## 071: PATIENT SATISFACTION MEASUREMENT FOR ACCOUNTABILITY VERSUS QUALITY IMPROVEMENT

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**Objective:**
To demonstrate the differing functions and values of patient satisfaction measurement for Accountability, and for Q.I. purposes.

**Methods**:
The experience of U.S. hospitals that have been using my survey to measure patient satisfaction for the past 15 years were examined to demonstrate the utility of such measures for identifying and addressing issues in the quality of care. In addition, we examined the experiences of U.S. states that implemented hospital patient satisfaction measures for public accountability.

**Results**:
We perceive very different functions for the two types of measure. We also note considerable confusion (both among health care providers and the public) about these functions. There is also professional distrust of published satisfaction scores among many hospital administrators. Much of this stems from defensiveness on the part of hospitals that score lower than others in the published results. We find far more trust of satisfaction scores (and use of them to pursue improvement) when the measures are strictly internal and non-public.

The two forms of measure differ significantly in both function and in the implications of their methodologies.

Functions of patient satisfaction measures for (external) Accountability include:

1. Facilitates public choice of providers by prospective patients (and payers or business in the U.S.)
2. Facilitates quality oversight by regulatory agencies
3. (Ideally) Acts as an incentive for improvement through public embarrassment of the provider.

Functions for (internal) Quality Improvement include:

1. Facilitates internal monitoring and improvement of the quality of care
2. Facilitates objective, quantifiable evaluation of staff
3. Facilitates growth of a patient-centered corporate culture.

Methodological Implications of patient satisfaction measures for accountability include:

1. Annual, one-time data gathering
2. Global, general data are desired. Miicro breakdowns of data (i.e. by nursing unit, shift, etc.) not essential for overall evaluation of the institution.
3. Timeliness of reports (following end of data gathering period) not critical.

Methodological implications for Q.I. measures include:

1. Continual surveying throughout the year is essential.
2. Timeliness of data analyses essential for problem solving
3. Reports must be quarterly or more frequently for effective monitoring and intervention.
4. Data must be broken down and reported by micro analytical units, including Nursing unit, shift, department, physician, condition, etc.

**Conclusions**:
Patient satisfaction measures for Accountability and Quality Improvement have differing functions and methodological implications. No one measure or method can fill both functions adequately. Recent studies indicate that U.S. patients, at least, do not give much weight to published satisfaction scores (or even to published clinical outcome information such as C-section rates, error rates, etc.) in selecting a provider. Rather, their own personal experience or the recommendations of significant others have more weight in affecting decisions to use one provider rather than another. Thus, published patient satisfaction scores (for Accountability) have little impact on patients. The impact on providers, too, may be modest. Hospitals, for their part, tend to view patient satisfaction measurement as an adversarial phenomenon when results are made public. This is likely to be the case in Europe and Asia as well as the U.S. Because of their defensiveness, hospitals will respond far more favorably to patient satisfaction measurement for Quality Improvement if it is kept as an internal mechanism, and methodologically handled as such.

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