Unlock The Power of Patient Satisfaction Surveys

A Special Report for Physician Group Management

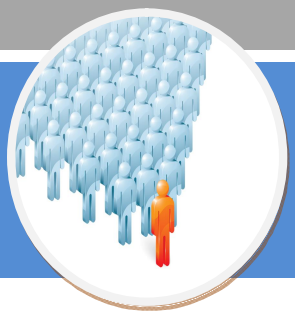
Whitepaper

Priority Metrics Group

TABLE OF CONTENTS

UNLOCK THE POWER OF PATIENT SATISFACTION SURVEYS

A Special Report for Physician Group Management



Whitepaper

Executive Summary

Current approaches to patient satisfaction surveys in physician group offices are wasting valuable time and other resources and are in dire need of repair. In general, a chronic level of weakness prevails in typical patient satisfaction surveys due to the following factors:

- Limited or no statistical validity,
- Use of only experiential attributes,
- Poorly communicated results,
- Absence of comparative benchmarks,
- Low importance placed on analysis.

Such weaknesses result in wasted time and money invested. Instead, they create missed opportunities for accurately measuring and monitoring patient experiences and satisfaction, establishing a baseline for monitoring change, identifying areas for improvement and developing quality improvement action plans and benchmarking the various dimensions of patient satisfaction. These weaknesses also undermine the critical goals for effective patient satisfaction surveys which are to improve group performance provide better quality healthcare and ultimately increase revenue.

Patient satisfaction surveys conducted in a large percentage of physician group offices are not producing valuable or actionable results. They are plagued by inaccurate results, low response rates, meaningless questions, high non-response bias, misdirected analysis, limited distribution of results, lack of management attention, and other shortcomings. In fact, the current approach to patient satisfaction surveys is so problematic that higher patient satisfaction has even been correlated with higher mortality! Moreover, with the upcoming federally-mandated Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey requirements, the incentive for gaining high-value, statistically valid and actionable data from patient satisfaction surveys is becoming more important.

95 percent of consumers have indicated they have shared a negative customer experience with others.

This PMG white paper argues that there is a better way to conducting patient satisfaction surveys and examines the critical need for change in current patient satisfaction approaches. Healthcare providers need actionable data to improve processes, reduce costs, grow patient satisfaction and loyalty, improve their bottom line and ï most importantly ï improve patient healthcare outcomes. In addition, based on a recent proprietary PMG survey across 50 physician group practices in the U.S., this paper addresses the failings, limitations or unintended consequences that ultimately have a negative effect on current approaches to patient satisfaction surveys.

This white paper also addresses various concerns about the overall effectiveness of patient satisfaction surveys from inside the medical community itself. And PMG is not alone. Other researchers have noted the same issues

from studies completed with healthcare consumers.

For example, UC Davis researchers published the results of a 2012 study based on data from nearly 52,000 adults. Among the studyôs findings were that the most satisfied patients spent the most on health care and prescription drugs, were 12 percent more likely to be admitted to the hospital and accounted for nine percent more in total health care costs.

The Current Condition of Patient Satisfaction

Patients are notoriously quick to voice their dissatisfaction to family, friends, or even complete strangers about negative experiences encountered when involved in the medical process, whether itôs unreasonably long wait times for appointments or the lack of information communicated to them about their specific condition or medications.

For example COLLOQUY (a provider of loyalty marketing publishing, education and research) reported in its 2010 COLLOQUY word-of-mouth study that of 3,295 U.S. consumers surveyed, slightly more than one out of every four (26 percent) said they are far more likely to spread the word to family, friends and coworkers about a bad experience with a product or service than a good one.[2]

In addition, a recent survey conducted by Dimensional Research and commissioned by cloud-based customer service software platform Zendesk, revealed that an overwhelming 95 percent of consumers have indicated they have shared a negative customer service experience with others.[3]

Strikingly, the findings also showed that these were the same patients who have a higher mortality rate. This report established a strong case for why high-value and more effective patient survey methods ï such as elevating the overall importance level, random sampling, ensuring the elimination of bias, controlling sample sizes, establishing higher response rates and improving anonymity and objectivity ï contribute to producing actionable results.[1]

In an effort to keep improving the healthcare experience for all patients, a continuous flow of meaningful feedback from those same patients is critical. And as choice continues to grow in the healthcare system, patient loyalty and satisfaction become even more important.

Patient satisfaction surveys are typically done either out of mere convenience or due to a need to meet some pressing internal or external obligation.

PMG research confirms that the medical community has been half-hearted about the way patient satisfaction feedback is obtained. The net result is a lack of measureable results about the level of patient satisfaction. Patient satisfaction surveys are typically done either out of mere convenience or due to a need to meet some pressing internal or external obligation. The surveys then result in a perfunctory exercise that becomes a poster child for the garbage-in, garbage-out truism.

Critical survey issues that need addressed

One of the most important survey issues that needs to be addressed is that current patient satisfaction approaches are typically conducted just for the value of an arbitrary score. If, for example, a physician group can claim that it has achieved a patient satisfaction level of 95 percent based on survey results, that result has limited value. The challenge is to get behind that score and understand what is driving patient satisfaction and how those processes can be improved.

Another significant problem with the way patient satisfaction surveys are being handled is the lack of statistical validity of the sample. Statistical validity is a function of random sampling and sample size. A random sample is one in which every member of the population has an equal opportunity to be included in the survey sample. The sample size must be large enough to provide a meaningful representation of the population. PMGõs research has found that current sampling techniques for many patient satisfaction surveys are not random. For example, if a physician group office provides a stack of satisfaction survey cards for patients to pick from, those who sit in the waiting room longer have a higher likelihood of picking up a card.

PMGõs physician group survey (covered in more detail later in this report) demonstrates that many groups have no idea how many surveys are being sent out to patients or how many are being returned. Such an informal approach to conducting patient satisfaction surveys and lack of attention to detail simply provides no statistically valid sample to generate actionable data. While conducting self-administered surveys is obviously a low-cost approach, it can also risk producing zero, or even negative value, if improper action is taken on misdirected results.

Weaknesses like these result in wasted time and money invested. Instead, they create several missed opportunities including:

- Accurately measuring and monitoring patient experiences and satisfaction ï haphazard efforts toward measurement and monitoring the patient data will not provide true indicators of patient perception and satisfaction.
- Establishing a baseline for monitoring change ï continuous monitoring is essential throughout any given time period (such as quarterly or yearly);the frequency of patient experience monitoring needs to correspond with reporting and use of information.
- Identifying areas for improvement and developing quality improvement action plans ï without clearly defining which areas need improvement and how such changes will be implemented and measured, initiatives will be plagued by a lack of follow through that will undermine efforts toward improvement.
- Benchmarking various dimensions of patient satisfaction ï results from one office or specialty can be compared to other offices or specialties, against normative data, and against the best alternate.

Adhering to the preceding guidelines will help to ensure that your office meets the critical goals for effective patient satisfaction surveys which are to improve group performance, provide better quality healthcare, and to ultimately increase revenue.

The profitability factor

One key area of concern among physicians concerning patient satisfaction initiatives is the correlation between satisfaction scores and the profitability of their practice. Satisfaction leads to higher profitability in several important ways:

1. Higher satisfaction results in higher loyalty. Patients are less likely to move to another practice. It has been shown repeatedly that it is 6-7 times more costly to attract a new patient than to retain an existing patient.[4]
2. The lifetime value of a patient can easily and quickly reach into the thousands or tens of thousands of dollars.
3. Although research results are mixed, satisfied customers are more likely to recommend your practice to others.[5]
4. Satisfied customers are more forgiving.[6]
5. Satisfied customers are less price sensitive, meaning that they are less likely to question service fees and charges or price increases.[7]

The case for patient equity management

Patient Equity Management (PEM) recognizes the long-term value of patients and advocates treating patients and prospective patients in ways that recognize that lifetime value. If a dozen laptops disappeared from a hospital in a week, a hospital would certainly learn how to stop the next dozen from leaving. However, if a dozen patients left ï never to return and never to refer another patient ï the hospital would never know.

To manage PEM effectively, healthcare providers should be able to answer the following questions:

- What is the ROI (return on investment) of retaining a patient once?
- What is the lifetime value of a patient?
- What does it cost to acquire a new patient?
- What is the cost difference between acquiring a patient and retaining one?
- What roles does patient satisfaction play in: retention, referrals and ñwin-backsò

The principles of PEM help an organization to understand why patients are loyal and why they refer other patients, what motivates them to pay on time or in full, and the financial impact of a poor patient experience.[8]

The Profitability Factor
Satisfaction leads to higher profitability in several ways:

1) **Higher satisfaction results in higher loyalty**
2) **Increased lifetime value of patient.**
3) **Increased recommendations of your practice.**
4) **More forgiving patients.**

Flawed survey methods produce waste

In an article published in *Forbes* in early 2013 titled, ñWhy Rating Your Doctor Is Bad For Your Health,ò the articleôs author asks the reader, ñwhy shouldnôt patients grade the quality of their medical care?ò and then provides readers the response, ñbecause many doctors, in order to get high ratings (and a higher salary), overprescribe and overtest, just to ósatisfyô patients, who probably arenôt qualified to judge their care. And thereôs a financial cost, as flawed survey methods and the decisions they induce, produce billions more in waste. Itôs a case of good intentions gone badly awry ï and itôs only getting worse.ò

The article also points out the following alarming statistics concerning the dangerous path of overtreatment based on misrepresented survey data:

- Nearly two-thirds of all physicians now have annual incentive plans, according to the Hay Group, a Philadelphia-based management consultancy that surveyed 182 health care groups. Of those, 66 percent rely on patient satisfaction to measure physician performance; that number has increased 23 percent over the past two years.
- In a recent online survey of 700-plus emergency room doctors by Emergency Physicians Monthly, 59 percent admitted they increased the number of tests they performed because of patient satisfaction surveys.

Flawed survey methods and the decisions they induce, produce billions more in waste.

- All told, overtreatment accounted for up to $226 billion in 2011, for things like unnecessary procedures and prescriptions that donôt help patients, according to Donald M. Berwick, the former administrator of the Centers for Medicare & Medicaid Services (CMS), which oversees those programs.[9]

PMG Physician Group Survey Findings

In August 2013, PMG conducted a comprehensive proprietary survey of 50 physician group practices in the U.S. The surveyôs primary goal was to discover details of current patient satisfaction survey initiatives conducted in group practices. Specifically, the study addressed the following issues and questions:

- Responsibility for conducting and managing the surveys
- Objectives and expected deliverables
- Survey methodology
- Frequency
- Response rate
- Survey analysis
- Communication and use of survey results
- The perceived value of the survey effort

The following section provides the results of that survey obtained from first-hand feedback from participating physician groups.

Out of the 50 physician groups surveyed, nearly 54 percent of group practices conduct a regular, formal patient satisfaction survey. In contrast, just over 46 percent of the group practices surveyed do not use a patient satisfaction survey. Physician survey groups that responded ñnoòwere not asked to provide a reason why they do not conduct patient satisfaction surveys. However, the balance of the survey explores that issue in broader terms.

Most physician groups started conducting a formal patient satisfaction survey within the past two to three years.

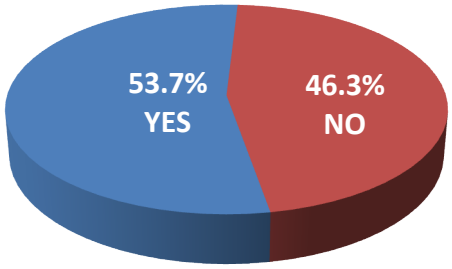


Figure 1 | Groups Conducting Patient Satisfaction Survey

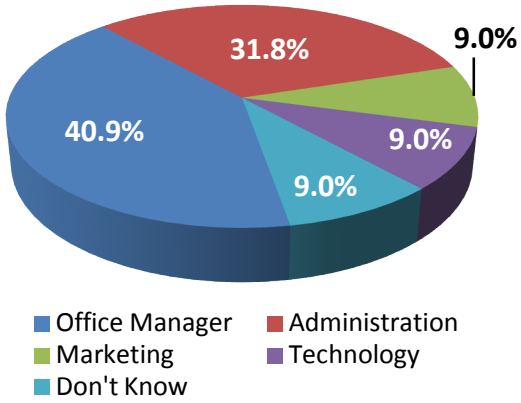


Figure 2 | Job Title in Charge of Survey Process

Almost 41 percent of the typical groupôs patient satisfaction surveys are conducted at the office manager level (Figure 2). The next highest percentage group of survey administrators came in a nearly 32 percent at the administration or assistant level. The remaining 27 percent of group survey participants indicated equal shares each at nine percent, stating either marketing or technology level staff conducted the patient satisfaction surveys. Nine percent indicated that they didnôt know who conducted their physician groupôs patient satisfaction surveys. This indicates that patient satisfaction is not generally seen as a strategic activity within the group.

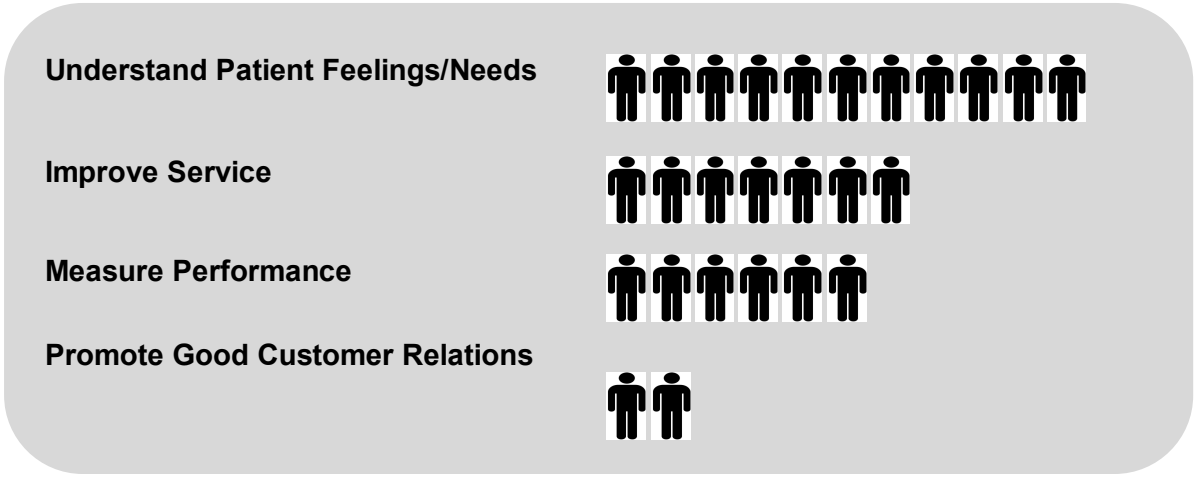


Figure 3 | Survey Objectives

From responses to this question, a patient survey is seen more as an administrative process rather than a key component of developing business and operational strategy.

The PMG survey also found that 73 percent of the patient satisfaction surveys are done voluntarily by the group, while 27 percent are mandated by their corresponding hospital or corporate parent.

As shown in Figure 3, a large percentage of physician groups indicated that the most important objective for their patient satisfaction survey was to ñunderstand patient feelings and needs.ò The next most common survey response was to ñimprove service.ò The least mentioned survey objectives indicated were to ñmeasure performanceòand lastly, to ñpromote good customer relations.òWhile it is certainly helpful to understand patient feelings, doing so does not lead to operational or strategic insight. It is questionable to drive any changes within the group operation based on patient feelings alone. Only a minority of practices are pursuing patient surveys with the intent of measuring performance ï and one would assume improving performance.

A plurality (45 percent) of group practices indicated that their surveys are distributed by mail as shown in Figure 4. An additional 30 percent of participants said that their surveys were done in the office, either through electronic means, or on paper. Only 10 percent conduct surveys via the web. Overall, more than 90 percent of the physician groupôs patient satisfaction surveys are returned as paper, either through the mail or in the groupsôoffices.

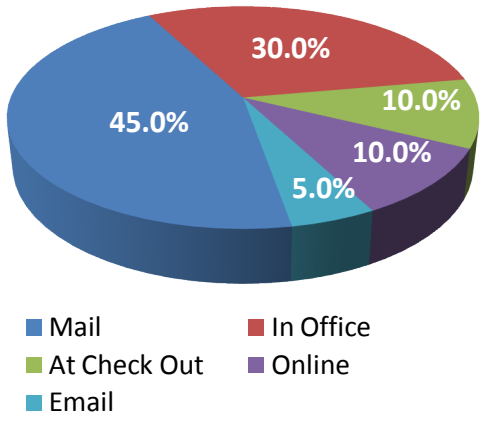


Figure 4 | Method of Data Collection

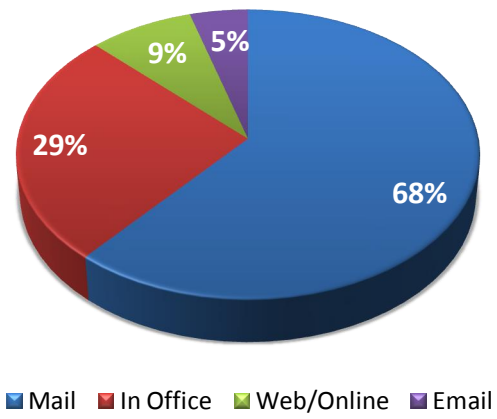


Figure 6 | Source of Completed Surveys

Some groups indicated that they receive their patient satisfaction survey results through multiple vehicles. The least used method of receiving survey results is via email.

Figure 6 clearly shows that mail, at nearly 70 percent of PMG survey respondents, is the leading method for receiving completed patient satisfaction surveys. Collection of completed surveys in physician group offices is a distant second at nearly 30 percent. In many industries, data collection methods are moving toward methods that provide faster response times at a lower cost. Within the health care industry, however, web/online collection ranks low at nine percent, with email an even less used method at only five percent. HIPPA rules and other inherent industry norms most likely are responsible for this trend.

PMG has found that multiple data collection methods help to improve the quality of a patient satisfaction survey through several means:

- Allowing patients to participate in a media that is most comfortable to them.
- Improving the overall response rate ï and resulting statistical validity.
- Generating a higher value and improved quality of comments and written/verbal responses.

Participants indicated that they tend to keep the length of their patient satisfaction surveys fairly short (Figure 5), with over 50 percent using ten questions or fewer. Fourteen percent of survey participants use surveys with as many as 30 questions. The remaining groups use from 15 to 20 questions for their patient satisfaction surveys.

PMG has found that the key issue is the perceived and actual time to complete the survey more than number of questions. If the respondent believes that the survey will take longer than they feel is worth investing, they will not begin the survey. If they do undertake the survey and then determine that it will take too long to complete, they will stop prior to completion. Neither is a desired outcome.

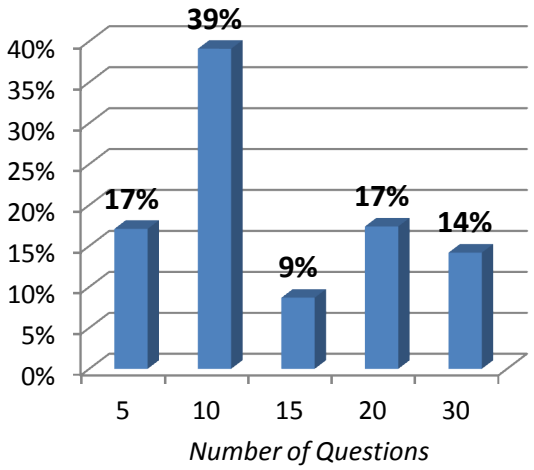


Figure 5 | Length of Questionnaire

It should take participants about 10 minutes to complete a survey. It needs to convey this reality through the appropriate use of white space and font sizes in cover letters and other material. Of course, if some respondents would care to take longer than 10 minutes, dwell on responses and write lengthy comments, they are certainly free to do so.

As shown in Figure 8, an overwhelming percentage (nearly 96 percent) of participants uses a single questionnaire for their patient satisfaction surveys. Only slightly more than four percent use multiple questionnaires for their surveys. This again reflects a rather tame view of patient feedback value. Probably none of these same practice managers would agree that OB-GYN patients utilize the same satisfaction criteria as ER patients, yet the question set is the same. PMG would suggest a common core of questions with a smaller set of rating and open-end questions that reflect the unique characteristics of each specialty. In that way, comparisons can be made across specialties

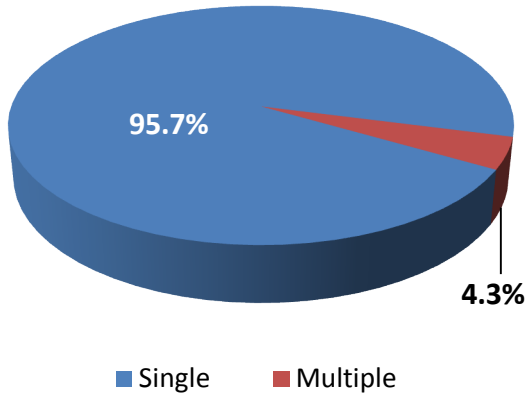


Figure 8 | Number of Different Questionnaires Used

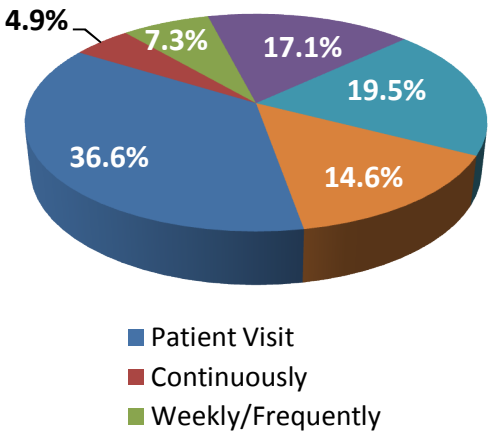


Figure 7 | Frequency of Survey

and offices, but more directly actionable information can be compiled and reported.

Physician groups lean toward conducting their patient satisfaction surveys during ñpatient visitsò in 36.6 percent of practices (Figure 7). 19.5 percent of group participants indicated that they conduct surveys at ñregular intervalsò, while just over 17 percent conduct patient satisfaction surveys only ñquarterly or lessò. Nearly five percent conduct surveys ñcontinuouslyòand more than 14 percent did not specify the frequency of their surveys. Just over seven percent of PMG survey respondents conduct their patient satisfaction surveys ñweekly or frequently.ò

This suggests that up to 63 percent of group practices are not getting data on a real-time basis. More importantly, this implies that if process improvements are made, patients may not see them for months (or longer) after they have provided their feedback. The implicit message to patients is that your opinions really donôt matter. So, the next time they are given the

opportunity to participate in a survey, they will be less likely to do so.

Most patients are allowed to complete a satisfaction survey anonymously, but for 32 percent of practices, patients may reveal their identity. PMG favors providing the option. If patients would like to remain anonymous, they can; but if they want to provide their name, they may do that as well.

In addition, 13 percent of participants compare performance to normative data. Norms allow a better determination of actual performance as they provide context for interpreting results. However, competitive benchmark data is even more valuable. Virtually no patient satisfaction surveys compare performance to any type of benchmarks, such as ñbest in classò or other practices. A comparison to the ñbest healthcare experienceò allows users of satisfaction data to gauge performance in comparison to this benchmark which may be in class (another similar physician or specialist) or out of class (any healthcare provider such as a dentist, walk-in clinic, minute clinic or other). If a group truly wished to provide high quality services, a high standard benchmark such as this is an invaluable comparative tool.

Regarding survey response rates, exactly half (50 percent) of the groups consider they are obtaining a ñgoodò response and nearly 23 percent ñdonôt knowò their survey response rate. As a whole, this indicates that nearly 73 percent of individuals in charge of their groupôs survey are not aware of their survey response rates. At the same time, only 18 percent of PMG survey participants (Figure 9) even have some kind of target number or percentage of response data available to serve as a reference. In addition, PMGôs physician group survey found that 86

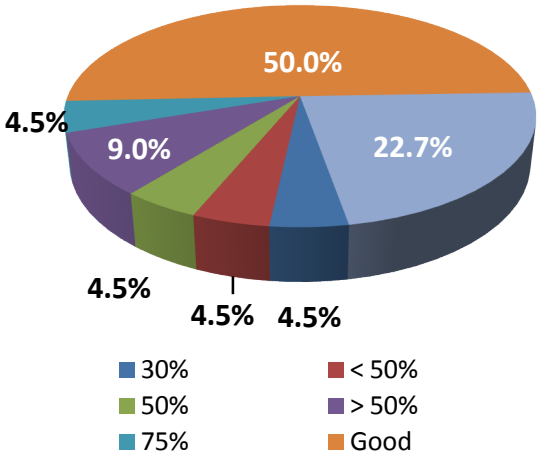


Figure 9 | Response Rate

percent of participants are doing nothing to improve their patient satisfaction survey response rates.

Response rate is a critical driver of statistical validity. If sufficient numbers of patients are not afforded the opportunity to participate in a random manner, and do not respond in sufficient numbers, the results of the survey ï while mathematically interesting ï are statistically meaningless. We can produce an average score or compare scores across specialties, but if the sample is not random and the response rate not high enough, the results are misleading at best and simply wrong at worst.

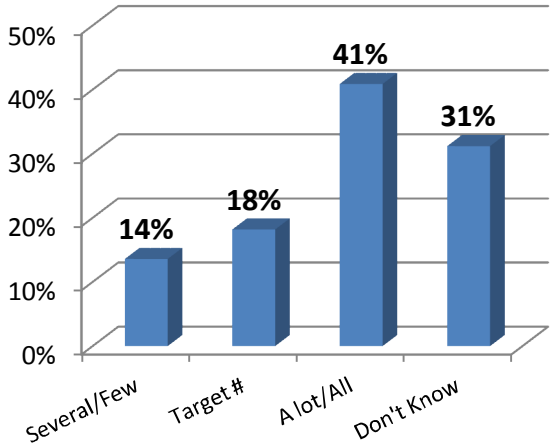


Figure 10 | Target Completion

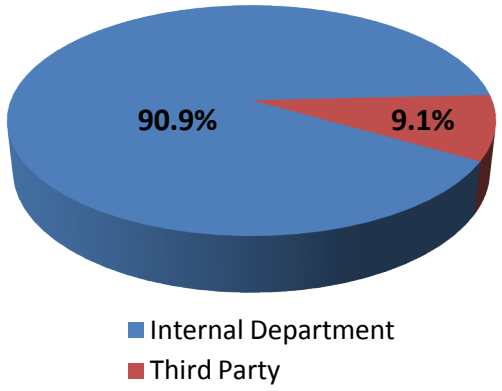


Figure 11 | Analysis Provider

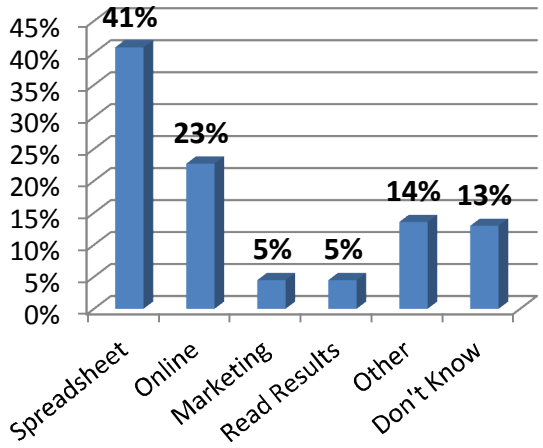


Figure 12 | Type of Analysis

The types of analysis used for patient satisfaction surveys is quite simplistic and far from being actionable. The most common form of analysis is to gather data and then use a spreadsheet for compilation. This analysis is typically conducted internally by individuals who have no training or experience in analyzing survey data. This type of analysis comprises 41 percent of current survey efforts (Figure 12). Figure 11 illustrates that internal departments are overwhelmingly charged with survey analysis, with only slightly more than nine percent using a third party.

The second most common form of survey analysis is done online, while some simply ñread results.ò Fully 27 percent of PMG physician group survey respondents indicated either ñotherò types of analysis are used, or they simply ñdonôt knowò what type of analysis is used for patient satisfaction surveys. Even in simple surveys, there is a wealth of information that can be extracted by a knowledgeable researcher. Unfortunately, it would seem that much of this valuable information is being left undiscovered.

For those physician groups that do generate measurable results from their patient satisfaction surveys, 60 percent share them among the entire group. PMG survey results also found that 35 percent of the groups (Figure 13) only share results among management, and the remaining 13.6 percent share patient satisfaction survey results among select employees.

One significant finding from the PMG survey is that very few physician groups share their patient satisfaction survey results with patients themselves; however, more groups are planning to do so in the near future. We believe that this is key to building a better practice and to

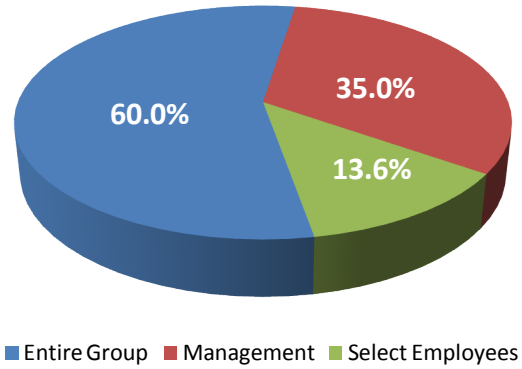


Figure 13 | Results Shared

ensuring future cooperation in survey efforts. We have seen time and again that customers and patients who perceive that their feedback matters have a more positive perception of the organization and are more likely to participate in surveys in the future.

The value of conducting patient satisfaction surveys is most often verbalized as knowing what needs to change, being informed and knowing that we are (your practice) meeting patient needs. The minority see the value of surveys as tracking performance, and none indicate that value derives from improving performance.

Most survey managers who participated in PMGôs physician group survey indicated that they can identify at least one way that the patient survey creates value for the group. But only 13 percent can cite general improvements that have been made as a result of the survey, and less than five percent can actually cite specific examples. So, while survey value is spoken of in general terms, it is very unusual that it can be associated with any improvements. This gets at the heart of the problem.

Patient satisfaction surveys are about improvement ï in satisfaction certainly, but more importantly in the drivers of satisfaction. If a practice can improve performance in the areas that matter most to patients, they are rewarded with higher retention and loyalty, new patients (through recommendations), and improved margins (through allocating dollars to areas of performance that are most important to patients).

PMG survey participants indicated that they would like to see more current patient satisfaction information. This is likely due in large part to the fact that more than 60 percent are not getting real-time data or anything close to real-time.

When asked to cite one or two specific improvements or changes that have come out of their survey process (Figure 14), several participants indicated that by conducting their patient satisfaction surveys, they now ñknow what needs to change.ò Fewer participants indicated that they are better ñinformedòin a general way. Fewer still said that they now ñknow weôre meeting patient needs.ò The fewest

Figure 14 | Survey Value

number of participants indicated that the surveys help them ñtrack our performance.ò

Due to the quality of incoming information, Individuals responsible for managing patient satisfaction surveys have difficulty in identifying the value of these efforts and articulating the success in achieving initial objectives.

The survey found that nearly 70 percent of physician groups believe the level of success in achieving their surveyôs objectives was ñgoodòor ñOKò, while 12 percent said that ñpatients are happyòas a key indicator of reaching their surveyôs objectives. Eight percent of survey respondents indicated they were ñnot sureò about the success of their surveyôs objectives. The remaining 12 percent indicated ñotheròas their response, citing reasons such as ñwouldnôt be doing it otherwiseòand ñnot seeing a financial benefit.ò

Data Collection Options

As the results of PMGôs physician group survey have shown, the offices are using a mixture of data collection options, including mail, at patient check-out, in-office during patient appointments and exams, via email and through the Internet via physician group websites. Each method of data collection has its share of advantages and disadvantages, as laid out below in Table 1.

Mail

The most popular form of data collection for patient satisfaction surveys is via surface mail. While inexpensive and somewhat efficient ï since mailings can be sent out as a batched group ï mailed surveys tend to have a very low response rate. Also, since younger patients tend to be more computer savvy and are inclined to be more receptive to online methods or surveys via mobile devices, mail is viewed as a declining form of communication that takes more effort than some patients are willing to expend.

Check-Out

Conducting patient satisfaction surveys at the time of patient checkout is one of the least used forms of survey data collection, but does offer some positives. This type of approach is viewed

Table 1 | Data Collection Options Have Shortcomings

Data Collection*	Pros	Cons
Mail (45%)	• Inexpensive • Batch process	• Low response rate • Declining communication form • Requires patient effort
Check-Out (10%)	• Non-intrusive • At time of service	• Biased sample • Non-objective (in office completion) • Low response rate
In Office (30%)	• Easy • Inexpensive	• Biased (and small) sample • Limited length • Very low response rate
Email (5%)	• Automated process • Inexpensive	• Perceived lack of anonymity • Low response rate • Email address availability
Internet (10%)	• Reliable (patient data entry)	• Self-selection • Perceived lack of anonymity • Easy to leave incomplete

*Percentage figures based on survey results illustrated in Figure 4.

as being non-intrusive since the survey manager already has the attention of the patient when they make the request for him or her to fill out the survey. The timing aspect is also a plus since the patient has just completed the appointment and the patient experience is still fresh.

On the negative side, patient satisfaction surveys conducted at check-out tend to be a biased sampling, and are considered non-objective since they are done in-office, perhaps under the watchful eye of the receptionist who is being evaluated. Also, check-out surveys produce a low response rate since many patients may opt not to participate due to other time constraints or commitments immediately following what might have been a time-consuming appointment. This is especially the case if the patient had to spend any considerable length of time in the waiting room prior to being seen by an attending nurse or their physician.

In Office

Patient satisfaction surveys conducted in office are reasonably easy to administer since the survey participant is present. They are also relatively inexpensive and this method of data collection is the second most popular for patient satisfaction surveys. Negative attributes are similar to those conducted at check-out, including biased sampling and very low response rates since completion is limited to those who choose to pick up and complete the survey. Patients may also prefer to spend their time in the physicianôs office dealing with their health issue compared to taking the time to fill out paperwork in the form of a survey. Survey lengths are also limited when conducted in office primarily due to patient time constraints and patient willingness to wade through numerous questions to provide responses.

Email

Even thought patient satisfaction surveys conducted via email can be automated and are inexpensive to administer, email is the least used method of data collection according to PMGôs data. Anonymity, which is easy to achieve with paper-based surveys, is lacking with email due the participants revealing their identities via corresponding email addresses and general patient data already stored in the physician groupôs office. Low response rates are common with email surveys, and the lack of email addresses for many patients can diminish efforts to conduct meaningful patient satisfaction surveys.

Internet

While the general public is accustomed to filling out various customer satisfaction surveys online, few physician groups use this method for patient satisfaction survey data collection. Although viewed by physician groups as a reliable way to collect patient data, it also presents some drawbacks. These include physician groups relying on patients to self-select when they participate in a survey, a perceived lack of anonymity among participants since they might have to compromise their identity in some way to participate in the survey, and risk of patients leaving some of the patient satisfaction survey incomplete. This again skews the results collected from the survey.

Survey Design

How patient satisfaction surveys are designed can have a dramatic impact on either producing or *not* producing high-value, statistically valid and actionable survey data. The following section of this report addresses six critical design elements of patient satisfaction surveys (Table 2) along with current practices identified in PMGõs physician group survey, as well as PMGõs recommendations to improve survey design.

Questionnaire Length

The length of questionnaires used for patient satisfaction surveys, according to PMG data ranges from five to 30 questions, all containing a quantitative (rating) approach to survey participants. While quantitative questions are useful, PMG recommends using a list of 12-18 rating questions along with two to three open-ended questions.

Frequency of Survey

Once again, PMGõs physician group survey received a variety of responses when participants were asked how frequently they conduct their patient satisfaction surveys. The largest percentage (37 percent) of survey participants indicated that they conduct surveys at the time of patient visits. However, a nearly equal number of participants (34 percent) did not specify how frequently they conduct their surveys (unspecified and regular intervals responses combined).

Interestingly, the least frequently used category that PMG survey participants chose was ñcontinuousò at just under five percent. A continuous flow of survey frequency is, in fact, the optimal practice that PMG recommends for patient satisfaction survey frequency, especially when triggered by various patient/office interactions, such as in person visits or phone calls.

Range of Questions

Physician groups focus on three question areas: patient feelings (42%), level of service (27%) and overall performance (23%). With so many physician group survey questions focused on patient feelings, the resulting data are not producing meaningful results. Instead, PMG

Table 2 | Current Survey Design Can Be Improved

Design Element	Current Practice	PMG Recommendation
Questionnaire Length	• 5-30 questions • All quantitative (rating)	• 12-18 rating questions • 2-3 open-end questions
Frequency of Survey	• Time of visit (37%) • Regular intervals (20%) • Quarterly or less (17%) • Unspecified (15%) • Weekly or more (7%) • Continuously (5%)	• Continuously ï triggered by interaction (visit, call, other)
Range of Questions	• Patient feeling (42%) • Service (27%) • Performance (23%)	• Patient experience • Performance evaluation • Future direction
Competitive Assessment	• Not included	• Patient views on choice and ñalternate supplierò options
Analysis	• Spreadsheet-driven • Internal	• Outcome-driven • Prescriptive • Third-party expert
Implementation	• Limited	• Communicate findings • Action plan development

recommends crafting survey questions around the patientôs experience at the time of service or treatment, implementing more performance evaluation criteria and allowing patients to expound on their thoughts about the future direction of their healthcare needs.

Competitive Assessment

The typical physician group does not utilize competitive assessment. There is a critical need to incorporate competitive assessment into patient satisfaction surveys. It is a reality that patients are aware that they have the freedom to make choices about their healthcare needs, and are actively shopping for the best healthcare available. In the absence of competitive evaluations, a survey risks drawing incorrect conclusions about the relative effectiveness of performance.

Analysis

To ensure the worthiness of any patient satisfaction survey initiative, it is vital that the data be properly analyzed to ensure actionable outcomes. PMGôs physician group survey participants indicated that they rely heavily on spreadsheet-driven analysis that is conducted internally. The main weakness of relying on internal analysis is that the group office administrative staff more than likely does not have the proper skill set to properly interpret statistically valid survey data In contrast, PMG recommends an outcome-driven form of analysis that is prescriptive ï meaning the analysis approach has clearly established methods and guidelines ï and is conducted by a third-party expert that has the skill and expertise to obtain statistically valid and actionable data through properly designed surveys.

Implementation

PMGôs physician group survey determined that even though more than half of the survey participants conduct their own patient satisfaction surveys, implementation of results is non-existent or weak. If a physician group is going to take the time to conduct surveys and ask their valued patients to take time out of their busy schedules to complete them, then they must ensure a statistically valid sample, carefully analyze results, identify priorities for improvement and develop an action plan to address those key survey findings that have the most direct impact on their patientsôhealthcare experience. Lastly, they should communicate the survey findings to patients and to the group employees and managers.

What About The Approaching CG-CAHPS Mandate?

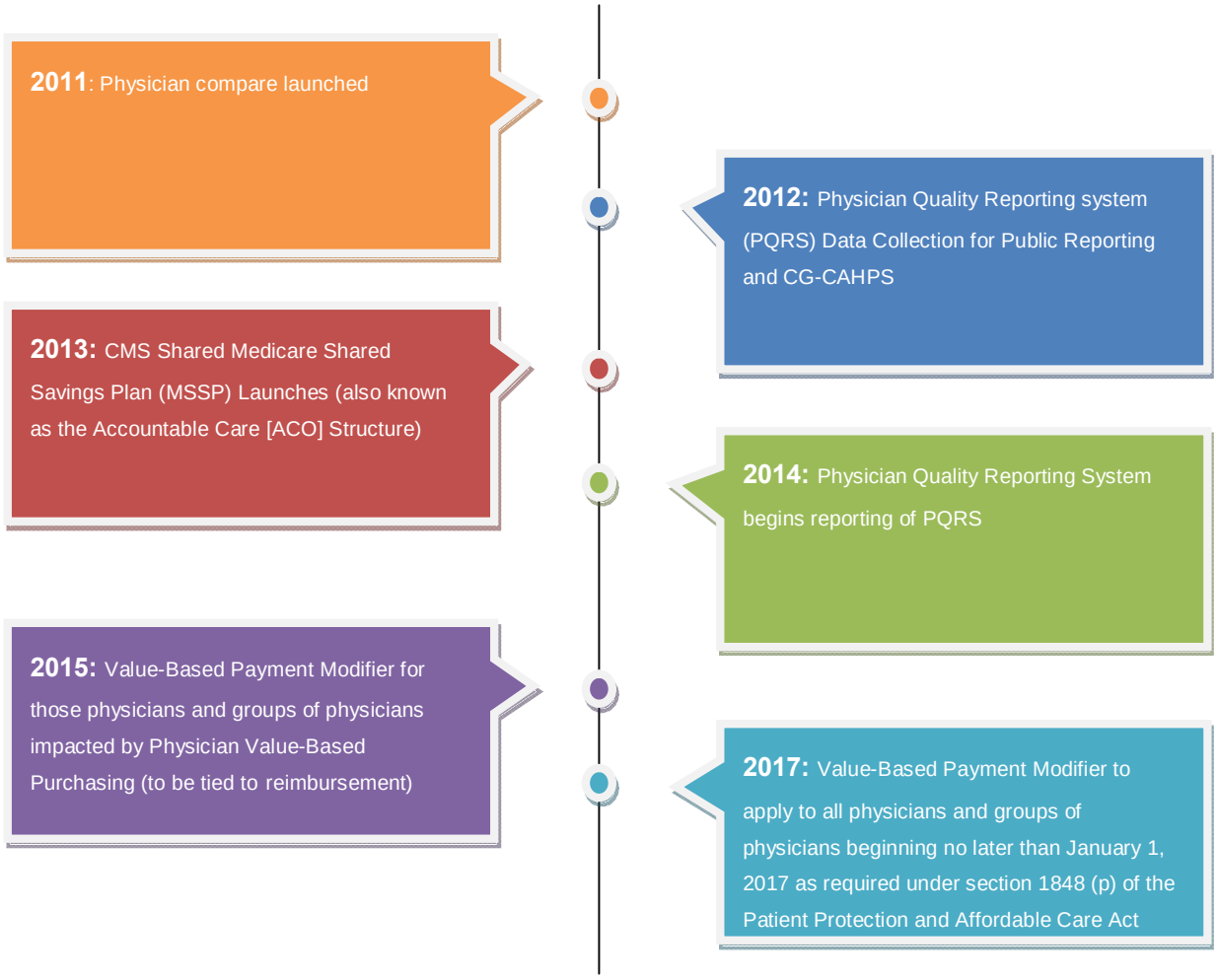
Similar to the federally mandated Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS, often referred to and pronounced as ñh-capsò) survey that assesses Medicare patient satisfaction after inpatient hospitalization, the upcoming federally mandated CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) is a standardized tool to measure patientsôperceptions of care in the physician office setting. CG-CAHPS is directly connected to the passage of the Patient Protection and Affordable Care Act (PPACA), which obligates U.S. healthcare providers nationwide to improve the quality, efficiency and overall value of the health care they provide, while meeting standardized metrics.

While many hospitals have historically collected information about patient satisfaction for their own internal use, until H-CAHPS, there was no national standard for collecting and publicly reporting information about patient experience of care that allowed for valid comparisons to be made across hospitals locally, regionally and nationally.

Through the upcoming CG-CAHPS mandate, the rationale is to provide the same types of comparisons regarding patient experience of care for physician offices. Much like H-CAHPS, CG-CAHPS will have a rating scale of 0-10, where 9ôs and 10ôs will be evaluated as the top scores. The primary domains for the CG-CAHPS survey include: access to care, follow up on test results, how well doctors communicate with patients and the courtesy and helpfulness of office staff.

The timeline for the CG-CAHPS mandate (see Figure 15) is now well underway, with a target completion date for all physician group offices to be participating by the end of 2017. Now is the perfect time for physician group offices to begin evaluating how they will comply with the mandate and what service they will use to analyze the data that their offices will collect. CG-CAHPS, supplemented with PMG modifications, will ensure that the data collected from surveys will provide real value to your physician group.

Figure 15 | CG-CAHPS Timeline



Source: www.cms.gov and other sources

PMG Recommendations: Patient Satisfaction Surveys

In order to construct an effective patient satisfaction survey that will produce statistically valid and actionable data, PMG recommends five success factors that will ensure the time, effort and expense invested in the survey are not wasted. They include: random sampling, conducting a complete analysis of the survey data, ensuring real-time performance tracking while using a continuous approach to gathering survey data, utilizing benchmarks and setting performance targets, and elevating the importance of the survey within the healthcare organization while making sure the survey outcomes are visible to all stakeholders.

Random Sampling

Currently, a high percentage of physician offices are relying on mail or in office data collection methods for their patient satisfaction surveys. Using the in-office method, or even conducting surveys at check-out, can lead to a biased sample of patient survey feedback.

PMG recommends developing a system for utilizing random questionnaire distribution and for providing multiple survey response vehicles, including mailings, phone and online sampling. A random sample is one in which every patient has an equal opportunity to participate. A questionnaire left in a stack on the waiting room table is not random ï those waiting longer have a higher likelihood of seeing the questionnaire and as their wait time extends and their blood pressure rises, they may become more likely to vent their frustration through the survey.

It is also equally important to track data resulting from non-response to various patient satisfaction survey questions. A well-executed survey should be one in which respondents and non-respondents do not differ in any systematic or material way.

Complete Analysis

The data collected from patient satisfaction surveys must be useful to more than just a limited number of staff. Instead, the data should be shared among various departments and functions to provide a broader perspective about how a physician group can improve its patientsô healthcare experiences. To have meaning and impact to various staff, it should address three key questions:

1. How are we performing against patient expectations?
2. What is important to patients?
3. How do we compare to the best alternate healthcare experience?

Each of these questions can be simply incorporated into a well-designed survey. The analysis would follow these same three questions, leading a practice to understand each of these questions and the implications for the group overall, and for each specialty, physician, region or any other classification.

Real-time Performance Tracking

Since one of the primary benefits of a patient satisfaction survey is performance improvement, the closer the survey process can get to providing real-time feedback, the more powerful and impactful the process improvement initiative can be.

Rather than looking at a quarterly, monthly or even weekly survey, PMG would suggest an experience-based survey process. Every patient

encounter with the practice can generate a survey. The resulting data can be accumulated across any classification variable (e.g. geography, physician, specialty) or for any time period so results can be examined as a time series (for example daily results for the past week, weekly results for the past quarter or monthly results for the past year).

Once the data collection and analysis process is in place, reporting can be accomplished via hard copy, electronic reporting, or user web interface. Whatever the chosen method, group staff and management should have easy access to charts and other data summaries providing access to information that will help them to make better decisions.

Utilize Benchmarks and Set Performance Targets

There are several important benchmarks in a well-designed patient satisfaction survey. While industry norms are interesting, they are the least important in driving real and lasting change.

Results can be compared to other practices within the group. Average results for any office-related variable (e.g. wait time) can be positioned against all other practices within the group showing each practice or office where they stand compared to the best and worst in the group. Note: the best and worst are not usually identified. Physician-related variables (e.g. explanation of my diagnosis) can be compared to the best and worst ï again not identified by name ï allowing each physician to gauge critical aspects of their performance against their immediate peers.

Results can also be compared to the best healthcare experience. This is a real-world comparison that may be in-class (similar physician specialty) or out of class (anything in healthcare) at the discretion of the patient. Analysis of this data reveals those areas where the practice is ahead of and behind the best healthcare experience. This can be combined with importance information to prioritize these criteria and isolate those performance attributes that are most influencing patient satisfaction.

Elevate Importance and Visibility

Taking the steps suggested above, the survey process will become a more vital management tool to the group and the member practices. We believe that patient satisfaction insight should be pulled, not pushed. To create that pull, the group must develop and implement a survey that provides valuable information helping a practice to grow and become more profitable. When a practice sees that value, they will demand that the survey be done and information provided to them on a real-time basis.

About PMG

PMG (Priority Metrics Group), based in South Carolina, offers real-world experience in patient satisfaction, marketing strategy development and implementation, market research, new product development and business growth.

PMG works with leading organizations in a variety of healthcare, manufacturing, service and other sectors, consistently delivering high value solutions through its experienced, practical approach to business issues. Since 1993, the firm has delivered unparalleled market insight helping clients grow through world-class customer satisfaction surveys, competitive assessments, and professional lead generation.

In addition, PMG publishes focused industry reports that provide analysis of an industry, market segment or key issue. For clients who are interested in business growth, PMG provides the market intelligence and strategic direction required that allows its clients to capture business expansion opportunities.

For comprehensive information about PMG and its various services, visit www.pmgco.com.

For more information about PMG's unique and innovative approach to designing patient satisfaction surveys, contact Priority Metrics Group at (864) 573-9853, or online at www.pmgco.com.

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Priority Metrics Group
PO Box 1943
Spartanburg, SC 29304
(864) 573-9853
www.pmgco.com