Study Guide: Patient Centered Care

Below is a brief outline for the course

Patient satisfaction is key to a successful practice and is an important component of marketing. To maximize practice efficiency, and create a great patient experience, pay attention to how patients interact with the practice. In particular, from the patient’s perspective, the patient-practice relationship encompasses four key phases:

- Making an appointment
- Entering the office
- Receiving treatment from the physician
- Leaving the office as a satisfied patient

Attention to each of these phases is necessary to maximize the efficiency and effectiveness of the entire patient flow process.

Although patients do not see behind-the-scenes practice activities like posting of charges and payments, completion of medical records, or processing of medical record copy requests, they are affected by any breakdowns in the system.

Proper patient scheduling is key to maximizing physician efficiency and staffing needs. There are several different scheduling methodologies that offer unique advantages and disadvantages. Three general types of scheduling are:

- Block - In block scheduling, several patients are told to arrive at the same time, such as on the hour.
- Modified wave - In wave scheduling, patients arrive in “waves.” For example, three patients are told to arrive on the hour, another patient 20 minutes later, and another 40 minutes after the hour.
- Individual schedule - In individual scheduling, each patient receives an appointment at a specific time in the schedule.

The specific method used should be based on physician and practice characteristics and the expectations of the patient population being served.

Other related activities that affect patient flow include, but are not limited to, reviewing medical records in advance, ensuring that patients complete intake forms at check-in, updating pertinent information for established patients at check-in, and determining what additional procedures or testing will be performed based on the type of appointment.

**Call Center** - Call centers can be an important part of customer-focused initiatives. A call center is a group of workers using phones, linked computer systems and data bases. The individuals working in the call center can be in your practice or at multiple sites – or even telecommuting from home offices. In all cases, the focus is the same: providing outstanding customer service.

Centers that are developed around triage systems are often staffed by nurses who provide health advice based on protocols. These protocols are developed and approved by physicians, physician assistants and nurse practitioners in response to frequently asked questions.

It is imperative that the protocols clearly indicate when a physician visit is required and how to employ emergency call protocols.

When developing a call center, the practice administrator needs to monitor quality, as well as productivity.

Continuous quality improvement (CQI) strategies can assist with both of these efforts. CQI strategy includes:

- Development and implementation of clinical algorithms for staff
- Establishment of quality indicators (e.g., expected or ideal outcomes for each protocol)
- Establishment of performance measurements to determine when performance deviates from the mean, which might indicate a problem
- Implementation of a monitoring system for all communications with patients
- Development of methods to reduce variations (i.e., standardized greetings, emergency-call protocols and standardized triage processes)
Provision of intensive staff education (both initial and ongoing).

Communication Systems - In order to keep the patient experience optimal, communication within the practice, among the employees and with patients is critical.

- Start with a Communication Plan - All organizations should have a plan or method by which internal communications occur. A plan sets expectations for all parties. When developing a plan, consider:
  - Who needs to know/who is the audience?
  - What is the message/content to be shared?
  - What is the best format or method for the message/content?
  - What is the frequency of the communication?
  - Who is responsible for managing the communication forum/method?
  - What resources are required?

- Communication Forums and Methods - The audience, the message, timing, and the location of staff will dictate how to best communicate across the practice. The way people best process information will also help determine the appropriate format.

- Formatting the Communication - Each day the staff has a limited amount of time to perform their work and duties. Meetings and other ways of sharing information are necessary, but may compete with the activities of the practice.

In an effort to make communication more effective and less burdensome, pay considerable attention to how the information is formatted. Having a consistent, standard look or common template helps facilitate clear communications.

Patient and business communication systems often use both the Internet and intranet. The Internet is the "highway" that connects your organization to other networks – both public and private. The intranet is your internal "highway"– the email or instant messaging system that links one computer to another in your organization. The practice administrator must be aware of system security and regulatory compliance specific to healthcare.

- Security: Security refers to all privacy-related issues such as access to servers or databases, end-user devices and network transactions. Fortunately, other industries such as financial services and banking already offer solutions to these issues. Common information technology (IT) security mechanisms discussed below include authentication, access control, data integrity, data confidentiality, nonrepudiation, firewalls and encryption software.

- Authentication: Authentication is the verification of the identity of a computer or computer user, a process in which secret information is known by both computers. That secret information is used to validate communication between the two systems. Common examples include user IDs, passwords and biometric sensors like fingerprints. More recently, increased security has been implemented with the additional use of digital certificates issued by trusted authorities (for example, Verisign).

- Access Control: Access control is a service that verifies and enforces a user’s authorized access to a computer network, specifying privileges and access levels. Data integrity and confidentiality are functions or services that verify the content of a message, file or program to ensure that it has not been changed without authorization... A common mechanism used to ensure data integrity and confidentiality is data encryption.

- Nonrepudiation: Nonrepudiation protects the user against system denial when sending or receiving data. A digital signature verifies the message or file as coming from a specific user.

- Firewalls: Firewalls are critical to Internet security. Firewalls provide content filtering for web-based content to prevent an organization’s computers from being used improperly or to prohibit access to unauthorized web sites.
• Encryption: Encryption software translates information into a coded form to prevent unauthorized access and is used in conjunction with security mechanisms and systems for devices.

• Confidentiality, Privacy, and Regulation: These are three concerns of email communication. Although email was previously used primarily for administrative purposes internally and between physicians, physician-to-patient email communication is becoming far more widespread. It is used in both Internet and intranet systems. There are distinct advantages to such communication, but there are also three principal sources of concern: confidentiality, medical-legal and regulatory issues. All three are clarified in the Health Insurance Portability and Accountability Act (HIPAA) rule. HIPAA applies to any health plan, healthcare clearinghouse or provider who transmits any health information in an electronic form in connection with a transaction. Transactions include electronic communication about enrollment, disenrollment, eligibility, premium payments, first report of injury, health claim or encounter data, and referral authorizations or certifications. The rules cover how information is transmitted between covered entities and their business associates and how patient information can be used or disclosed and how the information must be protected.

- The Privacy Rule applies to the use of patient information by business associates. It protects patients against unauthorized use or disclosure of individually identifiable medical information.

- Long-term practice success is directly related to the ability to identify, predict, and adjust to changes. Benchmarking, when used properly, is the best tool for overcoming these challenges. In particular, two key principles of benchmarking are: (1) if you don’t measure it, you can’t manage it, and (2) if you don’t value it, you won’t change it.

- The value of proper benchmarking consists of more than a simple comparison of numbers. The true value lies in the numbers combined with a strong understanding of the:
  • Current state of the practice
    ▪ Calculation of the difference between the current state and the new value or benchmark
    ▪ Knowing the context and background when interpreting results
    ▪ Deciding on a course of action and goal, and determining when the goal is achieved
    ▪ The basic math behind benchmarking consists of calculating the difference or percent change between two numbers. However, the importance of following a logical method to perform benchmarking cannot be overstated. A typical process might consist of the following:
      1. Determine what is critical to your organization’s success.
      2. Identify metrics that measure the critical factors.
      3. Identify a source for internal and external benchmarking data.
      5. Compare your practice’s performance to the benchmark.
      6. Determine if action is necessary based on the comparison.
      7. If action is needed, identify the best practice and process used to implement it.
      8. Adapt to your practice the processes used by others.
      9. Implement the new processes, reassess objectives, evaluate benchmarking standards, and recalibrate measures.
      10. Do it again – benchmarking is an ongoing process, and tracking it over time allows for continuous improvement.

• Why Benchmark?
  ▪ Practices benchmark to gain a deeper understanding of where they are, where they want to go, and how to get there. This is typically done through constant monitoring, measurement, and comparison.
  ▪ In addition to benchmarking, successful practices map workflow processes.
- Workflows are defined as a series of actions to produce a desired outcome, such as a prescription refill.
- Few practices take on the issue of workflow planning. Even without sophisticated technology, physician practices can make slight adjustments in culture and workflows that contribute to changes and/or improvements in practice efficiency, performance measurement and patient outcomes.

- Technology and the use of the Internet offer great opportunities for medical groups. Potential applications include clinical, administrative and financial functions.
  - Clinical applications - Decision making, results reporting, consultation, telemedicine and conferencing.
  - Administrative applications - Continuing medical education (staff, clinicians and patients), scheduling, marketing, advertising, call centers, messaging and transcription.
  - Financial applications - Payments, billing processes, and research access.

- Improved technology offers many potential benefits:
  - Improved quality of outcomes
  - Reduced cost
  - Improved patient care and access
  - Expanded staff participation
  - Group-wide interaction and resource availability for multiple locations
  - Business-to-business connectivity with electronic data interchange (EDI)
  - Remote access
  - Simplified patient billing and electronic data interchange
  - Real-time insurance verification
  - Provider and payer information

For all the potential benefits, the practice administrator can also encounter challenges and problems when using technology and the Internet. These include technical barriers, patient confidentiality, cost effectiveness and user acceptance.

- In addition, the general technological capabilities of a practice’s patient population must be considered to ensure the technology’s ease of use. The following are some other practice management issues to consider when developing or improving patient communication methods:
  - Communicate options/methods with staff to ensure that staff can assist patients in using the appropriate resources.
  - Provide support for education. Different people learn differently depending on the delivery types (e.g., audio, visual, interaction); provide resources using various formats.
  - Capture the needs and expectations of patients.
  - Anticipate the needs of non-English speaking patients.
  - Evaluate results and provide feedback.
  - Conduct a patient survey to uncover opportunities for improvement and validate the effectiveness of current activities.

**Patient Education Systems**
- Internet
- Resources and References
- Patient Training
- Staff Training
**Technological Knowledge** - Information technology is now widely used in physician practices. Good planning will enable fully integrated networks to update records. An integrated network will include interfaces to many applications, often including patient portals, websites, clinical portals, compliance information and links between providers and insurers. Well-integrated networks will also integrate financial data, management reporting and personal and clinical records.

The cost of such technology can be quite high. One of the responsibilities of the practice administrator is to carefully weigh the cost of the system versus the benefits. Additionally, one should consider the shelf life of the system. How long will it take to get payback on the capital outlay? Will the system be out of date and nonfunctional by the time the capital outlay is paid off? Considerations should also include:

- How the IT solutions fit in the practice’s business and technology strategies
- Identification of potential opportunities for the internet-EDI solutions
- Ensuring that the technology will work in the healthcare setting
- If the patients, clinicians and administrators are not trained and comfortable using the technology, you are wasting money.

**Implement a Plan to Control Pharmaceutical Supplies** - Management of pharmaceutical supplies can be challenging since you must address many of the normal considerations for supplies and equipment. However, many practices that maintain a pharmaceutical inventory must also address issues related to controlled (secured) medications, logs, inventory audits, rotation of stock, tracking utilization, and disposal of expired items.

- General attributes of pharmaceutical supplies:
  - Billable, consumable supplies - Maintenance within a practice is subject to various federal, state, and local regulations and laws.
  - Sample medications, narcotics and controlled substances must be kept in a secured location. Logs must be kept to track utilization and periodic audits of inventories must be conducted.
  - High costs and short shelf lives requires accurate and timely inventory control systems and rotation of stock.
  - Special consideration should be placed on sample medication since a practice becomes responsible for proper storage, control, documentation and disposal once the samples are accepted or dispensed. Many practices have found that the implementation of a sample inventory control process is necessary to limit quantities and reduce costs associated with proper disposal. Typically, samples cannot be returned to the manufacturer and the disposal process can be very time consuming and expensive.
  - In general, many practices use a cabinet or closet that is lockable for storage of samples and other pharmaceuticals. It is imperative that the administrator monitor and track pharmaceutical costs since these costs (purchase price, storage, staff management and disposal) can be a significant drain on the bottom line.

**Referral Management** - A referral management process should capture and manage patient referrals and medical documents through HIPAA-compliant information transfers, effectively eliminating the need for paper faxes. In addition, the process should:

- Include a method to electronically send alerts such as "New Referral Received" to email or mobile devices, providing automatic reminders.
- Send automatic updates back to the referral source, thus reducing telephone tag.
- Provide a real-time view of the status of referral activity.
- Include reporting and analysis at every level by location, referral source, user, service line, and payer. Custom reporting allows for workflow decisions based on current, accurate information.

Some guiding principles of a referral management process should consist of the following:
- Referral management’s prime purpose is to improve patient care. It should not lengthen or complicate the patient's journey. It must not be simply to save money, although it can. It should consider cost-effective use of resources.
- Referral management processes must only be introduced following discussion between a broad representative body of primary and secondary care doctors, managers and (where appropriate) other health professionals and patients. The discussions must demonstrate real engagement and agreed-upon common outcomes.
- Referral management processes should be transparent to the patient. Patients should be fully informed about the process that applies to their referral and should receive advice about the possible outcomes.
- Referral management processes must recognize and support the value of a specific referral by a patient’s doctor to a particular consultant or team for clinical reasons.

Any system of reviewing referrals must take proper account of the expert opinion of primary and secondary care clinicians and should only be undertaken by properly qualified clinical professionals. Referrals should be based on the expert views of physicians, consultants, and other specialists. There must be absolute clarity of responsibilities and accountability in any referred cases.

Any referral management process must include timely and appropriate consultation with and communications to all professionals and patients who could be affected.

The processes should facilitate collaboration between primary and secondary care clinicians. Any assessment and treatment services provided at this interface should be multidisciplinary in nature, drawing on expertise already available in the locality.

Any referral management system must have robust clinical governance arrangements and audits in place with strong leadership and clear accountability.

Consideration of any referral management process must assess the impact on existing services as well as the potential benefits.

Any referral management system should offer an educational element, including an appropriate program of staff training.

**Benchmarking** - The purpose of benchmarking is to collect and measure data from your practice, and to compare and contrast it to similar practices. For example, a cardiology practice can benchmark itself against other cardiology practices or a practice can benchmark its own physicians against one another. Benchmarking can also be used to compare and contrast the historical trends of a given practice. Almost any item in a practice can be benchmarked, such as salaries, collections, and days in accounts receivable, encounters and number of staff per provider relative value units (RVUs).

- The Value of Benchmarking - Benchmarking can be used to improve a practice, determine appropriate salaries, and determine the appropriate number of physicians for the number and types of cases. Practices typically benchmark productivity to ensure that physicians are working up to their potential. Benchmarks can be used to determine compensation, recruiting needs, business growth opportunities and productivity. Productivity can be measured by RVUs, encounters and/or revenue.

**HEDIS (Health Effectiveness Data Information Set)**

- **History**
  - In 1979, the National Committee for Quality Assurance (NCQA) was established. In 1991, NCQA began accrediting health plans.
  - In 1990, NCQA integrated the Health Effectiveness Data Information Set (HEDIS) as an audit compliance program as part of health plan accreditation to assess the plan’s information systems and performance for quality indicators.
  - Today more than 90 percent of health plans operating in the United States recognize and utilize HEDIS for tracking and monitoring performance across their provider network.
HEDIS is an area of focus for medical groups today as they seek to improve the care they deliver. Most health plans compare their providers to this national database as part of the pay-for-performance determinations. Knowledge of HEDIS indicators helps:

- To improve the quality of care being delivered to the group’s patients.
- To understand how the group compares to HEDIS standards.

Realistically, a group cannot focus on all the measures nor may all measures apply to the types of care and services the physicians provide. Typically, a practice will identify the top five or six HEDIS indicators. Once this is done, the practice can decide how to improve or maintain levels as deemed appropriate. Finally, the group tracks this data for trends and determines if its efforts are resulting in improvement.

**Patient Charts – Quality Assurance**

- Group practices have quality assurance programs conducted by an organized internal review committee. Typically, the reviews include acceptable performance in specific and randomly selected patient cases.
- Quality assurance programs vary substantially according to practice type, size, and the interest of the physicians. Practices closely associated with a hospital that share the same medical records are more likely to have a formal quality assurance program than a freestanding group practice.
- Although accreditation is voluntary in the ambulatory practices, clinics may elect to be accredited because the accreditation process helps the group evaluate their performance and establishes internal audit standards.
- To ensure accurate documentation and completeness of the patient chart, the following should be included:
  - Demographics, insurance and financial information
  - Legal agreements and consents
  - Problem and medication lists and immunizations
  - Health history and assessments
  - Patient-reported data
  - Clinical orders and diagnostic testing
  - Chief complaints and diagnoses
  - Clinical course of treatment and patient education
  - Procedures, surgeries and encounters

**Clinical Pathways** - With the growing influence of insurance companies and a demand for improved patient outcomes and cost containment, clinical pathways can be a useful tool for improving the delivery of healthcare and the management of high-risk patients. Group practices can achieve success with clinical pathways by collaborating with insurance companies on treatment plans.

The treatment plans, which can be negotiated and agreed upon by physicians, payers and insurance companies, help meet the objectives of patient care and cost containment. It may be necessary to review patient care with the plan’s medical director, case manager, care coordinator or utilization review team in order to deviate from the agreed upon clinical pathway.

**Patient Satisfaction** - Ensuring a good patient experience is critical to the success of your organization. Patients vote with their feet, and unhappy patients will seek their medical care elsewhere. Word of mouth is an excellent way to get patient referrals, so keeping your customers satisfied is critical. The quality of patient service is often related to malpractice risk.

One way to determine patients’ opinions of the service quality is to measure their satisfaction and meeting patient expectations. In addition, some practices directly tie patient satisfaction to physician compensation. Practices also use positive patient satisfaction results to negotiate third-party contracts. As healthcare moves to more accountability and value-based care, the patient’s perceptions and expectations will become exceedingly important.
Any of the following can be used to determine patient satisfaction:
- Surveys
- Informal patient discussions
- Patient complaint reports
- Patient focus groups
- Patient advisory groups

A specific practice division or an outside vendor can be contracted to collect data and analyze patient satisfaction.

Individuals with responsibility for compliance should get copies of the reports and then address service-related issues, especially those that are consistently reported.

Policies and procedures should be in place for addressing patient suggestions and for improving procedures.

In addition, patient complaints should be directly linked to quality improvement initiatives.

Patient satisfaction data should be trended and compared to the previous year and quarters. Are improvements resulting in higher satisfaction scores? If not, did the improvement address the right problem?

**Customer Service Programs** - Customer service programs should be a part of employee orientation and incorporated into the organization’s culture and corporate mission. An ongoing employee customer service recognition program can be effective. Physicians and staff could receive awards (pins, ribbons, or certificates) for exceptional customer service. These should be presented at physician and staff meetings. In larger organizations, service excellence luncheons for award recipients can also be a part of the recognition program.

**Accounts Receivable (AR) Benchmarking**

By monitoring the number of days in accounts receivable, the management can determine the efficiency of the business office staff and identify delays in payment. If the business office is writing or adjusting off too many charges, the reduced number of days in AR can provide a “red flag” and signal the need for further investigation with an internal audit.

The aging of the accounts receivable is also a useful benchmark. It helps a practice determine how quickly charges are getting paid. It can help detect breakdowns in the claims submission and patient payment systems and identify where attention needs to be focused. If very old, accounts receivable should be written off if they are determined to be uncollectible and repeated attempts to collect the funds have been unsuccessful.

Management of denials is also an important benchmark. Monitoring the percentage of denials is especially useful when trended against historical data. Changes in the number and type of denials can be caused by either the billing software or insurance carrier.

These discrepancies should always be investigated to determine the root cause. Staff should monitor for changes in plan requirements, coding and precertification processes that will impact claims processing or reimbursement.

**Pay for Performance (P4P)** - P4P provides financial incentives for meeting pre-established targets for delivering healthcare. These targets relate to quality and efficiency.

This is an alternative arrangement to fee-for-service payments. Many pilot P4P programs are underway, and evidence-based programs will drive future funding and payment mechanisms.

In larger organizations, this process might be managed by a Department of Clinical Effectiveness. Electronic medical records, registries and population health software will help administrators facilitate the data gathering process.

**Electronic Health Records (EHR)**
- Meaningful Use of EHRs
  - The American Recovery and Reinvestment Act (ARRA) of 2009 contains provisions affecting healthcare. In an effort to increase the adoption rate of EHRs in physician practices and improve the use of technology for patient care, the legislation includes financial incentives for eligible physicians that use qualified EHRs.
• In order to demonstrate the meaningful use of their EHR and receive payment, practices are required to attest to meeting program objectives.
• The Centers for Medicare & Medicaid Services (CMS) has released the final rule on Stage 2 of meaningful use requirements.
• There are final 17 core objectives as well as six menu-selected objectives, five of which are new. ARRA details the future changes that will occur in transitioning to stage 2 of this program, now delayed until 2014.

Objectives (Self check):
✓ Identify business processes to ensure effective and efficient clinical operations.
✓ Explain the value of benchmarking
✓ Define the 10 step process of benchmarking
✓ Define workflow
✓ View a sample of workflow
✓ Identify benefits of workflow
✓ Review relevant and accurate resources to enhance patients' knowledge, understanding, and participation in their medical care.
✓ Give examples of technology that enhance patients' knowledge, understanding and participate in their medical care.
✓ Explain practice management guidelines that will help improve patient communication
✓ Summarize security and regulatory compliance specific to healthcare
✓ Describe security, authentication, access control, fire walls, encryption, HIPPA
✓ Describe how HIPAA applies to practice’s communication systems
✓ Explain how adjustments in culture and workflow can improve practice efficiency, performance measurements and patient outcomes
✓ Explain a referral management process.
✓ Identify efficient patient flow patterns to maximize physician schedules.
✓ Describe front office operations to maximize patient satisfaction, collection of payments and customer service.
✓ Implement a plan to control pharmaceutical supplies.
✓ Identify and maintain benchmarks for establishing practice performance standards.
✓ Give examples of internal processes and systems to participate in pay-for-performance programs to enhance healthcare quality.