What Can You Bring to the Table?

Staff with the right skills can be effectively integrated into clinical patient care.

BY LYNN HOMISAK, PRT

To Our Readers: *There are no foolish questions. Chances are that if you have a question or concern in your practice, others are experiencing a similar situation. We're here to help. PM [doctor and staff] readers are encouraged to submit questions to lynn@soshms.com which will be printed and answered in this column anonymously.*

Re: Integration of Clinical Staff into Patient Care

Dear Lynn,

I've worked for my podiatrist for two years now. I applied for a medical assistant opening, but once hired, I was immediately positioned as a receptionist. Clinical work is what I was trained for and where I feel most comfortable; however, I stayed on because 1) I knew learning the front desk is important in understanding how the office functions, and 2) I was told it would be temporary. After my first year (still as a receptionist), I approached this job description change again with my doctor and he denied me, saying his patients only want him to care for them. I know I can make a difference in this practice by taking some of the burden off my doctor's plate (and help him stay on schedule). Instead, I feel stuck in a dead-end job. If I can't convince him to utilize my skills, I will need to look for work elsewhere. Got a magic wand?

Ah, what we wouldn't do for a magic wand, but we'll save that for another time. There is no question that staff can very effectively be integrated into clinical patient care, as long as they possess the right skills, are well trained, and are a good fit. Don't take that lightly. Certain qualifications are critical for success. Too many staff people are placed in positions unmatched with their talents, and it rarely has a good ending. In the same way that someone with the required skillset is an asset to a practice, poor placement can spell disaster—from dissatisfied employees and efficiency breakdown to general chaos and vanishing patients. No patients, no practice! Each position should have job requirements based on experience, education, preferred technical abilities, and behavioral qualities. Individuals should be hired if they fit the description or receive sufficient orientation and training. The person hired can (and should) be cross-trained to sit in additional seats when needed.

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It sounds as if your doctor is unaware of your potential, so even if you've already had an unsuccessful conversation with him about how you can better assist him and you are serious in pursuing a clinical position, reschedule some time with him again. Take your conversation to the next level—one that involves action. Perhaps he doesn't really understand why he should change.

Change is hard, so help him understand by sharing with him some of the advantages that your participation can have. In other words, what can you bring to the table? For one, he would be able to focus more intently on the work that only he is licensed to do by offloading non-invasive patient care services to you. Secondly, the efficiency and professionalism of the office stands to improve as would the patients' rapport, confidence, and compliance. And finally, an extra pair of "physician extender" hands will allow two rooms to generate revenue simultaneously. You mentioned that your doctor insists that his patients only want him to deliver services.

In truth, if the doctor has confidence in his or her qualified staff and communicates that confidence to his/her patients, patients are very accepting, even grateful. It prevents them from sitting in a chair for what feels like forever waiting for the doctor to

Continued on page 148

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Bring to the Table (from page 147)

come in. They actually perceive doctor and staff shared duties as more of a medical care team.

Before you decide to up and leave the practice, give it another chance. Try a more positive approach and show that you are willing to meet your doctor half way. Tell him you'd like to increase your knowledge and become a certified podiatric medical assistant. The American College of Foot & Ankle Orthopedics and Medicine (ACFAOM) has a program that helps to develop skills that, in addition to online didactic studies, includes a PMA "hands-on learning" internship. This in-office training period requires that your doctor approve all your clinical activities before you are granted certification status. So in essence, he not only becomes your trainer/teacher, but actually observing and accepting your accomplishments serve to also boost his confidence and satisfaction in your performance.

According to ACFAOM, some of the duties doctors are encouraged to delegate to their now-competent certified assistant include:

Conducting patient in-take and exit protocols.

- Mechanical/electrical debridement of fungal nails.
- Communicating and explaining home care instructions with patients.
- Performing foam and/or plaster cast impressions for orthotics.
- Orthopedic strapping.
- Callus reduction (using a #15 blade).

In addition to the clinical and didactic studies that ACFAOM offers through this certification course, students also come away with a knowledge and competence in radiology processing and safety (actually taking x-rays depends on individual state regulations), wound care, biomechanical conditions, aseptic care of keratotic lesions, proper PPE compliance, sterilization techniques, and so much more. Visit http://www.acfaom.org/education-credentialing/certified-clinical-podiatric-medical-assistant-program-ccpma for more information.

If, after you explain all this to your doctor, he still rejects your proposition, maybe your employment there is just not meant to be. You have to be happy too and your new education is a feather in your cap. If, on the other hand, you see even a glimmer of opportunity to grow in this practice, take it. With your initiative, you just may be able to convince your doctor to step outside his comfort zone. And when he does, he'll realize that THAT is where the magic happens, with or without a wand!

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Re: Embezzlement? Trust But Verify

Dear Lynn,

Add our practice to the list of naïve, trusting souls who recently faced embezzlement. We are still a little rattled after finding out we were deceived by one of our most trusted employees, right under our noses, too! Apparently, she pocketed cash payments, a little each day, and it wasn't until a patient called (because she received a statement for services she already paid) that our eyes were opened. It only proved to us that we had weak systems in place to manage our money. Although hindsight is 20/20, it's better late than never for us to change our ways and put a more secure system in place to prevent this from ever happening again. I'm just not sure where to start. We could use your help.

Sorry it happened to you, and you are absolutely correct, embezzlement generally occurs when a practice has absent or poor security measures. It happens because it can! Forensic accountants call this the 10–10–80 rule: 10% of people will always steal, 10% of people will never steal, and 80% of people will steal—because the opportunity is there. Here are some guidelines to help you set up more secure protocols. Keep in mind they are meant to protect the employee as well as the doctor/practice.

1) Have background checks done on prospective employees whose job description involves working with money or banking (i.e., collections, deposits, payroll, end of day or financial reconciliations, money transfers, etc.).

2) Always insist that employees issue patients a written paid (paper/NCR) receipt for cash payments. Even if the patient throws the copy in the trash, your copy provides an in-office paper trail. It would be advantageous if the receipts were numbered, to account for any numerical gaps.

3) Avoid having a "rub-

Continued on page 150

Bring to the Table (from page 148)

ber-stamp" of the doctor's signature made. In fact, if someone in the practice is managing accounts payable, make it a practice to have the doctor sign (or co-sign) every check—and attach an invoice itemizing the purchases for him or her to review.

- Also don't get in the habit of signing checks for new vendors without knowing or verifying their name and business.
- Don't leave blank, signed checks around.

4) Be suspicious of "territorial" workers or managers. These individuals reject assistance from co-workers and at the same time, send a stern message that no one should "touch my work" or cover for them when they are out. Not surprisingly, they are also the only ones handling money. Don't ignore blatant signs of over-protective behavior by saying, "Oh, that's just how they are; they're very fussy about their work." There may be some manipulation in progress, and they'll do what is necessary to guard "their" books—even if it means taking work home, staying late, coming in early, or giving up earned vacations.

5) Do NOT have one individual responsible for the money. This is critical! Set up protocols that requires shared duties so no one person is responsible for handling ANY transactions from beginning to end. To start, make sure:

- The person handling your cash is not also responsible for recording the cash.
- The person ordering materials is not also responsible for receiving.

6) Work with your accountant to customize internal control of checks and balances. Then advise your staff that you plan to monitor activity on a regular basis via auditing and unannounced spot checks to encourage accountability and clean operations… again, for everyone's benefit.

7) Review your bank records, credit card statements, cancelled checks and payroll records regularly for any potential red flags.

8) Have the final approval on all write-offs.

9) Trust but verify. **PM**

Ms. Lynn Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and inducted into the PM Hall of Fame. She is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer, and expert in staff and human resource management.