Patient and Family Advisory Council

1st quarterly meeting

March 29, 2017

7 patient advisors and 5 staff members present

Happy or Not Review of January and February reports and feedback:

- We reviewed the reports for AFK for January and February, both of which had scores of <80% and were provider-related questions. Sonia explained some of the changes that have been made this month including moving the survey system out of the waiting room to a more secure location. She had also talked to the providers and asked them to make sure they asked patients if they had any questions at the end of the visit and to remind them to answer the survey question on their way out. March reports are looking much better.
- The patients present reported no problems with their AFK providers at all. All the patients present said that they had seen the survey systems and answered them when in the clinic, but that neither the front desk nor nurses had pointed it out.

Introduction to CPC+, the big question: What can we do to reduce ER overutilization?

- Christa explained about CPC+ and our goals to keep people from going to the ER when it is not a true emergency and they need a clinic appointment instead. These are some of the barriers given by patients:
    1. Patients know that they can go to the ER and not have to pay anything where they have to pay something here. Perhaps we need to make patients aware that they can set up a payment plan with us.
    2. The lack of enough walk-in/same-day appointments. Especially in AFK where you have to call in the morning by a certain time to get an appointment that day. Once the "Dr. Open Access" process is fully implemented, we will have better access.
    3. We used to have somebody available on site to sign up patients for ACA insurance if they came in and said they did not have insurance and this is no longer the case.
    4. Some other providers and insurances have a referral system for frequent ER utilizers. For example if a patient frequents the ER for blood sugar issues, we could refer them to our Diabetic Educator.
    5. Until ER and insurances start being accountable and holding patients accountable, our impact is limited.

Phone system feedback and the other big question: How can we get our patients to answer the phones and update their phone info?

- Patients all reported that the front desk always asks them if their information is correct but suggested that instead the front desk should ask patient to verify their phone number aloud to see if it matches up with what is in our system.
- Patients reported that they often have to leave messages for both appointments and nurses and that the appointment line usually calls back quickly but the nurse does not. We discussed the appropriate call back time guidelines for the nurses which are that day if the call is before 3 pm, the next day if the call is after 3 pm. We also discussed that there are times like Monday mornings when the call volume is higher.
- Suggestion that patients may not answer the phone if they don't recognize the number. This varies depending on the patient's phone and caller ID, but caller ID should say UAMS Southwest.
- Terri explained some updates that have been made recently to the appointment line which will roll out to the nurse lines too, and that missed calls and voicemails have dropped significantly. We will revisit this at the next meeting and see if the new improvements helped.

Open discussion:

- Patient concern on the lack of wheelchair availability at FMC. Terri explained that we have had 2 wheelchairs stolen, so if a patient needs one there is a checkout process at the front desk. We need a sign that states "If you need a wheelchair, please ask at the front desk".
- Other front desk issues:
    1. They are not giving out team cards, patients do not know what team they are on.
    2. They need to be clearer in their communication about how much the patient is going to be billed. The patients do not know about billing levels and the ABN was not explained to them well. This discussion came about because a patient was told they would have to pay $75, then later received an additional bill, when they asked about it all they told them was "well you signed the paper". This patient did not have any labs or x-rays and wanted to know what the extra charges were for but could not get an explanation. The patient said they would like to know a basic range of what they will be charged.
- A patient had an issue with DME that was recommended over 2 months ago and still has not been received. The patient also needed a referral and was told that they had to find out who would do the surgery they needed instead of us finding out and letting them know and wanted to know if this was the usual practice. Christa will investigate these things further, but the DME delay seems to be a common problem. Perhaps we need to revisit the process on that. The paperwork seems to get put in the residents' boxes and stay there. We need to change the process or make residents check their boxes more often.