# Care Coordination

*Essential Behaviors to Improve the Patient Experience*

## Q. During this visit, did this provider seem to know the important information about your medical history?

- Consider posing questions such as, "You mentioned that you have been feeling fatigued for the past few weeks, is that right?" rather than, "So tell me why you are here today." **Confirmation questions allow the patient to interact and provide a signal to the patient that you are knowledgeable about the reason for the visit.**
- **Regularly refer back to the patient's chart when discussing their current condition**. If symptoms are recurrent, make sure to share that observation with the patient. Example statements include:
  - "It seems this pain has been bothering you for XX months/years."
  - "We've tried a few different approaches before."
  - "This has been an issue for some time now."
- **Use the sources of information you have before you ask the patient questions**. For example, instead of asking, "Do you have any allergies?" say, "The chart says you do not have any known allergies, is this still correct?"

## Q. During this visit, did this provider have your medical records?

- **Reference the medical record in conversations with patients**. Examples include:
  - "I see here in your medical record …"
- **When interacting with the medical record in the patient's presence (paper or electronic), position yourself so that you can easily glance from the record to the patient**.
  - Reference the medical record, but look up and make eye contact when speaking with the patient.
  - Avoid reading directly from the record.
  - If computer placement forces providers to have their backs to patients, require providers to explain this to patients. For example, "As I document our visit in the electronic record, I will need to turn around to use the computer. I assure you I am still listening as we talk."

## Q. In the last 3 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow-up to give you the results?

- **Whenever sharing a test result with a patient, also share what the result means**. Furthermore, if it is applicable, share the normal range for that particular test. Merely telling a patient his or her blood glucose level is not informative unless you provide context related to the results. Similarly, telling patients that their test results are "negative" or "positive" does not provide them with helpful information about their health.
- **Provide the results of each test and avoid the mentality of "we'll let you know if there is a problem**." Tests results can be misread, and communication problems sometimes happen. Many patients may never be at ease without confirmation and may suffer greatly from anxiety as they wonder whether someone forgot to call or had the wrong telephone number.

- **Set patient expectations regarding the turnaround times for various test results**. Help patients understand the steps of the test process. For example, a test is sent to a lab, read by a physician, who then calls the primary care doctor, who then deliver results to the patient—this entire process should be explained to the patient.
- **Avoid technical language as much as possible.** Describe the tests as the patient would experience them. Using the same words that are on signs or brochures will help with consistency.

## Q. In the last 3 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?

- **Use nontechnical, plain language.**
  - **Provide answers and explanations in understandable language.** Technical terms used by health care providers can be confusing for both patients and families. Using words that are easier to understand will lead to better patient retention of information about medications.
    - Use plain language guidance to simplify words for better comprehension, both verbally and in writing. Resources that provide more widely understood synonyms for medical language are available on the Internet. The National Institute of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ) offer such online resources.
    - For example, consider replacing the word "adverse" with "bad," "dangerous" or "harmful."
  - **Watch for cues to indicate a lack of understanding**, for example, if the patient stops nodding, fidgets, frowns, or displays facial signs of confusion, such as furrowing the brow.
- **Confirm that patients understand which medications are being prescribed and the directions** for taking them before they leave the office. The anxiety patients feel when they cannot recall information or become confused after a visit is unnecessary and may be minimized when providers confirm that patients understand medications.
  - **Covering each of these items allows the patient to process the information** in case he or she has questions (also include these in written materials):
    - Drug name, Drug purpose and the condition the medication treats, Intended effects
    - Dosage and considerations (e.g., how many should be taken each time, how many times a day, with/without a meal, etc.) including time(s) of the day the medication should be taken
    - How long the patient will need to take the medication
    - Potential side effects, including side effects warranting immediate medical attention
    - Whether it is a new drug for the patient
  - **Utilize the teach-back method to evaluate patients' understanding**. Have patients tell you about their medications.
    - "We've gone over a number of changes to your medications. In your own words and using these handouts, can you tell me what we've discussed? How will you make these changes at home?"
    - "What will you tell your husband when you arrive home about the changes we made to your blood pressure medicine today?"
    - Use handouts or written materials along with verbal explanations. This method supports the better retention of information.