Quality

WILL PATIENTS' HAPPINESS LEAD TO BETTER HEALTH?

THE ACA AND REIMBURSEMENTS

Sarah F. Fontenot, BSN, JD

In this article...

Physician leadership is needed to help smooth the transition from volume-based to value-based care, as doctors struggle with finding fair measures of patient outcomes and satisfaction.

TRAVEL THROUGH ANY HOSPITAL OR MEDICAL office today, and you're sure to hear grumblings about patient satisfaction because of its role in Value Based Purchasing (VBP), the extension of pay for performance to Medicare reimbursement within the Affordable Care Act (ACA).[1]

Connecting patient satisfaction to reimbursement represents a complete upheaval of the way in which providers are paid for patient care; as a country, we've begun to transfer our focus from the quantity of diagnostic and treatment interventions ("fee for service" reimbursement) to the quality that results from that care. Is the patient healthier? Is the patient satisfied? Furthermore, are those two outcomes related?

This has been a primary focus of hospital administrators since CMS announced the final VBP rules in April 2011. As many administrators will attest, one of the most difficult aspects of raising satisfaction scores has been obtaining physician cooperation with hospital initiatives. This working against each other has created a culture in which doctors are frequently perceived as the problem — not partners — in avoiding financial penalties. The resistance of the medical community threatens to get worse as it hears more about the Physician Value-Based Payment Modifier scheduled to roll out in 2015.

It is the paradigm that patient-centered care will ultimately lead to better health care outcomes (specifically in chronic diseases) as well as reduction of the cost of care in this nation that has many physicians raising a questioning eyebrow. It is the extension of that premise to the calculation of their own reimbursement that is raising their ire. Is it truly fair to measure the quality of their care on an indicator as subjective as "happiness?"

A casual observer to the backlash against VBP might conclude that patient satisfaction is a new concept and dismissed by the majority of physicians in this country. That assumption would be unfair and inaccurate.

PATIENT SATISFACTION IS NOT A NEW CONCERN — The Hippocratic Oath makes clear that patient satisfaction is core to the profession of medicine: I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug [modern version.][2]

Even when that ancient imperative isn't top of mind, concern for a patient's satisfaction still resonates for most physicians. Few people come into medicine without an inherent compassion and empathy for fellow humans. Most physicians want to partner with their patients and they'll strive to avoid unnecessary confrontation.

Beyond altruism, working toward patient satisfaction is good business practice in a competitive market and can even reduce liability. As physicians are well aware, when treatment outcomes are not ideal, happier patients are more reluctant to sue; patient satisfaction is ultimately good risk management. Physicians' professionalism, tradition, temperament, business sense, awareness and goodwill have always led them toward achieving higher patient satisfaction.

This rosy picture, of course, flies in the face of the stories all readers have heard from their family, friends and media about patients encountering rudeness, meanness and injuries from physicians. Many offices ignore even the most basic customer service norms. The history and core of medicine might point to compassion and concern, but any assertion that the medical community is primarily driven by satisfaction in all patient encounters would be naive and self-serving.

The point is physicians, as a whole, do care deeply about patient satisfaction, but that mark is far too often missed.

DOES PATIENT SATISFACTION EQUATE WITH PATIENT INVOLVEMENT? — The debate about the role that patient sat-

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isfaction should play in designing a new health care delivery system gets all the more interesting when it is coupled, almost without question, with patient participation in their own care.

The vision of patient-centered care, as put forth in the 2001 pivotal IOM study *Crossing the Quality Chasm*, equates understanding and choice with happiness and satisfaction. The study goes on to imply that involving patients in their own care wasn't already the norm in medicine. In fact, including patients (or families, as appropriate) in treatment decisions is a fundamental component of the standard of care in medicine. Informed consent to care, after all, has been the lynchpin of quality care for at least the past 60 years.

That said, some patients are frequently, and unforgivably, treated poorly by their physicians. A paternalistic, patronizing demeanor may have been the norm in the early years of American medicine. The AMA, medical educators and the profession in general rejected that vision of medicine more than a decade ago, but that does not mean it does not persist in a more subtle form.

In debating the role of patient satisfaction as an indicator of involvement and shared decision-making it would be more accurate, therefore, to recognize that physicians on the whole are fully supportive of both the intent and the importance of informed consent as well as patient participation in all matters related to their health, while also recognizing that in far too many cases that model is not achieved.

IS PATIENT SATISFACTION A MEANS TO AN END? — The two, looming issues in America that spurred the health care reform debate (up to and including the passage of the ACA) are poor health care outcomes across the population and the unsustainably rising cost of health care. These two concerns are inextricably bound, as treatment of chronic diseases accounts for 93 percent of Medicare expenditures.[3]

The ACA wasn't the first document to equate happier, cheaper patients with the sum of patient involvement and satisfaction. As early as 2001, the IOM listed patient-centered care as one of the six aims for reforming health care.[4] To illus-

trate the point, the IOM compares two hypothetical patients.

The first is treated in the "old" model, where the system works entirely at the convenience and for the benefit of the health care system itself, and that of the hypothetical future patient, who makes all of her own treatment decisions within a system that works entirely around her preferences. Not surprisingly, the empowered, proactive and fictitious patient in the patient-centric model of the future has a far better outcome than her disrespected, negligently treated and hopelessly confused counterpart.[4]

COMPLIANT PATIENTS SHOULD LEAD TO HEALTHIER (AND PRESUMABLY) HAPPIER PATIENTS.

As simplistic as these vignettes are, they do underscore the apparent bias among policymakers during this era of health care reform. By mandating improvement in health care through more patient involvement — as measured by their level of satisfaction — lawmakers believe that we'll achieve a healthier population while simultaneously reducing health care expenditures.

It does make sense that a fully informed, comprehending patient is far likelier to comply with their treatment regime. Most people that truly understand the connection between their disease or condition and the implications for their future functional ability (and longevity) will be more likely to follow their treatment plan, including necessary lifestyle changes. At the end of the day, compliant patients should lead to healthier (and presumably) happier patients.

It is also an easy intellectual leap to anticipate that a population with better compliance and healthier lifestyles will lead to decreased costs. It is far less expensive to give excellent, early intervention to a patient newly diagnosed with a chronic disease (such as heart disease), than to intervene with late-stage disease (such as post-stroke rehabilitation).

Informed patients, the reasoning goes, will always choose the best health care interventions and be counted upon to be logical. However, physicians arguing against VBP (as measured by patient satisfaction) respond that the one-two punch behind the policy sits upon faulty assumptions. Similarly, assuming that every patient will be motivated to choose the least expensive treatment option for the sake of societal good is at best optimistic.

It would appear that policymakers believe they have to convince doctors that well-informed, compliant and happy patients are the goal — as if physicians would not love to have waiting rooms filled with such perfect patients. Any disagreement between advocates of VBP and physicians is about the ultimate results achieved through patient satisfaction, not the importance of patient education, informed consent and participation in their own health care. The tension becomes palpable, however, when all of the theory behind patient satisfaction as a means to meeting the double aims of health care reform trickles down to the reduction of reimbursement based upon that measurement.

IS PATIENT SATISFACTION A FAIR CRITERION FOR REIMBURSEMENT? — To the physician community, the patient satisfaction modifier continues chasing an unfulfilled vision, is based upon theoretical assumptions and runs contrary to doctors' own experiences working with actual patients. Worse of all, the theory that is being put into motion is entirely at the provider's risk. The noncompliant patient sees no repercussions (other than poor health), and a patient demanding care that is neither effective nor cost-efficient at most invests a few dollars in the form of a small co-pay.

Take, for example, the diabetic who consistently breaks his diet by consuming sugary sodas, candy and excessive amounts of junk food. His doctor will see declining reimbursements for care as the patient's HbA1c climbs upward, while he is empowered to further decrease the doctor's income by expressing dissatisfaction with the physician's recommendation to follow a diabetic-friendly diet. In the end, it is not his insurance or lifestyle that will be hit; the physician's reimbursement will plummet.

Look also at the case of antibiotic overutilization. Is that being driven by physician indifference or patient demand? Countless patients want an antibiotic for their children, despite detailed and appropriate discussions with doctors who explain that the culprit is actually a virus, which is self-limiting and not treatable by the demanded drug.

The risk to the patient is minimal (perhaps a small co-pay), but the physicians lose income for failing to meet the "appropriate use of antibiotics" quality indicator. Here is the real rub: The pediatrician in that scenario was simultaneously being graded on quality as defined by patient satisfaction (Mom wants a prescription) and overutilization of antibiotics. Quite literally either way he will be penalized.

The converse of these scenarios is equally unfair. Well-liked physicians do not by definition give superior care. Unfortunately, we'll be living in this paradigm until this method of calculating "quality" has been fully implemented and tested. Ultimately, it will take data and demonstration of results (or lack thereof) over a period of years to bend either side toward agreement on this issue.

MOVING FORWARD — In the meantime, in order to effectively lobby against the means (reimbursement quality modifiers), the medical community must separate their concerns from any implication that patient education, participation, shared decision-making, informed consent and satisfaction are not all worthy goals. In fact, physicians should be the primary advocates for exactly these aspects of patient care. Each component is entirely consistent with the history, philosophy and heart of the medical profession.

To that end, the medical community must be far more demanding of excellence from one another. Any behavior toward patients that is not respectful must be subject to discipline, any attitude that is not patient-centric must be corrected. Every physician must bring this level of attention to his or her

own patients, partners and colleagues whom they work with or simply overhear in a break room. At the end of the day, physicians usually respond better to corrections from fellow physicians. That said, we must not discount the significant contributions that other players can bring, particularly hospital leaders who have years of experience in the arena of patient satisfaction. Doctors would be wise to listen, follow and learn.

All of this begs for physician leadership. On the level of lobbying, administration, and all the way through the system to the individual physician, it is important that physicians start leading the path toward a better patient experience while also effectively advocating for a change in the reimbursement structure under VBP. ■

Sarah F. Fontenot, BSN, JD is the health law professor for Trinity University (San Antonio) MHA Program in the Department of Health Care Administration and has been a member of the ACPE faculty since 2006.

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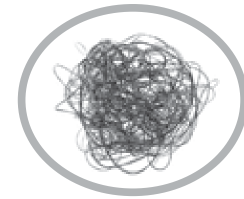

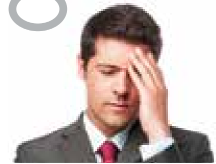

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