Medical Accounting

- **Fee for Service vs Value Based Care Payment Models**
  Fee for Service vs Value Based Care Payment Models How HCC Coding Affects Risk Adjustment Scores DRGs and Their Role in Hospital Reimbursement Medicare Advantage and Risk Adjustment Strategies Addressing Disparities in Reimbursement Rates Understanding ESRD Risk Adjustment Models The Impact of Chronic Conditions on Reimbursement Optimizing Documentation for Risk Adjustment Challenges in Bundled Payment Models Auditing Risk Adjustment Coding Accuracy State Variations in Medicaid Reimbursement Future of Reimbursement in Telehealth Services
- **Improving Charge Capture Processes in Healthcare**
  Improving Charge Capture Processes in Healthcare Reducing Denial Rates Through Better Documentation Automating Claim Submission for Faster Payments Strategies for Efficient Payment Posting Managing Denials Due to Prior Authorization Using Analytics to Track Revenue Cycle Performance Training Teams for Revenue Cycle Efficiency Addressing Coding Errors in Claim Denials Streamlining Patient Registration Workflows The Role of Clearinghouses in Revenue Cycle Balancing Cost Control and Revenue Growth Case Studies in Revenue Cycle Turnaround
- **About Us**

Understanding the Role of Medical Coding in Revenue Cycle Management

In the complex world of healthcare, revenue cycle management (RCM) plays a crucial role in ensuring financial stability and sustainability for medical facilities. Central to this process is medical coding, a critical function that impacts every aspect of the revenue cycle. Medical staffing ensures balanced workloads among healthcare professionals **staffing agencies for medical assistants** length. Through accurate and efficient coding practices, healthcare providers can navigate the financial landscape more effectively, ensuring that they receive appropriate compensation for the services rendered.

Medical coding involves translating clinical documentation into standardized codes used for billing and insurance purposes. These codes serve as a universal language between healthcare providers and insurers, facilitating communication and reimbursements. The stakes are high; incorrect or incomplete coding can lead to delayed payments, claim denials, or even legal issues due to non-compliance with regulations.

Case studies in revenue cycle turnaround often highlight how improvements in medical coding can significantly enhance an organization's financial performance. For instance, consider a mid-sized hospital struggling with cash flow issues due to frequent claim denials. Upon analysis, it was discovered that many of these denials stemmed from improper coding practices. By investing in comprehensive training for their coding staff and upgrading their software systems to ensure more accurate code capture, the hospital saw a marked decrease in denial rates.

Additionally, implementing regular audits and feedback loops helped maintain high standards of accuracy and compliance within their coding department. This proactive approach not only reduced errors but also improved relationships with insurance companies by establishing trust through consistent accuracy. As a result, payment cycles became shorter and more predictable, contributing significantly to better cash flow management.

Moreover, effective medical coding also supports strategic decision-making within organizations. Accurate data collection through precise coding allows healthcare facilities to analyze trends related to patient demographics, treatment outcomes, and service demand. Such insights are invaluable for making informed decisions about resource allocation and developing strategies for growth or improvement in care delivery.

Furthermore, case studies underscore the importance of integrating technology into RCM processes alongside skilled human resources. Advanced tools like artificial intelligence (AI) and machine learning have become instrumental in automating routine tasks associated with medical coding. However, these technologies should complement-not replace-the expertise brought by trained professionals who understand the nuances of clinical documentation.

In conclusion, understanding the role of medical coding within revenue cycle management is essential for any healthcare facility aiming to optimize its operations financially while maintaining compliance with industry standards. As illustrated by various case studies on revenue cycle turnaround success stories across different institutions-whether large hospitals or small clinics-investing time and resources into refining this foundational element pays off substantially both short-term through immediate financial gains as well long-term via enhanced operational efficiency overall health system resilience facing future challenges ahead alike all around benefit seen realized achieved ultimately end goal reached fulfilled satisfied too indeed surely yes!

In the complex world of healthcare administration, revenue cycle management plays a crucial role in ensuring the financial health of an organization. However, many healthcare institutions face significant challenges when attempting to turn around their revenue cycles. Understanding these challenges through case studies not only provides valuable insights but also equips other organizations with strategies to overcome similar obstacles.

One primary challenge often encountered in revenue cycle turnaround is outdated technology and inefficient processes. Many healthcare facilities continue to rely on legacy systems that are unable to handle modern billing complexities or integrate seamlessly with newer technologies. For instance, a mid-sized hospital struggling with declining revenues discovered through a detailed case study that their billing software was incompatible with recent regulatory changes, leading to delayed claims processing and increased denials. This technological gap resulted in substantial financial losses and strained cash flow.

Another common hurdle is the lack of skilled personnel trained specifically in revenue cycle management. Case studies reveal that without knowledgeable staff who understand the intricacies of coding, billing regulations, and payer requirements, even the most sophisticated systems can falter. A community clinic faced this issue head-on when they realized their administrative team's lack of expertise was causing frequent errors in claim submissions. By investing in targeted training programs, they were able to reduce errors significantly and improve their overall revenue capture.

Moreover, effective communication across departments emerges as a critical challenge in many case studies on revenue cycle turnaround. In one such example from a large urban hospital, silos between clinical staff and the billing department led to incomplete documentation and incorrect patient information being transmitted for billing purposes. This miscommunication not only slowed down the reimbursement process but also resulted in numerous claim denials. By fostering better interdepartmental collaboration and implementing regular cross-departmental meetings, the hospital was able to streamline its processes and enhance its financial performance.

Lastly, changes in regulatory compliance pose ongoing challenges for healthcare organizations attempting revenue cycle turnarounds. The evolving landscape of healthcare laws means that organizations must continuously adapt their practices to remain compliant while optimizing revenue streams. A regional health system faced this issue when new government policies altered reimbursement rates for certain procedures overnight. Through strategic planning and proactive policy monitoring highlighted in their case study analysis, they were able to adjust swiftly without compromising service quality or financial stability.

In conclusion, navigating a successful revenue cycle turnaround involves addressing several key challenges including outdated technology, inadequate staffing skills, poor departmental communication, and shifting regulatory landscapes. Drawing lessons from real-world case studies helps illuminate effective strategies for overcoming these hurdles-whether it be investing in modern technology solutions or enhancing staff training initiatives-to achieve sustainable financial growth within healthcare organizations.

Impact of Fee for Service on Medical Coding Practices

Title: Case Study 1: Successful Coding Optimization and Financial Recovery

In the complex landscape of healthcare finance, revenue cycle management serves as a pivotal element for sustaining financial health and operational efficiency. Among the multitude of challenges that healthcare organizations face, coding inaccuracies often emerge as a significant barrier to optimal revenue realization. This case study delves into the successful

coding optimization and subsequent financial recovery achieved by an innovative healthcare provider, illustrating how strategic interventions can transform financial outcomes.

The initial concern arose when the healthcare organization noticed a consistent decline in their reimbursements. A detailed audit revealed that coding errors were at the core of this issue, leading to denied claims and delayed payments. These inaccuracies not only impacted the cash flow but also strained relationships with payers due to repeated resubmissions and appeals.

Recognizing the urgency of addressing these issues, the organization embarked on a comprehensive plan focused on coding optimization. The first step involved assembling a cross-functional team comprising billing specialists, certified coders, IT professionals, and management executives. Their collaborative approach was essential in diagnosing underlying problems and devising targeted solutions.

Leveraging technology played a critical role in this turnaround effort. The team implemented an advanced coding software solution equipped with artificial intelligence capabilities that could automatically detect potential errors before claim submission. This proactive measure significantly reduced human error rates associated with manual coding processes.

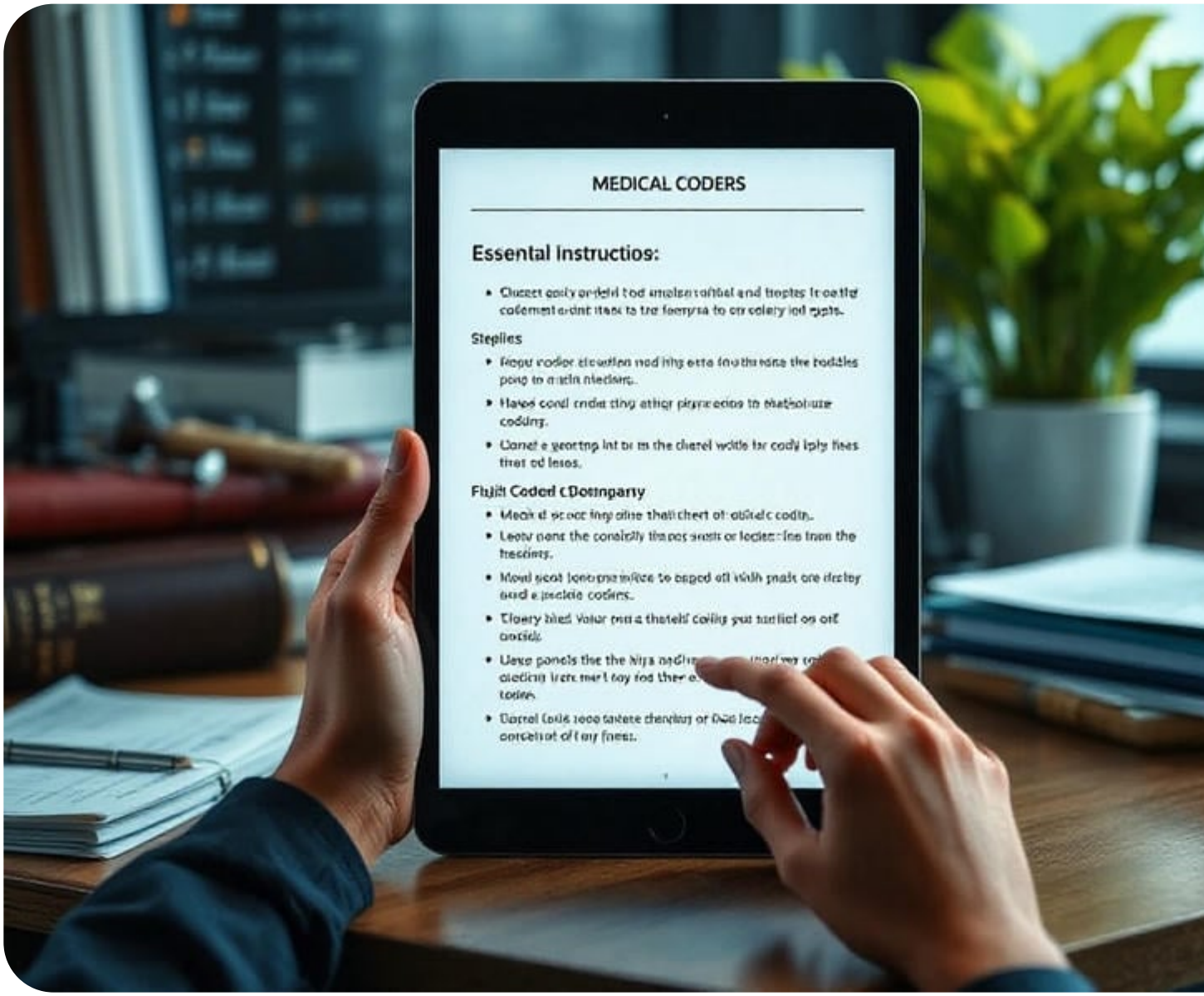
Moreover, continuous education was emphasized as part of their strategy. Regular training sessions were organized for coders and billing staff to keep them updated on ever-evolving coding standards and regulations. By fostering a culture of learning and adaptability, employees became more adept at navigating complex coding scenarios with precision.

Concurrently, process improvements were made to streamline workflows within the billing department. Standardized procedures ensured consistency in claim submissions while reducing redundancy in administrative tasks. Through these enhancements, operational efficiency improved markedly across all levels of the revenue cycle.

The results were transformative: within six months, denial rates decreased substantially while reimbursement timelines improved significantly. The financial recovery was evident not only through increased revenue but also via enhanced cash flow stability which enabled better resource allocation across departments.

Beyond financial metrics alone lies an equally rewarding outcome-the restoration of trust between stakeholders involved throughout this journey-from payers who experienced fewer discrepancies during audits; physicians whose documentation efforts aligned seamlessly with organizational goals; ultimately benefiting patients who received uninterrupted quality care without administrative hindrance or delay caused by payment uncertainties.

This case study underscores how strategic intervention targeting specific pain points such as incorrect medical billing codes can lead not just towards monetary gains but also contribute positively towards overall organizational resilience amidst dynamic industry changes-a testament indeed highlighting why investing resources into optimizing key aspects like accurate documentation practices remains paramount within today's competitive healthcare environment where every detail counts towards creating sustainable success stories akin to ours presented here today!



How Value Based Care Influences Medical Coding and Documentation Requirements

In the ever-evolving landscape of healthcare, maximizing efficiency and accuracy in revenue cycle management is paramount. One pivotal area that has recently seen significant transformation is coding accuracy, which is crucial for both operational success and compliance with regulatory standards. Case Study 2: Implementing Technology for Enhanced Coding Accuracy delves into the dynamic interplay between innovative technology solutions and improved financial outcomes in healthcare organizations.

At the core of this study lies a mid-sized hospital grappling with coding inefficiencies that were impacting its revenue cycle performance. The institution faced challenges such as high denial rates, prolonged claim processing times, and frequent compliance issues due to inaccurate coding practices. These issues not only strained the hospital's financial health but also hindered its capability to deliver optimal patient care.

Recognizing the need for a strategic overhaul, the hospital embarked on a journey to integrate advanced technology aimed at enhancing coding accuracy. This initiative was driven by two primary goals: reducing human error in medical coding and expediting the claims process to ensure quicker reimbursement cycles.

The first step involved adopting a sophisticated Computer-Assisted Coding (CAC) system. By leveraging natural language processing (NLP) algorithms, this system was designed to analyze clinical documentation and suggest accurate medical codes automatically. The implementation of CAC had an immediate impact-coders were now equipped with a powerful tool that reduced manual workload while improving precision in code selection.

Training played a crucial role in this technological transition. Coders received extensive training sessions focused not only on navigating new software but also on understanding how artificial intelligence can complement their expertise. This blend of human insight with machine efficiency resulted in coders being more confident and adept at handling complex cases.

Furthermore, the hospital integrated an advanced analytics platform capable of real-time data tracking and reporting. This allowed managers to monitor key performance indicators related to coding processes actively. Insights gleaned from these analytics enabled prompt identification of bottlenecks and informed decision-making, fostering continuous improvement within the revenue cycle.

The results were compelling: denial rates plummeted as coding errors decreased significantly, while average days in accounts receivable saw noteworthy reduction due to faster claim submissions. Moreover, by aligning closer with payer requirements through precise coding practices, compliance issues diminished considerably.

Beyond quantitative improvements, there was also a qualitative shift within the organization-staff morale improved as employees witnessed firsthand how technology could alleviate routine burdens and empower them to focus on more value-driven tasks like auditing and quality assurance.

This case study underscores a fundamental truth about modern healthcare operations: technology is an indispensable ally in overcoming longstanding challenges associated with revenue cycle management. By embracing cutting-edge solutions tailored toward enhancing coding accuracy, healthcare providers not only safeguard their financial viability but also enhance their capacity to deliver superior patient experiences.

In conclusion, Case Study 2 illustrates that implementing technology for enhanced coding accuracy is not merely about adopting new tools; it involves fostering an environment where innovation harmonizes with human expertise for transformative outcomes. As healthcare continues its digital evolution, those willing to adapt will find themselves at the forefront of delivering efficient and effective care amidst an increasingly complex landscape.

Challenges and Benefits of Transitioning from Fee for Service to Value Based Care in Medical Coding

Case Study 3: Training and Development Initiatives for Coders

In recent years, the healthcare industry has witnessed a rapid transformation, driven by technological advancements and evolving regulatory requirements. As part of this evolution, revenue cycle management has become an area of critical focus for healthcare organizations aiming to optimize financial performance. A key component of successful revenue cycle management is accurate medical coding-a task that requires skilled professionals who can navigate the complexities of healthcare documentation and billing codes. This case study explores the impact of training and development initiatives on improving coder proficiency within a healthcare organization, leading to significant improvements in revenue cycle turnaround.

Background

The subject of this case study is a mid-sized hospital located in a metropolitan area that was facing challenges with its revenue cycle processes. The hospital's accounts receivable days were longer than industry benchmarks, resulting in cash flow issues and reduced financial stability. Upon investigation, it became clear that inaccuracies in medical coding were contributing significantly to claim denials and delays in reimbursements from insurance providers.

Training Intervention

Recognizing the need for improved coding accuracy, the hospital's leadership decided to invest in comprehensive training and development programs for their medical coders. The initiative began with an assessment phase where existing coders' skills were evaluated through practical tests and error rate analysis. This assessment identified specific areas where additional training was necessary.

A customized training program was developed in partnership with an external consultancy specializing in healthcare education. The curriculum focused on updates to coding standards (such as ICD-10), documentation improvement techniques, and best practices for compliance with payer guidelines. Furthermore, interactive workshops were conducted to enhance problem-solving skills and foster collaboration among coding staff.

Implementation and Outcomes

The training initiative was rolled out over six months, during which coders participated in both classroom-style learning sessions and hands-on practice exercises using real patient records. To ensure knowledge retention, periodic assessments were conducted throughout the program.

The results of these efforts were notable:

1. Improved Coding Accuracy: Post-training audits revealed a substantial decrease in coding errors-from 12% pre-intervention to just 4%. This improvement directly contributed to fewer claim denials related to coding issues.

2. Enhanced Efficiency: Coders reported increased confidence in their ability to code accurately within shorter timeframes, leading to faster claims processing times.

3. Financial Impact: Within one year of implementing the training program, the hospital experienced a reduction in accounts receivable days by 15%, translating into improved cash flow management.

4. Employee Satisfaction: Coders expressed greater job satisfaction due to their enhanced skill set and clearer understanding of their role's impact on the organization's financial health.

Conclusion

This case study illustrates how targeted training and development initiatives can address specific challenges within the revenue cycle management process-particularly those stemming from medical coding inaccuracies. By equipping coders with updated knowledge and practical skills through comprehensive educational programs, healthcare organizations can achieve significant improvements not only in operational efficiency but also in overall financial performance.

Investing in employee development is not merely an operational expense; rather, it represents a strategic opportunity to drive meaningful change across key business functions-ultimately fostering resilience against future challenges while ensuring sustainable growth within an increasingly complex industry landscape.

Case Studies Highlighting the Effects of Different Payment Models on Medical Coding

Efficiency

In the complex and ever-evolving landscape of healthcare management, revenue cycle turnaround is a critical component for ensuring financial stability and operational efficiency. Case studies in this field provide valuable insights into the strategies and practices that can lead to successful transformations. The lessons learned from these case studies not only illuminate best practices but also highlight common pitfalls that organizations must navigate.

First and foremost, one of the key lessons gleaned from examining successful revenue cycle turnarounds is the importance of a comprehensive assessment. Organizations that have navigated through financial distress often started with a thorough evaluation of their existing processes, identifying bottlenecks and inefficiencies. This foundational step allows for a clear understanding of what needs to be changed or improved, setting the stage for strategic planning.

Another pivotal lesson is the role of technology in transforming revenue cycles. Case studies consistently show that leveraging advanced software solutions can significantly enhance billing accuracy, speed up reimbursement processes, and improve overall financial performance. However, simply implementing new technology is not enough; it must be seamlessly integrated into existing workflows with proper training provided to staff members to maximize its potential benefits.

Communication emerges as another critical factor in successful turnarounds. Open lines of communication between departments help ensure that everyone involved understands their roles and responsibilities within the revenue cycle process. Moreover, fostering a culture of collaboration encourages employees to share insights and propose innovations that can drive improvements.

Leadership plays a crucial role in driving change within an organization. Effective leaders are those who inspire confidence, manage resistance to change adeptly, and maintain focus on long-term goals while navigating short-term challenges. Case studies reveal that leadership commitment is often what sustains momentum in turnaround efforts.

Engaging stakeholders throughout the process cannot be overlooked either. From clinicians to administrative personnel, involving all relevant parties ensures buy-in and fosters an environment where everyone works towards common objectives. Stakeholder engagement also helps identify unique perspectives on potential issues or areas for improvement that might otherwise go unnoticed.

Lastly, patience and persistence are invaluable assets in any revenue cycle turnaround initiative. Transformations rarely occur overnight; they require ongoing monitoring and adjustments based on performance analytics. Celebrating incremental victories helps maintain morale while reinforcing positive changes.

In conclusion, lessons learned from case studies in revenue cycle turnaround emphasize thorough assessments, strategic use of technology, effective communication, strong leadership, stakeholder engagement, and persistence as key components of success. By applying these insights thoughtfully within their own contexts, healthcare organizations can achieve remarkable improvements in their financial health and operational effectiveness-ultimately enabling them to better serve their patients' needs while maintaining fiscal responsibility.

Future Trends: The Evolving Role of Medical Coders in a Value-Based Healthcare Environment

In the ever-evolving landscape of healthcare, maintaining efficiency in medical coding practices is pivotal for the financial health of any healthcare organization. Accurate medical coding not only ensures proper reimbursement but also enhances patient care and operational efficiency. Therefore, implementing sustainable strategies to improve these practices is crucial, particularly during a revenue cycle turnaround. This essay delves into several case studies that highlight successful strategies for sustaining improvements in medical coding.

One prominent case study involves a large hospital network that faced significant financial strain due to coding inaccuracies and inefficiencies. To address this, the administration launched a comprehensive training program focused on continuous education and skills development for their coding staff. The training included regular workshops on the latest coding standards and technologies, as well as access to an online platform for ongoing learning opportunities. By investing in their staff's expertise, the hospital not only improved coding accuracy but also boosted employee morale and retention rates.

Another notable example comes from a mid-sized clinic that integrated advanced software solutions to enhance their coding processes. They adopted an AI-driven coding platform that automatically validated codes against payer rules before submission. This technology reduced denials significantly by ensuring compliance with ever-changing regulations. Moreover, it allowed coders to focus on more complex cases requiring human judgment rather than manual data entry tasks. The integration of such technology proved instrumental in streamlining operations and keeping up with industry changes without compromising accuracy.

Furthermore, communication and feedback loops between departments played a crucial role in sustaining improvements at a community health center facing similar challenges. By fostering collaboration between clinicians and coders through regular meetings and shared performance metrics, they were able to identify common errors promptly and implement corrective measures swiftly. This collaborative approach ensured everyone was aligned towards shared goals, thus enhancing overall efficiency within the revenue cycle.

In conclusion, sustaining improvements in medical coding practices requires a multifaceted strategy encompassing continuous education, technological innovation, and interdepartmental communication. These elements are essential not only for addressing immediate challenges during a revenue cycle turnaround but also for laying down a robust foundation for future growth and stability in healthcare organizations. As demonstrated by these case studies, commitment to these principles can lead to significant advancements in both financial performance and quality of care delivery.

About overhead

Overhead may be:

Image not found or type unknown

Look up ***overhead*** in Wiktionary, the free dictionary.

- Overhead (business), the ongoing operating costs of running a business
- Engineering overhead, ancillary design features required by a component of a device
  - Overhead (computing), ancillary computation required by an algorithm or program
  - Protocol overhead, additional bandwidth used by a communications protocol
  - Line code or encoding overhead, additional bandwidth required for physical line transmission
- Overhead information, for telecommunication systems
- File system overhead, storage or other consideration required by a file system that is not directly related to data. For example, in tape data storage, the separator between one file and the next is overhead.
- Any physical object situated, or action occurring above:
  - Overhead line, for power transmission
  - Overhead cable, for signal transmission
  - Overhead projector, a display system
  - Overhead storage, for example overhead storage bins, racks, shelves, cabinets or track systems in aircraft, trains or buildings
- Overhead cam, a mechanical device
- Overhead join, in air traffic control
- Overhead press, an upper-body weight training exercise in
- Overhead crane or bridge crane, a type of crane sliding on two parallel rails

See also

[edit]

- Overkill (disambiguation)

Disambiguation icon

Image not found or type unknown

This disambiguation page lists articles associated with the title **Overhead**.
If an internal link led you here, you may wish to change the link to point directly to the intended article.

About patient

For the state of being, see Patience. For other uses, see Patient (disambiguation).

- v
- t
- e

Part of a series on Patients

Patients

Concepts

- Doctor-patient relationship
- Medical ethics
- Patient participation
- Patient-reported outcome
- Patient safety

Consent

- Informed consent
- Adherence
- Informal coercion
- Motivational interviewing
- Involuntary treatment

Rights

- Patients' rights
- Pregnant patients' rights
- Disability rights movement
- Patient's Charter
- Medical law

Approaches

- Patient advocacy
- Patient-centered care
- Patient and public involvement

Abuse

- Patient abuse
- Elder abuse

Medical sociology

- Sick role

A **patient** is any recipient of health care services that are performed by healthcare professionals. The patient is most often ill or injured and in need of treatment by a physician, nurse, optometrist, dentist, veterinarian, or other health care provider.

Etymology

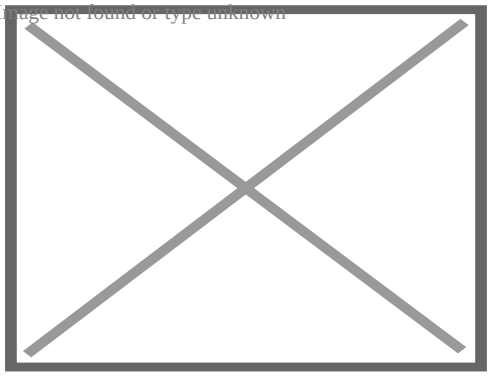
[edit]

The word patient originally meant 'one who suffers'. This English noun comes from the Latin word *patiens*, the present participle of the deponent verb, *patior*, meaning 'I am suffering', and akin to the Greek verb ?ÃŽÂ¬????? (*paskhein* 'to suffer') and its cognate noun ?ÃŽÂ¬??? (*pathos*).

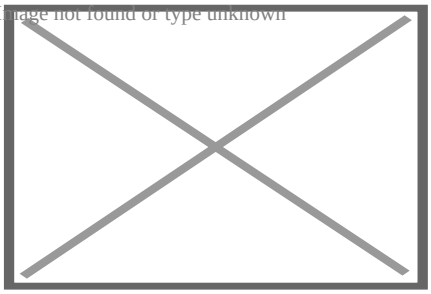
This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.[1]

Outpatients and inpatients

[edit]



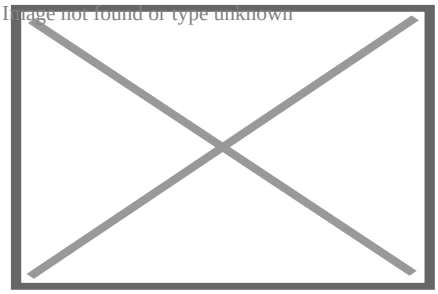
Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



Receptionist in Kenya attending to an outpatient

An **outpatient** (or **out-patient**) is a patient who attends an outpatient clinic with no plan to stay beyond the duration of the visit. Even if the patient will not be formally admitted with a note as an outpatient, their attendance is still registered, and the provider will usually give a note explaining the reason for the visit, tests, or procedure/surgery, which should include the names and titles of the participating personnel, the patient's name and date of birth, signature of informed consent, estimated pre-and post-service time for history and exam (before and after), any anesthesia, medications or future treatment plans needed, and estimated time of discharge absent any (further) complications.

Treatment provided in this fashion is called ambulatory care. Sometimes surgery is performed without the need for a formal hospital admission or an overnight stay, and this is called outpatient surgery or day surgery, which has many benefits including lowered healthcare cost, reducing the amount of medication prescribed, and using the physician's or surgeon's time more efficiently. Outpatient surgery is suited best for more healthy patients undergoing minor or intermediate procedures (limited urinary-tract, eye, or ear, nose, and throat procedures and procedures involving superficial skin and the extremities). More procedures are being performed in a surgeon's office, termed *office-based surgery*, rather than in a hospital-based operating room.



A mother spends days sitting with her son, a hospital patient in Mali

An **inpatient** (or **in-patient**), on the other hand, is "admitted" to stay in a hospital overnight or for an indeterminate time, usually, several days or weeks, though in some extreme cases, such as with coma or persistent vegetative state, patients can stay in hospitals for years, sometimes until death. Treatment provided in this fashion is called inpatient care. The admission to the hospital involves the production of an admission note. The leaving of the hospital is officially termed *discharge*, and involves a corresponding discharge note, and sometimes an assessment process to consider ongoing needs. In the English National Health Service this may take the form of "Discharge to Assess" - where the assessment takes place after the patient has gone home.[2]

Misdiagnosis is the leading cause of medical error in outpatient facilities. When the U.S. Institute of Medicine's groundbreaking 1999 report, *To Err Is Human*, found up to 98,000 hospital patients die from preventable medical errors in the U.S. each year,[3] early efforts focused on inpatient safety.[4] While patient safety efforts have focused on inpatient hospital settings for more than a decade, medical errors are even more likely to happen in a doctor's office or outpatient clinic or center.[*citation needed*]

Day patient

[edit]

A **day patient** (or **day-patient**) is a patient who is using the full range of services of a hospital or clinic but is not expected to stay the night. The term was originally used by psychiatric hospital services using of this patient type to care for people needing support

to make the transition from in-patient to out-patient care. However, the term is now also heavily used for people attending hospitals for day surgery.

Alternative terminology

[edit]

Because of concerns such as dignity, human rights and political correctness, the term "patient" is not always used to refer to a person receiving health care. Other terms that are sometimes used include **health consumer**, **healthcare consumer**, **customer** or **client**. However, such terminology may be offensive to those receiving public health care, as it implies a business relationship.

In veterinary medicine, the **client** is the owner or guardian of the patient. These may be used by governmental agencies, insurance companies, patient groups, or health care facilities. Individuals who use or have used psychiatric services may alternatively refer to themselves as consumers, users, or survivors.

In nursing homes and assisted living facilities, the term **resident** is generally used in lieu of *patient*.[5] Similarly, those receiving home health care are called *clients*.

Patient-centered healthcare

[edit]
See also: Patient participation

The doctor–patient relationship has sometimes been characterized as silencing the voice of patients.[6] It is now widely agreed that putting patients at the centre of healthcare[7] by trying to provide a consistent, informative and respectful service to patients will improve both outcomes and patient satisfaction.[8]

When patients are not at the centre of healthcare, when institutional procedures and targets eclipse local concerns, then patient neglect is possible.[9] Incidents, such as the Stafford Hospital scandal, Winterbourne View hospital abuse scandal and the Veterans Health Administration controversy of 2014 have shown the dangers of prioritizing cost control over the patient experience.[10] Investigations into these and other scandals have recommended that healthcare systems put patient experience at the center, and especially that patients themselves are heard loud and clear within health services.[11]

There are many reasons for why health services should listen more to patients. Patients spend more time in healthcare services than regulators or quality controllers, and can recognize problems such as service delays, poor hygiene, and poor conduct.[12] Patients are particularly good at identifying soft problems, such as attitudes, communication, and 'caring neglect',[9] that are difficult to capture with institutional

monitoring.[13]

One important way in which patients can be placed at the centre of healthcare is for health services to be more open about patient complaints.[14] Each year many hundreds of thousands of patients complain about the care they have received, and these complaints contain valuable information for any health services which want to learn about and improve patient experience.[15]

See also

[edit]

- Casualty
- e-Patient
- Mature minor doctrine
- Nurse-client relationship
- Patient abuse
- Patient advocacy
- Patient empowerment
- Patients' Bill of Rights
- Radiological protection of patients
- Therapeutic inertia
- Virtual patient
- Patient UK

References

[edit]

1. **^** *Neuberger, J. (1999-06-26). "Do we need a new word for patients?". BMJ: British Medical Journal.* ***318*** *(7200): 1756–1758. doi:10.1136/bmj.318.7200.1756. ISSN 0959-8138. PMC 1116090. PMID 10381717.*
2. **^** *"Unpaid carers' rights are overlooked in hospital discharge". Health Service Journal. 8 September 2021. Retrieved 16 October 2021.*
3. **^** *Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn, L. T.; Corrigan, J. M.; Donaldson, M. S. (2000). Kohn, Linda T.; Corrigan, Janet M.; Donaldson, Molla S. (eds.). To Err Is Human: Building a Safer Health System. Washington D.C.: National Academy Press. doi:10.17226/9728. ISBN 0-309-06837-1. PMID 25077248.*
4. **^** *Bates, David W.; Singh, Hardeep (November 2018). "Two Decades Since: An Assessment Of Progress And Emerging Priorities In Patient Safety". Health Affairs.* ***37*** *(11): 1736–1743. doi:10.1377/hlthaff.2018.0738. PMID 30395508.*
5. **^** *American Red Cross (1993). Foundations for Caregiving. St. Louis: Mosby Lifeline. ISBN 978-0801665158.*
6. **^** *Clark, Jack A.; Mishler, Elliot G. (September 1992). "Attending to patients' stories: reframing the clinical task". Sociology of Health and Illness.* ***14*** *(3): 344–372. doi:10.1111/1467-9566.ep11357498.*

7. **^** *Stewart, M (24 February 2001). "Towards a Global Definition of Patient Centred Care". BMJ. **322** (7284): 444–5. doi:10.1136/bmj.322.7284.444. PMC 1119673. PMID 11222407.*
8. **^** *Frampton, Susan B.; Guastello, Sara; Hoy, Libby; Naylor, Mary; Sheridan, Sue; Johnston-Fleece, Michelle (31 January 2017). "Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care". NAM Perspectives. **7** (1). doi:10.31478/201701f.*
9. **^** ***a b*** *Reader, TW; Gillespie, A (30 April 2013). "Patient Neglect in Healthcare Institutions: A Systematic Review and Conceptual Model". BMC Health Serv Res. **13**: 156. doi:10.1186/1472-6963-13-156. PMC 3660245. PMID 23631468.*
10. **^** *Bloche, MG (17 March 2016). "Scandal as a Sentinel Event--Recognizing Hidden Cost-Quality Trade-offs". N Engl J Med. **374** (11): 1001–3. doi:10.1056/NEJMp1502629. PMID 26981930.*
11. **^** *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. London: Stationery Office. 6 February 2013. ISBN 9780102981476. Retrieved 23 June 2020.*
12. **^** *Weingart, SN; Pagovich, O; Sands, DZ; Li, JM; Aronson, MD; Davis, RB; Phillips, RS; Bates, DW (April 2006). "Patient-reported Service Quality on a Medicine Unit". Int J Qual Health Care. **18** (2): 95–101. doi:10.1093/intqhc/mzi087. PMID 16282334.*
13. **^** *Levtzion-Korach, O; Frankel, A; Alcalai, H; Keohane, C; Orav, J; Graydon-Baker, E; Barnes, J; Gordon, K; Puopulo, AL; Tomov, EI; Sato, L; Bates, DW (September 2010). "Integrating Incident Data From Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant". Jt Comm J Qual Patient Saf. **36** (9): 402–10. doi:10.1016/s1553-7250(10)36059-4. PMID 20873673.*
14. **^** *Berwick, Donald M. (January 2009). "What 'Patient-Centered' Should Mean: Confessions Of An Extremist". Health Affairs. **28** (Supplement 1): w555 – w565. doi:10.1377/hlthaff.28.4.w555. PMID 19454528.*
15. **^** *Reader, TW; Gillespie, A; Roberts, J (August 2014). "Patient Complaints in Healthcare Systems: A Systematic Review and Coding Taxonomy". BMJ Qual Saf. **23** (8): 678–89. doi:10.1136/bmjqs-2013-002437. PMC 4112446. PMID 24876289.*

External links

[edit]

Image not found or type unknown

Wikimedia Commons has media related to ***Patients***.

Image not found or type unknown

Look up ***patient*** in Wiktionary, the free dictionary.

- *Jadad AR, Rizo CA, Enkin MW (June 2003). "I am a good patient, believe it or not". BMJ. **326** (7402): 1293–5. doi:10.1136/bmj.326.7402.1293. PMC 1126181. PMID 12805157.*

a peer-reviewed article published in the British Medical Journal's (BMJ) first issue dedicated to patients in its 160-year history
- *Sokol DK (21 February 2004). "How (not) to be a good patient". BMJ. **328** (7437): 471. doi:10.1136/bmj.328.7437.471. PMC 344286.*
  review article with views on the meaning of the words "good doctor" vs. "good patient"
- "Time Magazine's Dr. Scott Haig Proves that Patients Need to Be Googlers!" – Mary Shomons response to the Time Magazine article "When the Patient is a Googler"

- v
- t
- e

Articles about hospitals

History of hospitals, Hospital network, Category:Hospitals

Common hospital components	○ Accreditation ○ Bed ○ Coronary care unit ○ Emergency department ○ Emergency codes ○ Hospital administrators ○ Hospital information system ○ Hospital medicine ○ Hospital museum ○ Hospitalist ○ Intensive care unit ○ Nocturnist ○ On-call room ○ Operating theater ○ Orderly ○ Patients ○ Pharmacy ○ Wards
Archaic forms	○ Almshouse ○ Asclepeion (Greece) ○ Bimaristan (Islamic) ○ Cottage hospital (England) ○ Hôtel-Dieu (France) ○ Valetudinaria (Roman) ○ Vaishya lying in houses (India) ○ Xenodochium (Middle Ages)

Geographic service area	○ Base hospital (Australia) ○ Community hospital ○ General hospital ○ Regional hospital or District hospital ○ Municipal hospital
Complexity of services	○ Day hospital ○ Secondary hospital ○ Tertiary referral hospital ○ Teaching hospital ○ Specialty hospital
Unique physical traits	○ Hospital ship ○ Hospital train ○ Mobile hospital ○ Underground hospital ○ Virtual Hospital
Limited class of patients	○ Military hospital ○ Combat support hospital ○ Field hospital ○ Prison hospital ○ Veterans medical facilities ○ Women's hospital
Funding	○ Charitable hospital ○ For-profit hospital ○ Non-profit hospital ○ State hospital ○ Private hospital ○ Public hospital ○ Voluntary hospital
Condition treated	○ Defunct ○ Cancer ○ Children's hospital ○ Eye hospital ○ Fever hospital ○ Leper colony ○ Lock hospital ○ Maternity hospital ○ Psychiatric hospital ○ Rehabilitation hospital ○ Trauma center ○ Verterinary hospital

Century established	○ 5th ○ 6th ○ 7th ○ 8th ○ 9th ○ 10th ○ 11th ○ 12th ○ 13th ○ 14th ○ 15th ○ 16th ○ 17th ○ 18th ○ 19th ○ 20th ○ 21st
Lists of hospitals in: Africa, Asia, Europe, North America, Oceania, South America	
Authority control databases: National	○ Germany ○ United States ○ Japan ○ Czech Republic ○ 2 ○ Latvia ○ Israel

Image not found or type unknown

Edit this at Wikidata

Check our other pages :

- **Optimizing Documentation for Risk Adjustment**
- **Using Analytics to Track Revenue Cycle Performance**
- **DRGs and Their Role in Hospital Reimbursement**
- **The Impact of Chronic Conditions on Reimbursement**
- **Understanding ESRD Risk Adjustment Models**

Frequently Asked Questions

What are the key strategies used in successful revenue cycle turnarounds within medical coding?

Successful revenue cycle turnarounds often involve implementing advanced coding software to reduce errors, conducting regular training sessions for coders to keep up with changing regulations, and enhancing communication between departments to streamline processes and prevent bottlenecks. Additionally, thorough auditing and analysis of existing coding practices can identify inefficiencies that need addressing.

How do improvements in medical coding accuracy impact overall revenue cycle performance?

Enhancements in medical coding accuracy directly improve revenue cycle performance by reducing claim denials and rejections, accelerating payment times, and increasing cash flow. Accurate coding ensures compliance with payer policies and reduces the likelihood of costly audits or penalties. This results in a more predictable financial environment for healthcare organizations.

What role does technology play in transforming the revenue cycle through improved medical coding practices?

Technology plays a crucial role by providing tools such as automated coding systems, electronic health records (EHR) integration, and artificial intelligence-driven analytics that enhance efficiency and accuracy. These technologies help reduce manual errors, provide real-time data insights for better decision-making, enable faster processing of claims, and support ongoing coder education through updated software guidelines.

Phone : (813) 592-3807

City : Clearwater

State : FL

Zip : 33765

Address : 3000 Gulf to Bay Blvd Suite 313

Company Website : **https://altrustservices.com/**

USEFUL LINKS

medical staffing

medical staffing agencies

american medical staffing

consolidated medical staffing

Sitemap

Privacy Policy

About Us

Follow us