By Craig T. Williams

Improving the Patient Experience at Your Practice

A practice administrator who recently overhauled his department's administrative functions shares his insights into how others can achieve similar results.

In today's fast paced health care system, we sometimes forget that medical care needs to be centered on the patient. Payers have put providers under pressure to see more patients in less time, which has resulted in care centered not on the needs of patients but the needs of the system itself. As the financial burden of health care begins to shift more and more to patients, it is likely they will begin to choose providers based on how easy they are to work with, evaluating their service standards as well as clinical competency. Improving their satisfaction with administrative and support services will favorably impact both your patients' overall impression of your practice and their future health care choices. Some large group practices conduct formal patient satisfactory surveys so that they can provide insurers and prospective patients with hard data on the quality of their service and the overall patient experience at the practice.

Think about your own practice. Are you organized around patient service? When patients call, do they reach a live person? Do they wait on hold or are they sent directly to voice mail? Do they get transferred around your office without resolving their issues? How about when they arrive for their appointment? Are they greeted warmly upon arrival? Does your waiting room allow for privacy? Do patients leave with all follow up exams, visits and others issues scheduled and resolved? Given the hectic pace of most medical practices, it's easy to overlook these small but significant determinants of patient satisfaction, focusing instead on clinical care. Naturally, that's the most important piece of the puzzle, but patients consider the entire *gestalt* of the encounter when forming their opinions. So should you.

A Coordinated Experience

No one is going to argue against focusing on the clinical needs of patients when we are organizing our office staff and creating systems for patient access. However, when we think about the way we conduct our business, there are many opportunities to improve service.

Many private practices, hospitals and other organizations have undergone projects to transform the administrative activities surrounding a patient encounter. Most of these have a positive financial return on investment. When the focus is put on these administrative activities, new opportunities appear in the revenue cycle. These include improved insurance verification and managed care referral processes, as well as point-of-service cash collections. The financial aspect of health care is very confusing for our patients, so they appreciate upfront efforts to address issues that will prevent their bills from not being covered by insurance or will prevent them from being subjected to "surprise" copays.

One example of a neurology practice embarking on a customer service improvement process is the Brigham & Women's Hospital's Department of Neurology, where I practice. This was a pilot site for a hospital-wide Improved Patient Experience (IPE) program that focused on cultivating a well-coordinated, individualized approach to patient service-both prior to a patient's outpatient appointment and when they arrive for ambulatory care. The overall goal of the program is to offer a standardized customer service approach that supports a more patient-friendly environment.

Before the program was implemented, most of the business functions of the practice occurred at the front desk. This was where incoming phone calls were answered, patients checked in before their visit, copayment collection and insurance verification occurred, and patients checked out after their visit and scheduled any follow up testing or visits. The medical secretaries were responsible for all these duties and were often overwhelmed as they attempted to manage all of them at once.

This was disastrous for the patient flow, and it directly resulted in lost revenue. Copayment collection, insurance verification and referral management were often put on the back burner as the

staff prioritized their work based on the immediate needs of the patients in front of them or on the phone. Telephone management was also poor, as only 75 percent of the incoming calls were answered before the patient hung up. That meant that the practice was losing potential new patients and referrals because they could not get through to make an appointment.

Room for Improvement

The Improved Patient Experience provided our department with a template to reorganize the business processes and patient flow. The front desk "generalists" were allocated into more specialized and focused job descriptions. These positions were:

- The receptionist, who is responsible for greeting the patient, collecting copayments and directing patient to the waiting area.
- The patient access coordinators, who are responsible for all telephone interactions, including visit scheduling and physician messaging
- The patient service representatives, who are responsible for the checkout process including making arrangements for follow-up visits and scheduling tests.

Each of these persons had new, comprehensive job descriptions that created standard protocols for practice management functions specific to their work. They also rolled out a robust training program that included the following modules:

- Telephones, including training on etiquette, automated call distributors and menus, service hours, and voicemail.
- Scheduling at both basic and advanced levels.
- Registration and insurance verification, including basic registration, advanced registration, and insurance verification
- Managed care, which covers everything from basic to advanced managed care and includes referral management.
- Day-to-day practice operations, which include reception, check out, and other practice management topics.
- Customer service, which meant identifying customers, professional telephone techniques, and being aware of the influence of behavior on service interactions.

They also created a core set of metrics around several other areas such as doctor, staff and patient satisfaction; telephones, denials, registration quality, referrals, and point-of-service cash. These metrics were incorporated into a scorecard, which the departmental leadership and physicians used to measure the gains achieved from the program.

Managing the Managed Care Providers

The hospital also created a patient service center to help manage the insurance verification and referral management process. This is a call center that is located offsite from the hospital. Its staff runs electronic queries to participating insurance companies (about 90 percent of our payer mix) for all of our scheduled patients to check that there is a valid referral when required and that the insurance information we have on file is valid. If either the referral or insurance information is missing or invalid, the center works to obtain the correct information by calling the patient, primary care physician or referring MD. The practice is notified three days before the patient's visit about any patient with a problem that will result in a claim denial. This list creates a worklist or "patient flag" for the receptionist to identify patients who need to provide updated insurance information and/or sign a referral waiver or pay for the visit out of pocket.

Finally, the neurology department moved to a newly renovated space. This area was redesigned with the Improved Patient Experience Program in mind and included new features such as a reception desk staffed by a dedicated receptionist who greets and provides service to incoming patients. It also has an independent "check-out" area comprised of private offices, where patient services representatives help patients to schedule or coordinate follow-up appointments, explain financial matters and make payments, and triage other follow-up needs. And patient access coordinators now manage all incoming calls in a separate, private location and with the help of a revised, more user-friendly phone menu.

While BWH may have had a unique opportunity to introduce so many changes to its facility, a smaller practice may also be able to implement some of these ideas when working to improve patient experience. For instance, a private practitioner could still make the reception area more organized by setting aside areas for patient checkout and incoming calls, putting as much privacy between the two areas as possible. Having staffers get insurance information when collecting the information from a referral and submitting an electronic query before the appointment can also help to prevent payment problems.

Measurable Outcomes

The effect of IPE has been measurably beneficial. The telephone answer rate has increased to an average of over 95 percent (up from 75 percent) and the copayment collections increased by 40 percent over the prior year. In addition, insurance denials for registration and managed care referral issues were cut in half. Not only has patient satisfaction increased—physician satisfaction has increased as well, with many of our neurologists commenting on the smoothness and professionalism of the practice staff in this model.

By participating in the Improved Patient Experience Program, BWH's neurology department aimed to redefine the patient experience by focusing on areas that make for a more pleasant, efficient and convenient ambulatory visit. In the process, we improved the overall workings of the practice itself, and continue to reap the benefits. **PN**

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