Exploratory Fellowship Paper

Creating a Patient Centered Provider Practice

Title: Moving toward a Patient Centered Medical Practice.

There are numerous challenges to the implementation and management of a Patient Centered Medical Home (PCMH) in a complex and ever changing healthcare system. Over time the goal and vision in healthcare have remained stable; providing accessibility, quality care at fair cost\(^1\). There is evidence that profitability and sustainability are decreasing in private practice\(^2\). This exploratory paper will investigate primary care medical practices to identify operational successes. The discovery will highlight strengths of existing medical practices and identify the basic components of patient centered medical practice. The intended audience is a new primary care manager in the healthcare industry attempting to implement practice improvements and become a patient centered organization. Improvements as outcomes are poor across functional areas of healthcare such as reimbursements, patient and employee satisfaction, cost of care and compliance with mandated changes. The impetus to change is a survival method, no longer optional. Success of a medical practice is now being defined for medical providers by patients, payors and healthcare reform\(^3\).
If a medical practice put the patient at the nucleus of process and workflow, it would change the delivery of healthcare. This exploratory paper will review traditional medical practices and attempt to identify ideas and successes for future implementations. The exploration will pull on strengths of existing practices and seek to create a patient centered provider practice. We must put the product or customer first and build a system around them to create sustainable medical practices.

Primary care model defined:

According to John Hopkins Bloomberg School of Medicine, primary care is defined as:

“Primary care is the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it. It is the means by which the two main goals of a health services system, optimization and equity of health status, are approached”
It all starts at the primary care level of medical care. The primary care provider at the core of the decision making process. Patients seek care first with the primary care provider, regardless of the providers skills set to care for the condition. The responsibility of the primary care doctor is heavy and ongoing as they evaluate and see patients not only for acute care such as strep throat, flu, vaccinations, they also care for conditions management and make appropriate outgoing referrals. The ‘gatekeeper’ has the utmost responsibility as they are responsible for the entire continuum of care for a patient, over time. It is not uncommon for primary care Doctors advertise they see an inclusive ages 0-100. The scope and span of the knowledge and time is generational for some providers. They have seen the families grow, die and understand the medical lineage of what is in the family. This knowledge allows primary care physicians to identify and trend a specific family or disease. Primary care providers can create baselines for all physical systems and note patterns of change. Primary care is where the trust is built and the continuum monitored.

This model of care first seeking care with ‘your Doctor’ has changed over time as access has become more strained. The result of inability of timely access into your Doctor’s office
and/or funds to pay for care has created unnecessary trips to the Emergency Room.

Nobody is arguing that interested parties in the healthcare industry are making too much money. Profitability in private practice and sustainability of private practice ownership is decreasing and the future is blurry on necessary changes to implement administratively, that affect how practices provide good care.

Just as physicians treat patients over time, and watch the family changes over time, so has the way the providers receive payment for their services. Primary care has made markings historically for trading the service of medicine for basic commodities such as sugar, flour and chickens. House calls used to be common and payment would be sent home when they left in the form of consumables for the families of the physicians.

Payment methodologies have varied over time as political leaders change, economics of our country change and the population ages. There have been multiple attempts at finding the sweet spot for sharing risk and rewarding quality in healthcare.
In the past 35 years of healthcare delivery and reform we have seen the power pendulum swing back and forth. In the 1980’s and early 1990’s it was popular for employers to offer health maintenance organizations (HMO), preferred provider organizations (PPO), and point of service (POS) plans to offer employers cheaper options in exchange for restricting employees’ access to providers within a managed care network. Managed care paid providers contracted within their networks discounted fees subject to utilization review- largely in the form of preauthorization for services and networks of preferred providers. The structure also included financial incentives or bonuses for providers to keep costs down and restricted access through a network. This form of selective contracting and reimbursement discounts signaled a temporary shift in the balance of power from providers to managed care organizations in exchange for utilization review. Reviewing care both proactively via pre-authorizations was believed to keep healthcare costs down. Initially, managed care found it relatively easy to keep cost growth low. They negotiated lower prices from providers who were worried about losing patient volume if they were not included in managed care networks.
As a result, healthcare spending grew more slowly in the first half of the 1990s than it had in the prior decade. The ability of the managed care groups to continue paying providers at discounted rates waned concurrent to the profitability of these organizations. The utilization review and restrictions became unpopular with the general public as well as the healthcare community.

Capitation of payments became more popular and widespread. Capitated payment arrangement allowed a provider to receive set amount for each enrolled person, for a set period of time whether or not the patient sought care. The HMO’s still held the power of enlisting patients into the network and remuneration was on average expected health care utilization of patients accounting for factors that typically influence the cost of providing care. This reimbursement style was short lived as providers consolidated to gain market leverage to negotiate more favorable contract terms with managed care organizations.

Bonuses were paid to providers for low cost care but in the late 1990’s the pendulum swung back as a result of the poor model that did not save money or cut costs. Nearing the turn of the century providers consolidated, practice sizes grew in attempt
to gain contracting leverage to attempt to increase reimbursements.

The goal to distribute liability and risk had failed and the practice of medicine had again become a commodity in society. All attempts to compensate the physician practice for services were changing the traditional medical practice. Many organizations attempted over time to consolidate providers, in attempt to find economies of scale and gain more power with insurers but that strategies did not prove to be successful either.

The current model of a fee for service compensation is no longer able to sustain private practice. When a single practice attempts to negotiate with commercial payers, it has no leverage. The private medical practice has lost its bargaining power for increased reimbursements and thus the sustainability of smaller private practices is in question. The existing Health Maintenance organizations (HMO’s) and payors can stand firm on the basis of resource based relative value scale (RBRVS) for small production of patients. The RBRVS schema is used to help determine how medical providers are paid and variations negotiated around Medicare rates.

Some providers are choosing to simplify reimbursement strategy by not participating in federal programs such as
Medicare. Providers no longer want to watch the sustainable growth rate (SGR) decrease alongside their reimbursement for services. The SGR is a component of the formula Centers of Medicare and Medicaid Services (CMS) uses to calculate physician payments for providing services to Medicare patients. It is based on Gross Domestic Product (GDP) of our country not on actual healthcare practice costs. The SGR has produced steep cuts in physician compensation for services to Medicare patients.

The decrease in the Sustainable Growth Rate (SGR) for Medicare is one reason many single providers are choosing to opt out of participating in federal or state funded programs. Providers remain split over who should determine quality measures under a replacement Medicare physician payment system and how quickly to move away from the current reimbursement model, according to industry groups.

The struggle of motivating experimentation with different payment models is now somewhat forced upon a medical practices by healthcare reform. As payment methodologies continue to change and find a balance, it is important to note that fixed expenses a medical practice remain unchanged, or in some cases such as rent/utility/medical malpractice may increase.
Of note: According to the medical search and consulting firm Merritt Hawkins & Associates, primary care physicians earn the lowest salary of all physicians. The fact is the shift of power and risk needs to change, concurrent to the way healthcare is delivered.

Society needs to find the balance somewhere in between rewarding physicians for high quality care and allowing physicians to share the risk with payers and the center of all needs to become the patient.

Regardless of how doctors are paid for their services the patient is underserved in the current delivery of healthcare. Historically you call for an appointment with your primary care doctor and they tell you when you can be seen and is typically longer than you expect. Traditional care is modeled around the physician and medical office staff is clearly focused on the Doctor and their needs. Medical staff services the provider and providers make all decisions. Everything done and said indicates they are clearly helping the Doctor. Patients have been put through the process versus being part of the healthcare process. Time spent face to face with the Doctor is minimal. The organization is focused around the physician and what the physicians wants. Today, the hours of operation are similar to your bank teller hours, during the week only and
seeing your medical provider will be at his/her convenience and timeline. It is not uncommon to be told “we can fit you in in three days” or referred to urgent care. Once you see your primary care provider, traditionally test results and referrals are initiated from the physician office at the convenience of the physician office, all the while the patients waits and is dependent upon the system.

Risk on physicians in this physician centered, fee for service environment must change to make strides in reducing costs and maintaining good care. The risks for quality versus quantity needs balanced with liability for expenses in order to maximize supply and demand. The commodity based trade for services, the creation of CMS, HMO’s, captitatatated payments and even fee for service has moved the balance of power and risk but all shifts have proven to be temporary. All attempts were short lived and the balance of power from providers to managed care organizations not effective over time. Still attempting to find the competitive edge, physician practices continue to grow through acquisitions and mergers and gave providers find themselves with a small edge in contract negotiation.

Primary care providers maintain a panel size of patients too large to deliver consistently high quality care under the traditional practice model. Estimates suggest that primary care physicians with a patient panel size of 2500 patients would
need to spend 21.7 hours per day to provide all recommended acute, chronic and preventive care. The average United States (US) primary care patient panel size is 2300.

The number of medical students entering into adult primary care is decreasing, in part as a result of excessive work load and the fear of panel sizes will grow larger over time. This reality and demand is a clear economic problem.

Patients historically have healthcare happen to them as they are led by their physician. We must learn from the past and create an organizational design that meets the customer needs. Traditional hours of operation of Monday through Friday 9am-5pm with an hour closure for lunch will no longer meet the need of the patients. Communication methods need enhanced and expanded. We need access to our healthcare similar to other industries have of extended hours of operation coupled with 24/7 access to information. Healthcare needs are not Monday through Friday 9am-5pm or when the physician is available to work. In a physician centered organization, often times staff is told when vacations will be as it mirrors that of the physicians.

Traditional care models include handwritten medical notes and the use of the telephone. If you’ve had a blood test or CT scan, you probably have to call the office half a dozen times chasing
down the results. If you have been in the hospital you are responsible for arranging your own follow-up care. When you seek follow up care, it is possible your primary care physician is not aware you have been in the hospital. Patients are responsible for remembering to make appointments for checkups, screenings and vaccines. If you are referred to a specialist your primary care doctor and specialist may not communicate. Trying to navigate the healthcare world, of playing by the insurance rules is somewhat overwhelming for the average patient and can be overwhelming. Often times as a result of this frustration, patients seek care at an emergency room when their condition is not an emergency. This misuse of hospital emergency rooms and the emergency medical treatment and active labor act (EMTALA) laws that govern them is one reason believed for the rise in healthcare costs.

The model of Patient Centered Medical Home (PCMH) has been slow but steady as the industry moves to put the patient literally at the center of the practice. Implementation of the PCMH delivery model requires a mindset change among health care providers and patients. In the past the physicians were the focus of the health care delivery model and in the new, PCMH model, a new patient-centric approach is evident. Industry experts and government show support of these
initiatives and hope better outcomes will be the result. Physicians will partner with patients and collaborate for better health.

Industry experts agree that prevention, education and integration will yield a healthier population. The need for education on how to eat healthier, act healthier and get more fit is apparent in the United States. Achieving National Committee of Quality Assurance (NCQA) recognition and implementing a patient centered medical home includes well defined features. The Patient Centered Primary Care Collaborative (PCPCC) outlines essential definitions, strategies and potential impacts for practice transformation such as:

1. Patient centered- the design supports patients and families to manage and organize their care and participate as fully informed partners in health system transformation at the practice, community and policy levels. The impact goal is that patients are more likely to seek the right care, in the right place and at the right time.

2. Comprehensive care by a team of care providers who is wholly prepared to address patients’ needs-this includes prevention and wellness, acute care and chronic care. The impact of comprehensive approach is that patients are less
likely to seek care from the emergency room or hospital, and delay or leave conditions untreated.

3. Coordinated care ensures that it is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services and public health. The impact is focused on monetary avoidance of duplicate tests, labs or procedures.

4. Accessible care delivers consumer friendly services with shorter wait times, extended hours, 24/7 electronic or telephone access and strong communication through health IT innovations. The focus on wellness and prevention reduces severity of chronic disease and illness.

5. Commitment to quality and safety demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions. The impact has direct cost savings resulting from appropriate use of medicine, fewer avoidable ER visits, hospitalizations and readmissions.
Multiple initiatives have been placed on medical practices, some feel this transformation is just too large to try and motivation is low for practice transformation. A clear return on investment (ROI) is not apparent for practices.

Information Technology (IT) has changed almost all aspects of society today, including healthcare. The definition of traditional healthcare is changing as a result of technology. Perhaps no single element of healthcare has received as much attention, funding and enthusiasm as information technology. Attempting to achieve PCMH designation assumes investment by the practice. It assumes an Information Technology (IT) platform for electronic health records (EHR). It assumes that there is extra clinical staff available to become part of the coordinated care; it assumes mental health is as easy to access as physical health. The biggest assumption in the transformation of a patient centered medical practice assumes the patient is ready to change and be the center. The transformation also assumes out of practice efforts such as communities and policies are flexible and ready to change. Fully engaging/informing patients and opening access gate requires proper and secure communication both into and out of the practice. Trends in implementing technology including online appointment requests, implementing patient health portals, extending hours of care have all changed the industry.
The commodity staff person is now a clinical based, patient centered not physician centered person who has the ability to see the whole patient picture and assist with their overall healthcare needs.

The most significant change to healthcare IT is the mandate to move from handwritten medical chart notes to an Electronic Health Record (EHR). The Health Information Technology for Economic and Clinical Health (HITECH) Act is part of the American Recovery and Reinvestment Act (ARRA) Act of 2009. The intended outcome was to promote the adoption and meaningful use of health information technology. The intent to share information is thought to avoid duplication of care, overtreatment and abuse, and yield better (healthier) patient outcomes.

As the Hi Tech Act included incentives to implement a technological change it has affected the way a patient’s health is documented and shared. The cost of healthcare is believed to decrease over time but reports vary as to true cost value.

Historically physicians use the four part chart note per patient, Subjective, Objective, Assessment and Plan (SOAP). This form with multiple variations was the uniform and acceptable documentation. The implementation of EMR has created a different flow of documenting, each system following its own
format and flow but no longer can physicians rely on or expect to see a typical SOAP note. The incorporated tools can provide clinical decision support and identify gaps in care. The information technology often times can develop reports of clinical and financial performance that reflect the priorities identified.

As internal processes such as EMR is rolled out and changing the way physicians work, patients are in need of care, medications and education. The typical/traditional medical practice is struggling to achieve and push quickly a constant flow of needs. The need to change is faster than any other need in the healthcare industry.

The health expenditures in the United States continue to rise. In 2007 the national health care expenditures in the United States totaled $2.2 trillion or 16% of its gross domestic product, a 14% increase from 2000\textsuperscript{13}

Moreover, in 2010 it neared 2.6 trillion or 17.9% of the nation’s gross domestic product\textsuperscript{14}

Providers have been forced to manage financial risk as a result of failed reimbursement models as liability moves from insurers to providers. Providers now have dual responsibilities of assumption of risk management and provisions of providing care. The redistribution of risk is driven by how US health
systems will be encouraged to pursue strategy as market dynamics and economics play out.

Additionally, evidence supports accelerating consolidation of the provider’s side of the industry and a shift in payer contracting strategies toward their assumption of financial risk-contracting strategies that are designed to move market share in a positive direction for health systems taking the risk\textsuperscript{15}

No apparent approach our nation has tried, over the past thirty five years, to control healthcare costs has had a lasting impact.

Moving toward a Patient centered medical practice will create benefits for both the patients and the providers. Patients will benefit as they will be encouraged to take a more active role in their health. Partnerships between providers and patients seek to teach patients to seek care at the right place at the right time. Providers will benefit from the change and adoption of PCMH by creating partnerships with patients that will strive to yield an overall healthier patient base. PCMH allows better coordinated care and tracking. Resulting coordination and open lines of communication with patients and other providers is expected to save medical practices money and time.

The new primary care manager should analyze existing systems and create a plan for the future of their practice and decide if or how much the practice will conform to the trends in
healthcare. This exploration will guide not the best practices of workflow, but what the nucleus, the patient needs and the best way to move toward a patient centered medical practice.

The vision has not changed for either the payor side or provider side as the vision is to provide accessible care, high quality care to patients at a fair cost. Physicians want to make a good living and pay their school debts. They want to take good care of patients have a positive return on investment for their long schooling. They want to treat patients and practice medicine. Often, managers or practice administrators are hired to keep up with mandated changes and to provide operational leadership so physicians can focus on patient care.

The challenge of finding the appropriate balance of financial risk to achieve profitability and create alliances that patients and practices can create better outcomes is ever changing. Many practices have analyzed and tried delivery models including a variety of organizational designs. Organizational creation and variations are attempts of increasing quality and reducing costs and increasing overall outcomes in the way of delivery.

One method of organizing a firm is to integrate medical practices horizontally. In healthcare, one practice of same specialty absorbs another creating a single firm. These
practices become one firm involved in the same level of production and sharing resources. Depending on sizes of medical practices horizontally integrating, economies of scale can be achieved.

Opposite of horizontal integration is vertical integration, which is a popular trend across America now. One option for private practice to change is to integrate private practice into a vertically Integrated Health System (IHS). Vertically integration is the combination in one company of two or more stages of production normally operated by separate companies. In the vertically aligned operation, the ‘system’ can own the supply chain through their procurement divisions. The vertically integrated model creates a system of internal referral patterns, often time hospital dollars and the luxury of group purchasing organizations (GPO). A GPO is created to leverage purchasing power of businesses to obtain discounts based on collective buying power and can be entered into via membership for all organizational designs. GPO discounts are primarily used for high frequently used items such as medicals supplies to offer ways to reduce overhead expenses.

Physicians are becoming employed by hospitals and turning over the control of practice operations to the integrated
Established, independent physicians are seeking employment by community health systems in increasing numbers. As the integrated systems grow, there are opportunities for strategic facilities with the goal of cost of delivery becomes lower per square foot.\textsuperscript{16}

The hospitals are at fear of losing census and seek to maintain their levels by vertically (owning) the referral patterns in a given population.

The rate of independent practices remains varied as organizational models change. One of the newest offerings is the concierge practice that offers patients service, as the name concierge implies. Variations of this practice are paid by patients a flat fee for period of reliable, timely medical treatment. The scope of providers in this practice is limited. Referrals can be made by patient choice as there is no affect for the provider of outcomes of patients. If a cash only concierge practice, there are no quality measures to meet for payors. This is a patient driven method at a high cost for desired health needs. Tenured physicians in private practices succeed most often at concierge practice as they have established patient base from private practice. This type of delivery must bring with it a patient population even greater than normal care scope. For example, if the average primary care provider maintains a patient population of 2300, it must be saturated to
transition to concierge practice. This practice has established trust over time with patient who will essentially opt out of traditional health care. Timeliness is one of the greatest benefits of the patient of both time of service time and appointment availability. Physicians lower their risk by patient partnership and balance risk by being available, giving service and potentially save on administrative and overhead costs by simplifying the process and eliminating functions such as billing and collecting.

The assumption of financial risk through new types of contracting strategies with third party payers is moving from the known economics of fee for service reimbursements to the unknown economics of accepting financial risk for defined populations (at expected use and cost rates lower than those customarily realized in the fee for service markets). Providers in private practice will need to assume some of the traditional payor core competencies and should receive a portion of the premium for doing so. Reimbursing providers for quality care will require ongoing analysis of both the provider and payors.

Transformation of a practice into a patient centered medical home will require drastic change. If society can refer to the
“patient” as the “customer” that is drastic and a great place to start. Change quantity and high patient panels to quality and healthy customer panels and watch the downstream affect. Imagine that a new normal mindset and delivery model is to cringe to see any patient enter the hospital and consider this a loss of revenue. Imagine a normal day in primary care delivers better care with fewer patients with greater impact. The change in mindset is staggering for most practices.

Identifying the PCMH model as a preferred model and truly changing the delivery of healthcare requires the medical practice to look within. An organizational transformation should be compared to the mission statement. The mission statement should be reviewed regularly and should be used as guide in the decision making processes. Regardless of private, vertically owned, concierge or other organizational design, most intentions (mission statements) are created to document why the organization exists. Transforming into a patient centered medical practices will require commitment to the transformation and should align with the organizations mission statement and goals.

If a medical practice can create an environment of comfort, the psychological effects may be minimized. If the entire care team is constant with minimal turnover, and the focus shifts from the Doctor being the center of the visit to the patient it is believed
to create better outcomes. The creation of a care team focused on the patient with multiple care members truly puts the customer in the middle of the process.

Creating multiple care team members that focus on the patient may include redesigning existing staffing model. Reviewing skills and strengths of existing roles in a practice can be a healthy experiment for a well-established medical office. The approach should remain open to potential outcomes as staff and strengths/interests are uncovered. The impact on resources by duty realignment can change not only monetary impacts but analyzing the need to add to staff. The preferred model of PCMH involves the entire team, front desk to physician and any community members as well. It is rare these days not to be on an EMR and the impact of such technological change has lasting financial impacts. Historically and most commonly when a large investment is made for a medical practice, financing is obtained. Some small private practices still feel the past financial burden of having made such a large technological change to EMR. Financial impact of transitioning to PCMH is not yet well documented. The impact of current reimbursement models is not yet clear where the risk lies. Providers who achieve quality standards can be rewarded by incentives by payors. Technology has enhanced the information sharing and the relationships with medical
practices however private medical practices continue to struggle to find the balance of risk between cost, quality and access. Attempting to shift risk away from the physician and show demonstrated cost savings and increased quality is complicated by fact that the population of America is growing as the baby boomers reach their 70’s and more and more diagnostics are being ordered. As stated, the entry of medical school students going into primary care is decreasing, and as the population ages providers may be asked to care for not only individuals but populations as well. Trending has been noted that physicians may be rewarded for overall better, healthier populations and this tool will be used in the creation of reimbursement variations.

The impact on care plans has changed from a SOAP note to a computerized documentation and record of a patient history over time. Physicians are now typing, clicking and dictating into the EMR to document care plans. The new method outlined in PCMH is led by the patient. The patient is the center of the care plan, assisted by the care team at the medical office. A common care plan is called the patient centered care plan (PCCP). The PCCP is different from usual plan of care by:
Instead of plans being disease based, they are goal based. Typical plans identify gaps/deficits and on the new PCCP plan strengths are identified. Instead of being reactive to problems, the PCCP takes a proactive management approach. Healthcare becomes continuous instead of episodic. The focus of the plan changes from using the physician as the sole expert to considering the medical provider as an advisor/partner. The greatest change is that it shifts responsibility from the patient coordinating care to a team of partners with the patients to coordinate care.¹⁷

As the patient is the center of this improved medical practice, the appointment times and access into the medical office is broadened in the PCMH model. The patient calls to state when they would like to be seen, access on line with increased technology has opened timelines and office hours must be extended or at a minimum changed. The elementary example of access is to stagger provider schedules and remain open during the lunch hour as this is a common time society is available. Giving patients access to their health results 24/7 via online patient portals and setting expectations with the customer will have a huge and positive impact on access.
The operational plan for patient centered medical practices includes hiring a tenured team, clinically integrating the staff, creating patient resources including education.

Hiring employees is just a start to creating a strong work force and coordinated care team. If you have lived in the same area for a decade or more you probably have established medical care. Your primary care provider, gatekeeper, Doctor of record, you know exactly where the road turns to get to the office. The staff at the front desk should be familiar, comfortable in their approach and hopefully able to ease any nonphysical fears patients may have.

Going to the Doctor for acute illness or prevention requires a properly created care team to help facilitate the needs of the patient. When patients see familiar faces, appear to be happy in general and invested in the outcome of the patient not focusing on the physician can broaden the opportunities for success.

As the mindset shifts from physician centered to a patient centered care team it is advised that while revisiting staffing models and strengths that a “stay” interview is conducted. Stay interviews should be in addition to behavioral based
interviews for hiring and in addition to exit interviews when employees are leaving. Stay interviews include questions like: Why did you come to work here? Why have you stayed? What would make you leave? What are your non-negotiable issues? Research shows that employee retention can save a business time and money. It is common sense that when an organization has a stellar employee they would like to retain them. Staff development (investment) is one of many ways to retain staff. Fostering employee development could be training to learn a new job skill or offered tuition reimbursement or other variations of development opportunities. There are many ways to reward and retain employees if your goal is to create a tenured team.

Hiring well, by using behavioral based interview questions, conducting ‘stay interviews’, perhaps investing up front by a small amount of starting hourly salary increase to show investment, with the hopes of creating a tenured team and achieving return on your human investment.

Employers need to get creative in the way hiring takes place by considering new types of personnel such as care coordinators, and information technology staff as well as possibly mid-levels who can provide care in collaboration with physicians.
Integrating clinical coordinators into the practice plan and care plan. When reviewing priorities in a practice, an objective evaluation should surround appraising the quality of clinical guidelines, and identifying critical quality measures that are important to not only contracting but long term prevention and health of the patient. The clinical decision support tools are sometimes embedded in the EHR and can also assist in the measuring of the established measures, or may even align with technology goals if achieving meaningful use of your EMR. Often times using the criteria outlined by payor contracts (disease management, smoking cessation, body mass index) is an easy parallel for practices. Deploying effective methods of implementing clinical guidelines can be part of integrating clinical care team members as well as practice specific quality measures.

In a primary care environment moving toward centering the patient, the appropriate care team that includes clinical integration is deployed. Understanding patient needs or preferences can be simply met on the phone or in response to an online inquiry. “Your request is received, thank you”. Just knowing the medical online question or request for appointment did not go to cyberspace may ease the patient. Telephonically can be a sincere “thank you for calling, how can I help you today?” This consistent approach indicates that
patients are the focus. Decrease emotional response to an otherwise perceived negative experience and shut down barriers from the start. Informing customers of how the care team will work with them and for them creates immediate empowerment of the patient. Empowerment of the patient, to put them in the middle of the process as well as integrating clinically can yield positive outcomes. When visiting the medical practice in the patient centered medical practice, customers are welcomed by a familiar face at check in and greeted by a medical team member who shares “My name is Mary and I am your nurse today. I will assist you in your medical needs prior to and after you visit with Dr Smith. We will do vitals, talk through your medical history and our team will help you with your needs today. If you have questions about the process please let me know”. This type of direct communication can make the psychological fears lessen and creates clarity for patients and visit expectations.

Empowering the patient to become the leader of his/her own care also requires empowerment of the care team. Trust and communication are needed in the back office care team as the physician is not the only integral part. Care coordinators, visit planners, case managers help assess the whole patient and needs for proper care plan per the PCCP. Empowerment
should be across the practice including front desk. It is believed that employee satisfaction is seen and carried through to patient satisfaction as care team members are clearly interested and invested in patient satisfaction and comes and not disgruntled employees. A patient recovery tool has been used - a folder called ‘patient recovery’ intended to recover the patient if an error occurred. Recovery items may be a small gift card, a free ice cream coupon or perhaps a toy for a child. Everybody is empowered to use the system as it was intended and judgment is not questioned if for patients. If something went wrong, they can log and record where recovery items were dispensed. Each person from front office to back should be able to offer something to the center if a process failed. The center of a process in the patient centered medical practice is the patient. Elementary example would be if a urine sample was lost or spoiled due to spill (human error not patient safety) and a specimen must be recollected, the care team should be able to show accommodation. Use this simple demonstration of good faith, true caring and acknowledgement creates good will that will help the patient leave a bit more ready. Ready to act on the Doctors orders to get become healthy. The patient interaction and outcome is the goal of the visit with doctor’s orders to improve overall health. If a medical practice can be focused on direct and clarifying communication as outlined above we are well on the way. Communicating with
customers status of their expectations helps meet their expectations. They expected to see the doctor at 9am and if you tell the patient the customer that the doctor is running 15 minutes behind they will know what to expect. Communication, regardless of the message must be interactive, direct and clear. Communication should be clear on all aspects of health, including online communication.

Employee satisfaction shows through to patients and tenure is one way of measuring this. Nonverbal communication plays an important part in communication. If the mindset surrounds the patient and all facets of the visit, the employee or care team member becomes part of the solution to meet patient needs and expectations.

Often, patient needs are not medical in nature, but objective help to find resources. Navigating healthcare and insurance plans is not easy and in some cases may be the cause of non-treatment of medical orders. The aging population and growing frustrations have created opportunities for many medical advocacy firms to be created. Services vary from evaluating insurance options and resolving insurance billing
disputes to firms that aim to facilitate medical decision making it here!!

Navigating healthcare should not rest on the patient, but be part of the care coordination team, who surrounds the patient in the plan. The National Association of Healthcare Advocacy Consultants is one of many methods to seek navigation and educational resources. Care team members can assist patients to find resources in a variety of places, such as: CMS website, local governments, hospital affiliates, and often time navigation and educational opportunities are free. Assisting in the navigation process of healthcare, coupled with education will improve value.

The value we get for healthcare must go up. Health must be increased and the customer should be the leader of the process. Delivery and organizational design must change to sustain a viable business. Achieving this involves a heavy emphasis of implementation of parallel changes in people and work processes and on the interoperability of information systems. New technology must be blended into the social system, workflow, and physicians culture of the organization.

The future state of medical practice must include information technology, data on claims used to manage risk contracts. Comprehensive delivery of care, coupled with health
management capabilities, enables organizations to align reimbursement mechanisms with health strategies.

Having explored the strengths of patient centered medical practices by outlining historical precedence and identifying basic components of moving toward a patient centered medical practice, the new healthcare is ready to read the lengthy NCQA requirements. A strength, opportunity, weakness and threat (SWOT) analysis should be completed to assess the appropriate model and organizational design to participate in.

This exploration foundation and literature will aid the start the analysis and transformation. This exploration and goal is to guide and educate new managers entering into the healthcare industry. Moving toward a patient centered medical practice will require focus and follow up, analysis and collaboration of a medical practice and the way healthcare is delivered today.

Change is necessary for sustainability for managers, administrators, physician leaders and the medical industry as a whole to recognize. Managing and navigating changing market forces while focusing on performance excellence needs to be highlighted.

Opportunities for future research would be encouraged as it is through evaluation and learning that we succeed and make
permanent change. Thank you for the opportunity to participate in MGMA/ACMPE.

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References


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