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ETHICS CASE

Patient Satisfaction Reporting and Its Implications for Patient Care

Commentary by Shivan J. Mehta, MD, MBA

A hospital's Committee on Patient Quality meets monthly to discuss a strategic plan to address deficiencies in scores on its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results. Dr. Anderson begins the meeting by proposing a new pain management protocol to the group. He references the plateau in pain management scores in the HCAHPS report, warning that the organization will sustain substantial financial penalties by failing to improve in the "patient experience of care" domain. As Dr. Anderson begins to explain the new protocol for pain management and how it will bring about an upward trend in scores, Dr. Parker interjects.

"Can we take a step back for a moment? I understand that patient satisfaction surveys can provide a lot of useful information to our hospital system. But a low rating on—let's say pain control—doesn't mean the patient received low-quality care."

"I agree with what you're saying, but this is the reality of pay for performance. Plus, there is value in considering patient satisfaction—happier patients are more likely to adhere to our recommendations and return in the future. As you mentioned, we can learn a lot from these surveys—like how helpful it was to have extra volunteer greeters in the lobby to assist patients with finding their way in the hospital," explains Dr. Anderson.

"I still don't think it makes sense for Medicare to tie the survey results to our reimbursement," Dr. Parker counters. "Financial penalties for hospital-acquired infections and preventable readmissions make sense. Public reporting of morbidity and mortality encourages systemic improvements and patient empowerment. But all of these are objective measures. Patient satisfaction just isn't an objective measure of care quality."

Commentary

The discussion between Dr. Anderson and Dr. Parker highlights a growing emphasis on [patient satisfaction](#) across the country—more specifically, concerns over linking financial incentives to patient experience scores as part of the Hospital Value-Based Purchasing program authorized by the Affordable Care Act (ACA) [1]. Through both [financial incentives](#) and public disclosure, hospitals are being rewarded or penalized based on their patient experience scores. Dr. Parker is challenging the notion that these metrics are important for hospitals and asking whether hospitals should put resources towards

improving their patient survey numbers. Can we effectively measure patient experience, he asks, and, more importantly, should reimbursement be tied to these metrics?

Measuring Patient Experience

There are a variety of survey instruments to measure patient experience in both the hospital and clinic settings, and these metrics are being linked to financial reimbursement from Medicare and other insurers. For example, the Centers for Medicare and Medicaid Services (CMS) have used the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, a set of 32 questions administered to a random sample of hospital patients about their experience of care, since 2008 [2]. The results of these surveys are posted on CMS's "Hospital Compare" website [3]. Now, as part of the ACA's Hospital Value-Based Purchasing Program [1], CMS is withholding 1 percent of Medicare payments—30 percent of which is tied to HCAHPS scores—to fund the incentives of the program [4]. The proportion of the payouts that is withheld from hospitals will undoubtedly increase over time. There are similar incentive components in the Physician Quality Reporting System (PQRS). Overall, measurement of and incentives linked to patient experience are increasing [5].

Benefits of Patient Experience Measurement

As part of its "triple aim," the Institute for Health Care Improvement describes the patient experience of care as including both care quality and patient satisfaction, suggesting that these features are interrelated [6]. Regardless of whether one considers experience an indicator of quality, improving patient experience ratings is beneficial for patients and clinicians for a number of reasons.

As physicians, we want our patients to have not only better outcomes but also a positive experience of care. Patients' perceptions of their care are reflections of the doctor-patient relationship and include holistic aspects of healing and emotional well-being. If we care about the experience of our patients, why shouldn't we measure it and strive to improve our performance? HCAHPS is the most studied system for measuring patients' experience of their care on an individual and hospital level [7], so it is a useful step towards helping clinicians think more broadly about outcomes that matter to both them and their patients.

Patient experience scores may also have an association with more objective clinical quality measure scores. For example, hospitals with better patient experience scores also have some higher quality measures for acute myocardial infarction and aspects of surgical care [7-9]. There are two possible explanations for this relationship. First, hospitals that have better engagement with patients may encourage greater adherence to clinical standards of care and follow-up. Patients who are more satisfied with a practice may be more likely to come in for visits and follow the recommendations of the clinicians that they trust. Second, better patient experience scores could indicate that a

hospital has stronger teamwork, organizational leadership, and commitment to improvement, characteristics that could be associated with better quality measures and patient experience scores. Both of these possible explanations suggest that there is benefit for clinicians in measuring and rewarding patient experience of care, since doing so has the potential to improve overall quality of care.

There are also potential benefits to measuring patient experience of care for advancing hospitals' and practices' business goals. To take care of patients, hospitals and clinics need to be sustainable financially. A significant portion of revenue is related to volume, which includes new and repeat patient visits. Although there are some publicly available quality metrics, like the results of the HCAHPS surveys [3], patients often make medical decisions based on reputation and word of mouth. Thus, physicians need to focus on patients' satisfaction with care because it may drive patient volume more than technical acumen alone. Another reason physicians might focus on patients' experience of care is that there is evidence suggesting that "the frequency with which physicians are sued is related in part to patients' satisfaction with interpersonal aspects of medical care" [10, 11]. While these may not be the primary reasons for physicians to focus on patients' experience of care, doing so may actually provide operational benefit, in addition to better patient care.

Concerns about Patient Experience Measurements

Measuring patient experience raises a number of concerns. First, while measures of patient experience are associated with some quality metrics, there are some situations in which high-value care may be at odds with patient satisfaction. The Choosing Wisely initiative, for example, describes a number of commonly used procedures and services that could be considered low-value, such as early imaging for back pain or antibiotics for upper respiratory infections [12]. Given regulations and declining reimbursements, physicians have limited time to spend on each patient visit [13], and it may be time consuming to explain to patients who expect low-value treatments why they should be withheld. If a physician is faced with penalties for low patient experience scores, it may be the path of least resistance to agree to such requests; even the anticipation of patient dissatisfaction may drive unnecessary or different care in individual cases. Moreover, in one large study, high patient satisfaction was associated with greater inpatient health care utilization, higher overall health care expenditure, and higher mortality [14], findings that the authors subsequently explained by saying that "sicker patients may be both more satisfied and more likely to die" [15]. They acknowledged further that their study "suggests the need for careful appraisal of the nexus between greater health care consumption and a subjectively better health care experience" [15].

Second, there may be unintended consequences of incentive programs for underserved and vulnerable populations. Safety net hospitals typically do worse on patient experience metrics than their counterparts that provide less care to underserved populations [16]. If

institutions that have a greater safety net function have more challenging patient populations and fewer resources to devote to improving low scores, financial incentives could exacerbate existing inequities in care. Additionally, quality reporting can widen racial and clinical disparities in care [17]: faced with penalties for low patient satisfaction scores, physicians could avoid caring for patients who may be more challenging to treat and perceived to be difficult to please, that is, underserved minorities, those with lower socioeconomic status, and those with mental health concerns. There are already disparities in care across our health care system, and incentives for patient satisfaction have the potential to make the situation worse.

Third, there are concerns about the validity and implementation of patient experience measures and surveys. Patient experience measures are based on patients' expectation of care as opposed to objective measures of experience [18]. Patient perceptions also may not be correlated with technical quality [19]. Additionally, the voluntary surveys are relatively long and are often answered many weeks after the experience. There may be selection and recall bias in the responses of those with very positive or negative experiences. Limited sample sizes could also affect the validity of the scores across different hospitals and clinics. Moreover, it is not clear whether there is a "crowding-out" effect of patient experience surveys on other potentially more important or valid quality metrics. More research needs to be done on the consistency with which surveys are implemented.

Conclusion

Getting back to Dr. Anderson's and Dr. Parker's debate, patient experience surveys already play significant role in patient care across the country. Physicians can no longer choose not to participate in, but they can decide how best to engage with, incentive programs. Hospitals and clinics are using these scores to justify greater investment in improving experience for patients—a big step for an industry not known for customer service. That overall trend will likely be good for patients. Improving patient experience is certainly something that we want for health care, but implementing incentives based on patient experience can be risky. More evidence is needed about the validity of these measurements and any unintended consequences on care delivery. Patient experience scores should also be evaluated in the context of other clinician incentives, whether productivity or quality metrics. Physicians, hospitals, and policymakers must continue to refine these incentive programs and ensure that they play an appropriate role in care.

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