The Patient Experience No One Addresses

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A 50-year-old woman, accompanied by her 70+ year old mother who is the patient, appears at the doctor's office checkout station. The doctor ordered an ultrasound for the mother, who appears in pain and can hardly support herself using her walker, and the daughter asks to schedule the return visit. The checkout staff informs her the diagnostic exam must be scheduled prior to scheduling the return visit. The woman asks can she get the ultrasound done today instead of driving home and coming back, over a 50-minute one-way drive. The staff provides the hospital's scheduling phone number. The office, which is a hospital owned practice, is two floors above the hospital's outpatient diagnostic center. The daughter, with nothing scheduled, assists the mother to their car. This is just one of six similar situations, wanting to coordinate hospital and physician services, observed during a single

day. Office staff doesn't have the time to call and administration did not add capacity to do so.

We tend to quantify the patient experience when they are within our traditional boundaries; getting within those boundaries is often times not considered. From a pure business perspective, it is this disconnect where business is lost to competition. Worse, this is where customer impressions that will be difficult to both identify and influence, begin to form even if their business is not immediately lost.

As physician practices and even patient insurance relationships with the hospital change in today's healthcare delivery setting, there may be a new question for the administrator to consider; along with business development/marketing and strategic planning management. Today's Medical Center offers so many clinical services to which a physician's office may need to refer during an office day, how has administration accommodated communications? Is the office to continue using the prior methods or can communication across the multitude of disparate services be accessed quickly, easily and without adding costs for anyone, including the patient?

Central Scheduling capabilities, generally driven by finance, in most hospitals are unable to include the entire offerings of a modern medical center. The cost of forming a single contact point, along with the politics of departmental loss of control, is something administration would most likely not want to undertake. But this thought pattern represents how communication is traditionally accomplished. Is it time to take a non-traditional approach to coordinating and communicating? If you start with the assumption (maybe fact) that you are already spending for the capacity to provide access to each service, then the only factor is how to technically simplify accessing any and or multiple services by the user. Placing a human at that intersection, for example a referral center, will only add a failure rate probability, costs and a capacity limitation.

Another motivator for undertaking this rethinking may be the current costs being incurred by your medical practice that is often invisible as it is thought of as a normal cost for doing business. In the case described earlier, that patient (daughter) now must place a call to the practice's scheduling line to schedule a return visit. It could have been done at much less cost, for you and the patient, during checkout. If you have a 10% return visit rate, then you are paying for 10% more calls to be processed than is necessary. If an abandonment rate occurs on the scheduling line, you are probably incurring even more costs. The question remains, how to communicate such details to the hospital without adding cost to any of the parties?

Do you have an integrated system such as EPIC? The issue remains even after such a system is in place. Most hospital services will not relinquish scheduling control to a physician office and the office doesn't have the time or skill to conduct another department's scheduling protocol. Meantime your anticipated ROI is underachieved.