Improving Quality and Patient Satisfaction in Dermatology Office Practice

Many dermatologists are under pressure to improve the efficiency and effectiveness of their clinical care in an era of stagnant reimbursement and higher office expenses. In addition, dermatologists in the United States are under increased scrutiny from payers, regulators, and patients who expect uniformly high-quality service from their physicians. The presence of increasing numbers of nondermatologist health care providers marketing themselves as skin-care specialists also places increased pressure on dermatologists to demonstrate the value of their services.

Patient perceptions of quality health care are important to the physician. Patient satisfaction affects clinical outcomes, patient retention, and medical malpractice claims.1 Highly satisfied patients have improved outcomes in the management of chronic disease vs those less satisfied.1,2 This reflects increased compliance among satisfied patients. Furthermore, dissatisfied patients are 4 times more likely to seek care elsewhere within 6 months.1,3 Finally, an inverse correlation has been reported for patient satisfaction rates and medical malpractice claims.1,4

Quality improvement (QI) systems analyze processes to improve the quality of care, productivity, and efficiency.5 Hospitals and long-term care centers have had QI committees in place for years as a requirement for accreditation. Despite the advantages of self-assessment, many dermatologists in private practice have not implemented a system to analyze and evaluate quality of care rendered in their practice. Such a system could include quarterly meetings attended by not only the physician but also by representatives from the nursing, technical, and administrative staff. Establishing a small QI committee can also stimulate useful QI initiatives. Implementing QI systems based on information from a sampling of patients has been difficult because of their cost and inconvenience. An Internet-based system offers dermatologists a convenient and inexpensive method to obtain patient satisfaction information.

The DrScore Web site (http://www.DrScore.com; Medical Quality Enhancement Corporation, Winston-Salem, North Carolina) provides an online patient satisfaction survey designed to respond to the QI needs of dermatologists by providing data to individual dermatologists to help them improve quality of care and patient perceptions of physician quality. A dermatologist could use these data to design effective strategies to improve efficiency of dermatologic care and in so doing might fulfill the requirements of the American Board of Dermatology (ABD) Dermatology Maintenance of Certification (DMOC) program that mandates practicing dermatologists to evaluate their clinical performance.8 Dermatologists need only provide evidence of having participated in such a program; the data received from patients through this system will not be reviewed by the ABD.8

Methods. Raw data without patient identifiers from 394 dermatology office visits were obtained from DrScore patient satisfaction surveys from July 2004 to October 2005. The dermatologists evaluated in the surveys were from 35 states in the United States; they subscribed to the DrScore service and received patient satisfaction report cards. Over 90% of the physicians were in office-based practices, with just a few residents, university-based teachers, and dermatology administrators. No payments were made to DrScore for use of the data.

The preliminary data were assessed with a focus on judging the value to the practicing dermatologist and establishing benchmarks that might be used to quantify patient satisfaction with regard to quality and value parameters. Patient satisfaction was measured on a scale ranging from 0 to 10. The survey asked patients to rate how well the physician performed the following aspects of care: answered patient questions; examined patient thoroughly; included the patient in decision making; provided clear instructions; delivered test results in a timely manner; spent time with the patient; provided successful treatment; and followed up with the patient. Patients were asked to identify if anything could be better in 7 areas: (1) staff performance, (2) record keeping, (3) parking, (4) wait time, (5) making and keeping appointments, (6) physician’s care, and (7) ability to communicate information. Finally, the survey assigned an overall physician score.

Results. High satisfaction, defined as a score of 8 or higher on the 10-point scale, was reported for timely test results (82%), patient inclusion in decision making (76%), clear instructions (75%), and how well the physician answered questions (75%). The most common areas in need of improvement, defined as a score of 5 or lower, were problem follow-up (22%), treatment success (20%), and time spent with patient (20%). The overall parameter “perceived quality of dermatologist care” received scores of 9 or 10 on 58% to 74% of the surveys (Table).

From the “additional office parameters” section of the survey, the most common opportunity for improvement reported was “not enough time spent with the doctor.” This was noted by 27% of patients. Other potential
areas for improvement were office staff issues and wait times for an appointment.

Mean overall physician scores tended to be very high: 53% of the overall scores were 10, and 76% of physicians were ranked with an overall score of 8 or higher. Thus, most patients were highly satisfied with the level of care received from their dermatologist (Figure).

Comment. Overall, most patients surveyed were pleased with the care rendered by their dermatologists in this sample from the United States. Documenting patient perception of care provided by dermatologists is one of the primary values of this tool. In addition, patient satisfaction surveys are helpful for identifying areas of weakness that can be improved. Though individual dermatologists using the system will identify their own areas of weakness, the most common issues identified include increasing time spent with patients, problems with follow-up, and lack of treatment success. The latter issue may be related to communication problems associated with setting expectations as much as a sign of choosing therapies poorly.

Implementation of such a quality assurance tool in one’s office has several benefits. By using the system to provide and reward positive feedback, it may serve to help motivate staff. Survey results should regularly be reviewed with office personnel. Involving employees in the development of policy changes in response to patients’ documented responses will improve service. Teams of individuals with full understanding of the workplace can ultimately result in improved quality of care, productivity, and patient satisfaction.

The system can also be used to generate constructive criticism during employee reviews for areas of potential improvement, including interaction with office personnel. The physician might be able to use favorable survey results as a tool when negotiating payer rates. Also, data reports collected from such a system might serve as documentation for compliance with the upcoming DMOC requirements.

Finally, in an era of nondermatologist physicians and nonphysicians offering dermatologic care, it is critical that our patients see value in seeking dermatologist care. We must maximize patient satisfaction to maintain our roles as the primary providers of dermatologic care. The survival of the specialty of dermatology relies on the ability of dermatologists to demonstrate their “superior ability to provide high quality of care compared with other practitioners with less training and experience.”

Negative aspects of such a system must also be considered. Some physicians might find it demeaning to review negative comments about their office and staff. Also, surveys of this type might not reflect the views of a representative cross section of a physician’s patients. Dissatisfied patients might be more likely to complete the survey than satisfied patients. Furthermore, a disgruntled patient might attempt to bypass controls and complete more than 1 survey, which could potentially alter the overall satisfaction data. While the anonymous nature of such a system potentially allows patients to complete multiple surveys, the Web-based interface has mechanisms in place to detect multiple submissions.

Given the high marks dermatologists have received so far, patient completion of multiple surveys does not appear to be a common problem. However, the online nature of the survey might select for patients who are technologically savvy. Practitioners could eliminate this bias by having a limited number of printed surveys available.

More sinister problems might arise in a competitive market. A physician could manipulate the data in his or...
her favor by having staff members rather than patients complete surveys with uniformly high marks. Given the high levels of patient satisfaction currently observed, one would hope that this would be unnecessary. Certainly this type of data manipulation would not be motivated by the ABD, whose DMOC program requires participation in quality assurance programs; however, the ABD does not review data from individual dermatologists. In addition, an important question currently not included in the DrScore survey is “How likely would you be to recommend this practice and/or physician to others?” The addition of this question would likely make the tool even more useful to the subscriber.

A multitude of factors affect patient perception of quality health care. Some dermatologists might find it difficult to accept criticism of errors made by office staff. Nonetheless, physicians are ultimately held accountable by patients for the actions of new and inexperienced office staff members. The physician is the “ship’s captain” and is ultimately responsible for the patient’s satisfaction with the entire office visit. In a recent study focusing on the relationship between patient wait times and patient satisfaction, Anderson et al. reported that the time spent with the physician is of utmost importance to the patient and was the most powerful predictor of patient satisfaction, even greater than wait time. Satisfaction surveys providing insight into patient perceptions of time spent with the dermatologist would likely prove to be a valuable tool for any practicing dermatologist.

The cost of such a system will certainly be of interest to those implementing a quality improvement assessment program. The DrScore service costs $149.00 for the first year of membership and includes 4 quarterly reports. The Internet-based patient satisfaction surveys are cost-effective, and there is no limit to the number of surveys that can be conducted per medical office. The American Academy of Dermatology might also develop quality assurance tools designed to assess patient satisfaction and meet DMOC requirements for peer performance review similar to the systems under development by other specialty boards.

Conclusions. The potential for identifying valuable information with a quality assurance tool such as the online service used here must be weighed against its cost. The minimal financial cost and small investment in time required to use this system suggests that many dermatologists will find that the benefits outweigh costs.

Dermatologists in the United States continue to strive toward the ultimate goal of providing the highest quality of care. One measure of quality care remains the satisfied patient. Though curing and controlling disease is the most critical component of our work, the satisfied patient may be the key to successful outcomes through improved compliance, practice growth, and reduced liability. We believe that both physicians and patients benefit when physicians receive feedback on their patients’ satisfaction.

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Enhancing Patient Motivation to Reduce UV Risk Behaviors: Assessing the Interest and Willingness of Dermatologists to Try a Different Approach

Patients who continue to engage in high-risk UV behaviors despite being informed of the risk of developing skin cancers can be a source of frustration for many dermatologists. Typically, dermatologists attempt to educate and advise their patients about the dangers of UV exposure and the importance of using protective strategies, particularly if the patient has indicators of risk for developing skin cancer. Unfortunately, a substantial number of patients ignore this information and continue to engage in high-risk UV exposure, resulting in dermatologists feeling a sense of inadequacy in changing patients’ UV behaviors.

Physicians generally do not receive formal instruction related to behavioral change during their training and often provide educational information and direct advice to their patients hoping to promote behavior change. However, research from numerous health-related domains has routinely demonstrated that such educational approaches are not as efficacious as alternative approaches that enhance individuals’ motivation to change, particularly in modifying resistant behaviors such as smoking, alcohol abuse, exercise, and eating and/or dieting.

Arguably, UV exposure could be classified as a resistant behavior because a substantial percentage of individuals engage in intentional UV exposure despite known risks, and a significant number of individuals continue to intentionally tan even after being treated for skin cancer.

Efficacious behavioral interventions based on motivational interviewing (MI) have been developed by psychologists to be used in the context of a 50-minute session, which is much longer than physicians typically spend with their patients. Over the years, these interventions have been dramatically condensed and modified to fo-