There’s been a flood of different measures and metrics in recent years. CMS, Joint Commission, hospital organizations, and vendors each have their own way of calculating a hospital’s ranking and improving patient care.

While hospitals are already expected to conduct certain surveys by various agencies, how often should they conduct their own research? What measures should they use? And how do they use the information they have to drive improvement?

**The difference between them**

There are two definitions that are used often in conjunction with a hospital’s merit: patient satisfaction and quality of care. Patient satisfaction measures how a patient feels about the care they received. Care quality measures whether the care given was any good.

Janiece Gray, a founding partner of DTA Associates and author of the HCPro book *Beyond CAHPS: A Guide to Achieving Patient- and Family-Centered Care*, says that it’s important to know the differences between the two measures, as they aren’t always in alignment. She points to her experience with a former chiropractor as an example. She had been going to this person for about two years for a medical issue and from a satisfaction perspective, couldn’t have been happier.

“But after about a year and a half of going to this person and paying out-of-pocket for this issue [I had] that wasn’t getting any better, I finally woke up and was like, ‘It doesn’t really matter how much I like her, I don’t think
she’s able to fix the issue that’s going on,’ ” she says. “I was referred by a friend to a new provider and that person didn’t have the greatest bedside manner at all. She was kind of rough or abrupt, almost rude sometimes. But she knows her stuff and is helping me make progress on this same issue in a much shorter period of time.”

It’s important to recognize the differences between the measures, says Craig Deao, MHA, senior leader at Studer Group. Although the two measure different things, it’s a mistake to think one of them is more important, he notes. In fact, the two often correlate.

“There are a number of studies that support the idea that while patients may not understand the technical aspects of care, their perceptions of quality—what they see, hear, and experience—are really accurate,” he says. “In fact, there have been several systematic reviews of the literature that conclude that patient experience (the patient’s assessment of the care quality they received) data is positively correlated to clinical effectiveness, safety, and makes a pretty strong case that patients can accurately define quality. It’s not a different thing.”

The healthcare industry started looking into satisfaction about 30 years ago, he says, asking patients, ‘What does this facility do for you and how satisfied are you with that?’ ” It also included patient experience and a lot of service hygiene factors.

Care quality is traditionally measured by the healthcare industry’s view of what makes for good outcomes and good process measures to predict those outcomes. Examples of process of care measures include questions such as “Did you get your aspirin on time?” Meanwhile, outcome measures are statistics like morbidity and mortality.

**Measuring for quality**

There are several roadblocks to hospitals trying to collect actionable data from their measures. The first problem is the sheer number of measures that are available for them to use. Next is how they survey and collect information for those measures. Finally, there’s how to use that data to drive improvement.

When it comes to quality measures, hospitals at least have several good resources at their disposal, says Deao. These include the National Quality Forum (NQF), CMS, and the various medical specialty societies.

The NQF does an excellent job with curating quality measures, he says, while CMS has a very methodical process for selecting measures for reporting and incentivizing. Meanwhile, medical specialty societies (like the American Academy of Neurology or American Academy of Pediatrics) are great for finding measures relevant to your practice.

“So there’s no shortage of measures to look at every dimension of quality,” he says. “I think that organizations need to start by looking at those
endorsed measures and figure out which of them they need to track to best help them achieve their mission. Too many organizations I think don’t do that last step of deciding, ‘Let’s narrow down the thousands of possible measures to the handful that are really most relevant to me.’ ”

He warns facilities to resist the urge to come up with their own quality measurements. The measurements are already out there he says, and you shouldn’t start with a blank piece of paper and become “terminally unique.”

“It’s a whole lot easier to make improvement and have benchmark data if you choose from the nationally accepted data sets,” he says.

It’s also important to remember that nobody gets to define quality without the voice of patients, he adds. In that regard newer surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys have seen notable improvement over the years.

“These surveys are getting at whether patients can accurately rate things that correlate with quality,” he says. “The HCAHPS series of surveys are not satisfaction surveys; they’re frequency surveys. They don’t ask if your care is very excellent or poor or good. They’re asking if you ‘never,’ ‘sometimes,’ ‘usually,’ or ‘always’ saw some evidence-based practice at the bedside.

The only measures we had in the early days were satisfaction measures, which remain good, important, vital measures. And we’ve now added measures on how patients perceive the quality of care.”

Deao says measuring the frequency of evidence-based practices happening at the bedside is the best way to measure patient experience; like having their pain level control or reciting side effects of medications.

Gray says there’s certainly plenty of quality requirements out there, and a lot to measure in terms of clinical care quality. She says it helps to break down quality measures into categories, such as figuring out which measures apply best to what areas of your facility and focusing improvement teams accordingly. And you have to be thinking about various categories or types of measures, not just (often required) outcome measures but process measures as well.

“There are process measures along care quality, just thinking about things along routine clinical care, like are physicians having their patients have the recommended cancer screens, for example. That’s a process of care that can lead to a better outcome. And there are plenty of outcome measures out there, like survival rate for a heart attack. So, there are differences between the outcome we may be required to achieve and the process that we can measure to help us get there.”

**Measuring for satisfaction/experience**

When answering survey questions, Gray says, it’s often easier for patients to determine their satisfaction with their experience of care over its quality.
However, the metrics you use to determine patient satisfaction depend a lot on care setting; long-term care, home health, inpatient, etc. And across all of those categories there are obviously the Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction requirements to be mindful of (HCAHPS is the hospital version of the CAHPS survey).

“The other thing I think is often overlooked as missed opportunities are the qualitative comments that come back on your patient satisfaction surveys,” she says. “Honestly in the work that we do, it’s not just about what percentile you are on your HCAHPS survey. The next thing I’m always doing [with the organizations we work with] is digging into patient comments. Trying to look at any kind of categorization or trending you can do based on those patient comments.”

Part of that requires looking for other sources of patient voices in your organization, she says. Those can come from any place where you have comments coming in from patients; patient-family advisory councils, leader rounding on patients, looking at complaints and grievances.

The other helpful source of data that she thinks is certainly gaining steam are point-of-care tools people are using where you can take in-the-moment, real-time surveys or tools to get data.

“In addition to the HCAHPS survey, most of the survey vendors have custom items you can ask alongside HCAHPS items,” she says. “In my experience, both of those are really helpful in driving improvement. For example, looking at physician communication as an overall composite. There’s certain proprietary items that vendors may have related to medical team interaction and the communication between the care team members that can really inform how patients perceive their overall experience and communication. That goes well beyond the three questions that HCAHPS asks on physician communication.”

When it comes to measuring patient satisfaction and patient experience, Deao notes, there isn’t a nationally accepted set of measures.

“Those [measures] have really been driven by proprietary vendor measures that each ask slightly different questions on slightly different scales and how they combine all those responses together is how they determine satisfaction,” he says. “That’s probably the least standardized of the things you can ask patients.” However, patient experience surveys are just one of several patient-oriented measures that hospitals should consider utilizing. As an example, Deao also suggests that hospitals that are interested in market share study their net promoter score (NPS).

“There’s a lot of data coming out of Fred Reichheld’s work, [saying] essentially the only question you need to ask customers that helps predict whether you are going to gain or lose market share in the future, is you ask them the ‘likely to recommend’ question,” he says. “That is ‘how likely are you to recommend this hospital to friends and family.’ ”
The net promoter question is done on a scale of 0 to 10. Those who score 9 or higher are the promoters; the ones who will recommend your facility to friends and family. Those who score 0-6 are the detractors, the ones who’ll tell people not to use your service. Those who score 7-8 are neutral; they aren’t going to say anything either way.

To calculate your NPS, you subtract your 0-6s from 9-10s. This methodology can be used as a helpful benchmark survey that allows you to compare customer loyalty across industries, not just one healthcare organization to another.

“If somebody asks me, ‘What’s the valid measure set that we should look to predict market share, growth-oriented goals?’ you certainly want to look at that ‘likely to recommend’ question and net promoter score methodology,” he says.

Deao points out that when measuring, facilities need to be clear on their definitions. As an example, often the term “patient satisfaction” is mistakenly, interchangeably used to describe “patient engagement,” which is a very different assessment looking at whether patients will take ownership of their own health outcomes.

**Common measurement mistakes**

When it comes to surveying patients, Gray says it’s important to find a balance between surveying often enough to get useful data without wearing out patients.

“I really support organizations surveying to whatever level they feel they can take forward and that they can get to the level where their physicians and providers can believe the data,” she says. “You have to work and balance how to get at the right level of granularity to be able to report as specifically as possible.”

It’s fair for physicians to question data with too small a sample size, she says. Even back when she worked at a very large health system, they often had trouble getting enough survey results to satisfy clinicians.

“Even in that huge organization where we were surveying as many patients as possible as we could, sometimes we weren’t able to look at data on an individual physician or provider level,” she says. “Especially with clinicians, they want to go in and look at the data. And there were many times, even when we had the biggest possible numerator that we could for the overall denominator for the organization, sometimes that wasn’t enough for providers to trust and believe the data.”

Finding this balance is critical, she says, as many hospitals will rush to make major adjustments based on the feedback of a tiny fraction of their patient population. And while not measuring is bad, trying to make a decision with limited data isn’t good either.

“I still see organizations make judgments too quickly or create goals based on erratic data, or data with too low an [n-size],” she says. “So, they’ll
look at one month and see the med-surgery unit is tanking in the 3rd percentile and they’ll rush to change everything and beat them all up because they’re doing so awful. And in the same breath they’ll give the ICU, that show the 100%—because they only had one or two patients discharged from there—they’ll give them accolades for that. And neither one is necessarily correct because depending on the [n-size]. They’re either over-congratulating some units for their performance or over-penalizing other units [because] of how they are looking at their data.”

A big mistake that too many organizations make is simply letting regulatory requirements determine which questions they’re going to ask, says Deao.

“While I really support those—I think HCAHPS and those related surveys are excellent—if that’s all you’re measuring, you’re saying that you’re only looking for the answers to the questions that survey asks,” he says. “As examples, those mandated surveys aren’t market share surveys; nor are they deep enough to understand where to make precision improvements. If you’re just doing the bare minimum of meeting the mandate, rather than identifying what you need to know about or hear from your customers and go collecting that data, I think that’s the biggest mistake I see.”

Precision vs. accuracy in measurement

The second biggest measurement mistake that Deao sees is overpaying for precision when all you really need is accuracy.

In this case, “precision” and “accuracy” aren’t interchangeable terms. Accuracy is “is it roughly correct or not?” while precision is more “narrowly defining the fine points of accuracy.”

“There are a lot of organizations that are paying a whole lot of money for precision, when their performance is actually quite poor,” he says. “For example, many organizations with very low results pay more to their survey vendors for larger and larger sample sizes, giving them more and more precision about how bad they actually are. They would be better off directing those resources to putting into practice the evidence-based approaches that are known to improve the results; and only when they’re getting much better results, will they need the precision required to help fine tune the ‘last mile’ of improvement gains. Simply getting on the scale again doesn’t help you lose weight.”

Getting the most actionable data

No matter the tool, vendor, or measurement a hospital uses, they need to have a performance improvement team that can run the numbers and regularly meet with the vendor, says Gray. The team should have a data analyst or someone from the enterprise data warehouse team onboard.

“Things happen, data files get messed up,” she says. “But you want to have a lot of those safeguards in place and regular communications with
your survey vendor/partner to be looking at those and troubleshooting those together.”

Assuming that an organization is getting good quality data, there’s a lot of a different ways for it to approach improvement. Gray suggests one method is to get someone high up in your organization to sponsor and support improvement changes. From there, you should work with groups, leaders, staff, and patients across the organization to ask:

- How do you set goals based on the data coming back?
- What should your focus look like for the year?
- How do you start generating improvements?
- How do you get set up for success?
- How do you get structured appropriately?
- How do you support the physicians, nurses, and care team who are making these improvements?

Finally, facilities should never ask patients improvement questions if they don’t intend to do any improvements, Gray says. You don’t want to over survey patients, she says, and there’s no point in asking them a bunch of extra questions on the survey if the responses are never going to be looked at.

“You never really want to go to a group of patients and ask them something if you don’t intend to do anything with the information,” she says. “The patients say ‘well that’s worse than if you hadn’t even asked anything in the first place.’ ”

“It’s just a waste of that patient or family member’s time,” she added. “So, you want to be strategic and thoughtful focusing on what are we trying to improve, what changes can we make, and how do we measure that success. It’s making sure you survey process lines up with those goals.”

The feedback loop

To get from data collection to decisive action, facilities need to create a feedback loop, says Deao. A feedback loop is created when a person is able to adjust their behavior, see how that changes the data, and then uses that new data to adjust their behavior (and so on.)

As an example, he cites a Wired magazine article about methods of reducing speeding on the highway. Option A was a just a speed limit sign (35 mph). Option B was a sign that showed the speed limit and the speed that you’re actually traveling at (42 mph in the 35). And Option C was a law enforcement officer with a radar gun. Option B gave the best results, he says, because the flashing sign allowed people to adjust their actions and see the results within moments.
“When I change my behavior, I see how it changes the data,” he says. “So I take my foot off the gas and I see that I come into alignment with that expected performance norm. And it triggers in your brain an ‘Atta’ boy, nice job.’ That hardwires intrinsically that that’s good behavior and so it actually causes that effective speed correction to last the longest compared to the other two.”

For a feedback loop to be viable, it requires data that’s timely, relevant, and credible. Too often when it comes to patient satisfaction data, it’s the lack of those three attributes that makes it hard to act on data.

“Consider timeliness: if this information is from patients you saw nine months ago, that’s not very helpful to make improvement,” he says. “Is it creditable data? Well if it’s an n of three and I saw 4,000 patients in that period, that’s not really good creditability.

Is this compared to something that I care about? For example, if you’re collecting physician-specific data and comments, and you’re comparing my results to all the physicians in the organization, most of whom aren’t in my specialty, I’m going to say that’s not very relevant data to my patient population.”