Volume 2, Combined Issue 2 & 3

The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

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Inside DoctorsManagement: A Message from the President

The Good, The Bad and The Concerning

Here we are into the second quarter of 2014 and it seems the controversy surrounding health care could not be greater. To date, we have seen that both the House and the Senate passed measures to delay ICD-10 as well as create yet another temporary patch for the Medicare Physician Fee Schedule. Last week's patch was the 17th patch to the highly-flawed and antiquated reimbursement model, and it does nothing to fix the overall problem- it merely delays it further. Groups including the American Medical Association, the American College of Physicians, the American College of Surgeons, and the Alliance of Specialty Medicine strongly opposed the 12-month SGR patch because it further stalls efforts to permanently repeal the SGR. It is important to understand that the bill passed does much more than simply delay the SGR's planned cuts and delay ICD-10. The bill includes the following noteworthy points, as well as others not as relevant to provider-based services:

- Delays enforcement at the RAC level of hospital compliance to the "two-midnight" rule for inpatient reimbursement. MACs will still continue to perform "probe and educate" reviews, but full enforcement is delayed until March 31, 2015.
- Delays the implementation of ICD-10 until October 2015.
- Provides a 0.5% Medicare pay bump over a 12-month period.
- Creates additional scrutiny of work value in procedures to better revalue certain physician payment codes.
- Creates a program that will establish criteria for advanced diagnostic imaging so that future claims (January 2017) are held to a higher level of documentation to support the medical necessity of the service.
- Reduces payments for hospital outpatient and physician practices in which CT services may not meet certain standards (implementation scheduled for 2016).
- Extends therapy caps exceptions through March 31, 2015.
- Modifies the sequester implementation in 2024.
- Repeals limits on deductibles in employer-sponsored health plans in small group markets so they are not in effect for either 2014 or 2015.
- Authorizes a multistate pilot program designed to raise standards for mental health services and improve integration of care.

Another area of interest, or more likely concern, is that on the 2nd of April, the Obama administration said it would begin publishing data on the amount Medicare paid individual physicians in 2012. This will include the number of times the provider rendered a particular service or procedure, in what setting it was performed, the average amount charged to Medicare, the average amount the provider was reimbursed, and the total number of people treated by the provider. This all stems from a challenge in the Federal Court system by Dow Jones and Company, the parent company of The Wall Street Journal. Their argument is that the data released will assist the public's understanding of Medicare fraud, waste, and abuse, as well as shed light on payments to physicians for services furnished to Medicare beneficiaries. We encourage practices to be prepared for all inquiries by patients about the data. Additionally, each practice should access their providers' data in an effort to have a better understanding of what information the patient will have access to view. This information may be found through a cumbersome process on the CMS website, but the Wall Street Journal has provided a quick-access link with direct information access.

Throughout the year we will continue to monitor legislative actions and bring you suggestions to help you deal with the problems you may face. You never have to go it alone. Our team of experienced healthcare professionals can guide you through the process!

Sincerely,

Paul L. King
President
DoctorsManagement, LLC

Special Features

- Delay of ICD-10
- RAC Audits
- Interviewing & Psychological Testing

Let Us Show You How to Get Back to Being a Doctor

Inside this issue:

The Importance of Employee Communications

Great communicators have the ability to connect with employees. Their message is one that is properly received and understood, even if the other person does not agree. As a medical practice manager, are you communicating effectively with your employees so that your message is properly received and understood?

Do you make employee communication a high priority? Studies show that taking the time to communicate with your employees will help increase employee productivity, boost employee morale and, ultimately, improve the bottom line.

However, where do you begin? Start at the top by evaluating your management team – they set the tone for establishing the organizational culture and flow of daily communication to employees. Ask your employees what they think – do they feel communication is aligned with the mission and culture of the organization? Is it consistent and timely? Choose your means of communication carefully. Think about your audience and how to best communicate with them. Today, we tend to turn to e-mail and texting first, but keep in mind that this is often the least effective way to get your message across. When possible, face-to-face communication tends to be the most effective because we receive immediate feedback, we are able to clarify any misunderstanding and employees tend to listen more closely.

Here are some ways that good employee communication will benefit your practice:

Communication enables better patient service. Only informed staff will be able to convey accurate information to patients.

Communication promotes clarity of purpose. The critical question many employees ask is "Why am I here?" Every business encounters both planned and unplanned change. Your ability to navigate change successfully is directly linked to whether employees know your expectations and understand their role in the practice and its goals.

Communication boosts employee motivation and dedication to the practice. Talking regularly with employees lets them know they are a valued part of your team. If you can demonstrate to your staff that you depend on their input, they will assume ownership of the practice's goals and eventual success.

Communication encourages productive staff input. Consider the wealth of information your staff may be privy to that you are not currently collecting. Any bit of feedback has the potential to make a huge difference in your bottom line.

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Practice Assessment

You take your car in for service periodically. Maybe you even schedule a yearly physical for yourself. But be honest: Do we ever take the time to give our practice an annual checkup? Probably not. Every day we are so busy putting out fires and taking care of daily crises that we never take time for a basic checkup. Right now is a perfect time to do this. But how?

I suggest you take a broad view and drill down by asking questions like these:

General Practice Checkup:

- Was the practice's performance last year consistent with our vision, values, and mission?
- What were our accomplishments? Our failures? What lessons can we learn from both?
- How did our practice react to changes in the healthcare environment?
- A practice is like a living organism. Did our practice grow last year or is it dying? There is no "stayed the same."
- What did we do to grow our practice? Were we successful?
- How did our physicians function? Did we develop new leadership?
- Are we a patient-centric practice? How do we know? And if not, why not, and how can we become so?

Management Checkup:

- Did we perform as a finely tuned orchestra or as a cacophonous garage band?
- Did we meet our financial goals? Did we even *have* financial goals?
- Do we have the right staff in the right positions doing the right things? What are the opportunities for improvement?
- Did we work to improve our processes, and to increase effectiveness and efficiency?
- Did we evaluate the manager and his/her performance? Have we set goals for the manager and other key positions?

Revenue Cycle Checkup:

- Have we analyzed the revenue cycle from start to finish?
- Have we looked at each process to determine its level of effectiveness and efficiency?
- Have we reviewed our data acquisition accuracy?
- Have we analyzed our payer mix, contracts, and payer relationships?
- Have we focused on our KPIs (key performance indicators) and benchmarked our practice against "best practices"?
- Are we maximizing the features and capabilities of our practice management system?

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(Continued on page 8)

U.S. Department of HHS & OIG Work Plan for 2014

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan for fiscal year 2014 has released new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the current fiscal year (FY) and beyond. http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf

For FY 2013, the OIG reported expected recoveries of over $5.8 billion consisting of nearly $850 million in audit receivables and about $5 billion in investigative receivables, which include about $1 billion in non-HHS investigative receivables resulting from their work in areas such as the states' share of Medicaid restitution. They also identified about $19.4 billion in savings estimated for FY 2013 on the basis of prior-period legislative, regulatory, or administrative actions that were supported by OIG recommendations.

The OIG reported FY 2013 exclusions of 3,214 individuals and entities from participation in Federal health care programs; 960 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 472 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters.

The OIG Work Plan outlines their current focus areas and states the primary objectives of each project. Below are the new areas of focus for 2014:

Hospitals:

- *Outpatient E/M services billed at a "new-patient" rate*
- *Cardiac catheterizations and heart biopsies*
- *Payments for patients diagnosed with Kwashiorkor*
- *Bone marrow or stem cell transplants*

Providers:

- *Chiropractic services*
- *Portable x-ray equipment supplies and compliance with transport and set-up fee requirements*
- *End Stage Renal Disease (ESRD) dialysis facility survey cycle*
- *Mental Health Providers – Medicare enrollment and credentialing*
- *Prescription drug plan*
- *Medicare as a secondary payor*

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Interviewing vs. Psychological Testing for Effective Hiring

Interviewing, a subjective method of assessment, is very important when used in counseling education, personnel psychology, or clinical psychology. It provides valuable information for the interviewer. Interviews can be structured to guide the person being interviewed to answer predetermined questions to lead them in a specific direction. Another technique is an interview where the interviewee is directed in the beginning and then is left to discuss things freely to see where the conversation leads. When information is extracted from the interview, there are two important things that are retrieved. One is the person's history, which can predict what can happen in the future. The other is their observed behavior. The interviewer needs to have certain skills to conduct the interview to be able to take the data that is received and interpret it (Anastasi & Urbina, 1997). Testing, an objective method of assessment, mainly covers observations of a person's behavior. When a person takes a psychological test, the goal is rarely to measure behavior. It is used to test competency of the interviewee. The results give a glimpse into how this person's performance may be on the job.

These tests may not show the behavior that you are originally trying to reveal. Eventually, the relationship will appear. The predicted behavior may not show any similarity or it may be extremely similar. Tests can be varied to measure many behaviors (Anastasi & Urbina, 1997).
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Does Hiring an Independent Trustee for Your Retirement Plan Reduce Liability?

In the retirement plan world, there are three groups that generally want to be insulated from potential liability: (1) the trustees of the plan, (2) the committee that oversees the plan, and (3) the plan sponsor. Furthermore, there are two main sources of potential fiduciary liability that these groups generally seek to avoid: (1) liability regarding the choosing and managing of the investments for the plan, and (2) liability for running the plan incorrectly in terms of its administration (e.g., paying the wrong amount out to a terminated participant, failing to remit employee contributions in a timely manner, failing to amend the plan for law changes, etc.). Of the two, the former (managing the investments) is by far the greater source of potential liability. So, let's discuss it first.

INVESTMENT LIABILITY

Liability for the selection and monitoring of funds rests initially with those given the authority to do so, but it doesn't end there. It extends also to the employer who empowers the committee to make the ultimate investment decision and ultimately, even individually to the people who control the employer (i.e., the Board of Directors).

As preeminent ERISA attorney Fred Reish notes in a recent white paper, the way to break this chain of liability is to hire a discretionary 3(38) investment manager for the plan. Hiring an investment manager under ERISA 3(38) results in a complete transfer of potential investment-related liability based on the decisions of the investment manager. The only potential residual liability that remains with the employer, trustees of the plan, or the committee that hires the 3(38) manager is to have performed due diligence in hiring the manager (checking references, certifications, qualifications, experience, etc.). Provided basic due diligence is done, all employer-related parties are then relieved of liability for the decisions of the investment manager as to which funds are included, retained, replaced or watch-listed in the plan. The chain of vicarious liability is therefore broken.

If one is concerned about reducing liability for investment decisions, the only real alternative to hiring a 3(38) investment manager is to hire a 3(21) investment advisor. The difference between the two is that an investment manager is vested with authority to implement their own recommendations (in terms of which funds are added, retained, removed, watch-listed, etc.) while an investment advisor merely makes recommendations that the committee overseeing the plan for the employer either accepts or rejects. Thus, under this latter scenario, the committee retains fiduciary liability for those accept/reject decisions, and again, that liability extends vicariously up the chain to the employer as a whole and its Board of Directors. A 3(21) relationship is therefore a "co-fiduciary" relationship with respect to the investments of the plan, whereas a 3(38) arrangement transfers full fiduciary responsibility for investments to the manager.

In short, hiring a qualified 3(38) fiduciary manager would reduce the theoretical liability exposure of the sponsor and its board, the trustees, and the plan committee considerably. Note that doing this does not require the employer to appoint an independent trustee or administrator of the plan. In fact, an independent trustee does nothing to really reduce the fiduciary liability for investments, unless that trustee also agrees to act as a 3(38) investment manager. Rather, as discussed below, an independent trustee can be useful in reducing only the liability that results from defects in plan administration.

PLAN ADMINISTRATION LIABILITY

As noted earlier, the other source of potential fiduciary liability is not administering the plan in accordance with its written documents and all required rules and regulations. Examples of this include not funding required matching contributions on time, not submitting employee contributions to the plan in a timely manner, paying out the wrong amount to a terminated participant (for instance, by not reducing the payment for the portion that was non-vested), failing to amend the plan in a timely manner, etc. The administrator's liability in this respect can be mitigated if the sponsor has delegated most responsibilities in this regard to the plan provider and/or third party administrator (TPA). Even so, the employer and the trustees of a plan retain ultimate responsibility for insuring compliance. For example, if the provider errs and pays out the wrong amount to a terminated participant because their system thought that he/she was fully vested when he/she wasn't, then the employer and the plan trustees would be liable for this mistake, but the provider would likely be liable to indemnify you if the mistake was indeed theirs.

However, suppose that the sponsor had provided the vendor or TPA with the wrong hire date and that's what *(Continued on page 6)*

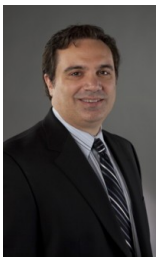
Other State's Medical Organizations Should Follow the Lead of Tennessee Organizations on Fee Reductions

A recent policy change by BlueCross BlueShield of Tennessee to reduce physician laboratory fees to fifty percent (50%) of the Medicare laboratory fee schedule, effective January 2014, has been met with outrage by most of the medical community in the state. Physicians and other healthcare providers, led by their respective state organizations, the Tennessee Medical Association (TMA) and the Tennessee Medical Group Managers Association (TMGMA), are fighting back.

The problem relates to payers changing the terms of a contract midstream, such as lowering rates for a particular service on a given effective date like mentioned above. They often have a take-it-or-leave-it attitude threatening your network status if you don't accept their terms.

A new bill advocated by these groups will be trying to make its way through the 2014 Tennessee legislative session. The bill is called the "Payer Accountability Act." The bill will attempt to prohibit payers from changing fee schedules in mid contract. According to a recent news blast by Yarnell Beatty at the TMA, "*We believe that medical practices are businesses and businesses must be able to predict for the year what their revenues will be in order to properly staff, purchase supplies, and direct services. These unfair business practices by health plans thwart good business efforts by making revenues unpredictable. Contracts are supposed to ensure predictability, not create chaos*."

DM advises all our clients to be active with your national and state organizations and to encourage them to push for or get behind similar legislation in their own states.



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The Importance of Employee Communications

(Continued from page 2)

Communication creates teamwork. Staff from various departments (e.g., front and back of the office) may feel they have competing work objectives. Communicate a practice-wide directive so all team members share the same ultimate goal. Then, encourage communication among the staff to ensure that all efforts focus on that goal --- great patient care.

Communication reveals integrity and honesty about you as a leader. Employees who sense that information is being kept from them (lack of or skewed) will fill in the blanks with negative perceptions. In fact, not communicating with your staff is a sure way to create doubt. You will never be able to prevent rumors altogether, but you can minimize them with an open information policy.

Below are some tips for effective internal communications:

Be clear and concise. Using or overdoing "big" or unfamiliar words will lead to confusion and misunderstanding. Keep it simple.

Set the tone at the top. Doctors and management need to set the tone. They need to be visible and accessible, and they need to understand that there is a connection between employee communication and the achievement of practice goals.

Understand your employees. You may need to communicate differently with different people. For anyone who does not regularly use computers or smart phones, email may be ineffective. To determine your employees' needs, consider surveying each employee – are they getting the information they need?

Provide context. Employees may struggle with information that comes to them "out of the blue." When appropriate, provide context by giving some background and a "bigger" picture.

Be the first to notify employees. When you prioritize your communications, always think of your employees first. Your employees should hear it from you before they hear it from anyone else; they should not be surprised by a third party.

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Does Hiring an Independent Trustee for Your Retirement Plan Reduce Liability? *(continued from page 4)*

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caused them to incorrectly calculate vesting. In this case, the provider or third party administrator wouldn't be responsible for indemnifying the sponsor. The liability would be the sponsor's alone. And, unfortunately, the most costly of these plan administration mistakes are usually ones that are made on the employer's end (failure to remit money withheld from employee paychecks in a timely manner, providing the wrong hire date to the administrator, etc.).

Given this, hiring an independent trustee doesn't result in a tremendous reduction in potential liability for administrative mistakes (since, again, the most costly of these mistakes often occur at the employer level rather than the trustee or plan administrator level). Hiring an independent trustee will never relieve the employer from liability for its own errors.

Having said that, there are some places where hiring an independent trustee can reduce the potential liability of the plan trustees (though not so much the employer). If the plan is ever sued for ANYTHING, the trustees will (in their individual capacity) almost always be named as defendants in the lawsuit, as will the employer. Even if the lawsuit is unfounded or doesn't involve the actions of the trustee to any significant degree, the plaintiff usually has no choice but to include the trustee in the lawsuit for a variety of reasons, including that the trustee owns legal title to the plan assets in dispute. In this case, the trustees now have to pay to defend a lawsuit merely by virtue of their office.

So, for this reason, some employers hire an independent non-discretionary trustee, usually called a "directed trustee," to hold legal title to the assets. Banks or trust companies often play this role. This prevents anyone associated with the employer from being sued merely by virtue of being a trustee to the plan (because they are not).

A non-discretionary, directed trustee like this charges only a few thousand per year because their only role is to hold legal title to the assets and bear the risk of getting sued someday. Otherwise, their agreement with the sponsor will disclaim any and all other responsibilities and will require the employer to reimburse them if they are ever held liable for anything. They don't custody any assets or choose any investments. They don't approve loans or distributions. They don't make any decisions with regard to the plan. They don't sign the 5500 form each year. They don't deal with auditors, etc. Again, they do nothing but hold title to the assets of the plan so that such title doesn't have to be vested in the names of individual human trustees who are concerned about being sued someday merely by virtue of their office.

A few independent trustees will go further. They will agree to act as a full discretionary trustee rather than a directed trustee, though they usually charge handsomely for the service. A full discretionary trustee not only holds title to plan assets, but also maintains custody over all or a portion of those assets. They will sometimes be involved in choosing the investments by acting as a 3(38) or 3(21). They will also act as a full-blown plan administrator and as such will approve loans and distributions, make decisions with regard to the administration of the plan, file 5500s, hire and manage the auditor, etc. Essentially, this is a "total retirement outsourcing" solution and, as such, it's usually only smaller employers, or those with no internal capabilities to manage the responsibilities of a plan, that choose this route.

However, this significantly degrades separation of duties. A full discretionary trustee usually has both title to, and custody of, plan assets. And, they do all the record keeping and administration. Said another way, the company that writes the check also reconciles the checkbook. Consequently, there is a greater chance for malfeasance, or at least for errors to go uncaught, since independent parties are not constantly looking over each other's shoulder. This is one reason why the discretionary trustee model is rarely used with large, established employers.

CONCLUSION

Moving to a 3(38) model in many cases would relieve the theoretical liability for managing a plan's investments that currently extends vicariously up the chain all the way to the company's board of directors. Hiring a directed trustee to hold legal title to plan assets would eliminate the possibility of anyone associated with the employer ever being named as a party to a lawsuit merely by virtue of serving as trustee. Hiring a discretionary trustee does not provide significant additional liability protection related to investments versus just hiring a 3(38) investment manager, and it doesn't relieve much administrative liability either (since most errors occur at the employer level anyway). It does, however, degrade separation of duties. A discretionary trustee is a good fit for smaller plans/employers that don't have the internal resources to manage any portion of a retirement plan on their own, but it's rarely a fit for larger plans.

Sean King, MAcc, JD, CPA Nick Jahn, MBA

SageView Advisory Group

What is a "RAC" Audit and Why Should I Care?

RAC Audits, also known as **Medicaid Audits, Medicare Audits, MAC Audits, or MIC Audits,** are **ongoing, aggressive, intrusive** programs with the sole purpose of recovering reimbursement from health care providers. These audits are expected to become more frequent in the foreseeable future.

Whatever type of audit is conducted, they pose a serious threat to your practice, finances, and reputation. These federally empowered auditing initiatives were set up to take back reimbursement from you and your practice.

How is a RAC audit different than any other audit by CMS? How does the RAC appeals process work? How can I avoid being audited in the first place? These are all questions any provider or medical entity should be asking themselves daily.

Over the past decade, CMS (the Centers for Medicare & Medicaid Services) has ramped up efforts to guarantee the taxpayer that healthcare providers are solely paid for services rendered that

1) Meet requirements as originally established within the Social Security Act
2) Meet the Medicare provider contractual obligations (Conditions of Participation)
3) Meet Medicare coverage criteria.

CMS spent 30 years collecting and analyzing outcomes data from internal audit programs (CERT, HPMP, QIO, etc.) and both Congress and CMS have committed unprecedented resources to enforce evidence-based coverage policies and stop Medicare fraud. After a 3-year demonstration project in selected states across the nation, CMS sold Congress on implementing and expanding Medicare Recovery Audits (or "RAC audits") nationwide.

Centers for Medicare and Medicare Services (CMS) is taking aggressive strides to accelerate the acceptance of evidence-based health care and lighten the load of a strained national budget. The modern Medicare auditing effort is both far-reaching and technologically advanced. Coordinated efforts of law enforcement, Medicare Recovery Auditors (RAC), Medicare Administrative Contractors (MAC audits), Zone Program Integrity Contractors (ZPIC), Medicaid Integrity Contractors (MIC) and a host of others are designed to crack down and eliminate fraud and abuse.

Compliance

The burden of compliance is the responsibility of healthcare providers. Outside of basic written guidelines, Medicare will not provide any specific guidance to the physician or provider.

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The Importance of Employee Communications

(Continued from page 5)

Be forthcoming and continuous. Always communicate both good and bad news. If you are honest and forthcoming in sharing bad news, the good news is more believable.

Match actions with words. If you say you will address a situation, do it. If you do not, you are undermining your credibility.

Emphasize face-to-face communications. Although today's employees may be more tech-savvy than ever, nothing beats human interaction. Most employees want to hear news and information from their supervisors.

Create a habit for communications. You know you need to communicate about policies, health and safety, benefits, and how a job should be done. However, remember that you also need to share information about your organization. What are your objectives? How are you performing? What are your plans? How can employees help?

Measure effectiveness. Set objectives and be prepared to assess whether you have met them. Do employees understand how their daily work helps the organization meet its goals?

Facilitate conversation. One-way communication is a thing of the past. Individuals are empowered to talk back, and feeling "listened to" enhances feelings of trust.

Be objective. Do not "spin" or try to dictate or assume how employees should feel about what you are saying.

Not to be overlooked, say "thank you" as much as possible. If an employee feels appreciated, he or she is more likely to feel engaged and eager to give back.

Do not take shortcuts or make a half-hearted effort in communicating with your employees. If you do, you are likely to fall short of your intentions and/or be putting out fires down the road. As George Bernard Shaw said, "The single biggest problem in communication is the illusion that it has taken place."

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What is a "RAC" Audit and Why Should I Care?

(Continued from page 7)

Internal changes for practices should be established to monitor documentation and coding for compliance as well as establishing a framework for tracking RAC requests. These are not new requirements to providers. The provider application and contract clearly state that it is the sole responsibility of the physician to follow all documentation rules and regulations as well as coding and billing rules 100% of the time. Offices setting up compliance guidelines should appoint someone who will be responsible for monitoring compliance regulations.

How to Prepare for a Medicare Audit

1) Meet the deadline - You have 45 days from the receipt of the letter to respond with their request. Respond to the letter immediately. Schedule the audit and make sure the date sticks. Many auditors travel, and canceling and rescheduling is inconvenient and not a good way to gain favor with your auditor. Avoid missing the deadline or trying to delay the audit. This will only cause problems for you and raise suspicion with the Recovery Audit Contractor (RAC) who conducts the audit.

2) Educate your staff - Everyone in the department (including providers, coders, billers, etc.) must understand the importance of the Medicare audit and the timely handling of the information received.

3) Create an audit team - Having a dedicated group of employees trained and prepared to respond to an audit will keep the process efficient and streamlined.

4) Contact an outside auditor - This will give you a different view aspect and keep you in compliance. It can be a good idea to "audit the auditors."

5) Decide who will meet with the RAC contractors - Designate one person to stay in direct contact with the RAC contractors. This is usually an attorney specializing in medical compliance or an inside auditor.

6) Don't stop after the audit - Conduct internal audits quarterly and possibly yearly audits by an outside company.

7) Stay compliant - Offer training to providers and staff. This is usually done on a quarterly basis.

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Interviewing vs. Psychological Testing for Effective Hiring

(Continued from page 3)

When hiring an employee, it would be best to use both methods. It would be ideal to have the applicants take a psychological test and then interview the ones that you feel fit the position best. Once you have an idea of how their behavior would be in certain situations, you can use the interview to get an idea of what they are like in person. If I had to choose one that I feel would be more effective, I would have to go with the interview. The interview can reveal quite a bit about the person's behavior. You can use some time in the interview to actually ask some of the test questions to get a feeling of how they would behave. Anastasi and Urbina state, "A critical qualification of the successful interviewer is sensitivity in identifying clues in the interviewee's behavior or in facts he or she reports. Such clues then lead to further probing for other facts that may either support or contradict the original hypothesis" (pp. 465, 1997).

Anastasi, A., & Urbina, S. (1997). "Historical Antecedents of Modern Testing". Psychological testing (7th ed.). (pp. 32-45). Upper Saddle River: NJ. Prentice Hall.

Anastasi, A., & Urbina, S. (1997). "Other Assessment Techniques". Psychological testing (7th ed.). (pp. 443-471). Upper Saddle River: NJ. Prentice Hall.

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Practice Assessment

(Continued from page 2)

Operational Checkup:

- Have we checked our compliance documents within the last year?
- Are we up-to-date on HIPAA training, OSHA training, etc?
- Have we developed a matrix of all our insurance policies? Does our coverage still suit our needs?
- Have we checked all of our contracts, leases, and agreements?
- Are our personnel policies and files up-to-date?
- Are we current on employee evaluations? Do we need to re-evaluate our job descriptions?
- When was the last time we analyzed our phone bill, to ensure that we aren't still paying for the five phone lines that we supposedly terminated three years ago?
- How effective are our programs to build employee morale and recognize outstanding contributions?

You get the idea. Your practice needs a checkup. But being your own diagnostician may not be worth the time it takes away from seeing patients. That's where DoctorsManagement can help with expert advice from the medical field. Contact us today for more details!

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