How to COMMUNICATE with patients

It's not always your fault when patients complain about “lack of communication.” Lots of people have never learned to communicate effectively. This article faces that fact, and shows what you can do about it...and why you must do something about it.

If you’re a physician, nurse, office manager, or anyone else who works in a medical practice, you’ve learned two things in a hurry and learned them well:
- listen for the key point in what “the other guy” is saying
- get your own key point across—quickly, forcefully, and memorably

You’ve learned these communication skills; but many of your patients have never had to. They’ve never worked in an environment that’s anything like a medical practice. In many environments, information can be exchanged in a casual, conversational manner. Many of your patients are used to communicating in this way. So, they don’t know how to get a key point across...and when the doctor goes searching for what the patient is trying to say, the patient complains, “My doctor never listens to me!”

They don’t know how to keep a conversation focused...and when the doctor tries to zero in on what really matters at the moment, they complain, “The doctor doesn’t care about me as a person; to him or her, I’m just a diagnosis!”

They don’t know it’s perfectly acceptable to say, “I’m not sure what that word means; would you please explain it?”...and instead they complain, “That doctor talks ‘way over my head!’”

Patients aren’t stupid! Not at all! They’re well equipped to communicate in the environments where they live and work and make their own contributions to society. They just don’t know how to communicate with you.

Since about half of all U.S. malpractice lawsuits grow out of “poor communication”...and since many patients communicate poorly with their physicians...it’s in your best interest to learn how to communicate better with them!

A four-step crash-course in Patient Communication.
1. Tape-record some random patient encounters.
   Many companies tape conversations between their customers and Customer Service staff. When this is done with employee consent and cooperation, results are often dramatic: mistakes and oversights can be spotted; sales opportunities identified; employee morale boosted; and customer relationships solidified.
This strategy can be adapted to a medical practice, often with similar results: improved doctor/patient communication; and closer practice/customer relationships.

To apply this strategy, have your officemanager or other staff member place a tape recorder in an exam room, and use it to record about a half day’s OVs. Try to include different types of patients in your recordings. When the taping is done, sit down and review the results.

Listen to the ways patients really speak to you, and how you really respond. Are these staff/patient conversations a little (or a lot!) different from what you imagined? At what point in the conversations do patients get around to bringing up the “key point?” How do they express it? Timidly? Evasively? With an obviously artificial bravado? What signals (hesitations; rising or falling tones of voice; a tentatively muttered “Mm?”) do they use to indicate they’d appreciate an immediate response? How quickly do you “pick up on” these signals? Do you ever keep the conversation running with brief, encouraging words such as, “Yes, please go on.” or, “I understand how you must feel.” or, “We’ve been able to help a lot of people who were going through that.”?

The signals patients give you, are their way of establishing (or trying to establish) empathy with you; your verbal responses are often the “yardstick” they use to measure your empathy with “The Real Patient.” Many healthcare professionals make written or mental notes that show a perfect understanding of the patient’s real problems—but the patient never sees those notes! To project the level of empathy you actually have, in a way your patients can see, learn to respond in the ways they expect. You can learn those expectations... and develop meaningful responses to them... simply by “studying your patients” on tape!

Once you’ve learned all you feel you can learn from these tapes, erase them for the sake of patient confidentiality.

2. Learn the “people-words” for medical terms.

There are many diseases and symptoms you deal with all the time. You talk about them in a jargon that’s as familiar to you as ordinary English is to the 225 million Americans who only deal with such things when they get sick. It’s very important to the doctor/patient relationship that your staff use the same words when you talk about those things... and it’s very unlikely that all those 225 million people are going to learn your words.

Happily, it’s very easy for you to relearn the ways you described these things before you learned medical jargon.

A. Make a list of ten diagnoses and treatments you deal with “all the time.”

B. Sit down with a friend who isn’t involved in the healthcare field. Tell him or her about each of these, one by one, and after you describe each one, ask, “How does that make you feel?” and/or “How would you describe this in your own words?” and/or “Does this make any sense to you at all?”

C. Listen to the verbal response. Try to identify feelings and emotions (often expressed in adjectives) as well as the facts of the matter (usually expressed in matter-of-fact nouns). You may be surprised to hear your friend use many words (especially those adjectives) that your patients
have been using all along. Now, when you hear patients use those words, you’ll have a better idea of what they mean.

D. Watch your friend’s body language—those involuntary squirms and facial grimaces that punctuate all meaningful conversation. Does any of that language look familiar? Good! Now you’ll be better able to understand what patients are saying when they grimace and scrunch up in the chair.

3. Practice “the fine art of rephrasing.”

One of the English words that’s expressed most frequently—and most eloquently!—in body language, is the word: “Huh?” It’s easy to look into someone’s face and see when he’s missed a point you’ve tried to make. The question then becomes: Did he miss it because I was vague? The answer is: treat him with consideration, and cement the relationship, by rephrasing your statement! Simply say—almost apologetically—“Let me rephrase that.” Then think: “Which words would he use to say what I want to say?”...and say it in those words.

If there’s anything (any verbal technique, that is) that’s better than rephrasing, it’s prephrasing. Here’s how it works:

A. Identify the phrases you use, that most often stimulate your patients to say, “Huh?”

B. Go back to your friend who helped you translate medical jargon into people-talk, and ask him or her to listen while you express each phrase in several different ways.

C. As you speak, watch your friend’s face to see how each phrase “registers.” You’ll soon be able to recognize various levels of comprehension, doubt, worry, pity, and other subtle expressions that tell, in no uncertain terms, how well you’ve “connected.”

D. When you hit upon a phrase that “registers” positively, work it into your vocabulary; when a phrase registers “negatively,” work it out. If you can’t come up with a positive phrase after a few tries, ask your friend to, “Say it in your own words”—and then make his or her words, your words.

Real communication has a little bit to do with what you say...but a lot to do with what the other guy hears.

4. Teach your patients to talk to you.

Most patients do not naturally speak the same language as the healthcare professionals they trust with their lives. Their minds are often overcome by fear, pain, embarrassment, and/or intimidation. They clam up the moment they get to your office; and after they’ve gone, both of you wonder: what was the point of that appointment. How can you get those patients past their clam-ups? Here are two suggestions:

A. Find out what the patient is interested in—sports; cooking; grandchildren; whatever—and begin the OV by asking a question that allows the patient to demonstrate his or her knowledge about that subject. Once the patient’s confidence is established, turn the conversation to medicine...and invite him or her to come to the key medical point with equal confidence.

B. Offer patients a “pre-interview” with a nurse. This should precon-
dition each patient to expect sensitive communication with a physician who talks your language.

Your “Returns On Investment” will include:
- better patient compliance with your instructions
- fewer follow-up telephone inquiries
- a higher quality of care—simply because patients have become more cooperative partners in their treatment
- shorter, more cost-effective patient encounters—because so many barriers to quick communication have been removed
- a reduced risk of malpractice lawsuits—because many of the lawsuits that grow out of “poor communication” no longer have any room to grow!

Don’t let Medigap become a reimbursement gap

In block 9d of the standard HCFA-1500 claim form, there is room to list one Medigap insurer. In your Medicare carrier’s claims department are many clerks, trained to look for one Medigap insurer in block 9d. If any practice tries to list two or more Medigap insurers in block 9d, Medicare will deny the claim. You will then need to resubmit, causing a gap between the time Medicare receives your claim and the time you are actually reimbursed.

To close the gap, enter information on just one Medigap insurer in block 9d. If a patient has additional Medigap coverage, use an additional sheet of paper to provide the appropriate information.
Save nickels, dimes, hours
...on your phone

Is a penny saved really a penny earned? Think about it; that doesn’t even make sense. The truth is, “A penny saved is twopence earned.” After all, it takes twice the effort to replace a penny (or a fortune!) that’s been once wasted.

Which brings us to your practice telephone, where everyone (without exception!) wastes money, time, and energy...or, far worse, allows people on the other end of the line (or telephone “services” in the middle!) to waste time and money for them.

Here’s how you’re wasting telephone time and money... and how to put a stop to it!

“Directory assistance” costs money; and long-distance assistance can cost more than the call itself. Stop using this “service,” and keep an updated name/address/phone list of suppliers, third parties, patients, and friends.

“Operator assistance” costs money; happily, you can place most calls just as easily (and often just as quickly!) yourself ...and make the operator tell you “how to do it” for free. Those computerized voices that tell you: “This number can be automatically dialed for 30¢ by pressing ‘1’” are about the worst money-wasters in the business. Let your fingers do the dialing! Actually, all it takes is a fingertip, touching a dozen buttons instead of one, to save your practice enough money to pay postage on a past-due statement.

Always use “800” numbers when vendors and third-parties have them. To see if an out-of-town party has an 800 number, call 1-800-555-1212 for toll-free “800” information. (This is especially useful for insurance companies.) Put the numbers in your rolodex, so you have them for future use.

Use WATS lines wisely.
WATS is designed to encourage out-of-town patients and referring colleagues to call easily, directly, and cheaply...and to provide reduced-cost calling for practices that place a high volume of long-distance calls. Dialing “800” numbers and calling for operator assistance on a WATS line is not cost-effective.

Restrict outgoing calls
by giving every staff member a “code” to access long-distance service. This will identify personal long-distance calls made by employees, and will prevent salespeople (and patients) from using your phone for their convenience.

Plan calls in advance.
Take a moment to think: “What point(s) do I want to get across —to how many people at this location—and what do I want to accomplish by this call?” It may help to jot these items down on a
“Stuff to Cover” list. When your call goes through, go straight to the point...get the information or other response you need...and avoid small talk. If one person tries to tie you up with chit-chat, ask for the next person on your “List.” Once you’ve accomplished your goals for the call, end it with a polite-but-firm “Thank You!”

Report unsatisfactory service—wrong numbers, bad connections, cutoffs, whatever—immediately. Call the operator and get a credit...and get across the point that you won’t accept second-rate service ever.

To save major money, review your telephone service once a year. Ask various transmission vendors (MCI, U.S. Sprint, AT&T, etc.) and equipment vendors to submit proposals and show you how much time, money, and aggravation you might save by adding, changing, or eliminating certain “amenities.” If you don’t feel comfortable making value-judgments between all the apples and oranges and bananas offered by all those different vendors, you may want to pay a telephone consultant to review their proposals and make an objective recommendation. If a review shows it could be very cost-effective to install a new system or contract with a new transmission vendor, don’t be afraid to tell your present vendor(s) and give them a chance to make you a better offer.

To extend friendship, extend credit terms

A good debtor is one who makes his or her payments on time, according to the schedule you’ve agreed upon—a schedule based upon the patient’s ability to pay. What happens if the patient’s ability to pay is suddenly disrupted...by unemployment, injury, or some other unforeseen problem? Does the patient automatically become “bad”?

Of course not! He or she is still a good friend of your practice...still a good source of word-of-mouth referrals...and still a good credit risk who’ll probably pay in full as soon as times get better. But—because good patients are often sensitive people to begin with—he or she may not have taken the initiative to call you and ask for a temporary credit extension. It pays for you to take the initiative for patients like these.

Whenever you notice a lapse in payments from a patient who has always paid faithfully, call and find out what the problem is. If it’s something beyond the patient’s control, ask what you can do to help. You may be able to reduce the monthly payments to fit into a reduced family budget...or grant a two- or three-month “collection deferment” until the patient can get back on his or her financial feet. Once you and the patient agree on new terms, follow up with a letter that spells out those terms and invites the patient to call you first if any new problems arise.

Tension piles up when credit patients fall behind. But when you grant credit extensions, you keep good patients...maintain slowed-but-still-steady cash flow...and eliminate tension. And that, dear reader, is why it’s called an “ex” tension.
Help celebrate a new (prospective) patient!

Whether you’re in pediatrics, family practice, or internal medicine, every new baby born into the family of one of your patients can become a new patient...sooner or later. There are several ways you can give the parents of these prospective new patients a lasting reminder that “Our Practice Is Family!”

1. Print up a supply of birth announcements with a message of celebration on the front, your practice name and logo on the back, a slot to hold a baby photo, and an imprint area that can be personalized with the baby’s name, birth date, weight, height, and parents’ names. Whenever a baby is born, surprise the parents with twenty or so announcements. As an extra nice touch, have the person on your staff with the nicest handwriting add the appropriate information...and present the proud new parents with a timely and valuable gift. (The more announcements you can print for each new birth, the merrier...because more of the baby’s relatives, friends, and neighbors will see your name and logo in a very positive setting!)

2. Contact an advertising specialty vendor (usually listed in the yellow pages under “Advertising Specialties”) and see how many gift items they offer that can be imprinted with your practice name, address, and telephone number. Baby bottles; diapers; educational toys; many of the little things your patients would buy for a baby are available as imprinted advertising specialties. So you’re sure to find a gift that people will appreciate; and that gift will be sure to promote your practice. You may want to try working with your pharmaceutical representative to offer a joint gift, such as an attractive diaper bag bearing the name of your practice and the name of the drug company.

3. Visit a local toy store or department store that [a] sells Teddy Bears and other stuffed animals; [b] offers monogramming services at a minimal charge; and [c] provides customers with neat cards that read “A Gift From....” Purchase a number of $5-to-$25 gift certificates; whenever a new baby is born into one of your patients’ families, present the parents with a card and a gift certificate they can [a] redeem for the animal of their choice; [b] personalize your gift with the baby’s initials; and [c] keep your gift until it’s an heirloom!

“OB/GYNs” used to be called “Baby Doctors.” They still are—only now, primary and specialty practices can use the letters “OB/GYN” to express interest in a new baby’s birth. Because now these letters can stand for, “Oh Baby! a Gift You Need!”
Evaluating Your Practice with a Quarterly Analysis
A continuing series by Laura Sachs

PART III Overhead
In tough economic times, it’s essential to take a hard look at your total practice overhead. During an economic recovery, it’s smart to keep track of those overhead dollars to make sure they’re working hard for you. Here’s how to keep a close eye on them.

1. Total your overhead dollar amounts and calculate their percentages of practice gross for the last three months. Break overhead into categories such as salaries, supplies, lab costs, and rent.

2. Total the number of staff incentive bonuses reached for the last three months and the total dollars earned in incentive bonuses.

Is Your Total Overhead Percentage On The Rise?
Figure the percentage of your overhead by dividing overhead totals by your gross production. If the percentages have risen since last quarter there are two possible causes.

1. You are producing less.
2. You are spending more.
It is essential that you determine the cause of either increase.

A runaway overhead often indicates inefficiencies, waste, or poor cost and resources control. Compare your quarterly percentages per category—salaries, rent, lab costs, etc., to help you locate precise problems.

It can also help to know whether you paid more or less to your staff in incentive bonuses so you can measure the effectiveness of your bonus programs.

Laura Sachs is the president of Laura Sachs Consultations, a Clifton, Virginia-based practice management and marketing firm. She is the author of Do-it-Yourself Marketing for the Professional Practice and The Professional Practice Problem Solver.

Don’t bill Medicare for “family matters”

Question: Does HCFA consider it illegal to bill Medicare for services rendered to the doctor’s immediate or extended family?
Answer: YES. HCFA’s interpretation of “family” includes parents, step-parents, cousins, even in-laws! Any claims made for care provided to any family members can be denied if Medicare finds out of the relation. The doctor (and staff!) may be liable for fines and criminal prosecution if Medicare didn’t know about the relationship when they paid the bill. So don’t do it, OK? OK!
Don’t let MSP put any extra demands on you

HCFA is serious: They are not going to pay benefits that a primary payer should pay. They are going to track down payments they’ve already made that may be in error and demand that the money be repaid to Medicare. Many primary payers (and medical providers!) are now receiving “Demand Letters” from HCFA…and what HCFA is demanding is a full and immediate refund. If you’ve received any of these demands it probably means: HCFA is paying more attention to your MSP paperwork than you are. And it may mean: HCFA has targeted you for an MSP audit.

How HCFA “pays attention” to your primary payer/MSP paperwork

First they computer-searched IRS tax returns dated 1987 thru 1989, and identified 9,000,000 Medicare beneficiaries who worked, or who were married to someone who worked, during those years. They followed up by sending questionnaires to the employers of those 9,000,000 people, asking for insurance information. The “primary payer” information in those responses was then computer-matched against Medicare’s reimbursement records; and guess what?! They found claims sent to, and paid by, Medicare...that should have been sent to a primary payer. They’ve found hundreds of thousands of such claims so far, and they’re just getting started. And every time they find one, a demand letter goes out.

Most demand letters, so far, have gone to employers and insurers; but more and more medical practices are beginning to receive these “Hello’s from HCFA!” If a practice receives one or two, HCFA will probably figure, “Mistakes happen.” But if a practice receives a lot of letters, some HCFA Fiscal Intermediary (FI) may just say, “Those people don’t seem too excited over this MSP thing; reckon I’ll mosey on down an’ do me some fancy auditin’.” Or other words to that effect.

How to avoid MSP problems

First—that is, beginning right now—have every Medicare patient complete a form similar to the one on page ten. You may copy our form as-is, or edit it to suit your practice.

Second, make sure the primary payer is identified in every patient’s billing records...that your records are updated at least once a year...and that primary payers are always billed first and Medicare is billed second.

Third, if you do receive a demand letter from HCFA, don’t pay it until you’ve checked your records to see [1] who paid what to whom, and [2] who should have paid what to whom. If it starts to get more complicated than it seems to be worth, remember these “basics”:

- You’re entitled to be paid for the care you provide.
- You do the billing; primary payers and MSP do the paying.
- If HCFA demands an MSP reimbursement from you, you’re entitled to demand an equal reimbursement from the primary payer.
- Again, in spite of all the federal laws and insurance rules and regulations and computer-searches and paperwork explosion and MSP demands—you are entitled to be paid for the care you provide!
Audits That Can Go Back Six Years. You’re probably familiar with the IRS’s usual three-year statute of limitations. But there are so many special rules and exceptions that you can’t always rely on it. The Tax Court recently upheld an IRS attempt to assess a Kentucky doctor for pension loans made five years earlier from a disqualified plan. The reason the IRS was able to ignore the three-year statute of limitations? Since the loans were never correctly reported to the IRS, the three-year statute of limitations never began running, and a longer six-year period applied.

Voice Mail In Your Office? If you resisted the computer and the fax machine, you’re probably also resisting voice mail—that electronic switchboard. Although prices may be coming down—newer systems are available for around $3500.00, and can be purchased at office supply stores—patients probably aren’t going to accept a mechanical receptionist. We believe that the nature of calls to a doctor’s office—emergencies, etc.—dictates the need for a caring, thinking human being on the receiving end of a call.

Tax-Free Lifetime Benefits. There’s been a whole new set of life insurance policies out there that pay “living benefits,” that is, benefits during your lifetime, if you need the cash as a result of an expensive terminal illness. Under traditional tax rules, receiving such benefits would be taxable. But the IRS has just proposed new regulations that would exempt such benefits from taxation if you’re terminally ill, which the agency defines as expecting to die within 12 months.

What To Look For In A Disability Policy. Disability policies are much more complicated than life insurance policies, so you’ve got a lot more to look for. Most important, look for a policy that’s noncancelable, defines disability in terms of your own specialty, provides for income replacement as you return to work, and includes a cost of living index that increases disability payments with inflation. Should you buy a policy with a longer or a shorter waiting period? Since policies with a longer waiting period are less expensive, you should first get as much coverage as the insurance company’s limits provide, and then determine the waiting period based on how much you want to pay.
MEDICARE/INSURANCE INFORMATION

Changes in the Medicare payment system regarding secondary and supplemental insurance benefits may affect how we handle your account in our office. For this reason we have found it necessary to update your records.

Thank you for completing this information so that we may help you to receive your insurance benefits as promptly as possible.

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Medicare #</th>
</tr>
</thead>
</table>

DO YOU HAVE ANY INSURANCE IN ADDITION TO MEDICARE?  □ Yes  □ No

IF YES, please complete this form.

1. Are you covered by a Medi-gap or supplemental insurance plan? (A plan which covers the costs of services approved but not paid by Medicare such as deductibles or the 20% coinsurance.)  
   □ Yes  □ No

   Name of Insurance Co. 
   Group #  Agreement #  Policy #

2. Are you covered by a basic insurance plan through your employer? (A plan which pays you the same benefits that other non-Medicare employees in your company receive.)  
   □ Yes  □ No

   Name of Employer 
   Name of Insurance Co.  Policy #

3. Are you covered by a basic insurance plan through the employer of your spouse or other family member? (A plan that pays you the same benefits that other non-Medicare employees of that company receive.)  
   □ Yes  □ No

   Name of Spouse or Family Member 
   Name of Employer 
   Name of Insurance Co.  Policy #
Enter our First Class Mail contest and you could win $50.

Send your practice management ideas (no clinical subjects please) to:

First Class Mail
The Doctor's Office
P.O. BOX 10488
1861 Colonial Village Lane
Lancaster PA 17605-0488

Idea: Use superbills to fight claims confusion two ways

Some of our patients like to have us file their insurance claims; others prefer to do it themselves; either way, all the procedure information on the superbill has to be entered into our computer. This created an interesting problem: how was our computer operator to know which patients wanted us to file claims and which didn't?

Our simple answer: When we file the claim, we give the patient a copy of the superbill, and we keep the original. If they want to file their own claim, we give them the original, and we keep the copy. Our operator knows the only time she has to generate a claim is when she's entering information from an original. Now our superbills serve an extra purpose... and the number of claims filed (or not filed) in error is almost zero.

Valerie G. Naylor, Office Manager
Pamela J. Whitney, M.D.
Nancy P. Schechter, M.D.
Raleigh NC

Idea: Enforce a "curfew" on patient charts

In our ten-physician office, it was a constant struggle to find patient charts when information was needed to answer over-the-phone questions or prepare for appointments. Charts were always at a doctor's or nurse's desk... or at our lab... or in transcription... anywhere but in our files.

To organize things, we gave each doctor, nurse, and operations manager a bin in our chart storage area. At the end of each workday, a clerk makes the rounds of our offices, gathers up every chart, and files each one in the bin labeled with the name of the person who had it last.

Now front-office people can find charts needed for the day's appointment schedules. Now back-office people can find charts needed for post-op and post-OV follow-up work. Now anyone who needs a chart in the morning can go to one central area and be sure that chart will be there—instead of sitting on a doctor's desk for days while he or she is on vacation, or under a pile of paperwork that someone was "going to get to!"

Chuck Chambers, Administrator
College Park Family Care Center
Overland Park KS
Now: an (U)LCER from HCFA

The "U" in ULCER stands for "UHHhhhh.h...h...h....." It's pronounced just the way it's spelled: a sharp initial outrush of air, such as might occur when receiving a blow to the abdomen, followed by a protracted sigh of exasperation. "LCER" stands for "Limiting Charge Exception Report"—as in those notices you may have been receiving from HCFA saying you've billed a patient more than the RBRVS fee schedule allows and if you don't refund the overcharge to the patient within 30 days you may be fined $2,000 per violation and kicked out of the Medicare program for five years. HCFA doesn't spell out the "U" in ULCER, but you shouldn't have trouble finding it.

To help reduce overbilling in the first place, HCFA has developed a two-level educational program. Lists of "most frequently overbilled" services in each region are published in Medicare Carrier Bulletins so that physicians can refer to these Bulletins, see if any of their frequently provided services are on the list, and bill those services more "carefully." On the physician level, individual practices are being notified of "overbilling patterns" which they can correct in order to avoid receiving LCRERs (and ulcers!) in the future.

Practices that receive a lot of LCRERs may be required to provide HCFA with proof that all refunds have been made. This proof must include the following:

1. A signed statement which documents the following:

   Patient Name ____________________________
   HICN __________
   Date(s) of service ________________________
   Procedure code(s) ________________________
   Description(s) __________________________

   Amount of refund $ __________
   Date of refund ________________________
   Check # __________________________
   Physician's name ______________________
   Physician's PIN # ____________________

2. Tangible evidence that the refund was actually made, such as:
   - photocopies of the front and back of the refund check; or
   - a copy of the slip showing a credit-card transaction; or
   - a copy of the patient's account records showing the outstanding balance reduced by the amount of the refund due.

   You do have the right to appeal LCRERs, just as you can appeal any other HCFA adjustments and denials. Just follow the regular appeal process: if the review shows the LCRER to be in error, proper adjustments will be made in your favor; if your appeal is denied, you'll have 15 days to refund the overbilled amount to the patient.

To take the "U" out of ULCER, review your RBRVS fee schedule now, and make adjustments to meet HCFA's Comprehensive Limiting Charge Compliance Program requirements. Then let HCFA send out all the Limiting Charge Exception Reports they like...your practice will remain Untouchable!