Hospital Medicine Practice

Empowering Hospitalists With Evidence-Based Reviews

HCAHPS And The Metrics Of Patient Experience: A Guide For Hospitals And Hospitalists

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Abstract

Patient satisfaction has become a widely used quality care metric that is increasing in importance for hospitals and hospitalists. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey standardizes and reports patient experience data, and it is used in determining reimbursement rates for inpatient care by the Centers for Medicare & Medicaid Services. This issue examines the principles and uses of the HCAHPS survey and looks at the evidence on utilizing patient satisfaction as a marker for care quality. Examples of interventions that healthcare organizations and institutions can (and have) employed to improve HCAHPS scores and patient care are reviewed. Specifically, the role individual hospitalists play in affecting HCAHPS scores and how to optimize physician communication skills, along with best practices and future directions for study, are examined.

CME Objectives

Upon completion of this article, you should be able to:
1. Describe the components of the HCAHPS survey and how it is administered.
2. Discuss the pros and cons of patient satisfaction as a quality care metric.
3. Discuss the interventions at both the hospital and physician levels that have led to improvement in HCAHPS scores across various domains.
4. Identify best practices to optimize communication with the hospitalized patient.

Prior to beginning this activity, see "Physician CME Information" on the back page.

Clinical Pearls

The HCAHPS Survey: Why Should You Care About Patient Satisfaction?

- HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems.
- Satisfied patients are more adherent to treatment plans, are more likely to continue using health services, remain loyal to their physicians, and recommend services to others.
- HCAHPS satisfaction scores are publicly reported (https://www.medicare.gov/hospitalcompare/search.html), and they have become the standard by which healthcare organizations and individual hospitalists are judged.
- Hospitals are subject to financial penalties for low satisfaction scores.
- Some evidence supports that improved satisfaction equals improvement in quality of care.

What Is HCAHPS? (Page 4)

- The first standardized, national, publicly reported satisfaction survey that allows consumers to make comparisons across hospitals.
- The survey is sent to a sample of patients aged ≥ 18 years with a medical, surgical, or maternity primary discharge diagnosis who have 1 overnight stay (not observation status) and are alive at discharge.
- It measures 10 key aspects of the inpatient experience: Communication with nurses and doctors, responsiveness of staff, pain management, communication about medicines and discharge, care at home, cleanliness and quietness, overall rating of the hospital, and willingness to recommend the hospital.
- There are 3 doctors-specific questions: During this hospital stay, how often did doctors:
  ◦ Treat you with courtesy and respect? (Q5)
  ◦ Listen carefully to you? (Q6)
  ◦ Explain things in a way you could understand? (Q7)

How Can Hospitalists Excel At HCAHPS? (Pages 9-13)

Training
- Utilize established/tested training programs for improving communication and satisfaction; ie, the Four Habits Model or REDE℠ model (Cleveland Clinic).
- Implement observed feedback through peer shadowing programs.

Physician Behaviors
- Make your patients respected partners in medical decision making.
- Provide full, satisfying explanations.
- Actively elicit and address patient concerns.
- Modify management plans based on patients' input.

Team Communication
- Fully explain to patients your role as a hospitalist, with attention to your being in charge of their care.
- Ensure patients understand the role of other physicians involved in their care (residents, consultants, etc).
- Distribute face cards and use informational whiteboards in patient rooms to improving patients' knowledge of names and provider roles.
- Maintain clear, consistent communication between physicians.
- Continually update the RNs on the plan of care.

System Improvements
- Institute structured interdisciplinary rounds (MD, RN, or patient-centered).
- Deploy hospitalists in innovative ways:
  ◦ Establish geographic localization of hospitalist teams
  ◦ In the ED, to expedite care for boarded patients
  ◦ In a rapid response "pain team"
  ◦ In postdischarge clinics
- Ensure hospitalists' job satisfaction and maintain a safe workload.

Best Practices For Physicians (Pages 10-13)

Demonstrating Courtesy And Respect
- Knock before entering a patient's room.
- Greet the patient by name.
- Introduce yourself and your role.
- Review the chart prior to entering the room.
- Treat every concern brought up as important and explain why you prioritize certain concerns over others in the hospital.
- Ask the patient for permission to conduct a physical examination.
- At the end of an encounter, ask for questions in an open-ended fashion
- End the hospital stay on a positive note.

Best Practices For Improving Listening
- Avoid interrupting the patient.
- Take notes so they know you take their concerns seriously.
- Summarize key points of a discussion.
- Pay attention to nonverbal cues, and acknowledge emotions.
- Sit at the bedside.
- Use social touch to convey empathy.
- Be comfortable with silence: allow 5 seconds to resume conversation when there is a pause.
- Watch your body language; don't appear hurried, bored or fidgety; don't cross your arms.

Best Practices For Explaining
- Avoid medical jargon.
- Explain physical examination findings as you are conducting the examination.
- Use the teach-back method to ensure understanding; utilize open-ended questions.
- Explain procedures/testing before they are ordered/performed.
- Write out important information, if needed (use whiteboards in rooms).
- Give patients a way to contact you with any questions after the hospital stay.

The Background Of Patient Satisfaction And Its Measurement

> "The most effective, efficient treatment or program is of limited use if it does not fulfil the needs of an individual or group receiving service."[1]
> —Avedis Donabedian, MD, MPH

Patient satisfaction is a highly desirable outcome of clinical care in the hospital, and it is considered by many to be an important measure of healthcare quality. Over the past several decades, considerable research has documented the role that patient satisfaction can play in influencing care. "Satisfied" patients have been found to be more adherent to treatment plans, more likely to continue using health services, to remain loyal to their physicians, and to recommend services to others.[2]

Critics of patient satisfaction as a measure of healthcare quality have pointed to the fact that there is little consensus in the literature around the definition of satisfaction, satisfaction surveys appear to have low discriminative abilities, and the marker is a subjective one.[2] Despite this, patient satisfaction has emerged as an increasingly important metric for healthcare. Patient satisfaction data have been used in the healthcare arena over the past several decades for 4 related, but distinct, purposes:[3] (1) to compare different healthcare programs or systems, (2) to evaluate the quality of care,[4] (3) to identify which aspects of a service need to be changed to improve patient satisfaction,[5] and (4) to assist organizations in identifying consumers likely to disenroll.[6]

Most recently, the inpatient experience has come into prominence as the assessment of patient satisfaction in the hospital has become standardized and publicly reported as a measure of high-quality care, via the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The impact of hospitalists on the patient experience has also gained attention with the advent of the HCAHPS survey. Slowly but surely, HCAHPS has become the standard by which both healthcare organizations and individual hospitalists are judged. Given this, it is imperative to understand the survey, the underlying drivers of patient satisfaction from both an organizational and provider perspective, and the most current literature on proven methods to succeed in this arena.

Introduction

> "Oh, when I first woke up, there was a line of them. I didn't like that. The group was just too much. It's hard enough being in the hospital, but all these people you don't know."[7]

Mr. A: I've had chest pain on and off before, but never quite like that. The pain woke me up from sleep, and I noticed it got worse with each deep breath I took. I was feeling pretty winded as well. I've never been in the hospital before, but I was so worried about whatever was happening to me, I made my way to the closest emergency room. After quite some time, I was finally told I was being "admitted for more workup," whatever that means. This sounded promising. To tell you the truth, I was feeling so bad, I was just excited to have a bed to call my own! On arriving to the floor, I was greeted by a flurry of activity, strange faces taking my blood pressure, attaching stickers to my chest, and putting needles into my arms. What was going on? What was happening to me? Was I dying? My anxiety continued to build. Isn't there supposed to be a doctor around to take care of me?

Mrs. B: I'd been having chest pain and shortness of breath all day long, along with some fevers. I noticed it was worse when sitting up, but it was still around when lying down. I never get sick – never! But I'd never felt anything like this before, so I went to the ER. The ER was a whirlwind. I saw at least 20 faces, and told my story at least 15 times, though I can't remember exactly what I said, I was feeling so out of it at that point. Lots of needles, IVs, fluids – that's what I remember. Somewhere along the line, I heard I was being admitted to the hospital. All I wanted was to see my doctor, who I hoped would fix everything and let me go home.

The acute care hospital is the pinnacle of healthcare—taking care of the sickest patients and the site of the most sophisticated, intense, diverse medical treatment available in most communities. However, the 2000 Institute of Medicine (IOM) report, "To Err is Human," pointed out that the quality of care in the United States is variable and, too often, inadequate. This was particularly noteworthy in the hospitals: too many patients were exposed to the risks of unnecessary services, opportunities to use effective care were missed, and, too often, preventable errors led to adverse outcomes.[8]

Over the past decade, the quality of hospital care has come to the forefront of the national agenda. The Hospital Quality Association (HQA), comprised of public and private entities, including the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission, became the group tasked with leading the improvement effort in the hospital sector. HQA initially began the move toward improved quality by collecting and producing quarterly reports

from hospitals on the provision of effective services for common conditions (now known as the Core Measures) as well as safety data. These data became increasingly available to the public, but a gap in the data was the lack of information on the quality of hospital care from the patients' perspective.[8]

According to the 2001 IOM report, "Crossing the Quality Chasm," provision of patient-centered care is a key element of a high-quality healthcare system.[9] To address this gap in information provided, The HQA developed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. While there have always been multiple venues for patients to share their opinions, including online ratings, the intent of HCAHPS was to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on healthcare. Prior to HCAHPS, many hospitals did collect data on the patient experience, but there was no universal standard for this collection process or benchmarking. Consumers were eager for information about their contemporaries' healthcare experiences, and HCAHPS was cited as having the potential to address these concerns. CMS felt HCAHPS would promote consumer choice, public accountability, and greater transparency in healthcare.[10]

HCAHPS gained support quickly, and it became the national standard for assessing patients' hospital experiences. In 2008, it became tied to the annual payment update for Medicare, which meant that general acute care hospitals were required to collect and publicly report HCAHPS results on the CMS Hospital Compare website (https://www.medicare.gov/hospitalcompare/search.html) or face a decrease of 2% in reimbursement rates from Medicare, otherwise known as the "pay-for-reporting" phase. The Affordable Care Act, passed in 2010, added another twist to the reimbursement of HCAHPS scores: not only would hospitals be financially incentivized to report scores, but they would also be reimbursed based on how they performed on the scores, beginning the "pay-for-performance" phase. As part of the Value-Based Purchasing program (beginning October 2012), CMS decreased by 1% the base operating diagnosis-related group (DRG) payments to hospitals to create an incentive fund. For the next several years, this fund will be preferentially distributed to high-performing hospitals based on several quality measures, 30% of which are based on HCAHPS scores.[10]

What Is HCAHPS?

"Every time Dr. X came in, he asked me questions. He listened carefully to me. He also took into consideration what I said to him. I was very happy he listened to me. Some doctors don't! You talk to them and they say, 'yeah yeah yeah,' and they do what they want to do. But he listened to me and when he saw that the first medication I was on wasn't strong enough, he immediately changed the medication, which took care of the problem, and which is taking care of the problem still. It's excellent. Really excellent."[7]

Mr. A: I had just reached my room when I heard a knock on the door. A lady in a white coat walked in, smiled, and put her hand out to shake hands. "I'm Dr. Anderson, one of the hospital doctors. I'll be taking care of you while you're in the hospital, and I'll be speaking with your primary care doctor as well. You look so tired! It must be so hard waiting in the emergency room when you're not feeling well. Let's talk about what's been going on with you and figure out how to get you feeling better. Does that sound okay?" She was so nice, and she made me feel really comfortable. I felt some of my anxiety decreasing, and began to tell her my story. "You see, doc, I woke up last night and just felt this pain in my chest…"

Mrs. B: At first, I was just so relieved to finally be in my room. I was just drifting off to sleep when I was startled awake. The door opened, and a gentleman wearing a white coat walked in. "I heard you were having chest pain?" I was still half asleep, but I tried to make some coherent sentences. "Yes, yes…I was…" He interrupted me. "I think we have to work you up for some scary things – you might be having a heart attack! I'm going to go order some tests." He walked out of the room, and I was dumbfounded. What just happened? Am I dying? What tests am I going to go through? Didn't he want to hear my side of things? And who was that guy, anyway?

HCAHPS is the first national, standardized, publicly reported information that allows consumers to make comparisons across hospitals. Public reporting of these scores aims to inform consumer decisions, allow hospitals and providers to identify and focus on areas that require improvement, ensure public accountability, and close an information gap that our available technical process measures do not have the scope or coverage to fill. In fact, HCAHPS is now widely used not just by consumers but by health plans, insurance companies, and employers to evaluate physicians and to determine incentive compensation. However, it must be kept in mind that these measures also come with significant disadvantages, such as the difficulty patients have assessing technical aspects of care given their limited clinical knowledge and the potential that scores may reflect other factors, such as a patient's general mood or response tendencies.[10]

The Survey Instrument

The HCAHPS survey consists of 32 items. (**See Figure 1** for a URL and QR code link to the instrument.) Numbers 1 through 25 include 18 substantive items used in publicly reported measures, including a new section on care transitions to home and screener items to determine eligibility of patients. Items 26 through 32 are demographic and are used in patient case mix adjustment. An important standard of the HCAHPS survey is that these questions may not be changed by a hospital to reflect their specific practice.[10]

Eligible patients are those who are 18 years or older on admission; have a nonpsychiatric primary discharge diagnosis for medical, surgical, or maternity care; have an overnight stay (or longer) at the hospital under inpatient status (as opposed to observation status); and are alive at discharge. Patients discharged to hospice, prisoners, and patients with foreign home addresses are excluded.[10]

Hospitals may administer the survey themselves or utilize an approved survey vendor. The survey can be administered via several different methods, and the choice is up to each individual hospital: mail only, telephone only, mail with telephone follow-up, or interactive voice-response phone calls. Eligible patients are contacted between 48 hours and 6 weeks postdischarge, and they have 6 weeks following initial contact to complete the survey.[10]

The HCAHPS survey measures 10 key aspects of healthcare quality:[11]
1. Communication with nurses
2. Communication with doctors
3. Responsiveness of hospital staff
4. Pain management
5. Communication about medicines
6. Discharge information
7. Care at home
8. Cleanliness and quietness of the hospital
9. Overall rating of hospital
10. Patient willingness to recommend the hospital to others

Figure 1. The HCAHPS Survey Instrument

For a PDF of the document, scan the QR code with a smartphone or tablet or go to: http://www.hcahpsonline.org/files/HCAHPS%20 V10.0%20Appendix%20A%20-%20HCAHPS%20Mail%20Survey%20Materials%20(English)%20March%202015.pdf

The "communication with doctors" questions consist of the following 3 questions, answered as "always," "usually," "sometimes," or "never."[11] During this hospital stay…
1. How often did doctors treat you with courtesy and respect? (Q5)
2. How often did doctors listen carefully to you? (Q6)
3. How often did doctors explain things in a way you could understand? (Q7)

With the exception of the global items, scores are reported as a "top box" score of the percentage of time the "always" answer choice was selected.

Publication And Use Of Survey Results

The survey results are made public on the Hospital Compare website, allowing the public to compare results between individual hospitals and to national and state averages. CMS also makes more detailed benchmarking tables available to determine performance for individual hospitals at the percentile level of national performance. The most recent development of public reporting is the roll-up of the results for items into a 5-category "star" rating of overall patient experience.

HCAHPS results are adjusted for both mode of survey administration, patient mix, and self-reported health status prior to public reporting. Hospitals and survey vendors are required to sample continuously over the year, with a goal of at least 300 completed surveys for each hospital per year, to achieve high reliability for the reported measures. Data have shown, with an n of at least 300, variation in adjusted HCAHPS scores at the hospital level represent true differences in patient experience much more than sampling error attributable to variation in the types of patients who respond to the survey. When there are only a total of 100 completed surveys/institutions, however, adjusted reliabilities fall below the minimum recommended reliability threshold of 0.7.[12]

Analyses of HCAHPS data have found that there are patient and hospital characteristics that are associated with optimal patient experiences. When Elliott et al examined scoring on HCAHPS for different subgroups of patients, the group found that there is substantial and significant heterogeneity to relative hospital scores for various patient subgroups.[12] For example, the best hospitals for relatively healthy patients may not be the best hospitals for the least healthy. This may reflect the fact that different hospitals specialize in certain patient types or processes, and hospitals are not "one size fits all."[12]

Looking to the future, in fiscal year 2015, the patient experience of care will remain 30% of the total value-based payment, and in fiscal year 2016, while the total DRG withhold from hospitals will

increase to 1.75%, the patient experience of care portion of the total value-based payment will decrease to 25%. Of note, CMS takes into account not only each individual hospital's performance compared to other hospitals when determining payment, but it also takes into account improvement from each hospital's baseline scores (the scores 3 years prior to the current fiscal year), making continued improvement for each hospital imperative.

The Relationship Between Patient Satisfaction And Quality Of Care

"I always try to get to know my patients personally. I ask them where they are from, and whether they have kids. That helps me a lot, being able to care for them as an individual person, and also creates a connection between us. I also try to round at the bedside whenever possible; patients perceive that as increased time spent with the physician and feel more in-the-know. I usually tell the patients that anything they don't understand ("medical-ese"), I will translate for them after the resident's presentation." – Dr. V[7]

Mr. A: I've been in the hospital for a day now, and I'm feeling considerably less anxious than when I first came in. Dr. Anderson spent a lot of time sitting with me, going over my concerns. My father had a heart attack and died when he was really young, so I was really worried that was what was happening to me. She reassured me and really made me feel like she cared. She sent me for a couple of tests this afternoon and told me she would be back later on to go over the results. My nurse, Beth, was really excellent too. She seems to know exactly what is going on all the time, and she always checks in with me to make sure I'm comfortable and not in any pain.

Mrs. B: I spent most of my second day in the hospital in a test-induced daze. I went from test to test, including a stress test. I'd had one just a few months earlier somewhere else, but the doctor never asked and I didn't think to tell him when I saw him. His visits are so quick, and for some reason my brain won't remember important points to ask about until after he has left. The nurses were really caring, but I don't think they had any more information on what was going on with me than I did! They were never quite sure what test I was going to or why. Why don't the doctors and nurses talk to each other?

Satisfaction with care has been linked to patient adherence to physician recommendations and loyalty to physicians, as well as decreased medical malpractice risk,[13] but over the past 2 decades, the evidence for a correlation of patient satisfaction with technical quality of care measures has been found to be mixed.[2]

Schneider et al found that enrollees in Medicare managed care plans that had higher performance on technical quality measures did not seem to have higher overall ratings.[14] Chang et al also found no relationship between patients' experiences and the quality of care among elderly patients in 2 different health management organizations (HMOs).[15]

However, Jha et al found a positive relationship between patients' experiences (as measured by HCAHPS) and the quality of clinical care in United States hospitals.[8] There were significant differences in quality between hospitals that received higher ratings on the HCAHPS survey and hospitals that received lower ratings. For example, those in the top quartile of HCAHPS ratings performed better than those in the bottom quartile with respect to the care that patients received for acute myocardial infarction (actions taken to provide appropriate care as a proportion of all opportunities for providing such actions, 95.8% vs 93.1% in unadjusted analyses; $P < .001$) and for pneumonia (90.5% vs 88.6% in unadjusted analyses, $P < .001$).[8] Isaac et al corroborated these findings in 2010, publishing a study noting relationships between patient experiences and complication rates.[16] They found that scores on the overall hospital rating and willingness to recommend questions were correlated with technical performance measures such as Patient Safety Indicators (PSIs) (correlation 0.15-0.63, $P < .05$). Patient experience was inversely associated with rates of decubitus ulcers, hospital-acquired infections, and postoperative pulmonary embolism/deep venous thrombosis (correlation coefficient from -0.17 to -0.35, $P < .05$).[16] Higher patient satisfaction ratings were also found to be associated with decreased readmission rates, as Boulding et al determined.[17] Looking at over 2500 hospitals, a statistically significant correlation was found between lower 30-day risk standardized readmission rates and patient satisfaction scores relating to discharge planning and care.

Examining the association of patient satisfaction with mortality, Jaipaul et al found patient satisfaction scores were inversely associated with mortality rates in 29 hospitals in northeastern Ohio.[18] Over 5 years, correlations were significant for coordination of care ($R = -0.40$; $P = .03$), discharge instructions ($R = -0.39$; $P = .04$), overall quality of care provided ($R = -0.38$; $P = .04$), information provided ($R = -0.37$; $P = .05$), and nursing ($R = -0.35$; $P = .06$).[18] Conversely, Fenton et al used a national database to show that higher patient satisfaction scores, over time, were associated with higher inpatient utilization (adjusted odds ratio [OR] 1.12; 95% CI, 1.02-1.23), greater total healthcare expenditures (OR, 9.1%; 95% CI, 2.3%-16.4%), and higher expenditures on prescription drugs.[19] In addition, this work indicated that the most-satisfied patients also had a statistically significant greater risk for mortality compared

with less-satisfied patients (adjusted hazard ratio [HR] 1.26; 95% CI, 105-1.53), leading the authors to conclude that satisfaction may correlate not with actual care, but to the extent to which physicians fulfill patients' requests.[19]

Interpreting The Elements Of Patient Satisfaction

Fueled by the studies that indicated, at best, patient satisfaction has no relation to quality, and, at worst, it was associated with poorer outcomes, many in the healthcare world began to raise strong objections to the use of patient satisfaction surveys (such as HCAHPS) for reimbursement and incentives, . Conversely, as other studies pointed out that there was a link between better patient experiences with improved outcomes, which side was correct?

According to a 2012 editorial by Kupfer and Bond, the main issue in this debate is the difference between patient-centered care (one of the IOM's pillars of a high-functioning healthcare system) and patient satisfaction.[20] They noted that patient-centered care is defined as patients and physicians working together, using available evidence to select between various diagnostic and therapeutic options, and it has been shown to improve adherence to physician recommendations. Conversely, patient satisfaction has its roots in consumer marketing and is a measure of how services or products meet or exceed the expectations of the customer. The difference between these 2 models is that, in a patient-centered practice, physicians are not obligated to satisfy all demands. In addition, patient-centered care is only one of the IOM goals for high-quality care; the others include safe, effective, efficient, and equitable care. Therefore, they concluded, the onus is on the healthcare system to not only provide patient-centered care, but to use resources effectively, efficiently, and equitably. How can these competing needs be balanced? If the medical evidence does not support patient demands, Kupfer and Bond felt that it should be the duty of the physician to deny the request, though satisfaction could decline. They did note that discussion and education should mitigate some of the dissatisfaction.[20]

Kupfer and Bond also made an analogy between medicine and other marketed services. Given that evaluation of care quality by patients is difficult, most patients tend to view action/intervention more favorably than counseling or monitoring. In addition, in medicine, the recipients of services and the payers are frequently different entities, as compared to other industries where evaluations of satisfaction are tempered by considerations of cost (expectations for a 3-star-level stay when paying for a 3-star hotel). The risk of patient satisfaction measures creating a "positive feedback loop of health utilization," where both providers and patients are incentivized

to overuse resources, Kupfer and Bond felt, could lead to creation of an unstable, untenable healthcare system.[20]

In response to this, Manary et al argued that patient satisfaction is a marker that captures interpersonal care experiences (such as communication) that correlate with technical care, but it also represents a unique dimension of quality.[21] Because healthcare is a service, measures of quality should include assessment of the extent to which the patient and the service provider reach a common understanding. They noted that, while there is concern that patient satisfaction is equal to fulfillment of desires, there are also data to show that increased patient engagement in medical care leads to lower resource utilization as well as increased satisfaction.[21]

Using HCAHPS In The Hospital

"With a difficult patient, I try to get ahead of the situation and start the interview expressing empathy – "I heard you had a difficult night. I am so sorry." Sometimes that cools off a situation and the patient is more willing to listen when I discuss stopping the intravenous narcotics. Patients also seem to appreciate it when I offer to come back later if they are eating breakfast." – Dr. B[7]

Mr. A: So I found out I had a clot in my lung. Dr. Anderson stopped by yesterday and gave me the update from the tests. So this is why my chest had been hurting and I'd been feeling so winded! She just started me on a medication to thin my blood, and while this is a pretty scary concept, Dr. Anderson took the time to explain the medication and how it works to me (and I hope I won't need to be on it for more than 6 months). I was really relieved to finally have a diagnosis for what was wrong with me and to know that I wasn't going to have a heart attack and die like my father. She told me I'll probably be going home tomorrow! Dr. Anderson also left a few sheets of paper explaining things in very basic terms with some diagrams, as well. I'm no doctor, but I felt like I had a pretty good idea of what happened to me.

Mrs. B: The days passed, and I remained in the hospital. Still with chest pain, still worse when I sat up, and the doctors didn't seem to know what to do with me. Lots of tests, specialists, different messages from each person I spoke to. I'm still not sure if I had a heart attack, how critical my condition was, or when I was going to be able to go home. On top of all the confusion and anxiety, I was getting absolutely NO sleep. The hallways were so loud at night with people talking and alarms going off! I was so stressed and exhausted, I was to a point where I didn't care anymore – all I wanted was to go home.

Hospitals that perform in the top quartile of HCAHPS scores and technical measures of quality appear to be small (< 100 beds), large (> 200 beds),

nonurban, located in New England or the western north central part of the country, and nonprofit.[22] Looking at various hospitals, it also appears that higher nurse-to-patient ratios play the most significant role in hospitals with higher scores as compared to lower-scoring hospitals. Jha et al found that, as compared with hospitals in the bottom quartile of the ratio of nurses-to-patient-days, those in the top quartile had a better performance on the HCAHPS survey (eg, 63.5% vs 70.2% of patients responded that they "would definitely recommend" the hospital; $P < .001$).[8] Safety net hospitals seem to have lower HCAHPS scores, as compared to non–safety net hospitals,[23] and hospitals with hospitalists have higher patient satisfaction scores as compared to nonhospitalist facilities (patient overall assessment, 87.9% with hospitalist facilities vs 86.2% with nonhospitalist facilities, $P < .05$).[24] Additionally, hospitals with a higher perceived "culture of safety" (as measured by the SOPS [Survey on Patient Safety and Culture] survey) appear to score better on HCAHPS. Higher overall Hospital SOPS composite average scores were associated with higher overall HCAHPS composite average scores ($R = 0.41$, $P < .01$).[25]

The Commonwealth Fund conducted a case study that looked at an individual hospital with consistently high HCAHPS scores, Munson Medical Center in Traverse City, MI. The study found that the following strategies and factors most likely contributed to Munson's success:[26]

- Maintaining high nurse-to-patient ratios.
- Fostering strong nurse-patient relationships by adopting acuity-adaptable care. If patients needed ICU-level care, they would not need to be transferred to another unit, but could remain on the unit where they were already known, since the staff on the unit were trained to provide both general floor-level care as well as ICU-level care.
- Tying managers' incentives to patient satisfaction scores.
- Identifying and meeting patient needs; ie, surveying patients on admission regarding basic needs, such as how they wished to be addressed, their treatment preferences, and their priorities.

The patient experience remains the top priority for American hospitals, according to the State of Patient Experience 2013 report published by the Beryl Institute (www.theberylinstitute.org). Many hospitals and health systems are embracing a 2-pronged HCAHPS strategy, with an emphasis on improving competencies in each of the core questions, alongside global efforts to improve the overall experience via leadership, engagement, and culture change. The report also noted that key components of patient experience improvement programs in the majority of institutions thus far include: sharing HCAHPS scores, hourly/more frequent rounding by the clinical teams, leadership rounding, staff training, and

special initiatives to target specific aspects of the HCAHPS survey.[27]

The different types of interventions taking place at individual hospitals across the country have been categorized into 6 distinct categories:

1. Interventions to directly affect the patient care experience
2. Interventions to improve patient advocacy
3. Interventions to enhance an institution's culture and leadership
4. Interventions to increase employee engagement
5. Interventions to increase patient and family engagement
6. Interventions to optimize physician engagement

Examples Of Successful Interventions

Following are a few examples of documented successful interventions across these various categories:

- **Nurse hourly "comfort" rounding:** This intervention took place on 27 nursing units across 14 hospitals nationally, and it found registered nurse (RN) rounds every 1 to 2 hours improved HCAHPS scores for the units from 79.9 (preintervention) to 91.9 (postintervention); $t = 736$, $P < .001$.[28]
- **Standardized medication education plan on discharge:** At NCH Hospital in Naples, FL, the way information about medications was communicated was standardized, including using only 1 source for information, developing a question-and-answer sheet for patients on frequently used medications, developing medication teaching cards by the pharmacy, and postdischarge calls. This resulted in increased staff satisfaction as well as improved HCAHPS scores for the units on which this was rolled out as compared to the control units.[29,30]
- **Noise reduction strategies at night to create a "culture of quiet":** At St. Francis Hospital in Federal Way, WA, a nighttime noise reduction program was undertaken, which consisted of white noise machines in patient rooms, padded doors, dimmed lights in the hallways, ear plugs available for patients, and TV sets that only worked with headphones for sound at night. They noted an improvement in the HCAHPS "quiet at night" scores from 39% to 58% between 2009 and 2011.[31]
- **Discharge conversation recording:** At Cullman Regional Medical Center in Cullman, AL, discharge conversations are recorded and provided to the patient to listen to again once they are at home, to ensure important discharge points are not missed. This has resulted in a 56.9% improvement in HCAHPS scores for the discharge domain.[32]
- **Employee "patient experience" training:** At the University of Pennsylvania in Philadelphia,

PA, the Penn Medicine Experience program was created to equip health system employees with tools and skills to provide a consistent, high-quality experience for patients, which resulted in an improvement of 49% in the "likelihood to recommend" question on the HCAHPS survey.[33]

- **Leadership rounds:** In the Veterans Administration-Connecticut health system, "just in time" leadership rounds allow everyone from the hospital CEO to the head of environmental services to speak with patients on a weekly basis and address issues that can be corrected immediately in real time, and provide real-time feedback to staff. This initiative has been met with positive input from staff and patients. A similar intervention has been undertaken with leadership rounding at Gordon Hospital in Calhoun, GA, with a steady rise in HCAHPS scores after implementation.[34]

Using HCAHPS To Improve Hospitalist Communication

"What I liked about Dr. X was his kindness and his willingness to talk and to explain things. He was good like that. He talked slowly so I could understand everything he was saying. He didn't seem like he was in a big rush to get out of there. That was important to me."[7]

Mr. A: Finally I got to go home! I was so excited! By the end of my pretty short stay, I felt a lot better. I was walking around, not feeling winded anymore, and definitely no more chest pain. I was really nervous about going home. As nice as everybody had been in the hospital, I didn't want to have to go through all of it again. Dr. Anderson made me feel so much better, though. She talked me through my new medications, what to expect when I got home, and when I should follow up with my primary care doctor. Apparently, she had already updated him on everything. Right before I left, she asked me, "Just so I know I explained things correctly, can you tell me what your diagnosis is and what you need to do on discharge?" I smiled at her; I was all over that! "Pulmonary embolism," I said, proudly…

Mrs. B: After what felt like forever, finally I got to go home. I couldn't wait to get out of there. The stay was a blur of tests, lab draws, and confusion. People telling me different things, half the time I didn't know who I was speaking with! Finally, somebody (not sure who) came by and told me I had some inflammation around my heart. What that meant and what I was supposed to do about it, I had no idea. Although I was feeling better the day I left, I actually had no idea I was going to leave until my nurse came in with the discharge paperwork. Most of the paperwork didn't make any sense to me, but by that point, I was so ready to be home, I didn't care.

Historically, the hospitalist movement's goals were to deliver on efficiency and quality and to avoid negatively impacting patient satisfaction. Critics of the model thought replacing traditional caregivers with new inpatient providers would lead to decreased satisfaction. Subsequent data found that such concerns might be overstated. In 2002, Wachter and Goldman noted that hospitalists improve inpatient efficiency without harmful effects on satisfaction.[35] The impact of hospitalists on the patient experience has gained increasing attention with the advent of the HCAHPS survey. Coming full circle, a recent white paper by the Phoenix Group stated that "hospitalists are now in the best position to improve survey scores overall for facilities."[36] However, hospitalists face multiple challenges in establishing quick rapport with new, acutely ill patients, and this is possibly amplified in the academic setting where trainees are also involved in patient care. These challenges are unique to hospitalists, and they can potentially adversely affect patient reports of satisfaction if physician communication is not optimized. While there are few studies that compare the subjective experience of hospitalist to nonhospitalist patients, preliminary analysis at Rush University Medical Center (among several hospitalist programs around the country) suggests that hospitalists do face more challenges as compared with nonhospitalists in optimizing communication and rapport.[37] Given that some of the onus for improving hospital satisfaction scores is falling on hospitalists, much has been published on potential ways hospitalists can improve physician communication scores at their institutions.

Previous literature in the field found that factors thought to be related to patient satisfaction include patient sociodemographic characteristics, physical/psychological status, attitudes and expectations of medical care, and the structure, process, and outcomes of care.[38] To further elucidate drivers behind physician communication scoring on the HCAHPS survey, Wild et al conducted in-depth, qualitative interviews with 30 of 96 patients on a hospitalist service who were surveyed. Analyzing the responses, 3 main domains stood out as being relevant to the HCAHPS survey scores related to physician communication.[7]

1. **Positive physician behaviors were reported when patients felt:**
   - They were a respected partner in medical decision making.
   - That physicians provided full, satisfying explanations.
   - That physicians elicited and addressed patient concerns.
   - That physicians modified therapeutic plans based on patients' input.

2. **Problematic behaviors were identified when:**
   - Patients were confused as to the role of various physicians on the team (including hospitalists)
   - Clear, consistent communication among physicians was not apparent.
   - Clear, consistent physician-nurse communication was not apparent.

3. **System issues caused patients to express dissatisfaction when:**
   - Emergency department wait times were too long.
   - Responsiveness to complaints was lacking.
   - Coordination of care was lacking.
   - Care was disorganized (scheduling of meals, procedures, basic care, discharge).

Wild et al also looked at which type of physician (ie, emergency physician, hospitalist, or specialist) was the most important factor in scoring on the survey, and they found that hospitalists were significantly more likely to be the target of the survey responses than the other physicians that patients typically see in the hospital. In a linear regression model, hospitalist rating was significantly associated with overall satisfaction scores (parameter estimate, 0.59, $P < .001$).[7]

Models For Improving Physician Communication Skills

"I was worried coming up here because I heard Dr. X (the primary care physician) couldn't come in…When I came in here, my doctor, he doesn't visit anymore, so we were confused about this situation. But, the more I saw [the hospitalist], the more I liked her. She represents my physician, which I find very interesting. I thought she took the time to explain things in a very, very fundamental way. I mean, she got to the heart of it."[7]

Patients surveyed by Wild et al had initial misgivings about being cared for by hospitalists, but they outlined behaviors that helped overcome these misgivings, mostly falling under the heading of communication skills, such as provider emotional availability, displays of interest, and empathy.[7]

The data on the importance of communication between physicians and patients are strong. High-quality communication has been linked to improved health outcomes, with a direct correlation on outcome measures such as emotional health, symptom resolution, functional status, physiologic measures (blood pressure and glycemic control) and pain control.[39] The Society of Hospital Medicine also notes effective communication skills as one of the core competencies of practicing hospitalists.[40] In addition, breakdowns in communication between patients and physicians, as well as patient dissatisfaction, are critical factors leading to malpractice litigation.[41]

Bonvicini et al corroborated that strong communication skills, manifesting as increased levels of expressed empathy, lead to higher levels of patient satisfaction.[42] Looking at how to clearly convey empathy, Blanden et al and Rothberg et al found that quantity of time at the bedside had no relationship with patient satisfaction scores, but, rather, was related to the quality of the interaction and communication.[43,44] Sitting, rather than standing, in the patient's room was also found to be related to improved perception of empathy and quality of interaction.[45] Montague found that empathy can be conveyed both verbally and nonverbally, as eye contact and social touch are both associated with increased patient perceptions of empathy.[46]

Verbal communication with patients can be improved in physicians by using standardized communication tools.[47] These tools have been studied extensively, mostly in the outpatient setting. Various models exist that have proven to be successful at increasing patient satisfaction. One model is Frankel and Stein's Four Habits Model, a relationship-centered framework for the medical interview. The primary elements of the Four Habits Model include: (1) Invest in the beginning, (2) elicit the patient's perspective, (3) demonstrate empathy, and (4) invest in the end.[48] **See Figure 2** for links to more information about the Four Habits Model.

Another model of standardized communication is the REDE[SM] model from the Cleveland Clinic.[49] (http://healthcarecommunication.info/our-story/) REDE stands for Relationship: Establishment, Development, and Engagement. A summary of the 3 phases follows:

1. Phase 1: Establish the relationship
   - Convey value and respect.
   - Collaboratively set the agenda for the encounter.

Figure 2. The Four Habits Model

For a PDF of the document, scan the QR code with a smartphone or tablet or go to:
http://ndep.nih.gov/media/The-Four-Habits-Model-508.pdf

- Demonstrate empathy using "**SAVE**":
  Support: "Let's work together…"
  Acknowledge: "This has been hard on you."
  Validate: "Most people would feel the way you do."
  Emotion naming: "You seem sad."

2. Phase 2: Develop the relationship
   - Engage in reflective listening (verbal and nonverbal; avoid distractors).
   - Elicit the patient narrative (use open-ended questions; summarize).
   - Explore the patient's perspective using "**VIEW**":
     Vital activities: "How does it disrupt your daily activity?" or, "How does it impact your functioning?"
     Ideas: "What do you think is wrong?"
     Expectations: "What are you hoping I can do for you today?"
     Worries: "What worries you most about it?"

3. Phase 3: Engage
   - Share diagnosis and information.
   - Collaboratively develop the plan.
   - Provide closure.
   - Dialogue using "**ARIA**":
     Assess: Using open-ended questions, assess what the patient knows about the diagnosis and treatment and how much and what type of education the patient desires/needs.
     ◦ Patient treatment preferences.
     ◦ Health literacy.
     Reflect patient meaning and emotion.
     Inform:
     ◦ Tailor information to the patient.
     ◦ Speak slowly and provide small chunks of information at a time.
     ◦ Use understandable language and visual aids.
     Assess patient understanding and emotional reaction to the information provided.

(Reproduced with permission from the Association for Patient Experience. Windover A, Boissy A, Rice T, Gilligan T, Vicente V, Merlino J. The REDE model of healthcare communication: Optimizing relationship as a therapeutic agent. *J Patient Exp*. 2014 May;1(1):8-13.)

Interestingly, communication skills training in hospitalist groups, thus far, has not been found to be correlated with improvement in HCAHPS scores, as it has in the outpatient setting; however, the data are limited.[50]

Observed feedback, both in real time and with standardized patients, has emerged as another important method for improving physician behaviors and patient satisfaction.[47] Bergin et al found that a best practices communication template along with scheduled, individualized feedback to medicine residents after observation from patients and nurses improved satisfaction scores on a teaching service (composite physician communication score increased from 53% to 78% from 2010 to 2012).[51] The communication assessment tool was also developed and implemented to provide hospitalists with real-time, individualized feedback from patients regarding communication skills, with high reliability (0.97).[52] At Rush University, on-boarding of physicians with direct observation and feedback from communication specialists as well as videotaped encounters with standardized patients played an important role in rapidly improving the hospitalist groups' HCAHPS scores by 400% between 2009 and 2014.[37] Development of a focused, patient-centered care curriculum consisting of observed resident-patient interactions by attending physicians, feedback on transitions in care, as well as patient home visits, was found to improve patient satisfaction with physician communication scores on a medicine teaching service (90% vs 85%, $P < .01$).[53]

Team Identification And Communication

"I try to make it clear who I am right off the bat. I speak before the resident and point out that I'm the attending and responsible for overseeing this team and their care. I'll also stay back for a few minutes after the team leaves and give the patient my card, and put my name on the whiteboard, let them know if they want to speak with me, they can have the RN page me directly." Dr. B[7]

Identified by Wild et al as another important category for patients when filling out their HCAHPS surveys, data point to a few best practices that can help with improving communication between the care team and the identification of physicians.[7]

Face cards work well in improving patients' knowledge of names of providers and their roles; however, the impact on satisfaction has not yet been demonstrated in a significant manner.[54] Use of whiteboards in patient rooms has also led to improved MD/RN perceptions of team communication.[55] Tan et al found that the use of whiteboards significantly improved satisfaction with overall stay ($P < .02$).[56] Leaving notepads at the bedside for patients to write down questions for their physicians led to improved qualitative satisfaction from patients, but communication scores were not significantly different between control and intervention groups.[57]

Communication between various teams of physicians has been optimized by setting expectations and standardization. The SBAR format (situation, background, assessment, and recommendation) has been used in hand-offs between emergency department and hospitalist physicians, with improved

perception of communication. Various institutions (such as UCLA and Kaiser Permanente hospitals) have also standardized expectations, most notably in comanagement services, where the roles and responsibilities of each type of provider were agreed upon by all parties, documented, and reviewed/revised often, with improvement in patient satisfaction.[58]

Communication between hospitalists, including at hand-offs, has been standardized at multiple institutions, with time being built in to sign out. Electronic sign-outs have also been trialed, as has the concept of paired rounding, where 2 hospitalists essentially take care of the same service over time, minimizing the number of hand-offs and new physicians the patient sees. To date, assessing the impact of hospitalist-to-hospitalist communication on patient satisfaction has not been evaluated.[58]

Various innovative rounding patterns have shown an impact on patient satisfaction. O'Leary et al suggested that structured MD/RN interdisciplinary rounds should improve satisfaction on the part of the patients,[59] while Mittal et al found that family-centered bedside rounding on pediatric units led to improvement in family engagement and team communication.[60] Geographic localization of hospitalist teams was also suggested as likely to help with communication between groups and patient satisfaction.[59] In addition, the stronger a hospital's measured teamwork culture, the better the patient satisfaction ratings.[61] Dutta et al found that incorporating attending PM rounds into a best practices model contributed to an increase in patient satisfaction scores for hospitalist care.[37]

Greenwald and Jack at Boston Medical Center created an intensive discharge protocol involving standardization of the discharge process.[62] This protocol called for scheduled follow-up appointments prior to discharge, pharmacist review of medications at bedside with the patient, all discharge communication and education given via the teach-back method, follow-up phone calls from RN/pharmacy 24 to 48 hours postdischarge, and documentation in the discharge summary of a 24/7 call-back number that patients could use with any questions. This protocol, called Project RED (re-engineered discharge), did show an improvement in patient satisfaction and a decrease in 30-day readmission rates.[62]

System Improvements

"This is the way it goes. You get nothing and then you get your breakfast and soap at the same time. I don't know when I am leaving; I don't know how I am leaving, whether I am going in an ambulance or a school bus."[7]

Though hospitalists themselves are not responsible for system improvements, according to Wild et al,

patients do take the functioning of the overall hospital system into account when determining physician communication scores.[7]

Innovative models of using hospitalists have been tried at institutions across the nation. Incorporating a hospitalist in the emergency department to expedite care for boarded patients has led to increased satisfaction on the part of staff and patients, according to Chadaga et al.[63] Briones et al also found that having a hospitalist in the emergency department led to improved throughput, timeliness of services, and satisfaction.[64] Aurora Medical Center incorporated a "pain team," staffed by hospitalists, which functioned as a rapid-response team for patients who felt their pain was not being addressed by their primary service.[65] Postdischarge clinics staffed by hospitalists also appear to improve patients satisfaction with their overall care, as the patients perceived continuity between the clinic visit and their recent hospital stay.[66]

Data are also available that indicate that hospitalist workload and job engagement play a role in patient satisfaction.[67] Michtalik et al found, in a survey of over 890 hospitalists, that a "safe" workload was considered by the majority to be 15 patients/shift; when the safe workload was exceeded, the majority of physicians felt they did not have the ability to fully discuss treatment plans or answer questions from patients and family members.[68] Mache et al also found a strong correlation between physician job satisfaction and patient satisfaction, noting that physician engagement and satisfaction were enhanced via a sustainable workload/schedule, mentorship, varying duties, and involvement in hospital operations.[69]

Best Practices

Mr. A: I reached home and felt great. I saw my primary care doctor the day after I arrived home, and the transition was seamless. I know I was only in the hospital 2 days, but I can't say enough about the care I received. I truly hope I never have to be in the hospital again, but I will, for sure, recommend this place to all of my friends. Dr. Anderson especially!

Mrs. B: I had been home about 3 days when I started feeling that chest pain again. I had been so anxious to get home, I didn't clarify all of my discharge instructions. Once I got home and tried to figure them out, I realized there was no number I could call to ask questions. My "new medication" list included ibuprofen. I'm not sure why I need to take that; it's just a pain killer, right? It really upsets my stomach, so I just took acetaminophen instead. But then I started feeling worse again. My daughter thinks I need to go back to a hospital. But not there! I'm willing to go for more care, but not back to that place. She agrees. She's so angry about the care I received there that she's thinking of filing a complaint against the hospital and physicians, especially if something really bad is happening to my heart!

While the patient experience consists of multiple layers, from the physician perspective, the most important interventions will be those that improve the humanistic aspects of care and enhance the quality of our communication. Dorrah examined the current literature and came up with a best practices template to utilize proven practices to enhance communication, aimed specifically at the questions on the HCAHPS survey.[70] Bergin et al[51] and Dutta et al[37] also outlined similar evidence-based best practices templates at their institutions, with improvement in communication scores on adoption of these templates. A summary of the main points in these templates is outlined in **Table 1**.

The Beryl Institute recently released a statement identifying important organization drivers to shape and guide an effective patient experience strategy at healthcare institutions:[71]

- Identify and support accountable leadership with committed time and focused intent to shape and guide experience strategy.
- Establish and reinforce a strong, vibrant, and positive organizational culture and all it comprises.
- Develop a formal definition for what experience is to their organization.
- Implement a defined process for continuous patient and family input and engagement.
- Engage all voices in driving comprehensive, systemic, and lasting solutions.
- Look beyond clinical experience of care to all interactions and touchpoints.
- Focus on alignment across all segments of the continuum and the spaces in between.
- Encompass both a focus on healing and a commitment to well-being.

Summary

Despite the mixed evidence on patient satisfaction as a measure of healthcare quality, there can be no doubt that when caring, concerned physicians communicate well with their patients, high-quality care will be the result. We are in the midst of a culture shift in medicine, and the patient experience and patient-centered care will likely remain important features of our healthcare system for the foreseeable future. In the inpatient setting, the onus will remain

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Table 1. Summary Of Best Practices For Physician Inpatient Communication[37,51,70,72]

How to convey courtesy and respect to your patients:

1. As a sign of respect, knock before entering a room.
2. Greet the patient by name. Use a formal name unless you are explicitly told by the patient to use the first name. Shake hands.
3. Introduce yourself and your role. Use face cards and white board, if available.
4. Make sure the patient is comfortable and ready and able to talk. If they are uncomfortable (ie, in pain, nauseous), identify a care plan to improve symptoms. If they need another blanket or water, provide this to them prior to beginning the interview.
5. Review the patient's chart prior to entering the room.
6. Reference the chart to the patient so he or she knows you have already looked at it.
7. Pay attention to the patient's social history, including his background, living situation, and support network.
8. Treat every concern brought up as important; explain why you prioritize certain concerns over others in the hospital.
9. Look directly at patients while speaking with them, and minimize interactions with the computer.
10. Ask for permission to conduct a physical examination.
11. Involve patients in the decision-making process and acknowledge their input.
12. If the patient appears uncomfortable, acknowledge this and ask why.
13. Ask for questions at the end of an encounter in an open-ended fashion ("What questions do you have?").
14. Update the registered nurse daily on the plan of care to avoid miscommunication and mixed messages.
15. End the hospital stay on a positive note: thank the patient for choosing your institution and let him know you value his feedback. Of note, it is permissible to ask for feedback via survey; however, according to government regulations, you cannot solicit for specific responses or use exact language from the survey.

How to ensure your patients feel they are heard:

1. Avoid interruptions (the average physician interrupts a patient within 23 seconds into the conversation).
2. Give patients a way to record their questions so they won't forget them (provide note pads).
3. Summarize the key points of a discussion.
4. Pay attention to your patients' nonverbal cues and acknowledge their emotions.
5. Sit at the bedside and lean forward to demonstrate engagement.
6. Use social touch to convey empathy (ie, handshake).
7. Be comfortable with silence; give a patient 5 seconds to resume conversation when there is a lapse.
8. Be aware of your body language; don't appear hurried, bored, fidgety, etc.

How to explain things in a way your patients will understand:

1. Avoid medical jargon.
2. Explain physical examination findings as you are conducting the examination.
3. Each morning, outline the plan of the day for your patient and the reasoning behind it.
4. Use the teach-back method to ensure understanding and utilize open-ended questions.
5. Use diagrams/visual aids to enhance comprehension.
6. Explain procedures and testing before they are ordered/performed; follow up on the results the same day. Try afternoon rounding to catch patients up on testing during the day.
7. Utilize written handouts to supplement verbal information, when possible.
8. Write out important information, if needed (use white boards in rooms).
9. Give patients a way to contact you with any questions after the hospital stay.

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on hospitalists and hospitals to create an environment where patients feel comfortable and empowered, communication is optimized between all involved in providing care, and the system is designed to keep a patient's stay as smooth as possible.

The literature on HCAHPS and ideas for improvement in patient satisfaction are fairly new. Many projects are currently ongoing that are designed to clarify the association between HCAHPS and technical aspects of care quality as well as to examine the impact of hospitalists and other aspects of hospital care. Future directions for this field include standardization of the hospitalist data so groups can benchmark their progress nationally compared to other physicians in the same specialty, incorporation of new technology into care transitions and to further optimize communication between all on the care team, and changes in traditional medical rounding and teaching structure.

"A pair of kidneys will never come to the physician for diagnosis or treatment. They will be contained within an anxious, fearful person, asking puzzled questions about an obscure future, weighed down by responsibilities, a job to be held, bills to be paid."

—Dr. Philip Tumulty

References

Evidence-based medicine requires a critical appraisal of the literature based upon study methodology and number of subjects. Not all references are equally robust. The findings of a large, prospective, randomized, and blinded trial should carry more weight than a case report.

To help the reader judge the strength of each

Risk Management Pitfalls For Patient Satisfaction

1. **"Why do I have to communicate with the nurse in order to optimize care for my patient?"**
Communication failures are increasingly being implicated as important latent factors influencing patient safety in hospitals. A retrospective study out of Australia showed that communication problems were the most common cause of preventable disability or death in the inpatient setting. Hospitals are complex systems made up of individuals at different hierarchical levels who must constantly interrelate and communicate critical information.[73]

2. **"What is more important than communicating with my patients is that I provide them with high-quality care."**
Strong communication skills that reduce malpractice risk also have been documented to be associated with improved quality of care. Satisfied patients are more likely to take medications as prescribed and return for follow-up visits. Patient-centered care is one of the pillars of a high-quality healthcare system, according to the IOM.[73]

3. **"I don't need communication skills training! What a waste of time."**
A breakdown in communication between patient and physician is more likely to incite a malpractice suit than an actual lapse in care quality. Physicians can improve their communication skills with education and practice. Effective programs include videotaping of physicians or training with standardized patients who provide feedback.[41]

4. **"I'm a really good communicator – I don't need to use these "best practices." Nobody has ever told me I'm not good!"**
While feedback for physicians in communication skills was not standardized and available in the past, with the advent of the HCAHPS surveys, as well as our current culture of transparency, physician communication scores are now readily available for both providers and patients (through both the government and other online survey sources). Providers tend to overestimate their communication skills; however, now that communication skills will be assessed publicly, feedback will be readily available, and physicians will also be able to benchmark themselves as compared to other providers.

5. **"I know what is best for my patient. He should accept my recommendations without question."**
The IOM advocates for shared decision making between physician and patient for prevention and treatment plans.[9] Shared decision making can be an important tool to promote patient autonomy and satisfaction. The source of malpractice claims is often not simply improper or inadequate medical care but is an expression of anger about some aspect of the patient-doctor relationship or communication. Physicians who understand and can respond appropriately to the emotional needs of their patients are less likely to be sued.

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reference, pertinent information about the study will be included in bold type following the reference, where available. In addition, the most informative references cited in this paper, as determined by the authors, will be noted by an asterisk (*) next to the number of the reference.

1. Donabedian A. *Exploration in Quality Assessment and Monitoring.* Ann Arbor, MI: Health Administration Press; 1980. **(Book)**

2. Hekkert KD, Cihangir S, Kleefstra SM, et al. Patient satisfaction revisited: a multilevel approach. *Soc Sci Med.* 2009;69(1):68-75. **(Prospective cohort; 20 hospitals)**

3. Locker D, Dunt D. Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. *Soc Sci Med.* 1978;12(4A):283-292. **(Review)**

4. Rubin HR, Gandek B, Rogers WH, et al. Patients' ratings of outpatient visits in different practice settings. Results from the Medical Outcomes Study. *JAMA.* 1993;270(7):835-840. **(Observational study; 17,671 patients)**

5. Jackson JL, Chamberlin J, Kroenke K. Predictors of patient satisfaction. *Soc Sci Med.* 2001;52(4):609-620. **(Prospective cohort; 500 patients)**

6. Weiss BD, Senf JH. Patient satisfaction survey instrument for use in health maintenance organizations. *Med Care.* 1990;28(5):434-445. **(Prospective cohort study; 2365 patients)**

7.* Wild DM, Kwon N, Dutta S, et al. Who's behind an HCAHPS score? *Jt Comm J Qual Patient Saf.* 2011;37(10):461-468. **(Prospective cohort study; 96 patients)**

8. Jha AK, Orav EJ, Zheng J, et al. Patients' perception of hospital care in the United States. *N Engl J Med.* 2008;359(18):1921-1931. **(Observational study; 2429 patients)**

9. Institute of Medicine. *Crossing the Quality Chasm: a New Health System for the 21st Century.* Washington DC: National Academies Press (US); 2001.

10. Giordano LA, Elliott MN, Goldstein E, et al. Development, implementation, and public reporting of the HCAHPS survey. *Med Care Res Rev.* 2010;67(1):27-37. **(Review)**

11.* Hospital CAHPS (HCAHPS). Available at: http://cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/hcahps1.html. Accessed March 23, 2015. **(Government web-**

Risk Management Pitfalls For Patient Satisfaction (Continued from page 14)

6. **"I don't have time to speak extensively with each of my patients every day!"**
Research has shown that quantity of time at the bedside has no relationship with patient satisfaction scores, but the scores are related to the quality of the interaction and communication.[43] Physicians' verbal and nonverbal communication influences patients' perception of time spent. In addition, malpractice attorneys asked to cite reasons patients pursue malpractice suits found that more than 80% are due to communication issues, 35% of which are physician attitudes, such as being in a hurry or having an air of superiority.[41]

7. **"My job isn't to come up with a treatment plan with my patients, but rather, for my patients!"**
Patients feel most satisfied with communication with providers when they feel that they are an active partner in discussing treatment options and understanding different therapeutic options. Breakdowns in communication and patient dissatisfaction are critical factors leading to malpractice litigation. As per Beckman et al, communication problems leading to malpractice claims fell into 4 categories, 1 of which was delivering information poorly and failing to understand patients' perspectives.[13]

8. **"I tell my patients who I am each time I walk in the room. Why do I need to waste my time with cards or writing on the white board?"**
Hospitalists face a difficult job of describing to patients who they are and the role they play in their care. Face cards and utilizing the white board have been shown to improve patient recollection of their main physicians. Knowing who your physician is in the hospital helps to optimize patient care; patients are more likely to initiate a malpractice claim against a physician with whom they do not have a relationship that is personal, caring, and respectful.[41]

9. **Patient: "I felt really violated when the doctor just lifted up my gown and examined me without my permission!"**
Key to making patients feel respected and understood is requesting permission prior to examination and ensuring the patient is comfortable and prepared for the encounter. **(See Table 1, page 13.)** This leads to higher levels of patient satisfaction, which has been clearly associated with decreasing malpractice risk.

10. **Patient: "I didn't know I wasn't supposed to eat that food while taking a blood thinner! Now I'm back in the hospital again."**
Communication is at the heart of malpractice risk. Ensuring that patients understand their discharge diagnoses, plans, and new medications will increase the safety of the transition in care and avoid adverse effects and readmissions. The teach-back method is a good way to ascertain your patients' understanding prior to discharge.

Coding For Education/Family Meetings

Increasingly, hospitalists are focused on impacting patient satisfaction and providing patient-centered medical care. A key requirement of success is patient education and coordination of care. You've been there: A quick follow-up visit turns into a 90-min family care conference. Unfortunately, it's a 992321 by coding criteria, typically only 15 min in duration. In these situations, we should use time-based coding and prolonged-care services. Traditionally, they're infrequently used. Why?

1. A lack of understanding of how and when to apply them. Lack of familiarity leads to infrequent use.
2. Audit fears. Rarely used and often misapplied, they are more frequently audited.
3. Some payers don't reimburse them.

But don't give up, and remember:

1. Education corrects the knowledge deficit. Many programs provide billing decision support.
2. Audit fears aren't an excuse for avoiding the correct billing code.
3. Revere the cycle. Insurance companies, citing low frequency of use, may exclude them from coverage. These codes can be submitted, even if not reimbursed. Next negotiation, ask why these encounters weren't reimbursed. This prompts discussion and potential payment.

Time-Based Billing

The E/M service codes (99221-99223, 99231-99233) are driven by the history, physical examination, and medical decision-making; however, time can be used if certain criteria are met:

1. The "normal" time for the level of service is exceeded. **(See Table.)**
2. > 50% of the visit involves education, counseling, and/or care coordination.

Required Documentation

1. A statement that > 50% of physician's time was spent in counseling/coordination: "Total time of 42 minutes, with > 50% in counseling."
2. A summary of the discussion: "Case reviewed with nephrology and counseled the patient on risk of nephropathy with tomorrow's angiogram. He wishes to proceed."

Scenario: A pneumonia visit meets 99231 complexity, yet bedside education of a worried spouse totals 36 min. This exceeds the normal 99231 time (15 min). 99233 is billed (normal time of 35 min). Prolonged services codes are added to 99221-99223 or 99231-99233 if total time exceeds the average assigned for that code. **(See Table.)** You must first max out the billing series.

- 99356: first 30-60 min
- 99357: each additional increment of 30 min

Example 1: time of 48 min
- 99231 (15 min) + 99356 (33 min) = incorrect
- 99233 (average 35 min) + 13 min additional unbilled time = correct

Example 2: 69-min follow-up visit. Correct charge is 99233 (35 min) + 99356 (34-min prolonged services).

Things To Remember

- For time-based codes, the typical required components of history and examination don't need to be present, but please don't use this as an excuse to exclude those components.
- For time-based codes (critical care, prolonged services), the time spent on any given day does not cross midnight. Providing 15 min before midnight and 20 min after midnight doesn't equal 35 min.
- Billing includes the (documented) time spent by you and your partners. What time counts?
  ◦ Treatment plan development with house staff.
  ◦ Reviewing images or old records.
  ◦ Coordination or discussion with other physicians.
  ◦ Discussing management options with the patient/family.
  ◦ Not included: time spent by house staff or time teaching them.

Pearls

- Make a habit of always documenting, in every note, the time spent in patient care. You never know when you or your partner will spend additional time later.
- Document specifics of the discussion, not just "education provided."
- Hospitalist groups are seen as one provider, for billing purposes.
- Prolonged services codes can be used, even if the time spent on that date is not continuous.
- If at least 30 min of additional time is spent, then prolonged service codes may be used.

Patient Education: Coding/Time Thresholds

CPT	Normal Time (Minutes)	99356 Threshold (Minutes)	99357 Threshold (Minutes)
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110

Abbreviation: CPT, current procedural terminology.

Centers for Medicare & Medicaid Services, Section 30.6.15.1.G

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

site fact sheet)

12. Elliott MN, Lehrman WG, Goldstein E, et al. Do hospitals rank differently on HCAHPS for different patient sub-groups? *Med Care Res Rev.* 2010;67(1):56-73. **(Observational study; 1,203,229 patients)**

13. Beckman HB, Markakis KM, Suchman AL, et al. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med.* 1994;154(12):1365-1370. **(Descriptive series review; 45 plaintiffs' depositions)**

14. Schneider EC, Lieberman T. Publicly disclosed information about the quality of health care: response of the US public. *Qual Health Care.* 2001;10(2):96-103. **(Review)**

15. Chang JT, Hays RD, Shekelle PG, et al. Patients' global ratings of their health care are not associated with the technical quality of their care. *Ann Intern Med.* 2006;144(9):665-672. **(Observational study; 236 patients)**

16.* Isaac T, Zaslavsky AM, Cleary PD, et al. The relationship between patients' perception of care and measures of hospital quality and safety. *Health Serv Res.* 2010;45(4):1024-1040. **(Observational study; 927 patients)**

17.* Boulding W, Glickman SW, Manary MP, et al. Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *Am J Manag Care.* 2011;17(1):41-48. **(Observational analyses; 2592 hospitals)**

18. Jaipaul CK, Rosenthal GE. Do hospitals with lower mortality have higher patient satisfaction? A regional analysis of patients with medical diagnoses. *Am J Med Qual.* 2003;18(2):59-65. **(Retrospective cohort; 29 hospitals)**

19.* Fenton JJ, Jerant AF, Bertakis KD, et al. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med.* 2012;172(5):405-411. **(Prospective cohort; 51,946 patients)**

20. Kupfer JM, Bond EU. Patient satisfaction and patient-centered care: necessary but not equal. *JAMA.* 2012;308(2):139-140. **(Editorial)**

21. Manary MP, Boulding W, Staelin R, et al. The patient experience and health outcomes. *N Engl J Med.* 2013;368(3):201-203. **(Editorial)**

22. Lehrman WG, Elliott MN, Goldstein E, et al. Characteristics of hospitals demonstrating superior performance in patient experience and clinical process measures of care. *Med Care Res Rev.* 2010;67(1):38-55. **(Observational study; 2583 patients)**

23. Chatterjee P, Joynt KE, Orav EJ, et al. Patient experience in safety-net hospitals: implications for improving care and value-based purchasing. *Arch Intern Med.* 2012;172(16):1204-1210. **(Observational study; 3096 hospitals)**

24. Fulton BR, Drevs KE, Ayala LJ, et al. Patient satisfaction with hospitalists: facility-level analyses. *Am J Med Qual.* 2011;26(2):95-102. **(Observational study; 1777 hospitals, 2,648,275 patients)**

25. Sorra J, Khanna K, Dyer N, et al. Exploring relationships between patient safety culture and patients' assessments of hospital care. *J Patient Saf.* 2012;8(3):131-139. **(Observational study; 73 hospitals)**

26. Silow-Carroll S. Munson Medical Center: constant focus on patient satisfaction. The Commonwealth Fund; 2008. **(Case study)**

27. The Beryl Institute. The state of patient experience in American hospitals 2013: positive trends and opportunities for the future. 2013. Available at: http://www.theberylinstitute. org/?page=PXBenchmarking2013. Accessed March 15, 2015. **(Report)**

28. Meade CM, Bursell AL, Ketelsen L. Effects of nursing rounds: on patients' call light use, satisfaction, and safety. *Am J Nurs.* 2006;106(9):58-70. **(Quality improvement study;**

27 nursing units)

29. Rovell KM, Bradle JB, Kruesi K. Implementation of targeted medication education for improved patient satisfaction. *J Obstet Gynecol Neonatal Nurs.* 2012;41(s1):S156-S157. **(Observational study; 2000 patients)**

30. The Beryl Institute. Patient experience case study - NCH Healthcare. Available at: http://www.theberylinstitute. org/default.asp?page=CASE0215. Accessed March 15, 2015. **(Case study)**

31. The Beryl Institute. Patient experience case study - St. Francis Hospital. Available at: http://www.theberylinstitute. org/?page=CASE0720112. Accessed March 15, 2015. **(Case study)**

32. The Beryl Institute. Patient experience case study - CRMC. Available at: http://www.theberylinstitute.org/default. asp?page=CASE0812. Accessed March 15, 2015. **(Case study)**

33. The Beryl Institute. The Penn Medicine experience: improving the patient experience through leadership alignment, innovation and skill-building. Available at: http://www. theberylinstitute.org/default.asp?page=CASE0215. Accessed March 15, 2015. **(Case study)**

34. The Beryl Institute. Patient experience case study - Gordon Hospital. Available at: http://www.theberylinstitute.org/ default.asp?page=CASE0213. Accessed March 15, 2015. **(Case study)**

35. Wachter RM, Goldman L. The hospitalist movement 5 years later. *JAMA.* 2002;287(4):487-494. **(Review)**

36. The Phoenix Group. The Phoenix Group addresses patient satisfaction. Hospitalist leaders advocate for patient satisfaction surveys specific to hospital medicine. 2008. **(White paper)**

37.* Dutta SF, Kim F, Wener J, et al. Building a patient-centered hospitalist culture [abstract]. *J Hosp Med.* 2015;10(Suppl 2). **(Abstract)**

38. Aharony L, Strasser S. Patient satisfaction: what we know about and what we still need to explore. *Med Care Rev.* 1993;50(1):49-79. **(Review)**

39. Stewart MA. Effective physician-patient communication and health outcomes: a review. *CMAJ.* 1995;152(9):1423-1433. **(Review)**

40. McKean SCW, Budnitz TL, Dressler DD, et al. How to use The Core Competencies in hospital medicine: a framework for curriculum development. *J Hosp Med.* 2006;1(1):57-67. **(Guidelines)**

41.* Levinson W. Physician-patient communication. A key to malpractice prevention. *JAMA.* 1994;272(20):1619-1620. **(Editorial)**

42. Bonvicini KA, Perlin MJ, Bylund CL, et al. Impact of communication training on physician expression of empathy in patient encounters. *Patient Educ Couns.* 2009;75(1):3-10. **(Randomized controlled trial; 160 physicians)**

43. Blanden AR, Rohr RE. Cognitive interview techniques reveal specific behaviors and issues that could affect patient satisfaction relative to hospitalists. *J Hosp Med.* 2009;4(9):E1-E6. **(Observational study; 50 patients)**

44. Rothberg MB, Steele JR, Wheeler J, et al. The relationship between time spent communicating and communication outcomes on a hospital medicine service. *J Gen Intern Med.* 2012;27(2):185-189. **(Cross-sectional time-motion study; 379 patients)**

45. Swayden KJ, Anderson KK, Connelly LM, et al. Effect of sitting vs. standing on perception of provider time at bedside: a pilot study. *Patient Educ Couns.* 2012;86(2):166-171. **(Prospective randomized controlled trial; 120 patients)**

46. Montague E, Chen P, Xu B, et al. Nonverbal interpersonal interactions in clinical encounters and patient perceptions of

empathy. *Journal of Participatory Medicine.* 2013;5. **(Randomized controlled trial; 110 patients)**

47.* Maguire P, Pitceathly C. Key communication skills and how to acquire them. *BMJ.* 2002;325(7366):697-700. **(Review)**

48.* Frankel RM, Stein T. Getting the most out of the clinical encounter: the four habits model. *J Med Pract Manage.* 2001;16(4):184-191. **(Model description)**

49.* Windover A, Boissy A, Rice T, et al. The REDE model of healthcare communication: optimizing relationship as a therapeutic agent. *Journal of Patient Experience.* 2014;1(1):8-13. **(Model description)**

50. O'Leary KJ, Darling TA, Rauworth J, et al. Impact of hospitalist communication-skills training on patient-satisfaction scores. *J Hosp Med.* 2013;8(6):315-320. **(Quality improvement; 464 patient surveys)**

51.* Bergin C, O'Malley CO, Gerkin R, et al. Improving patient satisfaction outcomes and resident interpersonal communication skills through training and patient feedback [abstract]. *J Hosp Med.* 2013;8(Suppl 2). **(Abstract)**

52. Ferranti DE, Makoul G, Forth VE, et al. Assessing patient perceptions of hospitalist communication skills using the Communication Assessment Tool (CAT). *J Hosp Med.* 2010;5(9):522-527. **(Cross-sectional study; 700 patient surveys)**

53. Ratanawongsa N, Federowicz MA, Christmas C, et al. Effects of a focused patient-centered care curriculum on the experiences of internal medicine residents and their patients. *J Gen Intern Med.* 2012;27(4):473-477. **(Quality-improvement program evaluation, resident surveys; 40 patients)**

54. Arora VM, Schaninger C, D'Arcy M, et al. Improving inpatients' identification of their doctors: use of FACE cards. *Jt Comm J Qual Patient Saf.* 2009;35(12):613-619. **(Quality improvement; 2543 patients)**

55. Sehgal NL, Green A, Vidyarthi AR, et al. Patient whiteboards as a communication tool in the hospital setting: a survey of practices and recommendations. *J Hosp Med.* 2010;5(4):234-239. **(Quality improvment; 253 nurses, housestaff, hospitalists)**

56. Tan M, Hooper E, Braddock CH 3rd, et al. Patient whiteboards to improve patient-centred care in the hospital. *Postgrad Med J.* 2013;89(1056):604-609. **(Quality improvement initiative; 144 patients)**

57. Farberg AS, Lin AM, Kuhn L, et al. Dear doctor: a tool to facilitate patient-centered communication. *J Hosp Med.* 2013;8(10):553-558. **(Single-center, cross-sectional survey; 664 patients)**

58. Greenwald R, Novelli M, Lorence T. Hospital medicine's evolution: literature search and interview study with practices. *Perm J.* 2011;15(3):51-60. **(Review)**

59. O'Leary KJ, Sehgal NL, Terrell G, et al. Interdisciplinary teamwork in hospitals: a review and practical recommendations for improvement. *J Hosp Med.* 2012;7(1):48-54. **(Review)**

60. Mittal VS, Sigrest T, Ottolini MC, et al. Family-centered rounds on pediatric wards: a PRIS network survey of US and Canadian hospitalists. *Pediatrics.* 2010;126(1):37-43. **(Quality improvement; 265 hospitalists)**

61. Meterko M, Mohr DC, Young GJ. Teamwork culture and patient satisfaction in hospitals. *Med Care.* 2004;42(5):492-498. **(Retrospective cohort; 125 hospitalists)**

62. Greenwald JL, Jack BW. Preventing the preventable: reducing rehospitalizations through coordinated, patient-centered discharge processes. *Prof Case Manag.* 2009;14(3):135-140. **(Quality improvement study)**

63. Chadaga SR, Shockley L, Keniston A, et al. Hospitalist-led medicine emergency department team: associations with throughput, timeliness of patient care, and satisfaction. *J Hosp Med.* 2012;7(7):562-566. **(Quality improvement study)**

64. Briones A, Markoff B, Kathuria N, et al. A model of a hospitalist role in the care of admitted patients in the emergency department. *J Hosp Med.* 2010;5(6):360-364. **(Quality improvement study)**

65. Bush H. Doubling down on the patient experience. *Hosp Health Netw.* 2011;85(12):22-25, 21. **(News article)**

66. Butcher L. Hospitalists' role in a value-driven organization. 2014. Available at: http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2014/May/fea-staffing-strategies. Accessed March 10, 2015. **(News article)**

67. Elliott DJ, Young RS, Brice J, et al. Effect of hospitalist workload on the quality and efficiency of care. *JAMA Intern Med.* 2014;174(5):786-793. **(Retrospective cohort; 20,241 patients)**

68. Michtalik HJ, Pronovost PJ, Marsteller JA, et al. Identifying potential predictors of a safe attending physician workload: a survey of hospitalists. *J Hosp Med.* 2013;8(11):644-646. **(Survey; 890 hospitalists)**

69. Mache S, Vitzthum K, Klapp BF, et al. Improving quality of medical treatment and care: are surgeons' working conditions and job satisfaction associated to patient satisfaction? *Langenbecks Arch Surg.* 2012;397(6):973-982. **(Cross-sectional survey; 120 patients, 109 surgeons)**

70.* Dorrah TE. Physician's Guide to Surviving CG-CAHPS and HCAHPS. Charleston, SC: CreateSpace; 2014. **(Book)**

71. The Beryl Institute. Guiding principles for patient experience excellence identified by the Beryl Institute. 2015. Available at: http://www.theberylinstitute.org/news/228542/Guiding-Principles-for-Patient-Experience-Excellence-Identified-by-The-Beryl-Institute.htm. Accessed March 15, 2015. **(Guidelines)**

72. Peraino RA. Improving patient satisfaction is not rocket science: ten easy ways to generate "thank yous". ACP Hospitalist. 2015. Available at: http://www.acphospitalist.org/archives/2015/05/patient-satisfaction-tips.htm. Accessed March 15, 2015. **(Review)**

73. Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: an insidious contributor to medical mishaps. *Acad Med.* 2004;79(2):186-194. **(Interview results; 26 residents)**

CME Questions

1. **What are different uses for measurements of patient satisfaction in healthcare?**
   a. Comparison between different healthcare programs or systems
   b. Evaluation of the quality of care provided
   c. Identification of the aspects of a service that need to be changed
   d. Assisting organizations in identifying consumers likely to disenroll
   e. All of the above

2. **Why was the HCAHPS survey created?**
   a. To promote consumer choice and transparency
   b. To decrease creation of healthcare monopolies
   c. To create a universal standard for patient satisfaction data collection and benchmarking
   d. A and C
   e. All of the above

3. **Where are individual hospitals' HCAHPS scores publicly reported?**
   a. Centers for Medicare and Medicaid Services website
   b. Hospital Compare website
   c. Individual hospital websites
   d. The White House website

4. **What percentage of the value-based purchasing program is currently tied to HCAHPS scores?**
   a. 20%
   b. 25%
   c. 30%
   d. 50%

5. **Which of the following groups of hospitalized patients is not eligible to complete the HCAHPS survey?**
   a. Patients aged > 18 years
   b. Patients with nonpsychiatric primary discharge diagnosis
   c. Patients in observation status in hospital
   d. Patients discharged to subacute rehab

6. **Which technique has NOT been shown to be successful in conveying empathy to a patient?**
   a. Eye contact
   b. Social touch
   c. Quantity of time at bedside
   d. Sitting at bedside

7. **Which aids have been trialed to help hospitalists convey who they are and their role to their patients?**
   a. Face cards
   b. Writing names on the white board in patient rooms
   c. Preadmission phone calls
   d. A and B
   e. All of the above

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Commercial Support: This issue of *Hospital Medicine Practice* did not receive any commercial support.

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