Beyond Patient Satisfaction – How to Astonish Your Patients aka Practicing Excellence – How to Not Lose 4-8% of Your Income

Jay Kaplan, MD, FACEP

Medical Director, Studer Group

Practicing Clinician and Director, Service/Operational Excellence, CEP America

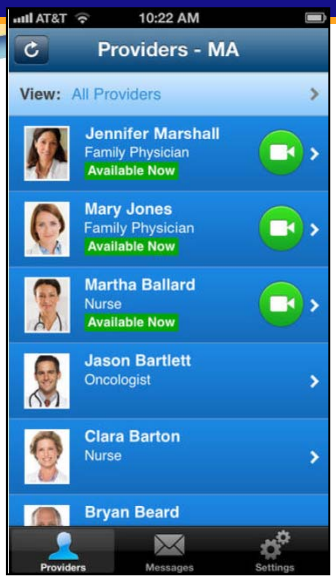
Board of Directors, American College of Emergency Physicians

Caveat #1: What Brought Us to this Dance . . .

Ain't Going to Get Us to the Next One . . . .

New York Times April 10, 2014

Direct to Consumer Mobile Video Visits



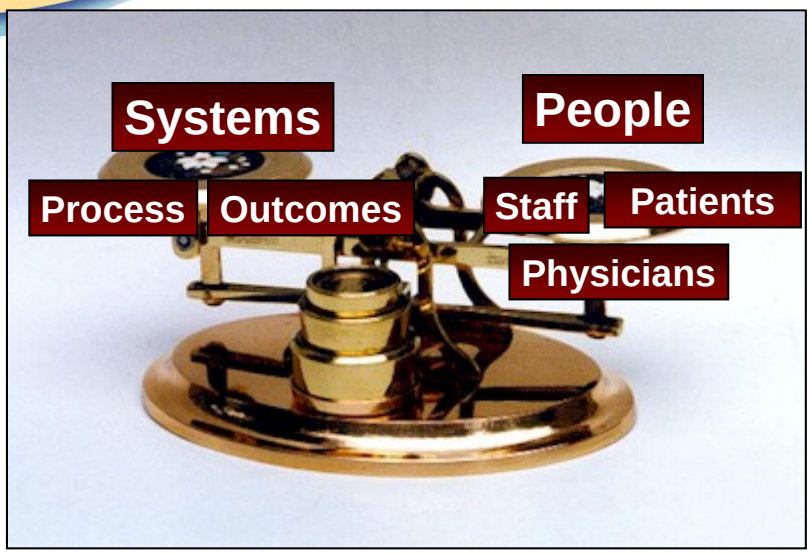
Now anyone with a camera-equipped smartphone, tablet, or computer can conduct a video visit with a physician for $49 — assuming you live in a state that doesn't prohibit it.

Caveat #2 –
The Best Definition of Madness is

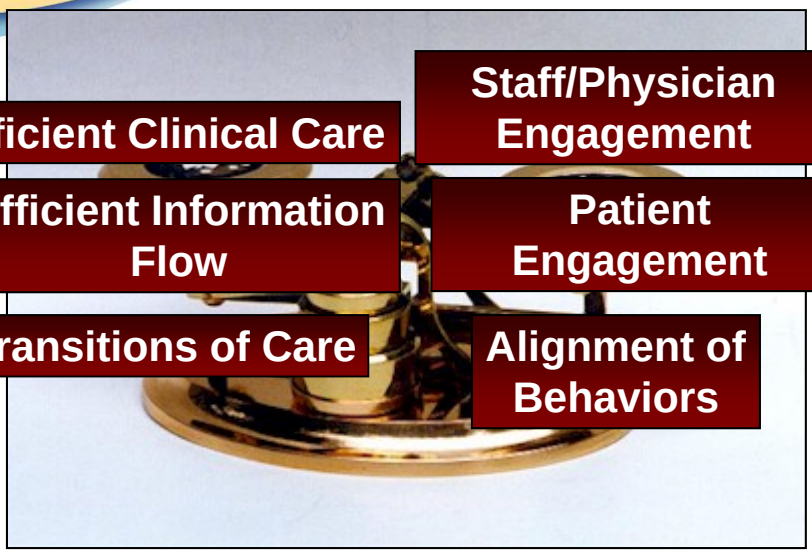
To keep doing things
the same way
and expect different
results . . .

Caveat #3
How Most of Us Approach Change

Caveat #4: To Get "Quality" Anything



Which Means . . .



Caveat #5: It's About The Team

While we give care seemingly individually,

- The Patient and Family Experience is dependent upon the coordinated actions of all members of the team . . .
- From the moment they walk in, to the moment they walk out or on . . .
- If it's not always . . . It's not great . . .

The Crucial Question Our Patients Ask

"Am I enveloped in a social fabric which feels SAFE and CARING?"

Where We Are

How We Need to Feel . . .
What We Need to Do

A Plain Fact

- Physicians are not trained for many of the roles they are being asked to play in today's healthcare environment.
- And even the role for which they were trained . . . has changed.

The Different Roles Physicians Have

- Craftsman: caring for the individual patient.
- Team player: being a part of the team which delivers that care in a coordinated and supportive manner.
- Manager: managing the process by which that care is delivered.
- Leader: creating the vision – getting everyone on board.

For which role(s) did physicians receive training?

Why is This Important?

- Declining Reimbursement
- Workforce Shortage
- Malpractice Risk
- Transparency of Data
- Pay for Performance – VBP
- Quality = Service = Quality

Why Is This Important?
#1 - Reimbursement

"Here you go…
thought you might like this"

Annals of Internal Medicine, May 2006

Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care

John T. Chang, MD, MPH; Ron D. Hays, PhD; Paul G. Shekelle, MD, PhD; Catherine H. MacLean, MD, PhD; David H. Solomon, MD; David B. Reuben, MD; Carol P. Roth, RN, MPH; Caren J. Kamberg, MSPH; John Adams, PhD; Roy T. Young, MD; and Neil S. Wenger, MD, MPH

2 May 2006 | Volume 144 Issue 9 | Pages 665-672

(PDFs free after 6 months)
Summary for Patients
Summary for Patients (PDF)
Figures/Tables List
Related articles in Annals

Services
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Alert me when this article is

"Better Communication Was Associated with Higher Global Ratings of Health Care"

Articles in PubMed by Author:
Chang, J. T.
Wenger, N. S.
Related Articles in PubMed
PubMed Citation
PubMed

Design: Observational cohort study.

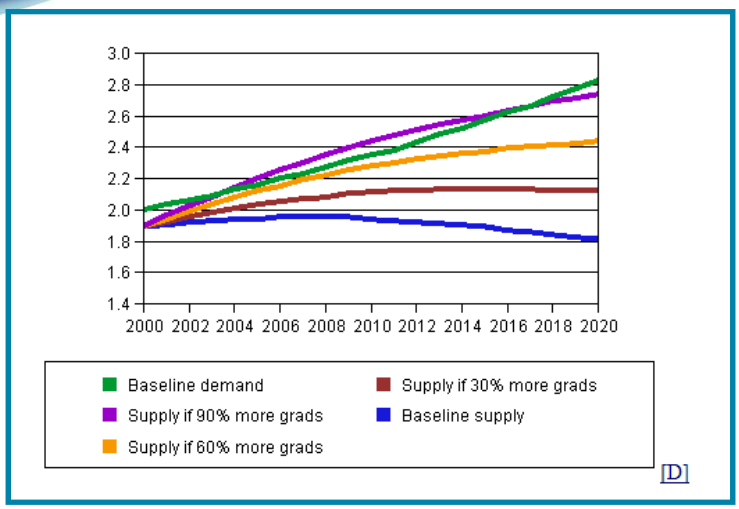
Setting: 2 managed care organizations.

Patients: Vulnerable older patients identified by brief interviews of a random sample of community-dwelling adults 65 years of age or older who received care in 2 managed care organizations during a 13-month period.

Measurements: Survey questions from the second stage of the Consumer Assessment of Healthcare Providers and Systems program were used to determine patients' global rating of health care and provider communication. A set of 236 quality indicators, defined by the Assessing Care of Vulnerable Elders project, were used to measure technical quality of care given for 22 clinical conditions; 207 quality indicators were evaluated by using data from chart abstraction or patient interview.

Results: Data on the global rating item, communication scale, and technical quality of care score were available for 236 vulnerable older patient In a multivariate logistic regression model that included patient and clinical factors, better communication was associated with higher global ratings of health care. Technical quality of care was not significantly associated with the global rating of care.

#2 Workforce Shortage - Nurses



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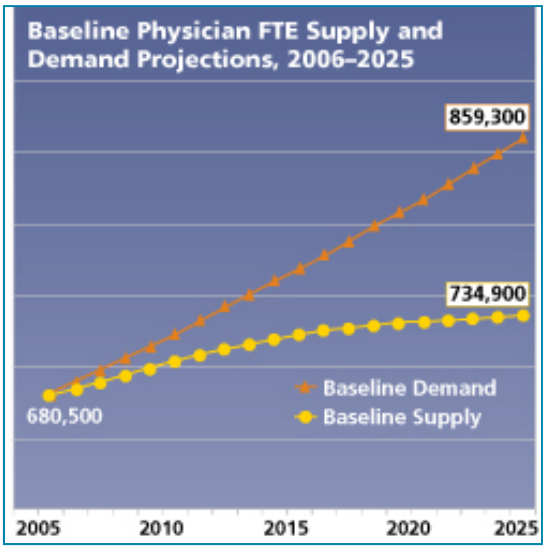
Workforce Shortage - Physicians



Reason #3 - Malpractice

Strategic Risk Management: Reducing Malpractice Claims Through More Effective Patient–Doctor Communication

Bernard B. Virshup, MD, Andrew A. Oppenberg, MPH, and Marlene M. Coleman, MD

Case Study Editor's Note: *This paper is presented because it so well makes the case that projecting the demeanor of a caring person does not diminish our professional image. One is not the antithesis of the other. Being human is as much the embodiment of medicine/healthcare as is science and technical expertise; and certainly as necessary and prudent.*

The author(s) have posited a theory with expedient practical implications, something on which to hang one's hat. The concept of patient–doctor relationship has more substance when related to risk management. More than "be nice," it illustrates how judicious it is to let patients know that we really do care about them and their overall well being. Additionally, this piece demonstrates the comprehensive nature of our specialty (Quality Assurance), which not only allows but compels practitioners to be cognizant of the holistic interconnectedness, interaction, interrelation, and interdependence of a myriad of aspects and components that impact the reality and perception of what constitutes quality medical practice/healthcare. The focus of this article is the impact of the patient–physician relationship on malpractice litigation—a risk management issue.

What is the quality of your patients' relationships with you? We urge the reader to use this offering as a tool for self-evaluation or as a personal case study, if you will.

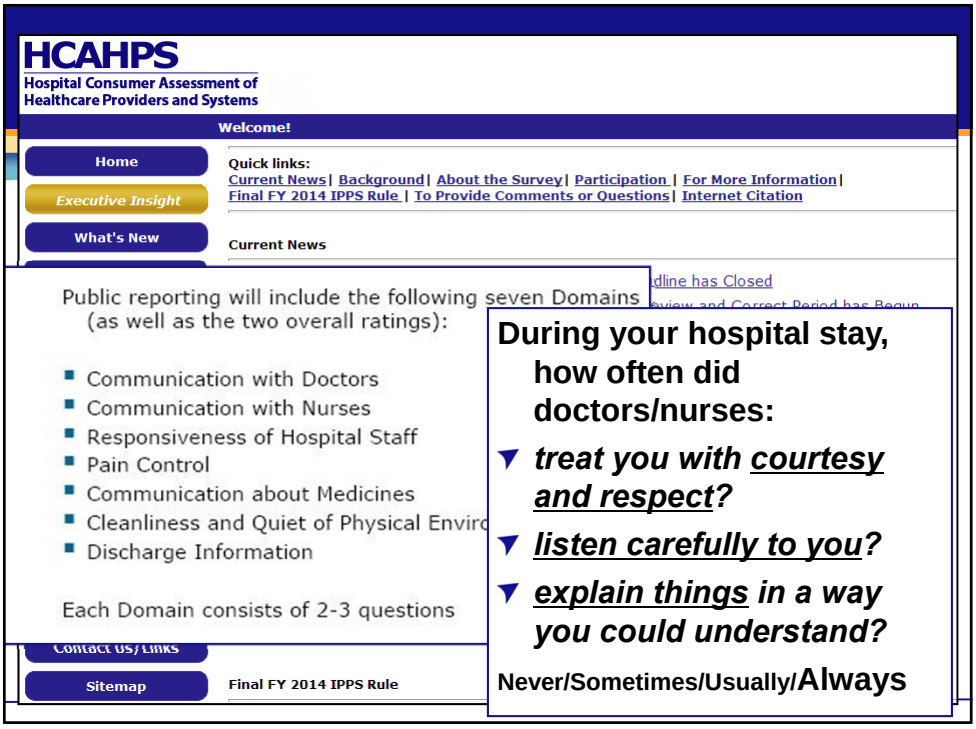
Beverly Carpenter-Mason, PhD
Case Study Editor

Relationship Between Patient Satisfaction, Complaints and Lawsuits

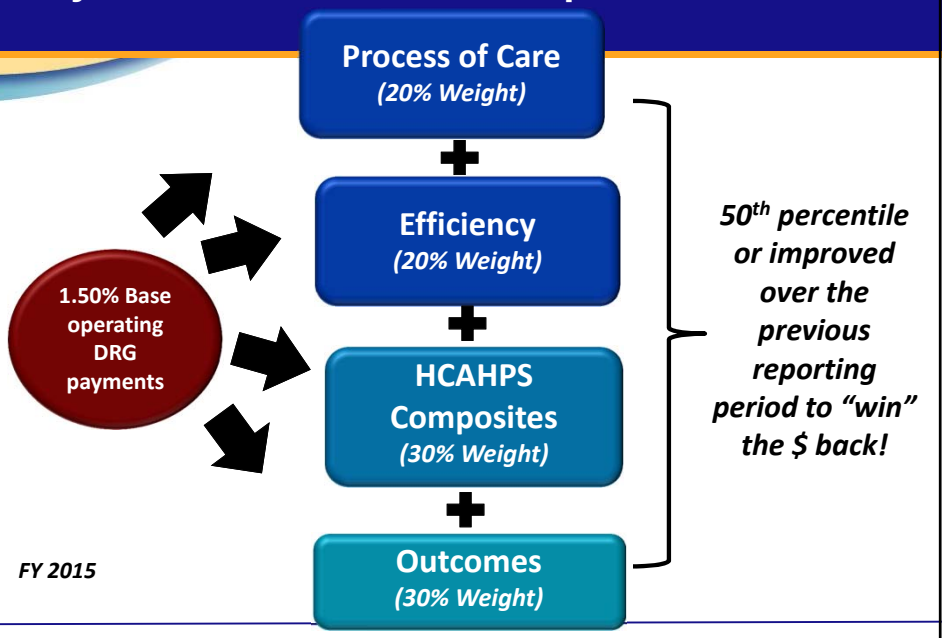
- Each one point decrement in patient satisfaction scores is associated with a –
  - 6% increase in complaints (RR 1.06, 95% CI 1.03 – 1.08;p<.0001)
  - 5% increase in risk management episodes (RR 1.05, 95% CcI 1.01 – 1.09;p< .008)
- Lower performing physicians were at greater risks for lawsuits (RR = 2.10;p 95% CI 1.13 – 3.90; p<.019)
- 75% of complaints were related to communication issues

Stelfox HT, et al, The American Journal of Medicine 2005; 118: 1126 – 1133

The Transparent Environment



Pay for Performance for Hospitals is Here . . .



Pay for Performance for Physicians Is Here . . .

- **Quality**
  - PQRS = Physician Quality Reporting System
  - PV = Physician Value-Based Payment Modifier
  - Payment is tied to quality and cost metrics
  - Cost and quality metrics are transparent via Physician Compare
- **Patient Experience**
  - HCAHPS is the patient experience component for inpatient practice
  - CG CAHPS is the patient experience component for outpatient/office practice

Physician Value-Based Payment Modifier (VBPM)

Statutory Timeline for VBM Implementation		
Reporting Period	**Value-Modified Payment Adjustment**	**Eligible Professionals Included**
2013	2015 payments	Groups ≥ 100
2014	2016 payments	Groups 10-99
2015	2017 payments	**ALL ELIGIBLE PROFESSIONALS**

Physician Quality Reporting System (PQRS):

- Quality metrics
- Specialty-specific
- Shifting from claims-based reporting to electronic registry or health record documentation
- Examples:
  - Hgb A1C
  - Prevention of Catheter-Related Bloodstream Infections
  - Smoking Cessation Discussion

National Quality Strategy Measure Development Framework

1. **Clinical Effectiveness**: promoting effective prevention and treatment practices for leading causes of mortality such as cardiovascular disease.
2. **Patient Safety**: making care safer by reducing harm caused in the delivery of care.
3. **Patient Experience**: ensuring that each person and family is engaged as a partner in their care (CAHPS).
4. **Care Coordination**: promoting effective communication and coordination of care.
5. **Population & Community Health**: working with communities to promote wide use of best practices to enable healthy living.
6. **Efficiency**: making quality care more affordable for individuals, families, employers, and governments by developing new health care delivery models.

Physician Quality Reporting System (PQRS): Total Potential Impact of PQRS Participation

For 2014 There Are Four PQRS Programs:

	2013 Performance Year	**2014 Performance Year**
1. Traditional PQRS Incentive	+0.5% payment in 2014	+0.5% payment in 2015
2. PQRS MOC Incentive	+0.5% payment in 2014	+0.5% payment in 2015
Total Potential PQRS Incentives	**+1.0% in 2014**	**+1.0% in 2015**
3. PQRS Penalties For Failure to Report	-1.5% in 2015	-2.0% in 2016
4. Value-Based Modifier (VBM)* For Failure to Report PQRS	-1.0% in 2015	-2.0% in 2016
Total Potential PQRS Penalties	**-2.5% in 2015**	**-4.0% in 2016**

******VBM applied to all TINs ≥ 10 NPIs for the 2014 Performance Year***

New PQRS Requirements (2014)

2010-2013 Performance Year:

- 3 Quality Measures for 50% of Medicare Beneficiaries
- to earn incentive OR avoid penalty

2014 Reporting Period:

- To Earn the Incentive (+0.5%):
  - **9 Quality Measures Across 3 NQS Domains for at least 50% of eligible Medicare patients**
  - (subject to the CMS Measures Applicability Validation [MAV] Process)
- To Avoid the Penalty for PQRS (-2%) or more for VBM:
  - At Least 3 Measures Across 1 NQS Domain for at least 50% of applicable Medicare patients

New PQRS Requirements

2015 and Beyond:

- No incentive, 2014 is final year for incentive
- To Avoid the PQRS Penalty:
  - **9 Quality Measures Across 3 NQS Domains**

For Example - ED Measures

Avoid inappropriate imaging for adult ED patients with atraumatic back pain	Efficiency	PCPI consultants to develop, specify and test measure with QMs TEP
Avoid inappropriate head CT in ED patients with minor head injury	Efficiency	PCPI consultants to develop, specify and test measure with QMs TEP
Avoid coagulation studies in patients with no acquired or inherited coagulopathy or bleeding.	Efficiency	PCPI consultants to develop, specify and test measure with QMs TEP
Sepsis Composite (lactate, cultures, antibiotics & fluids only)	Patient Safety	PCPI consultants to develop, specify and test measure with QMs

Clinician & Group CAHPS

Composites

- Access to care
  - Getting needed care
  - Getting care quickly
- Provider communication
- Follow up on test results
- Global rating of Provider
- Clerks and Receptionists
- Pediatrics includes Development & Prevention

The Survey

14. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

1 Never

2 Sometimes

3 Usually

4 Always ⟵

15. In the last 6 months, how often did this provider listen carefully to you?

1 Never

2 Sometimes

3 Usually

4 Always ⟵

19. In the last 6 months, how often did this doctor show respect for what you had to say?

1 Never

2 Sometimes

3 Usually

4 Always ⟵

20. In the last 6 months, how often did this doctor spend enough time with you?

1 Never

2 Sometimes

3 Usually

4 Always ⟵

The Survey

During your most recent visit . . .

How Well Providers (or Doctors) Communicate with Patients

The survey asked patients if their providers explained things clearly, listened carefully, showed respect, provided easy to understand instructions, knew their medical history, showed respect, and spent enough time with the patient during the most recent visit.

Q16	Provider explained things in a way that was easy to understand	**Response Options** • Yes, definitely • Yes, somewhat • No
Q17	Provider listened carefully to patient	
Q19	Provider gave easy to understand information about health questions or concerns	
Q20	Provider knew the important information about patient's medical history	
Q21	Provider showed respect for what patient had to say	
Q22	Provider spent enough time with patient	

The Global Rating Question

23. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

0 Worst provider possible

1

2

3

4

5

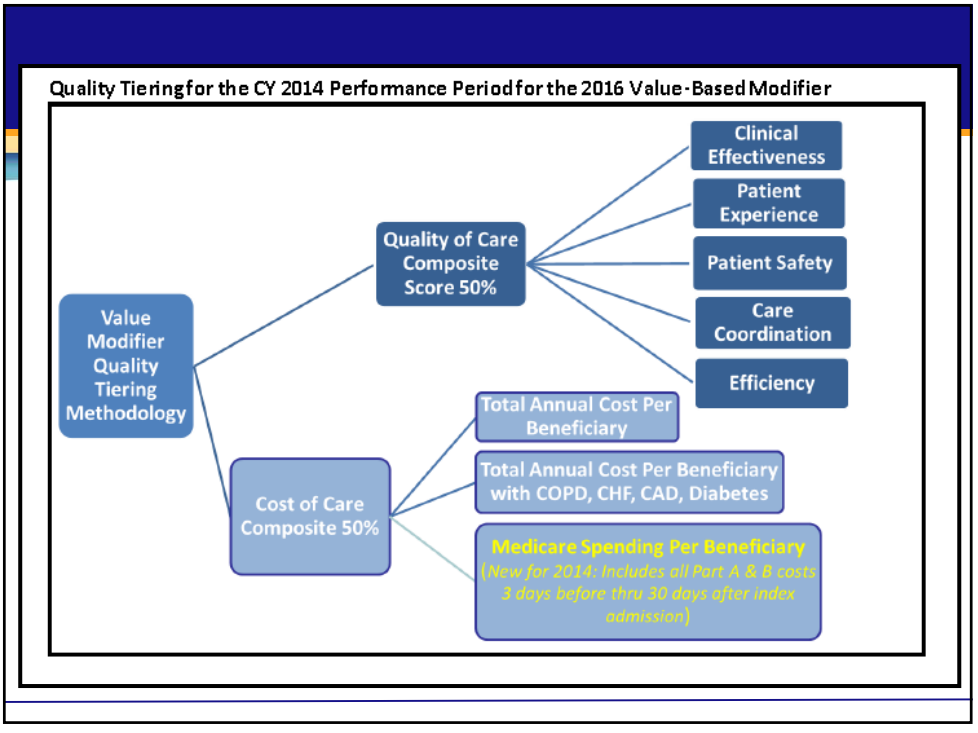
6

7

8

9

10 Best provider possible



Quality Tiering Approach

- Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g. how far away from the national mean).
- This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

WSJ: UNITEDHEALTH TO ROLL OUT VALUE-BASED PAYMENT PLAN

NATION'S LARGEST INSURER JOINS WAVE OF PAYERS CHANGING THEIR REIMBURSEMENT MODEL

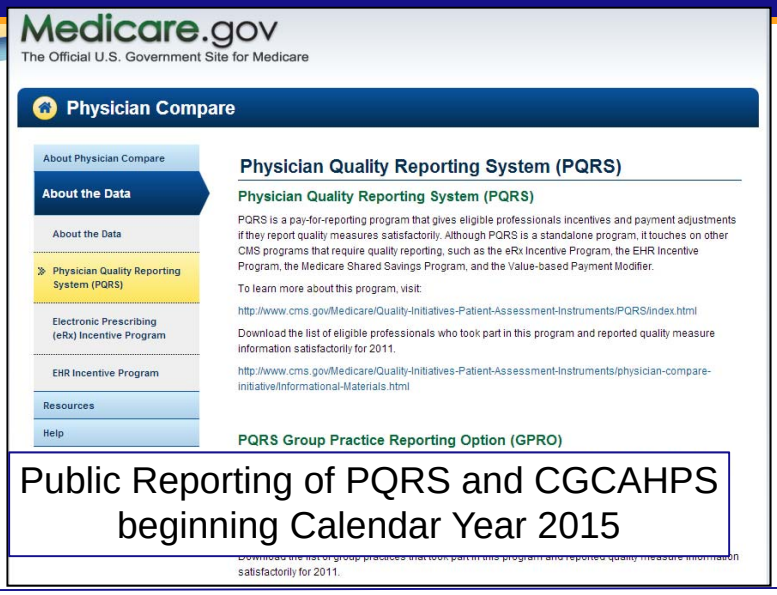
Topics: Accountable Care, Market Trends, Strategy, Pay-for-Performance, Shared Savings Model, Reimbursement, Finance

According to information provided to employer clients, between 50% and 70% of UnitedHealth's 26 million commercially insured members could be covered by value-based contracts by 2015, up from about 1% to 2% of members this year.

There will be preferred providers, who will have patients driven their way through lower premiums, lower deductibles, lower out-of-pocket costs.

According to information provided to employer clients, between 50% and 70% of UnitedHealth's 26 million commercially insured members could be covered by value-based contracts by 2015, up from about 1% to 2% of members this year. The insurer eventually plans to include most high-volume hospitals and medical groups in the model, the *Journal* reports.

Physician Compare



Public Reporting of PQRS and CGCAHPS beginning Calendar Year 2015

The Old Paradigm

Care = Income

The New Paradigm

Outcome = Income

Exceptional Clinical Quality
&
Extraordinary Patient Experience

= **$$$**

Reason #5 – Some Would Say . . .

- Clinical quality is the real deal, the “hard stuff.”
- Service excellence is the “fluff stuff.”

Higher Patient Satisfaction = Communication = Compliance = Quality

Physician communication correlates STRONGLY with adherence rates by patients in acute and chronic disease. There are now over 100 observational and 20+ experimental studies published demonstrating the correlation of communication (patient satisfaction) with compliance. **Compliance with treatment regimens has significant influence on quality measures in chronic disease and outcomes**.

Medical Care: August 2009 - Volume 47 - Issue 8 - pp 826

British Medical Journal 2013 http://dx.doi.org/10.1136/bmjopen-2012-00157

- Patient experience is positively associated with clinical effectiveness and patient safety.
- Associations appear consistent across a range of disease areas, study designs, settings, population groups and outcome measures
  - Positive associations 429 studies (77.8%)
  - No association 127 studies (22%)
  - Negative association 1 study (0.2%)

ORIGINAL INVESTIGATION

ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Patient Satisfaction in year 0 (2000)
Cost, ED & Hospital Admissions in year 1 (2001)
Mortality in years 1-6 (2001-2006)
Summary: Data mining . . . Invalid conclusions

Bac care pati ture

Met adul nati years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2005 subsample (n=36 428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.9 years.

...on and ex- ...atisfaction ...tion quar- ...ment visit .84-1.00), 1.12; 95% ...eater total ...reater pre- scription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Arch Intern Med. Published online February 13, 2012.

Academic Medicine - March 2011

Does a physician's empathy impact a diabetic patient's treatment?

- Hemoglobin A1c test results to measure the adequacy of blood glucose control according to national standards → lower = better control
- LDL cholesterol level → lower = better control

"Empathic engagement in patient care can contribute to patient satisfaction, trust, and compliance which lead to more desirable clinical outcomes."

Simple Truth #1:
We Live in a Service Economy

We must create "memorable" experiences for our patients.

"Astonish" them.

Differentiate ourselves.

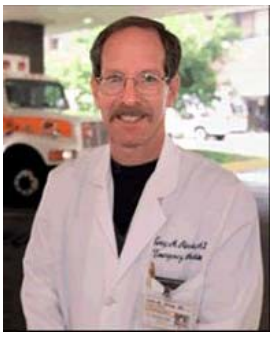
Patient Satisfaction is irrelevant.

Key Words for Us

- **Satisfy**
  - to please, to be adequate to an end in view, to meet an obligation
- **Astonish**
  - to strike with sudden and usually great wonder or surprise
- **Memorable**
  - worth remembering

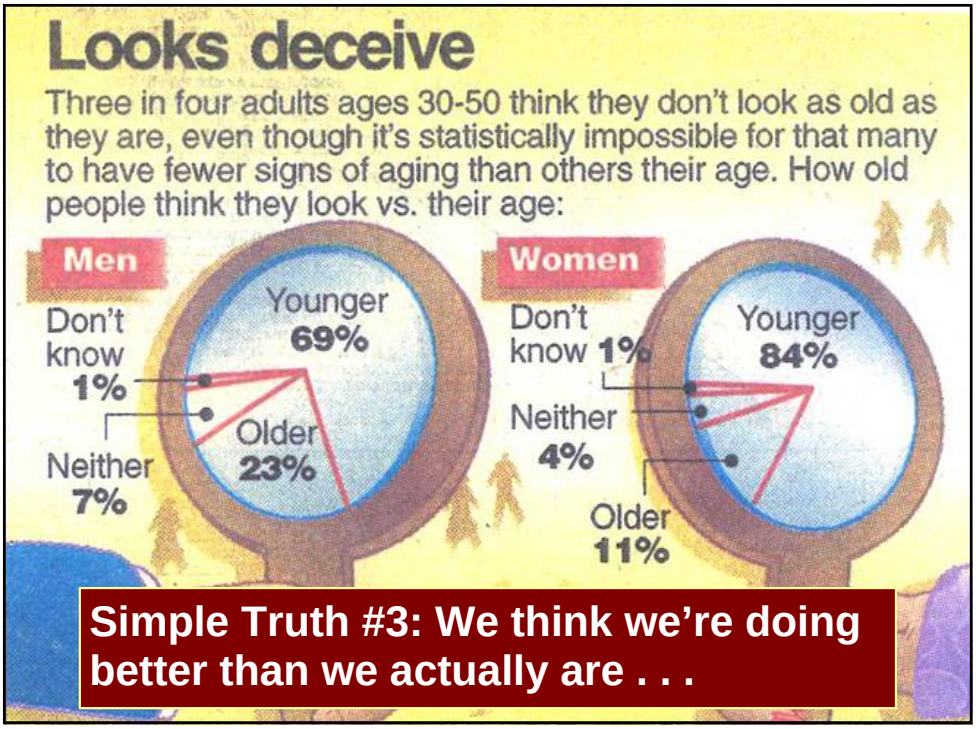
Simple Truth #2:
We All Believe We Give Great Service

We assume



= Patient Satisfaction

= Employee Satisfaction



Simple Truth #3: We think we're doing better than we actually are . . .

Wall Street Journal April 8, 2013


THE WALL STREET JOURNAL.

U.S. EDITION

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Seib & Wessel

Doctors need to work on their people skills . . .
It's something patients have grumbled about for a long time . . . Doctors don't listen. Doctors have no time . . .

JOURNAL REPORTS | Updated April 8, 2013, 3:30 p.m. ET

The Talking Cure for Health Care

Improving the ways doctors communicate with their patients can lead to better care—and lower costs

Article | Video | Graphics | Comments | MORE IN JOURNAL REPORTS: HEALTH CARE »

By LAURA LANDRO

Doctors need to work on their people skills.

Journal Report
- Insights from The Experts
- Read more at WSJ.com/HealthReport

More in Unleashing Innovation: Health Care
- 'Guided Missiles' Take Aim at Cancer
- Where to Store All Those Images?

It's something patients have grumbled about for a long time. Doctors are rude. Doctors don't listen. Doctors have no time. Doctors don't explain things in terms patients can understand.

It's a familiar litany. But here's what is

What is Excellent Physician Communication?

- The physician listened (RR 1.8; 95% CI 1.0 – 2.5; p< .001)
- The patient got as much medical information as they wanted (RR 1.6;95% CI 1.1 – 1.9; p< .001)
- The patient was told what to do if symptoms continued, worsened or returned (RR 1.4; 95% CI 1.2 – 1.5; p<.001)
- The patient spent as much time as they wanted with their physician (RR 1.8; 95% CI 1.3-2.2;p<.001)

Keating NL, et al, Annals of Internal Medicine 2004; 164: 1016 – 1020

Provider Communication . . . Really?

Physician Communication When Prescribing Medications: *(Arch of Internal Med, 2006)*

- 26% failed to mention the name of a new medication
- 13% failed to mention the purpose of the medication
- 65% failed to review adverse effects
- 66% failed to tell the patient duration of treatment

The Golden 2 Minutes

- 74% of patients are interrupted by providers when giving their initial history in an average of 16.5 seconds

(J Gen Int Med, 2005)

Simple Truth #4: No Rest For The . . .

"If the other guy's getting better, then you'd better be getting better faster than that other guy's getting better . . . or you're getting worse."

-- Tom Peters

The Circle of Innovation

What Does All This Mean For Us?

- There's a lot of work to do.
- We have to assure everybody's on board before we can expect consistency/reliability.
- We all need to recommit and understand "No more reserved seats on the bus."
- With the measurement feedback you get, if you personally are not where you should be, no need for embarrassment or resistance . . . just ask for help/skills training.

The Big Question

How can you, as a medical team, create a consistent high quality compassionate experience for your patients, despite:

- Staff Diversity
- Different approaches/training
- Different years of experience
- Different and rotating personnel
- The pressures for doing more with less
- Time – Time – Time

????

Please Note . . . A Great Patient Experience

It is not about our **Intent** . . . .

It is about our patients'

Perception . . .

And it is an outcome of

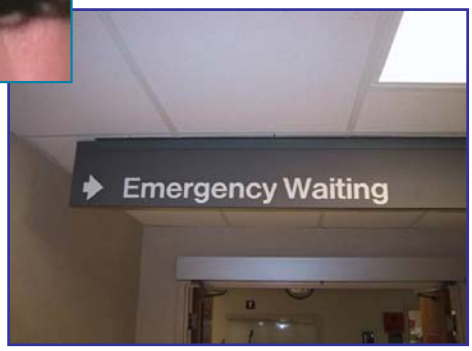
Great Teamwork.

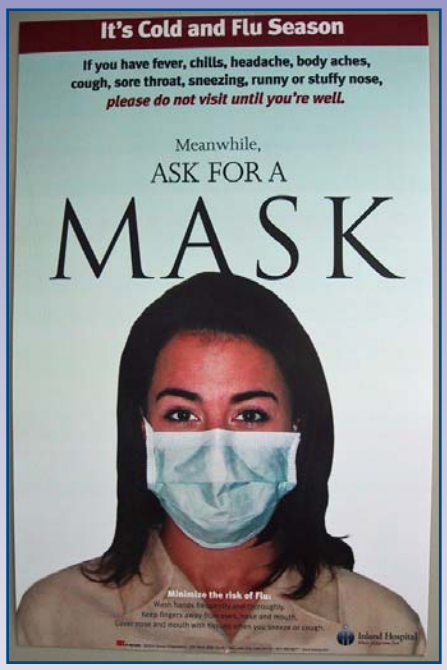
People - For Our Patients

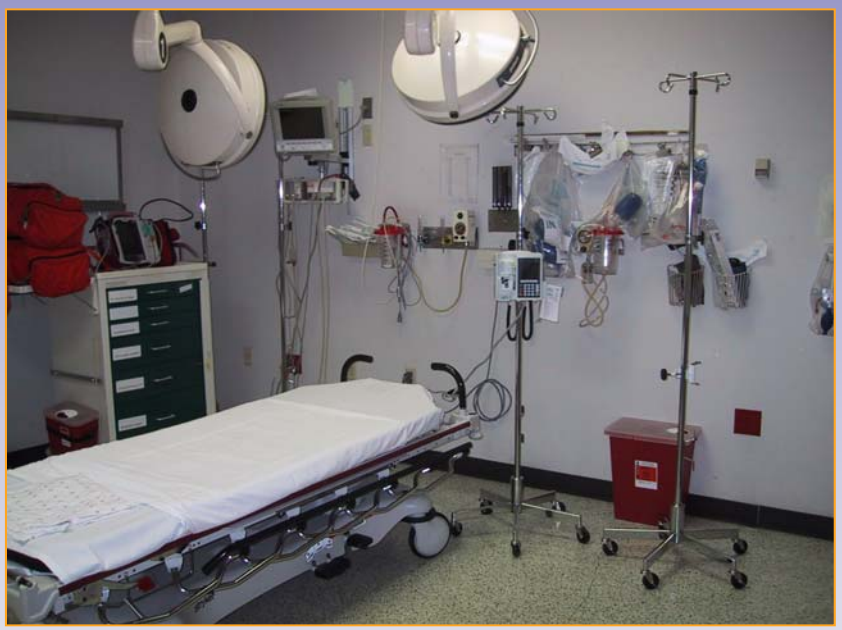
- Think Bakery
- Think Baseball – Touching All the Bases
- Rounding on Patients
- Discharge Follow Up Phone Calls

Think Bakery

What Do Our Patients See?







Take a Fresh Look – Change the Signs

SINCE 1946, THE MISSION OF THE SANGER CLINIC HAS BEEN TO PROVIDE COMPREHENSIVE AND COMPASSIONATE CARDIOVASCULAR CARE AT A LEVEL UNEQUALED IN THE REGION. WE ARE COMMITTED TO BUILDING ENDURING RELATIONSHIPS WITH OUR PATIENTS THROUGH PERSONALIZED SERVICE AND QUALITY CARE TO IMPROVE THEIR HEALTH.

SANGER CLINIC

As your physician, I am committed to:
- Putting your needs first.
- Treating you and your family with courtesy, respect, and compassion.
- Working collaboratively with you, staff and colleagues.
- Basing your evaluation and treatment on the best medical evidence.
- Earning your trust through my actions and service

SANGER CLINIC

What Do Our Patients Feel?

Sit Down

To Sit or Not to Sit?

(Annals Emerg Med 2007))

- Sitting: time overestimated 15%
- Standing: time underestimated 7%
- Providers overestimated time 6%

Patient Education Counseling
2012 Feb;86(2):166-71.

Effect of Sitting vs. Standing on Perception of Provider Time at Bedside

Surgeon on post-operative visits (admitted for elective spine surgery) - 120 patients

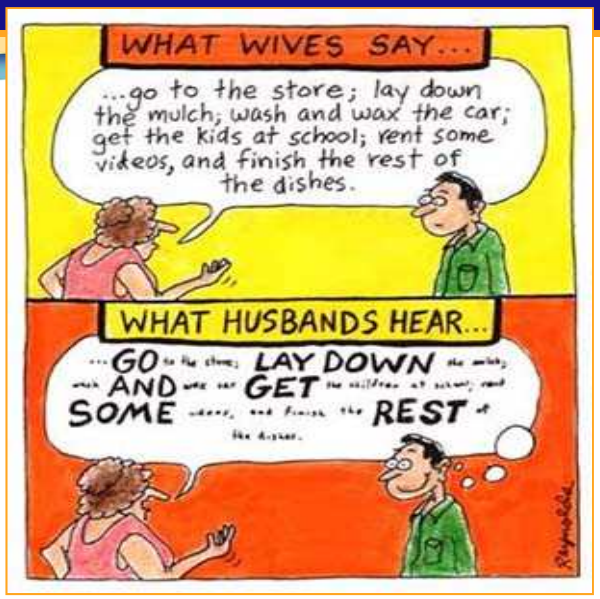
RCT to sit vs. stand, rest of visit same

Results:

Position	Actual time	Perceived time
- Stand	1' 28"	3' 44"
- Sit	1' 4"	5' 14"

*Positive patient feelings: sit= 95%, Stand = 61%

What Do Our Patients Hear?



People (Patients) will not hear all of your words . . . Use Key Words or Phrases to express your caring.

Use Key Words

- "For your safety"
- "For your privacy"
- "For your comfort"
- "To keep you informed"
- "Does this all make sense to you?"
- What questions do you have? "Is there you would like for me to go over again?"

Do Not Assume Our Patients Know . . .

- Who we are;
- How good we are;
- How much we care
- How long some process takes;
- What the process will involve;
- What will follow.

Key Strategy #2: Think Baseball - Touching All the Bases - Communication

A	**Acknowledge** patient and family, use a greeting, smile, make contact with all.
I	**Introduce** self with title, Manage Up, service recovery if needed
D	**Duration** - Explain how long evaluation and diagnostic work-up will take, Under-Promise and Over-Deliver
E	**Explain** the plan of care, what tests and treatments are to be accomplished, and what you feel is going on, Use Key Words
T	**Thank** - Say Good-bye to the patient Closure

Every Patient Interaction Has a . . .

- Beginning
- Middle
- End

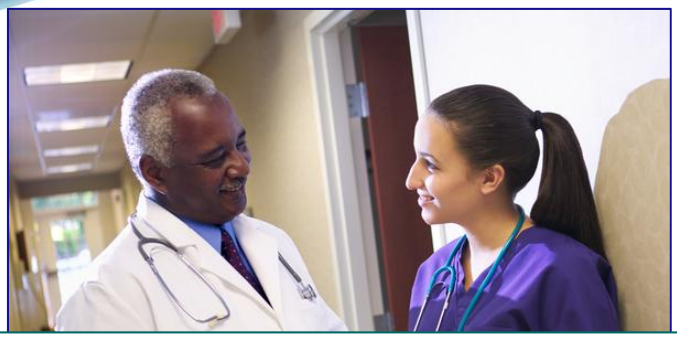
or seen in another way . . . It's about . . .

- Relationship
- Task
- Relationship

Key Strategy #3: Collaborative Rounding Inpatient Care

"Is there anything you want to tell me about the patient?"
"Do you have any questions about his/her illness?"
"Would you like to round with me?"

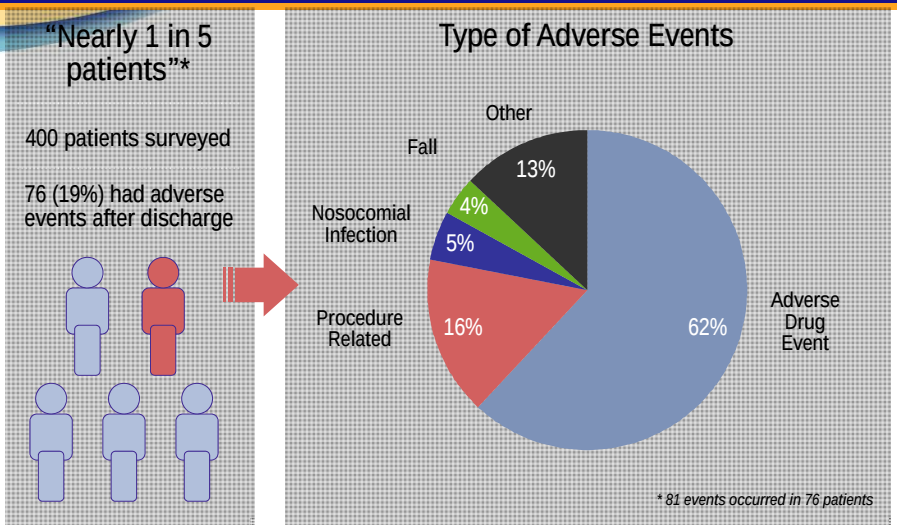
Key Strategy #3:
Collaborative Office/Outpatient Care



MA: "What is the one most important issue you want to discuss with your doctor to make this an excellent visit?"

Physician: "My MA has shared with me what is important to you and I want to make sure that we cover that first. We are a team caring for you."

Key Strategy #4:
Follow Up Phone Calls - Quality



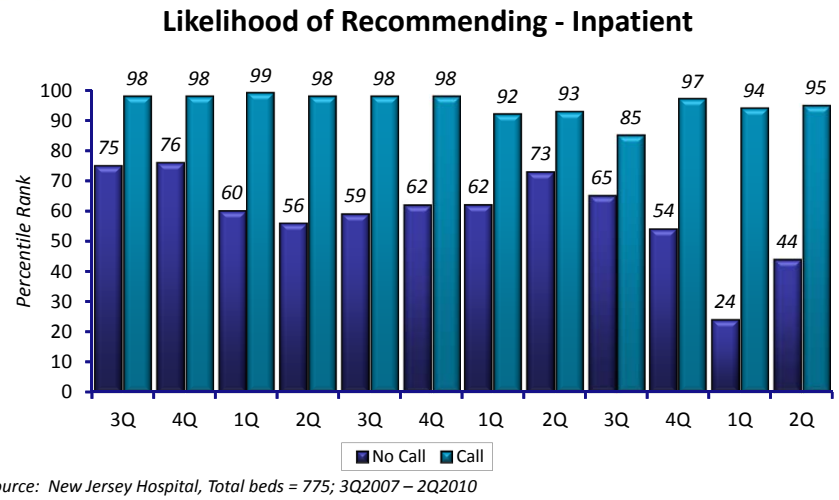
** "Adverse Events After Discharge from Hospital", Annals of Internal Medicine, February 2003*

Follow Up Phone Calls

Engel K, Heisler M, Smith D, Robinson C, Forman J, Ubel P, "Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware When They Do Not Understand?," *Annals of Emergency Medicine.* July 11, 2008

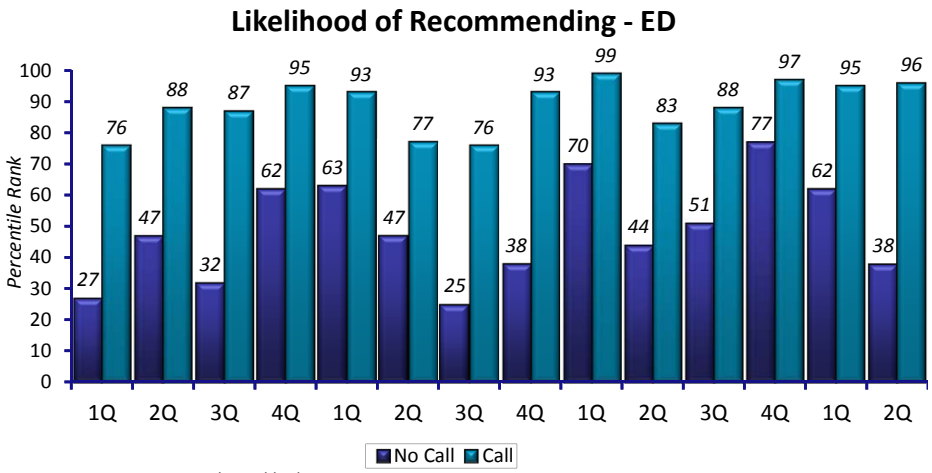
- 78% did not have full understanding
- 80% of that 78% did not understand that they did not understand

Post Visit Calls
Likelihood of Recommending – Inpatient



Source: New Jersey Hospital, Total beds = 775; 3Q2007 – 2Q2010

Post Visit Calls
Likelihood of Recommending - ED



Source: New Jersey Hospital, Total beds = 775; 3Q2007 – 2Q2010

Follow Phone Calls: 6 Reasons Why

- Quality
- Risk management
- Patients love it
- You will love it (lots of kudos)
- You will be a better clinician
- Decreased return visits/hospital admissions

Self –Test for Physicians

Date_____ **Physician/Provider**_____

High-Performing Physician/Provider (In Hospital) SELF-TEST

Are you doing all that you can in your practice to improve the patient experience? Rate yourself in terms of your behaviors. "Never" indicates that it is not part of your usual practice and "Always" means it is a strongly hardwired and consistent behavior.

		Never	Some-times	Usually	Always
1.	Do you acknowledge and make physical contact with the patient and others in the room when you first enter?				
2.	Do you introduce yourself and share your experience and commitment? Do you manage up the rest of the team?				
3.	Do you sit down at the patient's bedside?				
4.	Do you give the patient/family 2 minutes to tell their story?				
5.	When you get up to perform the physical examination, do you tell the patient? Do you articulate your findings?				
6.	Do you explain to patients/families what you have found and the meaning of their diagnostic and therapeutic results?				

Self –Test for Physicians

7.	Do you explain to patients/families the expected duration of the illness, diagnostic work-up, or healing process?				
8.	Are you using key words to convey to patients your commitment to their comfort and safety?				
9.	Before you walk in the room do you check with the patient's nurse and ask "Is there anything you want to tell me?" Are you collaboratively rounding on patients with the nurse in the room as a vital team member?				
10.	If a patient hand-off is required, are you managing up the oncoming provider? And when possible doing the hand-off at bedside?				
11.	Are you completing the patient visit with "What questions do you have for me? Is there anything you would like for me to go over again?"				
12.	Are you closing the patient encounter with a statement of gratitude and/or appreciating the patient?				

Summary

- We live in an experience economy.
- “Satisfy” is not enough.
- If the other guy’s getting better . . .
- Quality gets you in the game.
- Service helps you win.
- It’s about the TEAM.

Next Steps

- Answer the question: What is one thing I am going to do differently to create a memorable experience for my patients?
- Agenda for the year:
  - Nurses are from Saturn, Physicians are from Jupiter
  - Leadership & Accountability
  - Creating Benchmarks and Outcomes – The Nuts & Bolts

Thanking you . . .

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