As chair of the benchmarking committee, I would like to update everyone on our progress. First, I think it is important to define the term. Essentially, benchmarking provides a snapshot of the performance of your business and helps you understand where you are in relation to a particular standard. Without a way to measure relevant financial and operational indicators, you might find yourself relying on educated guesswork. As you may know, participation in the survey has been decreasing over the last few years. In the hopes of increasing participation in the annual survey we will have some testimonials on how the survey benefited other managers in their orthopaedic practices. In a survey we completed over the summer, one reason frequently given on why the survey was not completed was “My practice is too small and it does not compare with the larger practices”. Below, Meredith Robicheaux, office manager for a solo orthopedic surgeon explains the benefit she received from the survey:

Managers wear many hats, one of which is a financial overseer. That is exactly what I am not! I run a solo practice and can be found on many days up front, checking in patients, answering phones, pulling patients back...you name it I do it. So when we were about 3 years into the practice and my physician asked me for a report of our A/R breakdown I proudly ran the report and gave it to him thinking, “That was easy”. Little did I know he was actually reading the numbers to compare to an article he read. Later that week, he calls me in to talk about some things, and he wants to know why our A/R numbers don’t compare to what he read in this article, which was written by a member of a medical organization that is open to all providers with a high concentration of Primary Care docs. I had no answer for him other than, “Let me look into it and I’ll get back with you”. I didn’t have to look very far; I quickly pulled the results of the most recent 2 years of the benchmarking survey. Our percentages were very much in line with what our fellow orthopedists across the country were showing. This experience showed my doctor how different the picture can look between an orthopedist office and other physician offices. It also gave me a resource to turn to when I want some reassurance that we are not too far out the box. I use the survey results regularly to look at financials and meeting our staffing needs. Sometimes we are right on track, sometimes we aren’t. It’s my job to figure out why and if something needs further review or not. This survey gives me some of the information I need to do that.

Meredith Robicheaux, RHIA
Office Manager
Peter D Vizzi MD, AMC

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How One Solo Practice Member Utilizes the Benchmarking Survey cont...

This is a great example of how a manager of a solo practice utilized the results of the survey. As the saying goes, size does not matter. What does matter is someone taking the time to complete the survey, share data and compare their practice to the norm. As managers we should be looking for ways to improve efficiencies in our practice, control expenses and increase productivity. This can only be accomplished by analyzing benchmarks and using the information to benefit your medical practice.

We are going to be providing additional information in the future to help you prepare for the upcoming survey which will be distributed in early 2012. The committee thought listing all the reports you will need to complete the survey would be beneficial and save you time. Although not many changes will be taking place this year, we have deleted a few questions to make the survey shorter.

Lastly, I would like to thank all the members of the committee and their dedication to making the benchmarking survey a meaningful and useful tool to the members of the AAOE. Your commitment has been appreciated.

New Office Space

By Tom Ealey

A new office suite for the medical practice is an exciting adventure as well as being fraught with potential problems.

There is no substitute for patience and thorough planning. There is no detail too small (e.g. the location of electric outlets) for careful consideration.

Use this article to compile a detailed checklist of needs and to analyze possible locations.

Buy or Lease

This decision should be made in consultation with realtors, your lawyers and CPAs. There are a multitude of factors and objective advice is needed for such a major decision.

In many areas commercial real estate is still depressed in 2011, and perhaps for years, and this can be a major consideration in your office acquisition strategy.

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New Office Space continued...

Location, Visibility and Accessibility
Location is important for physicians, staff, patients and future patients.

Your office location should be easy to find and easy to access. This probably means a major highway artery, easy access to the complex from the highway, adequate parking (including parking for the disabled and injured) easy access to the building and easy access to the office suite.

Leasing in a hospital complex has pros and cons; proximity is valuable, but hospital complexes tend to be large, confusing and intimidating to many patients. Choose carefully, and remember to have your lawyer do a Stark review (as should be done with any hospital entity transaction).

Floor Plate and Floor Plan
All square footage is not created equal. The shape of the suite and the location of columns and service areas (floor plate) as well as the potential for floor plan (flow and usage of space) should be thoroughly analyzed. The service of an architect or a design/build contractor should be useful very early in the process.

The floor plan is all about efficiency and flow.

What do we want? What do we need?
Start with the ideal office, “what does the practice want?” Then, go through the list and determine “what does the practice needs?”

The number of providers and the numbers of days in the office are a key determinant of the need. Orthopedic surgeons should be in office 2 of 2 ½ days a week, depending on specialty and surgery block scheduling. Midlevel providers will need exam space and cast rooms must be adequate.

The practice should also consider future growth prospects. If building a new building, the first one or two expansions should be sketched into the plans.

Private Physician Offices
In my experience physicians spend less than 45 minutes a day in their private offices, yet physician groups commit large amounts of expensive square footage and spend large amounts on expensive furniture so each physician can have an office. There are options, but only a very brave and secure practice administrator should raise this discussion.

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New Office Space continued...

On recommendation for the office is to scatter small conference and consultation rooms (seating for 4 to 6 people around a small table) through both the clinical and support areas, these room will likely get a great deal of use.

Flow
Flow of patients in, through and out of the office are important. Patients will not react well to cluttered or confusing layouts. Patients should not need a GPS and a road map to get through the office, a clean flow and good internal signage are important. Clean design is also an issue in staff efficiency.

Much thought should go into the entrance, check in and waiting room layout and size. Patients do not want the feeling of being crowded and shoved through a cattle chute. There are also HIPAA privacy issues in the check in process.

Disability Access
We tend to think of all medical facilities as being automatically friendly to the disabled and injured, but this is not always true. Considerable though should be put into making the office friendly to those with limitations, especially limited ambulation.

Orthopedics practices, serving many the injured and elderly, should be especially sensitive to these issues. With the current increase in obesity and morbid obesity, disability design issues are even more important.

Don’t Forget the Unglamorous Pieces
Practices need supply closets, space for medical records processing and storage, nurses’ stations, adequate business office space, a tech room (server and telecom equipment usually) employee lockers, a break room and janitorial storage.

Ancillary Spaces
In-house ancillaries require us to think through location and flow, size, special construction requirements, internal waiting rooms, dressing rooms, film storage (or preferably digital equipment) and all other needs of the ancillary departments.

Practices considering leasing should check first on the acceptability of special requirement remodeling (e.g. lead walls) to the building owner.

Plan carefully, prepare lengthy checklists, analyze every socket, switch and knob, contract carefully, and the new office can be a marvel of efficiency and productivity.
The Value of an Administrator to an Orthopedic Surgeon

By John J Mara, M.D., Robert W. McAllister, M.D., and John O’Brien, M.D.

I have been asked to describe the ideal practice administrator from the point of view of an orthopedic surgeon and the value he/she brings to us and the practice.

In order to begin I have to consider what it is that an orthopedic surgeon wants.

Most of us want to do orthopedic surgery unless we choose to get an MBA and go into administration. Consequently, we want our office designed so that we can accomplish that goal with the least amount of distraction.

The day to day goal of a practice administrator is to manage the personnel in the office. This means organizing them, dealing with interpersonal relationships, seeing that they have defined tasks that can be monitored and measured, defining the mission of the practice and seeing to it that they feel a part of a team to accomplish that goal. By definition we surgeons are in the office for a finite period of time per week so we are unable to observe our staff in a meaningful way to ensure that these objectives are met.

The Practice Administrator fosters appropriate “cultures” and “vision” for the practice and facilitates a good working environment for the Physicians to provide outstanding patient care while keeping the practice competitive and moving forward.

The job description for an Orthopedic Practice Administrator is somewhat dependant on the practice size. For a small practice of four or five physicians and associated mid-levels, the administrator wears several hats. Equal importance must be placed on the management of human resources, clinical practices and protocols, billing/finance and economics, business development and marketing, physical plant management, compliance and a host of other responsibilities that might otherwise be divided between several individuals in a larger practice. In addition, the Practice Administrator must understand the personalities, idiosyncrasies’, strengths and weaknesses of each partner and develop appropriate relationships with each to facilitate overall management of the practice.

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The Value of an Administrator to an Orthopedic Surgeon continued...

With increasing government and private regulations around the practice of medicine a competent practice administrator needs to be aware of the demands of these payers and see that they are met. He or she also needs to be aware of state and federal regulations with respect to employee rights, benefits and the workplace.

The practice administrator also needs to be certain that we are in compliance when it comes to medical coding and documentation so that the practice can withstand any potential audit from the government or a third party insurer.

From a more global perspective the administrator needs to monitor the bottom line. Are there areas where expenses can be trimmed? Are there opportunities for growth either with existing personnel or by expansion? Are there opportunities for ancillary income to offset the bottom line? All of these concerns need to be monitored by the administrator.

Finally we need an advocate! We spent a lot of our lives learning how to be orthopedic surgeons. It is not fair nor should insurers expect that we will not be compensated commensurate with our skills. Therefore the insurers need to be monitored by the administrator and their contracts need to be measured and compared and those that are weak need to be given an opportunity to do better or dropped from the practice.

My last thought, as medicine evolves over time, is the importance of networking. I think that a Practice Administrator needs to be connected to his or her peers. Knowing what works and what doesn’t is critical to not “reinventing the wheel” in this increasingly competitive world not wasting time on a bad idea is invaluable.

It is equally important for the administrator to foster relationships outside of the practice networking with appropriate individuals in hospital administration and business relationships in the community to keep the practice as integrated, functional and contemporary as possible.

Benefits of AAOE Membership, Solo Practice Perspective
By Francis “Sam” Santschi, J.D., Member-at-Large, AAOE Membership Council

“I don’t care to belong to any club that will have me as a member”.
Groucho Marx

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I admit to having been somewhat leery about deciding to apply for AAOE membership several years ago. After all, practice management was supposed to be a temporary stop, a fill-in job for my doctor friend, Diana Kruse MD, while her real manager recuperated from a disability. Before long, I thought I would again be ensconced in the wood-paneled office of some bank on LaSalle Street in Chicago. So, if I was asked to escort a patient to an exam room or worse, help our ninety eight pound x-ray tech maneuver a patient around her table, I was really out of my depth. (You mean I have to touch a patient?) But then I grew to like the challenges (shoveling snow off the ramp in winter) and stayed on when that former manager never returned. I did however, need lots of help, which is where the AAOE came in and immediately made my membership more than worth it; showing me a new career path.

The benefits of AAOE membership are as priceless as Groucho’s line. For a nominal fee, you receive career development assistance and proven practice management help from all over the country. Why, a tip I received about CPT code G0180 from Kansas, more than funds my membership every year. Need forms or procedures? Montana knows about that. I’ll bet there are a lot of you out there like me who are originally from other industries. The ALPS program assigned me a mentor, who early on took the time to educate me on the vagaries of this industry and met with me at the AAOE annual conference in Chicago. From there I was able to connect with members of my state orthopedic practice management society and gain insight and other resources within my state. Many others have generously made themselves available for career guidance, contracting tips and counsel.

Two more of the valuable benefits are the AAOE Listserv and the Annual Benchmarking Survey. I look at the Listserv every day as it provides so much information, strategy, off-topic red state/blue state banter and other forms of comic hilarity that it should never be missed. Joining the Listserv is simple. There is a link to it, which may be found after you login to our membership site. Best of all, my doctor often asks me, “What are they saying out on that Listserv?” It has raised my competence and credibility substantially.

Participating in the Annual Benchmarking Survey, and thus having access to the data, has allowed me to rethink our office and provide my doctor with evidence based (sorry folks!) rationale to make positive changes to her practice. It also has helped me to greater understand what I should be focusing on for our mutual benefit. I urge all members to participate in the Survey.

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The Benefits of AAOE Membership continued...

Going forward, I feel the best is yet to come, as the AAOE is further developing its ability to “know what it knows” and provide even more web-based resources and other content rich programs for all members whether you work in a solo, semi-rural practice or in a multi-specialty large practice in an urban setting.

Evaluation of Invitations to Join Accountable Care Organizations (ACOs)

By Tom Ealey and Marcy Gilstad

The Patient Protection and Affordable Care Act (often referred to as “Obamacare,”) [1] intends to create a system providing better care at lower costs, and the federal government is putting Accountable Care Organizations (ACOs) at the core of its’ strategy.

The definition of an ACO is fluid. We know what we want them to do and have an idea of how we might get done it done. Some respected experts define an ACO as:

a local health care organization with a network of providers such as primary care physicians, specialists and hospitals that are accountable for the cost and quality of care delivered to a particular population. [2]

The big question: when should your orthopedic group join an ACO?

The Obama administration and its allies planned a phase-in of ACOs. The first phases would involve Medicare shared savings ACOs, and it was assumed providers would follow up by creating general population ACOs on the same model with the same advantages.

The plan looked reasonable until March of 2011 when it began to unravel.

On March 31st, 2011 the DHHS – Center for Medicare and Medicaid Services (CMS) issued draft regulations on the new Medicare SSP - ACOs due to be formed starting January 1, 2012. The draft ran 429 pages, was complex and bureaucratic, and was received about as well as a skunk at an outdoor wedding.

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Evaluation of Invitations to Join ACOs continued...

Providers ran the other direction. The administration countered with two new ACO models, a fast track and a subsidy model. These were received with the same lack of enthusiasm. There is considerable doubt ACOs can create the cost savings and gain sharing desired by the administration. Projections of startup and operations costs are higher than the government expected.

In October 2011 the Obama administration issued new simplified Medicare ACO rules, running 629 pages and only a little less complex than the first draft. As this is written we are still reading, but these rules look a little more realistic, and the model a little more realistic.

So will ACOs die on the vine? Not likely. ACOs will be created, the gestation period will be tougher than anticipated.

Are early adapters advantaged? There may be a great deal of pressure on physician groups to join ACOs, depending on your market and location. Hospitals with MSO captured physicians and large integrated delivery systems (IDS) may be early adopters.

The first push will likely be for primary care physicians, especially if the organizing entity starts a Medicare Shared Savings Program - ACO (SSP-ACO) in 2012 or soon thereafter.

If the ACO concept takes root there will be a push to expand provider panels beyond primary care physicians, and also to ancillary and allied providers. Specialists, particularly surgeons, may be susceptible to bigger risks in joining an ACO, dependent on the needs and competence of the ACO sponsor.

A physician group should not rush into joining any ACO; wait until the practice can be satisfied the ACO is a viable operating entity and until satisfied there is advantage for your group.

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Evaluation of Invitations to Join ACOs continued...

What entities might form and operate an ACOs?

- existing and expanding integrated delivery systems, particularly in urban areas
- large primary care groups or IPAs with sufficient size and resources
- hospital using a hub-and-spoke model, useful in areas with smaller populations
- large multispecialty physician groups, especially those with dominant market positions
- insurance companies

Could a physician group start and successfully operate an ACO? Possibly a very strong and diverse multi-specialty group with a commanding market presence, a strong reputation, a strong capital base and a reasonable relationship (or a strong arm relationship) with local hospital/s. Perhaps a large and well capitalized primary care group in a market without a dominant hospital or IDS would be suited for ACO formation.

There could be a move to the non-ACO, some new hybrid form seeking to exploit the advantages of the ACO form without the heavy upfront commitments and bureaucracy. Turned loose, innovation can go many interesting directions.

Medical practices evaluating ACO invitations must have a unified management team, sound professional advice and thorough due diligence. An invitation should be accepted only if the organization can meet the many and difficult challenges of forming and operating an ACO.

Notes:

[2] Managed Care, October 2010, by Boland, Polakoff, Schwab

Further reading:
Accountable Care Organizations Learning Network (a service of the Brookings Institution)

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Using Athletic Trainers with Mid-Level Providers to Add Clinical and Financial Value to an Orthopaedic Practice

By Joseph J. Greene MS ATC, Program Manager, Outreach and Development, Department of Orthopedics and Rehabilitation, University of Wisconsin Hospital and Clinics

As orthopaedic and sports medicine practices evolve and react to the challenges they face driven by national health care policy change and diminishing reimbursement, they are forced to consistently evaluate their processes and find ways to deliver care more efficiently and effectively. If done well, this evolution occurs while adding clinical value to the patient while simultaneously adding financial value to the practice.

Delivering value to the patient results in streamlined access, superb delivery of services rendered and excellent outcomes. Delivering value to the practice is manifested by managing overhead while increasing revenue and volume to the greatest extent possible. It is essential that value added initiatives should be designed around the consumer or patient first, but these initiatives must be achieved while improving the financial viability of the practice. I believe strongly that practices must evolve their utilization of ancillary allied healthcare staff to make them more efficient and allow them to function more autonomously. It is absolutely essential to have the right people doing the right things from a patient care and business perspective. This has always been critical, but never has this been more important.

At the University of Wisconsin Hospital and Clinics, we have been evaluating the utilization of our available staff very critically. Our utilization has evolved consistently over time, but the present is likely one of those times that the need for swifter change has become apparent. We have added to mid-level staff (PA's and NP's) substantially in recent years and we have also added to our athletic training
Using Athletic Trainers continued...

staff as our program has grown and we have added orthopaedic faculty. These allied health professionals provide the vast majority of our patient care within our sports medicine and orthopedic practices in addition to the residents and fellows that we train.

At this time, we are working to move our mid-level providers into as many autonomous roles as possible for two reasons. First, they can be more financially viable within our institution and second, they can improve access to our practice while generating revenue at the same time. Our challenge at hand is to remove our mid-levels from providing services that do not have financial value or improve access to our physicians. Our goal is to minimize or eliminate the occurrences of having two billable providers seeing the same patient at the same time and to have our mid-level's always functioning in a value added role, both clinically and financially. Specifically, to the greatest extent possible, we want our mid-level providers to run as many independent clinics as is practical, perform procedures, and function as a first assist in the operating room when their services are reimbursable.

In order to accomplish this, we have been slowly but consistently increasing the utilization of our 42 athletic trainers across our system in order to take advantage of their skills and allow our physicians and mid-levels to function with added value. This has allowed us to be creative and begin to shift our mid-level providers to the other roles. This began in our sports medicine sub-specialty, but now involves them working in our hand and upper extremity, foot and ankle, and total joint subspecialties. Additionally, we now utilize our athletic trainers as direct providers of rehabilitation services, across our orthotics department and for the delivery of incident-to services. Other institutions are using the athletic trainer in their operating room environment with additional credentialing that is institution dependent. Our program may head in this direction as well.

These transitions have not been happening in only a few isolated locations around our country. All institutions are unique and different, but I have been fortunate to visit many academic and private practices around the country and most are finding new and innovative ways to use the athletic trainer in a way that fits their practice the best. The athletic trainer functioning in the role of a physician extender is currently the fastest growing area of employment in the athletic training profession. This has been driven by orthopedic practices seeking the services of athletic trainers and athletic trainers increasingly pursuing this type of work because it fits their skillset exceedingly well. It is also important to note that athletic training preparation is improving for roles like this and the accreditation of one year...
Using Athletic Trainers continued...

residency training programs focused on thoroughly training the athletic trainer to work in all aspects of an orthopedic or sports medicine practice is on the horizon...

It is critical that we keep in mind what is best for the patient and the practice. It is also critical to utilize all the available abilities of the providers we have available to us in order to add value. If this is done well, mid-level providers, athletic trainers, nurses, and any other allied health providers utilized in an orthopaedic setting will be happier as they can use all their abilities while being able to justify greater financial and clinical value to the organization.
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