



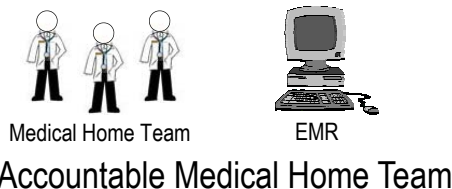
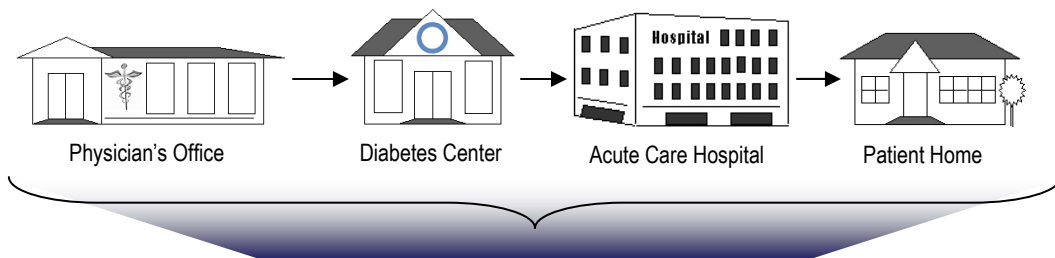
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# The JPA Examiner

**Inside this Issue:** *We're just a click away—www.JPAdocs.com* A publication of the Jackson Physicians Alliance, PC

- BCN News 2
- Congress delays cuts to Medicare doctor payments 3
- Michigan selected for CMS program 3
- In the Door 4
- OIG News 4

## ACCOUNTABLE CARE ORGANIZATION



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## Improving, Integrating, Coordinating Care Delivered by Multiple Providers

An Accountable Care Organization (ACO) is the new ‘buzz word’ for healthcare delivery integration.

In 2011, healthcare delivery is being pushed to create a “seamless” integrated delivery system and ACOs are being touted as the solution. By grouping a diversity of health care providers, such as a hospital, primary care physicians and specialists, ACOs aim to create a cohesive integrated framework, encourage accountability and create incentives and rewards to providers who focus on coordinating the overall scope of patient care.

Unlike the current fragmented model, the ACO is designed to enable and encourage

healthcare providers to take greater responsibility for controlling the growth of healthcare costs for a given population of patients. Simultaneously, ACOs will improve patient care quality. With more than 50% of the population dealing with a chronic condition, the current approach to providing episodic care and treatment is no longer the most appropriate. Healthcare delivery needs to address chronic care management and clinical integration when co-morbidities exist. Care needs to be coordinated and managed.

To start, patients need to be engaged and must take responsibility for their overall care

*See Accountable, page 3*

## Display Non-English Signage at Your Medical Practice



When it comes to your practice, providing multilingual signage may not be at the top of your list. It would be wise, however, to consider the demographic you serve and provide access to language services for patients with limited English proficiency (LEP).

While all entities that accept federal funding are legally required to offer meaningful access to language

*See Non-English Signage, page 2*

## Payer News

### 2011 *BCN Partners in Care* now available

Blue Care Network has mailed its 2011 edition of the *BCN Partners in Care* issue to contracted providers, with one copy to each address via standard mail. The issue, scheduled to arrive in early December, contains tips, tools and resources that can help providers do business more efficiently with BCN, such as finding many online provider resources.

The issue also announces that BCN is seeking provider practices that excel in one or more of the clinical quality focus areas identified for 2011:

- Antidepressant medication management;
- Comprehensive diabetes care;
- Controlling high blood pressure;
- Follow-up care for children prescribed ADHD medication;
- Lead screening in children, childhood immunizations and well child visits;
- Osteoporosis management in women who had a fracture; and
- Use of imaging studies for low back pain.

If your practice is doing an exceptional job in one of these

clinical quality focus areas, contact Cheryl at JPA. JPA will then discuss this with BCN so you can be considered for a future best practices profile. The first best practice profile on pharyngitis will appear in the January-February 2011 issue of the *BCN Provider News*.

*BCN Partners in Care* also features the updated *BCN Provider News* survey. When you receive your issue, please take a few minutes to provide BCN with feedback on your readership of their newsletter and encourage all your physicians to do so as well. Those who respond will be entered into a drawing to win a \$50 Premier Choice Award gift certificate.

The drawing is open to all active BCN providers. Enter by completing the survey by December 15 or by sending an e-mail with your name, phone number and "survey drawing" in the subject line to [BCNProviderNews@bcbsm.com](mailto:BCNProviderNews@bcbsm.com) by December 15th. The drawing will take place on or about December 20th. Winners will be notified by telephone or e-mail following the drawing.



## Non-English Signage

services, there are also many advantages to providing appropriate non-English signage including increased patient safety, increased patient satisfaction and treatment, better patient outcomes, reduction of litigation and overall regulatory compliance. Seeing familiar words and signs make the patient more relaxed and make it easier for the caregiver to help. The patient is also more likely to return to your office for medical needs and to spread the good word about your practice to others in the community. In addition, providing professional, effective, written translation in the form of signage, forms and consents, as well as spoken interpretation, lessens the chance of patient lawsuits.

**When placing signage,** look at first-entrance locations (including elevators) where non-English speakers might be unable to find an information desk. Signs should allow a person to simply point to their language in order to get help.



Professional translators understand both the language and cultural nuances, which are of particular importance in the translation of other materials like consent forms.

Not providing signage at all is the most common mistake, so be aware of which languages are spoken among your patient base, as well as in the local area, and provide signage for all of them. It will go a long way in making your patients feel comfortable and more positive about your practice.

Also consider places where safety directions and other information are typically displayed such as fire and emergency exits, directions to restrooms and drinking fountains. Another solution is to provide non-verbal signs that include universally understood illustrations in areas where multiple-language signage is needed.

When translating, be sure to use a certified and tested professional translator – never a computer program or an uncertified bilingual speaker – to avoid communication errors.

*From page 1*



**Don't Miss**

### Mark Your Calendars For JPA GENERAL MEMBERSHIP MEETING

The JPA General Membership Meeting will be held at 6:00 p.m. Monday April 25th at the Allegiance Health Auditorium. Topics will include: ACO Development; Medicare Demonstration Project; and PCMH.



**Don't Miss**

## Accountable Care

From page 1

and treatments. This means communication and collaboration need to exist among stakeholders – patient, providers, hospitals, community and health plan. Then, a “team approach,” in which all providers and staff work synergistically needs to be adopted. The team works with the patient to make them accountable for their own care.

An ACO should be developed using “natural community lines,” where caregivers already share some level of responsibility for a population. This way, some type of affinity with one another already exists and the providers are inclined to cooperate and trust one another.

The ACO model is intended to encourage participating primary care physicians, specialists, and hospitals to work collaboratively to ensure the care they deliver is well coordinated and designed to benefit patients and reduce waste. It involves prevention and wellness and organized systems of care to basically keep people out of the hospital instead of trying to put people in. For an ACO to be effective, hospitals and physicians have to psychologically and culturally come to grips with making a profit margin based on appropriate utilization that produces savings and managing the expense side of the profit-and-loss statement rather than the revenue side.

Because the savings to be shared are achieved by eliminating unnecessary expenses and improving overall patient quality, the model seeks to focus providers' attention on areas of health care delivery that are fragmented, inefficient, and inconvenient for patients. Under the new ACO system, a bundled price is paid to the ACO for all care services. The ACO then decides individual component payments.

While the ACO is a significant change in the way healthcare delivery is currently provided, there are sure to be financial and professional obstacles. Once implemented, the ACO should result in better care for the patient, improved payment for the provider and less frustration for everyone. In the midst of the change, practices that have streamlined their delivery and have adopted “best practices” are in a prime position to adapt to the new environment. Their practices will be looked to by others for replication.

Creating an integrated, seamless care continuum is the primary goal of an effective accountable care organization.

### Developing an ACO

The following are helpful elements to building an ACO:

- Practice according to current evidence and best practices;
- Incorporate robust clinical educational programs and peer review;
- Share practice quality data for review, transparency, and transformation;
- Seek to adopt the latest technology enhancements such as a disease registry, EMR, e-prescribing; and
- Demonstrate a commitment to excellence originating from the patient's leadership team.

## CMS selects Michigan for PCMH project

Michigan is among eight states selected by the Centers for Medicare and Medicaid Services (CMS) to participate in a new, three-year project intended to improve the efficiency of health care and reduce costs.

The Multi-Payer Advanced Primary Care Practice Demonstration will evaluate home health and patient centered medical concepts at 1,200 medical homes in the eight states, nearly 500 of which are in Michigan. Other states involved are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina and Minnesota. Patient Centered Medical Home (PCMH) medicine is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes and address chronic care conditions.

Medicare aims to determine whether the value of the PCMH is enough to benefit other patients and simultaneously reduce health care costs. If so, Medicare will ultimately make PCMHs available and encourage PCMH development through higher provider reimbursement across the nation.

### Congress delays cuts to doctor Medicare payments

On November 29th, Congress agreed to a one-month delay in planned Medicare payment cuts to doctors, giving a short-term reprieve to a looming crisis over treatment of the nation's elderly.

The House, in approving, by voice vote, the bill that passed the Senate earlier this month, postponed a 23 percent cut in doctors' pay scheduled to take effect December 1. That gives lawmakers a month to come up with a longer-term plan to overhaul a system that in recent years has bedeviled Congress, angered doctors and jeopardized health care for 46 million elderly and disabled.

With medical groups estimating that as many as two-thirds of doctors would stop taking new Medicare patients if the cuts go into effect, Congress has had to periodically step in to stop the automatic cuts. The bill (H.R. 5712) is designed to ensure seniors and military families can continue to see their doctors during December while Congress works towards a solution.

Congress is working on a 12-month postponement to allow time to devise a new system for paying doctors. Doctors will face a payment cut of almost 25 percent on January 1, 2011 if Congress doesn't act on another postponement.

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**Making  
Healthcare Better**

***Looking for a specific topic in The JPA Examiner?***

E-mail comments, ideas or suggestions to ErinW@RMSresults.com.

## OIG News

### **Increased frequency of identical documentation in Medicare records**

The 2011 Work Plan of the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services describes areas in which the OIG will focus specific audit, investigation, enforcement and compliance activities. The OIG indicated it will review the extent of potentially inappropriate payments for evaluation and



management (E&M) services. Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

The AMA's new **Practice Analysis Tools for Healthcare** (AMA PATH™) can help physicians analyze their individual coding and billing practices and compare them with national averages by specialty. Using AMA PATH™, a physician can, for example, analyze their billing patterns with respect to individual E&M codes and in doing so, enable the physician to identify and rectify any billing or coding practices or patterns that might draw the attention of the OIG or other governmental agencies. Visit [ama-assn.org/go/amapath](http://ama-assn.org/go/amapath) to learn more about this online tool or contact Cheryl at JPA.

## **In the Door**

**Welcome the following  
new JPA physician  
members:**

**Anu Garg MD**  
*Geriatrics*  
**Elias Hazzi MD**  
*Hematology/Oncology*



## **Participate in 2011 Practice Manager Survey**

In early 2011, JPA will conduct its Annual Needs and Satisfaction Survey. This survey is designed to explore practice needs and satisfaction with JPA, its contracted payers, and JPA's preferred vendors. It represents an opportunity for JPA's member practices to supply input related to the Physician Organization's (PO) operations and direction. Practice Managers/Administrators can either take the survey online or, if preferred, complete a paper survey version and fax it back to JPA. Last year, the survey was sent 90 JPA practices and had a 51% response rate. We hope to improve the response rate this year to better serve practices.