Shoulda, Coulda, Woulda

"Shoulda, Coulda, Woulda. It's so easy in the past tense." - Sarah Dessen

Contrary to popular belief, all medical negligence claims do not start and end with a physician or even a licensed healthcare provider. You may be thinking – “what are you talking about? Only a physician or healthcare provider provides medical care.” You are absolutely right. However, non-medical or non-certified office personnel and office systems account for a growing number of professional medical negligence claims and lawsuits.

Just as we all learned in school, every story needs five elements- who, what, when, where, and how. A medical practice needs much the same. Straight forward, organized, and effective office systems need to be in place. As an example, one important system that should be implemented is tracking: tracking what has been done and what’s next to be done. A medical office needs a systematic way for handling patient labs, specimens and diagnostic test results. Once a test is ordered, then what? How and when will a provider review and sign off on the test results? Does the patient need to follow-up? Was the patient notified (of normal and abnormal findings)? Were the results and patient notification documented?

Failure to implement office protocols could lead to a delay in diagnosis or treatment, treatment options and even the ultimate outcome of patient care. Rarely are errors in patient care the result of any one isolated action or inaction. It often has nothing to do with a provider’s lack of knowledge or diagnostic ability. Rather, errors are often the result of poorly designed, ineffective or non-existent office protocols.

Through the years, we have seen many instances where, had there been an office system in place, there would not have been a plaintiff nor a defendant because an incident would not have occurred. For instance in the case of a Mr. Sharpe [1], a 75 year old male who underwent a kidney biopsy for hematuria and suspected kidney cancer, there was no office system in place to track the specimen. The normal procedure was for the specimen to be reviewed for adequacy, separated into two vials, and given to an employee for further processing and transport to the pathology lab. Somehow, the specimens went missing. It was later learned that the vials were placed in a biohazard bag, the pathology lab courier arrived and the specimens were put in the transport bag along with numerous other specimens. The courier recalled putting the bag on the counter on arrival to the pathology lab. The bag was unpacked at the pathology lab, but the specimen in question was never logged and processed.

The physician office staff was not able to retrace their steps to determine if the specimen was logged in, given to the courier for transport to the pathology lab, or received by the pathology lab, because there was no documentation of such. No one knew what

happened. Upon the internal investigation, the original specimen container (before the frozen section was prepared) was the only evidence of the specimen. Unfortunately, the specimen could not be found. This left Mr. Sharpe with no other alternative but to have a second biopsy, despite having a very complicated recovery from the initial biopsy due to other health challenges.

It was unknown how the error occurred. Did the physician's staff not hand the specimen off for proper submission to the pathology lab? Did the employee not properly hand over the specimen to the pathology lab courier? Or did the error occur at the lab? While all regretted this unfortunate occurrence, this reactive posture became the perfect time for the physician, hospital, and pathology lab to all review policies and procedures related to chain of custody for specimens.

How does the physician's office ensure a report has been received and reviewed by the provider? While all office systems are important for minimizing risk of error, clearly, a simple tracking protocol would have outlined – (1) who the specimen was given to; (2) what that person does with the specimen; (3) when the specimen is sent to the pathology lab; (4) how the specimen is sent; and (5) where the specimen was sent (most important if multiple labs are used for different types of specimens). Well- established systems by both the physician's office and pathology lab may have prevented this scenario.

In addition to a tracking protocol, it is recommended that you have an office protocol for appointment scheduling, follow-up appointments, missed appointments, patient referrals, communicating test results, prioritizing test results, proper referrals, discharged patients, documentation, refilling prescriptions, telephone procedures, answering service, patient portals, emailing, and texting PHI, mobile devices, and all other office functions involving patient care. You and your staff should be properly trained to follow these office protocols consistently without fail. Otherwise, too much is left to individuality and personal judgment call. The potential for the patient to "fall through the crack" is too much of a risk. (Related: See "An Analysis of Pathology Closed Claims" from the January 2017 issue of The Sentinel)

Once office protocols have been implemented, it is imperative to periodically perform an assessment of said system(s). You must ask if a particular protocol is still effective. Have personnel changed, requiring additional training? Are all lab and diagnostic vendors electronically interfaced with your electronic health record system? If not, is there a separate tracking system for those that are not? Is it the most efficient means to achieve the goal? Keep in mind, just because you are not aware that there has been an incident or mishap, does not necessarily mean there does not need to be an improvement. Some risks are not worth taking.

The rule of thumb should **not** be "no news is good news." Advising patients to "call if you have not heard from us" allows your patients to serve as a safety net in the event of a system failure. The mode of operation should be proactive rather than being only reactive after an error has occurred. Otherwise, the focus is then on the past and you become a victim of the dismissive expression of "shoulda, wouda, couda," which are often useless

excuses for regrets, mistakes, and missed opportunities. Do not wait until something happens to take a pause to reflect, inspect, and adjust. Shouldas, couldas, and wouldas don’t count.

[1] All names have been changed

Turn the Daily Grind into a Successful and Satisfying Future

Managing a medical practice is an experience that can't be meaningfully compared to anything else. Daily operations often border on chaotic: Effective deployment of people, space and supplies is essential to success, but it can also be overwhelming. Most importantly, your patients' lives depend on your effectiveness.

This daily grind, however, is often just that – a daily grind. You can produce a fruitful and productive day, but are you also creating an effective practice and a path to a successful future? If you're not sure how to answer that question, it might be time to step back and determine a solid framework for your practice, your goals and your future.

The following tips can help you move from uncertainty into opportunity:

- **Use an internal communication tool**. Engage with an online team tool like Slack, Yammer or Jive to enhance communications within your practice. Create a collaboration platform for your practice to track projects, issue HR updates or announce a new employee; develop communication channels for each function so that nursing, lab and the front desk can each have their own network; and use the direct messaging function for one-on-one or small group contact. Instead of initiating calendar invites, printing meeting documents or forwarding emails, the tool can house and organize it all. This solution offers countless other functions, but even the basics can provide an exceptional enhancement for your practice. Like any online solution, vet the security level with an expert.

- **Gather feedback**. Medical practices are making significant strides at garnering patient feedback, but are not always as effective at engaging with employees. Paper surveys can serve a valuable purpose, but a modern (and cost-effective) tool like TinyPulse can be a great addition to your performance improvement initiatives. Gather quick feedback – and then use it to move your practice forward. Employees who feel they are listened to and respected become loyal and long-term members of your team.

- **Commence a work-from-home program**. While not all employee types can work from home, a variety of medical practice staff can easily function out of a home office. It's not uncommon for positions like billers and coders to work from home, and increasingly telephone operators can do this as well. Remote staff can benefit your practice during weather challenges, and often experience much higher levels of productivity and satisfaction than their colleagues. However, they must be managed. I recently visited a medical practice that had five team members working from home.

They were all employees who had been at the practice for at least a year, had little to no absences, and enjoyed high productivity and quality. Each of them had a webcam on during all work hours, enabling the manager to visualize and connect them whenever she wanted.

- **Establish or enhance your social media presence**. While some practices are reluctant to wade into the world of Facebook, Twitter, Instagram, and other social platforms, this presents an effective and even fun way to connect with patients and build your reputation. Granted, you should never communicate anything that is sensitive or protected via social media, but, when appropriate, you can share special events, good news, positive reviews, and patient stories. This takes a lot of time, but can make an impact. If you do choose to utilize social media, ensure all employees sign a workforce confidentiality agreement (download a sample here) and instill policies regarding who is allowed to write posts. Typically this is only the administrator.

- **Connect and celebrate**. When did your team last volunteer together in your community? When did you last celebrate a significant milestone? Community engagement can be a positive experience for staff and a way to build camaraderie while making an impact. And beyond the company holiday party, take some time to note anniversaries, birthdays, successes, and other special occasions to give your staff something to look forward to.

Creating a growth-minded culture that celebrates communication, opportunities, and individuals can lead to a practice where people want to work and where patients clamor to visit.

Buzz Word Alert: SDOH

Even if you aren't already familiar with the acronym SDOH, you have likely encountered the notion of "social determinants of health." The term is splashed all over the health care media as it relates to value-based reimbursement. It's a fancy term for a topic that your practice has been juggling for many years. SDOH are the economic and social conditions that impact and/or influence a patient's health. Conditions include housing, economic status, food security, and other non-medical risk factors. SDOH constitutes the non-medical profile that, accompanied by medical condition, impacts the patient's overall health.

Medical practices have been on the forefront of identifying and assisting patients in navigating these challenges. Efforts have been difficult, however, as the U.S. reimbursement system contributes nothing for these non-medical activities.

That is changing – and this may be a trend that can benefit your practice. Under risk-based reimbursement, it's crucial to understand not only your patients' medical acuity but also their external risk factors. In its simplest format, medical acuity could be measured by analyzing the ICD-10 codes you use. But quantifying the complexity inherent in the patient's non-medical situation can be difficult.

Although there are some Z codes that define social determinants, a comprehensive documentation of SDOH is much more difficult. Your practice may want to start with an economic analysis based on your patients' zip codes. Language and religious preferences are other areas you could assess, and some practices can examine their charity care applications for detailed economic conditions. The latter, of course, would represent only a subset of patients. And, those Z codes that most providers ignore – like Z59.9 "Problem related to housing and economic circumstances, unspecified" – can be integrated into your documentation and coding.

Understanding the patient's situation must commence long before a diagnosis code is chosen, however. The National Association of Community Health Centers® offers the tool PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) to jumpstart your initiative. It is designed to help providers collect the data needed to better understand and act on their patients' social determinants of health. It is also helpful to mull over other meaningful and appropriate methods to gather SDOH to benefit your practice – and your patients.

If you are looking for more information on social determinants of health, including best practices, communication, and the latest on SDOH, this recent article, "A New Way to Talk about the Social Determinants of Health," provides information.

Next, if you can identify opportunities to engage with social services in your community, take advantage of these programs. While your efforts may not yet be financially rewarded, the system is on the cusp of changes. Having a workflow in place when those risk-based contracts come your way will prove advantageous – to your practice and to your patients' health and well-being.

Billing for Chronic Care Management

Chronic Care Management (CCM) Services offer an opportunity to be paid for services you perform outside of the face-to-face patient encounter. Billing for CCM services may seem daunting, but the Centers for Medicare & Medicaid Services (CMS) offers extensive guidance about reimbursement protocols for Medicare.

Before we dig into the details, CCM is defined as: “the care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.” CCM requires a minimum of 20 minutes during a calendar month; services include non-face-to-face clinical staff time, directed by the billing provider. Only one provider may bill for CCM for a patient during a calendar month.

The FAQs presented herein are extracted from CMS guidance about CCM. However, other payers may have different guidelines, so it’s always wise to review the CPT® code descriptions, as well as the provider manual and/or any documentation from the payer.

If you perform them, you deserve to be paid for these services. Start by reviewing these responses to common queries – and then set up a time to discuss this opportunity internally with your team.

Q. When should a chronic care management claim be submitted?

A. The given service period comprises one calendar month. The claim can be held until the end of the month, but that is not necessary. The service can be billed “…after completion of the minimum required service time.” The date of service is the day on which the minimum requirement (i.e., 20 minutes) is met – or any day thereafter during that calendar month.

Q. Who qualifies as “clinical staff” when it comes to time spent during a calendar month?

A. CMS defers to the American Medical Association’s definition of clinical staff, which is "persons who work under the supervision of a physician or other qualified health care professions and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." While other staff can support chronic care management services, only the time dedicated by clinical staff can be counted towards CCM billing. Any and all time spent by the billing provider – which includes physicians, as well as physician

assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives - counts as well.

Q. A vendor has approached our practice about providing CCM services. Our practice would pay the vendor, and we would bill for the CCM codes. Is this possible?

Contracting is possible, but caution is warranted. CMS reveals: “A billing practitioner may arrange for clinical staff activities to be provided by an individual(s) external to the practice…if all of the applicable “incident to” and other rules for the [Medicare] Physician Fee Schedule are met and there is clinical integration among the care team members.” In other guidance, CMS reveals that “general supervision” is adequate. CMS espouses that the medical decision-making components, or the “ongoing oversight, management, collaboration and reassessment by the billing practitioner… cannot be delegated or subcontracted to any other individual.” Finally, CCM must be initiated by the billing provider during a face-to-face visit “…before CCM services can be provided directly or under other arrangements.”

Q. Can CPT codes 99487, 99489, 99490 and 99491 be billed together for the same patient?

A. No, even if it is just one patient in a given service period. Only one type of chronic care management can be billed at a time. In addition, complex CCM – codes 99487 and 99489 – cannot be reported during the same month as any other chronic care management code.

Q. What place of service (POS) should be reported on the claim?

A. The billing practitioner should report the POS for the location the billing practitioner would ordinarily provide face-to-face care to the patient. CCM can be billed for services provided in nursing and skilled nursing facilities as well as assisted living and other similar settings.

Q. Are we required to update the consent each month?

A. There is no need, according to CMS, to update the consent each month or even annually. The consent can be utilized in perpetuity, although it is important to note that it is required to be in place prior to rendering the service. Consent may be obtained verbally, but it must be documented in the patient’s record.

Q. Can face-to-face services count as billing time in terms of CCM?

A. Many CCM services are not typically face-to-face services – for example, communicating via phone, coordinating health information with other provides, providing referrals, coordinating with home-based services, patient education, reviewing test results and medical records, and so on. However, if there is an occasional face-to-face component, then the time associated with these services can be counted towards CCM if it is not an element of another service.

Q. Can our practice bill for CCM services if the patient dies during the given service period?

A. Yes, the CCM service can be billed if the required service time is met for that calendar month (as well as any other billing requirements for that time period). The date of service must precede the date of death.

Q. Can specialists also bill CCM?

A. While CCM codes were created for primary care practitioners, any specialist who meets the requirements can bill CCM. For example, cardiologists, rheumatologists, and nephrologists may manage the overall care for a patient and therefore qualify due to their comprehensive patient management and services.

Visit the CMS website for more information about billing CCM services for Medicare

Service Animals in the Clinical Setting

DOGS ALLOWED?

If you traveled by air in the past year, you probably noticed that the presence of animals is on the rise in airports and on airplanes. It is not just the airline industry facing the increased presence of service and emotional support animals. How you deal with them can expose you to litigation and negative publicity. Bear in mind that laws governing animals on planes are different than for those of us on the ground.

PET OR WORKER?

First and foremost, a service animal is distinguished from an emotional support animal and the rules of engagement for the two categories are different as well. While a business might be able to restrict access to an emotional support animal, the same is not true for a service animal. What is the difference between these two types of animals and what are the rules that govern them with respect to providing medical care and treatment to patients?

The service animal is considered a working animal - not a pet. Under the Americans with Disabilities Act, only dogs are recognized as service animals with an exception for miniature horses. Service dogs are not defined by breed. A service animal is trained to perform specific tasks for their owners and/or managing a condition. Some examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, and calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack. In contrast to this is the emotional support, therapy, comfort or companion animal. This animal is a pet whose sole function is to provide comfort or emotional support and therefore does not qualify as a service animal. The mere presence of the animal provides comfort.

The Americans with Disabilities Act defines service animals as dogs that are individually trained to do work or perform tasks for people with disabilities. The work the animal has been trained to do must be directly related to the person’s disability. The Americans with Disabilities Act mandates that all business organizations that serve the public must allow service animals to accompany people with disabilities into all areas of the facilities where customers are normally allowed to go. Medical care facilities fall within the purview. The companion animal does not enjoy the same accommodations.

Currently, emotional support animals, comfort animals, and therapy animals are not specifically protected under the ADA, unless the owner can legitimately state the support/comfort/therapy animal is specifically trained to assist with their disability.

What then happens, in the clinician setting, when a first time patient walks in to register for his appointment and he is accompanied by his 75-pound Labrador Retriever, Sally? During the process of sign in, the front desk personnel cannot help but notice the animal and inquire about same. The dog is not wearing any identification and the new patient has no outward appearance of disability. What questions can and cannot be asked of the patient and, more importantly, what allowances must be made for this animal and its owner?

Okay to Ask*

(1) Is the dog a service animal required because of a disability; and/or

(2) What work or task has the dog been trained to perform?

*A practice cannot ask these two questions when it is readily apparent that the animal is trained to do work for an individual with a disability (e.g. a seeing e dog).

Conversely, there are questions that must **not** be asked. The front desk personnel cannot ask:

Don't Ask

(1) What is the person's disability;

(2) For medical documentation, an identification card, or training document for the dog; and/or

(3) That the dog demonstrate its ability to perform the work.

There are potential concerns for a service animal to accompany a patient in all aspects of medical care and treatment. For example, in a surgical procedure with gowns and masks in a sterile environment, it would be extremely burdensome, if not impossible, to have a service animal present due to the sterile field. The law requires that the medical provider provide reasonable accommodation. There are reasonable limits with each situation which may be imposed on these animals that accompany a patient. Another example of a sterile environment where service animals can be excluded, in addition to the surgical setting, is a burn unit.

What might be a less clear situation? For example, let's say a patient is coming in for a procedure in the clinician's office which does not require a sterile field but will require gloves and penetration of the patient's skin. Can this healthcare provider preclude the service animal from accompanying the patient into the exam room where this procedure will be performed? What is the reason and rationale for excluding the animal? Allowing a well-groomed service animal in a clinical setting likely creates no greater risk of germs or

disease than a human being present, as long as the dog is under the control of the owner and housebroken. If the dog is not, access may be denied. Some facilities provide a crate on site where a service animal can be contained while the handler is in a restricted area or are able to provide for the stewardship of the service animal. Perhaps a family member can take the dog during the procedure.

Tennessee is not alone in seeing an upswing of litigation involving patients who have been denied access to medical care because of the presence of their service animal. As with any litigation, press coverage, which can have a negative impact on the healthcare provider's business, along with attorney's fees, costs and the stress of litigation are factors to consider. Service dog litigation is a hot topic and is likely to yield press coverage. It is worth noting that some states (23 out of 50) are enacting laws to punish those with fake service animals. At this time, Tennessee is not one of them. See this page for more information.

What damages could a person denied access to medical care seek if their rights under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act of 1973 have been violated?[i] Those defendants must be prepared to say that their actions were legitimate and non-discriminatory and that making allowances for this animal would fundamentally alter the nature of their services, program, and activity. Those aggrieved are likely to complain of emotional distress and, if a violation is deemed to have occurred, they will be entitled to damages for same and potentially, the prevailing party's attorney's fees. To award attorney's fees, on behalf of the plaintiff, is within the Court's discretion. These are usually awarded in cases of deliberate indifference or reckless disregard. The threshold for establishing deliberate indifference is not terribly high. The attorney's fees can be quite exorbitant in these situations and while there might be a low damage award, otherwise, the attorney's fees can become, quite literally, the tail that wags the dog (pun intended). A 2016 settlement between the U.S. National Federation for the Blind and Uber had attorney's fees in excess of $2,000,000.00 awarded to the U.S. National Federation for the Blind. *See* https://arstechnica.com/tech-policy/2016/12/lawyers-who-sued-uber-over-service-animals-will-get-2-38m-fee-award/

Case law on service animals in the health care setting is scarce, and the few cases that exist are fact specific and highlight the importance of individual assessments for each situation. For example, in *Tamara v. El Camino Hosp*., 964 F.Supp.2d 1077 (N.D. Cal. 2013), a patient sued a hospital because of its *blanket* policy excluding service dogs from its psychiatric ward claiming the presence of service animals would fundamentally alter the nature of its services because it would cause disruption. The plaintiff in that case used her dog to help her balance when walking and to perform other physical tasks, such as picking up dropped objects. The hospital provided a walker in place of the service dog, but the Plaintiff claimed this made mobility more difficult because she could not pick up dropped objects and could not maneuver in the bathroom. The court found that the hospital's policy of blanket exclusion of service animals without conducting an individualized assessment violated the Americans with Disabilities Act and the Rehabilitation Act. Specifically, the court noted that evidence of direct threat must be based on actual risk determined from an individualized assessment, not just speculation or generalizations. The court found that the

ward's most unstable patients were kept in a locked ward and therefore would not have any contact with the plaintiff's service dog. The court further found that the hospital should have assessed the plaintiff's ability to care for the dog and made reasonable accommodations for this, such as allowing a friend or other third party to take the dog out of the ward for care. Finally, the court found that other hospitals had policies which allowed service animals into psychiatric wards and that an occupational therapist who worked at the hospital was repeatedly allowed to bring her own dog into the ward.

In another example, *MCAD v. Unident Dental Center*, Docket NO. 05- BPA- 01057 (Hearing Officer Opinion, February 14, 2014), an office that provided dental services was sued as a result of their failure to allow Ms. Mahoney to have her toy poodle, which had been trained to assist her with her hearing deficits as well as provide her with emotional support, to accompany her to a double root canal procedure. The decision was made in the office, and in the presence of other patients, that the dog would not be allowed to go with the patient into the examination room. The patient was instructed to take the dog home and return for the treatment if she so desired. The patient claimed that this confrontation was unsettling and embarrassing and, thus, she had suffered emotional distress.

The staff at the dental office explained the concerns regarding performing a root canal procedure while the patient held her a dog during that procedure or examination. The dentist explained the increased health and safety concerns when a dog was in such close proximity to the patient’s mouth during this surgery. In this particular case, the Tribunal found this testimony to be quite credible. Due to legitimate worry about maintaining a sterile and sanitary operative environment along with concerns about possible infection, and the concerns of unanticipated movement or reactions of the animal to the noise of drills and machines while sharp instruments were being used, the dentist was found to have acted appropriately in excluding the dog from the root canal procedure. The presence of the dog could have potentially caused injury or harm to the patient or others.

What is clear in this case, and other cases, is that staff education and patient communication is key. Had the patient advised the dentist office prior to the day of the procedure or when the procedure was scheduled that she requested the presence of her service animal, this discussion could have been held privately and well before the day of the actual root canal. This communication issue is instructive to us. When scheduling patients, and particularly new patients, it might be helpful to include a question on whether a service animal will accompany the . Knowing this information in advance can educate and prepare the physician’s office or facility, as well as the patient, as to how each individual situation will be handled. Remember to avoid the “Don’t Ask” questions. Above all, if faced with an animal and the employee is unsure how to handle the situation, seek help and avoid any public confrontation that could be a catalyst for emotional distress, anguish or embarrassment.

Problems seem to arise when an unanticipated or unexpected event occurs when a patient with a service animal walks in and demands that the service animal be allowed to accompany them to their procedure or examination. This, coupled with a lack of education

on behalf of the employee, can result in a bad outcome. Bear in mind that a service animal may be denied access to areas where a patient would generally be allowed, when it can be demonstrated that the presence or behavior of that particular animal would create a fundamental alteration or direct threat to other persons or to the nature of the goods and services provided. The obvious example is the operating room where gowns and masks are required to reduce contamination and the environment is sterile. Accommodations might be made to allow the dog to accompany the patient in areas where family members can be until the patient is taken to surgery.

Can the physician's office decline to have the service animal go into the exam room with the patient even though it is a service animal that has been trained to perform tasks? Simply having a crate does not solve the problem. If the area is one where the presence of the animal would not alter the medical care provided and the animal is indeed a service animal that has been trained, then the correct action would be to allow the service animal in the examining room.

The issues with accommodating a service animal are legitimate and can result in serious consequences, litigation and unpleasant publicity among them. With the increase in emotional support animals on the rise, the lines can become blurred when dealing with true service animals. Best practices are to be informed, be prepared and educate your staff on what can be asked when faced with a patient and an animal and how best to handle the situation.

Sources:

https://www.ada.gov/service_animals_2010.htm

Service animals within health Care Facilities. Strategies for regulatory compliance. Hughes, Patricia A and Rozovsky, Fay A., ASPR: Understanding How to Accommodate Service Animals in Health Care Facilities.

[i] Section 504 of the Rehabilitation Act of 1973 comes into play when the facility is a Medicare recipient

Medical Practice Services Announces Advanced Practice Seminar

The healthcare landscape is rapidly changing! These changes can be overwhelming to say the least. Do you know there are groups that are not only embracing change but are doing so successfully? Do you want to lead your group by successfully navigating these changes, but you are not sure where to start? Join SVMIC for our first ever Advanced Practice Seminar August 15-16. Hosted by our Medical Practice Services Department, we will give you insight to the patient-centered practice of the future. You will walk away with action items and ideas you can immediately implement to improve your organization's performance.

With an emphasis on streamlining your practice while creating efficiency, we will focus on how to effect change. We will discuss the role of team members and the need to work to their full scope of practice. Beginning with the initial patient contact, we will walk through the ideal scheduling and workflow processes to optimize both efficiency and revenue as well. Technology is evolving. We will address how to use it as a tool in a positive way to support your staff and the create a positive patient experience. For more information on the agenda or to register, click here.
