



## Emergency Department Patient Satisfaction:

### The Emergency Physician Group's Role



Phoenix Physicians takes great lengths to be proactive, listen, and educate our Hospital partners by offering expertise and tools that can enhance the overall success of their Emergency Departments. Phoenix conducts annual surveys of all our Hospital partners to ensure we are meeting their needs and concerns. These surveys have helped us learn that many key issues are on the minds of all Administrators. Thus, we have created a series of White Papers to address these issues. These quarterly White Papers are titled:

- ▶ Throughput in the Emergency Department: What is the Responsibility of Your ER Physician Group? (Released February 2011)
- ▶ Emergency Department Patient Satisfaction: The Emergency Physician Group's Role (Enclosed)
- ▶ Mid-level Providers in the Emergency Department: How Much is Too Much? (August 2011)
- ▶ Emergency Department Physician and MLP Coverage Models: Do I Have What I Need? (November 2011)

On May 24<sup>th</sup> 2011, at 11:00 am EST, Phoenix will be holding a conference call led by Phoenix's CEO, Dr. Rob Scott and Phoenix's President, Mr. Chris Lutes, to review the material presented in this White Paper. The purpose of the call is to answer any questions and discuss the content further. If you or another member of your Administrative team is interested in participating, please contact Jason Jacobs at the number listed below to register for the call and receive the corresponding passcode. In addition, if you would like to receive an electronic version of this document or a previous White Paper, please do not hesitate to contact us.

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## Emergency Department Patient Satisfaction: The Emergency Physician Group's Role

Emergency Department (ED) patient satisfaction success remains a key initiative for all acute care Hospitals today. Executives, Board Members, and the community in general are all very interested in patients receiving efficient, friendly, and informative care in their local Emergency Department at all times. Having an excellent patient satisfaction program in an Emergency Department reduces malpractice risk for the Hospital, increases the patient's willingness to pay for the services received, and ultimately increases the likelihood of future Hospital revenue streams through repeat business, referrals, and new patient encounters. Even more, patients will usually share their Emergency Department experiences with friends and family upon conclusion of their visit. It is this kind of dialogue that will ultimately augment or decay the reputation of the Hospital's Emergency Department in the local community.

Creating an Emergency Department culture with a strong focus on patient satisfaction is multi-factorial and dependent on numerous Hospital departments and people. Such departments include, but are not limited to; the ED Physician group and their providers (both the Physicians and Allied Health Professionals), the ED Nursing staff, the Radiology staff, and all other personnel who may come into contact with ED patients and their families during an Emergency Department visit. Each of these clinical and non-clinical team members must bring a consistent focus and willingness to serve patients in the Hospital's Emergency Department every day.

At Phoenix Physicians, we are frequently asked by Hospital Administrators what specific things the Emergency Department Physician group must "be accountable for" in order to assist the Hospital in reaching their overall ED patient satisfaction goals. Based on our experience managing multiple Emergency Department practices across the U.S., our organization has identified four key actions the Emergency Department Physician group must take full responsibility for in order to maximize the Hospital's chances for sustained ED patient satisfaction score success. These four important actions include:

1. Acknowledging and embracing the importance of ED patient satisfaction.
2. Having a defined mechanism to separately measure ED patient satisfaction for each individual Physician within the group.
3. Performing prompt telephone service recovery on behalf of the entire clinical care team to address any suboptimal patient experiences in the Emergency Department.
4. The willingness to remove any member of the ED Physician group who cannot improve, or who refuses to embrace, service excellence within the Emergency Department.

Putting these four items into place alone will not solve all Emergency Department patient satisfaction challenges. It will, however, greatly increase the likelihood of sustained ED service excellence and high patient satisfaction scores for any Hospital today.

## Acknowledging and Embracing ED Patient Satisfaction

Essentially every Hospital has a survey mechanism in place to measure the experiences of patients who were recently treated in their Emergency Department. Although electronic survey mechanisms continue to grow in popularity, as of today most Hospital ED surveys are still mailed to patients via the USPS. As completed surveys are returned via mail or fax, they are tallied and data-based by the Hospital or an outsourced survey company for later review. These mail surveys typically ask the common patient experience questions ranging from nursing impressions, Physician attitude, Hospital cleanliness, to parking convenience. Although there is no “perfect” patient survey mechanism or exact set of questions to ask patients, Hospitals clearly invest significant dollars in patient satisfaction measurement tools every year and use those survey results to facilitate change and make process improvements. Even more, at many Hospitals certain survey questions are selected from the current Emergency Department patient survey mechanism in place and reported on a monthly basis via a dashboard or scorecard. Such ED survey results are also commonly shared with Administration and Board Members on a regular basis in an effort to assess overall Hospital quality and managerial performance.

Given this high level emphasis and significant financial investment made by Hospitals to measure and improve ED patient satisfaction, it is absolutely critical that any incumbent ED Physician group fully acknowledge and embrace patient satisfaction as vital to the long-term success of the Hospital. Although embracing patient satisfaction by the ED Physician group sounds very simplistic, getting full “buy-in” as to how the Hospital’s current survey tool works, what specific questions are being asked, how results are tallied, and understanding, embracing, and partnering with the Hospital to attain preset goals is not as commonplace as it would seem. A typical mistake made by ED Physician groups today is they either disregard patient satisfaction entirely, or “punch holes” in the Hospital survey mechanism currently in place in an attempt to deflect away poor scores. Uncooperative ED Physician group members who make statements such as “the sample size is too small,” “they only survey a certain segment of patients,” or “our drug seeking patients bring our scores down,” do nothing to improve the Hospital’s service culture or the Administration’s overall confidence in the ED group. Instead, this ED Physician criticism towards patient satisfaction only hurts the overall objective of improving ED patient experiences through ongoing measurement and improvement. In the end, every ED Physician group member must accept that all patient feedback is extremely valuable, whether favorable or unfavorable, and it is this feedback that should be embraced, used proactively to change processes and behavior, and/or validate positive actions.

A key first step for ED Physician “buy-in” to occur properly is for the ED Physician group to clearly designate one Physician in the group who will serve as the liaison between the Physicians and the Hospital. This Physician may be the Emergency Department Medical Director, or another designated member of the group. Who is ultimately selected is not as critical as the amount of time this Physician must dedicate to patient satisfaction on an ongoing basis, and using this protected administrative time to collaborate regularly with the Hospital’s patient satisfaction “champion” and communicate all findings and plans as necessary. It is imperative that this designated Physician fully understand the current Hospital survey in place, know what questions are being asked in the survey, how the results are tabulated and reported, and where improvements may be necessary in order to achieve previously identified ED patient satisfaction goals as set by Hospital leaders. In addition, this lead Physician must make certain that the goals and expectations of the Hospital regarding ED patient satisfaction scores are clearly communicated to each Physician in the group. There should be no confusion or

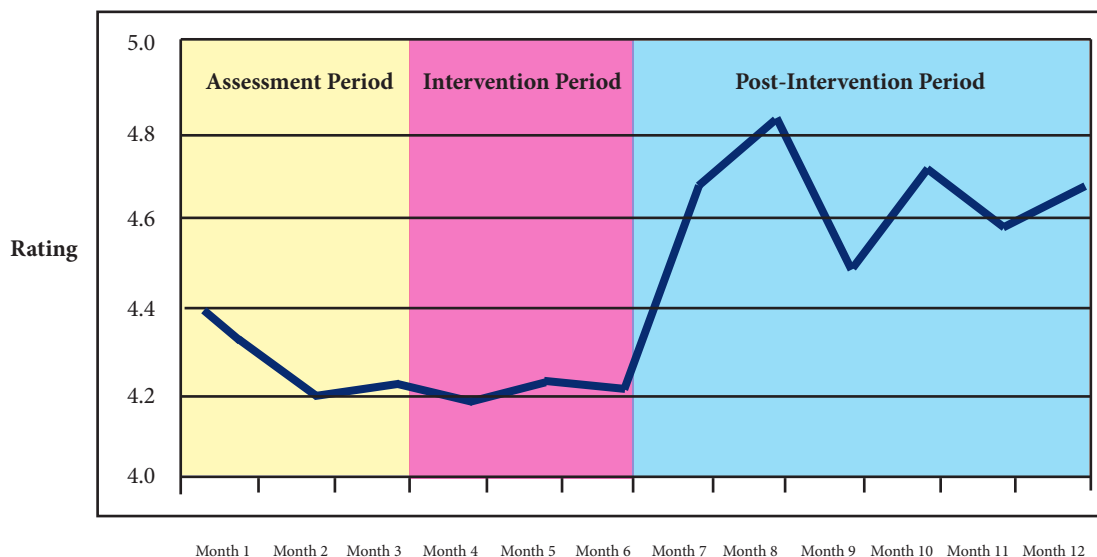
misunderstanding whatsoever by any member of the ED Physician group as to the survey questions being asked, how scores are trending of late, where improvements may need to occur, or what the Administration's specific expectations are for the ED Physician group concerning patient satisfaction scores in the Emergency Department.

### **Mechanism to Separately Measure Each Physician in the Group**

Although it is very important that the entire ED Physician group embrace and work collegially with Hospital Administration on their overall ED patient satisfaction initiatives, it is also extremely valuable for the incumbent ED Physician group to have the ability to consistently measure and score the performance of each individual ED Physician at the bedside. In other words, the ED Physician group must have an established mechanism to perform a "root cause analysis" as necessary for any suboptimal patient satisfaction scoring as it concerns their ED Physicians. A proactive ED group will have a mechanism to clearly and rapidly identify why the ED Physician group may not be scoring as well as they should relative to industry benchmarks. For instance, is the suboptimal Physician scoring because every Physician in the group is performing below expectations, or is it because a couple of Physician "outliers" are bringing down the overall performance of the group as a whole? In either potential scenario, the ED Physician group must have a way to easily identify the poor performing Physicians in the group, and work with those Physicians to promptly correct any bedside manner problems as soon as possible. Without a defined mechanism to objectively identify the problematic Physicians within the group, the incumbent ED group runs the risk of giving interpersonal skill ultimatums to the top Physicians, and at the same time potentially failing to focus on the "low scoring" Physicians who need to make the most immediate changes at the bedside in order for overall satisfaction scores to rebound.

Given this challenge as to how to identify which specific ED Physicians may be bringing the overall group's averages down, we at Phoenix Physicians have developed a valuable patient satisfaction ED Physician monitoring mechanism that allows our company to independently survey ED patients via telephone about the care they received from the specific Emergency Physician who treated them. All of these patient telephone surveys are professionally conducted within 30 days from the date of care, and they serve as a key supplemental adjunct to the Hospital's patient satisfaction mail survey program currently in place. Most importantly, this telephone survey program allows patient surveys, and the detailed feedback provided in them, to be instantaneously linked back to the specific ED Physician who managed the case. Even more, all patient telephone surveys are audio recorded and archived; thus they can be listened to and thoroughly reviewed by the treating ED Physician, the on-site Emergency Department Medical Director, or a Hospital Administrative leader through a web-based secure portal at any time. Although a Hospital's mail survey program may have some ability to tie back the returned surveys to the specific ED Physician who treated them, we have found that such a process can be quite cumbersome and generally does not work that well. Thus, we have found that it is much easier and more effective for the ED Physician group to conduct a "parallel" patient survey program in a proactive fashion that will monitor the bedside manner for every ED Physician in the group every single month. Having now completed in excess of 20,000 patient telephone surveys since program launch, our organization has gained a tremendous understanding and clarity as to what actions ED patients truly want from an ED Physician, what specific techniques should be used to modify Physician behavior if interpersonal shortcomings are identified, and ultimately when it may be time to cut ties with a problematic Physician who is unable or refuses to change their approach at the bedside.

One further key point to emphasize about these telephone surveys is the true value of the audio recordings and the Physician “buy-in” that occurs when listening to them. As we have previously suggested in this White Paper, ED Physicians in general have a tendency to downplay patient perceptions of the care received, often arguing that a patient has no way of fully understanding and judging the scope of the medical care provided or the medical decision making that was required to treat them. However, unlike a written mail or online survey, the recorded voice of a patient describing a Physician encounter makes it crystal clear to the treating ED Physician that patients actually do a tremendous job of recalling their ED visit, especially as it concerns the ED Physician who treated them. Therefore, one could refer to any suboptimal audio patient survey recording as a “smoking gun,” and use these negative surveys as hard evidence to prompt ED Physician behavior change at the bedside. The audio recordings simply cannot be disputed or discredited; they are very powerful to hear.



To demonstrate the value of an ED group being able to independently measure the bedside performance of each ED Physician, the above graph demonstrates a practice in which Phoenix initiated our patient satisfaction telephone survey program within the last twelve months. Successive months are plotted along the horizontal axis, and the vertical axis shows how patients rated the overall performance of the treating ED Physicians in the practice on a scale of 1-5 (5 being the best) in each month. As one might expect, because we were able to quickly allocate every patient survey to the appropriate ED Physician who treated them, we were able to rapidly assess whether any specific Physicians in the group were performing below expectations as compared to the others. What we learned at this practice very quickly was that the overall ED patient satisfaction scores for the group were being weighed down by a single ED Physician within the group, and that all other Physicians in the group were actually performing very well at the bedside. Thus, within three months of this survey program’s commencement, this low scoring ED Physician was clearly identified (yellow shaded area). This identified Physician was promptly counseled, asked to review all negative patient survey recordings in detail, and told that they must make improvements or potentially be asked to leave the practice (pink shaded area). In the end, despite all reasonable efforts to modify the behavior of the Physician for the good, the Physician was not very successful, and ultimately chose to voluntarily separate from the practice three months later. The blue shaded area indicates the sustained positive jump in patient satisfaction scoring for the ED group following the separation of that one provider.

## Telephone Service Recovery

A third key step for improving patient satisfaction scores in the Emergency Department is to implement a consistent patient call-back program for any dissatisfied ED patient identified through the various ED patient satisfaction survey mechanisms. It is inevitable that any Hospital, regardless of how well their patient satisfaction program is performing, will have patients that are unhappy with some aspect of their ED care. In such instances, there is commonly a short window of time where rebuilding that patient's trust and confidence in the Hospital is possible. Even if patients are unhappy with some part of the care received, in a majority of cases these same patients are greatly appreciative of any call-back/service recovery effort that apologizes for all suboptimal perceptions of care, and assures them that the Hospital is grateful for the feedback and will use the information to make positive changes for all future patients. Unfortunately, this service recovery technique is not consistently done as often as it should. Patients indeed appreciate a personal telephone call in response to their negative survey feedback, and the amount of knowledge obtained from these conversations is tremendously valuable for modifying patient satisfaction initiatives in the Emergency Department going forward.

In order to put into place an effective call-back program for negative patient surveys arising from the Emergency Department, the following items must clearly be defined and sorted out in advance of program launch:

1. The designation of the individual(s) who will contact any disappointed patient by telephone within a certain defined period of time and to discuss and understand their negative perceptions of care in a service-oriented manner.
2. A call-back log mechanism to record the general nature of any service recovery phone conversation, along with any follow up actions that may be necessary.
3. An in-person meeting platform performed on a regular basis where both ED group members and hospital ED team members can learn of care perceived as negative, and collectively develop action plans to minimize or eliminate such events from happening again in the future.

It is very important to note that the purpose of this negative survey call-back program is to improve overall Hospital customer service going forward and to make a best effort to recover Hospital trust from the patients who had a frustrating ED experience in the recent past. It is by no means intended to simply identify which nurse, doctor, etc. was to blame for the suboptimal ED rating.

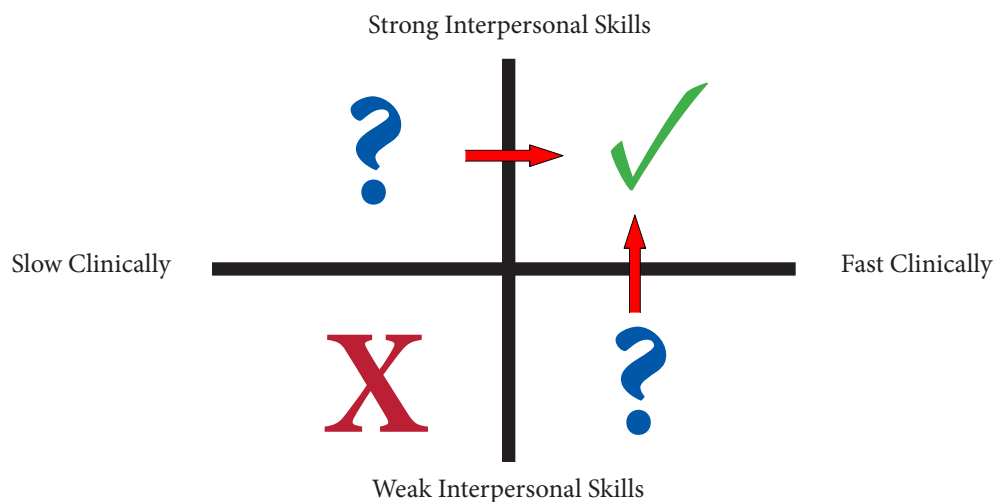
At Phoenix Physicians we perform numerous ED patient telephone surveys each month in parallel with the Hospital's mail survey program, so it is inevitable that we learn of suboptimal patient feedback from time to time that must be acted upon. This feedback may be about a Physician's poor attitude, ED wait time, Hospital cleanliness, a rushed triage nurse, a rude phlebotomy tech, and so on. Regardless as to whether such negative feedback concerned an ED Physician's actions specifically or not, an ideal way to systematically manage all negative surveys is to have the ED Physician group's designated patient satisfaction "champion" place a call to the patient within 10 days of obtaining the negative survey feedback. On that call this ED Physician should hear and understand the patient's frustrations, "gently" attempt to recover the patient's trust in the Hospital's Emergency Department, and manage any follow-up actions as needed based on the conversation in order to prevent a similar experience from occurring in the future. Depending on the exact nature of the patient's feedback,

follow up action items may include sitting with and counseling the treating ED Physician, providing feedback to a clinical nursing supervisor about a Hospital team member's suboptimal interaction with the patient, investigating an "unclean" patient treatment area, working on ED throughput initiatives, etc. As noted, this ED Physician champion should keep a detailed log of all patient discussions and plans of action seen through to resolution.

### Removing Resistant ED Physicians

From time to time, despite the best efforts of the ED Physician group leadership and the Hospital to modify Physician behavior for the better, certain ED Physicians either refuse to change their approach at the bedside or are simply unable to change. In such cases, the ED Physician group must be willing to separate that Physician from the practice for the overall good of the ED group and the Hospital. Because the failing interpersonal skills of a problematic Physician hurt the efforts by the rest of the clinical care team, on occasion an ED Physician's removal is the only logical solution. Even more, top ED groups should monitor and manage their Physicians on an ongoing basis and they should make group member changes in a proactive fashion as necessary, instead of forcing the Hospital Administration team to mandate an ED Physician's removal.

So how does one know if you have a problematic ED Physician in the group? A very simple way to evaluate any Emergency Physician is to consider their practice speed versus their interpersonal skills. These two attributes are clearly the most important to Hospitals, patients, and the Medical Staff, and have remained so for quite some time. Therefore, an easy way to assess any ED Physician is to plot them in one of the four quadrants as outlined in the drawing below:



On the vertical axis interpersonal skill is plotted. On the horizontal axis clinical speed is plotted. As one should expect, ED Physicians who are both fast clinically and possess great interpersonal skills (top right quadrant) are in high demand and are vital for a successful Emergency Department. All ED Physician groups and Hospitals are constantly looking for these kinds of ED Physicians.

Likewise, in the bottom left quadrant are the ED Physicians who are both slow clinically and possess poor interpersonal skills. These kinds of ED Physicians never last at a practice in the long term, as their slow clinical pace and bad attitude do nothing but damage the overall culture of the Emergency Department. Their removal from the practice is inevitable and should be done sooner rather than later.

The ED Physicians placed in the top left and the bottom right quadrants are the most challenging. These are the ED Physicians who have great interpersonal skills but are slower clinically (top left), and the ED Physicians who are fast clinically but lack superior interpersonal skills (bottom right). These two types of ED Physicians are very common, all practices have them, and they may or may not survive in the practice long-term. Their survival, without changing, really depends on what the ED Physician group and the Hospital value most. Sometimes speed is valued over interpersonal skills, and the ED Physicians in the bottom right quadrant survive long-term. Likewise, sometimes interpersonal skills are valued over speed, and the ED Physicians in the top left quadrant survive long-term. Ultimately, regardless of what is most valued to the Hospital and the ED group, speed versus interpersonal skills, in both scenarios the ED Physician group's leadership team must always be working with these ED Physicians to move the ones that fall into either of these two quadrants into the top right quadrant (as indicated by the red arrows). Importantly, it is also worth noting that our organization believes it is easier to modify the interpersonal skills of an ED Physician than it is to increase their clinical speed. ED Physicians typically practice at a pace they feel comfortable with, and significantly increasing their speed can prove difficult to do. An RVU-based productivity model may have some impact on speed, but in many cases slower ED Physicians exit practices where RVU models are used because their pay ultimately suffers. Interpersonal skills however, can be corrected much more easily with intervention and proper education.

So ultimately, if problematic ED Physicians within the group are identified and cannot be “rehabilitated” within a reasonable time period, that Physician's removal from the practice may be the only remaining option. Removals however, do not typically happen as timely as perhaps they should. Common reasons that ED Physician removals are not done timely include:

- Lack of willingness by the incumbent ED Physician group to remove a Physician.
- Inability to quickly recruit a new Physician to fill the pending vacancy.
- Fear of “political” repercussions or legal entanglements following the removal.

In most Physician removal situations, it is recommended that any ED Physician being removed “involuntary” by the ED group be discussed in advance with the designated Hospital Administrator who oversees the Emergency Department. This review is simply done as a courtesy to make certain there are no unidentified issues to be discussed or resolved with Hospital Administration in advance of the ED Physician's removal from the practice. Failing to predict the unintended consequences of a Physician's removal in advance may prove problematic for multiple parties.

## Summary

As we have outlined in this White Paper, if a Hospital is finding ED patient satisfaction to be a continuous challenge, it is our belief that their Emergency Physician group has four fundamental responsibilities to that Hospital. Once again, these four responsibilities of the ED Physician group are:

1. Acknowledging and embracing the importance of ED patient satisfaction.
2. Having a defined mechanism to separately measure ED patient satisfaction for each individual Physician within the group.
3. Performing prompt telephone service recovery on behalf of the entire clinical care team to address any suboptimal patient experiences in the Emergency Department.
4. The willingness to remove any member of the ED Physician group who cannot improve, or who refuses to embrace, service excellence within the Emergency Department.

There is no quick and easy way to reach a Hospital's overall patient satisfaction goals for the Emergency Department. However, if a Hospital is certain that their ED Physician group is performing these four actions on a consistent basis, that Hospital is well on their way to superior ED patient satisfaction scores in the near future.

# About Phoenix Physicians

Phoenix Physicians is a leading Physician-owned practice management company based in Fort Lauderdale, Florida, providing adult and pediatric Emergency Medicine services to Hospitals and Health Systems nationwide. Phoenix currently provides quality care to over 750,000 patients annually and all of our partnering Hospitals can attest that we focus our operations on key clinical initiatives that result in enhanced patient safety and satisfaction, successful Physician recruitment and retention, and positive financial outcomes for our Hospital clients.

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