Are You Getting Your Message Across to Your Patients?

If the answer is no, consider an alternative presentation style.

BY LYNN HOMISAK, PRT

To Our Readers: *There are no foolish questions. Chances are that if you have a question or concern in your practice, others are experiencing a similar situation. We're here to help. PM [doctor and staff] readers are encouraged to submit questions to soslynn@gmail.com which will be printed and answered in this column anonymously.*

Topic: Are You Getting Your Message Across to Your Patients?

Dear Lynn,

Lately, I've noticed that my patients get this blank stare as I explain their condition to them. I try not to use medical terminology in my explanations, and although I get a lot of head nodding, I can tell my words are not getting through to them. This became painfully evident when I walked back into a treatment room and overheard my patient asking my staff to "please explain what the doctor said."

Unless this is a one-time incident, a sensible move would be to consider an alternate presentation style, one that allows you to connect with your patients on a more engaging level. Words are great. Layman's terminology is better. X-rays help. So do diagrams and examples. These methods of communication are essential (read: necessary, extremely important). However, on their own, they do not possess the quintessential (read: most perfect) element for your patient to fully understand what you are saying.

When you go into your well-rehearsed clinical explanation, what your patient perceives is that YOU know what you are talking about. And while that, of course, is necessary and extremely important, some of what you have explained to them translates as medical gobbledygook. And if you raced through it, you've really lost them.

On the other hand, if your message is delivered in a way that helps THEM know what you are talking about, you've nailed it!

So, what IS that quintessential, "most perfect" element of which we speak? It's real-life analogies…a game-changer. One way to bridge that gap with your patients is to first verbally explain in layman's terms how and why, for example, they are experiencing pain in their heel. Then, connect these words to something that they can personally relate to, such as a real-life situation. They will walk away with a clearer understanding and be able to explain it to curious friends and family the same way.

Here is a real-life example explaining plantar fasciitis. These presentations make sense and resonate with patients. "Imagine this is your plantar fascia muscle," the DPM explains as he grabs an elastic band. "This muscle runs along the bottom of your foot, attaching your toes to your heel and forming your arch." With that, the doctor proceeds to demonstrate how the band is pulled and stretched with each step while he proceeds to explain. "When this muscle is overstretched, it can cause inflammation and pain, or a term you may have heard… 'plantar fasciitis'".

Redirecting this patient's attention to the x-ray taken, the doctor continues. "This constant pulling on the heel bone, can also result in a heel spur which you see here." The DPM circles the heel spur on the x-ray image. "While you may assume the pain is coming from this bone overgrowth, it's actually the inflammation of the plantar fascia muscle that is causing your discomfort." He snaps the elastic band "Ouch!" just for effect. The DPM uses words, simple terminology, imaging, and demonstration…verbal, visual, and bringing it to life with physical interpretation. Patients follow along. Their eyes light up, the light bulb over their head goes off, and they have it. It can best be described as an "AHA moment"! A powerful presentation.

In another scenario, a very frustrated patient presents with what he was told is gout, but how he developed this condition is confusing to him. He looks to the doctor for an explanation asking, "Why me?"

"A gout attack is a function of an accumulation of uric acid in the joints. We all have a certain amount of uric acid in the bloodstream as a function of the foods we eat and the things that we drink. Uric acid is excreted in the urine. Gout attacks occur when there is an elevated uric acid level in the blood which at a certain threshold crystallizes out of its solution and into the coolest joint in your body, which is most commonly your foot.

An analogy to think about is if you dissolve Kool-Aid, or instant iced tea in a pitcher of water. If you put the prescribed amount of crystals into the water, it dissolves into a solution, as it

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should. However, if you continue to add crystals into the water, it will oversaturate and come out of solution and build up on the bottom of the pitcher. If you only have half of the water necessary to dissolve the crystals, the normal amount of crystals cannot dissolve. The same occurs with gout in the body. Too much uric acid can lead to this phenomenon. A function of the body's difficulty eliminating the uric acid in the urine, or some degree of dehydration, can cause a lower overall fluid level in the bloodstream."

While you may choose to use a different narrative and/or analogy, the objective remains the same. Take what might be an otherwise unfamiliar medical condition, break it down using a comparison, and make it more relatable to the patient.

The bottom line: before patients can get on board with a proposed clinical treatment plan, they need to make sense of the "hows and whys" of their condition. This is made possible by the physician's ability to connect with them and explain it in a personal, meaningful way.

That is not to say that other dynamics do not play a role in a patient's overall acceptance of care. Other influencers such as a compassionate chair side manner, an open and honest approach, competence and confidence, respect, offering to collaborate with their other medical care professionals, personable communication skills, and genuine humanity all carry a great deal of persuasion. Put them all together and your clinical presentations cannot help but take on a whole new level of patient education, trust, and to that end, treatment compliance.

Topic: "Simple" Workflow Evaluation

Dear Lynn,

Is there a simple way for me to evaluate our workflow to see what systems need to be improved?

You can absolutely make significant changes in your practice while still keeping it simple, although it completely depends on what "simple" means to you. Any kind of thorough evaluation or analysis is going to require a certain amount of effort. It would be helpful to get your staff on board, make a plan, and approach this activity as a team project/goal.

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Here are six areas that you may want to explore:

1) Identify those processes you feel need to be improved.

Could phone calls be handled more effectively to drive more patients to the practice? Who is managing the schedule—your office or the patients? Are you interrupted too frequently in the treatment room? Are important messages not being received? Do lab tests occasionally get lost? Are orthotic calls being made in a timely manner? Are there charting delays or insurance errors? Do new patient calls and paperwork snafus upset patient flow and cause unnecessary delays? Are policies being overlooked or ignored; not doing what they are expected to?

2) From these identified processes, focus on the three that you feel are your most taxing systems (to start). Then list, in step-by-step detail, how they are currently being carried out.

For example, create an easy outline of a new patient call. What happens from start to finish? If you are familiar with flowcharting format and symbols, you can illustrate these steps for a more visual understanding, as long as the main focus does not shift from fixing the problem to how pretty a chart you can create.

3) Think about what can be done differently to save wasteful steps and make the process more functional?

Using the same example, what is our preferred method that these calls should be handled? What patient information should be obtained that is immediately necessary? How can we make better use of our time on the phone? How can we not waste time chatting, but still sound welcoming? What questions can/cannot be answered by the front desk? Would a Q&A script be beneficial to address some common patient questions? How can we turn a new patient call into an appointment?

4) Consider the practicality of the change.

Who will it affect and how? What are the potential challenges? Risks? Benefits? What are the associated costs—do these make sense? Is there a current staffer who could best fit this position? What additional training needs to be provided? Will this change increase flow efficiency? How can we monitor its success?

5) Try it out and get feedback.

Put the newly developed system into action; tap into staff for identifiable snags and suggested last-minute changes. Finally, survey (or just ask) patients if the changes made have improved their office visits. Make subsequent changes based on their feedback and the performance of the new system.

6) Don't stop there!

Move on to the next issue in the practice; and don't forget to celebrate your progress! **PM**

Ms. Lynn Homisak, President of SOS Healthcare Management Solutions, carries a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and was inducted into the PM Hall of Fame. She is also an Editorial Advisor for Podiatry Management Magazine and is recognized nationwide as a speaker, writer, and expert in staff and human resource management.