9 Mistakes You Don't Want the Patient Care Coordinator to Make

By Karen Zupko

Looking to build the skills of a newly hired Patient Care Coordinator (PCC)? Need an objective approach for showing the PCC how to polish her professionalism? Want to help your PCC go from good to *great?*

This article offers some options.

It covers the most common mistakes we observe PCCs making while interacting with patients. They are so common, in fact, that even PCCs themselves recognize them. When we cover this topic in our aesthetic practice workshops, the discussion is a lively learning experience for everyone.

Here are the nine mistakes you don't want the PCC to make.

1. Poor training and orientation.

Lack of training and professional development is a significant deficiency in many offices we visit. It's often due to a combination of the PCC not asking, and the surgeon not offering.

A good remedy is to create a checklist of training tasks *(See Table 1.)*, assign completion dates, and follow up with the PCC to ensure training is complete. Although the first ninety days are critical to getting a PCC up to speed, development should be ongoing. Encourage the PCC to read industry publications, attend Webinars, register for business classes, and attend workshops for aesthetic practices.

A lack of training and development is the most common staff deficiency we find in our work with aesthetic practices. Develop a list of training tasks and schedule target dates for completing them.

Table 1. Sample Patient Coordinator Training Plan

Training Task	Target Date for Completion	Date Completed
1. Thoroughly review the practice's Web site and all social media channels.		
2. Read all emails/e-newsletters sent to patients over the past year.		
3. Read patient ratings and comments on all online rating sites.		
4. Review all print and marketing material that is provided to the patient—from brochures and welcome letters to price quotes and pre-op packets.		
5. Read assigned ASAPS and ASPS materials in print and on the web.		
6. Review Dr. Surgeon's curriculum vitae (CV).		
7. Shadow 10 aesthetic consultations. Summarize key learnings and discuss them with the team.		
8. Role-play the consult process with the staff.		
9. Schedule vendor training for the practice management system.		
10. Conduct mystery calls to five local aesthetic surgery practices and summarize key learnings.		
11. Observe surgery and postop care with Dr. Surgeon.		
12. Register for a community college course in business or marketing.		

2. Failing to build rapport with the patient.

This common side effect occurs when the patient is "processed through the system." We frequently observe it when we conduct mystery shopping for clients. For example: We arrive at check-in, are dutifully handed paperwork, and pleasantly asked to sit and wait. We sit and wait beyond the appointment time and nobody bothers to tell us why. The surgeon does the exam and consultation and doesn't ask us anything about us beyond the procedure interest. And when we meet with the PCC, she only seems interested in providing us pricing—not in knowing who we are.

When you "process" patients like this, it feels to them as if they've just visited the internist or the gynecologist. An aesthetic consultation should be an entirely different experience than a regular or routine visit. You know this. So create a patient experience that achieves it.

A big part of this is learning how to build rapport. For this, we recommend the FORD Method—a framework that helps tease out personal information in four areas, and use it to enrich patient conversations.

FORD is an acronym for: **F**amily, **O**ccupation, **R**ecreation, and **D**reams. The method's concept is simple: the more you know about the patient in these four areas, and the better you are about using that information in patient communications, the faster and deeper you can take the relationship. And the deeper the relationship, the more valued your practice is to the patient, creating stronger connections, faster scheduling decisions, and increased loyalty.

Train your staff to review the patient's paperwork and ask questions about one or more of the "FORD points." If the patient is a realtor, you might inquire, "How is the local market these days? What's trending as an up-and-coming neighborhood?" You can also pick up clues from patient questions. To the patient who asks, "How long will I have to stop running? I just got a lottery entry for the New York Marathon," you could respond, "What is it like to train for a marathon? How do you find the time?" Seemingly small questions like these can have a big impact on building rapport and a sense of sincerity.

3. Being unprepared or disorganized during the patient meeting.

A PCC who appears disorganized will not win points with busy patients who are often already anxious. Patients took time off from work or their hectic family schedule to come to your office. They have likely paid a

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Try morning "huddles"—quick, stand-up meetings during which the care team and PCC review who is coming and what everyone should know about them. Several of our clients have told us that this one change in the daily workflow has made a significant improvement in patient loyalty, referrals, and scheduled surgeries.

consultation fee. They deserve to speak with someone who is prepared and focused on their needs. Anything less is not the five star service I'm sure you aspire to deliver.

The key to being prepared is knowing who is coming that day and having a plan for how the team will leverage relationships and manage hand-offs to give the patient the best possible experience. Try morning "huddles"—quick, stand-up meetings during which the care team and PCC review who is coming and what everyone should know about them. Several of our clients have told us that this one change in the daily workflow has made a significant improvement in patient loyalty, referrals, and scheduled surgeries. A surgeon in the South told me that huddles have completely changed his practice for the better.

During the huddle, make a plan for key conversations. Notes are most useful if built around FORD. For instance, if the patient being seen at 10:00am is the sister of a loyal patient, discuss how you will acknowledge this and who will do it. Or, perhaps you'll be seeing three returning patients, and two are coming in for second consults. Review the notes from these patients' first visits to identify whether there was a special event the patient mentioned that might impact a surgery date. Or comments about family or job that would make the patient feel remembered.

4. Leading with the quote instead of a question.

This is one of the most common of the common mistakes, and one of the easiest to fix. At issue: After introducing herself, the PCC goes full speed ahead into reading the patient the quote. Often this is a robotic recitation of procedures, cost, what's included, cancellation and refund policies. The PCC does not come up for air to let patients ask a question, or she speaks so fast that the patient doesn't absorb all the information. It's a didactic instead of an interactive experience.

Here's a simple change: after introducing herself, the PCC can open a conversation by asking the patient a question. Notice that the following are all open-ended.

- So, Janet, tell me what you learned during your consult...
- Those shoes (or blouse, or jewelry) are fabulous. Give me the backstory!
- I'm curious, Betty, how long have you been thinking about making this change?

You have to admit, these are a lot more interesting than, "So, how was your consultation with Dr. Smart?" To which, of course, most patients are going to respond with: "Fine." That answer tells you nothing.

Ask the PCC to create a repertoire of three or four questions that she can mix and match appropriately with patients throughout the day. Coach her to understand that a little dialogue is essential before reviewing the quote—and that the quote review can be a conversation instead of a soliloquy. The PCC can also give the patient permission to slow things down, which gives the decision-making power to the patient. Example: "Mrs. Jones, I want you to stop me if I am going too fast, or if there is something you'd like me to repeat or clarify..." In some cases and with certain patients, it's effective to let the patient read the quote and ask the PCC to highlight key points.

5. Talking too much and listening too little.

Some PCCs confuse telling with selling. Effective sales people ask thoughtful, open-ended questions. The right questions allow patients to open up and express their real needs. For instance:

- Who supports you in your decision to have a breast reduction?
- How long have you been thinking about having a rhinoplasty?
- I see you have a three daughters. If you told them you are contemplating a facelift, I'm curious what you think their reactions would be...
- Tell me about any special events coming up on your calendar.
- As you think about scheduling your facelift...what is your ideal timeframe?
- How will having surgery fit into your schedule?

6. Interrupting patients when they are telling their story.

My Midwest upbringing taught me that interrupting others was rude. Not everyone grows up with this same teaching, so your staff may need a little coaching here.

Patients come to the point of considering aesthetic surgery from so many places. The mom who wants her body back after raising three children. The bank professional whose life has dramatically changed after he dropped 130 pounds. It's essential the PCC listen to the patient's story completely, nodding and showing other signs of empathy.

Interrupting also occurs when the patient is expressing an objection. Whether that is about the fee, the plan, or the sports bra they want to eliminate from the quote because they can get it at Target. PCCs are often quick to

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jump in with a defensive or "corrective" response. (Perhaps, according to the practice "script.") But any good sales trainer will tell you—listen until people have had their full say before responding. Let them vent. Sometimes, that's all they really wanted to do in the first place. Once they've gotten things off their chest, you're positioned for negotiation or decision-making.

7. Taking "no" personally.

When a patient says, "I'm not comfortable scheduling here" it is not a rejection of the PCC, in most cases. However, I've watched some PCCs visibly bristle when the patient decides not to schedule with "their" doctor.

The mature PCC understands that when a patient passes on scheduling, it's not a personal rejection on her or the surgeon. You don't know what the patient heard through the exam room wall. You don't know if the doctor wasn't on his or her "A" game that day. Help your PCC understand that not all patients will schedule. It's not a personal rejection. Learning to listen and use feedback is important to not making the same mistake in the future.

8. Getting defensive when asked pricing questions.

This goes along with taking "no" personally. What this means is that the patient doesn't value the proposition in your proposal. The worst response to patients saying "the fee is too high" is for the PCC to respond "But Dr. Smart is board-certified!" The patient isn't disputing the doctor's credentials. It's the fee they are objecting to! If you don't explain the value of a board-certified plastic surgeon, for example, the patient won't intuit it. Or, the patient might be comparing an apple with a pear; you are proposing an augmentation with a mini lift and the patient got another quote for just an augmentation. She doesn't understand the difference. It's the PCCs job to explain it calmly and rationally. One way to do this is to ask the patient if she is comfortable sharing other quotes so the can highlight what might be the differences.

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9. Not scheduling the post-consult follow-up.

A certain percentage of patients will not schedule surgery on the same day as their first consultation. That's fine. And expected. They legitimately need "to think about it," talk with their spouse, or organize their finances.

Once they leave your office, patients get busy. Maybe their kid graduated from high school. Or work demands got the best of them. Or they went on vacation. Too many practices underestimate patient inertia. Yet, follow up is essential to ongoing relationship building, even with the busiest of patients. For many PCCs, reaching out to patients several weeks after the consult is uncomfortable. They aren't sure what to say, and many tell us it feels like a "cold call." So here's the key to making it warm:

Ask all patients who choose not to schedule on the day of the consult, "When can we chat about your decision to schedule?" And when the patient responds with something like, "two weeks would be great," the PCC asks, "What time of day is most convenient? Do you prefer a text or should I contact you on your cell phone? What works for you? Closing the patient meeting by asking these few questions will reduce PCC anxiety when following up, turn a cold follow up into a warm conversation, and increase the likelihood the patient will be responsive.

Review these nine mistakes with your PCC and prioritize the ones that you agree are the biggest issues. Don't try to address all of them at once. Choose one or two, make a plan, and work your plan for a few weeks or a month to smooth out the bugs. Evaluate how the change impacts key metrics such as scheduling volumes and the patient acceptance rate. With success under your belt, it'll be easier to move on making other changes.

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