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## Concern for the patient's experience comes of age

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A journal devoted exclusively to the patient's experience? A patient satisfaction survey mandated by CMS for all hospitals **and** a portion of reimbursement dependent upon the scores? An Institute and an "Association" addressing Patient Experience? A new hospital administrative position labeled "Chief Experience Officer"? Some 30 years ago no one would have predicted any of these.

An industry concern for the patient's experience of care began to form in the early '80s.

Outside healthcare the "Total Quality Management" concept was gaining great popularity. Industries of all kinds were focusing on process and quality improvement. New metrics and graphs were employed to determine whether processes were under control. "Quality" began to be monitored closely. "Customer service" was being billed as the key to sustaining sales, client loyalty and profits. "A satisfied customer will tell a few others; a dissatisfied customer will tell 10 others" was a common mantra of the new service consultants.

Healthcare itself was undergoing significant change and was no longer immune to consumerism or wider societal litigiousness. A "malpractice crisis" was gaining momentum, spurring a defensive increase in tests and procedures. Premiums were skyrocketing, bottom lines were affected and providers were scrambling for an understanding of why patients would bite the hand that heals them. In 1980 the American Society for Hospital Risk Management (ASHRM) was formed. Reflecting the growing concern to understand the motivation behind malpractice suits, I was invited to keynote their second annual convention in 1983. My topic: Satisfied patients are less likely to sue.

At the same time, the cost of healthcare was rising to a point where both government and payers intervened to cap expenses. The Health Care Financing Administration (HCFA, which later would become CMS) established reimbursement limits for specific conditions or procedures (DRGs), thus capping what hospitals could charge for care. Managed care was developing for the same purpose – to cap expenses by representing large numbers of patients for a set fee.

Hospitals were forced to compete for these HMO and PPO contracts and for patients in general (increased volume could theoretically offset reduced reimbursements or charges). Patients were gaining some clout in that they could shop HMOs for a hospital they preferred. Or their employer could do the shopping for them if they'd voiced positive or negative opinions about service at a local institution (for example, Press Ganey switched insurers – and hospitals -- when employees complained about ER care offered through the company's HMO. The first hospital lost the revenue of over 150 insured families). Individuals as patients may be reluctant to confront a hospital about poor service, but as employees they are far less hesitant to complain to their employer about the hospital in their health plan. For the first time, patients could be viewed (reluctantly, of course) as customers. But no one in healthcare was ready to use the "C" word. Rather, patients and their families were re-defined as "guests" of the hospital. "Guest relations" emerged as the descriptor for the new programs and tactics aimed at making patients more satisfied with their experience. As yet, there was no widely-shared, healthcare-specific body of knowledge or techniques to address the issue. Suggestions for improvement were often simplistic (be friendly, courteous, etc.) and guest relations programs were often dismissed or trivialized by referring to them as "smile school". If hospitals and health care associations wanted to offer a program on patient satisfaction, the consultants and speakers were usually brought in from the airline and hotel industries.

By the mid to late eighties, it was almost impossible to attend a professional health care conference without a keynoter from Marriott or Ritz Carlton. Among the very few consultants and speakers at that time who focused exclusively on patient experience (rather than generic customer service issues) were Kristi Peterson (who established K.E. Peterson Associates.), Wendy Leebov (founder of the Einstein Consulting Group), and me. I (a Medical Anthropologist at Notre Dame) had spent a year as Visiting Professor observing doctor/patient and nurse/patient interaction at Jackson Memorial Hospital in Miami. I felt that I knew what patients wanted from hospitals, but mine was still a voice in the wilderness.

In this wilderness, hospitals sensed that their relationship with patients was changing, but were unsure where it was

going. Ours was an increasingly mobile society. Neighborhood and hospital loyalties were weakening and a guaranteed local patient constituency could no longer be taken for granted. Patients were suing and (usually through their employers) actually shopping around for providers. Hospitals initiated unprecedented marketing campaigns and began to compete for patients by touting the latest (expensive) machines and services. All claimed high quality. Sensing a need that was still unclear, hospitals were sending staff people to conferences where quality and patient satisfaction were on the agenda. They hired Patient Representatives. They began to survey their patients.

In the early '80s, few hospitals actually monitored patient satisfaction. Of those that did, surveys were handed out or mailed sporadically – usually annually. Some relied on outside (marketing) firms to construct and conduct the surveys. Most, however, employed homegrown instruments. Typically, patients were asked only to agree or disagree (“yes” or “no”) with a positively worded statement (“Nurses were caring”). Images of concerned, attractive physicians and nurses often paraded across the tops of the survey to convey the institution's quality and concern (and to suggest a more positive response). Not surprisingly, hospitals were accustomed to near perfect scores and had little doubt that patients were 100% satisfied with care. As there were no comparative data available, hospitals assumed they were better than the competition on every issue. Patients who turned in a negative survey were viewed as cranks or ungrateful.

I recall being invited by an east coast hospital to evaluate their readiness for a “Guest Relations Program”. I interviewed staff at all levels and judged the whole organization to be dysfunctional – interdepartmental rivalries, jealously guarded turfs, distrust of management, etc. During a meeting with nursing staff, their leader waved a patient satisfaction survey report in my face, hollering, “Why do they [management] need such a program? What more do they want from us? Our patients love us!” Of course it was a “yes/no” survey consisting of statements no one could disagree with. Their guest relations program never got off the ground.

It was this experience that prompted me to add a discussion of survey construction to my presentations on patient satisfaction improvement. It was becoming clear to me that in spite of the insights I or others were offering providers, it was our voices they were hearing – not the patient's. Unless providers were convinced that (1) patients were concerned about their experience of care and that (2) they (providers) really had no idea of how their patients actually experienced care, there was no incentive to take serious action. In 1984, the National Society of Patient Representatives (formed in 1971, later became the Society for Healthcare Consumer Advocacy and is now

the Patient Advocacy Community of The Beryl Institute) invited me to conduct 5 all-day workshops across the country focusing on measuring, as well as improving patient satisfaction. Following these presentations, dozens of attendees would bring their surveys up to me for evaluation. They were uniformly abysmal and useless, guaranteed to whitewash the hospital. That's when I contacted Rod Ganey (a Sociologist and colleague of mine at Notre Dame, specializing in survey methodology and statistics) to partner with me in developing a valid instrument and data analysis. Press Ganey debuted in late 1985.

Even when hospitals began utilizing meaningful, reliable, patient satisfaction surveys (designed and analyzed by Press Ganey and other outside firms), they often didn't like the data. Scores were typically much lower than hospitals were used to with their homegrown, amateur instruments. Hospitals would complain that the responses were skewed because only the most disgruntled patients send in a survey (completely false – a methodological issue facing surveyors is getting patients to gripe if there is a problem of care). Or providers would complain that the results weren't statistically significant if only 15% or 20% of ER patients and 20% - 40% of inpatients responded (again, false).

It was easier to shoot the messenger than dig into the issues. Early on, it was not unusual for a client to call us (at Press Ganey) and complain, “Hey, we've been with you guys for two years and our scores haven't gone up! What's going on?” As though the data, in themselves, could generate change. Hospitals simply didn't have the personnel, organizational structure or culture to utilize the information. Patient satisfaction still wasn't a meaningful priority and hospitals couldn't (or wouldn't) put in the effort to use the data effectively to diagnose causes and generate behavioral changes.

One hospital contacted me about low scores for one of their survey items, “How well blood was taken (quick, little pain, etc.)?” They wanted me to check on the validity of the low scores before investing in an expensive, hospital-wide re-training of nurses in blood drawing and IV starting. I looked at their data and immediately noticed that there was a significant difference in scores by patient age. Older patients were actually quite satisfied with blood draws and IV starts. Youngest were very dissatisfied. These data were right there in the reports. Yet no one at the hospital had looked deeper (or more to the point – no one had been designated to look deeper) than the overall scores on the executive summary page. Of course, the first thing I asked the client was whether different nurses were taking blood or starting IVs for older and younger patients. The answer was “no” -- the same nurses did both groups. So obviously, it wasn't a technical skill issue. Clearly, patient age itself made the difference. A

discussion I led with nursing staff led to the simple conclusion that older patients were more familiar with the procedures, while younger patients, who had never experienced blood draws or IVs, were intimidated, scared and stressed by them. Nurses realized that they had to take more time explaining the sticks to young patients and expressing empathy for these “routine” (to nurses) procedures. Scores subsequently rose.

The point is the keys to improving patients' experience of care are neither obvious nor effortless. Hospitals and other providers have to work at it. Staff positions and organizational structures have to be created for data analysis and root cause identification, improvement design, project implementation and staff performance evaluation. Everyone – including physicians - must be accountable for the patient's experience. There must be skin on the table. And whoever is in charge of patient experience must have the organizational clout to enforce the programs.

All of this is actually beginning to happen. “Beginning” is the operant word here. We still need to develop a true culture of concern for the patient's experience. This is still a challenge for many hospitals. Yet, meet the challenge they must. 1% of CMS inpatient reimbursement is already dependent at least in part on satisfaction with the experience of care (HCAHPS). This will increase to 2% by 2017. Pay for performance is here to stay. Over the next decade, the stakes will increase even more as outpatient, ambulatory surgery and emergency department surveys are inevitably added to the HCAHPS inpatient mandate and commercial payers join in the demand for proof of quality across the entire spectrum of care. Of course, bonuses and bottom lines are important. But there are other, broader advantages to ensuring that a culture of patient experience becomes commonplace in health care.

There is growing evidence that providing a more positive patient experience is not simply “the right thing to do” (which is sufficient in itself), but is also potentially associated with a number of desirable, tangible outcomes. It is imperative that staff be aware of them – and convinced of their relevance -- if an effective culture is to develop. These include the relationship of patient experience to:

1. Reduction of complication rates
2. Reduced resource utilization
3. Enhanced compliance – both during care and after discharge
4. Error reduction (through increased trust and communication)
5. Reduced 30 day returns to hospital or practice
6. Reduced malpractice claims
7. Increased staff satisfaction and lower turnover

Although further research into these and other relationships is certainly necessary (and will undoubtedly

occupy much space in the new Experience journals), the implications are already significant enough to require that they become familiar to all who interact with patients and manage their care. Behavioral change cannot be achieved if all are not convinced that it's worth the effort. Merely announcing a program, attaching some incentives and giving it a catchy acronym is no longer sufficient.

Concern for the patient's experience is coming of age. We've graduated from elementary “smile school” and are now embarked on “higher education”.

The developing pay-for-performance mandates, journals, white papers, webinars, associations, conferences and unprecedented administrative positions reflect the beginnings of a culture of concern for the patient's experience.

There are many definitions of what constitutes a “culture”. One of the most basic is this: “A culture exists when its members share values and behaviors that they take for granted”. A culture of patient experience will exist when all in healthcare unquestioningly accept that it benefits not just the patient, but everyone involved in the medical enterprise. It will exist when everyone – both public and provider -- accepts that the patient's personal experience is as much a part of “care” as are the diagnostic procedures, surgeries, therapies and medications administered.