Improving Patient Experience through Implementing a Priority Clinic Program

Focus paper submission

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**Introduction**

Better patient experience according to the Centers for Medicare and Medicaid Services star ratings is associated with favorable clinical outcomes (Trzeciak, Gaughan, Bosire & Mazzarelli, 2016) and excellence in the patient’s experience is a key component of medicine today. It contributes to quality, which is clearly reflected in patient outcomes (Glickman, Boulding, Manary, et al., 2010).

Differences in how providers and staff members interact with patients can have a direct impact on the perception of high-quality care and, consequently, on the survey scores which may drive future financial incentives. Lack of a system for effective training for front and back office support staff can lead to inconsistencies in patients’ perceptions of their overall experiences. The development of a well-coordinated Priority Clinic Program is essential.

A Priority Clinic Program is a systematic process of observation, assessment, coaching, certification, and ongoing follow-up evaluation of the medical clinic, focusing on delivering a consistent, high quality patient experience to every patient, every time.

**Tracking, Understanding and Improving the Patient Experience**

The duties of front office/reception staff (hereinafter referred to as Patient Service Representatives, or PSRs) are generally well established and defined, as are the clinical steps followed in Medical Assistant (MA) and Registered Nurse (RN) visits. Therefore, observations will not focus on clinical process workflows (unless defects in such workflows are uncovered), but instead will focus on behaviors and the perceptions that result. One objective of this study was to understand the root causes of low RN/MA and PSR patient satisfaction scores. This was accomplished through direct observation of the RN/MA, from the initial rooming of the patient through the end of the visit, and by observing PSR interactions with patients in the lobby and at
the front desk. A second objective of this study was to attempt to improve upon the underperforming areas and raise scores by creating a system of targeted coaching and training interactions, followed by a certification process. The process developed in this second objective is the Priority Clinic Program (PCP).

Areas addressed in this paper include the role of patient perception in the care experience, securing patient satisfaction data, tracking it over time, and interpreting the results. Other areas include tools and resources for effecting positive change in the patient experience, identifying effects and adjusting tactics, and matching the right solution to the right problem.

Challenges in decision making also will be addressed, including avoiding costly mistakes and identifying cost-effective, patient-centric solutions. These will be followed by a Priority Clinic Program case study, in which patient experience scores, utilizing survey results from a nationally-recognized patient experience survey organization, for a family medicine clinic with two dozen providers, were studied. Initial patient experience scores for this clinic were significantly below the national mean and were also below the established patient satisfaction annual goals for the organization.

**Methodology**

The methodology for the study included literature reviews from several published and online sources on the current state of patient experience in medical clinics, including a review of responses to widely-used patient experience survey questions. In addition, personal interviews with staff provided context to the experiences and perceptions discussed. For clinics who have used, or are considering using, a patient experience measurement tool, these reviews and experiences will allow their clinics to compare and contrast their own experiences with those presented to see if adoption of a formal measurement system would be beneficial.
Discussion

Patient Perceptions through the Continuum of Care

It is important to understand the impact of patient perceptions in the delivery of current healthcare services. Patient experience is the sum total of all interactions shaped by an organization's culture that influence patient perceptions across the continuum of care (Wolf, Niederhauser, Marshburn & LaVela, 2014). Patients’ perceptions of the way they were cared for by their primary care provider and staff are more important now than at any time previously for several reasons (Shirley & Sanders, 2013). In the past, patients were passive recipients of care. Today they are consumers of healthcare, and see themselves as the driver of the decisions (Barry & Edgman-Levitan, 2012). The fact that patients come to their visits armed with information secured from the internet and friends is a significant indicator of the shift in patient expectations and demands.

Many of today’s patients assume that their primary care provider is a fully knowledgeable and excellent clinician, and their focus can be as much on the experiences they have interacting with their provider and staff as it is on the specific clinical information they receive (Gidman, 2013). The patients’ perception of care is not limited to just the provider, but extends also to their medical and office support staff (Osbourn et al., 2014). This can be very challenging to providers and support staff who have not been thoroughly trained on understanding and managing the perceptions of their patients. Patients are people, and they are emotional, irrational, and human. They feel fear and stress; they are overworked and underpaid; they are time starved; they have ambition and goals; and they have an insatiable need to feel important and appreciated. Each personal interaction creates an experience that they remember (Blount, 2013).

The decision to change the reimbursement structure of health care delivery to be tied to patient experience has added increased urgency and gravity to the situation (Price et al., 2015). A negative patient experience that historically may have had little or no consequence now may have
a direct effect on actual reimbursement. Also, social media can make a single poor or mishandled patient experience go “viral”, and be seen by patients who then select a different provider once the review is read.

**Background**

Patient experience is not a new concept, and it hearkens back to what was called “bedside manner” by previous generations. A good patient experience in the past meant that the procedure was successful or the injury got better. If the medical provider happened to be kind, caring or considerate, that was a welcomed but unexpected benefit.

Patients now have different expectations (Nygårdh, Malm, Wikby, & Ahlström, 2012). Patients of today see themselves exactly as what they are – consumers of healthcare. They not only have access to an internet full of information and an app for nearly any illness or disease/condition, they also have an expectation of how the visit should go, and expect to be much more engaged and involved in their health care decisions (Phillips & Labno, 2014). In this age of transparency, customers have the ability to find information about providers, products, services, companies, and competitors in an instant, with minimal effort. Also, to the consternation of many business leaders, customers have the ability to easily tell others how they feel about their experience through many social channels (Blount, 2013).

Healthcare, and the expectations of the experience of healthcare delivery, are inextricably interwoven. Price transparency is pushing the experience of receiving care to a whole new dynamic of shopping for the best available price, with clinical excellence a built-in assumption (Wu, Sylwestrzak, Shah, & DeVries, 2014).

All of this has a large impact on physicians, providers and clinical/non-clinical support staff. Providers are often unaccustomed to challenges to their medical advice, and may even dismiss patients whom they see as argumentative or non-compliant (Bodenheimer & Sinsky, 2014). Visits that historically took 15 minutes now take 30 minutes because patients have so
many questions, which causes stress on providers, other patients who have their visit run behind, and staff who have to attempt to keep the patients happy, or at least not angry. Clinic managers are faced with a stream of “service recovery” phone calls and letters. Patient satisfaction scores, previously computed by the number of thank-you cards received, now focus on every aspect of the visit, from the condition of the lobby to the friendliness of the provider, with printouts of trend lines and goals and biggest opportunities. Additionally, poor patient satisfaction scores have been linked to higher incidences of malpractice claims (Fullam, Garman, Johnson, & Hedberg, 2009). The process of successfully managing the satisfaction of patients can be very challenging and stressful.

**Stakeholders**

Stakeholders in this process are certainly not limited to the care providers. Patients, the family members of patients, clinical and non-clinical support staff, and practice management are all stakeholders who are impacted by these interactions (Manary, Boulding, Staelin, & Glickman, 2013). The entire patient experience paradigm is crucial to study and evaluate, as it represents the future of the practice. There are a multitude of steps that make up the patient’s experience of their healthcare, and failure at any one of them can result in a negative overall patient experience. Success lies in having a comprehensive approach to avoid negative experiences by any stakeholder.

**Case Study**

**Statement of the Problem**

The problem occurs when the medical practice receives its first patient satisfaction survey results. There are several different survey measuring companies to choose from, and the costs of having a survey administered can be significant, so care must be taken when selecting the survey company that is best for the practice. Initial reactions of staff/management/providers to patient
satisfaction survey results can run the gamut, and common reactions include confusion, shock, anger, frustration, feelings of helplessness, and denial. Most clinic stakeholders have a high opinion of the care provided in the clinic, and by association a high opinion of the team who delivers the care. It is normal for a clinic to perceive its own patient experience performance as above standard, and receiving the first patient experience scores can be a startling realization that patients do not perceive their experiences in the way the clinic staff members imagined they do.

The case study clinic had the opportunity to address three areas of patient experience: the front office/reception, the MA, and the care provider. While interactions with care providers are an essential component of the patient experience, this paper will focus on the first two opportunities, as these may get less attention from clinic administrators/management. Scores for the PSRs, MAs, and RNs from the case study clinic, as reported from a nationally-utilized survey organization, were very low, around the bottom third of national scores for these reporting groups. Scores were slightly lower for the PSRs than the MAs or RNs in the case study practice.

Continuation of these low scores could result in several negative outcomes, including a diminished perception of high-quality care from the community, the loss of established patient satisfaction incentive payments to staff, and eventual loss of vital future financial incentives for the clinic. A decision on how to move forward was required.

**Alternative Decisions Considered**

There were several decision making processes involved in this case study. The first was to decide to do nothing and hope that scores will improve. The second decision involved actively trying to improve the patient experience and related scores to effect a positive change.

There were several pros and cons to doing nothing. On the pro side of the argument, it was possible that the initial results might improve on their own just through the knowledge that patient experience was being measured and reported. If such an outcome were to occur on its own, there would be no extra effort or added cost, and as such, this represented additional support
for this course of action. On the con side of this decision, there was the risk of scores not improving and possibly getting worse. If this were to occur, there would be a continued negative perception of care quality in the community, and this lack of action could also set a negative precedent for any future improvement attempts.

A second option was attempting improvement through the hiring of outside patient experience vendors. One potential benefit was receiving a structured approach to improvement, with a track record of proven results if such a plan were to be correctly implemented. A drawback was the amount of time required to choose, contract with, and implement an outside vendor program. Additionally, the cost for outside vendor programs varies widely and can be quite significant.

A third option was developing a training program using internal resources. On the pro side of this decision was the amount of internal control over material focus and timelines, as well as the fact that costs could be contained through utilization of current staff. On the con side of this decision was the possibility for unknown outcomes, as training materials would be created in-clinic and thus would not have proven positive results. Also on the con side was training staff bandwidth, as current staff had multiple projects in process which could be delayed.

**Decision**

A decision was made by clinic management to attempt to train PSRs, MAs, and RNs on improving their customer service skills. As the clinic did not have training materials, clinic management reached out to the author, who had previously conducted unrelated training for clinic staff. A training program was created, called the Priority Clinic Program (PCP), which utilized core customer service skills from various service industries such as retail and banking. These components were then matched to best practices for PSRs, MAs, and RNs, and the resulting checklist was utilized.
Priority Clinic Program Implementation

The PCP patient experience training started with a kick-off breakfast celebration at the clinic with all PSRs, MAs, and RNs in attendance. The PCP training was designed to take place over five weeks, and the entire process was reviewed with all in attendance, with time allowed at the end for questions.

Week 1

The first week was one-on-one observations of each PSR and MA/RN. The trainers wore scrubs that matched those of the PSRs, MAs, and RNs, and, with the patient’s permission, the trainers went into the exam rooms with the MA/RN and patient to make the observations. As previously stated, observations focused not on procedures or systems, but rather on perceptions by the patients. A guideline of best practices was put together for the PSRs, MAs, and RNs, and observations were compared to these best practices. Observations were compiled and reported to the clinic management at the end of the first week to keep them fully aware of the results and to compare management perceptions with observations of the training team.

For the role of MA/RN, seven steps were identified as best practices. The first step was a warm greeting and introduction (see Appendix A and Appendix B). This encompassed a variety of steps, including (1) looking at the patient’s picture in the electronic medical record (EMR) so as to identify the patient seated in the waiting room; (2) walking over to the patient, instead of announcing their name across the lobby; (3) approaching every patient with a smile; (4) greeting the patient by name and identifying which provider they will be seeing; and (5) introducing oneself and one’s role to the patient (e.g., “Hi, I’m Lorena, I’m Dr. Smith’s medical assistant, and I get to help take care of you today”).

The second step was to make a personal connection with the patient. To do this, RNs and MAs were reminded to talk to the patient, not at the patient, always keeping it a two-way dialogue. Staff was encouraged to notice small details about the patient; for example, if the
The patient was wearing a uniform, collegiate shirt/hat, veteran’s attire or a colorful purse, these could be great opening talking points. Patients like to feel connected with their care provider and support team, so staff were encouraged to listen for important triggers (i.e. comments about family, friends, work), and pay attention and remember something that was significant. It was suggested that staff make note of key observations by placing a sticky note in the EMR, as a reminder for future visits.

The third step was to narrate the patient’s care. MAs and RNs were instructed to walk patients through all steps of care, even when taking vitals, remembering that this may be new and unfamiliar to them. Asking patients for permission to take their pulse, blood pressure, and the like shows respect and reminds the MA/RN to narrate what they are doing. Remembering to give patients the results of those measurements also shows politeness and respect, because most patients want to know their numbers. Patients don’t like surprises, so frontloading the process and expectations helps remove the element of surprise, increasing patient compliance and satisfaction.

The fourth step, one often overlooked, was introducing the computer. The in-room EMR system is a vital communications tool, not a barrier to communications, and as such, should be introduced near the beginning of the visit. MAs and RNs were asked to instruct patients about the benefits of this tool, and to include patients in the process of reviewing their records to ensure accuracy. MAs and RNs were also asked to use this time to enroll patients in the EMR online patient portal. While working at the computer, it is important to be mindful of body position, and MAs/RNs were reminded to face the patient as often as possible. Additionally, they were guided to include all the parties in the room, such as family members, and to maintain eye contact and conversation throughout the computer interaction.

The fifth step was setting the agenda for the visit, by reassuring patients that their reasons for visiting the clinic were known; by asking probing questions to uncover additional concerns they wanted to discuss; and by framing what was to be discussed during the visit and setting follow-up expectations.
The sixth step was checking for understanding of the visit itself. As many patients lack understanding of medical abbreviations or jargon, RNS and MAs were asked not to abbreviate “AVS” but use “After Visit Summary” instead. RNs and MAs were taught to review the AVS with patients so they’d be aware of the next steps, and then to ask patients to restate and confirm those next steps. In this way, MAs and RNs were assured that patients knew what they were supposed to do, and patients knew and felt comfortable with their outlined plans, both best practices in this area. Lastly, if the patient had a prescription listed on the AVS, confirming the patient’s preferred pharmacy was vital.

The seventh step was concluding the visit/closing the loop. If the AVS called for a follow-up appointment, RNs and MAs were guided to schedule the appointment in the room with the patient at that time. Other essential closing tasks were asking patients if they had further questions or additional needs; reminding them that they might be receiving a patient satisfaction survey; thanking them for the opportunity to care for them; and walking them out to the front lobby.

For Patient Service Representatives (PSRs), three key steps were identified (see Appendix D and Appendix E). The first step was lobby and line management, which included stopping, looking up and acknowledging the line; making eye contact with the patients; smiling, and offering a quick expectation greeting such as “We will be right with you”.

The second step was the welcome greeting, which included offering a helpful and warm welcome such as “I’d be happy to help you here”, or “I can take care of you over here”. Making a personal connection, and noticing small details (college gear or veteran’s hat) were suggested as great openers. An identified best practice was to ask the patient, “May I have your name?”, followed by writing it down and using it as least twice during the ensuing interaction.

The third step was setting the expectation, which included discussing a time frame, even if it was general. For example, a PSR, noticing a patient was very early, was instructed to let the patient know if the provider was running late, and to keep the patient updated while in the lobby.
PSRs were instructed to ask for a co-pay up front, every time; asking for payment and knowing how much to collect were identified as best practices.

**Week 2**

The second week consisted of reviewing one-on-one the best practices with all PSRs, MAs, and RNs, and comparing the observations to the best practices for each position. A copy of the best practices was given to each staff member to review (see Appendix B and Appendix E). Questions from staff were answered on how to personalize the best practices for each staff member to make them authentic.

**Weeks 3 and 4**

The third and fourth weeks consisted of the second round of observations with the PSRs, MAs, and RNs, with the added component of certification (see Appendix C and Appendix F). Using the best practices steps for each position, the staff were individually scored on observed steps versus best practice steps, with a requirement to obtain a minimum score for certification of passing.

**Week 5**

The fifth week was spent revisiting the best practices with the staff and selecting Patient Experience Champions, whose role was to make certain the best practices continued to be used in the clinic after the trainers left. The Patient Experience Champions were responsible for organically influencing and coaching their team on the organization’s focused patient experience goals, as outlined in the Priority Clinic Program. They were empowered with determining the best rollout method/approach that would speak to and engage their teams in this process. The Patient Experience Champions were an extension of management’s efforts to ensure that these goals were being hardwired into the fabric of the culture and not treated as something temporary. They
helped management hold the team accountable by ensuring teams adhered to the standards of excellence through observation, coaching and feedback.

Patient Experience Champions were selected based on the following criteria:

- they were passionate about patient experience,
- they could effortlessly lead by example,
- they had the ability to be direct in a constructive way, and
- they had the pulse of what was happening in the clinic/among their team.

Additionally, the Patient Experience Champions had strong communication skills; were confident, creative and had good energy; they had the ability to inspire and influence; they had the ability to motivate in the face of disengagement; and they had the ambition to want to become a supervisor and/or manager.

There were several requirements to being a Patient Experience Champion, the first of which was a six-month commitment to the position. Each clinic could volunteer/select one PSR and up to two MAs to represent their clinic as Patient Experience Champions, and these individuals met once per month during the lunch hour in an offsite location for a two-hour block of time. The general luncheon meeting format consisted of learning empowerment and leadership skills, learning enhanced communication skills, practicing conflict management and peer coaching skills, sharing best practices, and discussing, from previously rolled out methods, what worked well and what didn’t work. The Patient Experience Champions also discussed organizational patient experience goals, clinic specific patient experience areas of opportunity, and worked to understand factors influencing the current scores.

The Patient Experience Champions also identified no more than two focus areas (one the MAs could impact and one the PSRs could impact), and worked to determine the rollout strategy/method via small group discussions. They then reported to practice management on identified areas and selected rollout methods, including a rollout timeline, a rollout method
(discussion, role play, memo, etc.), rollout format (i.e. small group huddles, one-on-ones, operations meeting, etc.), as well as measurement and accountability. It was important to note that the Patient Experience Champions shared their identified goals for that month and their rollout strategy with their practice management to ensure they are on the same page and had their complete support.

Lastly, upon completion of the fifth and final week, a celebration lunch was served, where patient experience certificates and stars were presented to all certified staff.

Analysis

Upon completion of the PCP training in week five, patient satisfaction scores for the PSR and MA/RN positions for the clinic were monitored for a one-month period. Scores were then compared to the average of the same scores from the previous quarter.

Scores for both the PSRs and MAs/RNs rose significantly. MA/RN scores rose from the 38th percentile to the 60th percentile. PSR scores rose from the 31st percentile to the 57th percentile. Statistical analysis showed that the results were conclusive in all cases, and that these increases did not occur randomly (see Appendix H and Appendix I).

Follow-up interviews with staff upon completion of the program yielded productive feedback. While nearly all of the staff participants reported the Priority Clinic Program to be a helpful tool and reminder of best practices for their area, negative feedback consisted of complaints at having to learn certain scripting (i.e. narration of care given to patients, and using the patient’s name three times over the course of the interaction). Negative comments were addressed in follow-up training opportunities with the Patient Experience Champion.

The most common areas of low scores for the focus clinic included the patient’s perception of wait times, the patient’s perception of adequate time spent with them in the appointment, and the patient’s perception that all of the patient’s concerns had been addressed. The key parts of the Patient Experience Program that address the first concern include keeping
the patient continually informed of wait times and changes, and managing the expectation of the wait time during the initial and subsequent interactions. The key part of the program which addresses the second concern includes forming a personal connection with the patient, narration of care given, and involving the patient in the process/setting the agenda. The key part of the program which addresses the third main concern includes checking for understanding, setting the agenda, and review of next steps. These three areas were challenging for the clinic in question; however, it is understood that different clinics may have different areas of challenge and require different areas of focus.

Common pitfalls and red flags in decision making were discovered when attempting to select individuals for the Patient Experience Champion position, as these individuals are key to the ongoing success of the Priority Clinic Program and require leaders with the skills and time available to adequately inspect and drive improved performance. A second pitfall is fully staffing the training commitment necessary to make the program successful. The time requirement for observation of the interaction of staff with patients proved challenging, and required more observational resources in the form of staff than initially anticipated.

**Summary of the Topic**

Disparities between provider and staff interactions with patients have a direct impact on critical scores which will ensure consistent perception of high-quality care and drive future financial incentives. These negative disparities with staff interactions, if left unaddressed, can place the practice at significant risk. There are a large number of factors that go in to the patients’ perceptions of the experiences they have in a clinic, and these factors can be addressed and improved upon using a comprehensive and systematic approach, such as that found in the Priority Clinic Program described in this paper.

The Priority Clinic Program should be considered by any clinic manager or supervisor who would like to improve the patient experience interactions of their staff, especially in the light
of the transition to value-focused reimbursements and the upcoming transparency of provider patient satisfaction scores. The Priority Clinic Program’s direct observation of the patient/PSR and the patient/MA/RN interaction can be instrumental in uncovering key gaps and opportunities in the patient experience process. By coaching to these gaps and opportunities, and providing a framework for the PSR/MA/RN to navigate the interaction successfully, overall patient experience and satisfaction can be positively and significantly improved for all stakeholders.
References


Appendix A

Medical Assistant 7 Most Important Steps:

Step 1: Warm Greeting/Introduction
- Before you get the patient, look at their picture in the EMR to familiarize yourself with them, walk over to the patient versus shouting their name across the lobby
- Approach every patient with a smile 😊😊😊
- Say the patient’s first name and which provider they are seeing; “John for Dr. Smith” or “Betty for X-Ray”
- Introduce yourself, your role, and how you will be helping the patient today; “Hi, I’m Sally, I’m Dr. Smith’s medical assistant and I get to help take care of you today”

Step 2: Make a Personal Connection
- It’s important to talk to the patient, not at the patient -- keep it a two-way dialogue
- Notice the small stuff, for example, if the patient is wearing a uniform, collegiate shirt/hat, veteran’s attire or a crazy purse, these are great opening talking points
- Patients like to connect. Listen for triggers that are important to them (i.e. family, friends, work)
- Pay attention and remember something that was significant, make a note of it so that you can mention it the next time you see them (best practice: sticky note in EMR)

Step 3: Narrate Their Care
- Walk the patient through their care, even when taking vitals; remember this is new/unfamiliar to them
- Ask them for permission, this shows respect and reminds you to narrate what you’re doing
- Give them the results of their weight, blood pressure and pulse, etc. -- the patient wants to know their numbers
- Patients don’t like surprises, frontloading your process and expectations will remove the element of surprise and help increase patient compliance and satisfaction

Step 4: Introduce the Computer
- Use the computer as a tool, not a barrier
- Introduce the computer in the beginning & teach the patient about the benefits of this tool
- Include the patient in the process to ensure accuracy
• Use the computer to get the patient signed up for patient portal/EMR online communication tool in the room
• Be mindful of body position, try to be open to the patient as often as possible
• Include the parties in the room, i.e. the impaired patient and/or family members
• Maintain eye contact and conversation throughout the computer interaction, AVOID DEAD AIR

Step 5: Set the Agenda
• Reassure the patient that you know what they are in our clinic for
• Ask probing questions to uncover additional concerns they want to discuss
• Frame what will be discussed during the visit and set follow-up expectations

Step 6: Check for Understanding
• Don’t abbreviate “AVS” to the patient, they don’t know what that means, say; “After Visit Summary”
• Go through the AVS with your patients (review it beforehand so that you know what their next steps are). ASK the patient to tell you what their next steps are so that you are sure that they know what they’re supposed to do and so that the patient feels comfortable with their outlined plan
• If the patient has a prescription listed on the AVS, confirm the pharmacy they wanted listed

Step 7: Conclude the Visit/Closing the loop
• If the AVS calls for a follow up appointment, be sure to make that appointment in the room with the patient
• Ask the patient what further questions they have and/or what else we can do to help them with
• Tell the patient that they might be receiving a patient satisfaction survey
• Thank the patient for giving us the opportunity to care for them
• Walk the patient out to the front

--- SANITIZE HANDS WHEN ENTERING / EXITING THE ROOM ---
Appendix B

MAKE IT PERSONAL “RELATE IT” MA’s Most Important Steps:

Warm Greeting/Introduction
- **Smile**, approach each patient saying their first name and the provider they are seeing; “John for Dr. Smith” or “Betty for X-Ray” etc.
- Introduce yourself, your role and how you will be helping the patient; “Hi, I’m Sally, I’m Dr. Smith’s medical assistant and I get to help take care of you today”

Make a Personal Connection
- **Talk to** the patient, not at the patient – look for clues to great opening talking points
- Listen for triggers that are important to them (i.e. family, friends, work, events)
- Remember significant comments and mention on subsequent visits (best practice: **sticky note**)

Introduce the Computer
- Introduce the computer as a tool, not a barrier
- Maintain eye contact and AVOID DEAD AIR by using conversation. Try to face patients as often as possible
- **Include the patient** in the process to ensure accuracy, and enroll them in patient portal in the room

Narrate their Care
- **Explain everything you are doing** in the visit, every time, to remove any surprises and increase patient compliance and satisfaction
- Ask for permission, and give the results of weight, blood pressure, pulse, etc.

Check for Understanding
- Don’t say “AVS”, be sure to say “After Visit Summary”
- **Review** the steps in the AVS with your patients and **ASK** the patient to tell you what their next steps are to verify understanding and comfort
- For prescriptions listed on the AVS, **confirm the pharmacy** they wanted the medications sent to

Conclude the Visit
- Schedule any AVS-directed follow-up appointment while in the room with the patient
- **Ask** the patient what further questions they have and/or what else we can help them with
- **Mention** that the patient may receive a patient satisfaction survey, and thank them for giving us the opportunity to care for them, and walk the patient out to the front
Appendix C

Medical Assistant Patient Experience Certification (MAPEC)

<table>
<thead>
<tr>
<th>Medical Assistant: __________________________</th>
<th>Observer: __________________________</th>
<th>Date: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 - Warm Greeting/Introduction</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Smiles when calling the patient back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses &quot;best practice&quot; greeting when calling the patient back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduces themselves/their role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanitizes hands when entering the exam room</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>#2 - Make a Personal Connection</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Makes the patient feel at ease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks with the patient about non-clinical topics</td>
<td></td>
<td></td>
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<tr>
<td>Makes a note of memorable things the patient mentioned</td>
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<td></td>
</tr>
<tr>
<td>Uses the patient's name at least 3 times throughout the visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#3 - Narrate their Care</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>***Asks the patient for permission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives the patient their results/numbers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educates patient on what their numbers mean (good/bad/normal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frontloads all processes, removing the element of surprise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#4 - Introduce the Computer</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>***Introduces the computer as soon as they begin to work on it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaches the patient about the benefits of this tool</td>
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<tr>
<td>Includes the patient in the process to ensure accuracy</td>
<td></td>
<td></td>
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<tr>
<td>Uses the computer to get the patient signed up for MyChart</td>
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</tr>
<tr>
<td>Uses open body language when using the computer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains eye contact and conversation during computer interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all parties in the room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#5 - Check for Understanding</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Reviews the AVS prior to talking with the patient about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tells the patient what an &quot;After Visit Summary&quot; is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the patient what their next steps are according to this plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirms the pharmacy the patient wants the medication sent to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#6 - Concludes the Visit</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Made the follow-up appt in the room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>***Asked the patient &quot;What questions they have&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Told the patient about the PG survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thanked the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walked the patient out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Certified Score = 23 standards of 28 met for 82% or better)
Appendix D

Patient Service Representatives - 3 Most Important Steps:

Step 1: Lobby and/or Line Management
- Stop, look up and acknowledge the line:
- Make eye contact
- Smile
- Offer a quick expectation greeting “We will be right with you”

Step 2: Welcome Greeting
- Offer a helpful and warm greeting...
  - I’d be happy to help you here
  - I can take care of you over here
  - If you want to come over here, we will get you taken care of
- Make a personal connection
  - Notice the small stuff (college gear or veterans hat) these are great openers
- Use the patient’s name
  - “Can I get your name” – WRITE IT DOWN
  - Use it as least twice during your interaction

Step 3: Set the expectation
- Discuss time frame, even if it’s general
  - Notice if they are really early, frame the expectation
  - Let them know if the provider is running late, we will keep the patient updated
- Ask for a co-pay up front, every time
  - If it doesn’t pop-up, look for the previous co-pay in the resources tab to know how much you will need to collect
  - Co-Pay affects two key areas (Patient Satisfaction and Expenses per wRVU)

Practice Words that WOW
- Absolutely - It’s my pleasure - I’d be happy to
- Of course - That’s what I’m here for - How can I help?

ABOVE ALL BE FRIENDLY - SMILE, MAKE EYE CONTACT, MAKE A PERSONAL CONNECTION!!!
Appendix E

*Laminated reminder for PSR workstation*

MAKE IT PERSONAL - A PSR’s Most Important 3 Steps:

**Line Management**
- Stop, look up and acknowledge the patients in line ASAP
- Make eye contact & smile 😊😊😊
- Offer a quick expectation: “We will be right with you”

**Welcome Greeting**
- Offer a helpful and warm greeting: “I’d be happy to help you here” or “I can take care of you down here”
- Make a connection with the patient, notice the small stuff (college gear or veterans hat) these are great openers
- Use the patient’s name at least 2 times during your interaction

**Set the expectation**
- Discuss time frame, even if it’s general
- Look for/collect a co-pay every time

<table>
<thead>
<tr>
<th>Practice words that WOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolutely - It’s my pleasure - I’d be happy to</td>
</tr>
<tr>
<td>Of course - That’s what I’m here for - How can</td>
</tr>
<tr>
<td>I help?</td>
</tr>
</tbody>
</table>
Appendix F

Certification form for patient service representatives

Patient Experience Certification (PEC)
Observation Form

<table>
<thead>
<tr>
<th>PSR: __________________________</th>
<th>Observer: __________________________</th>
<th>Date: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 - Lobby and/or Line Management</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Stops, looks up and acknowledges the patients in line ASAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes eye contact &amp; smiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers a quick expectation: “We will be right with you”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Score 3 / 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#2 - Welcome Greeting</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Offers a helpful/warm greeting and invites the patient over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes a connection with the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses the patients name at least TWICE during their interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Score 3 / 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#3 - Set the expectation</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Discusses time frame, even if it’s general</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looks for/collect a co-pay every time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Score 2 / 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#4 - Uses Words that Wow</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Absolutely, It’s My Pleasure, Of Course, I’d Be Happy To...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal Score 1 / 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score

(Certified Score = 8 standards of 9 met for 88%)
The Patient Experience Champion Program Outline

Premise:
The Patient Experience Champion will be responsible for organically influencing and coaching their team on the organizations focused Patient Experience goals. They will be empowered with determining the best rollout method/approach that will speak to and engage their teams in this process. They will be an extension of management’s efforts to ensure that these goals are being hardwired into the fabric of the culture and not treated as the flavor of the month. They will help management hold the team accountable by ensuring they adhere to these standards of excellence through observation, coaching and feedback.

Selection Criteria:
- Passionate about Patient Experience
- Effortlessly leads by example
- Has the ability to be direct in a constructive way
- Has the pulse on what is happening in the clinic/among their team
- Has strong communication skills
- Is confidant, creative and good energy
- Has the ability to inspire and influence
- Has the ability to motivate in the face of disengagement
- Has ambition to become a supervisor and/or manager

Requirements
1. 6-Month commitment (Program runs from March 2016 to Sept 2016)
2. Each clinic can volunteer/select one PSR and up to two MA’s to represent their clinic as the PEC Champ
3. PEC Champs will meet once per month starting in March during the lunch hour in an offsite location
4. Luncheons will be held city specific to minimize travel (Grants Pass, Medford and Ashland)
5. Luncheons will be 2hrs

General luncheon format:
- Will learn empowerment and leadership skills
- Will learn enhanced communication skills
- Will practice conflict management and peer coaching skills
- Will share best practices (from previously rolled out methods – what worked well/what didn’t work)
• Will discuss organizational Patient Experience goals
• Will discuss clinic specific Patient Experience areas of opportunity
• Will understand factors influencing the current scores
• Will identify focus area (No more then 2 – One the MA’s can impact and 1 the PSR’s can impact)
• Will determine rollout strategy/method via small group discussions
• Will report out on identified areas and selected rollout methods
  ✓ Rollout timeline
  ✓ Rollout Method (Discussion, Roll Play, Memo, etc.)
  ✓ Rollout Format (i.e. Huddles, One on Ones, Ops Meeting, etc.)
  ✓ Measurement
  ✓ Accountability

**NOTE:** Upon returning from the PEC Luncheon the PEC Champ will share their identified goal for that month and their rollout strategy with their PM to ensure they are on the same page and have their complete support.
Patient Satisfaction survey results were measured over the 30 days following implementation and completion of the Priority Clinic Program (from 1/11/16 – 2/9/2016) and the results were compared to the previous quarter’s results (10/1/15-12/31/15).

The resulting clinic scores and rank, as reported by a leading patient experience survey company, increased significantly for the clinic for both RN/MA and PSR positions.

The RN/MA score increased from 92.6 for Q1 (pre-PCP program) to 94.1 (PCP-program), and more significantly, the rank for the same period went from the 38th percentile to 60th percentile. There were a total of 303 RN/MA surveys returned for the PCP program period.

The PSR score increased from 91.9 for Q1 (pre-PCP program) to 94.0 (PCP-program), and again, more significantly, the rank for the same period went from the 31st percentile to 57th percentile. There was a total of 305 PSR surveys returned for the PCP program period.
Appendix I

Priority Clinic Program Rollout & Results Recap

<table>
<thead>
<tr>
<th>Nurse/Assistant</th>
<th>PSR Rank Results</th>
<th>MA Rank Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2 (to date)</td>
<td>Improved</td>
</tr>
<tr>
<td>NO of Surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>511</td>
<td>283</td>
<td>24th</td>
</tr>
<tr>
<td>281</td>
<td>127</td>
<td>54th</td>
</tr>
<tr>
<td>792</td>
<td>410</td>
<td>73rd</td>
</tr>
</tbody>
</table>

***As of 2/9/2016 - Results are pulled from "Service Date" over the last 5 weeks

Program Facts:
Focus was on PSR & MA patient interaction
Roll out date: 1/11/2016
Phase 1 conclusion: 2/9/2016
Phase 2 will continue over the next 6 weeks

Further analysis of data collected on 3/21/16 for the test period 1/11/16 to 2/9/16 is as follows:

<table>
<thead>
<tr>
<th>Nurse/Assistant</th>
<th>Q1</th>
<th>Q2</th>
<th>Courtesy of registration staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>92.4</td>
<td>94.6</td>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
<td>13.8</td>
<td>10.8</td>
<td>SD</td>
</tr>
<tr>
<td>Pop. Size</td>
<td>952</td>
<td>439</td>
<td>Pop. Size</td>
</tr>
</tbody>
</table>

An independent one sample t-test was conducted to determine if the two means from Q1 to Q2 were significantly different. The results were conclusive.

Nurse/Assistant:  
t = 4.2681  
p = 0.00001209  

Courtesy of registration staff:  
t = 4.8848  
p = 0.0000007314  

A second 2 sample t-test was also conducted. The results were conclusive.

Nurse/Assistant  
t = -3.2237  
p = 0.0006519  

Courtesy of registration staff:  
t = -3.8183  
p = 0.00007144  

Since both p-values are less than 0.05 level of significance, it is concluded that a significant increase in the means from Q1 to Q2 exists in all cases.