LEE COUNTY MEDICAL SOCIETY INC.
Physicians Caring for our Community

Bulletin

Volume 35, Issue 1 | Editor: John W. Snead, MD | April 2011

2011 Meetings and Events

No Meeting in April

Save the Date
Thursday, May 19, 2011

Speaker:
Ronald Castellanos, MD

Program:

- **MedPAC Recommendations to Congress on physician fees for Medicare & Medicaid**
- **ACOs**
- **HIEs**
- **EHRs**

Insert

- **Advertising in the LCMS Pictorial Directory**

Inside this issue:

President's Message

Kids, Guns and Politics

Shahid Sultan, MD

Recently Sen. Greg Evans (R-Crestview) introduced a bill that will prohibit doctors from asking patients if they own a gun or denying treatment if patient refuses to answer the question regarding gun ownership. The bill earned its first approval by the Senate Judiciary Committee by a vote of 4-1 in favor.

Doctors have strongly objected to this bill. Doctors, particularly pediatricians, ask questions regarding guns in the house to provide advice to the parents regarding gun safety and how to prevent accidental injury to the children.

State Rep. Jason Brodeur, (R-District 33) also introduced a bill in the House that could send the doctors to jail for up to 5 years and fine them up to $5 million for asking about gun ownership, refusing the treatment if the patient or the parent does not answer the question or entering the gun ownership information in the patient records. This bill has the support of The National Rifle Association.

These bills have been introduced in response to American Academy of Pediatrics guidelines encouraging pediatricians to talk to parents about accident prevention. It includes use of booster seats in cars, swimming pool safety and proper gun storage.

Doctors, specifically pediatricians, strongly oppose these bills. Louis Petery, MD Executive Vice President of the Florida Chapter of the American Academy of Pediatrics said "we are not against guns per se. What we are concerned about is proper gun storage and handling of the firearms". The Florida Chapter of AAP and FMA oppose this bill also. Jeff Scot, General Counsel of FMA said "as written, the bill is absolutely unacceptable, and we will fight it".

The AMA policy of gun ownership also supports the storage of unloaded firearms in locked cabinets with trigger locks. This policy, in addition, supports the legislation holding gun owners legally responsible for injuries or death caused by a child gaining unsupervised access to a gun, unless reasonable precautions were taken by the owner.

Gun rights advocates say that questions regarding gun ownership are an inappropriate invasion of privacy. Marion Hammer, former NRA president said "physicians should stick to diagnosing illness. She also said that, "it is a constitutionally protected right that has nothing to do with health care".

Politicians traditionally have pandered to the special interest groups but politics does not have to be a zero sum game; when one wins, some one else has to lose, especially when it comes to innocent non-voting children. It is our moral obligation to keep children out of harms way and no one is better suited to do this than a pediatrician. The main focus of Pediatrics has always been prevention of disease process and injury. It is the concept of prevention that led to the development of vaccines and eradication of diseases like polio and smallpox. Though, still there are people who refuse to get their children vaccinated.

There are pediatricians who own guns and support the right of gun ownership. Talking with parents has nothing to do with the laws of the land it is purely for the sake of keeping the children safe and away from harming themselves, their friends or family. Pediatricians should not be prevented from educating the parents about gun safety as they do about the use of car booster seats, swimming pool safety, vaccinations, prevention of obesity and proper nutrition.

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Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meeting minutes are available for all members to review.

Membership News

New Member

Cayce Jehaimi, MD
Pediatric Endocrinology & Metabolism
The Children's Hospital of SWFL
Tel: 239-274-5660

New Office Location

Carlos Cuello, MD
Heart Rhythm Specialists Inc.
6101 Pine Ridge Road
Naples, FL 34119
Tel: 239-304-0167

Mentoring New Physicians

New member Dr. Jitka Vasek and LCMS member Dr. Krista Zivkovic met as part of the Mentoring Physicians Program. Dr. Zivkovic writes, "We had a very nice time together. My partner, Dr. Tracy Vo, was there as well. We plan to meet again soon!"

Recently We have paired up Dr. Jeff A. Neale, MD with Dr. Brian Kurland, MD. Please contact our office at 239-936-1645 to join the Mentoring New Physicians Program since the greatest number of new doctors come to town after June.

2011-2012 Pictorial Directory

The Lee County Medical Society will be publishing our bi-annual membership directory this summer and we are requesting that you:

1) Send in your correct office information to the Medical Society office (forms were sent to each member's office, call us if you did not receive.)
2) Advertise (see enclosed form)

This directory is available at no charge to all physicians' offices and the public. Please contact our office at 239-936-1645 if you have any questions.

Have You Paid Your Dues?

Please contact us if you will need to make payment arrangements. LCMS dues have not increased since 1993.

As I Recall...

Roger D. Scott, M.D.

Nurses Notes IV

I know several articles have been dedicated to nurses, but I must do at least one more to honor these gallant ladies. **Hanne Host Steen (now Nillson) R.N.** was a 14-year-old Norwegian girl whose family, seeking a better life, immigrated to the United States in 1950 after having been subjected to Nazi domination during World War II. She states that the nine-day cruise across the North Sea and the Atlantic Ocean before any stabilizers on cruise ships was terrible. On her first day of school she told the principal that becoming a nurse was her dream, and he advised her of the courses needed for entrance into a three-year nursing diploma school. Her English-language skills were elemental from her sixth and seventh grades while in Norway. Here she took the usual courses and especially two years of Latin and "copious notes every day for the next 3 ½ years." She states, "The attitude in 1950 was demanding. My social studies teacher laughed and announced to the class I did not need a textbook since I could not read English anyway. After sitting in class for two weeks, I had written her a note requesting a book that day." Her father told her that they don't accept failures so she spent 3 ½ years proving she could do it by graduating with a New York Regents and Academic High School diploma.

"I sent my application/letters to all the major hospitals in New York City. All of them were rejected/denied because I was not a citizen of the United States. I was devastated but not crushed. Miss Mary Faithful, Directorate of Nurses at the Norwegian Lutheran Deaconess Home and Hospital (NLDH) in Brooklyn, New York accepted me in the three-year Diploma Nursing School in September 1954 and my prayers were answered that day. The day that I was sworn in as a citizen was November 1955 and was celebrated by all my fellow students and the faculty. We were not allowed to wear any adornments on the uniforms, only the school pin and name tag. On that day when I reported on duty for a 4-12 tour, Miss Faithful pinned an American flag on my bib for that shift only. That was one of the many privileges I was given as a student at the NLDH during the happiest three years of my young life." (The Museum has her American flag pin with the attached note, "I am a citizen of the USA," her School of Nursing ring, her Norwegian and American nursing pins attached to a segment of her student uniform, and a picture of her cap and a Florence Nightingale candle 1955).

Hanne's class was the last to graduate from the NLDH that was originally begun in 1883 by an immigrant nurse from Norway who was asked to come and take care of fellow emigrants along the Brooklyn, New York waterfront. "By graduation in September 1957, we were merging with the German Lutheran Hospital and the name became Lutheran Medical Center." She worked in Pediatrics for one year at Lutheran and then returned to Norway to visit family and friends and obtained a job at the University Hospital in Oslo for one year caring for pediatric patients and learning dermatology issues and treatments. In 1960, she worked in Geriatrics in a New York nursing home facility; 1961 Pediatrics in Vermont; 1962-64 MedSurg, 1965-70 Newborn and Preemie Nursery, and 1970-72 MedSurg all in Long Island, NY; 1973 returned to school for teaching certification in nursing programs; 1973-78 taught high school Nurses Aides, Adult Nurses Aides and LPN's; 1978-1992 retired from school nursing in BOCES for challenged children 12 to 21. "I had a richly satisfying life for 35 years in my chosen profession. My gratitude to Miss Faithful." Upon reading this article, Dr. Mary Lewis, Associate Dean of Edison Nursing & Health Professions commented that this shows "strength, persistence and love of nursing."

Albina M. (Tommie) Thompson, R.N. from Falmouth, Massachusetts graduated in 1942 from Worchester Hahnemann Hospital School of Nursing in Massachusetts. She worked there for a brief period but felt the call of duty to be of more use in World War II and therefore joined the U.S. Army Nurse Corps in 1943. After basic training she was sent to Miami Beach to wait for a plane to be a flight nurse. A plane never arrived for her so she applied for a transfer and was assigned to the U.S. Army Hospital Ship (USAHS) *Algonquin* where she boarded the ship in New Orleans. During all my years, I thought all the hospital ships were run by the Navy, but actually the U.S. Army (see you never get too old to learn!) had 17 with two more being converted in 1945 and also the conversion of five troop ships into new ambulance type hospital ships. The hospital ships were actually fully equipped "floating hospitals." They were painted white with a 5-foot green band around the hull and a large red cross painted on the side. At night they sailed with all the lights ablaze. There were no weapons on board and the crew maintaining the ship was civilian Merchant Mariners rather than Navy sailors. The U.S. Navy had only five hospital ships but six more were planned in 1945. Most of the original hospital ships were converted pre-war ocean liners. Much of the previous material I have obtained from the archives of the *National Geographic* Magazine 1945.

Nurse Tommie served on the USAHS *Algonquin* from its maiden voyage in July 1943 until her discharge on December 9, 1945. The ship visited many ports including Gibraltar, Oran, Algeria, Bizerte, Tunisia, Naples, and France. She was in the 203rd Medical Complement that worked 12-hour shifts every day caring for 463+ patients. There were one or two nurses with corpsmen assisting on each ward, with a total of 21 nurses on the ship. The nurses were responsible for the medications and the medic helped with the dressings and gave daily care. The *Algonquin*, along with 11 other hospital ships, took part in the Allied (D-DAY Normandy) invasion of southern France. Incidentally hospital ships lose their immunity from attack during an invasion, making this dangerous duty. Tommie believes that she made 18 crossings between Europe and the United States in the non-air-conditioned and unstabilized ship before transatlantic air transportation was possible.

After discharge Tommie took a year away from nursing and worked in a factory and took courses at Massachusetts College of Art. She then went to work at West Roxbury Veterans Hospital in West Roxbury (Boston) Massachusetts at the VA for 31 years. She opened the first Medical Intensive Care Unit at the VA and one of the first in Boston around 1969. She retired from the VA in 1976. She spends time in Cape Cod and in North Fort Myers now.

On November 18, 2009, First Lady Michelle Obama hosted Tommie and 129 military women at the White House for tea on the 65th anniversary of VE Day (for you youngsters VE Day was the day World War II in Europe ended). First Lieutenant Albina Thompson received the French Legion D'Honnerier and was deemed a chevalier of the Legion of Honor. Both of these are deserving rewards for this outstanding nurse. Congratulations on a life well led.

Maximum Number of Prescriptions in Registered Pain Management Clinics

REVISED 12/14/10 - Rule 64B8-9.0134/64B15-14.0054

The limit on the maximum number of prescriptions set forth in this rule does not supercede the standard of care for the use of controlled substances for the treatment of pain.

The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions ***per physician***. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions ***per physician*** shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

Rulemaking Authority: 458.3265(4)(c)/459.0137(4)(c), F.S.
Law Implemented: 458.3265(4)(c)/459.0137(4)(c), F.S.
History -- New.

LCMS General Membership Meeting

The Lee County Medical Society General membership met on March 17, 2011 at Edison State College.

Scott Nygaard, MD, Chief Medical Officer Physicians Services of Lee Memorial Health Systems gave a slide presentation on Graduate Medical Education in Lee County. Lee Memorial plans to partner with Florida State University on the residency program.

John Katopodis, MD, Chairman of the FMA Council on Legislation gave an update on the 2011 Legislative Session and encouraged members to join FMA PAC as this year's open legislative seat will be important to medicine.

Please join us for our next General Membership Meeting on May 19, 2011.

Add Us To Your Safe Senders List

Communication is an important part of your membership in the Lee County Medical Society. It is important that you let us know how we can better serve you - our members. It is also important that we are able to quickly communicate with you on issues that will affect you, your practice, and your patients. We also feel it is important to let you know of projects, meetings and events that we are involved in for the benefit of our local community.

Email is the quickest, most efficient means of getting our message across. Please add the Lee County Medical Society to your safe senders list. To be added to our email list please call our office at 239-936-1645 or email valerie@lcmsfl.org.

Tobacco Cessation: The Health Care Provider's Critical Role

Eliseo Rangel, MSW

Physicians have a powerful opportunity within a clinical setting to motivate patients to stop smoking and to refer them to effective and free resources. Often, smokers and other tobacco users are victims of an ongoing battle within themselves to stop using tobacco products but can't because of nicotine's highly addictive properties. Of course, the single best thing they can do to immediately begin improving their health is to quit. The physician plays a vital role in their patient's success in overcoming this severe addiction. *Quit Smoking Now* is a free program that is available to anyone interested in quitting.

It is believed that a smoker must be "ready" in order to stop; however, guiding smokers in the right direction can move them to a stage of readiness and provide them with a glimpse of hope to overcome their addiction. Overall, cigarettes kill half of those who continue to smoke, and tobacco ranks first in causes of preventable deaths - over 435,000 annually - above alcohol, illicit drugs, poor diet, and more. Because nicotine is delivered to the brain in huge surges by inhaled tobacco products, it is highly addictive, and its use continues despite the deadly consequences.

Individuals are more likely to quit smoking if their tobacco use is discussed during each visit to their physician, but most important if they are referred to a free program such as *Quit Smoking Now* that offers the tools and resources that will aid them in the cessation process. Giving individuals prescriptions to medications or recommending nicotine replacement therapy (NRT) such as patches, gum, and lozenges is highly beneficial. It is also important to emphasize the behavioral aspect of the addiction. An individual must recognize the triggers that cause them to crave tobacco and make a conscious effort to change both their behavior and the environment around them that are associated with tobacco use.

Quit Smoking Now is a program sponsored by the Everglades Area Health Education Center (EAHEC) and is available free of cost to anyone in the community. A trained tobacco cessation specialist facilitates this six-session, group program that provides participants with the support, knowledge, resources, and tools for a life without tobacco. It is designed to provide tobacco users with an individual prescription for success. Sessions include tobacco education, relapse prevention, and stress management techniques with post-class follow-ups. A limited amount of nicotine replacement therapy is also offered at no charge for eligible recipients and while supplies last.

Most tobacco users attempt to quit many times, but success is learning how to be tobacco free for good. With the right program, positive outlook, and a commitment to the process, freedom from tobacco can be achieved for life.

Health care providers possess the clinical skills to motivate patients to participate in Quit Smoking Now and the referral process is quick and easy. Contact EAHEC at 877.819.2357 or info@eahec.org for basic referral information and for Quit Smoking Now classes near you or visit www.eahectobacco.com.

Eliseo Rangel, MSW is a Tobacco Cessation Specialist with Everglades AHEC, 5237 Summerlin Commons Blvd., Ft. Myers, FL. 33907, Phone: 239-989-9809, Email: e.rangel@live.com.

Should You Practice With an Uninsured Physician?

By the Risk Management Experts at First Professional Insurance Company

The information below does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained herein are generalized and may not apply to all practice situations. First Professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

In some states, physicians that fail to carry malpractice insurance must post a notice to their patients that they are uninsured, or "bare". However, such statutes do not compel that any form of notice be given to one's colleagues. Commonly, it is not until a claim arises that a colleague's lack of insurance is disclosed. Not until then does the impact to those who are insured become painfully apparent – often in tandem with the plaintiff's theory of liability.

Practicing with those who are bare can and does increase your risk of being sued. Most physicians understand the term "deep pocket" in the context of malpractice – being targeted for one's insurance coverage instead of culpability. As illustrated in the referenced case, plaintiff attorneys often direct their case of liability to where the insurance coverage is. When a bare physician is sued, it is almost a given that they will be approached by the plaintiff's attorney with an offer of settlement at some point during the litigation. The attorney will usually offer the bare physician an offer of settlement whereby the plaintiff will not proceed with the case against the bare physician in exchange for the bare physician's agreement to criticize the insured codefendant physicians in deposition or at trial. Refusing to do so subjects the bare physician to aggressive action by the plaintiff attorney.

> Consider the case of an oncologist who was sued for an alleged failure to diagnose cervical cancer that was missed by the patient's gynecologist, who was uninsured. The gynecologist had referred the patient to the oncologist because of an abnormal PAP study. The oncologist examined the patient and recommended pursuit of appropriate diagnostic follow-up that was made known to, but never pursued by the gynecologist. The thrust of the plaintiff's case, however, was made against the oncologist. Not surprisingly, the gynecologist took the position that the oncologist was at fault for failing to obtain the necessary diagnostic workup.

The rising number of physicians electing to forego professional liability coverage increases your likelihood of participating in healthcare delivery with an uninsured colleague. Legislation designed to enforce financial responsibility of bare practitioners is unlikely to impact the risk of being sued when practicing with a bare physician. The fact of the matter is that an uninsured physician still faces the same chances of being sued as those who are insured. However, the primary issue for those physicians that are insured is one of increased risk of loss exposure. In terms of effective risk management, carefully consider the potential consequences of practicing alongside those whose claim exposure you may ultimately be forced to underwrite.

For more information regarding this and other medical professional liability insurance risk management issues, please contact the risk management consultants at First Professionals Insurance Company at (800) 741-3742, ext. 3016 or send an e-mail to rm@fpic.com.

Send a Child With Diabetes to Summer Camp

Each year the Lee County Medical Society requests that physicians submit names of children with diabetes that would benefit from attending the Florida Camp for Children and Youth With Diabetes (www.fccyd.com). The Medical Society provides scholarships for the camp.

If you know any children that would benefit from going to this camp, **please contact the Medical Society for a recommendation form - 239-936-1645**. After we receive the completed form we will then contact the parents to make the arrangements.

Autonomy or Empowerment

Ralph Kristeller MD

Last week on Sunday 27 February, the Board of Trustees of the Medical Society of New Jersey held its regularly scheduled meeting. As part of the proceedings William F. Owen, Jr., MD, the President of the University of Medicine and Dentistry of New Jersey, gave an update on activities at the University. In addition he commented on the current status of health system reform. As I heard him, he said: "The issue for physicians is AUTONOMY. I repeat the issue for physicians is AUTONOMY!"

At the same meeting Dr. Peter Carmel, President Elect of the American Medical Association, gave a presentation, that included the use of slides, on Accountable Care Organizations. With regard to health system reform and Accountable Care Organizations the following is my assessment.

Health system reform is not about Quality Medical Care for our citizens it is about POLITICS ? POLITICS.

That said: The issue for the country with regard to ACOs is EMPOWERMENT. ACOs do not empower the patient ACOs do not empower the physician. ACOs do not empower our once renown free market system. ACOs empower the GOVERNMENT.

The delivery of real Quality Medical Care is based on trust between Patients and Physicians in an equality relationship in which physicians provide medical care, to the best of their ability, for the welfare of patients, without interference, because they are autonomous.

Accordingly, autonomy for physicians and government empowerment are at opposite ends of the spectrum or, as I prefer to phrase it, they present an irreconcilable difference!

The choice for the American People is: Real Quality Medical Care or Government Medical Care. There is no middle ground.

For those physicians who are assessing whether or not to participate in ACOs, I offer the following for their consideration:

When Fear enters, Judgment leaves.
When Greed enters Judgment leaves,
When Anger enters Wisdom leaves.

Is Your Telephone Hurting Your Practice?

Emily Berry, American Medical News

Imagine an auditorium filled with your patients, prospective patients, every physician who sends you referrals and every pharmacist who handles your prescriptions. If you wanted to make a good impression, would you keep them waiting, then send your least-experienced staff member to address the crowd without a script?

That's effectively what many physicians do every day when it comes to manning their office telephones, experts say. They forget to train anyone in the office how to deal with the barrage of questions callers may have and leave the responsibility for making a good impression on staff members without telling them what to say—or what not to say.

Patients' impressions about their phone interactions with office staff are a significant contributor to their overall satisfaction with physicians' offices. Health industry survey firm Press Ganey asks patients every year about their satisfaction with various elements of the doctors' offices and consistently hears complaints about poor service over the phone, according to its most recent "Medical Practice Patient Satisfaction Pulse Report," released in November 2010.

In the report, which was based on a survey of 2.7 million patients, the firm reported, "Patients continue to voice frustrations over the ease of scheduling appointments, the helpfulness of telephone staff and the promptness in return calls."

Jeffrey Denning, a practice management consultant based in La Jolla, Calif., said patients' first judgments of a physician's office often are based on almost subconscious impressions. When patients have a hard time finding the office, can't find a parking spot or arrive to find a dirty office, they judge the quality of the practice, even if it has nothing to do with the physician's clinical skills. The same is true of phone interactions, he said.

Denning and other experts say, the person answering your phone should sound relaxed, comforting and professional, no matter how busy the office is. The person calling should not sense stress or frustration from the person answering the phone—something customer service consultant Nancy Friedman calls "emotional leakage."

Consultant Denning advises doctors to script everything they possibly can. That means nothing is left to chance, staff members are empowered to help callers rather than just take messages, and patients get better service.

Scripted responses are good for more than the initial greeting, experts say. When everyone knows how to answer the phone

What to Say

Some sample scripts and tips from customer service expert and self-described "telephone doctor" Nancy Friedman:

When a staff member picks up a call:
First, he or she should smile—it helps make the staff ember's voice sound more friendly. Then, in a relaxed and cheerful voice, the staffer should say: "Good morning/afternoon, Dr. Smith's office. This is Nancy." When a staffer says his or her own name last, it helps keep the name in the caller's memory and prompts the caller to share his or her name. That helps establish a genial rapport. Don't have anyone ask, "How can I help you?" It goes without saying that the practice is there to help.

When a staff member needs to put the caller on hold:
"Finding that information you need is going to take me about five minutes. Are you able to ;hold?" This gives the caller an idea of how long the wait will be, and lets him or her choose whether to stay on the line. Most of the time, the caller will agree to wait, but the staff member can offer to take a name and number and call back.

When a patient gets voicemail:
Leave clear instructions for the caller, including a number to press in case of emergency or to speak to a nurse. Avoid these phrases: "I'm sorry I missed your call," and "Your call is important to me." These sound disingenuous. Don't say, "I will return your call as soon as possible." The phrase is vague, because that could be in 10 minutes or 10 days.

Hold the Phone:
Avoid These Common Pitfalls

Telephone service experts say they see physicians and their practice make a lot of the same mistakes when it comes to customer service over the phone:

- Sounding annoyed or rushed
- Speaking too quickly. For older patients especially, speaking slowly and clearly is essential.
- Putting the least-trained staff member on the phones.
- Setting up an automated system with more than three options.
- Putting a caller on hold to speak to a patient in the office. The person on the phone can't see what's going on and might feel slighted.

correctly, staff can meet regularly to talk about the kinds of calls and how best to handle them. Perhaps another physician in town in your specialty retired—What do you tell her patients when they call looking for a new doctor? Maybe you decided to drop out of a certain insurance carrier's network - what do you tell that plan's members?

At a more basic level, Denning said the person answering the phone should know what type of patients you want to see more of, what type you don't see, which insurance coverage you do and don't accept. The goal is for the person answering to be able to handle virtually every call without consulting someone else.

Posting scripts by the phone is useful if you have an issue you know will prompt calls. For example, if you change office hours, make sure the staff has scripts to explain why. For a smaller practice, the scripts may be unofficial.

In many physicians' offices, one person is the receptionist, answering phone calls while also greeting patients who come in the door. That's not a good formula for good customer service, Grigsby said. If you can afford it, have one staff member devoted to answering phone calls, Denning said. Even better, have that person sit far from the front desk, in the same room as patients files, or in front of a computer where they can access the office electronic medical record. That allows the person to grab a patient file quickly to consult it or make an entry in the file while on the phone.

If that person is a nurse, he or she can triage by listening to the caller and decide whether the patient should come into the office and if so, how soon. If the nurse can handle prescription refills, even better—that will eliminate the stack of requests from piling up on the physician's desk. It may sound like a waste to have a highly trained staff member answer phones, but Denning said that's a common mistake. "Traditionally, we break people in on the front desk, and we promote them away from it."

Of course, physicians should handle some calls themselves. Denning said he worked with a pediatric practice that had a "mother's hour" every day, when physicians were available to talk to parents over the phone. Doing that, he said was a wise alternative to exchanging messages or having the parent schedule an unnecessary appointment. That may not make sense for other specialties but there are other times, particularly with angry patients, when a physician should handle calls.

Denning said it's not hard to tell when physicians need to pick up the phone: "When a patient is not satisfied with somebody else, and you know it when they won't let it go, using your best technique, you ask the patient, 'what can I do to make this right?'"

In many cases, he said, complainers just want to be heard. Otherwise, they wouldn't bother speaking up. They would just stop calling. Reprinted from the March 14, 2011 *American Medical News.*

Will Your Patients Return? The Foundation for Success.

Introduction

Few professions have experienced as much change in the past two decades as physicians. Medical practices today are facing numerous challenges, including reduced payments, new pay-for-performance requirements and higher malpractice rates. Costs are outpacing revenues, and margins are shrinking.

If that were not enough, patient dissatisfaction with increasing costs and decreasing access to care is fundamentally changing consumer roles in the health care equation. Patients who pay more demand better service quality. If they do not get it, they go elsewhere.

Focusing on patient satisfaction fulfills the essential mission of health care and makes business sense. Even if you do not have competition right now, it is smart to measure patient satisfaction. It is less expensive than competing for patients later.

The High Cost of Patient Turnover

Although consumers have access to an increasing array of health care information, service quality continues to play a disproportionate role in their choice of provider.

Primary care physicians are in a particularly vulnerable position. Although specialists rely heavily on referrals, primary care physicians must focus on keeping patients. Dissatisfied patients are less likely to return to a doctor or seek treatment at all, which increases patient turnover and costs.

Physicians with patient satisfaction ratings in the lowest 20% are nearly four times more likely to have patients leave within six months than physicians in the highest 20%.[1] More troubling, perhaps, is the fact that dissatisfied patients can damage a provider's business through negative word-of-mouth to others – whether they leave or not.

A conservative 5% dissatisfaction rate among patients can cost a physician $150,000 in revenue.[2]

The costs associated with lost patients – from the expense of acquiring new patients to reduced capitation rates – add up quickly. It is simply more cost effective to satisfy the patients you have than to continually attract more.

The Future of Patient Loyalty

Patient satisfaction is still overlooked by medical practices that regard it as unimportant. "Who has time to be nice? We are just trying to get through the day."

The truth is, patient satisfaction is critical to your success.

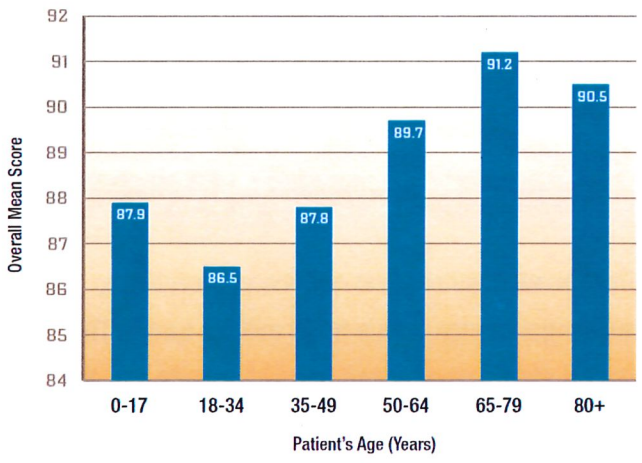
The chart in Figure 1 demonstrates generational effects on patient satisfaction. Each bar represents the overall satisfaction of a different age group of medical practice patients over the past year – over 1.5 million patients.

The 18-to-34-year-olds are the least satisfied – they rated their patient experiences the lowest – while the 65-to-79-year-olds are the most satisfied.

Younger generations become accustomed to faster, easier and more accessible service very quickly. And they come to expect it every time. If you want to develop long-term loyalty with these patient populations, you need to continuously improve service quality.

While many physicians and medical practices are not worried about patient loyalty now, they will be in the future as younger generations grow older and more demanding. If you want your practice to be successful in the future, you need to start building patient loyalty today by improving patient satisfaction.

FIGURE 1
GENERATIONAL EFFECTS ON PATIENT SATISFACTION

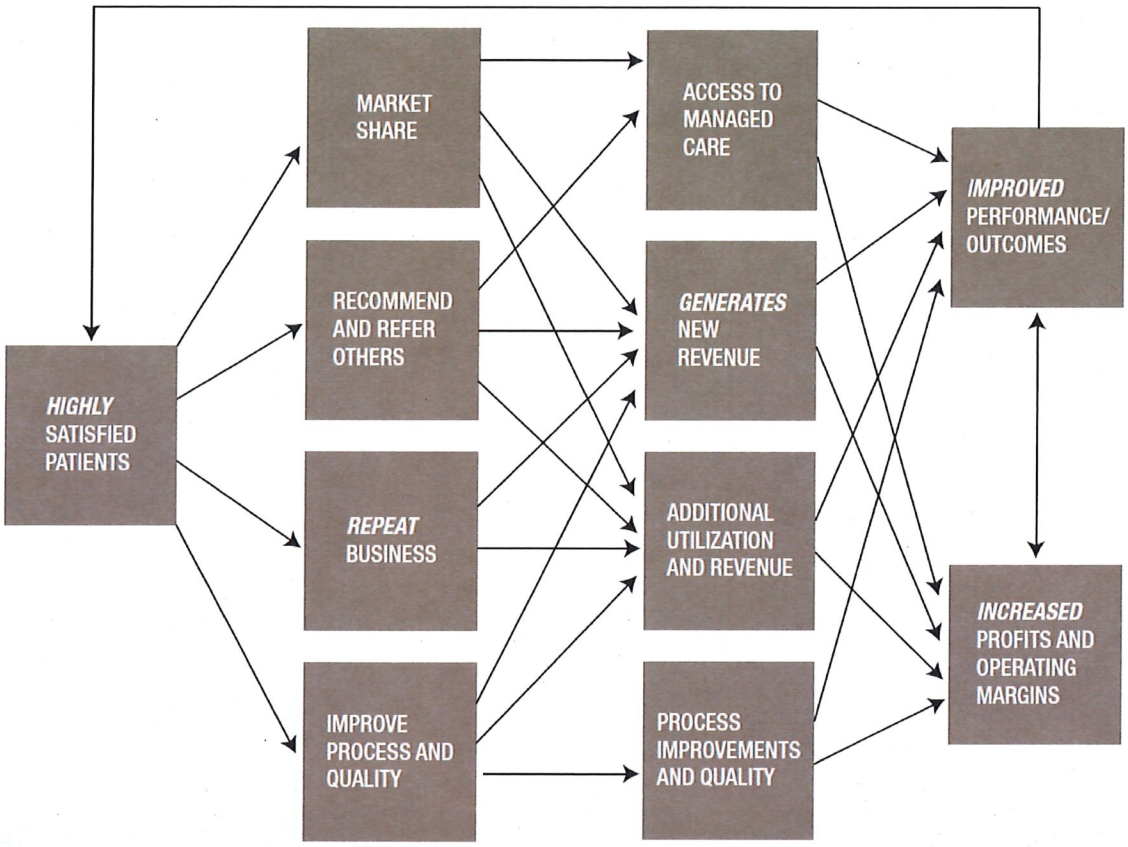


The Importance of Patient Satisfaction

In addition to mounting patient expectations, the health care industry is under significant pressure from consumers, employers and payers to reduce costs. In the current climate of accountability, measuring health care quality has become a fact of life, with public report cards on hospitals, medical groups and even individual physicians now commonplace.

Fortunately, patient satisfaction is a leading indicator of quality and financial performance.

FIGURE 2
MODEL OF PATIENT-SATISFACTION PROFITABILITY



Source: *How to Use Patient Satisfaction Data to Improve Healthcare Quality*, by Ralph Bell and Michael J. Krivich, © 2000. ASQ Quality Press, Milwaukee, WI.

Added to these, measuring and improving patient experiences can:

1. Improve medical outcomes.
2. Reduce risk
3. Lower malpractice rates and insurance costs.
4. Increase your marketing advantage.
5. Reduce patient turnover and costs.
6. Reduce physician and staff turnover
7. Increase physician and staff productivity
8. Create buy-in for incentive compensation.

Measuring and improving patient satisfaction is the foundation.

What Can You Expect if You Improve Patient Satisfaction?

Better P4P Performance. As consumers pay more out of pocket for health care, they will demand better service, prompting payers to increase their profiling efforts.

The shift toward pay-for-performance (P4P), which rewards physicians and practices for superior outcomes, is placing increased emphasis on patient satisfaction.

It is estimated that there are more than 160 P4P programs covering more than 85 million Americans, double the number of programs that existed in 2004.[3] There is increased pressure from payers to standardize patient surveys and improve patient experiences using a trusted survey methodology.

Greater Administrative Ease Simply put, satisfied patients are easier to take care of, more rewarding to care for, take up less physician and staff time, and sue less often.

Every day your patients and staff work together. Without connecting with patients, staff may try to solve problems on their own, which may only decrease satisfaction and drive costs up.

How much time is spent resolving conflicts? How much is that time worth? If a practice has a staff of 10 care providers with an average labor cost of $50,000 each, the practice is wasting $165,000 if a third of each day is spent settling conflicts.

Surveying patients can prevent a problem before it begins, reduce costs and give physicians and staff more time to do their job. Improving patient experiences also increases physician and employee satisfaction, putting practices in more competitive positions to attract both patients and staff in the future.

[1]Rubin, H. R., Gandek, B., Rogers, W. H., Kosinski, M., McHorney, C. A., & Ware, J. E., Jr. (1993). "Patients' ratings of outpatient visits in different practice settings: Results from the Medical Outcomes Study." JAMA, 270(7), 835-840.
[2]Drain, M., & Kaldenberg, D.O. (1999). "Building patient loyalty and trust: The role of patient satisfaction." Group Practice Journal, 48(9), 32-35.
[3]Med-Vantage (2004). Provider Pay-for-Performance Incentive Programs: 2004 National Study Results. Available from http://www.medvantageinc.com/Pdf/MV_2004_P4P_National_Study_Results-Exec_ Summary.pdf

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