Viewpoint

Can't Get No Satisfaction? The Real Truth Behind Patient Satisfaction Surveys

By Shari J. Welch, MD; Ronald A. Hellstern, MD; Kirk Jensen, MD; John L. Lyman, MD; Thom Mayer, MD; Randy Pilgrim, MD; and Timothy Seay, MD

There is a lot of chatter lately within our specialty about patient satisfaction surveys. Many emergency physicians are affronted by the idea that patient perceptions of their practice style should come under such scrutiny.

Others say emergency medicine is different from other specialties because we have no continuity with our patients and see them under adverse circumstances: Illness, distress, and fear are inherent in the encounter. Still others focus on the possible statistical invalidity of survey methodologies like those of Press Ganey, Professional Research Consultants, and Gallup, or on their unsuitability for credentialing or as contract accountability measures.

While all of this is understandable in a era of crowding, rising expectations, and declining revenues and resources, we make a case for embracing these surveys, working to improve them, and using their results to improve your practice for the benefit of your patients, your ED staff, and your relationship with hospital administration.

The successful delivery of emergency medical care in a capitalist society is part science, part business, and part service industry. Emergency medicine has done a good job improving its scientific quality with residency training, board certification, and evidence-based approaches that decrease the variability of clinical care and improving outcomes. Many of us tend to forget, however, Peter Drucker's advice, "Quality in a service or product is not what you put into it. It is what the client or customer gets out of it."

In other words, regardless of how great we think we are, the proof lies in how our care is perceived by our patients.

Patient satisfaction makes sense for clinical effectiveness. Patients satisfied

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In this and every issue, *Emergency Medicine News* offers two CME activities: 1) InFocus, the clinical evidence-based column written each month by James R. Roberts, MD, and 2) Living with the LLSA, a review of the American Board of Emergency Medicine's Lifelong Learning Self-Assessment reading list by various authors.

Target Audience Statements: The InFocus CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in the diagnosis and treatment of various disease processes commonly seen in emergency departments, with special emphasis on evidence-based medicine. The Living with the LLSA CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in studying for the annual American Board of Emergency Medicine's Lifelong Learning and Self-Assessment examination.

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Advertising Representatives:
Jim Nagle
Breuning Nagle Associates
(203)801-0055
(203)801-0011 (fax)
jimn@bna1.com

Classified Advertising:
Mike Rusch
(215)521-8404
(215)689-2453 (fax)
mike.rusch@wolterskluwer.com

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SATISFACTION

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with their care are more likely to be compliant, and respond better to treatment. (*Psychosom Med* 1995;57[3]:234.) Patient satisfaction also makes good sense for risk management. Caregivers who participate in a system of good customer satisfaction experience fewer malpractice suits than their counterparts. (*The Quality Connection in Healthcare: Integrating Patient Satisfaction and Risk Management*. San Francisco: Jossey-Bass; 1991.)

Those who have been ED medical directors know from experience that patient complaints will tell you what isn't working in your ED long before it becomes apparent any other way. And there is a connection between patient satisfaction and staff satisfaction. Results of Press Ganey surveys in which patient satisfaction and staff satisfaction were measured show a clear relationship between the two, and while customer satisfaction increased in one study, employee turnover decreased by 57 percent. What is good for the patients appears to be good for the caregivers as well. (*Patient Satisfaction: Defining Measuring and Improving the Experience of Care*. Chicago: Health Administration Press; 2002.)

Finally, and perhaps most importantly, the reason to embrace service quality as an integral part of the patient's health care experience is that it makes your job easier. It is simply easier and more pleasant to work with A team members than B team members, a phenomenon every emergency physician understands. (*JAMA* 1999;282[13]:1281.)

Patient satisfaction surveys aim to capture the patient's perceptions of the care received, and portray them in numerical terms for benchmarking and trending. Every successful service provider has a method for capturing these data, and it would never occur to a Starbuck's barista or a Nissan salesman to dismiss customer service satisfaction data out of hand. It is true that the transition from customer service to patient satisfaction has some inherent challenges.

First, patients are not very good at evaluating the appropriateness of care or the technical skill with which it was performed. Clearly, some patients are very satisfied with "bad medicine." Secondly, the patient perceives his health care for a particular problem as a series of episodes over a continuum of care. Take the acute coronary syndrome patient who goes quickly and tenderly from the ED to the cardiac cath lab only to have a subsequent bad encounter with a CCU nurse. The bad encounter may taint the answers the patient gives on an ED patient satisfaction survey. (*Health Expect* 2008;11[2]:160.) Finally, measuring patient satisfaction is not a simple task. While a restaurant may track patrons and profits, measuring patent satisfaction is not as straightforward as the survey companies would have us believe.

Despite these limitations, most highly successful medical organizations are increasingly focused on this. Indeed, for more than 100 years, one of the world's most successful and respected institutions, the Mayo Clinic, has placed service excellence alongside clinical excellence as a fundamental value, as reflected in its "Patient First" motto. (*Management Lessons from Mayo Clinic*. New York: McGraw-Hill; 2008.) Medicare's Value-Based Purchasing initiative requires it, and the best medical organizations recognize that it makes economic sense, too. "An ED visit is a significant encounter between patient and hospital, and one that affects 'repurchase' decisions for future healthcare," noted J.V. Mack in an analysis of ED choices among Medicare patients. (*J Ambul Care Mark* 1995;6[1]:45.) Despite the elderly being disproportionate users of health care, surprisingly about half don't have a regular physician and choose ED care. One study found that 97 percent had a choice of ED, and more than half had been

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Fatalities

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naloxone. After resuscitation, pulse and blood pressure returned, and the patient was transferred to a regional hospital on pressors. Ultimately, he developed multiorgan failure, and died on the second day after ingestion. Blood samples obtained at autopsy revealed a fentanyl level of 9.6 ng/mL. Urine drug screen was negative. The cause of death was listed as acute fentanyl intoxication.

Comment: Fentanyl patches contain extremely high levels of the drug to maintain the gradient that produces transdermal absorption. They can be abused in all sorts of ways: ingestion, insertion into various body orifices, or applied to the skin at multiple locations. In one reported case, a fentanyl patch was steeped in hot water like a teabag. Ingestion of the resulting brew caused coma and hypoventilation. (*Vet Hum Toxicol* 2004;46[1]:30.) The patient recovered after treatment with naloxone.

There are several things to note about this case. The patient's urine drug screen was negative. This is not surprising. Fentanyl is such a potent opiate that an amount causing significant clinical manifestations may not be present in a sufficient concentration to turn the urine positive. And because fentanyl is so potent, treating overdose often requires large doses of naloxone In this case, it would have been reasonable to administer a bolus of 10 mg, but because the patient was already asystolic, it is doubtful the outcome would have changed.

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Aphrodisiac Exposure

A 35-year-old man complained of chest and abdominal pain approximately 12 hours after ingesting an aphrodisiac product called "Piedra." Initial evaluation revealed bradycardia, hypotension, and a serum potassium of 7.0 mEq/L.

Initial treatment included insulin, glucose, bicarbonate, and albuterol to address the hyperkalemia. For continuing bradycardia, he was given atropine 0.5 mg with good response. Because of the history and presenting manifestations, the treating emergency physicians suspected that the toxin ingested was bufotenin, a supposedly aphrodisiac resin usually used topically that contains dried venom from the *Bufo* toad. This toxin has cardiac glycoside activity, causing effects similar to those of digoxin overdose. The patient's digoxin level was 2.9 ng/mL. [*Note: The NPDS report states that the level was 2.9 mcg/mL, which is almost certainly a mistake.*] Despite treatment that included 35 vials of digoxin-specific antibody fragments (Digibind), the patient suffered cardiac arrest on the second hospital day, and could not be resuscitated.

Comment: This case occurred in New York City, which saw six similar cases in the 1990s. The supposed aphrodisiac is illegal, but appears under the names Love Stone, Jamaican Stone, Chinese Rock, Rock Hard, and Chan Su.

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Satisfaction

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referred on the advice of others. This verbal networking and relatively high utilization of ED services by the elderly has huge implications for the future importance of patient satisfaction.

It is the physicians who typically lag behind in accepting the important role of patient satisfaction who fare the worst, which has not gone unnoticed by the American Board of Medical Specialties (ABMS). March 16, ABMS, of which the American Board of Emergency Medicine is a member, approved the following in a Maintenance of Certification statement:

"By 2010, each Member Board will assess a diplomate's communication skills with patients … using at least a 'Communication Core' physician CAHPS patient survey (or other equivalent survey that addresses communications …) at least every 5 years." (http://bit.ly/ABMSmoc.)

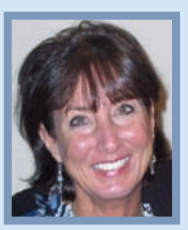
While the earliest patient satisfaction surveys were not validated instruments, had built-in biases, and yielded low response rates, survey instruments designed specifically for the emergency department have emerged over the past several years. (*Ann Emerg Med* 2001;38[5]:527.) Certainly these instruments are not without their flaws, and will require continuous improvement, but they allow us to draw important correlations between patient satisfaction and the practice of emergency medicine, strongly suggesting that patient satisfaction surveys must be considered as one marker of quality care in the ED. A close review of the literature makes it clear that better patient perception of service satisfaction is correlated with:

- Better patient compliance.
- Better response to treatment.
- Better risk management profile.
- Better staff satisfaction.
- Lower staff turnover.
- Fewer malpractice claims.
- Better fiscal performance.

Regardless of the limitations of current survey methodologies, better scores correlate with what every practicing emergency physician wants for himself, his patients, his group, and his hospital partner. There would seem to be no downside to having good scores or working to improve the ones you have. When tracked over time, patient satisfaction scores can provide practitioners feedback on the patient's experience of care and guide quality improvement efforts.

It is time to treat these surveys for what they are: an integral part of our daily practice of emergency medicine. The surveys are in fact an open-book test; we know what the questions will be before they are asked. Why not use the surveys as a tool to help identify and accentuate A team behaviors and processes, instead of a club used to beat up people over their scores.

The train of consumerism in medical care delivery has left the station and isn't coming back, but the caboose is still in sight. If we start running now, we can catch it and climb back on because, as noted author Tony Alessandra, PhD, said, "Being on a par in terms of price and quality only gets you in the game. Service wins the game."



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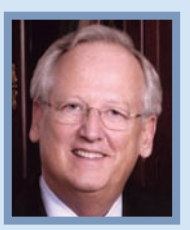

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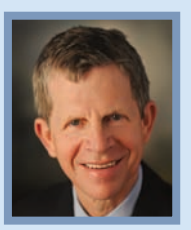

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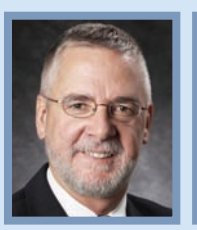

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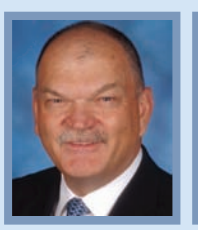

Dr. Mayer

Dr. Pilgrim

Dr. Seay

Dr. Welch *is a fellow with Intermountain Institute for Health Care Delivery Research, an emergency physician with Utah Emergency Physicians, and a member of the board of the Emergency Department Benchmarking Alliance (EDBA).* ***Dr. Hellstern*** *is a founding faculty member with ACEP's ED Director's Academy and an independent emergency medicine practice management consultant.* ***Dr. Jensen*** *is the chief medical officer of BestPractices and the medical director for the Studer Group.* ***Dr. Lyman*** *is a regional medical officer and the director of emergency medicine residency relations for Premier Health Care Services, a past president of the Emergency Department Practice Management Association (EDPMA), and a member of the board of directors for EDBA.* ***Dr. Mayer*** *is the chairman of BestPractices and the chairman emeritus of the Board of Visitors of Duke Medicine.* ***Dr. Pilgrim*** *is the chief medical officer for the Schumacher Group and the chair of EDPMA.* ***Dr. Seay*** *is the CEO and medical director for Greater Houston Emergency Physicians, the CEO of Hospital Inpatient Group, and the vice president of the Emergency Medicine Risk Retention Group.*