We Can Improve the Patient Experience!

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The Centers for Medicare and Medicaid Services Hospital Value-Based Purchasing (VBP) Program enacted by the Patient Protection and Affordable Care Act started in October 2012 and is very important for all hospitals and hospitalists, as 1% of each hospital’s Medicare payments are now tied to its performance on VBP metrics. For FY2013, the hospital VBP payments will be based on two components: 1) 70% will be based on the clinical process of care domain (i.e. whether patients with acute myocardial infarction, congestive heart failure, pneumonia, and certain surgical outcomes received recommended treatment), and 2) 30% will be based on the patient experience of care domain. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is the basis of the patient experience of care domain.

The HCAHPS survey is the first national publically reported survey of patients’ perspectives of hospital care. HCAHPS is a 27-item survey instrument sent to a random sample of adult inpatients contacted between 48 hours and six weeks of discharge. Ten HCAHPS measures (six summary measures, two individual items, and two global items) are reported publically on the Hospital Compare website for each participating hospital. The six composites summarize how well nurses and doctors communicate with patients, how responsive hospital staff are to patients’ needs, how well hospital staff help patients manage pain, how well staff communicate with patients about medicines, and whether key information is provided at discharge. The two individual items address the cleanliness and quietness of patients’ rooms, while the two global items report patients’ overall rating of the hospital and whether they would recommend the hospital to family and friends.

Patient satisfaction is complex, and what is being measured is a combination of patients’ expectations before the visit, patients’ experience at the visit, and the extent to which patients experience resolution of the symptoms that led to the visit. This is a departure from measures of health care quality that have traditionally focused on standardization (e.g. trauma protocols, DVT prophylaxis, aspirin for acute myocardial infarction). Regarding satisfaction, less satisfied patients tend to be younger, of lower socioeconomic status, sicker (i.e. having two or more chronic illnesses vs. one), and more likely to receive care at safety-net hospitals.

Additionally, studies have shown that high patient satisfaction is not necessarily associated with better patient outcomes. Covinsky et al. found that patients with similar health status at discharge had similar levels of patient satisfaction regardless of whether that discharge health represented stable health, improvement, or a decline in health. Also, the survey tool itself is only as reliable as the number of surveys that are returned. Sitzia analyzed 195 studies of patient satisfaction data and found that only 6% of surveys reported content validity and criterion or construct validity and reliability. More importantly, Ed Piper, MD, president and chief executive officer of Onslow Memorial Hospital, notes, “A fallacy in the patient satisfaction survey opinion movement is the assumption that patients are always rational.” Nonetheless, these are tools that all physicians are measured by, and we are already being “graded” by our patients.

How Can Hospitalists be More Patient-centered?

Physicians need to take the time and effort to elicit patients’ expectations. Also, physicians should listen to patients’ concerns and ideas without interruption for a few minutes. This gives the sense that the physician has taken the problem seriously and respects the patient as a person. Communicating regularly with the patient, family, and primary care physician will add respect to the hospitalist. Talking with a patient or family should be a top priority rather than an afterthought, as reflected by statements such as “I’m busy seeing other patients right now” or “I’m off to another meeting.”

Physicians and nurses should round together. The nurse will then know the plan for the day and can reinforce physician instructions. In addition, the nurse will feel more empowered as part of the team and can directly relay concerns and comments to the physician without having to page the physician about it later. Small steps, such as distributing business cards and brochures with pictures of attending physicians, giving patients a copy of their discharge summary/med list, implementing a post-discharge follow-up call, and trying to ensure continuity in the hospitalist schedule, can help improve patient satisfaction. Some hospitalist groups have boosted physician communication scores by publically sharing HC-
AHS performance scores among their groups, implementing incentive compensation for hospitalists based on patient satisfaction scores, and developing patient courtesy training programs for all staff.9

**A Worry**

In January 2013, Forbes editor Counsel Kai Falkenberg wrote, “Many doctors, in order to get higher ratings (and a higher salary), over prescribe and over test, just to ‘satisfy’ patients, who probably aren’t qualified to judge their care.” And there is a financial cost, as flawed survey methods and the decisions they induce, produce billions more in waste. It’s a case of good intentions gone badly awry—and it’s only getting worse.”11 Each hospital is spending thousands to hundreds of thousands of dollars for survey tools and consultants to improve “satisfaction” scores. Maybe we should focus on spending more time with our patients.

**References**

2. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73146