

Best Practices for Patient Satisfaction

A discussion paper for PMG Physicians

Wells Shoemaker MD, Medical Director, February, 2006

Once upon a time, patient satisfaction was regarded as a “soft” issue, dismissed by some doctors as secondary in importance to the intellectual precision and technical skill of the practitioner. Times have changed. PMG’s Pay for Performance bonus opportunity now hinges heavily upon our patients’ perception and rating of our services, and these results are widely posted for the inquisitive public. Our individual PCP quality scoring includes satisfaction, too.

In actuality, there is a great deal of experience and considerable science on the subject of patient expectations and satisfaction. Better yet, there is an abundance of Best Practice examples within our network.

I would add that this challenge must be met by every single person who engages a patient: the doctor, certainly, but also the receptionist, medical assistant, billing staff...everybody who is attached to your name. The doctor needs to lead by example, but that’s not enough. The doctor must be a "manager" of this aspect of quality. He must seek training for his staff, monitor their work, solicit feedback continually, and be willing to change personnel. His livelihood depends upon it.

In 2003, PMG Physicians created this "Top Ten" List of satisfaction strategies:

- 1. Rapid access to office appointments**
- 2. On time service**
- 3. Human beings answering the phone**
- 4. Extended hours**
- 5. Reliable, fast call-backs on evenings and weekends**
- 6. Answer questions thoroughly**
- 7. Solicit feedback from the patients’ perspective**
- 8. Personal touches from doctors and office staff—expressions of caring**
- 9. Follow-up by phone (or e-mail) for unfolding problems**
- 10. Help patients navigate complex systems**

As we have learned steadily over the intervening years, the general themes for success in satisfaction tend to fall into 4 categories:

- Access
- Reliability
- Communication, or perhaps “Perception of Caring”
- Coordination.

Access

- Very few patients really want to interrupt their lives to go to see a doctor. They need to get a babysitter, get coverage at work, drive through freeway traffic, relay a complaint to non-physician staff half your age, wait for an hour, put on a paper garment, get grilled about your lifestyle miscues, then go to a pharmacy, wait in line, drop a few 20 dollar bills, then get back to work or home and try to catch up.
- Patients are driven to us by anxiety, obligation, and sometimes self-reproach...rarely a desire to spread joy. Most of the time, the negative feelings are reasonably based upon plausible fears, common sense, and self-knowledge. This is not a warm and fuzzy mindset, and small aggravations are easily magnified. A closed door or an unanswered phone is an immediate irritant, as we have all learned when we trade places.
- There is NO virtue in arguing with patients about their desire to be seen. They are usually right—what are you possibly going to gain by disputing their judgment over the phone? If they see you later than they wanted and they (or worse, their child) are still sick or sicker, they'll figure your complacency allowed it to get worse. More likely, they'll go somewhere else, occasionally making a really dumb and expensive choice.
- Most insured adults in our county are working for a living. Getting time off is not easy for many, and what we doctors may condescendingly call "convenience appointments" may have big financial implications for families living on the edge of affordability in Santa Cruz.

What Works: Open the door

1. Open Access is becoming the Gold Standard for both patient satisfaction and office efficiency. Satisfaction of both patients and physicians has SOARED in every installation that has bitten the bullet to clear out appointment backlog and put it in place.
2. For offices which aren't quite ready to take that leap, "Open Access Lite" works at offices such as Art Dover's and WMA Pediatrics. All sick patients are assured to be seen that same day. *No argument, just come, we're here to protect your child's health, and we'll catch up on preventive stuff and education if we have time, too. Good to see you...*
3. People still prefer to see their own doctor. (SCMC gets ripped for this, by the way.) We know from experience when people want to see us for pressing problems. Monday mornings in peds and family practice are predictably crowded with patients who have struggled through the

- weekend to see their own doctor. If they can't get in, that's a big time zero for the doctor. Leave lots of slots open.
4. "Convenience" is understandable. We like it, too. The end of the work day and early evenings are precious for working adults and parents. Offices with extended hours see big boosts in satisfaction. Saturday morning is a bonus opportunity (PMG pays higher rates to our PCPs who have schedulable hours in evenings and weekends).
 5. Telephones need to be answered by a living, breathing person. Voice mail and phone menus, to use our local vernacular, *just totally suck*. There is NO conceivable overhead economy which can offset the instantaneous irritation of an electronic voice after a patient has reached the threshold to ask for help, especially if there is no escape from voice mail hell to reach a human being. The resentment can create domino consequences for months.
 6. Answer the phone at lunch, please. Many working people use their lunch hours as the only free time to call, and it's a slap in the face to get a machine. If you have one of those messages that cites your office hours, please *adhere to them!* Imagine what it feels like when you call at 4:45 PM and get the recording: *"Our usual office hours are 9 AM to 5 PM. If you are calling outside these hours...."*
 7. Electronic connectivity with patients is rapidly gaining popularity. Furthermore, it will save doctors expensive overhead for lots of perfunctory services which currently involve big staff inefficiencies: Rx refills, lab results, appointment verification or changes. The serial phone calls, faxes and re-faxes, & chart pulls for Rx refills gobble up hours of expensive time. Using Relay Health, you can also get reimbursed for your clinical advice, often at a fraction of the amount of time required for a personal visit.

Best practice suggestions from successful PCP's

Availability is always a biggie—both in having the phone answered by a real person who is pleasant and capable and being able to schedule same day appts.

Don't use phone trees, use people.

Reliability

We are not good doctors just because we got high grades and worked hard for 11-12 years after high school. We are good because of what we did yesterday, do today, and will do tomorrow, reliably and consistently. Our patients put a great deal of trust in us initially, but that needs constant reinforcement, and it doesn't take much to erode it.

What Works: Close the Loop

1. Call every patient who went to the ER for any reason the day before. That avoids dropped clinical balls for serious problems needing follow up. It also demonstrates that not only are you on top of your patients, but you care what happens when they are out of your office. After establishing that beachhead of goodwill, choose that time to educate about proper ER use if necessary.
2. Follow up on lab studies. These are always inconvenient, they usually hurt, and patients pay handsomely for the information. They are usually worried about the results. Delays are deadly as uncertainty grows like mushrooms. Don't make them call you—you call first.
3. Use secure e-mail for correspondence for the 50-60% of patients who want it. It is also part of your record, which is good for follow-up, reinforcement, and CYA.
4. Follow up on illnesses in early or uncertain stages, and not just with kids. "How are you doing?" calls, aside from demonstrating caring, can keep you out of medicolegal nastiness. The cumulative time spent over decades doing this is minor compared to the heartache of one deposition for failure to diagnose.
5. Realize that your on-call partners are, in essence, YOU in different clothing. If your partners are not going to deliver the same level of responsiveness as you, speak tersely to your patients, or fail to update you on what happened...you are really hurting yourself. Make a change.

Quote from a high-performing PCP:

Quick availability on the weekends and night. The idea of the answering service batching calls is very tedious and patients wait and wait for the return calls. Making the time between the patient calling and either having an immediate response or a very quick 10 min turn around is very important.

Communication

Even with modern imaging marvels, DNA probes, and nuclear stress testing, 90% of the information used by a physician to make a diagnosis still comes from the patient's history. Beyond that, patients' recollection of how they were heard plays prominently in their assessment of our skills and our caring.

What Works: It's both you and your staff on the same page

1. Patients need to feel that we consider it a PRIVILEGE to serve them, not a pain, not a duty, not a "squeeze in," not a resented capitulated encounter. "What is important to you today?" Personalize every visit at the beginning so the patient knows he or she is being treated as a unique individual.
 2. Office staff need to use their eyes and faces, appear to truly care that a problem gets solved, and say something comforting to every single patient. If a visit will be delayed, tell the patient an actual truth about why and how long, and ask whether that will cause serious problems for the patient, and be willing to make some adaptations.
 3. Office staff can collect invaluable information by asking the departing patient if his or her questions were answered, whether he or she has a clear understanding of next steps, and when the next encounter should be. Asking "How did we do today?" can yield tremendous insight, not to mention goodwill. You don't need a consultant to get those answers.
- *Exam room skills for doctors learned through "motivational interviewing":*
4. Don't interrupt. Honestly, doctors rarely listen for even 30 seconds before butting in to channel the conversation. Good studies have shown the total length of the visit is LESS when we don't interrupt in our attempt to limit the scope of our work, and patients immensely appreciate being heard. They don't really need us to rebut or deprecate their concerns. They usually can't argue on the same plane as we, aren't given the chance anyway, so they just go quiet and leave...unsatisfied. Remember they are paying hard earned money for the privilege of our company.
 5. Get eye contact early and often. Staring at the chart bugs people. Ask permission if you need to dig for a while for their benefit, or take notes. Sit down to show you're not about to vault out the door.
 6. Ask, don't command. Rephrase what you heard to see if you got what they wanted. Verify that your suggestions mesh with what the patient is willing and able to do...otherwise the echoes of our words die.

7. Ask if you covered things satisfactorily before you leave the room, and be willing to fix it if necessary, even if that means setting a future appointment.

Here is a quote from 2 PMG physicians who aced the Patient Satisfaction Survey last year.

- *The patient wants some human contact Everyone in our office tries to see the patient as a friend and possible long term contact—so asking about how they are feeling, family, pets, children—something other than why they are here. Avoid giving people the impression that they are taking up our valuable time with their complaints. Keeping joke books in the waiting room, toys for the kids to play with, rewards for the kids.*
- *The patient needs to feel comfortable enough to have all their questions answered, not necessarily all on the same day. Reschedule if needed. (Also a real good way to never get sued)*

Coordination

Our patients typically assume that we doctors are far better connected than we usually are. They assume that we know the results of x-rays and lab tests, that specialists are sharing their insights with the primary care doctor, and that our staff relayed what they discussed over the phone. They assume that our recommendations represent the consensus of many smart doctors to whom they paid fees. That's not the case always.

What works

1. Specialists need to respectfully acknowledge the PCP who referred the patient—directly to the patient—and describe what next steps would follow in communication. Ask permission and preferences.
2. Do the smart work-up in advance so the specialist has everything she needs.
3. PCPs need to take responsibility that patients actually show up at the specialist office with all of the information needed. Failed appointments are cold lamb grease.
4. If there are previous difficult medical experiences, historical roller-skates on the stairwell, or behavioral vulnerabilities, make sure the specialist knows about this in advance. Use the phone.

5. If a PCP can't get a patient in to a specialist in the timing that he or she feels necessary, **use the phone—doctor to doctor**. *I have virtually never heard of a situation where a PMG physician would rebuff a colleague where there is a real clinical threat facing a patient.* Office staff, however, may see their job as protecting the doctor from overwork, or getting home on time. It's your job to get through the interference. Patients will be forever grateful, plus they'll see you as an influential advocate...just don't cry "wolf."
6. PCPs need to make rounds on their hospitalized patients—early in the day—and insist that specialist recommendations make sense and are launched in a timely way.

Quote from a conscientious PCP Office

If other doctors' offices would not be so snotty when you call looking for copies of reports or such. We all deal with the public and we are all customers to one another and she be treated like customers.

Wells' epilogue:

Putting a wrinkle on Abraham Lincoln's famous quote: *You can please some of the people all the time, and all of the people some of the time, but you can't please all of the people all of the time.* We need to try, however, and I think we can do better.

I am sure you have many other suggestions. Please share them!

Sources for these opinions:

- Patient compliments, comments, and complaints
- Formal survey of PMG physicians for best practices
- Ad hoc comments and observations of community physicians
- PMG educational sessions 2000-2004
- CMA Practice Management course and NorCal Risk Management courses
- Materials and presentations from BCCP, OPS, CHCF fellowship 2002-2006
- 10+ years reviewing formal complaints and grievances in medical care
- 6 years in Blue Shield statewide QI committee, including 200+ selected complaints quarterly
- Personal practice experience in multiple settings