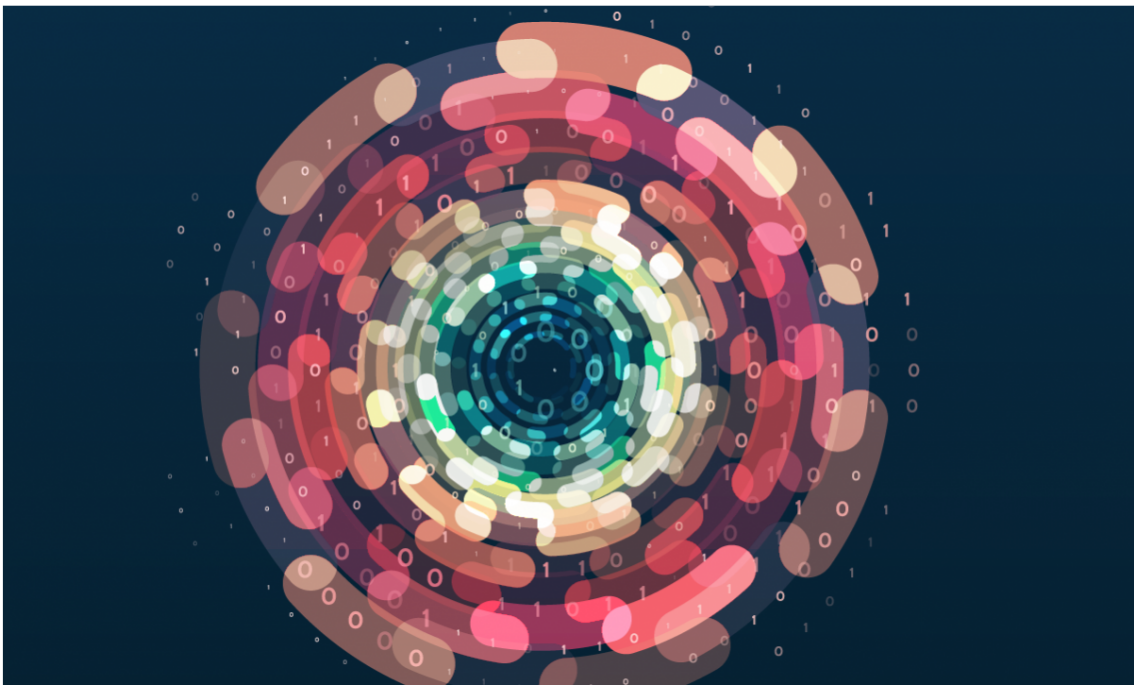
Data Before Drama



By Elizabeth Woodcock, MBA, FACMPE, CPC

How many times have you heard sentiments from colleagues, administrators, employees – and perhaps yourself – describing your practice? When it comes to the business of a medical practice, we often rely on anecdotal evidence to manage:

> *If appointment lead times are rising or patients are being turned away, our response is: "Well, we're just too busy…"*
>
> *If patient or employee experience is suffering, our response is: "She [referring to a patient or employee] is just crazy…"*
>
> *If collections are dropping, our response is: "It's just Medicaid; they are the worst…"*
>
> *If the fill rate of our schedule is declining, our response is: "If only patients would show up…"*

In a world where you use evidence to make decisions about caring for patients, it's surprising to consider the lack of rigor related to managing the business of medicine.

Anecdotes often serve as the basis for decision-making. The deficiency of evidence may result in determinations that hinder the practice.

In management, data are evidence – and they can prevent the drama that adversely affects many medical practices.

While this list is not exhaustive, it provides a foundation to build your practice's management metrics to avoid problems that ensue from a failure to understand an opportunity.

Demand:

- Measure patient requests – fulfilled and unfilled, including inbound phones, faxes, and electronic referrals.
- Keep tabs on the oldest outstanding request and the volume.
- Track the new patient requests separately; this is particularly important for specialists.
- Recognize that the longer the lead time for appointments, the lower the attendance rate. That results in reduced volume, unless well-managed.

Supply:

- Monitor the minutes or slots available for patient care, ideally establishing a fair (equal) expectation for available capacity if there is more than one provider.
- Measure, also, the weeks worked, as time is the practice's most precious asset. Use data related to availability of provider appointments to determine how much demand (new and established patients) can be accommodated. This may inform your practice's protocols about limiting or closing patient panels, as applicable. (See below section regarding patient panels for primary care.)

Receivables:

- Our business model centers on collecting based on accounts receivable, not sales.
- Identify days in receivables outstanding and the aging of receivables.
- Also watch for the *inputs*: payer mix (and shifts), production (relative value units and volume), denials (volume and type), and services (CPT codes).
- Further, be sure to account for the revenue cycle nuances that have a substantial impact on data. For example, credit balances offset accounts receivable and should be accounted for on billing reports.
- Further, receivables sent to a collection agency should be written off the books and tracked using a write-off adjustment code. Changing protocols related to collections, therefore, can significantly impact the data.

Experience: It's challenging to gather data about the experience of stakeholders, but that doesn't mean that we shouldn't try.

- Capture patient experience through simple, one-question post-call and/or post-visit

survey (for example, “Using a scale of 0 to 10 where 10 is Very Likely: how likely are you to recommend the practice to a friend or family member?” See sidebar on “Net Promoter Score.”).
- Administer the survey yourself – or look for a vendor that can support the capture and delivery of *timely*
- Consider a suggestion box (physical or email); although it can be painful, scan your online reviews to understand patients’ views of your practice. If you spot a bad review aimed at another business (which happens often), follow steps to report it. (Instructions outlined here.)
- Have postcards ready with directions to post an online review – proactively give one to any patient who offers a compliment; ask them to share their praise with their community. Although not every patient will, this small step builds a positive online reputation and costs very little.
- Your team is another guidepost for experience – listen during staff assemblies, hold 1:1 meetings with your employees (and ask for feedback about the practice), and always perform exit interviews.
- For specialty practices, identify your top-ten referral sources – meet (at least once per annum) and listen to their feedback.

Given the complexity of a medical practice, analytics may vary based on how data are run. Therefore, establish a dashboard, agree on definitions (inclusion and exclusion criteria, as well as timing), and allow self-service viewing for your team. Sit down with every employee in a management role, share the dashboard, and provide examples of how data can be useful. During meetings, ask your team to share evidence – and use it yourself for management decision-making.

Data can – and should - prevent drama!

What is a Patient Panel?

A patient panel is the cohort of patients under a primary care physician's care, including direct in-person or virtual encounters and the associated indirect, non-visit work. The latter includes everything from preventive and chronic care management to messages and refills. The calculation of a patient panel focuses on attribution. Sum the number of unique patients seen within the past three years.[1] Next, adjust for acuity and complexity. For this step, consider guidance from industry experts like researchers from the University of Wisconsin's Department of Family Medicine or Dr. Mark Murray, who co-authored several articles about the topic, including "The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity."[2] Increasingly, patient panels are managed via a care team approach – a physician joined by a nurse practitioner, for example. In this case, the calculations are made for the pair. The notion of a "perfect" panel size is elusive, although many believe that number is between 1,500 and 2,500 patients per provider. Most importantly, the panel should be a size in which the physician, provider, and/or care team can effectively and efficiently deliver quality primary care.

[1] The calculation may be 12, 18, or 24 months; there is no industry standard.

[2] Weber, R. MS, & Murray, M. MD, MPA (2019, November/December). The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity. *Family Practice Management, 26*(6), 23-29.

Risk Matters: Be mindful of risks as the popularity and functionality of wearable medical devices continue to grow

By Justin Joy, JD, CIPP

The potential benefits of wearable medical device technology in assisting with monitoring and managing general patient wellness, as well as chronic conditions, have been generally recognized for nearly a decade. As aptly stated earlier by one author, “Mobile health is at the swirling confluence of remote sensing, consumer-facing personal technologies, and artificial intelligence (AI).”[1] The adoption and improvement of this technology has continued to grow rapidly. According to some reports, the global wearable medical device market was estimated at $33.85 billion in 2023. To put that into perspective, that is enough for a $100 device on the wrist of every single American. By some estimates, the market category is expected to grow at an annual rate of 25% for the next five years.[2]

As part of any conversation regarding the use of wearable medical devices, clinicians

need to distinguish between direct-to-consumer wearables and devices[3] recognized as medical devices by the Food and Drug Administration (FDA) for remote therapeutic monitoring or remote physiologic monitoring.[4] While generally less advanced than FDA-recognized medical devices from both a user and clinical perspective, consumer wearable devices continue to improve in their functionality and potential for clinical utility.

As is the case with any technology in a medical practice, clinicians must be aware of the risks of utilizing wearable medical devices for monitoring and managing patient health, including the functional and clinical limitations of devices. For example, on February 21, 2024 the FDA issued a warning to healthcare providers and others about risks related to the use of devices claiming to measure blood glucose levels without piercing the skin.[5] The notice reminded readers that the "FDA has not authorized, cleared, or approved any smartwatch or smart ring that is intended to measure or estimate blood glucose values on its own" and recommended that providers talk to patients about this risk.

Additionally, the hardware and software technology associated with these devices continues to evolve rapidly, which can result in changes in functionality or even availability. For example, due to an intellectual property dispute, Apple has recently disabled blood oxygen level measurement functionality on certain Apple Watch models.[6] Clinicians who may have requested patients utilize this device for monitoring blood oxygen levels obviously will no longer be able to rely on the availability of such data from patients with impacted models. Of course, privacy and security risks need to be managed as well. There remains a common misperception that all wearable device data is protected by HIPAA. It's probably not.[7] However if a medical practice collects any data from a device, it then becomes part of the patient's HIPAA protected health information.

As consumer wearable devices continue to permeate the market and improve in capability, medical providers must remain aware of the evolving risks accompanying the growing list of potential benefits from these devices that are increasingly becoming a part of patients' daily lives.

[1]. Ida Sim, "Mobile Devices and Health," New England Journal of Medicine (September 2019)

[2]. https://www.grandviewresearch.com/industry-analysis/wearable-medical-devices-market

[3]. To be sure, specific software applications may "transform" the built-in functions of a mobile platform into a regulated medical device. https://www.fda.gov/medical-devices/device-software-functions-including-mobile-medical-applications/examples-device-software-functions-fda-regulates

[4]. In certain circumstances, remote monitoring services may be reimbursable. https://www.aapc.com/blog/87433-know-when-to-bill-for-rtm-services/ There are several

consumer wearables that have been FDA cleared for specific use cases. https://www.medicaleconomics.com/view/what-physicians-need-to-know-about-consumer-wearable-health-technology.

[5]. https://www.fda.gov/medical-devices/safety-communications/do-not-use-smartwatches-or-smart-rings-measure-blood-glucose-levels-fda-safety-communication

[6]. https://www.npr.org/2024/01/18/1225432506/apple-watch-blood-oxygen-levels-pulse-patent-masimo

Closed Claim Review: Fortitude Pays Off

By Grace Gilliland, J.D.

A lawsuit is often described as a marathon, not a sprint. In some cases, that marathon takes longer and includes more hills to climb than expected. The COVID-19 pandemic certainly emphasized the challenges faced in litigation and created the perfect storm of repeatedly delaying a case ready to go to trial. In this case, Dr. Bass faced numerous delays with tremendous fortitude, and she finished the trial marathon as a victor.

The patient was a 71-year-old male who had significant cardiac history and suffered complications from a laparoscopic hernia repair surgery. The patient's cardiac surgeries included a double coronary artery bypass, repair of an abdominal aortic aneurysm, and a balloon angioplasty of the renal artery. The patient was ultimately referred to Dr. Bass *(critical information has been altered to protect identities)* in early 2015 due to a right inguinal hernia in the area of the previous reduction of the femoral artery.

At the time of the 2015 examination with Dr. Bass, the patient did not have acute cardiac

issues. However, the patient was prescribed both Plavix and Aspirin. Dr. Bass recommended surgery due to the hernia being symptomatic, and she decided to keep the patient on anti-coagulants due to his extensive cardiac issues. She performed the hernia repair with no noted complications.

The patient went to recovery shortly after completion of the surgery, and a nurse reported a hematoma at the incision sites. Dr. Bass ordered ice to be applied to the incisions, and the patient was discharged the same day. Later that evening, the patient's wife reported that he was having pain and had only taken ½ of a tablet of hydrocodone. She was instructed to have the patient take the remainder of the tablet and go to the ER if there was no improvement. Just after midnight, the patient went to the ER in respiratory distress and was intubated by EMS. The patient had a CT of his abdomen which showed blood around his spleen. The patient continued to deteriorate with additional bleeding and labs confirming cardiac arrest. The patient expired about a week later.

The patient's estate filed a lawsuit in 2016 against Dr. Bass and her clinic alleging negligence and wrongful death, claiming the hernia surgery was optional given the patient's underlying health issues, and that it should not have been performed without stopping the anti-coagulant medication. The lawsuit initially progressed as any other suit through the lengthy discovery process of depositions and expert testimony. However, the COVID-19 pandemic struck soon after the case was first set for trial in 2020.

The case was initially set for trial in November 2020. All experts in the case had been deposed at that point – with a "frequent flyer" Dr. Archibald being the sole expert for the plaintiffs. Dr. Archibald had many criticisms of Dr. Bass's care. Nonetheless, the defense prepared several experts to address those criticisms and stood ready to go forward with the trial. Unfortunately, the trial was continued because the docket was overbooked with other trials set for the same dates.

With her case ready, Dr. Bass eagerly awaited her next trial date. Her eagerness to proceed, however, was met with a court order suspending trials until late 2021. The court order prolonged the case to its next setting, September 2021. Then, the trial was continued two more times as the COVID virus infected essential parties in the case. Although disheartening, the date for trial was pushed once more to early 2023. Dr. Bass surely thought she would finish the trial marathon in early 2023, but Mother Nature had other plans. The trial date was moved – again – due to inclement weather.

Between crowded dockets, pandemic protocols, and harsh weather, the trial finally commenced in late 2023 – over eight years after the patient died.. Through all the litigation challenges, continuances, and circumstances beyond her control, Dr. Bass patiently waited until she had her day in court. She tirelessly stayed the course of litigation from start to finish, and it paid off. She was successful in defending her decision to keep the patient on his anti-coagulant medication and to move forward with the hernia surgery. After just twenty-nine minutes of deliberation, the jury returned a verdict in favor of Dr. Bass.

The process of litigation is never easy, but it can be worth it. It can be quite draining for

physicians to remain steadfast in defending their case, especially with many unforeseen circumstances. Although Dr. Bass's case was significantly impacted by the COVID-19 effect on conducting court business, most cases are now moving faster and will not face as many roadblocks on the path to trial. A well-prepared case still requires stamina and fortitude throughout litigation. Ultimately, it is that stamina and fortitude that pays off when cresting the hill of trial and crossing the finish line with a favorable defense verdict.
