

# Implementing Practice Management in Local Health Departments

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## DPH Consultant Guidance

Developed for DPH Consultant Training  
2/12 -2/14/14

DPH Consultants included Training and Technical Assistance Nursing and Administrative Consultants, Child Health, STD/CD and Women's Health  
Training was targeted to DPH Consultants providing the majority of administrative and clinical services.

**Tips for Starting Practice Management (PM) Implementation  
In Local Health Departments (LHD)**

## **Reminders:**

- The LHD may not be using HIS so you need to assure they can collect the data needed to make their initial assessment (report names/numbers may be different from HIS) and the LHD may have to share data with the consultant if it is not accessible through HIS.
- The LHD needs to submit their data and assessment materials so that consultants can review prior to the site visit. This includes reducing raw data to manageable components using DPH Data Dashboards.
- The LHD must designate a PM leadership team prior to the initial meeting.
- The initial meeting with local staff should be with PM Team or the PM Lead, Health Director, DON/Supervisor, Management Support Supervisor and Finance Officer.
- A Lead Consultant and Administrative Consultant should work together on assessing data. Other consultants will be involved based on the agency request, how services are delivered in the agency (open access or specific services on specific days), staffing patterns and areas of concern.
- If the agency has concerns about generating additional revenue or funding, budget cuts or the exhaustion of fund balances consider what services other than clinical the agency is offering or has the capacity to provide such as outreach (Postpartum Home Visits, Skilled Nurse Visits, Case Management) and community services (partnering with other agencies or providers) to meet the needs of the community. It is important to be familiar with funding and payor sources that generate revenue for the agency.
- PHNs must be providing services through approved Standing Orders that are current and written in the Board of Nursing format.

## **Steps for the DPH Consultant to Prepare for the initial Visit**

1. Identify the number of services by program the agency is providing by the week or month. Compare this to the no show rate and number of open appointments (provided by the LHD) to assess demand and capacity for the agency.
2. Review provider visits per day and nurse visits per day to compare to PH benchmarks. Also, review the average number of total visits per day for the agency.
3. Review the services by provider report to make sure that RNs or Lab staff are not billing E&M codes and providers are not routinely billing 99211 nurse visit codes. Also assure the RN is not billing other E&M codes that are outside her scope.
4. Encourage the use of LU Codes to assist agency with accounting for staff productivity; however, this may not be possible for agencies using Patagonia or Cure MD. For example, if a CH ERN completes a physical assessment for a client but requests the provider evaluate client for abnormal findings, the provider will bill for the well child visit and the ERN will use a LU code to also get credit for providing services to the client.

5. Review the staffing model, Clinical Data Staffing Worksheet, Clinical and Clerical Staff duties Matrixes and Data Summary tools developed by the agency to assess utilization of staff. May need to ask more questions ahead of time or when you meet with the PM team/coordinator.
6. When looking at the agency staffing model, assess the amount of administrative time that each staff member is allotted. Often times, staff are allotted a certain amount of administrative time because “it has always been like this” instead of addressing the volume of tasks each staff member is assigned.
7. Administrative Consultants need to review the Data Dashboard and assess any outstanding billing, EOB follow-up etc.
8. Clinical Consultants need to review the Clinical Data Dashboard to assess utilization of staff and service demands.
9. May need to plan a date to observe clinic flow using the Value Stream Map to observe waste in the clinical flow and identify processes for improvement to test using PDSA cycles. For consultants who have not completed the QI 101 Training this might be an observational assessment of clinic flow to look at areas for improvement such as duplication of services, decreasing time clients wait for services in the process or the number of stations the client stops at for services, whether all steps in the process are necessary, whether steps can be merged and the layout of the clinic to decrease steps for the provider and client.
10. May need to conduct a billing and coding audit to assure LHD has coded and billed services correctly otherwise, quality improvement work may be based on flawed data.

### **Programmatic Clinical Assessment Issues/Questions To Assess and Consider**

#### **Administrative**

1. Registration/Intake staff may be cross trained to provide all services for registration and billing or the processes may be separated based on the physical layout of the agency. There must always be more than one person trained to do each process.
2. Review tasks that each management support staff is doing. Often times this will reveal duplication of effort or performing tasks that are no longer necessary.
3. There needs to be good communication between clinical and management support staff. Many of the problem areas that are identified are due to communication issues (i.e. change made in registration process that clinical staff is unaware of-impacts flow)
4. It is critical that the LHD be aware of the “cost of doing business”. The ability to determine how much it costs to provide services, and to make changes, can have a major impact on your bottom line.
5. Effective implementation of any Practice Management strategies will likely require a culture change within the organization. The Health Director and PM Team will need to be committed and supportive of the process and keep the staff on board and moving forward.

6. All clinical staff should account for their time using Local Use Codes even if the services are not billable.

### **General Recommendations for Clinical Area and Clinical Services**

1. Encourage all exam rooms to be stocked the same.
2. Forms and supplies should be centrally located in the rooms or clinical area to avoid excess movement of staff and lost time in the clinic.
3. Remember the 5 S's – Sort, Set In Order, Shine, Standardize, Sustain
4. Nurse visits should be placed on a separate schedule than provider visits to increase the number of available appointments for the provider. This will increase staff productivity by preventing staff from sorting through charts to decide which chart the staff member wants to select. Nurse visits include: BP checks, TB skin tests, immunization only visits, Depo, pill pick-up, STD treatments, and pregnancy tests.
5. When providing clinical or administrative duties staff should not be multi-tasking so much that they are inefficient when providing open access services.
6. In general every process should have more than one staff person who is trained to provide each task.
7. Utilize CHAs for problem visits. Interpreters can be trained to obtain vital signs and chief complaint if the clinic has a high number of non-English speaking clients.
8. May recommend a billing/coding training from PHNPDC to ensure providers are not under coding.

### **Child Health**

1. If the agency's no show rate is high, ask agency staff how far out they are scheduling appointments. Preventative visits should be scheduled in advance for clients under 2 years of age and for follow-up visits that are needed in less than a month. An agency should not schedule preventative visits 1 year in advance because this will increase the no show rate.
2. Schedule a time to assess clinic flow and recommend use of best practice flow models for well child visits and pediatric primary care visits. Recommend all parent completed BF forms (initial history, pre-visit questionnaire, developmental screening, etc.) be provided to parent/guardian at registration desk. Encourage vision & hearing screening to be completed in exam rooms to limit the number of steps a client makes (if exam room size allows this to be done).
3. Support providers with 1-2 clinical staff to function as a team. Support the CH ERN as a provider as well to increase productivity and revenue. More than one staff member should be cross-trained to provide services.

4. Review referral/follow-up process to make sure staff are not tracking unnecessarily. For example, the required referral for clients 3 years of age and older to establish a dental home do not need to be tracked. Providers can offer parent/guardian a list of local dentists and advise them to schedule an appointment. Providers will document the referral under plan of care. There is no need to continue tracking the client.

### **Family Planning**

1. Assess waiting times for new and annual exams. Clients should be seen ASAP but no more than two weeks out. Consider Quick Start/Advance Start methodology as needed.
2. Schedule a time to assess clinic flow and recommend use of best practice flow models. Obtain labs after the provider evaluates the client as much as possible. Sometimes a pregnancy test may be needed prior to the provider exam.
3. Assure that providers (including RNs) are utilizing the appropriate modifiers (FP, UD) for services and contraceptives. The UD modifier is not placed next to the preventive or E&M codes on the encounter form. The “UD” modifier is used only when 340b purchased contraceptives are provided to the client and billed to Medicaid.
4. Assure that nursing staff are not providing detailed contraceptive education to every client unless requested or identified as a need. Information on all contraceptive options must be provided to new clients but this information can be provided by utilizing other venues such as providing the *Birth Control Facts* brochure for review while the client is waiting to see the nurse or provider. Target education based on the needs of the client. Sometimes you provide education by reviewing prior responses and asking a question such as “are you continuing to” or praising the client for initiatives they are doing to improve and maintain their health. Education classes are not required for teens or any FP client.
5. Avoid administrative programmatic time to review all FP charts at the end of the day or another day. The nurse discharging the client should do a quick audit for documentation compliance and completion of the encounter form
6. Avoid providing primary care services in FP that are not related to problems associated with the client’s contraceptive method. Refer to the memo dated 6/22/11 on coding and billing follow-up encounters in the FP Clinic.
7. Avoid giving clients appointments for supplies including Depo injections. Clients can be placed on a pending clinic schedule (such as a Saturday clinic) for appointment reminders and tracking no shows.

**FP Clinic Change Requirements:** If agencies decide to close FP clinical services or add sites for clinical services a request must be submitted to the Office of Grant Management (OGM) to identify a change in scope of service. This request **must** be submitted **prior** to the opening or closing of any Title X clinic sites. A detailed letter must be submitted to the Women’s Health Branch and Regional Title X Office explaining your clinic closure process. Please include the following: 1) your process for informing the grantees; 2) when the clients were informed; 3) the method used to inform the clients of this closure; 4)

how the clients' medical records were secured; and 5) what provisions were implemented to ensure that clients are not lost to care.

### **Maternal Health**

1. Validate that services are coded by the visit even if they are not billed by the visit (package billing). There should already be a process in place to track how visits are billed.
2. Avoid scheduling entire clinics for New OB histories unless the need is there. Try to move this process into an RN schedule if possible. Consider whether there are components of the New OB exam that can be done at the time of the pregnancy test if the client is going to seek prenatal care at the LHD.
3. If the agency uses MH routing sheets, complete these at discharge for the next appointment.
4. For agencies who continue to copy information to be mailed or delivered to Labor and Delivery at the hospital, avoid pulling charts multiple times for review. Identify a process to identify charts that need copying as clients are discharged.

### **STD**

1. Symptomatic clients or contacts to a diagnosed case should be assured an appointment within one working day of request for service. If an agency is unable to accommodate the client within one working day a referral to an alternative care provider is required.
2. HIV, Gonorrhea, and Chlamydia testing is a standard requirement for each STD exam. Appropriate CPT codes should be indicated. Exception: Agencies are not required to provide Chlamydia testing to male clients or female clients that do not qualify for testing performed by SLPH. Clients may opt-out of HIV testing.
3. Syphilis testing is a standard requirement for each STD exam unless the client has been tested with in the last 30 days. Appropriate CPT code should be indicated.
4. ERRNs must use "T codes" when billing Medicaid. 99211 can be used if billing private insurance with client's permission.
5. STD clients may be charged for STD testing not provided by the SLPH or conducted in-house i.e. herpes serology, Hepatitis C, or Chlamydia testing for males. STD clients may be charged for follow-up treatment of genital warts after the initial diagnosis is made.

## What is 5S?

A workplace organization method that helps standardize work areas and improve work flow by eliminating hunting for items.

## What is the S in 5S?

The names of the five phases come from five Japanese words that start with **s** both in Japanese and in their English translation: *seiri*, *seiton*, *seiso*, *seiketsu*, and *shitsuke*

- **Sort** (*Seiri*) – Remove any unwanted/unnecessary items from the area.
- **Set in Order** (*Seiton*) – Place the needed items back into the work area in an organized and efficient manner.
- **Shine** (*Seiso*) – Clean! Inspect while cleaning. Make cleaning easier by creating “home” locations for cleaning supplies.
- **Standardize** (*Seiketsu*) – Utilize visual controls and establish rules to control the first 3 S’s.
- **Sustain** (*Shitsuke*) – Train and communicate the success of the 5S project so all potential users of the area understand. Use a scoring system as a visual control to protect the area from backsliding.

## Goal of 5S

*Which results in improved . . .*

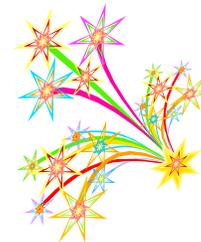
- Control
- Efficiency
- Visibility
- Safety

*And thus . . .*

- Reduced waste
- Reduced cost



**5s is foundational!**



If you cannot do 5S, you cannot do quality improvement.