

By Heather Grimshaw

A MATTER of PERSPECTIVE

How patients' fears affect care

Imagine a medical facility where staff members bake cookies every afternoon, valets park patients' cars, dogs roam the halls to visit sick patients, and staff members wear name tags printed with one reason why patients can trust them. >>





This is not a fictional scenario. It happened at a midsized hospital in Indiana where Colleen Sweeney, MS, RN, worked as the director of innovation. And it can happen — in varying degrees — at your medical group.

“Everything is important to patients,” Sweeney told hundreds of attendees at the MGMA 2012 Annual Conference in San Antonio. “Someone is watching you at all times.”

What do they see? And how does that affect their impression of your organization?

As founder and owner of Sweeney Healthcare Enterprises, Tampa, Fla., she has a keen appreciation for the direct link between patients’ perceptions, compliance and, ultimately, better outcomes.

The belief that patients’ perceptions have a powerful influence on care and compliance prompted Sweeney to embark on the Patient Empathy Project, a three-year endeavor to help medical professionals engage patients in more meaningful ways. She shared details from the project — and the top 11 patient fears — during her workshop titled “Clinicaphobia: What patients fear and we have to know.”

And Todd Barnes, MBA, CMPE, MGMA-ACMPE member, took note. “It was interesting to see the ranking of patient fears,” says Barnes, business administrator, Department of Neurosurgery, College of Medicine, University of Oklahoma, Oklahoma City, who shared the fears with his own staff and some of the physicians. “Most of them were as surprised as I was about some of the fears our patients may harbor,” he says.

They are not alone, according to Sweeney, who laments the fact that few medical professionals ask about or even think about patients’ fears.

“Why don’t we ask? Because we’re afraid of the answer,” she explains. “We’re afraid we’ll feel inadequate. We’re afraid it will take too much time.”

Rosemarie Nelson, principal, MGMA Health Care Consulting Group, agrees that practice administrators might not be cognizant of patients’ perceptions or fears. “The day-to-day financial pressures begin to create a bubble around

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the management of the practice,” she says. “It is too easy to be distracted by outcome measures and forget what inputs create those outcomes. ... If more administrators cultivated an environment and staff orientation to putting the patient first in all considerations, the group would see positive results in outcome measures.”

From a practical standpoint, Nelson adds, “Simply acknowledging and informing the patient of delays in wait times is good service. Providing explanations of diagnoses and treatment plans in plain language instead of clinical speak puts patients and their families at ease. Many groups would raise the issue that it takes more time to do this, but in reality, they end up spending the same amount of time — or more — answering patient questions on the phone.”

Tapping your power

Practice administrators have a lot of power when it comes to creating the type of environment that Nelson

mentions. From encouraging front-office staff to be friendly and accommodating to creating processes that ensure smooth patient flow and inform patients about delays, the key is to know what puts patients at ease and to act accordingly.

During interviews with patients for the Patient Empathy Project, Sweeney learned that “whatever the patient’s biggest concern is, it’s usually not a clinical thing.” This was echoed by the *Experience Radar 2012: Customer Insights for the U.S. Healthcare Provider Industry*,¹ a report from Pricewaterhouse-Coopers LLP, New York City, that summarizes interviews with 6,000 consumers.

Regardless of origin, these fears — and others — weigh on the minds of patients and distract them from provider interaction, Sweeney says. “Most of the people who receive doctors’ instructions have no idea what was just said,” she adds. And instead of asking a question, “they figure they’ll just Google the diagnosis when they get home.”

For medical practices, the Patient Empathy Project identified the following eight fears specific to group practices, many of which — as Sweeney noted — can be controlled by practice administrators:

- Diagnosis/prognosis
- Wait times
- Communication issues
- Cancer
- Rude doctors
- Scale location
- Cost
- Germs

“Shame on us that we’ve allowed rude people to take care of our patients,” she says. And worse, she adds, “In some cases we have esteemed” the people who display that type of behavior.

First impressions

At the MGMA 2012 Annual Conference, Sweeney started her session “Clinicaphobia: What patients fear

and we have to know" with silence. Three seconds of silence, to be exact. And then she explained why: "In the last three seconds you've formed your opinion of me. You probably asked yourself, 'Why the little purple dress, pearls and stockings?'"

In practice, "you have three seconds to make an impression on your patients," she continued. "Three seconds is all we have to convince patients that this is a good place, that they want to come back. And it's almost impossible to change someone's opinion."

As a result, when she was hired as the director of innovation, Sweeney set out to make sure that what patients saw during their first three seconds at the hospital impressed them. And she asked C-suite executives to do the same. "The front desk has a lot more control than we think," she said. "They can set our clinicians up for failure."

After listening to front-office staff interactions with patients, Sweeney was appalled to hear a staff member wish a patient "good luck" as she ambled off to find her doctor. Sweeney quickly learned the staff member had the best intentions when she wished patients luck as a send-off. That solidified Sweeney's belief that there is a serious difference between intention and reality, and it prompted her to investigate scripts for front-desk employees.

Service with a smile

Acknowledging that medicine is a service industry, Sweeney bristles when people use the word "customer" instead of "patient."

"They're not ordering a latte," she explains. "Our patients may be at the lowest ebb of their lives, and it's our job to make them totally happy and satisfied."

Although she talked mainly about her experiences at nine hospitals, the lessons apply to all medical facilities — from large hospitals and

integrated delivery systems to small group practices.

"Patients don't know about quality, but they do know if you care," says Sweeney, who talked about the importance of hiring people who have friendly faces and are willing to engage patients and express genuinely positive emotions by — as Sweeney says — smiling with their eyes.

To gauge this in your own practice, Nelson suggests that administrators invite fellow administrators to visit the practice as patients and share their experiences. "Granted, it is a sample size of one," Nelson says, "but where there's smoke, there's fire!"

You can also go straight to the source with a new Patient Satisfaction Benchmarking Tool² that was created by MGMA-ACMPE with the SullivanLuallin Group (mgma.com/connexion-satisfaction).

Quality of care and patients' perceptions of it, which affect satisfaction, are increasingly important to medical professionals for myriad reasons, including the fact that commercial payers are rewarding higher scores and the Centers for Medicare & Medicaid Services recently included Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) in its physician fee schedule quality reporting measures.

"Scores are coming to a medical group near you," says Sweeney, referring to CG-CAHPS.

Toward that end, identifying patients' fears — and working to overcome and allay them — becomes increasingly important. Some of the fears that made Sweeney's top 11 list (see sidebar) — and were noted repeatedly by patients in the Patient Empathy Project — might surprise you: From white walls and cold room temperatures to medical mix-ups and long wait times, patients told Sweeney stories about rude nurses and doctors and described their unease caused by not

Top 11 patient fears*

1. Infection
2. Incompetence
3. Death
4. Cost
5. Medical mix-up
6. Needles
7. Rude doctors and nurses
8. Germs
9. Diagnosis/prognosis
10. Communication issues
11. Loneliness

— From the Patient Empathy Project, Colleen Sweeney

*Regardless of venue of care (includes hospital and group practice settings)





knowing what came next in the medical process.

Patients want to feel secure; they want to know what's coming next, she adds. And they want to know that you are present with them in the room, that providers are interested in their care and want to help. One way to accomplish this is to tell patients what you're doing — that you will ask questions and type the answers into the EHR.

“Shame on us that we’ve allowed rude people to take care of our patients.”

It’s not just about looking at someone when you talk, she says. It’s about seeing that patient as a person, and if he or she doesn’t ask a question about a diagnosis, suggest a few that other patients have asked to encourage the lingering questions. “Some people are worried about looking stupid,” Sweeney says. “You can open the door by suggesting questions. I promise you, they have questions.”

Members might also be interested in researching the Empowered Patient Coalition,³ a nonprofit organization created by a California-based dentist to empower patients to ask questions and play an active role in their treatment. The website — empoweredpatientcoalition.org — provides fact sheets and lists of questions that patients can use in the exam room to bolster their confidence with providers.

To help medical professionals connect with patients, Sweeney suggests asking providers to make mental notes about a patient’s eye color during an exam. It might not be something that is normally done, but it helps pull busy professionals out of their routine and recognize that the patient sitting across from them is a person, she says.

As Sweeney shared messages from her Patient Empathy Project, a theme emerged: Medical professionals who want patients to be partners in their care must take a different approach to engaging them. And as healthcare professionals are judged by patient satisfaction, more attention will be paid to creating a safe, welcoming environment, asking about patient fears with the goal of diminishing them, and ensuring that patients are comfortable and at ease.

“Healthcare providers have some of the toughest jobs in the world,” Sweeney says. “There is so much necessary documentation and protocol that we have forgotten the patient. We care for people every day who suffer from silent terror and rarely tell us of their fears. And we rarely ask.” 🌐

Additional reading:

MGMA *In Practice* Blog: How happy are your patients? 3 ways to assess satisfaction (Oct. 22, 2012), mgma.com/perspective-happy-blog.
MGMA *In Practice* Blog: How to benchmark patient satisfaction (Nov. 20, 2012), mgma.com/perspective-benchmark-blog.
Patient article series — online exclusives — mgma.com/perspective-connexion.

Notes:

1. *Experience Radar 2012: Customer Insights for the U.S. Healthcare Provider Industry*, pwc.com/en_US/us/advisory/customer-impact/assets/pwc-experience-radar-healthcare-provider.pdf; accessed December 2012.
2. MGMA-ACMPE Patient Satisfaction Benchmarking Tool: <http://data.mgma.com/PtSat/rdPage.aspx>.
3. Empowered Patient Coalition, empoweredpatientcoalition.org.



Learn more about patient experience at the upcoming MGMA 2013 Patient-Centered Medical Home Program, April 21-23 in Chicago. More details at mgma.com/perspective-pcmh.