

# Virtual Mentor

American Medical Association Journal of Ethics  
February 2013, Volume 15, Number 2: 125-130.

## BANDER ESSAY CONTEST

### 2011 Runner-Up Essay

#### Secret Shopper Evaluations: Quality Improvement or Economic Profiling?

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#### Scenario

Delta Health was one of three large health insurers that shared a Midwest multistate market. Recently all individual and group practices and clinics that were among Delta's preferred provider organizations (PPOs) received letters from the company informing them that Delta was about to perform a quality audit on some providers, in the hope that the objectively acquired and reported information would help the physicians maintain or improve the quality of care. Delta employees would be calling to schedule appointments and reporting on the ease of getting a timely appointment, the helpfulness of the telephone and office staff, the physician's attentiveness and response to their reasons for the visit, and the treatment recommendations. The results concerning a physician or clinic would be shared with that physician or clinic only.

Reaction to the Delta Health letter at one PPO, Mid-West Internal Medicine Clinic, was typical. At a specially called meeting, 12 of the clinic's 15 physicians met to discuss what steps they should take to prepare for Delta audits if, indeed, they were among the "providers" visited.

"This is a secret shopper attack," said the first speaker, "and we're not Wal-Mart, and our patients aren't customers. We have difficulty seeing everyone who really needs care in a timely manner. Now that patient is going to have to wait while we see a secret shopper who's not even sick. It makes no sense."

"I'm not worried in the least," said a second physician. "It's a one-time thing. They're not going to send these fake patients in week after week. And we could get some observations that would really help. I don't have a clue what patients expect when they first walk into the waiting room."

But others feared that what Delta Health called "information to help maintain or improve quality care" was really going to be economic profiling. A physician whose husband had been getting treated at the faculty practice organization associated with an academic health center in a neighboring state said that Delta had recently dropped that organization as one of its PPOs.

#### Commentary

In the mid-80s, legislation allowing insurers to contract selectively with different providers at different reimbursement rates provided a starting ground for the development of preferred provider organizations (PPOs) [1]. Generally, the term PPO refers to a third-party payer system that contracts certain providers for patient services on a discounted fee-for-service basis. Patients are encouraged to select these “preferred providers” with economic incentives including broader coverage, and in-network providers gain a larger patient base in return for their discounted services [1]. Unlike health maintenance organization (HMO) coverage, PPO patients retain the ability to go out-of-network for care. Although patients are responsible for most of the costs in such situations, there is usually a yearly limit on out-of-pocket payments that allows patients who experience severe chronic conditions to access long-term out-of-network specialty care without prohibitive costs. PPOs have made a huge leap in the past two decades as a model for health insurance [2]: In 1988, PPOs represented 11 percent of employer-provided health care; by 2005, 85 percent of large employers offered at least one PPO option [3].

Surveys have revealed that a primary motivation for patients’ selection PPOs is the choice of doctors, which is exchanged for a small reduction in the comprehensiveness of coverage [2, 3]. PPOs not only offer the flexible option of out-of-network care, they typically have larger provider networks than HMOs [2]. Having numerous in-network and a vast number of out-of-network physicians to select from promotes patient choice and a competitive environment, and this competitive environment can be a major incentive for providers to maintain quality care. A 2010 study performed to determine the effects of hospital competition on patient-perceived quality of care revealed that the addition of competition to a health care market can lead to an unusual pair of effects, reduced fees and improved patient-perceived quality of care, both results of efforts to attract more patients. If price is not regulated and hospitals reduce fees, quality of care can drop because the hospital reduces care to match the lower payment. However, when the patient pays a fixed price regardless of provider, as with a PPO, providers are forced to distinguish themselves in non-price domains and quality of care rises [4].

This finding is relevant to the situation at hand, because it demonstrates a clear incentive for PPO providers to maintain high-quality care. If a clinic is competing with several others in the area, all of which are considered “preferred” and cost the patient the same, customer service, patient satisfaction, and quality of care are all expected to increase as the clinics attempt to distinguish themselves from their competitors. Furthermore, although out-of-network providers exact greater cost-sharing from patients, economic models have shown they are increasingly preferred by patients whose diseases become more chronic or severe and who have to spend more time at health care facilities [2]. Therefore, in-network providers must also compete in the general provider market and can hardly become lax about the quality of care if they expect to maintain patient inflow.

This competition inherent in PPO networks means that internal and external competition should help maintain basic quality standards, and Delta Health has no

need for “secret shopper” visits to maintain quality among their providers. However, some would claim a mystery patient would add to this endeavor, making already good providers great and aiding them in attracting patients. Are these claims substantiated? As early as 2006 such services were highlighted in the *Wall Street Journal*, in 2010 AARP ran an article explaining their benefits, and in 2011 the Obama administration proposed utilizing secret shoppers to study providers’ responses to Medicare patients [5-7]. Secret shoppers are already popular in evaluating customer service at stores and restaurants across the nation, and, to some, making the leap to the medical field seems only natural.

Anecdotally, such services receive positive reviews. Improvements in quality care have been reported by OhioHealth, a nonprofit organization of 15 hospitals and other health care services in Ohio, Medical City Dallas Hospital, and individuals in private practice utilizing a secret shopper service [6]. AARP reports:

At Beth Israel Deaconess Medical Center, a Harvard University teaching hospital in Boston that recorded nearly 700,000 outpatient visits last year, eight secret shoppers regularly assess staff performance by posing as patients on the telephone and in visits to its 51 waiting rooms.... Appointment waiting time has been cut from an average of 12 days to five, and telephone customer service ratings have improved. Waiting room ratings increased from 78 percent in 2007 to 90 percent in 2009 [6].

However, due to concerns about privacy, allocation of resources, and difficulty establishing guidelines, there have not been any significant large-scale studies of the benefits of such services. Furthermore, there are significant obstacles to evaluating care, the consideration of which should make providers wary when considering secret shopper visits.

First, the quality of health care is very difficult to define. It can be generally divided into two categories. Technical quality refers to the knowledge and judgment exercised by a physician in reaching a diagnosis and the skill with which the patient is treated. It is often assessed via broad, objective measures such as mortality, rates of complication, and adherence to established guidelines [4]. Interpersonal quality comprises the second category and can be assessed by evaluating parameters such as staff and physician attitude, respect, timeliness, and communication [4, 8]. Increases in interpersonal quality do not always correlate to increases in technical quality, and papers published in 2004 and 2008 in the *Journal of Public Economics* even established a negative correlation between clinical quality as measured by mortality rate, and interpersonal quality as measured by short waiting time, suggesting it may be worse for patients in the long run if interpersonal quality is unduly emphasized [9].

Furthermore there are inherent biases in the patient-physician interaction, particularly if the patient is not actually ill but rather pretending, all the while

scrutinizing minute details of the clinician's service. Far from the retail mantra of "the customer is always right," a physician is often called to make recommendations the patient may not like or agree with. Recommendations for an invasive or painful diagnostic test may easily seem excessive to an evaluator who knows he or she is perfectly healthy, but may be welcome news to a patient anxiously waiting in pain to discover what is troubling her. Similarly, a physician may seem harsh or inconsiderate concerning a person's weight, but this may stem from a genuine concern for the patient's health. Inasmuch as only 20 percent of patients seeking medical care are ready to change unhealthy behavior, physicians often have to be more forceful in their recommendations than an evaluator might expect [10]. Avedis Donabedian, considered by many to be the father of quality assurance in health care, argues that when an evaluation lacks highly precise guidelines and is based on the assessor's own judgment, "very expert and careful judges must be used" [11]. This can hardly be applied to a standardized patient who is not suffering from the ailment he or she imitates and does not have the extensive medical and clinical knowledge of a practicing physician.

Another difficulty lies in predicting physician and staff responses. An excerpt from the Department of Health and Human Services standardized patient script for calling to schedule an appointment demonstrates this issue, one of the reasons the department decided in June not to proceed with the study:

I've had a cough for the last two weeks, and now I'm running a fever. I've been coughing up thick, greenish mucus that has some blood in it, and I'm a little short of breath [7].

This script could provoke a variety of reactions based on such qualities of the patient calling as age, gender, and overall health, and the experience and discretion of the doctor or office staff. Although the script was written as part of an appointment-scheduling evaluation, Glen Stream, MD, president-elect of the American Academy of Family Physicians, surmised that office staff, far from scheduling the patient an appointment, would most likely refer this person to urgent care [7].

Another problem is that of wasted patient resources. Although some doctors in the scenario speculate the visits will be a "one time thing," it is unlikely that one visit would provide an adequate statistical assessment of care quality. The proposed HHS survey consisted of three rounds of mystery shopper visits, and OhioHealth, which reported positive experiences with mystery shoppers, utilized 240 visits over the course of a year to its 15 clinics [5]. Furthermore, previous research shows that, in larger practices, quality of care varies widely by department and procedure type [12]. Therefore, it is probable that far more than one visit would be needed for the shopper service to be of any worth, and the repeated visits have a great potential to tie up resources needed by sick patients. The justice of repeatedly expending time and money on healthy people when there are many patients who actually need care is dubious and a legitimate concern for those physicians opposing the visits.

Finally, there remains the question of economic profiling. A main weakness of PPOs, noted even in the earliest stages of development, is their lack of incentive to network participants to deliver efficient care and control health care costs [1]. An increase in the number and complexity of procedures may even negate the savings insurers realize through PPO contracts [1]. Therefore, it is likely that Delta Health has a motive for screening providers who cost them too much. Although cost control is a necessity, it is not always in the best interest of the patient. A group of health care economists analyzed hospital secondary data to compare strategies for selecting “preferred” providers [12]. The 2007 survey looked at four claims-based measures of inpatient quality and patient safety, two structural quality measures, and hospital costs in five markets. It found that there was little overlap between lists of the top 25 percent of hospitals selected by quality alone and the top 25 percent selected by low cost alone (a 0 to 33 percent overlap) [12]. This sets quality and low cost at odds with each other, and, although in an ideal world an insurer would seek to optimize both, it is clear that one often comes at the expense of the other when selecting preferred providers. Therefore, doctors have reason to worry that such economic profiling could occur and that it could lower the quality of patient care supplied by in-network PPO providers.

Based on all of the information reviewed above, it would be in the best interest of the physicians to oppose Delta Health-established secret shopper visits, at least for the time being. Competition both within and outside the network already provides an incentive for providers to deliver quality care. At worst, the third-party payer is seeking to “economically profile” providers, and at best, the clinic may be placed in a position where what is good for business is suboptimal for clinicians and patients. Given the numerous unresolved problems of secret medical shopper programs and the potential for economic profiling, practices should be wary of the Delta Health visits. Should the clinic wish to improve its quality, it retains the option of hiring such services on its own behalf and tailoring visits and feedback to their needs.

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