PAIN MEDICINE CASE REPORTS

ISSN 2768-5152

Volume 7, Number 7, pp. 307-313

Breaking the Press Ganey Patient Satisfaction Survey Code

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Background: Several leading patient satisfaction assessment tools have emerged, one of the most common surveys is conducted by Press Ganey. The use of patient satisfaction surveys has been controversial with correlation inconsistencies with outcomes, accuracy, and bias.

Case Report: We seek to review changes in the patient satisfaction scores over time as measured through Press Ganey® surveys. Some changes include increasing access to care, improving scheduling, decreasing wait times, improving communication between patient and staff, increased staffing, and conducting team building activities.

Conclusion: The overall standard mean score through the entire study period was 88.6 (range, 77-94.3, SD 3.4). After the implemented changes, plotting the quarterly scores over the study period demonstrated a steady improvement over time with a linear trend line demonstrating a R^2 value of 0.3052.

Key words: Posttraumatic neuralgia, common peroneal nerve injury, neuromuscular electrical stimulation, neuralgia, neuromodulation

BACKGROUND

Patient satisfaction assessment has become ubiquitous in the health care industry. There are many methods and metrics to assess the patient experience which have been reviewed in a variety of health care settings (1-9). Aspects of care queried from patients may include doctor and staff communications, responsiveness, medication and discharge education, environmental cleanliness, facility quietness, overall ratings, and the likelihood of recommendations, among others (10).

The management of pain is a commonly rated parameter in patient satisfaction surveys. Pain assessment questionnaires stem from the "pain as the 5th vital sign" campaign from the American Pain Society instituted in 1996 (11,12). As many institutions continued to adopt this metric, surveys have persisted to ask about pain management either directly or indirectly. This includes widespread surveys distributed by the Centers for Medicare and Medicaid Services (CMS) via the Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS) surveys. The HCAHPS survey has been challenged as to whether this contributes to overly aggressive treatment of pain, particularly with the use of opioid medications prompting defenses of the practice (13).

The balance of treating pain with safe therapies may strike at odds with patient expectations or outcomes. The use of opioid medications can complicate this balance as the United States grapples with a continued opioid epidemic (14). It has come into question as to whether an inquiry into pain management satisfaction increases opioid prescribing, and this has been the topic of discussion at high levels of policy-making. Former Indiana State Health Commissioner and current Surgeon General, Jerome Adams, highlights Question 14 of the HCAHPS survey in a published editorial (15). This ques-

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Disclaimer: There was no external funding in the preparation of this manuscript.
Conflict of interest: Each author certifies that he or she, or a member of his or her immediate family, has no commercial association (i.e., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted manuscript.
Patient consent for publication: Consent obtained directly from patient(s).
Authors adhere to the CARE Guidelines for writing case reports and have provided the CARE Checklist to the journal editor.
Accepted: 2023-06-16, Published: 2023-11-30

tion asks, "How often did the hospital or provider do everything in their power to control your pain?". Dr. Adams notes the resistance of patients for non-opioid options when a 'quicker solution' exists, such as opioids. He acknowledges the difficult decision-making that weighs opioid use and patient expectations.

While HCAHPS surveys are widespread at the institutional level, there is a growing trend of individual physician evaluations based upon patient satisfaction. These are implemented through many inpatient and outpatient settings. Several leading formats have emerged, one of the most common surveys is conducted by Press Ganey. This private company provides surveys which are currently utilized by 41,000 health care facilities with a network of over 40 million patients (16). The use of patient satisfaction surveys has been controversial with correlation inconsistencies with outcomes, accuracy, and bias (17-21).

Pain physicians, in particular, may face increased pressures in patient satisfaction given the nature of practice and expectations regarding pain management. The specialty has been shown to have higher proportions of negative reviews in online rating systems when compared to other specialties. This is postulated to be a result of the nature of certain medications used that have risks of dependence and abuse (22). Observational studies have identified a correlation between the denial of specific patient requests and a decline in satisfaction levels, such as for inappropriate referrals, treatments, or medications (23). The balance of appropriate care and expectations can be challenging, but often mitigated with proper education in a multidisciplinary, team-based approach that is patient-centric and responsive.

In this article, we seek to review changes in the patient satisfaction scores over time for our pain clinic as measured through Press Ganey® surveys. We will describe several techniques utilized successfully in our institution to improve rating scores and discuss some of the challenges for the pain management practices in the setting of increasing emphasis on patient satisfaction. We also explore the advantages and disadvantages of patient satisfaction surveys for this patient population and how they may correlate with other outcomes, as well as it's relation to opioid prescribing.

METHODS

We retrospectively studied the data reported by Press Ganey® patient satisfaction surveys. These surveys are commonly used by many health care institutions to assess patient experience. Patients receive survey questionnaires after a clinical encounter covering various aspects of their experience which is then converted into a numerical value on the scale of 1 to 100, with 100 being maximum patient satisfaction. Each participating institution is provided the survey results as a mean overall standard score with benchmark comparison data.

The Division of Pain Medicine within the Department of Anesthesiology at our institution spans practice across 3 sites. The survey is administered to patients at all the 3 sites and cumulative data is reported. We analyzed the standard overall mean scores from October 2011 to March 2019 with results averaged quarterly.

Because the survey scores were low historically, many measures were initiated through this period to improve patient satisfaction. These included changes for increasing access to care, improving scheduling to decrease wait times, improving communication between patient and staff, increased staffing and conducting team building activities. We also visited Pain Medicine clinics with high patient satisfaction scores. A detailed report of the changes implemented is provided below.

The survey results were analyzed using Microsoft Excel, with mean overall scores averaged through the quarters to generate a trend line and estimate the R-score. Two-sample t-test assuming unequal variances was performed to compare mean score between the years 2011-2015 and 2016-2020 (2-sided level of significance of 0.05).

Techniques Utilized Successfully in our Institution to Improve Rating Scores

A) ACCESS TO CARE

An area of patient dissatisfaction was the inability to reach the practice by phone. We tried to obtain the phone system report to analyze call data, but it did not prove to be very useful. Now we have a common list where the patient calls are logged in and are answered by the providers with the help of residents and fellows. This has helped us to effectively reduce the time lag between patient calls and the response time.

Call volume was also an issue. Changing the phone system where it rang to a live person before going to voice mail and increasing the phone lines from 3 to 7 ensured that the patient calls did not go unanswered. Also established a direct phone access to schedule new patient appointments and procedures

Updated website and developed email access for new patients via PMC website: paininfo@anes.umm.edu

B) CUSTOMER SERVICE

The staff was encouraged to use previously scripted standard greetings for patients in person or when answering and ending phone calls.

C) SCHEDULING

Previously patients were dissatisfied with having to call back to schedule a future appointment. We started using master scheduler to allow patients to schedule appointments beyond 6 weeks from their last date of service. With EPIC Go-Live in November 2015, the ability to schedule appointments was increased to up to one year in future

D) INCREASED STAFFING

A temporary MPR II (medical assistant) was hired to assist the front desk with increased volume to better serve patients in person and on the phone. This was eventually turned into a permanent position and filled. Registered Nurses and Nurse Practitioners were hired to assist with increasing volume, telephone triage, and assistance with clinically related phone calls

E) CONTINUITY OF CARE

Front Desk (FD) staff members were assigned one-on-one with each physician with the goal of completing all tasks associated with that physician and their patients (scheduling appointments, communication, messaging, etc.). This also helped patients develop a personal relationship with their physician's "scheduling assistant" and know who to contact for issues

F) IMPROVING WAIT TIMES

The criteria most commonly receiving a low score in our practice initially was for wait time in the clinic. We had initiated an Attendee tracking form in March 2013 to log in the arrival time for providers. The goal was to determine if the times the providers came in was directly impacting the patient waiting time by delaying the start for the first patient and initiating a domino-effect.

In July 2014, we also initiated a room and round technique where we write the time the patient is put in a room. This technique started showing good results as was evident in the wait-time reduction for the patients in the subsequent surveys as seen previously. Except for the temporary increase in the wait time in November 2014 (50% patients waited longer than 15 mins), there was a steady decrease in patient wait-times every month. Decreasing reporting time, especially before a procedure, from one hour to 30 minute long wait times as well.

Despite our best intentions, delays do occur. In such scenarios, we inform patients about delays throughout their visit.

G) PATIENT CARDS

Patient cards were printed in March 2014 with names of all the staff in the division including providers, nurses, front desk staff and radiographers. The front desk staff circled their name and name of the provider and handed the card to the patient at check in. The card was updated throughout the visit with all those involved in the patient's care. The card went home with the patient to assist in completion of the PG survey should they receive one. This helped the patient complete the Press Ganey survey more effectively as often times, by the time the survey was mailed to the patient, they had forgotten the name of the staff who assisted them.

The patient card also had an expectation agreement, both for the pain clinic staff and the patient. These printed commitments helped manage expectations in a doctor-patient relationship and helped foster a healthier doctor-patient relationship.

H) PATIENT PARTICIPATION

One important factor which helped us improve our survey scores was to improve patient participation for responding to the surveys. Informing the patient about surveys during the visit, encouraging them to complete the surveys with the survey reminder cards, moving to eSurvey and completing the billing in a timely manner all improved response rates. A lot of satisfied patients would not complete the survey which led to lower scores. As the 'n' number increased, it was a more appropriate reflection of ratings we received.

I) PATIENT PRIVACY

HIPAA was reinforced with all staff. While we have some space issues that make it difficult to be completely private, attempts were made to ensure patient privacy, like avoiding discussing patient data by the front desk.

J) COMMUNICATION

Press Gainey Survey results are shared via email, posted on conference room bulletin boards and discussed at all meetings. The results are reviewed and areas are identified to improve patient experiences. All the faculty also attended the PEP Workshop (Program

for Excellence in Patient- Centered Communication) in 2017.

RESULTS

The overall standard mean score through the entire study period was 88.6 (range, 77-94.3, SD 3.4). Plotting the quarterly scores over the study period demonstrated a steady improvement with time with a linear trend line demonstrating a R^2 value of 0.3052, which may be acceptable given the expected interobserver variability that might be seen in such patient surveys (Fig. 1). Analyzing mean scores between 2011-2015 versus 2016-2020, showed a significant increase in the second half ($P = 0.045$) (Fig. 2).

DISCUSSION

Chronic pain is persistent pain that lasts beyond 3-6 months (i.e., pain may continue after healing of an injury or illness). A physician may be frustrated by the lack of objective findings in a patient with chronic pain because the extent of an injury does not always correlate with the severity of the patient's discomfort (24). When patients present with doses of opioids that are felt not warranted for their clinical condition, a discussion on weaning on opioids may distress the patient and generally perceived by patients that the provider is accusing them of drug seeking behavior or abuse. Although such an interaction or discussion on addiction or abuse does not occur, patients may misinterpret and accuse providers of ill intent. This interaction could lead to poor patient satisfaction. To avoid such interactions and displeasing the patient, opioids are more likely to be continued even though they are not always indicated. Thus, the provider may continue over prescribing with the expectation of a good patient satisfaction survey.

A portion of patients who do not agree on the biopsychosocial model are reluctant to attempt other modalities and lower the opiate doses, such patients state to be on doses which has been effectively working for them and question our judgment for discontinuation or reduction of chronic opiate therapy. Redirecting patients to non-narcotic modalities has been challenging. The concept of incorporating behavioral therapy is viewed by some as a psychological issue and they do not agree with this kind of treatment modality. Thus, the perceptions perceived by the provider may lead to continuation of doses with expectation to improve patient satisfaction surveys.

The need to improve patient satisfaction may also be based on compensation issues which can be affected by a poor patient satisfaction survey. All such situations may lead to continued prescribing of opioid doses even when not warranted. It is found that prescription opioid use is associated with higher patient satisfaction, such payment incentives may be perpetuating the prescribing of these medications (25).

The insurance industry has incorporated patient satisfaction surveys to improve quality of care that in turn relates to compensation. Since the implementation of patient satisfaction surveys, providers are working effortlessly to improve the quality of improving their patient satisfaction scores. In our experience, it is felt that if

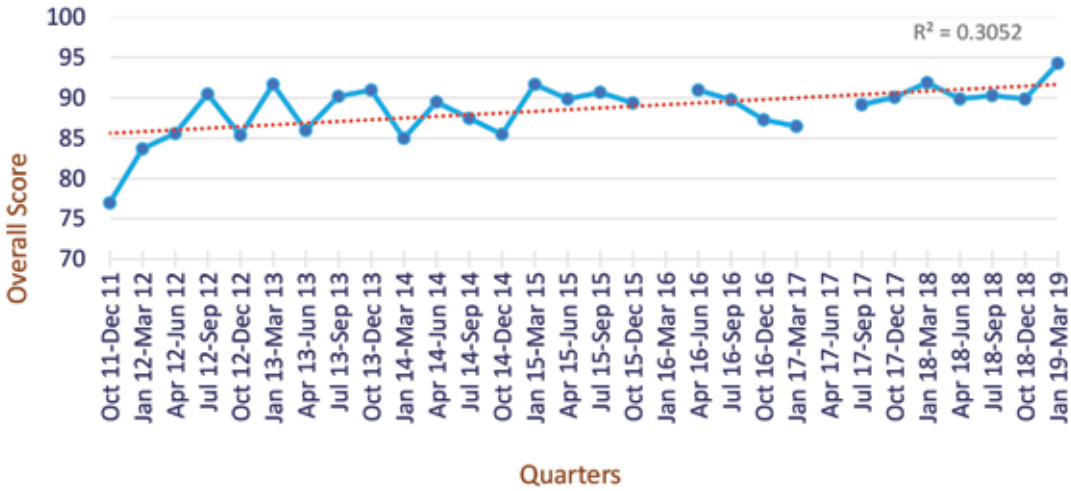

Fig. 1. Quarterly mean patient satisfaction scores from Press Ganey reports.

providers attempt to please patients by yielding to their demands, it may contribute to better patient evaluation and patient satisfaction scores. Some patients demand to be on doses that has been sufficiently controlling their pain even when such doses are not appropriate for their condition. This results in over prescribing and unnecessary prescribing of opioids. As per the perception of provider, such prescribing practices may result in an improved feedback and patient satisfaction survey. However, such a prescribing practice may not be the appropriate step in their opioid management.

On the other hand, poor satisfaction surveys may result in warnings from the employer which is also directly related to economic incentives. The stress on the physician for possible warnings may drive the physician to prescribe unnecessary doses of opioids or prescribe opioids to high risk patients. Providers also view the monetary compensation is tied to patient satisfaction, and this may not necessarily relate to meaningful quality of care.

Medical literature included studies and insights into prescribing opioid practices relating to patient satisfaction of family practice physicians, inpatient hospital stays, emergency room physicians and other fields. According to some of the medical literature, such as patients with musculoskeletal conditions, those using prescription opioids are more likely to be highly satisfied with their care (26). As per the patient satisfaction news, patients using prescription opioids to manage their pain are 32% more likely to report high patient satisfaction scores, according to recent research out of Dartmouth-Hitchcock Medical Center (26). The rise in prescribing opioids was presumably initially driven by a desire to improve the well-being of patients having pain. If, in fact, prescription opioid use is associated with higher patient satisfaction with care, such payment incentives may be perpetuating the prescribing of these medications (27). In the article by Carrico et al (27), family physicians reported no impact of patient satisfaction surveys on their decision to prescribe opioids, those reporting financial incentives for survey results were more likely to report such an impact. During hospital stays, patient satisfaction surveys became an integral part of Medicare and Medicaid payments to hospitals and the simplest way for physicians to improve their scores, is to be more liberal with opioid pain medications (28). Due to the pressures of overprescribing, this article recommends that the pain questions be revised in HCAHPS and other future patient satisfaction surveys. The link between patient satisfaction scores and pain management plays

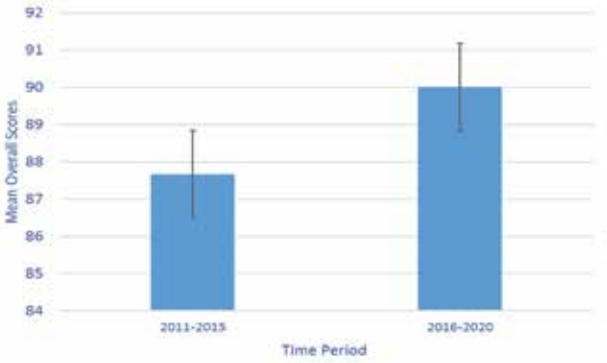

Fig. 2. Comparison of mean scores over the 2 halves of the study period, compared using 2-sample T-test.

out daily in physician offices and emergency departments as physicians who recommend physical therapy and nonopioid pain management encounter resistance from patients who simply want a quicker "solution" with pain pills. This leaves well-meaning professionals with the unsavory choice of prescribing opioids or facing dissatisfaction from disappointed patients on patient surveys (29). Another study in the emergency room setting, attempts were made to utilize multimodal approaches, however patient satisfaction scores remained unchanged following implementation (30).

Very little research was found where patient satisfaction is tied to the opioid epidemic. The related articles were studies on practices other than pain management. Some evidence suggests that there is a correlation between patient satisfaction scores and opioid prescribing; however, it is not sufficient enough to suggest that this practice contributes to the opioid epidemic. It is unclear if the satisfaction measures are accurate and need to be changed. Further research is needed to correlate opioid prescribing practices with and without patient-satisfaction-based incentives in a chronic pain management setting.

The US is currently undergoing an opioid epidemic. Health care facilities have incorporated patient satisfaction surveys to assess if opioid prescription leads to better patient satisfactory survey outcomes.

Various factors are incorporated and have been implemented to improve patient satisfaction, some view that incorporating an effective patient physician communication is sufficient enough to improve the patient's experience and will translate to better patient satisfaction scores. Continuing opioid therapy may be perceived by some as a potential pathway to enhance patient satisfaction outcomes.

CONCLUSION

There is insufficient evidence to support the concept that patient satisfaction surveys alone reflect the true quality of care. Furthermore, institutional pressure to achieve high scores on such surveys might create an inadvertent pressure to prescribe more opioids (31). This calls for a self-reporting survey by physicians to include self-perceptions if opioids truly improved patient satisfaction scores. Further research is needed to correlate actual opioid prescribing practices with patient-satisfaction with and without incentives. Most of the studies using patient satisfaction data look at whether satisfaction with pain management correlates with overall satisfaction with the episode of care. It does not attempt to validate the questions, but merely seeks to identify whether one question or a set of questions correlates with another (32). Primary care providers with a greater rate of opioid prescribing did not have higher patient panel satisfaction scores for pain management. In primary care, providers who want to improve patient satisfaction should focus on other components of patient care besides opioid-based pain management.

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