Improving the Patient Experience

Improving patient access to care, care coordination, and communication between provider and patient

Contents

Introduction

This toolkit is a collaborative effort, **developed by providers for providers** and distributed to assist in improving the patient experience by offering useful guidelines, tips, and other materials. The toolkit is based on recommendations, feedback and best practices that were received from the participating providers. There are many resources available throughout the toolkit. Applying these tips and guidelines may help increase patient satisfaction and provider satisfaction scores.

Please take a moment to review the toolkit to determine which tips and resources may be useful in improving the patient experience at your site. Each of the following sections provides recommendations on how to address elements of the patient experience process:

- Access to care
- Care coordination
- Provider-patient communication

Small changes in your practice can have a huge impact on the patient experience and retention. It is our hope that these resources are useful to you in increasing patient satisfaction.

Tips for Improving Access to Care

Improving access to care and the patient's experience with access is about:

- Finding the correct balance between supply and demand for appointments
- Demonstrating flexibility to patients by offering same-day appointments and convenient and sufficient hours of operation that takes into account the needs of the populations being served, and the appointment scheduling standards for the region and insurance product line
- Timely returning patient calls, especially after hours, when urgent or emergent medical advice or services are needed
- Keeping patients informed of process, timelines and outcomes when a referral and authorization for a service is needed; provided in a format and language the member can understand
- Keeping waiting room patients informed of any delays due to emergencies or unexpected events
- Having a process in place to timely and appropriately provide patients with test results (refer to the Tips for Improving Coordination of Care section – Notify patients of test results for further details)

Measuring Supply and Demand for Appointments

One of the top challenges to accessing care that members cite in patient satisfaction surveys is the inability to get an appointment with the provider at a convenient time. It is important to maintain convenient, appropriate and sufficient office hours to provide timely access to care. Additionally, requesting a convenient date or time from the patient, and offering at least three appointments dates and times that meet the patient's criteria may help improve patient satisfaction.

The disproportion between supply and demand not only contributes to a delay in meeting patients' needs and member dissatisfaction, but can also result in quality of care issues that may be detrimental to the patient's health. The demand for any kind of service – appointment, advice, requests for laboratory or radiology results, or leaving a message for a provider – can be predicted over time based on the types of populations served, the scope of the provider's office practice and the particular style of each provider in the practice. Analysis of supply and demand data can be used by providers to predict periods of high or low demand for their practice sites.

For example, by measuring your supply and demand, you may learn that you need to increase your hours of operation on certain days of the week, when demand is higher. Conversely, you may identify that demand is low on other days of the week, which provides an opportunity for you to schedule follow-up types of appointments. This approach will help balance the supply and demand throughout the week.

Open Same-Day Appointment Slots

To improve patient satisfaction, serve the acute and urgent needs of your patients, and meet Arizona Health Care Cost Containment System (AHCCCS) standards, our plan encourages a system of appointment scheduling, which allows for same-day access for your patients. In order to assist your migration from a fully booked schedule to one with several appointment slots reserved for same-day appointments, it is recommended that you monitor the daily requests for urgent visits. Based on that number of requests, reserve an adequate number of open slots each day. It is recommended that those slots remain unfilled until the afternoon, in order to accommodate any late walk-ins or requests to be seen. If your practice is unable to conduct the recommended measurements, employ the following quick-start method.

Quick-Start Method:

During the first week, leave two to four appointment slots open each day (evenly divided between late morning and afternoon). These slots should only be given out the same day. Record the time of day that those open slots are filled. After one week, if the appointments have been regularly filled before 2:00 p.m., add two to four more for available appointments. Continue weekly adjustments based on the demand seen. Modify the number of open slots based on the days with higher (typically Monday) or lower (often Thursday) demand.

Improve After-Hours Access to Care

Directing patients to the appropriate level of care using simple and comprehensive instructions can improve member satisfaction and outcomes, and reduce the inappropriate use of emergency room (ER) services. We encourage you to discuss after-hours and weekend access to care during your first visit with each patient and annually thereafter.

If possible, offer a brochure reinforcing your office hours, which hospital the patient should use for emergency care and other details about accessing care after hours.

Urgent Care

Educate patients about how to contact you with urgent questions after hours and your availability for urgent visits. It is particularly important to review access availability during weekends or holidays. Your patients should:

- Seek care from their primary care physicians (PCPs) if they have conditions that require prompt attention, but do not pose an immediate, serious threat to health or life
- Call their physicians' offices to determine whether to go to the emergency room (ER) or call our 24-hour nurse line (**Nursewise 866-534-5963**) to answer questions about medical conditions or behavioral health crises, or how to access detox services.
- Seek support for behavioral health by calling the **Peer Operated Warm Line** for Maricopa at **800-327-9254** or Southern Arizona (including Pinal) at **888-404-5530**, staffed by trained peers (members with lived experience overcoming mental illness). Peers provide a friendly voice, support, and help alleviate loneliness and isolation.
- Inform you of any urgent care or ER visit so you can obtain those records and provide necessary follow-up care within a few days of the visit

Address Multiple Problems

Try to handle more than one problem during the visit to help reduce future visits. Go beyond the chief complaint by asking patients to list all conditions and concerns at the start of the visit. Providers may use the Patient Agenda-Setting Form enclosed in the back of this toolkit to gather patients' needs, negotiate priority and identify if additional follow-up appointments are needed to address all the patient's problems, concerns and questions. Remember to ask patients if they need assistance with the written forms.

- Review the patient's problems prior to the visit
- Conduct recommended preventive screenings or schedule a follow-up appointment for preventive services, as appropriate, even when a patient presents for other reasons.
- Address self-management techniques and coping strategies with patients based on their needs
- Schedule quarterly or monthly follow-up appointments before the patient leaves the office

The decision to extend the period between visits may depend on the patients' ability to self-manage and seek care if and when their conditions worsen.

Tips for Improving Care Coordination

Health Care Team

Current research and industry standards encourage the creation of a health care team to fully enhance the patient experience and improve the coordination of care across the spectrum of specialists, mental health, community resources, hospitals, pharmacy, and durable medical equipment (DME) providers.

The health care team is designed to be a system of care that facilitates access to and coordination of a full array of primary and acute physical, mental health and other support systems for individuals. The medical/health home understands and partners with patients and their families and respects unique needs, culture, values, and individual preferences. Patients are supported in learning to manage and organize their own care. Patients and families are considered core members of the care team and are informed partners in developing plans of care.[1]
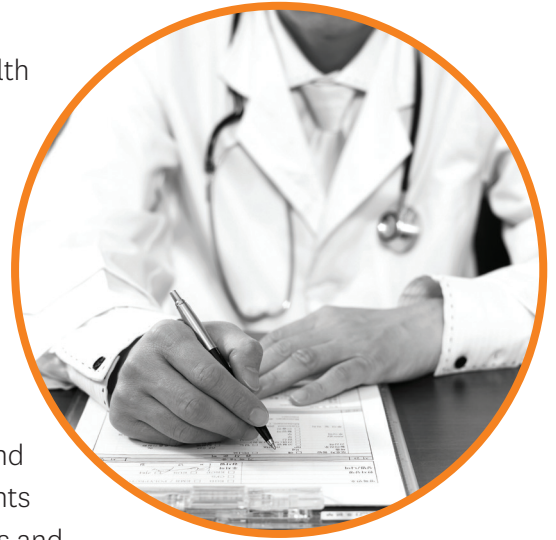
Our plan can help coordinate communication between your office, behavioral health services and the patient's home or facility regarding the patient's medications, use of hospital or day programs and other programs. Community services for your patients, such as Community-Based Adult Services (CBAS), In-Home Supportive Services, Meals on Wheels, and school-based Individual Educational Programs (IEPs), are all important to your patient's health and should be recorded and tracked through the health record as part of the coordination of care.

The approach enhances coordination and integration of medical and behavioral health care to meet the needs of patients. Coordination of care is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital or other inpatient settings. Access to care is important and the system strives for:

- Shorter waiting times for urgent needs
- In-person around-the-clock telephone support
- Electronic access to a member of the care team, with alternative methods of communication, such as email

Patients' preferences regarding access are considered to facilitate partnerships between individual patients and their physicians and, when appropriate, families. These partnerships are meant to build clear and open communication for all members of the care team.[2]

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1   Focus on Health Care: www.kff.org
2   Agency for Health Care Research Quality: www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

The American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and Administration on Aging (AOA), representing approximately 333,000 physicians, have developed the following joint principles to describe the **characteristics of the health care team**:

- **Personal Physician** – Each patient has an ongoing relationship with a personal physician trained to provide first contact, as well as continuous and comprehensive care
- **Physician-Directed Medical Practice** – The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
- **Whole-Person Orientation** – The personal physician is responsible for providing for all health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, including acute care, chronic care, preventive services, and end-of-life care
- **Care is coordinated and/or integrated** across all elements of the complex health care system (such as subspecialty care and care in hospitals, home health agencies and nursing homes, as well as the community (including family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to ensure patients get care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety hallmarks of the medical/health home feature:

- Practices advocating for their patients to support attainment of optimal outcomes defined by a care planning process that is driven by a compassionate, robust partnership between physicians, patients and the patients' families
- Evidence-based medicine and clinical decision-support tools that guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement
- Patients actively participating in decision-making, with providers seeking feedback to ensure patients' expectations are being met
- Information technology supporting optimal patient care, performance measurement, patient education, and enhanced communication
- Practices undergoing a voluntary recognition process by an appropriate entity to demonstrate practices have the capabilities to provide patient-centered services consistent with the medical/health home model

Notify Patients of Test Results

Notify patients of all test results, even if normal or expected. Notification can be by telephone, letter or email. Establish the following protocols to efficiently manage and communicate test results in a timely manner:

- **Normal results**: No action required or ordering practitioner specifies action that is needed
- **Abnormal results**: Action required and specify necessary action to be taken
- Detecting when **test is not obtained**
- Handling **results that require** a telephone call from a clinician or a visit from the patient

Use of pre-formatted letters can assist to relay normal results of common reports. Provide patient education handouts to assist with any further guidance. Include a section at the end of the clinical note listing tests ordered as a result of the visit. Provide copies of lab results to the patient when appropriate. Develop all letters and materials at a sixth grade reading level to ensure patients will understand their prognosis or next steps.

Resource: The Exploring Ideas for Improving Care Coordination presentation is available online at **www.calquality.org.**

Communicate with Patients' Other Health Care Providers

Maintaining continuity of care is critical to ensure successful outcomes. To include patients in the process, ask them or their families whether care was received from any other providers. Be sure to share pertinent treatment information with other specialty providers, including behavioral health providers. The Council of Subspecialty Societies (CSS) of the American College of Physicians (ACP) Workgroup recommends the development of care coordination agreements between primary care providers and specialty/subspecialty practices to further establish a means for facilitating increased coordination and integration of care.

Review Patient Charts in Advance of the Visit

To prepare for the patient encounter, review the patient's medical history prior to the visit. Be sure to identify visits with other providers and follow-up tests/results as well. During the review of the chart, identify any necessary preventive screenings, tests or immunizations that the patient needs to complete.

- ☑ General Health History
- ☑ External Providers?
- ☑ Screenings Needed?
- ☑ Immunizations?

Enhance Care Transitions

When a patient moves between care settings, it is ideal to include a customized plan of care that accompanies the patient to the next setting. Additionally, the treating provider should transmit the care plan to the receiving provider or practitioner. A smooth transition can help prevent adverse medication events, ER visits and re-hospitalizations. Smooth transitions also can improve the patient's experience and satisfaction. The key factor to the success of transitional care is timely and accurate communication between the patient, primary provider, specialist, hospital, home health or hospice agency, skilled nursing facility (SNF) or ER. Providers should contact patients and/or caregivers promptly after a transition with a focus on:

- Facilitating a patient follow-up appointment within seven days of the transition
- Providing access to patients to trusted office staff or clinicians who can answer questions, provide advice and help ensure safe transitions and stress the importance of the follow-up visit
- Conducting medication reconciliation and confirming patient understanding and compliance with their medication schedules
- Educating patients on proper management of their conditions. Use of teach-back techniques to assess the patients' or family caregivers' understanding of the instructions and ability to provide self-care
- Educating patients to recognize, respond to and report urgent symptoms of their conditions

Promote Medication Reconciliation

Medication reconciliation ensures safety and reduces adverse medication events when there is a transition in care. The purpose of the reconciliation process is to avoid or minimize errors of transcription, omission, duplication of therapy, drug-drug interactions, and drug-disease interactions. Consider the following:

- Encourage patients to bring all medications to appointments, including vitamins, herbals and over-the-counter medications and medications prescribed by other providers, including behavioral health specialty providers
- Encourage patients to keep a current list of their medications with them to inform physicians and nurses
- Encourage patients to ask questions if they do not understand medication changes made when they are discharged from an inpatient or ER status
- Ask patients to inform you of any medication changes made by other physicians since the last appointment
- Explain the importance of keeping providers informed of unusual symptoms or medication side-effects
- Assess whether the patient would benefit from any additional support, such as adherence counseling, or devices, such as pill organizers, medisets, etc.

Utilize Electronic Prescribing (E-Prescribing)

The development of health information technology, including electronic prescribing (e-prescribing) was meant to improve the quality of healthcare for patients, as well as efficiency for providers. E-prescribing has been shown to improve member satisfaction by allowing the member to make only one trip to the pharmacy, rather than one to drop off the prescription, the wait time to have the prescription filled, or a second trip to the pharmacy to pick up the medication.

Utilize the AZ Board of Pharmacy's Controlled Substance Prescription Monitoring Program (CSPMP)

Arizona State law requires pharmacies and practitioners who dispense certain controlled substances to register and report prescription information to the Board of Pharmacy's CSPMP database. The CSPMP provides a tool to assist providers and pharmacies in identifying potential safety issues related to multiple prescriptions of controlled substances, and to identify controlled substances that have been prescribed by other providers that have seen your patients.

Once enrolled you or your delegate will be able to view prescriptions for controlled substances regardless of what pharmacy was used to fill the prescription. **To register with the AZ CSPMP, go to the following AZ Board of Pharmacy website: https://pharmacypmp.az.gov**

On the right hand column of the opening web page there is a section addressing registration. Once enrolled, you may identify delegate(s) who will be able to access the system under your registration & DEA number. Once a patient report is generated, you are able to convert it to a PDF and print or save for insertion into the patient's record.

Benefits of E-Prescribing

Depending on the e-prescribing system, potential benefits of e-prescribing include:

- A direct and immediate connection with the patient's pharmacy
- Reduced potential adverse drug events and errors.
- Improved management of time and work-flow efficiency at the practice level, by decreasing the volume of phone calls and faxes; as well as the number of callbacks from pharmacies
- Potentially improved medication adherence
- Overall improvement in the quality of care provided; access to the member's medication, prescribing , refill history and fill patterns

Developmental Screening Within the First 3 Years of Life

The first three years of a child's life are full of immense growth and development. Early development typically follows a sequence, for example, motor development follows this sequence: hold up head, roll over, sit, roll from back to stomach to sit, crawl or creep, move from sit to crawl and back again, pull to stand, stand alone, cruise and finally walk.[1] Knowledge and awareness of developmental norms are necessary to identify developmental delays, which may require a referral to specialist or service who deal with issues surrounding developmental delays. Concurrently, early identification of developmental delays is crucial when providing effective interventions. All children develop at different rates; however a child may need a developmental screening if that child fails to demonstrate a skill that should be mastered at an expected age.

Children with identified developmental disabilities need health care services which give them the education and tools needed to live healthy, productive and fulfilling lives. While some developmental disabilities can be improved with the right types of therapeutic interventions others may be a lifelong disability which can be managed, also with the right types of interventions

During a well-child visit a provider needs to look for potential concerns using both developmental surveillance and discussions with parents regarding concerns they may have. If any issues are noted, the provider should follow through with a developmental screening. AHCCCS has approved developmental screening tools which should be utilized for developmental screenings by all practitioners who care for children between the ages of 1 and 3 years. Practitioners must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed on your patients from birth through three years of age during the 9 month, 18 month and 24 month well visits.

1   **Ashford, Jose B and LeCroy, Craig Winston.** *Human Behavior in the Social Enviornment A Multidimensional Perspective.* Belmont : Brooks/Cole, Cengage learning, 2010.

Tips for Improving Provider-Patient Communication

Negotiate an Appointment Agenda with Patient

17 At the beginning of each visit, establish an agenda for the appointment with the patient's input. Ask the patient to complete the Talking with My Doctor (included with this toolkit) in the waiting room prior to the visit. The form helps to elicit key concerns by asking patients to prioritize their goals for the visit in writing or verbally with the medical assistant prior to the visit. The physician or medical assistant can reference this form to determine what else is important to the patient and what is the one thing he or she wants to be sure happens before ending the visit. It also reminds the provider to share items of importance with the patient, and enables consensus on how to allocate time.

Make a Personal Connection

Face-to-face contact and empathic statements can strengthen the sense of personal connection with and trust in providers. Tips to foster strong patient-provider relationships include:

- Face the patient and shake hands when entering the room
- Use welcoming words and tone of voice
- Sit down to be at the same level as the patient
- Acknowledge the reason for the visit and make a brief, personal connection before beginning the visit
- Demonstrate appreciation of patient concerns through empathic statements
- Encourage patients to ask questions and express any concerns

Provide Closure by Summarizing Action Plan

To help patients understand and comply with their care plans, repeat the goals of the visit and any next steps:

- Summarize and affirm agreement with the plan of care
- Discuss and clarify any follow-up needed with patient
- Address patient's priorities by asking, "Did we address what you wanted to cover today?"
- Provide The patient with a written summary of the visit, if appropriate

Resource: **www.calquality.org**

De-Escalation of Patients in an Office or Community Setting

Some patients may feel unsafe or angry when seeking medical services. Providers should prepare office staff in verbal crisis de-escalation techniques to support members in managing crises, while maintaining member and staff safety. Keys to effective de-escalation include:

- Emotionally detaching from the patient's anger
- Listening with empathy
- Trying to understand where the person is coming from

Working as a team provider staff can support a member in a difficult situation to prevent further escalation of behaviors, until the situation is resolved or needed medical care is available.

REMEMBER!
Crisis Line
Maricopa: 800-327-9254
Gila: 877-756-4090
**Southern Arizona:**
866-495-6735
TTY/TDY: 711

Tips for Improving Coordination with Specialists

Providers are responsible for identifying and treating, or making specialty referrals for the conditions that cannot be managed by the primary care provider. In the event a member needs specialty services, facilitate the following:

- Make available all necessary medical records, medication records and other documentation related to the diagnosis and care of the condition that resulted in a referral
- Ensure the appropriate documentation is included in the member's record.
- Request copies of records from the specialist to whom the member was referred
- For primary providers receiving requests from behavioral health specialists, respond within 10 days of the request
- Develop and use collaborative care agreements that outline clearly the roles for co-management and communication. Clearly outline who will manage the specific condition; primary provider, the specialist or both providers.
- Develop a systematic approach to identify and track the patients who are referred to specialists, including whether the patient followed through with an appointment and any response received back from the referral
- Ensure that neither the patient or the family are solely responsible for the follow-up and coordination[1]
- Consider adoption of the Institute for Healthcare Improvement (IHI) 9-step closed loop referral process (see diagram below)[1]

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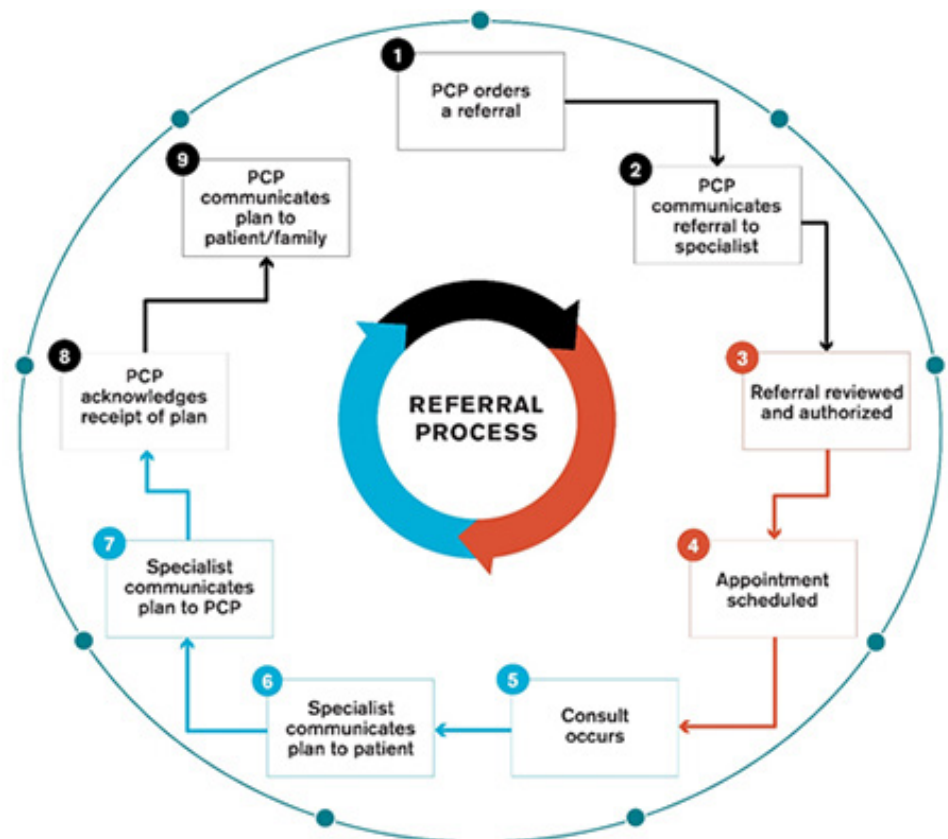
1   Institute for Healthcare Improvement / National Patient Safety Foundation. *Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era*. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at www.ihi.org)

Cultural and Linguistic Interpreter Services

Cultural and linguistic **interpreter services are available to both providers and members at no cost** 24 hours a day, seven days a week, 365 days a year. These services ensure access to qualified interpreters trained on health care terminology and a wide range of interpreting protocols and ethics; as well as support to address common communication challenges across cultures.

Providers are responsible for using the plan's interpreter services resources to provide interpreters to members who require or request them. To meet language services' established requirements, providers must:

- Ensure limited-English proficient (LEP) patients are not subject to unreasonable delays in the delivery of services
- Not require or encourage patients to use family or friends as interpreters. The plan strongly discourages use of minors as interpreters, unless used in an emergency situation
- Provide interpreter services at no cost to patients
- Extend same participation opportunities in programs and activities to all patients regardless of their language preferences
- Ensure that services provided to LEP patients are as effective as those provided to others
- Record the language needs of the patient in his or her medical record
- Document the patient's request or refusal of interpreter services, in his or her medical record

Online Resources
and Additional Tools

The following websites include easy-to-follow paths to access the documents mentioned throughout the Patient Experience Toolkit.

www.calquality.org

There are many resources offered on the California Quality Collaborative website. Use the search field to find the materials listed below as well as other resources:

· First Impression Checklist
· Improving Patient Experience presentation

www.noplacelikehomeaz.com

More information on patient satisfaction is available on the No Place Like Home website at www.noplacelikehomeaz.com/satisfaction.html.

www.ahrq.gov/qual/goinghomeguide.pdf

The Agency for Healthcare Research and Quality (AHRQ) includes useful resources for Health Net Access members, such as Taking Care of Myself: A Guide for When I Leave the Hospital that providers can complete after hospital visits to provide more information to indicate how members are taking care of themselves after the hospital visit.

www.caretransitions.org/documents/checklist.pdf

Care Transitions is an organization that provides a checklist for members as they are discharged to ensure they understand the next steps in their care.

www.iceforhealth.org

The ICE Cultural and Linguistics (C&L) Provider Toolkit is located on the ICE website. Once on the home page, choose Library and search by the title to locate this reference.

Notes: