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How To Make Changes In Your Healthcare Organization

By Donald Bryant

For many of us change is a difficult process. In organizations like healthcare it seems to advance at a snail's pace sometimes. There is a need for change in healthcare, most agree, though we would be hard pressed to agree upon the changes needed. One incentive for change is pay-for-performance programs now beginning in several areas. I would like to describe a couple that affect primary care physicians and then give a few suggestions as to how to adopt changes to take advantage of these programs. Even if you are not in a primary care physician program, the methods suggested for change will be helpful, I believe.

In 2006 Medicare plans to institute a pay-for-performance program at the primary care physician level. Right now a model is being tested and seems to be doing quite well. In several states Blue Cross Blue Shield organizations are testing pay-for-performance programs. Here in West Michigan, Priority Health, a healthcare insurer, has promoted such a program for over five years. How does this work, you may ask? Priority Health, for example, funds the program for each of its patients a set amount. Doctors who meet a requirement of the program for a patient are rewarded with extra money for that patient. Hence, with many patients the income for the practice can be boosted considerably. The fact is that many are not rising to the opportunity. With planned cuts in Medicare reimbursements over the next few years, this source of income cannot be ignored! Healthcare programs need to change, no matter how difficult.

The impetus for change should rest with the leadership of an organization, although the change should not be the sole responsibility of the leaders. Representatives from all parts of the organization should be involved. Once the need for change in a process is agreed upon, either because of extra revenue from pay-for-performance programs or other agents or data that positively affect the bottom line, leaders should convene a task force to plan the change. With input from all, leaders should map the process as it currently exists and then should make a new map of how they would like it to be to incorporate the positive changes. The new procedure should be standardized for all to adopt.

How do you go about adopting these changes on a daily basis? This is probably the hardest part. Because humans learn in a variety of ways, it will take a variety of ways to implement the changes. The implementation of the changes should be based upon the learning styles of the individuals

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involved. Let me provide an example using the Medicare program. A patient who enters the Medicare program is entitled to a paid initial physical. A primary care physician should take advantage of this. Many don't. If I were the manager of such an office, I would remind my staff who set up appointments to be aware of this fact. I would remind them at regular staff meetings. I would post visible reminders in the office. I might even have a message flashed on the computer screen once in a while. Then I would review the appointments of patients who have become Medicare qualified and see how many had their initial physical or were booked for it. I would adjust my methods to remind staff of the need for such examinations and continue to improve on this until the office achieves 100% compliance with the goal.

Booking the exam is not the only needed change. Doctors who perform the physical must accomplish examination details and actions laid out by Medicare. Hence, to be paid for the exam, each doctor must adhere to the exam details. I would help the doctors accomplish this in a variety of ways, depending on the doctor's learning style. For example, a checklist of the exam details might be included in the patient history folder when the exam is performed. That way the doctor will not miss any

steps. As the leader of the change, I would check with billing to see that all the steps were performed and adapt new approaches or reinforce existing ones to see that the changes are accomplished 100% of the time.

Changes such as these should be a part of a continuous quality improvement program at every healthcare provider organization. Let me quickly review the most important steps. First leaders should identify the changes needed. Then, the leaders should convene a committee of all affected staff to develop how to accomplish the change. Once the staff agrees upon the approach, the leaders should develop ways to implement the change on a daily basis adopting methods that incorporate learning styles of affected individuals. Then, they should continually analyze the progress of the changes and make necessary adjustments until the goals are accomplished. They should then audit the changes occasionally to be sure that the organization doesn't fall back into old habits.

I believe that adopting such a change process will dramatically help at your site. You will see savings in time, increased patient or client health and satisfaction, as well as an improved bottom line!

Donald Bryant helps healthcare providers meet their challenges. If you liked this article and want more free tips, visit

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The ABC's Of Health Insurance Plans

By JM Bauer

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In today's health insurance marketplace, three primary types of healthcare coverage are available. They are the Indemnity plan, the Preferred Provider Organization (PPO), and the Health Maintenance Organization (HMO). Each approach offers consumers the opportunity to choose between flexibility and control in their healthcare choices vs. the expense of their healthcare coverage. Almost universally, healthcare plans that offer more consumer flexibility and control are also more expensive, while plans allowing the insurance company to control healthcare delivery choices are usually more affordable. Let's look at each of these plans.

The Indemnity plan approach represents healthcare as it was offered in the days before managed care. In an Indemnity plan, the policyholder is free to go to any doctor, specialist, hospital or laboratory to pursue the medical care they believe they need. These healthcare services are billed to the insurance company at the individual rate set by the healthcare provider. The insurance company pays a fixed proportion of the fees (usually 80%) and the consumer pays the remaining percentage (usually 20%) of the billed medical fees. Each healthcare provider is free to set their fees at a level they choose, and the consumer has little incentive to consider overall medical expenses. While Indemnity plans are still available today, they are not widely utilized since they are too expensive for the average consumer. The monthly premium for an Indemnity plan is generally 50% to 100% higher than premium for a PPO or HMO plan.

On the opposite end of the spectrum, Health Maintenance Organizations or HMOs were introduced by insurance companies as a way to combat the rising costs of healthcare being experienced by employers providing health benefits to their employees. In an HMO, the policyholder selects or is assigned to a Primary Care Provider (PCP) such as a family practitioner, internist or pediatrician. The PCP is responsible for coordinating all healthcare services delivered to the policyholder (except for emergency care). The policyholder can only see a specialist, use a lab service or check into a hospital if they are referred for such services by the PCP. Any services that are not referred by the consumer's PCP are not reimbursable under the health insurance policy. Within the HMO network, healthcare providers agree with the insurance company on negotiated rates for specific services. Once approved, these healthcare providers become part of the network available to the PCP for referring patients when additional care is required. Based on the insurance company's strict control of the healthcare providers used and the rates they will charge, an HMO is usually the least expensive alternative for a healthcare plan.

In the middle between the wide-open Indemnity plan and the strictly-controlled HMO, insurance companies also offer a third alternative called a Preferred Provider Organization or PPO. In a PPO plan, a policyholder is free to go to almost any healthcare provider they choose, including doctors, specialists, labs and hospitals, and usually without a medical referral. However, the amount reimbursed by the insurance company for the delivered medical services will vary depending on whether the healthcare provider is within their negotiated network or not. As with an HMO, the insurance company negotiates fees in advance with selected healthcare providers and approves them for inclusion in the plan's preferred provider network. Healthcare services delivered by these in-network providers are generally reimbursed to the consumer at high rates of 70% or more. On the other hand, when the consumer uses a non-network healthcare provider, the reimbursement will be much lower, ranging from 0% to 50% of the incurred medical expenses. Since the vast majority of PPO policyholders use

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in-network providers to reduce their out-of-pocket expenses, PPOs are very cost-effective for insurance companies. As a result, PPOs are somewhat more expensive than HMOs, but are still very reasonably priced for the average person.

JM Bauer offers unbiased consumer information on today's healthcare choices. For more information visit the

<http://www.california-health-insurance-guide.com>



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