ROLE OF PATIENT SATISFACTION SURVEYS

(Compiled by Deep Banerjee, Marketingpundit.com)

Measurement of patient satisfaction stands poised to play an increasingly important role in the growing push toward accountability among health care providers. Overshadowed by measures of clinical processes and outcomes in the quality of care equation, patient satisfaction measurement has traditionally been relegated to service improvement efforts by hospitals and larger physician practices, and to fulfilling accreditation requirements of health plans, while some plans tie satisfaction scores to financial incentives as a portion of their calculation of payment bonus to primary care physicians with capitation contracts.

As physicians and hospitals experience growing pressure to increase the quality of their outcomes, enhance the safety of their patients and lower the cost of their care, analysts expect greater attention and scrutiny to be given to the accountability function of patient satisfaction scores, and to ways in which patient satisfaction measurement can be further integrated into an overall measure of clinical quality.

Variation in measurement tools, however, is an obstacle to making patient satisfaction a reliable part of the quality equation. Data on patient satisfaction is currently collected by various entities, for different purposes and at different levels in the health care system - including health plans, hospitals and physician practices. Only recently have efforts begun to bring uniformity to patient satisfaction measurement for hospitals, as part of a hospital report card initiative launched by the Department of Health and Human Services.

Even if redundancy and variation of patient satisfaction measurement can be minimized to permit meaningful comparisons across providers, questions remain as to how patient satisfaction surveys can be modified to fulfill an expanded role of quality of care measurement, whether it is even appropriate to consider patient satisfaction as a valid clinical quality indicator, what weight patient satisfaction should be given in the context of other quality of care measures, and what impact its expanded use will have on physicians' practice and on malpractice liability.

Hospital Use

Perhaps the largest context in which patient satisfaction is currently measured involves hospitals using patient surveys to assess and improve their "hotel-motel" functions and do a better service job to maintain a competitive posture in their markets.

Hospital industry's leading independent vendors of patient satisfaction measurement and improvement services uses patient discharge information to select a sample of recipients who receive mailed satisfaction surveys. Core surveys of agencies are designed by focus groups of industry experts who develop lists of topics important to various aspects of health care, which are then tested and refined in test surveys. As high as 50 surveys can be designed for various health care contexts, including general inpatient, pediatrics, emergency department, outpatient medical practice, ambulatory care, behavioral care, long term care and home health care. The majority of surveys use a five-point scale of responses ranging from "very poor" to "very good."

Customize surveys are carried out to match the specific services offered by a hospital or clinic. , Satisfaction survey firms have a consultant division that keeps abreast of any changes in the medical industry that might warrant survey alterations. A typical client adds four or five

customized questions to the 40 odd standard questions on inpatient survey.

Survey data allows clients to compare their own satisfaction scores to peer groups, e.g., hospitals with the same bed volume, to benchmark their scores. Benchmarking may not be valid if comparisons are made to hospitals who use surveys of other vendors or different survey methods, he adds.

Patient satisfaction data regarding inpatient and ambulatory care play a significant role in the strategy and tactics a hospital uses in delivering patient services. In a competitive health care environment, patients want and expect better health care services than they did in the past, and medical centers are concerned about maintaining their overall image.

Often agencies carry out syndicated patient satisfaction surveys at frequent intervals and the consequent results by hospital units help in benchmarking best practices across hospitals within the health system. The data is used to make adjustments in areas such as efficiency of the admissions process, managing admission of patients to a clinical unit or bed, and maintaining sensitivity to the needs of patients.

In response to patient satisfaction data, hospitals change the way its telephone system interfaces with patients, implements a service excellence program in its clinical practices devoted to increasing the awareness of office staff to the needs and expectations of patients, focusing on issues such as improving telephone etiquette, reducing delays and scheduling appointments efficiently.

The very process of measuring patient satisfaction reinforces an ethos of quality by alerting patients that physicians are held accountable, and showing physicians that patients are pleased with the quality of care they receive. Physician ratings tend to be the highest scores of any category on surveys which continues to reinforce for physicians the positive relationships they foster with patients, who in turn encourage other patients to seek care at particular hospitals.

Physician Use

Patient satisfaction measurement also takes place at the level of physician office practice settings. Physicians offers for purchase satisfaction questionnaires and procedural guidance on survey sampling and distribution techniques. Patient satisfaction is eliciting more questions from medical practices than ever before and notes that competition is driving an interest among physician groups to satisfy their patients and address the requirements of purchasers and accrediting agencies.

Practices use the surveys to retain patient populations and attract more market share, to verify patient satisfaction results collected by managed care organizations, to help negotiate third-party contracts and to assess and measure specific initiatives.

Enthusiasm for patient satisfaction measurement may not be widespread across specialties and is a reflection of personality difference between physicians in surgical and medical specialties.

Practices that do audit patient perceptions can acquire customized surveys to identify issues specific to the nuances of their practice, to identify services that they may need to add to the

practice, to reinforce areas of excellent performance and to substantiate suspected problems.

A radiology group, for example, discovered through surveys that patients found MRI scanners to be uncomfortably noisy and claustrophobic, and the practice developed ways to alleviate those effects. Surveys in other practices revealed problems such as a pattern of lateness to the office by a particular physician, inefficiency and rudeness of staff and accessibility problems in the front office.

Patient satisfaction data are also valuable for staff training, morale-building and creative marketing. Survey results can be creatively displayed through posters, banners, merchandising. The creative display items elicit questions by curious patients that give physicians and staff the opportunity to answer enthusiastically. Other practices have designed patient education materials on the basis of questions patients repeatedly asked in written survey responses.

Future Expansion and Constraints

Given the push toward increased provider accountability and health care quality improvement initiatives, the attention and weight given to patient satisfaction is going to increase.

Satisfaction data represents real events that transpire between providers and patients. It needs to be seen as equivalent to clinical indicators as a parameter of quality of care. The patient is the final arbiter of what the experience of care has been. It is said that, "If you do not pay attention to it at some level, you will not understand how your processes can be improved so that the patient can walk away with an experience that is multidimensionally okay."

Satisfaction is related to the overall effectiveness of communication between physician and patient which is necessary for achieving good outcomes, while ineffective communication can lead to poor quality. Satisfying the patient and addressing their concerns is an outcome in and of itself. The patient is the best judge of whether their needs are being met.

The changing ethos of medicine has led to an increased sensitivity to patient satisfaction. Patients as persons, and not just as bodies that bear pathology, is an idea whose time is here. There is no doubt that 'patient as person' is the dominant model in most medical institutions.

Six characteristics of quality health care: it is safe, equitable, evidence-based, timely, efficient and patient-centered. The latter three goals are directly influenced by patient satisfaction. Hospital surveys have made physicians much more aware of patients' expectations of service quality as a separate component of quality of care.

An increased focus on enhancing relationships with patients can result in a reduction in medical errors to the extent that it makes patients more comfortable asking physicians questions about their medications and treatment. As the patient population ages and presents providers with more chronic aliments, better provider - patient relationships will lead to better self-care by patients.

It is also believed that more satisfied patients are less likely to file medical malpractice lawsuits.

Lack of comparability of patient satisfaction data, however, remains an obstacle to its expanded use. Measured by different entities, for different purposes, using different instruments, patient satisfaction data is far from uniform.

Some hospitals also adapt the survey results for use in assessing individual physician practices.

Even if the data is made uniform, hospital surveys provide a minimal degree of feedback to physicians about service performance, except in the rare case that a patient specifically mentions a physician by name in the comments section of the survey. Efforts have recently begun to increase such feedback, as some hospitals want surveys to be designed to target improvement efforts with particular units in the hospital, such as cardiovascular and pulmonary disease.

The biggest single methodological obstacle to expanding the use of surveys to targeted groups of patients is the ability to collect a large enough sample from each group to yield valid results. Data must also be collected monthly or quarterly to avoid making generalizations based on annual snapshots.

Survey expansion also raises the question whether patient satisfaction measurement should broaden its focus beyond quality of service and begin to measure perceptions of clinical outcomes. Some believe that patient surveys should add more specific questions about clinical quality to open a new window on provider care practices and further drive quality improvement, while others see fundamental barriers to integrating perceptions of service and clinical quality.

While satisfaction measurement is being used primarily to monitor and improve service excellence, some hospitals are beginning to ask more sophisticated, clinically-oriented patient satisfaction questions, such as if a person felt safe during hospitalizations and if they observed a medical error occur. More patients will be quizzed about their concerns in these areas.

As patients become more sophisticated in their understanding of provider report cards, outcomes and complications rates, their perceptions of clinical quality should increasingly become part of the evaluation and satisfaction ratings.

Some satisfaction survey agencies plan to include more clinically-specific questions in future satisfaction surveys. While most clinical quality indicator information can be extracted from claims data, there are certain aspects of care for which there is no claim, such as how much effort is made by physicians to talk about smoking cessation. After it collects baseline data on the new clinically-specific questions, agencies may incorporate physician scores on the new items into their QIPS bonus calculation.

It is believed that there is going to be some movement in the industry toward asking patients more direct questions about the perceived level of the quality of care delivered, such as whether they were given the wrong medicine, whether the provider made the diagnosis accurately, and whether the patient got better. But such a trend has limitations. Patient perception data about clinical processes and outcomes may lack validity, and not many tools currently exist to measure what is going on inside a hospital or a physician's office.

Patient satisfaction measurement is best kept to the quality of service side rather than become integrated with quality of care issues.

Preliminary research on the relationship between perceptions of care quality and actual outcomes highlights the difficulty of integrating the two in a patient survey. A study noted that emergency department patients who waited more than an hour for treatment rated the thoroughness of their exam as very good or excellent far less frequently than did patients who waited 15 minutes or less. While longer waiting times increase patient frustration, it was unknown whether large differences in waiting time reflected actual differences in clinical quality. Patient perceptions of emergency department care quality were also much lower than perceptions of care quality at other ambulatory care providers, even for patients with similar waiting times.

The perfect health care delivery is a perfect outcome and a perfectly happy patient.