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Connecting you to the Heritage Provider Network

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EXCLUSIVE

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Heritage Provider Network believes in the power of social media. That's why we've partnered with Main Street Hub for an exclusive offer for Heritage Provider Network physicians. *Continued*...P7

WHAT'S INSIDE

EDITORIAL

The practice of medicine has been transformed in the last decade. I'm not referring to the obvious technological advancements, but to the more subtle evolution of medicine as a business. Patients are now savvy healthcare consumers, who approach their medical care with a whole new set of expectations.

Baby Boomers, the largest segment of the healthcare consumer marketplace, particularly value the patient experience. In order to succeed in this new environment, we, as healthcare providers, must adapt to these new expectations.

This shift in the healthcare delivery model requires a new approach to patient care, one that focuses on improving the patient experience. Providers must now focus on customer service, quality, access and cost-effectiveness in order to be successful.

Critically important is care coordination, something Heritage Provider Network excels at. Effective care coordination results in better outcomes and higher patient satisfaction. In this issue, you will find information on some of the care coordination programs we have available to you.

HPN is aware that improving the patient experience is crucial to our ability to thrive and grow as a medical group. We will be focusing on helping our providers improve the patient experience throughout the entire spectrum of care.

Richard Merkin, M.D.
President and CEO of HPN

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FEATURED STORY

Patient Engagement

Meeting Consumer Expectations

Providing quality care is no longer only about practicing medicine. Now, more than ever, physicians and their clinical and administrative support staff must remember that they are not just treating patients. They are working with well-informed, well-connected customers.

Under the old model a physician's education, certification and years of experience did all the talking. These credentials carried with them an assumed expertise, and patients rarely looked any further when selecting a new physician. The new engagement model is about transparency and consumer perception. Modern consumers are not afraid to share experiences and opinions in very public forums and it doesn't take long for an individual's experience to become a market perception.

As savvy consumers turn to the Internet and social media to comparison shop, they look for the best value proposition whether they are considering a retail purchase, or medical services. They want not only the best clinical benefit for their healthcare dollar, but also the right service experience. The patient, as a consumer, expects to be treated well by everyone.

In the face of this increasing consumerization of medical services, physicians must take the initiative to structure their practice as a business. Like any business, it is also a brand. In order to build brand loyalty, customer service must be an integral part of the business model and engagement strategy. Successful practices will be mindful to provide their customers with what they want.

What Do Consumers Want?

- **Consumers want more for their money**
- **Perception is the truth in the eyes of the consumer**
  - Transparency in quality and delivery on promise
- **Customer centric culture in the doctor's office**
  - Personal interaction – treat the patient, not the chart
  - Customer service needs to be a competence instead of a function
  - Focus on customer emotional needs, not just clinical outcomes

In the current market the success or failure of a practice depends upon how it is graded by its customers. In response, our industry has made a significant shift in how they define best practices, judging physicians not only by the quality of their care, but also by the level of their customers' satisfaction.

Checklist for Gauging / Improving Customer Satisfaction

- ☑ Customer Satisfaction Surveys
- ☑ Customer Service Training
- ☑ 5 Star Rating
- ☑ Facebook Comments and Likes
- ☑ Twitter Engagement
- ☑ Yelp Reviews
- ☑ Ease of Online Searchability
- ☑ Reputation Monitoring and Management

For tips and more information on how to engage customers online, please see page 7.

Patient–Centric Care

Making a positive impact through specialized care programs

Bakersfield Family Medical Center (BFMC)
The Weight Management Program

BFMC Health Education Department offers patients a Weight Management Program that has lifelong results. The six-month program encourages healthy weight loss, but is much more than a diet; it's a change in lifestyle to improve overall health. The program helps patients gradually change life-long habits related to nutrition, physical activity, and behaviors that affect well-being. After the six-month program, participants will have the skills and strategies needed to continue on their path to a healthier lifestyle.

The philosophy of our Weight Management Program is to empower our patients to adopt a healthy and balanced lifestyle. We recommend weekly goals; however, their drive, motivation, and readiness are the most powerful indicator of success in the program. We provide the tools and the patient is responsible for putting those tools to use.

Patients may be referred into the program by their provider, or they may self-refer. On the first visit, height, weight, and measurements are documented, along with the calculated Body Mass Index (BMI). Our Health Education Registered Dietitian (RD) instructs the class on the importance of attendance, completion of food diaries, exercise logs, goal sheets and class assignments. We encourage the patients to register at **www.myfitnesspal.com**. Patients attend a weekly two-hour class for the first nine weeks and then meet individually with our dietitian every two weeks until the program has ended, and/or the patient has lost ten percent of their body weight.

A new Weight Management Program began in August 2012 and the Health Education staff tracks the thirty-two enrolled patients on their BMI and weight change. After four months of participating in the program, BMI decreased by an average of 1.6 per patient and the average weight loss was 10.41 pounds per patient. Final measurements, total weight loss, BMI change, Hemoglobin A1C labs, lipid panels (labs are performed at the beginning, middle, and end of program) and Patient Satisfaction Surveys will occur in February 2013.

The Health Education Department is constantly reviewing patient feedback and adjusting the program as needed. Some of the patient comments from the August series have been;

"Cutting out certain foods and knowing healthier choices is helpful," "Class info was a good reinforce for me – I knew these things, but I didn't practice them," "I am very happy to be enrolled in this class; I am thrilled about this program," The most help has been the accountability and weighing in each week," "Class is informative and motivating," "I learned new and helpful things."

Class participants who complete the Weight Management Program report that of all the "diets" they have tried, BFMC/HPN's program has been the most practical, informative, and effective for overall improvement in weight and health.

Our goal is achieved when patients learn to make better choices with regard to nutrition and lifestyle, resulting in reduced risk for disease complications.

High Desert Medical Group (HDMG)
Care Coaching Program

In the United States, seventy-five cents of every healthcare dollar spent is related to a chronic disease. With limited resources, we are required to develop innovative approaches to meet our patients' needs; an approach that HDMG has implemented is Care Coaching.

Care Coaching helps the patient utilize the care plan that the provider has established and empowers the patient to take the lead in managing their health condition. The Care Coach collaborates with the patient to identify the aspect of managing the health condition that they would like assistance with. For example, many patients ask for help with their diet and the Care Coach provides dietary knowledge and skill education. To support the diet change, the Care Coach calls the patient weekly to provide encouragement, answer questions, and help the patient to set small goals. Care Coaches also take on the role of Care Coordinator, assisting the patient to schedule and complete routine preventive care, such as eye exams and lipid screenings.

Our data indicates that patients actively engaged in Care Coaching see a one to three point improvement in their hemoglobin A1C labs. Care Coaching allows HDMG to provide on-going interaction with our patients outside of the clinical setting, and helps our patients to feel more confident in their ability to take care of their health.

Desert Oasis Health Care (DOHC)
The Disease Management Program

In 2009, the estimated direct and indirect cost of treating heart-failure patients in the United States was more than $37 billion. The average stay lasts about 5.8 days, and as many as 25% of heart-failure and COPD patients are readmitted within 30 days of discharge.

- The understanding is that repeated disease flare ups or exacerbations to the heart or pulmonary system cause weakening of the heart, lungs, and affect other body systems with resultant decreased likelihood that patients will return to their previous baseline.
- RN's manage higher acuity Congestive Heart failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD) patients. LVN's assist with managing patients who are relatively cardiac stable or that need reminding regarding different aspects of their disease process or self management plan of care but for whom utilization or non-adherence may be an issue.
- Collaboration with Nurse Practitioners and the Cardiologist provides medical support and case management provides whole patient support for not only the above disease processes but for other coordination of care and whole person issues.
- Referrals come from many sources
  - Hospital case managers may identify and refer patients who have had frequent utilization of the Emergency Department or hospital admissions.
  - Primary care providers may refer a patient they feels would benefit from more intensive education about medications, diet, exercise or their disease process.
  - Social services or case managers of other programs may identify a patient as being able to benefit from the services provided.
- Case managers manage the patients so not all patients are automatically sent to the Cardiology clinic for appointments, the focus of the program is to provide the necessary education and risk assessment for admission and to refer only those patients who truly need the intervention of an expert provider to prevent hospitalization.
- Health risk assessment to help to identify the patient's risk factors, and an assessment of the patient's physical and psychological condition helps guide the action plan for care.
- Assessment of modifiable risk factors such as diet, smoking, obesity, cholesterol levels, exercise level and stress levels.
- A clinical services assessment tool is used to identify issues such as Durable Power of Attorney (DPOA), Physician Orders for Life Substantiating Treatment (POLST), depression screening, functional levels, medications and assess the patient's level of understanding of what they know about their disease process and medications prescribed as well as their level of readiness or motivation to change their current behaviors and replace them with healthier ones.
- Education, re-education, patient and family support as well as assistance with coordination of care are key functions of the program.
- To reduce hospital admissions or readmissions, the use of remote biometric monitoring devices that can identify trends and changes in the patient's status, allows for more real-time changes in patient's plan of care.
- As the disease process continues to progress the disease management staff assist the patient to begin the preparation for the progressive deterioration of their health and elicit the collaborative assistance of palliative care or hospice.

What is Success to our Patients?

- Satisfaction with not only their disease manager but with the extra years they have gained to spend time of their loved ones and their increased enjoyment with their life.
- Patients will frequently return to speak to their disease managers and express how helpful the educational process and coordination of care with other providers and referrals has been.
- Several of the disease managers have received positive feedback and recognition through "care" cards. We seek to help the whole person even though our primary focus is on disease such as coronary artery disease, congestive heart failure or chronic obstructive pulmonary disease.
- In the words of one patient they are *"angels who are all things to us. They are so patient when we feel at our worst. They may cajole, encourage and support us when we need it most. They even tell us when we need to straighten up and pay attention if we want to live longer."*

Regal Medical Group (RMG) and Lakeside Community Healthcare (LCH) **OB/GYN Care-Improvement Program**

RMG and LCH recently implemented a one-of-a-kind OB/GYN Care-Improvement Program under the direction of Dr. Jim Ingaglio (OB/GYN), with fantastic results. **The program objective:** *Improve utilization and safely shorten length of stay.* **The method:** *Practice preemptive, rather than reactive, medicine.*

The RMG and LCH medical management team engaged the cooperation of forward-thinking OB/GYN physicians within their provider networks. By working with solution-minded individuals, the team was able to foster intense collaboration, which led to the rapid identification of key issues and the strategies needed to resolve them.

Once strategies were defined, the team quickly implemented the program's operational, educational and procedural changes.

- Simplification and streamlining of the prior-authorization process according to ante-partum testing/fetal surveillance guidelines.
- Establishment of regular and consistent communication to avoid missed opportunities and over-ordering of tests.
- Education of OB/GYN network regarding the program.
- Collaboration with Johnson & Johnson/Ethicon to institute single-site laparoscopy to promote faster healing and safer, earlier discharge of GYN patients.
- Development of a screening test using cervical length measurements to predict a mother's risk for pre-term labor and to proactively treat them with progesterone to prolong the pregnancy. This will allow the opportunity to give the mother steroids to speed up fetal lung maturity if needed, so if the baby winds up in the NICU, he/she will be in better shape.

To further ensure success, the team also implemented the Mommy & Me Safe and Secure Aftercare program. This program provides for voluntary hospital discharge after 24 hours for vaginal deliveries and 48 hours for C-section deliveries by providing home care, education and assistance for new mothers and their families. Under Mommy & Me, new mothers without medical issues calling for hospitalization are able to safely leave the hospital and receive special at home care and training including home health visits, newborn care training to promote baby's health, and postpartum assessments, care and follow-up to promote mom's health and well-being.

Overall results under the entire program were very impressive. Before the program, only 5% of mothers eligible for safe discharge were released from the hospital within the 24 to 48 hour window. After program implementation, safe post-partum discharge rates rose between 41% and 63% in 2012 (depending on the campus). Thanks to the success of the program, it is due to be rolled-out to select HPN affiliates in the near future.

Sierra Medical Group (SMG) **Disease Management Coumadin Clinic**

SMG believes that disease management is the foundation of better healthcare. By providing coordination between healthcare providers, efficient processes and information sharing, timely interventions, and improved communications, we are able to create and maintain effective disease management programs such as our Coumadin Clinic.

SMG's Coumadin Clinic offers assistance to both in-house and IPA providers with anticoagulation therapy management for their patients. Having a specialized program increases coordination of care while eliminating duplication in care, services provided are improved, and individualized attention to each patient becomes possible.

Communications between the Coumadin Clinic coordinator, pharmacist, patient and primary care physician focus on transitions in care as well as everyday follow-ups, which include patient education, compliance counseling, blood draw reminders, and regimen adjustments. Through targeted interventions, we have had no adverse drug events due to anticoagulation therapy after enrollment in the Coumadin Clinic in the past year.

The dedicated anticoagulation therapy management provided by SMG's Coumadin Clinic is only one example of how disease management programs can improve healthcare quality, delivery and patient satisfaction. By constantly improving our disease management programs, we will continue to provide the guidance and education necessary to encourage our patients to partner with us to improve their health.

Testimonials:

" The pharmacist is absolutely wonderful and so kind… I couldn't be happier!"

" I'm being carefully managed and well taken care of… I'm very satisfied."

FEATURED STORY *continued from P3...*

TIPS for Engaging Customers Online

1 **Go to Them –** Don't expect your customers to come find you online. Having an appealing website, blog or Facebook page isn't enough to draw customers in. Research to find out where your customer demographic congregates online and meet and engage them there. If you do, customers will look for you elsewhere online.

2 **Platinum Rule of Communication –** Communicate with your customers the way that they prefer, not the way that you do. Some customers may resent you using up their phone minutes with a call, or prefer texting over e-mail. Never assume; if you're wrong you risk being ignored, or worse, resented.

3 **Write for Your Audience –** Remember, you're connecting with patients, not other doctors. Make sure you use appropriately accessible language and remember that online readers scan and skim. Keep things brief and weave appealing graphics in with your text.

4 **Platinum Rule of Engagement –** It's about what interests your customers, not you. Go back to those places where they *"hang out"* online and pay attention to what they're responding to. Are they engaging in online Q&A about general health tips or looking for chunks of condition-specific information? Create similar opportunities and content for them on your blog and pages.

5 **Pay Attention –** Use tools like Google Alerts or Yelp reporting to stay on top of what customers post about you and your practice. Consider and absorb what they've posted and respond promptly and courteously using language that not only shows that you've heard what they're saying, but also that you actually respect what they're feeling.

6 **Let Them Contribute –** Ask your customers for input. What works for them? What would improve their experience? If you implement a customer suggestion, give them credit.

7 **Say Thanks –** Often. And mean it. These are your customers. They don't have to spend time with you or patronize your business and they know it. Do you? Thank them sincerely after every online and in-person encounter. It's simple and doesn't cost you a thing, yet there is nothing like it for building positivity and loyalty.

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