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Getting satisfaction: drivers of surgical Hospital Consumer Assessment of Health care Providers and Systems survey scores



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ARTICLE INFO

Article history:

Received 22 July 2014

Received in revised form

10 January 2015

Accepted 18 March 2015

Available online 24 March 2015

Keywords:

HCAHPS

Outcomes research

Clinical outcomes

Surgical health outcomes research

Surgery

Satisfaction

ABSTRACT

Background: Hospital consumer assessment of health care providers and systems (HCAHPS) survey scores formally recognize that patients are central to health care, shifting quality metrics from the physician to patient perspective. This study describes clinical predictors of patient satisfaction in surgical patients.

Methods: Analysis of a single institution's Surgical Department HCAHPS responses was performed from March 2011–October 2012. The end points were top box satisfaction on two global domains. Multivariable regression was used to determine satisfaction predictors including HCAHPS domains, demographics, and clinical variables such as comorbidities, intensive care unit stay, emergency case, discharge day, floor transfers, complications, and ancillary procedures.

Results: In total, 978 surveys were evaluated representing admissions to Acute care and/or Trauma ($n = 177$, 18.1%), Thoracic ($n = 169$, 17.3%), Colorectal ($n = 107$, 10.9%), Transplant ($n = 95$, 9.7%), Vascular ($n = 92$, 9.4%), Oncology ($n = 88$, 9.0%), Plastic ($n = 49$, 5.0%), and Cardiac ($n = 201$, 20.6%) divisions. Overall, 658 patients (67.3%) had high satisfaction and 733 (74.9%) gave definite hospital recommendations. Hospital satisfaction was positively associated with an intensive care unit admission (odds ratio [OR] = 1.64, confidence interval [CI]: 1.20–2.23, $P = 0.002$) and satisfaction with provider and pain domains. Factors associated with decreased satisfaction were race (non-black minority compared with whites; OR = 0.41, CI: 0.21–0.83, $P = 0.012$), self-reported poor health (OR = 0.43, CI: 0.27–0.68, $P < 0.001$), ≥ 2 floor transfers (OR = 0.50, CI: 0.25–0.99, $P = 0.046$), and postoperative complications (OR = 0.67, CI: 0.55–0.82, $P < 0.0001$). In addition, weekend discharge (OR = 1.76, CI: 1.02–3.02, $P = 0.041$) was associated with hospital recommendation.

Conclusions: Clinical course, particularly complications, impacts patient satisfaction. However, more important than what happens is how it happens, as evidenced by the much

Poster presented at the American College of Surgeons Annual Meeting, Washington DC, October 9, 2013.

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0022-4804/\$ – see front matter © 2015 Elsevier Inc. All rights reserved.

<http://dx.doi.org/10.1016/j.jss.2015.03.045>

greater influence of surgeon and nurse–patient interactions. These results help inform future quality improvement and resource allocation.

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1. Introduction

For the first time in the United States, patients' perception of their care is being publicly reported in an effort to hold hospitals accountable for health care quality, defined more broadly to include the patient experience [1]. Reporting of the hospital consumer assessment of health care providers and systems (HCAHPS) survey scores is aimed at improving quality by standardizing performance metrics in a transparent way allowing for meaningful comparisons between hospitals nationally. Scores can be found on the hospital compare Web site (www.medicare.gov/hospitalcompare). This effort aims to incentivize hospitals to improve the patient experience by driving patients toward high performing institutions and through reimbursement incentives.

The Patient Protection and Affordable Care Act of 2010 included a provision for the hospital value-based purchasing program [2]. As part of this program, hospital Medicare reimbursement will be tied to a total performance score (TPS). The TPS includes a clinical process of care domain (70% of TPS), and a patient experience of care domain defined by the HCAHPS score accounting for the remaining 30% of TPS.

According to the value-based purchasing agreement, the Center for Medicare and Medicaid Services withholds a percentage of reimbursement from all hospitals, starting at 1% in fiscal year 2013 and increasing to 2% by 2017 [3]. Withheld funds are now being redistributed, from low performers to high performers, with a zero net gain. Institutions are scored on both their performance compared to other hospitals and whether they have improved their scores [3]. Some question the impact of this approach as the amount of withholding may seem small when compared to the annual Center for Medicare and Medicaid Services hospital payment. Nevertheless, given the tight margin that hospitals rely on, and the global economic pressures these radical changes to hospital funding, this may have broad impact on the health care system at all levels, from the boardroom to the janitor closet.

Using satisfaction as a quality metric is controversial as patients' may not be equipped to know what should really drive their care or the complexities of health care coordination. Many patients have no prior experience to compare their care to nor may they understand what has gone on behind the scenes. Many worry that giving patients this power could have deleterious effects as hospitals shift resources to favor cosmetic changes over other initiatives that may actually improve patient outcomes or over treat patients based on their preferences toward more testing or invasive procedures. Nonetheless, HCAHPS has become part of the government's assessment of hospital performance, and understanding the impact of these domains is an important step to better understanding patients and improving their experience.

HCAHPS performance is divided into eight domains (communication with nurses, communication with doctors, staff responsiveness, pain management, communication about

medications, discharge information, cleanliness and/or quietness, and overall hospital rating). Credit is awarded only if the highest mark is recorded or "top box" response and then converted to a 100-point scale [1]. There is a paucity of data on drivers of top box scores and how individual HCAHPS questions impact the global domains of overall satisfaction. HCAHPS performance in surgical care and the individual drivers in this unique patient population are completely lacking in the literature. To help understand how to target hospital resources toward improving patient satisfaction, this study aimed to describe drivers of overall satisfaction within the HCAHPS domains, and patient factors that may influence these scores.

2. Methods

A retrospective review of HCAHPS responses at a single institution's Surgical Department was performed from March 2011–October 2012. The HCAHPS survey is 27-question survey instrument composed of three major domains with additional background and demographic questions. Provider interactions are gauged in the "composite domain" on a Likert scale and include questions regarding both physician and nurse explanatory skills, responsiveness, listening, communication about medications, pain management, and discharge planning. The "individual domain" assesses the hospital's environment including cleanliness and noise level. The "global domain" assesses overall satisfaction in two ways including an overall hospital rating on a scale of 1–10, where 10 is the best possible hospital and 0 is the worst, and willingness to recommend the hospital to family and friends on a Likert scale with definite recommendation as the "top box" response [1]. The main end points for analysis were the two assessments of the global domains. A positive response for both was considered a "top box" response as defined by HCAHPS (9 or 10 of 10 on overall satisfaction and definite recommendation on willingness to recommend).

The HCAHPS demographic and validation questions include race, education, language, and self-described health state. To capture other relevant differences, additional clinical characteristics were abstracted from the medical record. These clinical characteristics included emergent operation, discharge day of the week (weekday, Friday, or weekend), length of stay, intensive care unit (ICU) admission, insurance type, transfers between hospital wards (assessed as a binary variable with two or more floor transfers), Elixhauser comorbidity score, occurrence of a complication, and additional ancillary procedures such as blood transfusion, total parenteral nutrition or enteral feeds.

Cases were excluded if they were admitted to hospice, only seen in the Emergency Department, were missing data about procedure type, or if they responded to less than 50% of the survey. Missing data were recoded as the reference group for each variable. As respondents had informative results in other

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