

BULLSEYE



E - A - S - Y

Handle Mail and Memos IMMEDIATELY

The great paper shuffle consumes an enormous amount of our precious time. On average, we touch each piece of paper that crosses our desk over a dozen times - shuffling it from the right pile to the left pile to the credenza, etc.--before we act upon it.

To facilitate handling all that paper, Patty Kreamer a professional organizer, has come up with the **EASY** Method:

- **E** - Eliminate it. Ask yourself what's the worst that can happen if you don't save this piece of paper? If there aren't any consequences, then throw it away instead of adding it to a pile and shuffling it another dozen times—and then throwing it away.
- **A** - Act upon it. If you can complete the task involved with the piece of paper in less than 15 minutes do it immediately, don't set it aside.
- **S** - Send it away. Pass it onto whoever should handle it. Don't add it to a pile only to delegate it at some later time.
- **Y** - You file it. If you absolutely must keep the document, file or scan it then and there. Don't add it to the stack—you'll only have to touch it again.



PRACTICE MANAGEMENT GROUP, LLC

TARGETING THE BUSINESS OF MEDICINE

24 Hours are Plenty • “Tips for Accomplishing More Everyday”

You hear it all over corporate America: “Do More with Less.” It's the 21st century buzz term for downsizing and reducing costs. It's also a recipe for stressing out the folks who are remaining and expected to absorb the additional work load.



- 1** = Critical must be done ASAP or there are negative consequences.
- 2** = Important but can wait until number ones are completed.
- 3** = Nice to do but neither critical nor important.

Then make sure you start with the items labeled with the number one!

CREATE A SUCCESS LIST

After completing a task don't just cross it off the list and add another. Write the completed task on a success list. I'm always amazed how people will accomplish 9 out of 10 items on a To Do list and then worry about the one task they didn't finish instead of celebrating the 90% they completed. By looking only at the tasks remaining, we place added pressure upon ourselves. We should spend more time celebrating our victories (completed projects) versus beating ourselves up because we have remaining items on our list. This technique will help lessen your anxiety and replace the feeling of stress with a sense of accomplishment.

TAKE A STRESS BREAK

We perform more effectively and efficiently when we are less stressed. So it's our responsibility to determine what works best for us as a stress reliever. It could be taking a walk, reading, or listening to inspirational or educational material. Taking a stress break gives you a new perspective and renews your energy.

Always keep in mind that, you'll never have time to do everything but you will always have time to do the most important things.”

Trying to maintain the same level of performance with fewer resources is a never ending struggle. Whether you are the president of your company or a mail clerk, we all have only 24 hours in every day. Many of us seem to run out of week long before we run out of work.

Balancing work and our personal life requires the mastery of certain skills which were never taught in school. How can we increase productivity without continually sacrificing personal time? The key is how we utilize our time. Here are some strategies for accomplishing more in the same amount of time.

CREATE A TO DO LIST

A “To Do” list is a road map for planning your day. Having a definite plan gets your day off to a fast start by focusing your thoughts. Instead of getting your first cup of coffee and then sitting at your desk and scratching your head as to what to tackle first, establish and maintain a To Do list. Make it out when you leave the office in the evening and have it sitting on your desk for the morning.

List all projects, whether long or short term, and assign a targeted completion date. Then establish a ranking system based on the task's importance.

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Points to Ponder

- From January - September 2007, 17.5% of persons under 65 years of age with private health insurance were enrolled in a HDHP, 4.5% were enrolled in a CDHP, and 16.9% were in a family with a FSA for medical expenses.

- From January - September 2007, 43.7 million persons of all ages (14.7%) were uninsured at the time of the interview, 54.5 million (18.4%) had been uninsured for at least part of the year prior to the interview, and 31.2 million (10.5%) had been uninsured for more than a year at the time of the interview.

- The percentage of children under the age of 18 years who were uninsured at the time of the interview was 9.2% in the first 9 months of 2007.

- In the first 9 months of 2007, more than 54% of unemployed adults and almost 23% of employed adults aged 18-64 years had been uninsured for at least part of the past year, and about 33% of unemployed adults and almost 14% of employed adults had been uninsured for more than a year.

- Since 1997, there has been a decreasing trend in the percentage of children who were uninsured.



A couple of intriguing theories have emerged following a study into the cost-effectiveness of giving free samples of prescription medications to patients. It seems the free samples are closely linked to some pretty steep out-of-pocket expenses immediately before and after the free samples are dispensed.

Using the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey, researchers monitored 5,709 patients from across

the nation for as long as two years each. The mean patient age for study participants was 48. Seventy-six percent of the participants were covered with private medical insurance policies and 84% were white. During the study period, 2,343 free samples of medications were handed out. The study participants' out-of-pocket

expenses varied widely between those who did not receive free samples and those who did. Study participants who did not receive free samples during the course of the study paid an estimated \$178 for prescriptions over a six-month period. The average estimated cost associated with the free samples was determined to be \$622.

Out-of-pocket expenses for patients who did receive free samples was estimated to be \$166 for the six-period before receiving the free samples, another \$244 for the six-month time period in which the samples were given, and an additional \$212 for the six-month time period after receiving the samples.

Free Drug Samples Costing You More?



Older patients and those using Medicaid as their medical insurance provider were less likely to be offered free samples.

Lead author for the report based on the study, G. Caleb Alexander, MD, a University of Chicago Medical Center's assistant professor of medicine, suggests caution when dispensing free samples as a means of reducing patient prescription costs. He presents the following scenarios for why the free samples may lead to added expense:

- The medication is often continued as a long-term prescription after the sample medication has been taken. Free samples are most often the newest and most expensive medications avail-

able although less expensive medications that have been available for longer may work as well and be more cost effective in the long run.

- Patients receiving samples may have been experiencing underlying health issues which made them more ill initially than those not receiving samples.

Alexander points out that the study was designed to determine only the patient prescription costs

associated with free samples, not the reasons why patient cost is higher when samples are received. The research team plans to continue studying the economic impact of prescription medications under various circumstances.

As a result of this study, Alexander urges physicians and patients alike to examine alternative ways to reduce out-

of-pocket prescription expenses, such as purchasing a three-month supply instead of a one-month supply, eliminating all prescription treatments that are not essential, and using generic prescription medications more often.

More research is needed, according to Alexander, to explore communications between physician and patient where free samples are concerned, the reasons behind the decision to provide the samples, and the manner in which different physicians, in different types of practice, distribute samples to their patients.

The study was funded by the Robert Wood Johnson Foundation and details will be published in the March 24 issue of Medical Care.

Source: University of Chicago Medical Center

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By MedHeadlines • Mar 25th, 2008 • Category: Drugs, Editor's Picks, Lifestyle, Odd MedNews, Prevention, Supplements

CMS PROPOSES TO EXPAND QUALITY PROGRAM FOR HOSPITAL INPATIENT SERVICES IN FY 2009

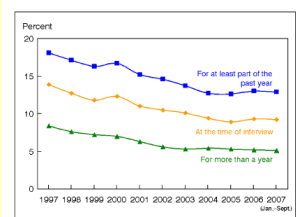


Figure 1 - Percentage of children under 18 years of age who lacked health insurance coverage at the time of interview, for at least part of the past year, or for more than a year: United States, 1997-September 2007.

DATA SOURCE: Family Core component of the 1997-2007 National Health Interview Surveys. The estimates for 2007 are based on data collected January through September. Data are based on household interviews of a sample of the civilian non-institutionalized population.

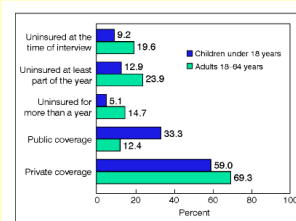


Figure 2 - Percentage of persons without health insurance, by three measurements and age group, and percentage of persons with health insurance, by coverage type and age group: United States, January-September 2007.

DATA SOURCE: Family Core component of the 2007 National Health Interview Survey. The estimates for 2007 are based on data collected January through September. Data are based on household interviews of a sample of the civilian non-institutionalized population.

The Centers for Medicare & Medicaid Services (CMS) today proposed additional steps to strengthen the tie between the quality of care provided to Medicare beneficiaries and payment for the services provided when they are in the hospital.

CMS is proposing to expand the list of conditions which are reasonably preventable through proper care and for which Medicare will no longer pay at a higher rate if the patient acquires them during a hospital stay. In addition, CMS is adding 43 new quality measures for which hospitals will have to report data in order to receive the full annual payment update for their services.

“CMS is taking aggressive actions to ensure that beneficiaries get safe, high quality, and efficient care from their health care providers, and the actions we are announcing today build on our efforts,” said CMS Acting Administrator Kerry Weems. “The status of the Medicare Hospital Insurance Trust Fund requires us to find the best solutions to ensure that Medicare stays strong while paying providers appropriately for the care they deliver. The reforms we are proposing in this rule should lead to greater value for Medicare beneficiaries and the Medicare program.”



The proposed regulation builds on efforts across Medicare to transform the program to a prudent purchaser of health care services, paying based on quality of care, not just quantity of services. CMS is also making hospital quality and cost information available to help consumers make more informed choices. On March 28, CMS posted updated pricing and quality information at www.hospitalcompare.hhs.gov, along with the results of surveys of patients about their experience with the care they received while in the hospital.

The proposed rule would apply to services provided to patients who are discharged from the hospital during fiscal year (FY) 2009, which begins on October 1, 2008.

Numerous studies have documented the detrimental effects on patients and their loved ones and the increased costs of health care services resulting from a preventable patient’s injury or condition acquired due to hospital errors. These can include “Never Events,” those events that never should occur, like amputation of the wrong limb or transfusing patients with the wrong blood type. CMS is working with the National Quality Forum (NQF), a national organization working to promote patient safety and improve hospital care, on ways to reduce or eliminate 28 Never Events identified by NQF.



In its 1999 report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine (IOM) concluded that medical errors, particularly hospital-acquired conditions (HACs), may be responsible for as many as 98,000 deaths annually, at costs of up to \$29 billion. In 2000, the Centers for Disease Control and Prevention (CDC), estimated that hospital-acquired infections added nearly \$5 billion to hospital costs. At the same time, a 2007 survey by the Leapfrog Group of more than 1,200 hospitals found that 87 percent did not follow recommendations to prevent many of the most common hospital-acquired conditions.

“When these conditions occur during a hospital stay, the patient and his or her family suffer needlessly. To make matters worse, these conditions are likely to result in higher medical bills for the family to pay for additional services for physician care, prescription drugs, and other items and services that would not have been necessary if proper care had been provided,” said Weems. “Medicare can and should take the lead in encouraging hospitals to improve the safety and quality of care and make better practices a routine part of the care they provide not just to people with Medicare, but to every patient they treat.”

The rules proposed by CMS expand two key initiatives that began to link payments for healthcare

Insurance Statistics

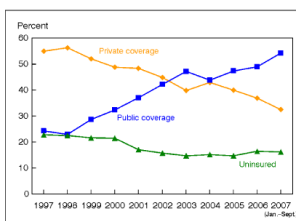


Figure 3 - Percentage with health insurance, by coverage type and percentage uninsured at the time of interview for near poor children under 18 years of age: United States, 1997-September 2007.

services to quality of care – the Hospital-Acquired Conditions and the Hospital Quality Measure Reporting initiatives. Under the HAC initiative, beginning October 1, 2008, Medicare will no longer pay hospitals at a higher rate for the increased costs of care that result when a patient is harmed by one of several conditions they didn't have when they were first admitted to the hospital and that have been determined to be reasonably preventable by following generally accepted guidelines.

The HAC provisions in Medicare regulations required hospitals to begin reporting on their Medicare claims on October 1, 2007, whether certain specified diagnoses were present when the patient was admitted. The first eight conditions, which were selected last year because they greatly complicate the treatment of the illness or injury that caused the hospitalization, resulting in higher payments to the hospital for the patient's care by both Medicare and the patient, were:

- Object inadvertently left in after surgery
- Air embolism
- Blood incompatibility
- Catheter associated urinary tract infection
- Pressure ulcer (decubitus ulcer)
- Vascular catheter associated infection
- Surgical site infection- Mediastinitis (infection in the chest) after coronary artery bypass graft surgery
- Certain types of falls and trauma

CMS is proposing to expand the list of conditions that need to be reported if present when a patient is first admitted and is seeking public comment on whether they should be added to the list in the final rule to be announced later this year. The list in the proposed rule includes:

- Surgical site infections following certain elective procedures
- Legionnaires' disease (a type of pneumonia caused by a specific bacterium)
- Extreme blood sugar derangement
- Iatrogenic pneumothorax (collapse of the lung)
- Delirium
- Ventilator-associated pneumonia
- Deep vein thrombosis/Pulmonary Embolism (formation/movement of a blood clot)
- *Staphylococcus aureus* septicemia (bloodstream infection)
- *Clostridium difficile* associated disease (a bacterium that causes severe diarrhea and more serious intestinal conditions such as colitis)



Beginning October 1, 2008, Medicare will no longer pay the hospital at a higher rate for the original eight conditions or any conditions added to the list in the final rule, if they were acquired during the hospital stay.

The second initiative CMS is proposing is the expansion of the hospital quality measure reporting program, which reduces the amount a hospital is paid if it does not participate in the voluntary reporting of standardized quality measures. These are measures that are publicly reported on Hospital Compare. Hospitals are currently required to report 30 quality measures on their claims for Medicare inpatient services to qualify for a full update to their FY 2009 payment rates. CMS is proposing to add 43 quality measures to the list in order to get the full inflation update for FY 2010, bringing the total number of measures in FY 2009 to 73. The proposed additions include the measures of the following types:

- Surgical Care Improvement Project (SCIP) – 1 new measure
- Hospital readmissions – 3
- Nursing care – 4
- Patient Safety Indicators developed by the Agency for Healthcare Research and Quality (AHRQ) – 5
- Inpatient Quality Indicators developed by the AHRQ – 4
- Venous thromboembolism measures (VTEs) - 6
- Stroke measures (STK) – 5
- Cardiac surgery measures –15

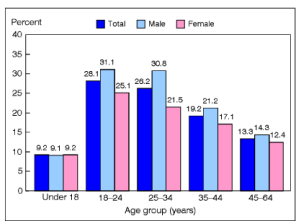


Figure 4 - Percentages of persons under 65 years of age without health insurance coverage at the time of interview, by age group and sex: United States, January-September 2007.

DATA SOURCE: Family Core component of the 2007 National Health Interview Survey. The estimates for 2007 are based on data collected January through September. Data are based on household interviews of a sample of the civilian non-institutionalized population.

Insurance Statistics

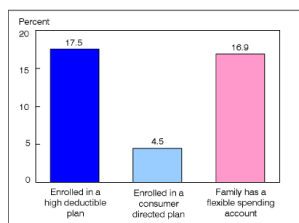


Figure 5 - Percentages of persons under 65 years of age with private health insurance who are enrolled in a high deductible health plan, a consumer-directed health plan, and in a family with a flexible spending account for medical expenses: United States, January - September 2007.

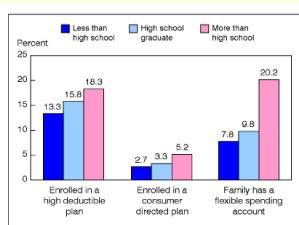


Figure 6 - Percentages of persons 18-64 years of age with private health insurance who are enrolled in a high deductible health plan, a consumer-directed health plan, and in a family with a flexible spending account for medical expenses by education: United States, January - September 2007.

DATA SOURCE: Family Core component of the 2007 National Health Interview Survey. The estimates for 2007 are based on data collected January through September. Data are based on household interviews of a sample of the civilian non-institutionalized population. A person can be counted in more than one category.

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In proposing to require hospitals to report on readmissions, CMS notes that almost 18 percent of Medicare patients are readmitted to the hospital within 30 days of discharge, potentially exposing the patients and their families to significant additional suffering. Taken together with the patient satisfaction information recently reported on Hospital Compare web site that shows the effectiveness of nurse and physician communication with the patient, including discharge planning, the building blocks for monitoring and improving the entire episode of care will be available. The impact on taxpayers is also significant. According to the Medicare Payment Advisory Commission (MedPAC), readmissions cost the program \$15 billion annually, with \$12 billion of those costs potentially preventable.

The proposed rule would apply to more than 3,500 acute care hospitals paid under the Inpatient Prospective Payment System (IPPS). The IPPS was intended to reward hospitals for being efficient

by making a single payment to the hospital based on the average costs of treating a patient with a particular diagnosis, rather than paying for the actual costs of each case. However, until recently, Medicare did not have the legal authority to use its payment system to encourage hospitals to improve the quality of care they furnish.

The proposed rule also includes proposals to update Medicare payment rates and policies for inpatient hospitals for FY 2009. Overall, the proposed rule is estimated to increase Medicare payments to acute care hospitals by nearly \$4.0 billion.

Comments on the proposed rule will be accepted through June 13. CMS will respond to comments in a final rule to be issued on or before August 1, 2008.

For more information, please see the CMS Website at: <http://www.cms.hhs.gov>

NEW TO BUSINESS CONTINUITY?

Business continuity can be defined as 'the processes, procedures, decisions and activities to ensure that an organization can continue to function through an operational interruption'.

In other words it is about making proactive and reactive plans to help your organization avoid crises and disasters and to be able to quickly return to 'business as usual' should they occur.

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Business continuity involves two distinct areas:

Business continuity planning - where a plan is developed that, when implemented, will help to prevent operational interruptions, crises and disasters happening and will help the organization quickly return to a state of 'business as usual' should any of these events occur. Once it has been prepared the business continuity plan must be tested and exercised to ensure that it will perform as anticipated.

Business continuity management - this is:

- The ongoing management of the business continuity plan to ensure that it is always current and available.
- The ongoing management of operational resilience and process availability within an organization, with the aim of ensuring that the organization experiences the minimum possible day-to-day disruption.

Business continuity achieves various things for organizations, with the degree of success in each area dependent on the amount of effort, skill, resource and commitment provided by the organization in question, but the following are outcomes which should be achieved by every organization which takes business continuity seriously:

- A deeper and clearer understanding of the organization.

The processes involved in developing the initial business continuity plan and then in maintaining and managing the BCP result in a clear overview of the overall organization; its structures, dependencies, suppliers and stakeholders. This information is not only essential for business continuity management it can also help planning and strategy in other non-related areas of organizational development and management.

• Proactive measures

Proactive measures are designed for the prevention of interruptions to organizational activities. The essence of good business continuity management is the identification and implementation of measures which can be put in place to proactively prevent operational interruptions taking place, and to prevent crises and disasters occurring. Business continuity management, at its highest level, is about keeping organizations operating at their maximum capability.

• Reactive measures

Reactive measures are designed for recovery from interruptions to organizational activities. Business continuity management programs includes plans for the reactive measures that will be taken should the proactive measures that are in place fail, become overwhelmed, or are bypassed by some unforeseen and unexpected crisis. Reactive measures enable the organization to return to an acceptable level of operations within a desired timescale following an interruption, disaster or crisis.

• Culture change

Business continuity management programs involve an exploration of organizational culture. Effective programs will utilize change management techniques to ensure that the organization encourages a culture where all employees are sufficiently aware of everyday risks and their individual responsibility to report, manage and mitigate risks.