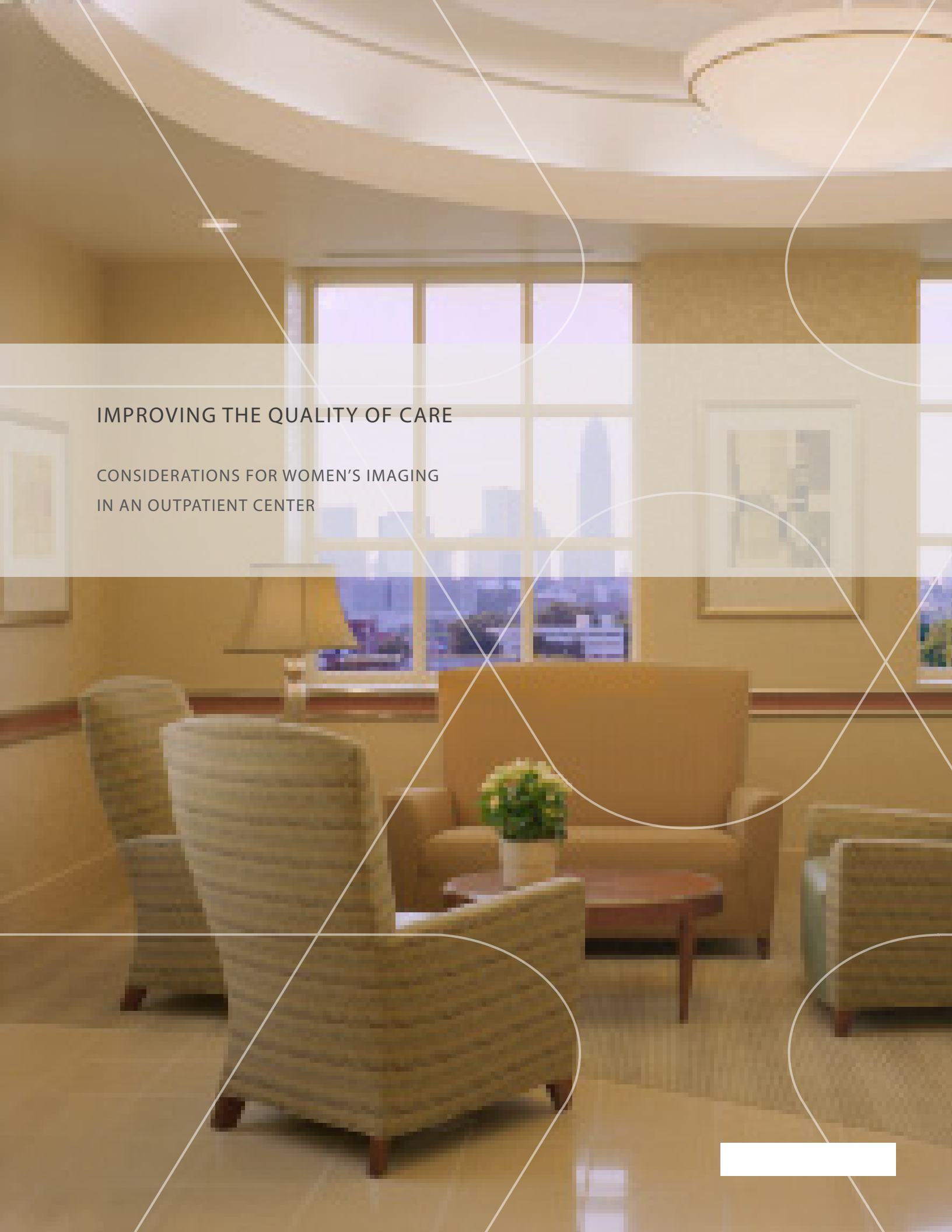

IMPROVING THE QUALITY OF CARE

CONSIDERATIONS FOR WOMEN'S IMAGING IN AN OUTPATIENT CENTER

Many women visit an outpatient imaging center in fear of bad news.

When one out of every eight women born today will be diagnosed with breast cancer[1], scheduling a diagnostic scan or biopsy can be a very unnerving experience. At the same time, retail alternatives for women's imaging threaten providers' market share and patient satisfaction. When an annual mammogram is an experience fraught with fear, why wait two weeks for an appointment when it is possible to get a same-day appointment at Nordstrom?

Who wouldn't prefer to take care of an unsettling chore in a convenient and non-clinical setting?

While decreased revenues due to healthcare reform continue to exert downward pressure on non-essential facility amenities, healthcare executives will struggle to balance reducing cost and satisfaction related to HCAHPS scores. We are entering a new era of patient choice with new decision makers and a new healthcare delivery system that will present growth opportunities for discerning health systems.

We work with many providers for whom a non-clinical setting is not possible, and have helped them implement strategies for improving the quality of care. Plush chairs, WiFi, and a water feature are always appreciated but will not make a long wait time shorter, nor do they necessarily contribute to the bottom line. The following describe the programmatic implications of managing patient anxiety, minimizing inconvenience, and delivering bad news in ways that make financial sense.

1 National Cancer Institute at the National Institutes of Health. Breast Cancer Risk in Women. http://www.cancer.gov/cancertopics/factsheet/detection/probability-breast-cancer

DESIGNING WAITING SPACES TO MINIMIZE ANXIETY AND ENHANCE PRIVACY

The ideal waiting scenario is not having to wait at all, and providers are competing against the option of a 15 minute mammogram at Nordstrom. At FreemanWhite we use computer simulation modeling to test registration queuing, number of changing rooms, and size of waiting and subwait areas based upon the imaging modalities and lengths of stay. We can decrease throughput time, and ultimately how long the patient must wait, by manipulating the quantity of changing rooms and waiting space in the design and recommending different staffing and operational models. Women's imaging centers that are sized according to the volume of patients that will be seen are a win-win for patients because their wait time will be shorter, and for providers because the space will not be overbuilt.

Our designs often propose separate waiting spaces for screening patients visiting for their yearly checkup and diagnostic patients who are addressing a specific concern. In subwait areas, we seek to avoid mixing patients who are returning from receiving a negative diagnosis with patients awaiting initial diagnostic exams. Another best practice is to segregate non-gowned patients from gowned patients. From a patient satisfaction standpoint, all of these techniques offer environmental sensitivity. From a proforma standpoint, there are no additional seats, they are just distributed appropriately along the patient flow process. Decentralized waiting can also translate into a more comfortably sized main waiting area because you don't have to put all of the chairs in one place. Even though waiting areas are non-revenue producing spaces, they serve a vital function in queuing and moving patients through their visit. Without them, a patient going from registration to changing directly to their modality would not work because the departmental throughput would be negatively impacted, resulting in reduced utilization of expensive equipment.

2 P. E. Schofield, P. N. Butow, J. F. Thompson, M. H. N. Tattersall, L. J. Beeney, & S. M. Dunn. Psychological responses of patients receiving a diagnosis of cancer. Annals of Oncology 2003; 14: 48–56. http://annonc.oxfordjournals.org/content/14/1/48.full

3 A.L. Back, S.B. Trinidad, E.L. Hopley, R.M. Arnold, W. F. Baile, K.A. Edwards. What Patients Value When Oncologists Give News of Cancer Recurrence: Commentary on Specific Moments in Audio-Recorded Conversations. The Oncologist Mar 1, 2011: 342-350 http://theoncologist.alphamedpress.org/content/16/3/342.full.pdf+html

DESIGNING AN APPROPRIATE SPACE FOR DELIVERING BAD NEWS

Patient outcomes are measurably affected by the ways in which providers communicate the news of a cancer diagnosis.[2] Many patients will start their cancer journey hearing those fateful words in a less than appropriate manner in a less than appropriate setting[3]. Studies have linked the ineffectual delivery of bad news with increased rates of psychological morbidity so it is critical to optimize both the setting and approach. Distressed patients are hindered in their ability to be good health advocates. Patient engagement makes them partners in their own care, which in addition to being high quality care, generally improves the fiscal outcome for providers.

Environments for delivering bad news reinforce the following tenets through their design:

- The provider recognizes the gravity of the moment and appreciates its effect on the patient,
- The provider recognizes the emotional content of the news,
- The provider helps the patient feel as though they have a major say in their treatment plan, reducing the likelihood of depression.

Providers can demonstrate their acknowledgement of the emotional nature of the situation by locating consult rooms on an interior corridor, with a discreet exit path from the consult room that does not go through the main waiting area. This gives the patient the privacy to have an emotional reaction without fear of broadcasting it to other patients. Similarly, acoustical and visual privacy helps keep patients from overhearing others' conversations.

A consult room sized and furnished appropriately for family members also subtly translates that the patient doesn't have to navigate their situation alone. To have sufficient space for the patient, their family, medical staff, and sometimes a surgeon to begin the dialog on a treatment plan and explore possible options, six to eight people may need to be accommodated in a standard-sized consult room.

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