HEALTH & MEDICINE FOR PHYSICIANS

HIPPOCRATES

End-of-Life Decisions

Patients' wishes for end-of-life care often aren't met. Your involvement in thoughtful planning can make the difference.

(page 32)

Meet Our New Editor

Editor-in-Chief Dr. Joseph E. Scherger looks to the future of HIPPOCRATES and primary care

(page 8)

HOW AM I DOING?

By Lauren M. Walker

Last month, we talked about what it takes to please patients, and how the same techniques that lead to high scores on patient-satisfaction surveys — good office management and good patient-interaction skills — also increase patient compliance and improve outcomes. This time, we address the nuts and bolts of conducting patient polls.

There are good reasons for physicians to canvass their own patients. A practice's reception, telephone, appointment, or other systems can seem very different to a patient trying to navigate them than they do to those on the inside. Likewise, we are not always the best judges of how we seem to others — and doctors are no exception. Because the doctor-patient interaction can be so important to patient compliance, outcome, and sense of well-being, it's good medical practice to conduct surveys. "All physicians want patients to have a good experience when they come to the office," says Jerry Seibert, president of Parkside Associates, a Chicago-based health care quality measurement firm. "Getting feedback is a tool that can help you accomplish that."

Payer relationships often include a patient-satisfaction requirement. Starting this year, HMOs must canvass members for accreditation purposes; IPAs may need survey data to land contracts; and government programs have patient-satisfaction components. Managed care organizations often tie part of a doctor's capitation bonus to patient-satisfaction scores. That raises the question: with all the surveying that's already going on, do physician practices really need to do their own?

PHOTO COLLAGE BY JEFF BRICE

"The HMO in which we participate began surveying our practice. And the way they did the survey just wasn't useful to our doctors or our office," says Steven Atwood, MD, of Whiteside Adult Medicine in Springfield, MO. "Our physicians had concerns about the validity of the process, and it didn't really address the question of whether the patient received quality care. We couldn't add questions specific to our office, and the results weren't detailed enough for us to take action on them. That was when we decided to start doing our own polling."

Who conducts the poll matters, according to Seibert, whose company is a subsidiary of Advocate Health Care, because different constituencies have different concerns and different biases. "If you leave it to someone else, you have to live with their questions and the way they conduct the survey. If it's an HMO, they'll only survey their members, and the number of members you saw in their evaluation period may be quite small. You also may not know when they surveyed your patients. A patient could be dissatisfied over a problem you've since corrected, but the report you get from an HMO might not reflect that."

Probably the most compelling reason for practices to do their own surveying is to ask the right questions. "Health plans don't ask the kinds of questions a practice would," says consultant Meryl Luallin, of Sullivan/Luallin, Inc. in San Diego. "A practice might want to know, 'Were you satisfied with the courtesy of the person who took your call?' 'How would you rate our communication material?' If you do your own poll, you can be very specific."

Finally, surveys are a good marketing device for a practice. "Medical marketing is still largely word-of-mouth," notes Carl Cunningham, director of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) Center for a Competitive Advantage. "Surveying gives you the tools to improve patient experience, and if the patients are satisfied, they'll go out and tell their friends and family. If you get good scores, you have something to tell the world, too."

Choosing the Right Strategy

In mapping out a survey strategy, a good place for practices to begin is by deciding what they want to know, and how they plan to use their results. "We ask practices to consider their reasons for doing a survey," says Jon Snyder, senior research analyst at Stratis Health, a Bloomington, MN, health quality consulting firm. "Is this to be part of an ongoing program of improvement? Or are they doing it one time, to meet an accreditation requirement? Is the practice looking to evaluate its processes or to assess specific doctors? That influences what kind of program they need."

A practice must decide how frequently and how thoroughly it wants to poll patients, choose or devise a questionnaire, and find the tools to make sense of the results. Some guidelines: Experts advise surveying at least once a year and as frequently as four times. A practice that wants to use its results to improve patient satisfaction over time will want to canvass patients more frequently than one that only needs an annual snapshot of how things are going.

In a typical mailed survey, a practice can expect a response rate of about 25%; a survey completed in the office typically generates a response rate of about 40% to 50%.

Related to frequency is the number of responses needed, and that depends on how thoroughly the practice wants to poll. Consultants advise gathering at least 50 to 100 completed questionnaires per physician. In a typical mailed survey, a practice can expect a response rate of about 25%; a survey completed in the office typically generates a response rate of about 40% to 50%, according to Luallin. That means mailing questionnaires to at least 200 patients, or handing them to at least 100. Getting the response rate above these numbers involves sending out reminders or a second survey to nonresponders, which can add a daunting expense to the process without generating a significant difference in satisfaction scores. "Some research has shown that once you have a 40% to 50% response rate, getting the nonresponders to respond — boosting the rate to 60% or 80% — doesn't change the results much," says Seibert. "A group can put their data to the test by analyzing their results when 30% to 35% of results are in, and then again when the rate is around 50%, and see if the scores change." If a practice's response rate is much below 25% on a mailed survey or 40% on an in-office poll, take the results with a grain of salt, or keep distributing questionnaires until a larger pool of responses is generated. But given the limited resources most practices can expend on surveying, the total number of responses is likely to be a more important issue than response rate, and 50 to 100 responses provide a reasonable slice of the typical primary care physician's patient panel. Luallin notes that to get the margin of error below 3% would require the average physician to collect about 385 responses, which would mean sending out about 1,500 questionnaires per provider, beyond the resources of most practices.

It's also important to try to distribute the questionnaires to a representative sample of patients, again within limits of practicality. If gender- or age-specific results are important, you may want a sam-

Consultants may offer large, specialty-specific databases, sophisticated questionnaires, and comprehensive data collection and analysis services.

ple with representative distribution of those characteristics — and you'll probably want a somewhat larger pool, to make sure you get a useful number of responses from each category. If you're looking for an overall view, try surveying every third or fourth patient for each doctor until you've collected your target number of responses.

And while it may be tempting to make up a questionnaire on your own, there are advantages to using an existing survey tool. For one thing, the questions have probably been crafted to elicit an unambiguous response. "Inexperienced people often roll two or three dimensions into one question," says Luallin. "For instance, asking, 'How would you rate the caring, professional sensitivity, and tact of the person you saw?' What if the doctor was caring but not tactful? You won't know which element generated the patient's negative evaluation." Another advantage to standardized questionnaires is that results can be compared with those of other practices who have used the same form.

Existing survey instruments include proprietary questionnaires — those developed and copyrighted by an organization or private company, which a practice generally must pay to use — and those in the public domain, which can be copied and used for free.

Public Domain Questionnaires

Public domain instruments range from the 13-question Visit Specific Patient Satisfaction Survey (VSPSS) developed in the 1980s for the Group Health Association of America to the 46-item Consumer Assessment of Health Plans Study (CAHPS) questionnaire developed by the Agency for Health Care Policy and Research. HMOs are now required to submit CAHPS results as the patient-satisfaction component of the Healthplan Employer Data Information Set, used to accredit health plans. VSPSS covers the basics (see box), including four questions about the practice's accessibility and convenience, four about the interaction with the health care provider, and a rating for the visit overall. The VSPSS, as its name implies, is intended to evaluate a specific visit, and is usually given to the patient at the time of the visit or mailed shortly after.

At the other end of the spectrum, the somewhat longer CAHPS survey is built around a core adult questionnaire, with the option of adding topic areas to address specific populations. CAHPS emphasizes the quality of the plan, and so has questions about access to specialist care, whether the patient has a primary provider, delays in care, paperwork, and plan customer service. Only about one fourth of the core questionnaire asks about the patient's experience during physician visits, and it doesn't distinguish between primary care and specialist care for all of them. It's not keyed to a specific visit, but asks about all care episodes over the past 12 months. This is the survey HMOs are required to use, so it may be helpful if a practice's main concern is anticipating HMO results.

A practice can make such public domain instruments the basis of a survey program, adding a few of its own questions and distributing the surveys to patients either at the time of visit or by mail. The VSPPS is particularly well suited to this use because it's visit specific and focused on the characteristics of the practice, and is typically given to patients at the time of the visit, avoiding postage expense.

But devising supplementary questions that elicit the right information, polling a valid sample of patients, tallying the results, and evaluating them are not insignificant tasks. "Most people don't realize until they get into it how easy it is to introduce bias to your data," notes Seibert. "Having someone who understands the impact of various survey methodologies can be helpful." As a result, many practices that conduct their own patient-satisfaction surveys do so with some kind of help.

Professional Organizations

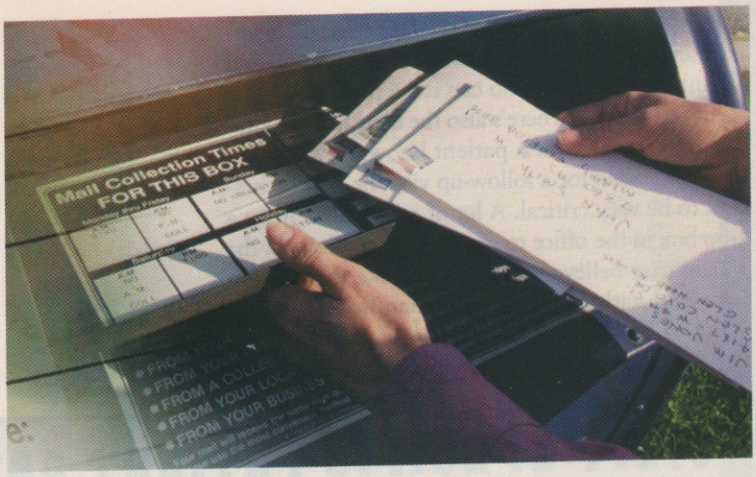
One relatively low-cost option is to use the resources of a professional society. The American Academy of Family Physicians (AAFP) offers a Patient Satisfaction Survey Kit as part of its Vital Signs series of practice management aids, for $10 to members, $15 for nonmembers. The AAFP's guide includes a sample questionnaire, along with step-by-step checklists to prepare, conduct, and score your evaluation, including tally sheets and mathematical conversions to arrive at standardized results. That allows a practice to compare its scores with benchmarks derived from AAFP's national database of results. The kit also includes strategies for improving future scores. AAFP's questions are particularly detailed about access and convenience issues — for instance, differentiating between the ease of making routine appointments versus appointments when sick. It also includes questions about patient information and patient education, as well as ones about how the staff works together, and how caring the doctor, office staff, and medical staff are. Analysis software that performs the calculations and compares scores to benchmarks is available for an additional $5 ($10 for nonmembers).

The ACP-ASIM's Patient Satisfaction CheckUp Program, administered through its Center for a Competitive Advantage, provides questionnaires, enters the data, and reports results at a cost $150 per member, $175 per nonmember, with varying volume discounts. The program's emphasis is on improvement over time, so the fee includes two full administrations, and recommends they be conducted six months apart. The ACP-ASIM's proprietary questionnaire was designed by and for internists, and includes detailed sections on staff and physician interpersonal and clinical skills. The evaluation also includes comparative information from its database of other practices. "You can compare your practice with the medians," says Cunningham, "but more importantly, you can also look at trends. For instance, patients in general score their physicians higher than they score the staff. So if you see that tendency in your practice, you may not want to spend a great deal of thought on it, knowing that it's a typical pattern." Part of the value in calling in outside help is this kind of perspective on what the results mean.

Calling in a Consultant

Nonprofit consultants Stratis Health, for instance, use the public domain VSPPS, but bring their experience, as well as a national results database, to bear on their program. "We chose the VSPPS because it was heavily tested when it was developed, so we knew it was a good instrument," says Snyder. "But we can customize it to the practice's needs, add questions about specific things a provider needs to know and build them into the process. A practice may treat a particular population base, a cultural group, or one with a language issue. We can build questions to reflect that." Stratis' results include both comparative norms and benchmarks — the results of practices scoring in the top 5%. Their analysis also highlights the correlations, if any, between specific factors and patients' overall satisfaction with the practice. "Say the practice scored poorly on the patient's assessment of the providers' technical skills," posits Snyder, "and that correlates highly with the patient's overall dissatisfaction with the clinic. That would make that element a high priority for improvement." According to Snyder, what factors correlate most highly with overall satisfaction varies widely: In some practices, it's parking, while in others it's getting through to the office by phone. "But it's generally true that the patient/physician interaction is a strong contender." Stratis' services include more specific follow-up surveys to explore areas that need improvement, and consulting services on how to improve a practice's results.

Consultants may offer larger or more specialty-specific databases, more sophisticated questionnaires, and more comprehensive data collection services. "What physicians typically find most appealing about our services is our database," says Luallin. "We have 90,000 responses that we can categorize by specialty and by region. That gives practices very specific data to compare themselves against." The consultant's experience and familiarity with results can be an asset, too: "Left to their own devices, practices often compare their scores against the average, and if they're not below it, figure they've done well. But the average is mediocre —would you settle for a C if this were a test in school? Because that's what the average is. Sometimes what you need to know is how much better you would have to do to be superior."



If a practice's self-evaluation program is successful, improved patient satisfaction will follow, and that's bound to lead to better scores on everybody's surveys.

Seibert emphasizes the quality of the survey instrument, and recommends examining a consultant's questionnaire and asking for documentation of its validity. "You want a survey tool that's been through rigorous scientific testing, so you don't have to worry about that aspect of it," says Seibert. "You need something that will be administered relatively soon after the encounter so you can link the results to practice conditions in a specific time frame. And you want to make sure that the content of the tool focuses on what's important to the patient."

Although canvassing patients at the time of the visit has its advantages, and provides an inexpensive way to gain a fairly high return rate, for some practices, other considerations may be more important. "In the typical process, the front desk gives patients a questionnaire on the way out, and the patient fills it out and drops it in a box in the office," Seibert observes. "But if a patient had a bad visit, the desk staffer may just not follow through. It's not intentional, but when you know someone is distraught, it's

just easier to let that one slip by." That leads to underrepresentation of unhappy patients in the data — and it's unhappy patients who can tell a practice what it needs to change. "There's also the issue of anonymity," says Seibert. "If a patient knows he's coming back next week for a follow-up visit, he may be hesitant to be very critical. A lot of programs rely on a drop box in the office to provide anonymity, but the patient may believe you can still make the connection. And with a primary physician, whom they're going to have to see again, that may inhibit their response."

Seibert recommends a mailed questionnaire in those cases, with follow-up postcards to bring the response rate to an acceptable level. But such a process can be expensive: He estimates a 10-physician group, getting quarterly results, with 100 completed surveys for each physician, postage included, could spend $15,000 to $20,000 a year. "That would be for a turnkey program, where all the practice had to provide us with was a list of names," Seibert adds.

Even if a practice needs help, however, there are ways to economize. Some consultants charge by the number of questionnaires sent or analyzed. The rec-

VISIT SPECIFIC PATIENT SATISFACTION SURVEY

(Adapted from the Visit Specific Patient Satisfaction Survey, Copyright © 1998, Stratis Health)

Thinking about your visit with the health care provider, how would you rate the following: (Check one box on each line)	Poor	Fair	Good	Very Good	Excellent
1. How long you waited to get an appointment	❑	❑	❑	❑	❑
2. Convenience of the location of the office	❑	❑	❑	❑	❑
3. Getting through to the office by phone	❑	❑	❑	❑	❑
4. Length of time waiting at the office	❑	❑	❑	❑	❑
5. Time spent with the health care provider	❑	❑	❑	❑	❑
6. Explanation of what was done for you	❑	❑	❑	❑	❑
7. Technical skills (thoroughness, carefulness, competence) of the health care provider	❑	❑	❑	❑	❑
8. The personal manner (courtesy, respect, sensitivity, friendliness) of the health care provider	❑	❑	❑	❑	❑
9. The visit overall	❑	❑	❑	❑	❑
10. In general, would you say your health is	❑	❑	❑	❑	❑

	Definitely not	Probably not	Probably yes	Definitely yes
11. Would you recommend the health care provider you saw to your family or friends	❑	❑	❑	❑

12. Are you male or female (check one answer) — Male ❑ Female ❑

13. How old were you on your last birthday (write in) _____ years old

Comments: _____

ommendation of 50 to 100 completed surveys per physician is based on polling patients two to four times per year. But if a practice doesn't need to track its progress that often, it can save money by reducing the frequency. If, on the other hand, quarterly measurement is important, it may be acceptable to settle for a lower number of responses — closer to 50 than 100. Or, if the practice is mainly interested in systemic and access issues, it may not be necessary to go into detail about each physician — a 100-patient sample analyzed for practice-wide characteristics rather than 100 responses for each physician may be sufficient. "You could get quarterly results for the practice as a whole and break down the results once a year by physician," Seibert says. That would mean a practice would only have to reach 100 completed questionnaires per physician over the course of a year, instead of each quarter.

Doing more of the work in-house can also save on consultant costs — for instance, having the staff mail out the questionnaires, or enter the practice's data before it's sent to the consultant for analysis. But remember to factor in the cost of the staff time.

Making Use of Your Results

"Before a practice embarks on its first survey, you have to think about what you are going to do with the results," says Seibert. "For some reason, people take patient evaluations very personally. It's easy to understand that — these are your patients saying things about you. It speaks to the heart as much as to the head. So if results aren't as high as you'd like, it can be hard to accept. That needs to be talked about openly before the first results come back."

The best way to make the evaluation a positive experience is to view it as part of an ongoing program of improvement. "We think the greatest value in the survey process is in looking at the areas where you might improve, working on those areas, and surveying again in six months to see how you did," says Cunningham. "Of course you can't do that with just one report; it's just a starting point. So we advise people not to make snap decisions based on one set of results."

In the interest of practice self-improvement, ACP-ASIM includes a patient satisfaction tip book with its survey reports. Other consultants offer more extensive services: Sullivan/Luallin, for example, conducts seminars for physicians on "Excelling in the Art of Medicine," to help teach effective patient communication and improved practice productivity strategies.

Practices may also use their survey results to challenge unfavorable HMO results, particularly important if the HMO ties compensation or participation to your scores. "If you use a scientifically designed questionnaire and a good method, you can go back to them with your results and ask how they did their survey," says Seibert. "If they say, 'This is based on seven members who answered the questions about doctors and who we had coded with you as their PCP,' then for all you know the patients may not even have been talking about your practice at all." Faced with the results of your own well-designed program, the HMO may yield.

But more importantly, if a practice's program is successful, it points the way to genuine improvement in patient satisfaction, and that's bound to lead to improved scores on everybody's surveys. "Hopefully, if the HMO's survey is at all accurate, we should have covered the major factors, and the satisfaction level should be high," says Cunningham.

And in the end, it's the patient satisfaction, more than the evaluation, that counts. "We tend to get really focused on the methodology," notes Snyder, "but really what's important is what we get from it. What practices are looking for are insights, clues, and ideas that will help them do their jobs better, so they can feel that they've made some contribution to the world when they go home at night. They want patients to feel they've been cared for and treated appropriately. And surveys are simply one of those tools that help us listen to patients a little more carefully and a little more systematically." **H**

Lauren M. Walker is a senior editor at Hippocrates.

Resources

The AAFP and ACP-ASIM both offer survey guidance:

American Academy of Family Physicians
8880 Ward Parkway
Kansas City, MO 64114
816-333-9700
www.aafp.org/vitalsigns

American College of Physicians-American Society of Internal Medicine
Center for a Competitive Advantage
2011 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006-1834
800-523-1546, ext. 2600
www.asim.org

Information on health plan accreditation and surveying
National Committee for Quality Assurance
2000 L Street, NW
Suite 500
Washington, DC 20036
800-839-6487
www.ncqa.org

Consumer assessment of health plans surveys and information
Agency for Health Care Policy and Research
Center for Quality Measurement and Improvement
Executive Office Center, Suite 600
2101 East Jefferson Street
Rockville, MD 20852
800-492-9261
www.ahcpr.gov/qual/cahpfact.htm