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Answers to Common Physician Questions and Objections

The following document highlights five common questions or objections Consultants, Account Executives and Account Managers can expect to receive from providers when those physicians first receive their satisfaction scores. The five general topics are:

- Questions concerning sample size
- Objections to the legitimacy or validity of the comparative scores in the database
- Concerns that the scores on the survey translate to a percentage and letter grade
- Questions that the scores equal patient evaluations of physicians' clinical skills
- Objections that a focus on service will hurt physician productivity

This document includes sample questions or objections for each topic, as well as sample scripting in response to those physician concerns.

Topic: Sample Size

Sample Questions:

- I see several hundred patients a year. How can 30 responses be adequate?
- What sample size does Press Ganey say is statistically significant?

Answer: First, provide physicians with some context so that they don't compare their background in the physical sciences to our social science research. Secondly, explain the difference between predictive and historical data. Finally, explain the social science standards that legitimize our research. A sample explanation might be:

"First, it's important to note that there's a difference between *predictive* and *historical* data. Correct me if I'm wrong, but when you read peer-reviewed journal articles or other medical research, you're used to seeing response rates above 80% and you need very large patient populations because you're evaluating clinical paths. You need to be reasonably certain that if you prescribe a certain treatment, your patients will have a positive outcome. That data you see on a regular basis is predictive in nature."

"Our data is not predictive. It's historical. We're not telling you what your patients will think of you. We're simply giving you feedback from your patients for a given point in time. In fact, it's very likely your data will change from period to period because you're either working toward improvement or your service is getting worse."

"With that distinction made, social science research tells us that, as long as we have 30 responses for a particular group – be it a provider, a specialty or a site – that data is stable, it falls along a normal bell-shaped distribution and the outliers aren't as likely to affect the mean. BUT, 30 is the absolute *minimum*. As you know, more data is always better, which is why we recommend a sample size of 50. That helps us shrink the standard error and be even more confident that the mean we report is your true mean."

"As long as our sampling is random – meaning, everyone has an equal chance of receiving the survey – and representative of your patient population, we don't need large patient populations to draw meaningful and valid conclusions."

Topic: Legitimacy of the MD Database

Sample Questions:

- Does the benchmarking really tell us anything if most of the physicians are within a point or two of each other?
- With double-digit standard deviations, is the benchmarking for physicians valid?

Answer: Again, it helps to provide some context in your defense of the benchmarking. Describe the competitiveness of the medical practice database in comparison to our other databases.

"That's a great question. The medical practice database *is* very negatively skewed, which means that the organizations in the database and the physicians who drive the scores are higher performers. In contrast, our inpatient and ED databases are much more spread-out and there are wider variations in the scores."

"You also need to keep in mind who is in the medical practice database. These are all highly-intelligent, highly-educated, competitive men and women. So, think back to medical school. Was there a big difference in performance between the physician who ranked 8th in the class and the physician who ranked 28th. Probably not, but the rankings were still legitimate and provided you with a good gauge of performance and direction."

"Or, put another way, think of the 10 or 12 men who take to the track in the Olympics for the 100m dash. Is the sprinter who finishes last at the Olympics a slow man? Of course not. He still would beat most of the world's population in a foot race. These are the best of the best at what they do."

"It's the same with our medical practice database. It's comprised of a self-selective group of high-performers, so we wouldn't expect big differences in mean scores. But just because the

database is comprised of high-performers doesn't mean the comparative information is invalid. Rather, it means the margin for error is much smaller."

Topic: "4" = 75% = C

Sample Questions:

- How can the data be accurate if a "4" means I get a 75%?
- My patients don't understand that if they give me a "good," then it really means I get a failing grade.

Answer: Many physicians assume that the conversion of the five-point rating scale to a 100-point scale means that we convert their scores to a percentage and corresponding letter grade. Often times, they've been misinformed by administrators. Sometimes, they draw that conclusion themselves. Whatever the case, it's important to educate and provide them with the proper interpretation of the score. A sample response to this line of questioning might be:

"It's a common misconception that a "4" equals a 75% or a "C" letter grade, but that's not true. First, we don't use percentages when we report your scores. While we convert the scores to a 100-point scale, we could have just as easily used a 50-point scale or a 20-point scale. As a result, there also aren't letter grades attached to the scores."

"It's also important to note that a "5," or 100, doesn't mean the experience was perfect. It simply means that you exceeded expectations. Likewise, a "4," or 75, doesn't mean that you're failing your patients. It means that you're meeting expectations. Nothing more, nothing less."

"Think about it from your patients' perspective. If they rate you a "4," then they know they're not giving you the very best score. They're telling you that, however small, there's some room for improvement."

Topic: Scores are Patient Evaluations of Clinical Skills

Sample Question:

- How can my patients reasonably evaluate my skills as a physician from one quick encounter?

Answer: Many physicians, because they've always received top grades, take the scores very personally. It's important to illustrate that the scores are not a critique of their clinical skills, but rather, an assessment of their customer service.

"I need to stress to you that this data isn't a critique of your clinical skills. Clinical excellence is assumed by your patients. If they didn't think you were clinically competent, they'd already be going somewhere else. It's the service element, or bedside manner, that causes patients to consider going elsewhere or staying right where they are. So, this data really serves to highlight your strengths and weaknesses in terms of providing customer service. And I'm assuming that most of you didn't receive a course in customer service in medical school. That's why you've engaged Press Ganey. We're here to help you improve that patient experience."

Topic: Issues with Productivity

Sample Objection:

- I see 2,000 patients. I'm not paid to hold hands.

Answer: When you receive this statement, it's best to answer the physician in terms of the bottom-line, because he or she is implying that they can't be productive (or profitable) and provide good service at the same time.

"I understand your need to produce, which means you need to see as many patients as possible. But it's a common misconception that good patient satisfaction scores means 30-minutes of hand-holding with each patient. That's not true. We've found that a quality, eight minute visit can *feel* like 20 minutes to the patient because he or she isn't watching the clock. If you talk with patients for just two to three minutes about their life outside of their role as a patient, and then allow them to participate in the decision-making process and ask you questions, your scores will improve."

"This is a strategic decision, as well. If you want to improve your payer mix – if you want to attract more cash and privately-insured patients – then you need to focus on service. It's the service that matters to these patients because they have options. Because they expect to receive good clinical care, if they don't receive a high level of service, then they'll find a different physician who can provide it."

Topic: Other Statistical Questions

Answer: It's important to know your limitations. If physicians ask you about p-values, standard deviation or other statistical issues, the odds are good that they're trying to sound intelligent and cast doubt on the validity of the data. A good response can be:

"That's a great question, doctor. I'm not a statistician, so rather than waste your time and insult your intelligence, I'm more than happy to connect you with one of our Ph.D.s back in South Bend. I can provide you with contact information after the meeting and get your question answered. Is that acceptable?"

Rarely does a physician actually pursue the matter further when offered the opportunity to speak with someone knowledgeable in statistics.