



# Let's Talk:

*A guide for transforming the patient experience through improved communication*

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Some of the content in this guide was developed following a community roundtable in November 2011. Presenters at this roundtable are noted throughout the guide. We thank them for their real-time quality improvement projects: Their problems, solutions and results.

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*Guide Authors: Diane Mayberry and Myonghee Hanson*

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## Introduction

Many healthcare organizations in Minnesota are working on improvements in “the Triple Aim,” which includes setting goals in three areas:

- Improvements in population health
- Reducing or controlling health care costs
- Enhancing a patient’s experience and interactions when being cared for by a healthcare provider

How does the topic of this guide, improved communication, fit into these goal areas? Good communication with patients and their families gives them access to information as well as providing the skills and tools needed for self-management. These enriching interactions and experiences with providers and the healthcare system, ultimately advances their health and improves health outcomes. Helping patients and families self-manage their conditions is an idea whose time has come. This concept is one of the six aims mentioned in the 2001 Institute of Medicine’s *Crossing the Quality Chasm* report and is central to certification as a patient-centered medical home in Minnesota.

In addition, Minnesotans banded together in 2010 to form a collective impact collaborative on Shared Decision Making ([www.msdmc.org](http://www.msdmc.org)) ... and for good reason. Many patients do not understand what their doctors have told them and do not participate in decisions about their care, which leaves them ill-prepared to make daily decisions and take actions that lead to good self-management. Others are not yet even aware that taking an active role in managing their conditions, or health in general, can have a big impact on how they feel and what they are able to do. Enabling patients to make good choices and sustain healthy behaviors requires a collaborative relationship—a new health partnership between health care providers and teams, and patients and their families—that supports patients in building the skills and confidence they need to lead active and fulfilling lives.

**The purpose/scope of this guide is to:**

- Introduce patient experience measurement in Minnesota and nationally.
- Through patient stories of their experiences with providers, show examples of the importance of good communication in influencing care and health outcomes.
- Provide case studies of medical groups that have made successful changes to enhance communication.
- Finally, the concepts, stories, case studies and other resources in this guide are intended to give busy clinical practices an overview of proven activities and changes that have already supported patients and families in the day-to-day self-management of their conditions and overall health.

“Self-management support is the assistance caregivers give to patients with chronic disease in order to encourage daily decisions that improve health-related behaviors and clinical outcomes. Self-management support may be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviors; and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership ... The purpose of self-management support is to aid and inspire patients to become informed about their conditions and take an active role in their treatment.”<sup>1</sup>

<sup>1</sup> *Thomas Bodenheimer, MD “Assisting Patients to Self-manage their Chronic Conditions.” Oakland, CA: California HealthCare Foundation, 2005.*

## Acknowledgements

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**Robert Wood Johnson Foundation (RWJF)** focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 30 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime.

**Aligning Forces for Quality** is an unprecedented commitment of the RWJF to improve the quality of health care, reduce disparities related to race and ethnicity, and provide models of healthcare reform. RWJF launched the first phase of Aligning Forces for Quality (AF4Q) in 2006 as an effort to help communities build health care systems where none existed. Right now, while pockets of excellent health care exist across the country, most health care markets function as fragmented sectors, with different entities often working within their own silos. The first phase of AF4Q provided community leadership teams with grants and substantial expert assistance to help them work with physicians to improve quality of care, to measure and publicly report on the quality of ambulatory care, and to engage consumers to make informed choices about their own health and health care. The program expanded in June 2008 to include inpatient care, as well as a focus on reducing racial and ethnic gaps in care and enhancing the central role that nursing plays in good health care.

**MN Community Measurement** is the lead organization for the RWJF Aligning Forces for Quality grant. MN Community Measurement (MNCM) is a collaborative effort in our state among those who believe that you cannot improve what you do not measure. MNCM works with health plans, physicians, hospitals, employers and consumers to increase health, reduce cost, and improve patient experience. MNCM has been a trusted source of health care quality measurement and public reporting since 2004. Through MNCM, the Minnesota health care community has pioneered collaborative health care quality reporting: building a set of 76 measures that are widely accepted and aligned across all payers and providers; establishing a process that allows efficient collection of quality and cost data for measures from hospitals, medical groups and health plans; and reporting the results to health care providers and the public on more than 700 sites of care. Our measures have received national endorsement from the National Quality Forum, and Medicare now uses our measures nationwide for its value-based purchasing initiatives.

**Institute for Clinical Systems Improvement (ICSI)** is an independent, non-profit health care improvement organization that unites clinicians, health plans, employers, policymakers and consumers to bring innovation and urgency to improve health, optimize the patient experience and make health care more affordable. A special thank-you to the ICSI staff and its Patient Advisory Council for collaborating closely with MNCM to identify patient stories that help illustrate the challenges of improving communications between providers and patients.

# Environmental Context

## *Environmental Context for focusing on the Patient Experience*

Several broad-based, national forces are driving performance measurement in the outpatient setting. Among official agencies are the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration Bureau of Primary Health Care, and the American Board of Medical Specialties. These forces—plus recent federal legislation to spur accountable-care organizations and Minnesota-based 2008 health reform, which created patient-centered health care homes—have brought patient experience to the forefront. Most poignant is the rise of patient and consumer expectations of quality and service; one need only spend a few minutes on the internet to find impassioned and detailed consumer reviews of physicians. The state of Minnesota began to lay groundwork in the 1990s for voluntary public reporting on health care quality measures. The MN Health Data Institute and Minnesota Care program were instrumental in establishing the value of public reporting. MN Community Measurement, established in 2002, has worked to refine data collection and reporting processes, with participation for voluntary public reporting of patient experience of care data from nine medical groups (124 clinic sites) in 2008 and 18 medical groups (110 clinic sites) in 2010. In 2012, public reporting on patient experience of care is mandated in all clinic sites with sufficient adult visits and numbers of physicians working at the site.

A wide array of internal process improvement and public accountability measurement strategies have been in use for decades in Minnesota. Clinical practice is ripe for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Program. Endorsed by the National Quality Forum, CAHPS has been sponsored by AHRQ since 1995. The program offers the most widely used tools to evaluate patient experience in health care. CAHPS surveys span the diversity of primary and specialty care, including coverage to facility surveys as specific as an in-center hemodialysis survey. Within the ambulatory family of tools is the CAHPS Clinician & Group Survey (CG-CAHPS) which prompted the half-day, multi-stakeholder meeting on which this report is based. **A unique strength of the CG-CAHPS design is that it focuses on topics for which the only source of data is the consumer.** Going beyond mere “satisfaction” scores, the data collection tools were scientifically developed and rely upon direct patient reports and ratings, which easily translate into organizational improvement strategies.

For the purposes of this guide, we have categorized office visit improvements into the categories of:

- **Pre-visit** (such as timely access to appointments and adequate preparation for the visit)
- **During-the-visit** (including communications from all caregivers and their supporting workforce)
- **Post-visit** (such as evaluating the patient—or family member’s—understanding of instructions given to the patient, follow-up on laboratory results, etc.)

This locally produced guide is intended to supplement the CG-CAHPS Improvement Guide and all its publicly available instruments<sup>2</sup>, to assist performance improvement by a wide range of ambulatory care providers.

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<sup>2</sup> *A comprehensive guide to improving the patient experience including a searchable database of interventions based on performance problem or specific survey topics.* <https://www.cahps.ahrq.gov/qguide/default.aspx>



# Patient Stories

For perspective, three patients share personal stories of pre-visit, during-the-visit and post-visit communications issues. Each patient—Tim, Darlene, and Erika—speaks from the heart about rewarding and disappointing encounters that, for them, are representative of the clinician-patient relationship. Their perspectives and reflections are offered in the spirit of providing insight into the challenges they faced and inspiration for those who are operating health care systems.

We thank them for their courage in speaking up.

## TIM

### **Tim’s story about a pre-visit scheduling snafu**

Institutions make a first impression when patients telephone to schedule appointments. In Tim’s case, he bore the brunt of one specialty clinic’s disorganized scheduling practices over the course of his wife’s bladder cancer. The rigid protocols of the system—the requirement of a whole day’s attendance for tests and a separate whole day to hear the results—presented quite an imposition for them to take time off from work. The burden was compounded by substantial travel to and from the office. His trust was diminished when scheduling staff initially neglected to inform him and his wife that a certain preparation would span the course of two days; Tim haphazardly stumbled into clarification of the “mandatory” second day to hear results. When the written itinerary arrived later, Tim was dismayed to find the official appointment omitted the second date of a two-day affair. The onus was upon him, as the family member, to contact the large system to set the dates straight and tell schedulers to please correct the error. Had Tim been unavailable to make this extra effort, he and his wife would have potentially wasted a trip rather than receive potentially life-saving care. “That doesn’t sound like good customer service to me,” lamented Tim.

On top of that, when Tim and his wife reported to the check-in desk for their specialty appointment, the wrong check-in desk had been listed in their itinerary. Hence, they had navigated themselves to entirely the wrong location. This was the start to a day-long visit where their appointments were not coordinated on behalf of the patient’s experience, but rather, the patient and family repeatedly felt pushed, pulled, and forgotten by a system built up around itself to serve itself.



### Tim's during-the-visit good experiences with resourceful nurses

Tim recalled his and his wife's good experiences with the nurses at all the clinics. "They made things happen. They got her in, got her treated, kept her safe. Nurses in general were wonderful at protecting us and getting things done and getting the schedules to work and literally going around the scheduling staff and saying: we're going to make it happen."

Tim's wife has a urostomy (an artificial opening on the abdomen for the urinary system) and Tim observed that the recurring mandated urine test was more complicated than going to the regular restroom for a urinalysis, and the scheduling staff didn't understand that. The nurses, however, did understand the complexity and helped his wife get the resources and time she needed.

### Tim's elusive post-visit test results and more follow-up scheduling challenges

Regarding the tools used to schedule follow-up tests and visits, and to get test results, Tim described a frustrating experience.

"I can't get online to see what the doctor's availability is and schedule it. The current system is archaic to me. I can do it with cars, I can do it with hotels, I can do it with airplanes."

In addition, when he initially called the care system, the scheduler was busy, and when the system returned his call, he himself was busy.

"That kind of experience amounts to more aggravation in a situation that is already aggravating. When we went to a clinic six weeks in a row, I could only schedule out one week. Why is that? 'Well we don't know the doctor's schedule ... we just don't do it that way.' That says something



to me clearly about who the customer is and who the customer is not. I'm 65 years old and I interact with technology and I expect it. I carry a phone. I expect communication and interaction. Why do I have to go to the doctor's office just to get results when I could do that on Skype or with my video conference ... it would even save the doctor time."

# DARLENE (DAR)

## Dar's during-the-visit clinician errors and omissions

Dar, whose professional life as a special education teacher spanned more than 30 years, learned to trust herself through her trials in health care. First she realized surgery personnel were confused about basic details of her surgery. Despite Dar's explicit attempts to correct their mistaken plan, the surgeon refused to change course. Tragically, the surgeon's error resulted in a permanent colostomy<sup>3</sup> for Dar. The permanent colostomy would have been avoided if the surgeon or one of the employees had simply listened to her. Second, Dar's trials and tribulations with stomach pain and Crohn's<sup>4</sup> disease in the ambulatory setting crystallized her conviction not to be victim by a system that does not listen.

Dar described an occasion when she had extreme stomach pain. She suspected there was an infection because her abdomen was hot to the touch and painful. She tried to alleviate the pain by taking a shower but with a permanent colostomy and loss of bowel, the lower abdominal pain alarmed her. She explained her 30-year history of Crohn's disease to the primary care physician, but the doctor dismissed the pain that caused Dar's visit, "Oh, it sounds like nothing. It must be just because you came out of the shower or something." Dar insisted time and again that her problem needed further examination. She stuck to her intuition that "something just didn't feel right." Rather than problem-solve Dar's extreme abdominal pain, the physician later asked Dar, "What is it exactly that you want me to do?" Dar ventured, "How about a scan or something."

After Dar made several attempts to elicit diagnostic actions on the doctor's part, the primary care physician finally placed an order for an ultrasound to investigate Dar's extreme abdominal pain. It was something of an accomplishment to have the doctor schedule an ultrasound, and now Dar credits the physician with some degree of shared decision-making by acting upon Dar's request.

## Dar's post-primary care visit – imaging misses the mark & urgent care delays answers

Dar reported for the exam, but to her dismay the sonographer scanned only the upper part of the stomach where the pain was not located. Dar pointed out the obvious shortcoming of not imaging the very area that was afflicted. The technician said, "I don't have an order for that part. You will just have to come back at a later date."

Dar was effectively blocked from the care she needed due to the physician's incomplete or inaccurate imaging order. With the weekend upon her, and immediate issuance of a new doctor's order not an option, Dar turned to urgent care. After examination, the physician announced, "It looks like an abdominal abscess and I would lance it right here but for it being so close to the colostomy; so go home with some medication."

Next she ended up in the emergency room, where the ER physician said the abscess definitely needed to be lanced.

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<sup>3</sup> A colostomy is a surgical procedure in which an opening is formed on the abdominal wall and the large intestine is pulled through this opening and sutured into place. This opening provides a channel for feces to leave the body. It may be reversible or irreversible depending on the circumstances.

<sup>4</sup> Crohn's Disease is an inflammatory bowel disease that may affect the digestive track causing pain, diarrhea, vomiting or weight loss.

Dar said that her biggest disappointment was the physician not listening to her. “I just kept saying ‘I know something is wrong;’ we just weren’t connecting there.”

One can only imagine the degree of mental discomfort, heaped upon the physical anguish, the chain of errors must have caused a sick patient.

### **Dar’s post-primary care visit—emergency room and primary care communications success**

Dar found herself in crisis: the primary care office failed to thoroughly investigate her pain; the urgent care office cut short remedial actions due to the relative gravity of the pain’s location; and suddenly Dar was in the emergency department. Despite this difficult odyssey, Dar reflected, “What was really nice is this ER surgeon read through all of my history and I told him, I am so nervous to have another surgery. I’m anxious because I just cannot afford to lose any more bowel. I formed, in a short amount of time, a relationship with this ER doctor because he said, ‘I read your history, and I will try to calm your anxiety.’ That really helped me to know he knew my history. In the end, it wasn’t an abscess but an abdominal fistula.”



Dar noted that some aspects of the patient-physician communication went well. “It was great that the first physician called to say, ‘What is it you want me to do?’ I thought it was part of shared decision making in a different way. And the ER doctor reading my history and really understanding where I was coming from ... not just with the physical piece but with the emotional piece, too. After all of this, I wrote a letter to the primary care physician who didn’t seem to be listening to me, and she did call me back. She disclosed, ‘A lot of my colleagues said don’t call her [Dar] back’ because of seeing me as a dissatisfied patient. I really gave her credit that she went against her colleagues’ advice. The physician’s response was, ‘I really learned from this.’ I really think it was a teachable moment: Listen to your patients. We do know our bodies. That first physician, she learned to really listen to her patients. So, be more proactive in your health care.”

# ERIKA

## **Erika's pre-visit**

Erika has recently become a U.S. citizen. She described her experience as a pregnant woman who spoke little English seeking pre-natal care in a health care system with which she was unfamiliar. “I just found people who speak Spanish, so I say where I can go? I ended up going to this clinic, this hospital to take care of my pregnancy. I had several bad experiences.”

## **Erika's during-the-visit uninvited observers**

She explained that sometimes there was an interpreter, but sometimes not, and at each visit, she had a different doctor. She was also frustrated by the long wait times—often an hour or two—with no explanation except that appointments were running late. Then came her delivery. “When I have my baby, and it should be a very nice experience, but for me it was bad because all of a sudden I had a team of students looking at me and in a very vulnerable place and, you know, kind of like a soccer game, you know like ‘yeah, yeah’ and everyone talking. I’m putting my head down and I got very uncomfortable. And I didn’t know I could say ‘no,’ and I didn’t know I had another choice.”

## **Erika's post-visit smack**

After her baby was born, he required medicine for an illness. Erika's visit to the pharmacy was also unpleasant. “They tried to tell me how my middle name is Maricella and it was hard to spell. So I take a long time thinking how to spell my name in English and I say to the lady, ‘I can write it down for you,’ and I take a pen and paper, and she totally slapped my hand. And I was in shock, thinking this lady just actually slapped my hand. There were other people watching that—her coworkers—and they didn’t say anything when the pharmacist slapped my hand. And I didn’t know where to go I didn’t know what to do. I didn’t want to hit her back. I just feel frustrated, right, that someone was extremely disrespectful to me, and I just had to be quiet and not do anything.”

## **Erika's medical record misfortune**

“After I had my baby and all this, I received a huge bill and I thought ‘Why?’, when my insurance paid for this, and there is a dermatologist? It takes a long time to call, and of course another call to another call to another call. I found there was another lady with the same name as I am, and they mixed up the medical records. So I received bills for a problem with skin that I never had. And then I became very worried because what if they put I had this and I had this I didn’t know now, my history, my medical history, was totally mixed up.”

### **Erika's post-visit choice**

“So I was really frustrated until finally I decided I have to stop going to this clinic. And then I found out, like after TWO years, that I can actually choose another place to go – that wasn't the only choice. My English started getting better and better. So now I come to a different place [for health care].”

### **Erika's post-visit communications success**

After some humiliating encounters with the care delivery system, Erika became aware of how the matter of choice can enter into her decisions about where to seek care. “I called the insurance and



I found out that I can actually choose another place to go! They treat me like a person. They treat me so respectfully. I go to my appointment where I always see the same doctor. They actually call me, ‘okay you need this medication, how do you feel?’

I feel like I can choose where to have my baby. I can have a tour and see the process. I can have a doula. It was a totally different experience for me.”

### **Erika's views on during-the-visit pitfalls**

“So then I found that there's many people who are really vulnerable, not only immigrants, but older people, poor people, or people in depression. [At the first clinic], I don't think they are taking care for the staff; I don't think they are careful how they treat the patients. I was a number, like 1, 2, 3, not a patient. Like next, next, next. And the second place really treated me like a human being, with dignity. They always make sure they understand me. They empowered, listened to me and make sure I feel okay with that.”

## *Patient Panel Final Recommendations*

**Tim** said, “I still have to [recommend] the use of new tools, and I understand the regulations, however using what you can as fast as you can, easily, it doesn’t have to be expensive things. Take as many chances as you have as fast as you can and make it so the patient has easy access to you and vice versa.”

**Dar** reiterated the importance of listening to the patient and shared decision-making and to be a bit more of a team [with the patient]. She also added, “I agree with Tim, but also don’t underestimate the impact of the good old fashioned phone call. You know I had a doctor call me at 6:00pm on a Friday, and to me that really, really meant something. I guess the good old fashioned way is pretty intimate too.”

**Erika** urged, “Get to know your patients, at least who they are. Probably they will give you an idea of what they need, and also I agree with Tim about making it easier for the patients to communicate with you.”



## Quality Improvement case studies

Often, a clinician may ask, “Where do I begin?” Finding the time and learning the skills to partner with patients to support healthy behaviors is challenging given the demands on in-office care today. But clinicians can use similar skills and tools to change their practices as patients use to change health behaviors: start small, choose one skill or process to change, try it with just a few patients, and then assess the experience. Engage others in the care system to take a role. Together, problem-solve the issues that arise and build on successes. Below are a few examples of ways to begin.

### **Build a shared agenda:**

Choose one of the case study concepts or other tools in this guide and try it with five patients. Did using it help to make the communication and/or patient-family conversation more collaborative? Did it give you more information about each patient’s (or family member’s) concerns? Mail a pre-visit preparation form (see Example #2 in the Pre-Visit Case Study section: Gathering Clinical and Patient Experience Data) to five patients before their scheduled visit. Did the patients have more questions? Was the conversation during the visit more productive?

### **Provide clear information:**

After providing information about treatment or medication during the visit, use the “closing the loop” technique described in Example #3 in the During-the-Visit Case Study section: Addressing Health Literacy. Were the patients able to repeat the instructions? Did they follow through on lab and radiology appointments? Call them at home two days after the appointment—did they remember their instructions accurately?

Complete after-visit summaries with five patients (see the case study by Stillwater Medical Group in the Post-visit section). Did patients have more questions? Did they follow through on lab and radiology appointments? Call them at home two days after the appointment—did they remember their instructions accurately?

### **Set goals and make action plans:**

Ask five patients what they would most like to work on to improve their health. Note the goal in their charts, and then ask them to meet with a nurse or medical assistant to complete an Action Plan. Follow up on their next visit to see how they did.



**Choose a “population of focus,” such as patients with diabetes, with whom to test changes:**

Identify diabetes patients who have upcoming visits scheduled by reviewing the next day’s appointments. Choose one of the tools in this guide to test with this patient population. Place a copy of the tool in the chart in advance of the visit to remind the care team to review the tool with the patient.

**Engage other members of the care team:**

Discuss the changes you are testing with the entire practice team. Are there ways that they can help prepare or complete some of the tasks so the visit goes smoothly? Assign roles and tasks to each team member to enhance each patient’s care experience (see Example #3 in the Pre-visit Improvement section: Implement Office Huddles). Ask patients how they feel about the changes to the visit that you are testing. Getting their feedback early in your change process will help you become more effective.

# Pre-Visit Case Study Improvements

## Example 1—Setting the Stage

Presented by Janet Wied, Director of Patient Service and Access Strategies, Allina Clinic

Patients' judgment of their health care experience begins before they set foot in the clinic building for an appointment. Communications when scheduling an office visit and additional follow-up encounters have set the tone by the time the patient comes face-to-face with a clinician. Janet Wied of Allina describes several pre-visit improvement projects accomplished within her large clinic system.

### The Problem:

In the Allina case study, the problem was defined as necessary information being incomplete when the patient comes into contact with the clinician, making it difficult to have enough time to accommodate actual care when already the scheduled encounter time is very short.

### The Solutions:

Allina came to realize there are multiple solutions with no single magic bullet, and that an improvement project will neither be complete nor perfect. First of all they tackled the process of scheduling the appointment. They found several factors in this process that alone contributed to the crunch experienced at the appointment, including the lack of available appointments, little expertise, too many calls in and out, inconsistent practices to schedule appointments and it was designed around the provider. To hit upon eventual solutions they had to begin with opening themselves to possibilities of new ways of working—*namely by establishing more standardization.*

Tactical solutions to standardize appointment scheduling and thereby improve the process were varied. ***Successful tactics included:*** scripting for professionals staffing the appointment line; automatic reminders of appointments for patients; automated voice system prompts; the use of MyChart (an on-line tool for patient access to appointments and medical information) and ending the practice of scheduling physician appointments based on personal preferences. Barriers were overcome through adaptive tactics such as: acceptance of the enormity of change management; commitment to sticking to the change decision and perseverance—continuing to check in on performance and ask the right questions. For instance, Allina ***explored use of a pre-visit questionnaire to garner all relevant information directly from the patient.*** When the survey was disseminated from the check-in desk, Allina did not see the results they wanted. Hence, they are trying new approaches using on-line tactics and not relying exclusively on their first attempt. They

gave thought to the way the survey pilot was introduced and will continue to reflect on the rollout of each strategic effort to learn from each pilot regardless of its success. Critical thinking is a resource useful in helping overcome barriers yet to come.

*Process improvement tactics* included mobilizing patients to take action. With *new scheduling scripts*, patients were told to bring medications to every appointment and to review their list prior to seeing the clinician. They were also asked “What else do you need?” and “Is there anything else I can help you with?” At times patients were reminded: “Let’s schedule your eye exam and/or mammogram or colonoscopy right now.”

### **The Results:**

By collecting data on incoming, outgoing, abandoned phone calls and claims data, Allina reached a 67 percent decrease in abandonment rate and 100 percent drop in calls formerly re-routed due to no answer, while overall call volume increased by 20 percent and eligibility denials have dropped by 50 percent. Patient survey comparisons reflect improved ratings on access and telephone service levels for sites that employed process changes and not for the sites that did not pilot the changes.

## ***Example 2—Gathering Clinical and Patient Experience Data Before the Visit***

### **The Problem:**

Today, visits to the doctor are short, while treatment regimens for common conditions like diabetes and heart disease are more complicated. The number of required tests and conditions primary care doctors are supposed to screen for has skyrocketed. It’s estimated that a doctor with a panel of just 2,000 patients—and without a strong primary-care team—would have to spend more than 17 hours a day providing all of the recommended care. This is not a recipe for optimal care. One Canadian and U.S. study found that doctors interrupt their patients on average within 23 seconds from the time the patient begins explaining their symptoms. In 25 percent of visits, the doctor never even asked the patient what was bothering them. In another study that taped 34 physicians during more than 300 visits with patients, the doctors spent on average 1.3 minutes conveying crucial information about the patient’s condition and treatment, and most of the information they provided was far too technical for the average patient to grasp; disconcertingly, those same doctors thought they had spent more than eight minutes. In another study, three out of four doctors failed to give clear instructions on how to take medication. When asked to recall their medication instructions, half of patients had no idea what they were supposed to do.

In summary, physicians rarely have time in a visit to adequately support patients in managing chronic conditions. A team approach may help manage a physician’s time more effectively during the office visit. This strategy involves the efficient use of support staff to elicit patient needs prior to the visit—optimizing the physician’s time with the patient during the appointment.

## The Solutions:

1. Designate a member of the care team to gather two areas of information in advance of the patient visit:
  - **Clinical information** such as
    - recent lab results,
    - current diagnoses that need routine monitoring and follow-up (such as hypertension, depression, asthma)
  - **Patient “experience” information.** This should be collected in advance of the visit by having a receptionist or scheduler mail a Visit Preparation Form, asking the patient to bring medications or records of medication use to the visit. In addition the form should ask them to:
    - Make a note of successes and problems they had in achieving their health improvement goals and/or action plans
    - Make a list of concerns and questions they have about their condition, medications, tests, treatments or health in general
    - Let the clinic know if they require special needs during the visit, such as an interpreter
    - Because depression is such a common co-morbidity in people with chronic conditions, you may also wish to include depression screening questions (such as the PHQ-9) in the Visit Preparation Form

When the patient checks in for the appointment, have the receptionist ask for the completed form. If the patient forgot to bring the form, ask them to complete it again while waiting to see the physician.

2. Having all information readily available for the clinician frees up time for the clinician and patient to communicate about the high-priority issues of concern. Visit time can be spent on recommendations about treatment and collaborating to develop a care plan to help the patient and family members manage better at home. Consider the flow of a planned care visit and the personnel available in the office, and determine who is the best member of the care team to carry out the information gathering tasks above.
3. With standing orders, medical assistants can prepare for the visit by arranging for screenings and labs to be done in advance and ensuring that the results are readily available in the chart.

## The Results:

Having current information on the clinical indicators *and* patient concerns prepared in advance provides the clinician with more time to address clinical concerns and the patient’s own goals, and the time to build a collaborative relationship that supports self-management. Care teams may find it useful to hold a brief “huddle” at the beginning of the day to review the patient schedule along with clinical information to aid in preparing for each patient’s visit that day.

## Example 3—Implement Office Huddles<sup>5</sup>

### The problem:

Sometimes we can learn a lot from another industry. If your practice is looking for efficiencies and methods to benefit from teamwork, a quick huddle, like football players, can ensure everyone is on the same page. Daily huddles are being tested as a new model of family medicine practice enhancement that can address a number of critical issues. Huddles allow practices to plan for changes in daily workflow, manage crises before they arise and make adjustments that improve patient's access and staff member's quality of work life.

### The solution:

Practices that have implemented daily huddles that include physicians and staff say they have improved their communication. Intended to be quick and efficient, the huddles are often limited to no more than seven minutes during which everyone stands. Huddles can benefit practices of any size. In large practices that use multiple hallways or pods, someone from each hallway can attend the huddle and take important information back to his/her area. Huddles have helped to eliminate these type of situations:

- Confusion about provider availability for scheduling
- Lack of awareness about broken equipment, unavailable labs
- Lack of preparation for scheduled patients who require extra time and assistance, such as an interpreter
- Chaos due to last-minute schedule changes, caused by patient cancellations, unexpected provider hospital visits, computer network down, traffic jams, etc.

### The keys to successfully implementing huddles in a practice are as follows<sup>5</sup>:

**Get physician buy-in.** Regardless of whether the physician attends the meeting, his or her support of daily huddles is critical to their success.

**Settle on a time to meet consistently.** It's important that the "huddle time" becomes a part of everyone's daily routine. However, it might take some experimenting to figure out what the right time should be. If the first time you pick doesn't seem to be working, don't give up. Try another time of day. Early morning huddles have worked well for some practices, while other groups prefer to meet after lunch or late in the afternoon.

**Experiment with different participants.** The best huddle won't necessarily involve everyone in the practice. At some of the practices, the physicians attend. In other practices, the medical assistant or registered nurse attends and then reports back to the physician.

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<sup>5</sup> Text taken directly from the article in *Family Practice Management*, June 2007. *Huddles: Improve Office Efficiency in Mere Minutes*, Elizabeth E. Stewart and Barbara C. Johnson. For more information on the national demonstration project, see *TransforMED Tries to Rebuild Family Medicine*, *FPM*, May 2007.

**Limit huddles to seven minutes or less.** This keeps the meeting focused and prevents team members from becoming long-winded.

**Hold the huddle in a central location.** For example, you might simply gather in the hallway outside the nurse's station.

**Have everyone stand the entire time.** This helps keep the meeting short so you can get back to seeing patients.

Two additional guidelines can be disregarded after a few weeks if everything works correctly:

**Designate a huddle leader and put together a structured agenda.** (See “Suggested Huddle Agenda,” below.) After a few weeks, the huddle will run itself.

**Identify a huddle champion who can provide daily discipline.** It's best if the champion is a physician or office manager. Once the huddles gain momentum, the benefits become self-evident and no extra effort is required. In practices that have experimented with this, this has usually happened somewhere between two days and two weeks.

#### **Suggested Huddle Agenda:**

- Check for patients on the schedule who may require time and assistance due to age, disability, personality, language barriers. Identify who can help.
- Check for back-to-back lengthy appointments, such as physicals. Determine how they can be worked around to prevent backlog.
- Check openings that can be filled or chronic no-shows that can be anticipated. Identify and give any special instructions to the scheduler.
- Check provider and staff schedules. Identify who needs to leave early, or break for a phone call or meeting.
- Decide if lab results, test results and notes from other physicians are ready in the patient chart. Identify gaps, track down and retrieve results. If these tests are still needed, determine the most efficient flow for the patient.
- Decide if the patient has any routine tests that are needed (mammogram, colon cancer screening, etc.) and flag the chart for the physician.

#### **The Results:**

Many of the practices that have implemented huddles have a hard time imagining a day without them. They have seen how these mini-meetings between physicians, nurses and receptionists have empowered each team member to achieve day-specific goals that reduce wait times, strengthen communication, improve customer service and improve other office efficiencies.

# During-the-Visit Case Study Improvements

## *Example 1—Patient Experience Shadow Coaching*

**Presented by Nancy Salazar, Director of Care Innovation and Measurement, HealthPartners Medical Group and Clinic and by Cheryl Magnuson-Giese, Senior Director Physician Services, HealthPartners Medical Group and Clinic**

### **The Problem:**

Nancy Salazar and Cheryl Magnuson-Giese of HealthPartners, teamed up to present an improvement project that required their two departments to work in tandem. The problem was identified as an achievement gap in patient satisfaction scores of the care experience provided by physicians and advanced practice providers. The additional challenge when thinking of a solution was that physicians and advanced practice providers had very limited time, away from patients, in which to learn about an improvement tactic.

### **The Solution:**

Given the barrier of physicians'/advanced practice providers' lack of time, HealthPartners sought a model that could be applied during physicians' regular office appointments. Experience Shadow Coaching is one such approach. Developed by Fallon Clinic in Massachusetts and Dean Clinic in Wisconsin, it consists of systematic and real-time feedback to the caregiver based on their actual office visits with patients. It requires trained shadowers who can skillfully give feedback to physicians/advanced practice providers and organizational support for the caregiver to change their behaviors.

Physicians/advanced practice providers do not have extra time to shadow and train each other on patient satisfaction and the chosen model uses non-clinicians to do this job. At HealthPartners, time and dollars are saved by leveraging volunteers rather than paid staff. In fact, the shadowers come from within the employer organization and commit to 1.5 days per month over the course of one year. Volunteers are trained in effective observation, logistics and optimal techniques to use to give feedback. To make data available for improvement, volunteers learn checklists of specific behaviors which correspond to patient satisfaction. They may also offer subjective observations. Feedback must center on the positives after the first shadowed appointment, to build rapport. Over the course of a full day, the volunteer documents the caregivers' behaviors on checklists and completes the report for physician/advanced practice provider review within 48 hours of shadow day.

For shadow coaching to be appealing and effective, it is made optional to the caregivers, and they are asked to rate their experience of being shadowed, including evaluation of their shadow coach. Ratings of the caregiver are kept confidential so each professional can be in charge of how s/he proceeds in improving his/her patient satisfaction behaviors without fear of it damaging performance evaluations. Each caregiver receives real-time results from the patients' perspective in the form of surveys completed by patients whose appointments were shadowed and, comparatively, surveys completed by a patient cohort 45 days post-shadow date. Patient consent to the shadow's presence must have been recorded, and appropriate materials were provided to clinic administrative staff in preparation for each physician's training experience. Site manager and other resources employed



in preparation of the shadow day help to make it run effectively, generating the required consents and survey completions. Hence, not only are coaches evaluating each caregiver, but their actual patients add street credibility to deepen teachable moments. The patients provide what is essentially a dry run of the CG-CAHPS scoring that will ultimately carry significance for the performance evaluation of each caregiver and clinic group. Coaches record physician behaviors based on factual and observable measures that can be assessed in simple yes/no answers. For instance, one measure is: Did the physician knock on the door prior to entering? The objective nature of the measures results in consistency of data, fostering positive behavior change, which can easily be measured against the benchmark. Effective measurement enables the improvement in physician communications that everybody values.

Using a cadre of volunteer labor for shadow coaching within busy schedules is not simple. The complexity was overcome by dividing responsibilities between two departments. Physician Services undertook the overall program coordination of a) matching of coaches to each volunteering physician/advanced practice provider, b) sharing information, and c) follow-up. Care Innovation and Measurement managed the survey process and delivered results to physicians. It also analyzed success of the program overall.

### **The Results:**

Through collaboration, the shadow coaching strategy has resulted in tremendous benefit to physicians, advanced practice providers and patients. Most physician leaders chose early in the program to be shadowed. They received pre/post-data and have the option to apply the learning experience toward CME credit. Patient scoring focuses on the specific behaviors that were of interest on the shadow coaches' checklists. An impressive 71 percent of shadowed caregivers demonstrated improved patient satisfaction scores upon comparison of the patient cohort on shadow day to the patient cohort 45 days later. The range of improvement spanned 1 percent to 59 percent. Those who started with lowest scores on shadow day were those who enjoyed the greatest improvement. Physician/advanced practice provider evaluation of the program has kept it in operation. On a scale of 1 to 5, they rate it 4.3 as helpful in improving patient interactions, and 4.5 as a tactic they would recommend to others. Subjective feedback includes:

- “It is the only way for me to get fresh eyes on my practice style and habits.”
- “Shadow coaching points out things I do not usually think about.”
- “Amazingly thorough and gave specific examples and suggestions.”
- “Enjoyable experience and patients appreciated the effort.”

To keep shadow coaches primed for success they attend regular meetings to discuss improvements. Physicians/advanced practice providers rated their shadow coaches' performance at 4.54.

This case study demonstrates strategies used to overcome cost and confidentiality barriers, and additional roadblocks such as physician personal preference in how the scheduling occurred. With physicians and advanced practice providers having hectic schedules, the shadow coach sets up the date based on the caregiver's availability. As with any volunteer operation, the continuity of coaches is a staffing concern. However, it seems that drawing from employees of the very organization trying to improve helps to build a deeply committed crew of coaches. Employee coaches also tend to have managers who are amenable to switching their hours to accommodate the innovative coaching service. Thus far, the supply and demand for coaches has met the program need. Leadership must be committed to keeping the program voluntary for it to enjoy the desirable status it currently holds in physician and advanced practice provider development.

## Example 2—Addressing Health Literacy<sup>6</sup>

### The Problem:

Health literacy has been defined as the ability to read, understand and act on health care information.<sup>7</sup> People with low health literacy have trouble reading, interpreting and understanding patient educational brochures, prescription labels, consent forms, appointment cards, medical history and insurance forms, etc. Most of these individuals tend to not have completed high school and many come from lower socioeconomic status. A disproportionate number of individuals with low health literacy represent racial/ethnic groups, but surprisingly, the largest numbers are white and native to the United States. Approximately 25 percent of people with low health literacy are immigrants and 44 percent are over the age of 65. Evidence suggests that low health literacy may be related to adverse health outcomes. One of the findings associated with these poorer health outcomes is confusion with verbal and written physician-patient communication.

Regardless of health literacy, studies have shown that 40 to 80 percent of the medical information patients receive is forgotten immediately<sup>8</sup> and nearly half of the information retained is incorrect.

### The Solutions:

Physicians must be alert for the possibility of low health literacy among all patients. Patients may be unaware of how inadequate their literacy skills are—and many who are aware are deeply ashamed. Most people with low literacy hide their problem.

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<sup>6</sup> Ideas and text taken from *Roadmaps for Clinical Practice: A Primer on Population-Based Medicine*, American Medical Association; 2002. VI. Health Literacy and Cultural Competence, pgs 52-54.

<sup>7</sup> *AMA Health Literacy Introductory Kit*. Chicago, Ill: American Medical Association; 2000

<sup>8</sup> Kessels RP. Patients' Memory for Medical Information. *J.R. Soc Med.* May 2003; 96 (5): 219-22

Physicians and relevant clinic personnel can informally assess patient health literacy. Numerous instruments exist for a formal assessment; however, many experts are strongly opposed to routine testing of patients to assess level of health literacy because of risk of embarrassment. Here is a recommended two-step approach.

**First**, informally assess patients' comprehension by reviewing with them written or oral treatment instructions.

**Second**, enhance effective communication through simplifying and organizing the essential patient education information, providing only two or three concepts at a time and then checking for understanding.

For each of these steps—check for understanding by asking the patient to “teach back” the information by asking them to answer these simple questions:

- Tell me how you will do this at home
- Show me what you will do
- When you go home, what will you say to your family members about what we talked about today and what you plan to do?

**Other tips for the teach-back method:**

- **Start slowly.** Initially you may want to try it with the last patient of the day.
- **Plan your approach.** Think about how you will ask your patient to teach-back information based on the topic you are reviewing. Keep in mind some situations will not be appropriate for using this technique.
- **Use handouts.** Reviewing written materials to reinforce the teaching points can be very helpful for patient understanding (given there are no literacy concerns or language barriers).
- **Clarify.** If patients cannot remember or accurately repeat what you asked them, clarify your information or directions and allow them to teach it back again. Do this until the patient is able to correctly describe in their own words what they are going to do, without parroting back what you said.
- **Practice.** It may take some getting used to, but studies show that once established as part of a routine, it does not take longer to perform.

**Other solutions you should consider include:**

- Make sure all materials (forms, educational materials, medication instructions, written care plan, etc.) are in the patient's primary language.
- Make sure materials are at a lower educational level.
- Make arrangements to have a relative, trusted friend, or interpreter at the visit to help the patient understand the medical diagnosis, the plan for follow-up care and testing, medication instructions and have the opportunity to ask questions and demonstrate teach-back in their primary language.

## The Results:

A recent study by the Agency for Healthcare Research and Quality found strong scientific evidence that “asking patients to recall and restate what they have been told improved patient safety.”<sup>9</sup> In another study<sup>10</sup> of physician communication with diabetic patients who had low health literacy, physicians in studying recall and comprehension of new concepts, found that patients whose physicians assessed recall or comprehension were more likely to have hemoglobin A1C levels below the mean versus patients whose physicians did not use this technique.

## Example 3 – Collaborative Agenda Setting<sup>11</sup>

### The Problem:

Often, despite great care taken to provide patient-centered care, between 30-80 percent of patients’ expectations are not met in routine primary care visits. Important concerns may be overlooked or not addressed because the physician is not aware of these worries. Physicians often redirect patients at the beginning of the visit, giving them less than 30 seconds to express their concerns. Later in the visit, physicians tend to not involve the patient in decision making, differences in agendas and expectations are not reconciled and not surprising, many patients forget more than half of the physicians’ clinical recommendations. Adherence to treatment is poor and these problems will likely persist even in the face of practice redesign, unless communication between patients and physicians is addressed.

### The Solution:

Use principles of patient-centered communication to structure the initial moments of a medical encounter so that the physician can reliably elicit, explore and respond to patient concerns. Two important elements are drawing out a patient’s true concerns and then identifying which ones to address first. Don’t assume the first concern mentioned is the most important one. Also don’t assume the patient will spontaneously report all of his/her fears and concerns. Eliciting all of the patient’s concerns early in the visit can be as simple as asking, “Is there something else you’re concerned about?” until the patient answers “No.” Doing this at the beginning lowers the likelihood patients will bring up additional concerns late in the visit when there is no time left to address them. When all concerns are elicited, prioritize them explicitly with the patient. **NOTE:** the physician will have an

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<sup>9</sup> Agency for Healthcare Research and Quality. *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. July 20, 2001. AHRQ publication 01-E058.

<sup>10</sup> Schillinger D, Piette J, Grumbach K, et al., *Closing the Loop: physician communication with diabetic patients who have low health literacy*, *Arch. Intern Med.* 2003 Jan 13; 163 (1): 83-90

<sup>11</sup> Text taken directly from Epstein RM, Mauksch L, Carroll J, Jaen CR. *Have you really addressed your patient’s concerns?* *Family Practice Medicine*, March 2008: 35-40. Full article can be found here: <http://www.calquality.org/documents/ipe/AgendaSettingArticlefpm.pdf>

<sup>12</sup> Kravitz RL. *Patients’ expectations for medical care: an expanded formulation based upon review of the literature*. *Med Care Res Rev.* March 1996:3-27.

easier time addressing all concerns during the visit if the patient has identified concerns in advance by completing a form at home or in the waiting room prior to the office visit. (See Example #2 in the Pre-visit section of this guide: Gathering Clinical and Patient Experience Data before the Visit).

### **Establishing Focus: Collaborative Agenda Setting**

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<b>Step 1: Orient the Patient.</b>	“I know we planned to talk about your blood pressure, but first I want to check if there are some other concerns you hoped to discuss. This way, we can make the best use of our time.”
<b>Step 2: Mindfulness cue.</b>	Remind yourself that you may not be able to address all problems and issues in one visit.
<b>Step 3: Make a list.</b>	“What concerns would you like me to know about today?” Then: “Is there something else?” and “Something else?” <b>Or</b> – “Let’s read through this form you completed before the visit listing the concerns and questions you had for me today.” Then: “Has anything else come up since you completed this form?” and “Anything else?”
<b>Step 4: Mindfulness cue.</b>	When necessary, make space for the patient to tell his/her story before the entire list of concerns is elicited.
<b>Step 5: Avoid premature diving into diagnostic questions.</b>	“Excuse me for a moment. I am getting a little ahead of myself. Before we talk further about your headaches, do you have other problems or concerns you wanted to discuss today?”
<b>Step 6: Mindfulness cue.</b>	Ask yourself, “Do I feel able to address all the patient’s concerns today? Do I need to put some concerns off for a later visit?”
<b>Step 7: Confirm what is most important to the patient.</b>	“My impression is that talking about _____ is most important. Is that right?” Or “We may not be able to do a good job on all these concerns today. Which concerns are most important today?”
<b>Step 8: If needed, express your concerns about particular issues and negotiate how to best spend your time.</b>	“In addition to talking about your neck pain, I would like to discuss your blood pressure.”
<b>Step 9: Seek confirmation and commitment.</b>	“OK, let’s start with your neck pain, and we can check in on blood pressure. If we cannot do a good job on the other items, then let’s arrange for another visit.”

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## The Results:

Patient-centered communication involves focusing on the patient's needs, values and wishes. It is associated with improved patient trust and satisfaction,<sup>13</sup> more appropriate prescribing,<sup>14</sup> and more efficient practice.<sup>15</sup> Other research has shown the agenda forms have resulted in greater number of concerns addressed, and greater patient satisfaction with the discussion. Physicians have had fears that eliciting all of a patient's concerns would lengthen the visit. It has been found that with training in the use of the Establishing Focus Protocol, physicians were able to address more concerns without affecting visit length.

## Post-Visit Case Study Improvements

### Example 1—Using After Visit Summaries to Improve Patient Experience Outcomes

**Presented by: Larry Morrissey, Pediatrician and Medical Director for Quality Improvement, Stillwater Medical Group**

#### The Problem:

Patient care does not end when the clinician exits the exam room. The Stillwater Medical Group launched the After Visit Summaries (AVS) project to improve patient experience ratings of the clinic encounter—specifically to improve performance on the CG-CAHPS question, “During your most recent visit, did this doctor give you easy-to-understand instructions about taking care of these health problems or concerns?” Additionally, leadership was mindful of needing to comply with meaningful use criteria<sup>16</sup> and decided a handout of the clinician's summary of diagnoses and patient instructions had potential to constitute meaningful use of the electronic health record (EHR).

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<sup>13</sup> Fiscella K, Meldrum S, Franks P, et al. Patient trust: is it related to patient centered behavior of primary care physicians? *Medical Care*. 2004; 42:1049-1055.

<sup>14</sup> Epstein RM, Shields CG, Franks P, Meldrum SC, et al. Exploring and validating patient concerns: relation to prescribing for depression. *Ann Fam Med*. 2007; 5: 21-28.

<sup>15</sup> Epstein RM, Franks P, Shields CG, et al. Patient-centered communication and diagnostic testing. *Ann Fam Med*. 2005; 3: 415-421.

<sup>16</sup> The Centers for Medicare and Medicaid Services (CMS) electronic health record (EHR) financial incentive program to spur the “meaningful use” of certified EHR technology to achieve health and efficiency goals. By putting into action and meaningfully using an EHR system, providers could reap benefits beyond financial incentives—such as reduction in errors, availability of records and data at the point of the encounter, reminders and alerts, clinical decision support, and e-prescribing/refill automation. The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.
- Simply put, “meaningful use” means providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.

## **The Solution:**

Stillwater Medical Group is a multi-specialty site including primary care in family medicine, internal medicine, pediatrics as well as urology, surgery, obstetrics, occupational medicine and more. To set the stage, medical group leadership had already proclaimed patient-centered care as their core priority and fostered careful attention to systems that resulted in supporting the quality of services they wished to render. The EHR—one of those supporting systems—had “built in text” for important and common conditions, and the visit summary printout was automated along with standardizing the distribution of the hardcopy to the patient. The visit summary report is given to the patient to take home and outlines all the issues addressed during the visit, test results, lists the medications and important follow-up steps to take. On a strategic level, this routine issuance of a handout felt like an achievable goal as the computer systems were ready to start producing the after visit summaries and collecting data for patient satisfaction was already in place.

During the course of the improvement project, a few barriers quickly became evident. Clinicians did not consistently use the AVS tool, it required time for them to use it and hand it out, and evaluating if the information was actually useful to the patient was an area to assess and improve upon. In the project launch, the strategy was to seek out early adopters to promote the new practice. When the results of these early adopters revealed dramatic improvements in their individual scores, a promotion and sharing campaign of the AVS project to the providers en masse occurred.

## **The Results:**

As mentioned, the clinic had already instituted data collection on patient satisfaction facilitating their ability to track the results of this particular improvement project. The CG-CAHPS domain of clinician/patient communication is broad, with no guarantee that a strategy focused on any particular element of the patient experience will translate into improved scores overall. With many different measures to choose from, Stillwater elected to improve ratings on the question, “During your most recent visit, did this doctor give you easy to understand instructions about taking care of these health problems or concerns?” The performance on this question was strongly correlated with the CG-CAHPS survey question that asks patients to give an overall rating of their doctor. Hence, the post-visit problem they tackled was twofold: to improve patient satisfaction vis-à-vis scoring on whether care instructions were easy to understand, and to fulfill meaningful use requirements.

The performance data collected from the project conveyed the use of AVS in various specialties. Across the entire practice, use increased from one quarter to another, and then dipped in the third quarter of implementation. Perplexing performance dips like this might be easily explained by something as simple as a printer losing its connection to the server or the printer location changing and clinicians not making the hardcopy available to the patient. In grappling with variation, Stillwater found that many diverse factors affected the outcome. However, with a steady increase in the use of AVS, the patient ratings of “easy-to-understand instructions” increased in parallel fashion.



## Example 2—Communication and Tracking of Test Results

### The Problem:

Health care organizations continue to struggle to ensure good communication and follow-up with the patient after the patient leaves the office. This becomes a safety and liability concern especially if abnormal diagnostic test results are not communicated or acted upon in a timely and appropriate manner. And why keep a patient guessing with a “no news is good news” policy as this too can be a liability nightmare? Emerging evidence highlights vulnerabilities in test result communication practices along the entire spectrum of test result abnormality and severity. In the 2001 Institute of Medicine report *Crossing the Quality Chasm*, its examination of medical errors found that although the ultimate error is generally a mistake in treatment or diagnosis, 55 percent of these errors are set in motion by informational or personal miscommunication. The National Practitioner Data Bank – Public Use File – September 30, 2007, shows that most common Diagnosis Related Claim is Failure to Diagnose.<sup>17</sup> A majority of these claims are tracking and communication errors in which test results are not completed, lost, or not communicated to the patient in a timely manner. This can be completely prevented with a well thought out patient communication and tracking system.

For the purposes of improving a patient’s experience with your clinic practice, improving patient safety and reducing malpractice risks, every practice should be sure that:

- Every test (including normal results) is communicated to patients
- The need for follow-up is stressed
- Non-compliance is addressed
- Everything is documented

In addition to addressing safety and liability concerns, getting results communicated even when non- life- threatening and even if the results are normal is an important connection point between clinic/provider and the patient. Good communication about test results is an important factor in the global experience the patient has with your practice as well as opens many doors for improving care and health.

Even with these clear goals and good intentions, ensuring delivery of all test results can be challenging for many reasons, the following reasons being the most common:

- Difficulty in identifying the correct ordering provider and/or his/her contact information
- Transmission of information must be accompanied by backup procedures to ensure delivery actually occurred, and
- Verbal notification of results must be accompanied by read-back procedures to ensure accurate transcription

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<sup>17</sup> *Communication and Tracking of Lab Results – a Modern Approach*; [www.executivehm.com](http://www.executivehm.com), 2012

## The Solution:

Proper tracking and communication of test results is no longer an option for offices – it is a requirement. It should be a policy goal for every practice to require a provider to communicate test results to each patient in a relatively short time (1-2 week) period. For best results, the optimal solution should be time and cost effective and easy to learn and use. Achieving 100 percent communication may not warrant direct verbal communication, and given today's information technology infrastructure and levels of privacy other methods can be used such as secure fax, e-mail, pre-formatted letters and/or patient log-in section in the electronic medical record. Ideally, every patient should be asked what communication method would work the best for them – optimally a practice would have the ability to implement more than one method depending on patient preferences, their access to and use of technology, as well as the office's availability of information technology and adequacy of staffing.

### Three different ways patient tracking and communication could occur are detailed here:

- 1. Paper tracking and calling patients manually** – This is a time-honored method that is generally recommended. Tests ordered are entered into a ledger or tickler file, crossed off when the result returns, and then periodically checked to see what tests have not been completed. At that time, the patient is reminded (by phone or mail) that the test has not been completed and encouraged to do so. Test results are called to patients, sometimes by the physician (especially for abnormal results and if planning needs to occur for further tests and/or referrals) or by ancillary staff.

**Challenges** – This method is time consuming and fraught with error. If you choose to use this method, ensure you have a very tight policy and procedure in place where all have been trained on the steps and staff roles and responsibilities are trained on rigorously. Also, be sure responsibilities between providers is clear (primary care provider versus specialist and/or covering provider). It is best to take the practice that if you are the ordering provider (you ordered the test be performed), regardless of specialty or routine relationship with the patient, then you take responsibility for communicating and initiating any other follow-up of abnormal results. Be sure your procedures also include a time frame/limit for communicating results (from the time the result becomes known to when the patient is notified); and that this time schedule include prioritizing reporting of abnormal results. Finally, audit your entire tracking and communication process to ensure compliance with your policy and procedure, your thoroughness of tracking and the timeliness of communication, including timeliness of follow-up for abnormal or missed/yet to be obtained test results.

- 2. Automated tracking calling systems** – This method addresses the challenge of managing protected health information, since it can take multiple calls to reach a patient and due to privacy rules, you should not leave test results on an answering machine. A variety of calling systems are available that can save time on contacting patients. The best choice would be a system that can free up enough staff time to do the manual tracking portion. There are web-based applications that combine an automated tracking system with a unique calling system which allows you to send not only test results but also reminders and messages to patients – without ever using the

telephone. The office would need access to broadband internet connection to implement this solution. The results and messages are delivered to secure and private patient voicemail box and the patient can then dial a toll-free number to listen to the message. These applications can also alert the office staff if tests are not completed or messages are not retrieved.

**Challenges** – This method may add expenses your office can't afford; however, staff time saved should be factored into the expense and return on investment calculations. There still is some manual work involved in that a staff person needs to enter all tests, referrals and follow-ups and record test result messages (preferably in the physician's own words). This method also does not eliminate the need to have office policies and procedures, provide rigorous training on them and periodic audits of the automated system to ensure time frames are met and tests results are not lost.

### **3. Patient notification and access of results via automated Electronic Medical Record (EMR)**

– This method is being used as more and more EMRs are installed and fully utilized in medical office settings. Within the EMR, tests are ordered, patients are assigned to a physician and every test result is sent to this physician (as well as the ordering or covering physician if the patient's primary physician did not order the test). The EMR has a functionality that can be employed where patients are notified via e-mail that a test result is available. The result can be accompanied by a message from the physician either interpreting the result (e.g., congratulations, your test result is normal) or to call for further information or schedule a follow-up office visit for more in-depth interpretation, more testing and/or referrals and/or care planning.

**Challenges** – for any severely abnormal or life-threatening results, verbal notification is still the most likely to be timely, to ensure the patient understands and to get timely initiation of treatment. So, this method should not be used exclusively but in combination with calling patients. Additionally, not all patients will have access to e-mail or computers. The office policies and procedures should reflect both methods, provide rigorous training on both, and periodic audits on how the multiple systems are working in concert with one another.

### **The Results:**

The main points to remember with any of the above examples of patient-provider office communication that will generate the best patient experience results are these:

- Standardize your policy and procedure for notification of test results to patients; the underlying principles no matter what method you use should be the same (all methods should be crystal clear on roles, time limits for notification of patient, how to handle severely abnormal results, periodic audits to ensure system is working as planned to limit liability and promote efficiencies)
- Have a policy to notify the patient for EVERY test result (normal as well as abnormal)
- When receiving phoned-in test results, be sure your procedure includes a read-back process (confirm correct patient and correct result)

## Example 3—Consider How Technology Can Improve the Care Experience

### The Problem:

If ever an industry were ready for change, it is the American healthcare industry.<sup>18</sup> On average, in 2012, we spend about \$7,600 a year per person on healthcare<sup>19</sup>, one in two adults live with a chronic disease<sup>20</sup>, and the average wait time to see a doctor in a metropolitan area is 20 days. Entrepreneurs are responding to address these issues by inventing healthcare technologies that have the potential to change the way patients interact with your office. They also are responding by focusing on “chronic complaints” on how the American health care system does not work—especially in the area of care coordination, an area fraught with complicated webs of multiple providers of care for one patient and its associated communication challenges.

### The Solution:

Embrace new communication technology whenever you can! We are about to see a fundamental transformation in the way that patients will interact with the healthcare system. For example, more and more patients have Smartphones and mobile applications. Ideally your office would be using these same applications to make your jobs easier and more efficient. Here are some examples from a December 4, 2012, New York Times article: “Vital Signs by Phone, Then, With a Click, a Doctor’s Appointment.”

### The Big Idea #1

**Dave Chase, who founded Microsoft’s health platform business, helped create Avado to give patients a place to manage their health information. “It’s like a mint.com for health care,” said Mr. Chase, who founded the company along with Bassam Saliba, a software developer, in February 2011.**

**How it works:** A doctor subscribes to Avado and gets a suite of tools that enable the easy creation of a Web site where patients can fill out intake forms, schedule appointments, ask for weekly medication reminders and track symptoms for chronic conditions. Patients and doctors decide together which metrics they will track—blood sugar, blood pressure or frequency of asthma attacks, for example—and that information is shared. Avado, Mr. Chase said, “considers the patient a partner in the process.”

**How it will make money:** The founders put in half a million dollars. Avado operates on a subscription model—\$100 per month per clinician, although there is a free version that includes the Web site and secure e-mail.

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<sup>18</sup> Text taken from article: <http://www.nytimes.com/2012/04/12/business/smallbusiness/start-ups-use-technology-in-patient-doctor-interaction.html>

<sup>19</sup> U.S. Census Bureau, *Statistical Abstract of the United States: 2012; Health Consumption Expenditures – Per Capita Spending by Type of Expenditure and Source of Funds*.

<sup>20</sup> <http://www.cdc.gov/chronicdisease/resources/publications/aag.htm>

## The Big Idea #2

**When he was chairman of the health care committee of the President’s Information Technology Advisory Committee from 2003 to 2006, Jonathan C. Javitt led the development of the policy to adopt electronic health records. What was missing from those discussions, he says, was a direct connection between patients and their health information.**

**How it works:** Telcare’s first product is an F.D.A. approved glucose meter that transmits each reading to the cloud, where it can be read by a group of people preselected by the patient. Feedback is sent back to the patient’s meter from a diabetes educator, for example, or a pharmacist, nurse or parent. “What we are doing today, essentially, is enabling the mother of a diabetic child to know what’s happening when her son is at school,” said Dr. Javitt. “We can put an app on mom’s iPhone and send a text message for every reading her child takes. Achieving this type of feedback may be critical, because even a 10 percent improvement in glucose control reduces the likelihood of diabetes complications—blindness, amputation, stroke and heart attack—by 40 percent.”

**How it will make money:** Telcare raised \$7 million in a combination of debt and equity. The company began shipping the product in February. Revenue comes from sales of meters, which cost \$150, and test strips, which have a list price of \$72 for 50 strips. Cellular connectivity, back-end server service and Smartphone apps are all included in the meter price.

### The Results:

These are new technologies and the communication impacts are yet unknown. However, giving patients the tools to access their own information and giving them faster, easier, better access to the healthcare system faster, easier, better would seem to only improve their ability to be their own effective, healthcare advocates. These novel approaches taken by medical practices to trial new tools in the delivery or monitoring of a patient’s health between their providers’ visits serve to transform the ability to improve health outcomes faster, easier and better.

Skills and tools to transform the patient/caregiver experience through improved communication

## Strategies in Summary

### *Pre-Visit*

- Establish systems to have physicians to use their time efficiently and institute patient self-management by gathering clinical information and patient experience data prior to the visit.
- Have schedulers ask (or messages in your automated scheduling system asking) patients to bring questions, concerns, medications and health monitoring information to their appointment.
- Daily hold seven-minute “office huddles” to rapidly identify areas for bottlenecks and inefficiencies to occur and address immediately.

### *During-the-Visit*

- Collaboratively develop a visit agenda with the patient and family, handling as many concerns as possible, and plan return visits as appropriate.
- Engage the entire practice team in supporting patients, use “warm handoff” introductions, and explain team member roles to patients.
- Ask about patient goals to improve their health and help them make action plans that build confidence in their ability to reach these goals.
- Use “teach-back” (or ask-tell-ask) to provide just the right information at just the right time and “close the loop” to ensure patients know how to use the information.

### *Post-Visit*

- Prepare a written care plan or visit summary that includes goals and action plans to ensure patients and families know what to do when they leave the visit.
- Use group medical appointments, peer-led support groups, or patient education classes to provide opportunities for patients to share experiences and support.
- Organize follow-up support to help patients sustain healthy behaviors between visits.
- Extend care into the community by linking patients to community program.

## Patient Experience of Care Improvement Guide:

To continue to make progress on any quality improvement effort, you need to keep measuring your progress. In Minnesota, there is a statewide mandate to measure and report patient experience results every two years using the CG-CAHPS survey instrument. In between this two-year cycle, there are other inexpensive options you can use to monitor and measure your progress in your quality improvement efforts in this area. You can use telephonic or mailed surveys; you can also ask patients to complete short surveys at the point of service. After obtaining results, it is important to communicate the survey results to the clinic team members involved. In the reports, show results over time and compare to peers and to pre-set goals. Routinely review the results for opportunities for improvement. Focus on the domains/questions/results where you perform least well.

It may be helpful to develop a tool like the one below—or adapt this one to guide your improvement effort:

Clinician and Team Skills for Impressive Patient Experience												
Patient Experience survey items in CG-CAHPS “how well doctors communicate”	Warm connection	Engage the patient as a person	Invite all the patient’s concerns: what else?	Discover the patient’s priorities	Discover the patient’s expectations	Express empathy	Develop reflective listening	Use empathetic re-focus the agenda	Ask before advise	Funnel question	Invite patient contemplation of self care	Check patient understanding
Listen carefully				✓		✓	✓					
Spend enough time				✓			✓	✓	✓			
Explanations /instructions easy to understand						✓			✓			✓
Know patient medical history			✓		✓					✓		
Show respect and make a personal connection	✓	✓			✓	✓			✓		✓	
Explain things well					✓				✓			✓



### **Make a warm connection**

When greeting the patient, make eye contact, smile, shake hands, position height to align your eyes with same level as patient's, remove barriers, greet patients companion and learn their name and role.

### **Engage the patient as a person**

At each visit, invite the patient to tell you about something non-medical in her life. Do not ask about weather or parking. Make a note in your record of the visit. Review the previous visit note before seeing the patient. Mention that personal item at the next visit. "I recall you were taking your grandchildren for a holiday at the shore. How did that go?"

### **Invite all of the patient's concerns**

Acknowledge the reason for visit given to staff, "What were you hoping to accomplish at this visit today?" "And what else?", and summarize patient's concern.

### **Discover patient's priority**

"What is the one thing you want to make sure happens before you leave here today?"

### **Discover patient's explanations and expectations**

When discussing symptoms, invite the patient to tell you what they think might be causing it. Ask about other people in patient's life. "When you go home tonight, who will ask you, 'What did the doctor say?' What are they concerned about?" Ask patients what they think should be done to diagnose or treat the problem.

### **Express empathy**

Identify feeling, label it, and express concern.

### **Reflective listening**

Paraphrase what you heard the patient say to let them know you are listening and to check your understanding.

### **Use empathic bridge to re-focus agenda**

When patient digresses from the agenda for the visit, empathize with the concern, and then bridge back to the patient's priority items on the agenda you previously set.

### **Ask-before-advise**

Before giving information or advice, ask the patient what they know, have already tried, and want to know.

### **Funnel questions**

Move from broad, open-ended questions (e.g., "how has your asthma been?") to focused, open-ended questions (e.g., "how do your symptoms affect your sleep?"), to closed-ended questions (e.g., do you get wheezing when you exercise?).

### **Invite patient contemplation of self-care**

Ask the patient to rate the importance of a self-care behavior on a 0-10 scale. Then invite consideration of pros and cons by asking, for example, "Why 3 rather than 0 or 1?" Then invite contemplation of change by asking, for example, "What would it take for your importance to move from 3 to a 4 or 5?"

### **Check patient understanding**

Learn what the patient has taken from your discussion of their health and care plan. "When you go home today, who will ask, 'What did the doctor say, and what will you tell them?'" "What are the key things you understand that are important for managing your heart condition?"



