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the State of Medical Practice

How do you encourage patient responsibility?

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It has become imperative for us to focus on patient outcomes and ask ourselves, as practice management professionals, how we can help patients assume more responsibility for their care. Innovation in this area has become a major focus as scrutiny to providers will continue to increase.

One example: use of the Hospital Consumer Assessment of Healthcare Providers and Systems' (HCAHPS) ongoing measurement of treatment outcomes and experiences of care (especially for medical groups directly associated with health/hospital systems). To assess how HCAHPS has influenced processes, we asked members on the MGMA Member Community (community.mgma.org/home) for ways they have enabled patients to co-create care experiences and improve treatment outcomes.[1, 2]

We identified noticeable trends, such as extensive patient education and the use of ancillary providers, pre-visit education and direct calls to increase patient responsibility, compliance and preferred outcomes. Trends like these offer suggestions for future research to help ensure optimal patient satisfaction and establish better treatment outcomes.

Co-creating care

The impetus for this research was a personal care experience with a local health system that made me (Lieneck) recognize that a successful treatment outcome required an obligation for self-care. It has also been described[3] as a patient's responsibility to "co-create" a treatment experience to fulfill his or her end of the bargain as required by condition, diagnosis and care plan. (See sidebar.)

Current practice

We received 50 responses that included 10 physician groups that are associated with larger network systems that receive HCAHPS outcomes assessments for Medicare patients.

Important, underlying constructs identified in overall sample responses (n=50):

- While we expected an ongoing push for electronic patient education materials, more than half of the respondents said that tangible, paper patient education materials were still distributed during office visits, often in conjunction with verbal orders for patient responsibility. Examples include weight loss, smoking cessation, and/or other community health initiatives.

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- More than 75% of respondents claimed that patient education (such as telephone counseling or website resources) was initiated before patient visits. Examples offered by survey participants involved administrative actions, such as scheduling procedures, office location information and contacting clinical staff. Only five respondents referenced clinical patient education efforts before an episode of care or office visit (for example, fasting prior to a clinical laboratory blood draw and/or coming to the office visit prepared to provide a urinalysis sample at the beginning of a scheduled appointment time).

The 10 respondents associated with larger health/hospital systems stated that HCAHPS patient experience of care surveys affected their patient co-creation and patient education efforts, with several categories of results summarized below (n=10):

- Respondents noted a significant increase in the documentation of patient education efforts in addition to regular patient care efforts. Responses included EHR documentation of printouts, staff phone call inquiries/responses and patient counseling visits directly related to patient co-creation in the treatment process. All practices in this category reported beginning the education before the episode of care (appointment) and continuing after the office visit.
- Economies of scale associated with a larger health/hospital system were noticed in this response category. For instance, the use of allied health providers, such as social workers, counselors and other ancillary providers, were referenced as resources to aid in the patient

Examples of effective care co-creation	Examples of ineffective care co-creation
Patient is prescribed medicine to treat a condition and takes it as prescribed.	Patient reduces frequency of pills taken, cuts pills in half or does not get the prescription filled in an attempt to reduce out-of-pocket healthcare expenditures.
Patient fasts appropriately before a morning blood draw for laboratory processing.	Patient does not follow fasting instructions the night prior to a blood draw and receives inaccurate laboratory results.
Patient receives a physician's recommendation to lose weight by maintaining a healthier diet to limit current symptoms.	Patient does not alter his or her regular diet, thus continuing to experience (or possibly increase) symptoms.
Patient receives physician order for physical therapy three times/week in addition to pain medication for joint pain.	Patient continues to take the pain medicine as prescribed yet does not participate in prescribed physical therapy sessions.
Patient is honest, clear and forthcoming with information during a routine physical examination. All medical treatments, including alternative medicine practices, are disclosed to a physician.	Patient does not involve the physician in alternative medicine experiences, and disclosure of any/all specialist care is vague and/or not mentioned at the annual exam.

Source: Cristian Lieneck, PhD, FACMPE, FACHE, FAHM, MGMA member; Michael Mileski, DC, MPH, MSHEd, LNFA

co-creation experience. Additional system resources (information technology and dietary) were also noted as support of this initiative.

- All respondents mentioned termination of the physician-patient relationship as a viable option if a patient did not comply with medical advice and/or treatment requirements. Almost all responses referenced the physician's overall decision as final authority in the case of patient noncompliance and/or a lack of co-creation, regardless of practice documentation. However, seven of these 10 respondents referenced a "three strikes and you're out" policy for patients who do not adhere to prescribed services and recommendations (medications, skilled therapy, diet restrictions, etc.).

As we continue to concentrate on outcomes and measurement of quality indicators, it is imperative for practice leaders to pursue these initiatives into their workflow and processes to include patient co-creation requirements and assessment.

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