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Perspectives on Patient Experience: A National Survey of Hospitalists

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Abstract

Despite efforts to improve patient experience (PX), little is known about the perspective of hospitalists regarding PX initiatives and priorities. A survey was distributed to hospitalist groups across the country assessing involvement in PX initiatives and their perceived effectiveness, what PX means to providers, and facilitators/barriers in improving PX. Ninety-nine percent of respondents had encountered some improvement activity around PX. The most prevalent were communication training, group Hospital Consumer Assessment of Healthcare Providers and Systems data, and interdisciplinary bedside rounding. Respondents rated most initiatives a 5 to 6 out of 10 for their effectiveness, with the perception of effectiveness increasing with respondents' assessment of patient experience priority. Learning about others' experiences in improving PX and learning about potential collaborations for quality improvement or research in these areas were areas of interest for future work. Qualitative work highlighted potential barriers in improving PX such as workload and staffing constraints, uncontrollable environmental factors, and unrealistic patient expectations. Improving PX is a priority, and there are many initiatives in place with perceived variable success and perceived barriers in improving PX.

Keywords

hospitalists, communication, HCAHPS, patient expectations, qualitative methods, quantitative methods

Introduction

Patient and family experience of care is a keystone of high-value care and the Center for Medicare and Medicaid Services (CMS)'s value-based purchasing incentives for hospitals (1). As a result, most hospitals and health systems nationally have invested in improving patient experience (2). Hospitalists are physicians who specialize in providing and managing the care and treatment of hospitalized patients and can greatly influence their experience. Despite this, little is known about the perspective of hospitalists regarding patient experience priorities.

In 2010, the CMS implemented value-based purchasing, a payment model that incentivizes hospitals for reaching certain quality and patient experience thresholds and penalizes those that do not (3). While having low patient experience scores impacts institutions financially, more importantly, it reflects patients' perception of their care, and as some studies suggest, the quality of care (4). Hospitals with higher patient experience scores tend to score higher overall on clinical care processes such as core measures compliance, readmission rates, safety culture surveys, and quality measures (5–8).

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is the survey tool utilized by

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CMS to assess patients' experiences regarding their inpatient stays. Hospitals' HCAHPS scores are publicly reported on the Hospital Compare website (3,9). The percentage of top box scores (the most positive survey responses) are utilized to compare hospitals and ultimately to tie the scores to the reimbursement or penalty a hospital will receive. While these data are publicly available, physicians may be unaware of how their hospital is ranked, let alone of the scores that are reflective of provider-specific care. Patient satisfaction scores may be affected by many different entities (10–15); however, Wild et al found that physician communication scores are strongly influenced by patient experiences with hospitalists (16).

Currently, little is known about how hospitalists perceive patient experience or the magnitude of hospitalist involvement in patient experience initiatives in their group and at their respective institutions. In order to successfully implement initiatives to improve patient experience, an understanding of hospitalist perception and involvement in current initiatives will be important. The aim of this article is to analyze results of a national survey of hospitalists to determine (a) hospitalist involvement in patient experience work at their institution and within their group, (b) the types of patient experience initiatives and their perceived effectiveness, (c) qualitative assessment of what patient experience means to providers, and (d) the facilitators and barriers to improving patient experience.

Methods

Study Design

Experts in patient experience and members of a national Patient Experience Committee developed a 1-time survey of providers who self-identified as hospitalists. First to obtain face validity, the survey questions were reviewed by experts in patient experience and by someone familiar with survey design. Second, we pilot tested with a subset of survey participants and used that to revise our survey according to feedback from this subset. The final survey was then distributed to all members of The Society of Hospital Medicine (SHM) who subscribed to email notifications.

The survey's main components covered (a) Respondent demographics including whether or not they were in a leadership role and what type; (b) whether respondents received patient experience data and how helpful the data were perceived to be; (c) what interventions their group or institution had implemented and its perceived effectiveness; (d) whether or not their group or institution utilized consultants to help improve patient experience; (e) whether or not financial incentives were offered based on patient experience scores; (f) and questions about whether or not patient experience was a priority for the respondent, their group, and their institution. The survey also included 3 high-level open-ended questions exploring perspectives on (a) the meaning of patient experience, (b) challenges for improving patient experience for the individual, the hospitalist group, the institution as a whole and overall, and (c) the resources considered most helpful (Supplemental Appendix 2).

We selected members of the SHM given that its membership of over 15 000 represents a broad sample of private and academic practices throughout the country and internationally. Members were also encouraged to forward onward to other non-SHM members who are hospitalists in their group/hospital.

Setting

An email survey was advertised to members of SHM. Survey requests were sent a total of 3 times. Members were also encouraged to forward the survey to other institutions and colleagues.

Inclusion and Exclusion Criteria

Inclusion criteria for the study included members of SHM who work within the field of hospital medicine and self-identified as "hospitalists" and interested hospitalists who were nonmembers of Society of Hospital Medicine. Exclusion criteria were refusal to participate, previous participation, and membership on the Patient Experience Committee.

Ethics and Patient Consent

This study was reviewed by the respective institutional review boards and considered exempt.

Data Collection

REDCap (17), a secure, web-based application for building and managing online surveys and databases, was used to collect and manage all project data. Only de-identified data were exported from REDCap to SAS for the analysis. The only identifier that was collected was an email address to ensure participants did not take the survey more than once. Survey data were collected in a fashion that assured that the email address was not linked to survey responses.

Data Analysis

Quantitative analyses were performed using SAS Enterprise Guide 8 (SAS Institute, Inc.). Frequencies with percentage or means with SD are reported. A Pearson's correlation coefficient was used to assess the correlation between the priority of patient experience and the perceived success of each intervention. Applying a Bonferroni's correction for multiple comparisons, a P value $<.004$ was considered statistically significant. Themes and concepts were derived from responses provided to 5 open-ended questions included in the survey. Free text responses were coded by 3 team members (A.K., K.I., and R.K.) and a synthesis of results emerging from the responses to each of the open-ended questions was summarized by 1 team member (A.K.).

Table 1. Demographics.

What best describes you, n (%)	
Nurse practitioner	35 (8)
Physician assistant	13 (3)
Physician	396 (88)
Other	4 (1)
Department, n (%)	
Internal medicine	372 (84)
Pediatrics	23 (5)
Family medicine	29 (7)
Other	19 (4)
Missing	5 (1)
Years in practice, mean ± SD	9 ± 6
Leadership role, n (%)[a]	
Division/section chief	46 (10)
Leadership role within my hospitalist group	122 (27)
Leadership role in health system	55 (12)
Medical Staff Leadership	41 (9)
Other	41 (9)
Leadership role in patient experience, n (%)	
Hospitalist group	74 (17)
Institution	55 (12)
Type of institution, n (%)[a]	
Private	67 (15)
Teaching	245 (55)
Community	210 (47)
Safety net	50 (11)
University Hospital	175 (39)
Subacute nursing facility	1 (<1)
Long-term acute care hospital	5 (1)
Other	4 (1)

[a]Respondents may have selected more than one choice; accordingly, the total exceeds 100%.

Missing Data

If a variable was included in a specific statistical test, then respondents with missing data were excluded from that analysis (ie, complete case analysis). However, missing data were minimal and reported in Tables 1 and 2.

Results

Quantitative Results

Demographics. From October 9, 2017, to February 3, 2018, a total of 448 surveys were completed. Demographics are shown in Table 1. The majority of respondents were internal medicine physicians and 57% (n = 256) of individuals who responded were reported having some sort of leadership roles. Sixty-five (N = 290) percent reported working in an academic environment. The survey represents at least 192 unique institutions (missing or unclear, n = 28).

Patient experience as a priority. On a scale of 1 to 10, with 10 being highest, respondents overall rated the patient experience as a priority for them personally (8 ± 2), for their hospitalist group (7 ± 2), and for their institution (8 ± 2). The vast majority of respondents reported either personally having a health care experience or experiencing it via a family member or close friend (86%).

Patient experience initiatives. Ninety-nine percent of respondents noted awareness of improvement activity around patient experience in their group or institution. The most prevalent initiatives were (a) communication training (53%), (b) group HCAHPS data (46%), and (c) interdisciplinary bedside rounding (44%). Respondents rated most initiatives a 6 of 10 for their effectiveness, with initiatives promoting individualized HCAHPS data and financial incentives receiving a rating of 5 of 10 (Table 2). The use of financial incentives was reported by a less than a third of the respondents. Eighty-five percent of those who did report financial incentives reported having them at the group level and 24% at the individual level with the majority of respondents reporting that the financial metric was tied to the HCAHPS doctor communication question (data not shown).

Perceived effectiveness of patient experience initiatives. Perceived success of the various patient experience initiatives is shown in Table 2. On a scale of 1 to 10, most initiatives fell in the range of 4.7 to 6.9. For all initiatives rated by respondents, as personal priority of patient experience increased, the perceived success of each initiative increased, although not all correlations were significant (Supplemental Appendix Table 1). We found statistically significant correlations between priority of patient experience for the respondents personally and perceived effectiveness of etiquette-based communication ($P < .001$), communication training ($P < .0001$), hourly rounding ($P = .0033$), leader rounding on patients ($P < .0001$), individualized HCAHPS feedback/data ($P < .001$), group HCAHPS feedback/data ($P < .0001$), interdisciplinary bedside rounding ($P = .0006$), and provider observation and coaching ($P < .0001$).

Use of consultants to help with patient experience initiatives. Twenty-seven percent of participants stated their group or hospital system utilized consultants for patient experience work, with 41% being uncertain as to whether or not consultants had been utilized. The majority of participants (70%) who reported their institution working with consultants stated they were involved in interventions implemented by consultants. Participants rated the helpfulness of consultants' recommendations 5 of 10.

Interest in learning more about patient experience initiatives. With regard to potential opportunities for learning more about patient experience initiatives, respondents reported interest in learning about others' experiences (53%), learning about potential collaborations for quality improvement or research in patient experience (50%), and attending in-person communication skills courses (35%).

Table 2. Receipt of Patient Experience Data, Interventions Utilized to Improve Patient Experience, and Perceived Effectiveness.[a]

Question	All surveys n = 448	Private, n = 67	Teaching, n = 245	Community, n = 210	Safety net, n = 50	University hospital, n = 175	Other, n = 10
Do you receive quantitative or qualitative patient experience data, either for yourself, for your hospital medicine group, or for your health care system?							
Daily, weekly, monthly, quarterly, rarely, n (%)	413(92)	63 (94)	220 (90)	199 (95)	45 (90)	160 (91)	8 (80)
Do not receive, n (%)	34 (8)	4 (6)	24 (10)	11 (5)	5 (10)	15 (9)	2 (20)
On a scale of 1 to 10, how helpful are these quantitative data in understanding how your patients experience their care? Mean ± SD	5.5 ± 2.4	6.0 ± 2.4	5.4 ± 2.4	5.6 ± 2.4	5.5 ± 2.6	5.4 ± 2.3	4.6 ± 3.0
On a scale of 1 to 10, how strongly do you feel that these quantitative data have changed how you provide care to patients? Mean ± SD	5.0 ± 2.4	5.3 ± 2.4	4.9 ± 2.3	5.1 ± 2.4	4.9 ± 2.5	4.9 ± 2.3	4.4 ± 3.1
What interventions has your group or hospital system implemented?							
Etiquette-based communication, N (%)	99 (22)	17 (25)	46 (19)	53 (25)	15 (30)	30 (17)	3 (30)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.5 ± 2.2	5.9 ± 1.9	5.1 ± 2.1	5.4 ± 2.3	4.7 ± 2.8	5.4 ± 2.1	5.3 ± 2.5
Communication training, n (%)	239 (53)	30 (45)	133 (54)	123 (59)	24 (48)	96 (55)	5 (50)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.8 ± 2.0	5.9 ± 1.9	5.7 ± 2.0	5.8 ± 2.2	5.3 ± 2.2	5.8 ± 2.0	4.8 ± 2.0
Hourly rounding, N (%)	80 (18)	9 (13)	48 (20)	38 (18)	10 (20)	32 (18)	1 (10)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.9 ± 1.8	6.2 ± 2.5	6.2 ± 1.4	5.8 ± 2.0	6.7 ± 1.4	5.9 ± 1.3	N/A
Leader rounding on patients, N (%)	116 (26)	17 (25)	69 (28)	61 (29)	18 (36)	45 (26)	1 (10)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.7 ± 2.0	6.1 ± 2.1	5.6 ± 2.0	5.7 ± 2.0	5.7 ± 1.9	5.7 ± 2.2	N/A
Leader rounding on providers, N (%)	44 (10)	5 (7)	20 (8)	24 (11)	9 (18)	15 (9)	0 (0)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.8 ± 2.0	6.0 ± 1.9	5.7 ± 2.1	5.8 ± 1.8	5.6 ± 2.3	5.8 ± 1.9	N/A
Real-time patient feedback to providers, N (%)	63 (14)	11 (16)	30 (12)	39 (19)	8 (16)	19 (11)	0 (0)
On a scale of 1-10, how successful was this intervention? Mean ± SD	6.4 ± 2.1	6.6 ± 1.3	6.0 ± 1.8	6.3 ± 2.2	6.1 ± 2.1	6.3 ± 2.3	N/A
Individualized HCAHPS feedback/data, N (%)	117 (26)	17 (25)	53 (22)	63 (30)	12 (24)	43 (25)	1 (10)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.2 ± 2.3	5.1 ± 2.3	5.1 ± 2.2	5.6 ± 2.3	5.2 ± 2.4	4.7 ± 2.3	N/A
Group HCAHPS feedback/data, N (%)	206 (46)	27 (40)	108 (44)	113 (54)	24 (48)	73 (42)	3 (30)
On a scale of 1-10, how successful was this intervention? Mean ± SD	5.2 ± 2.1	4.8 ± 2.2	5.3 ± 1.9	5.1 ± 2.1	5.1 ± 2.1	5.1 ± 2.0	2.0 ± 1.0
Interdisciplinary bedside rounding, N (%)	195 (44)	30 (45)	117 (48)	85 (40)	22 (44)	88 (50)	2 (20)
On a scale of 1-10, how successful was this intervention? Mean ± SD	6.4 ± 2.2	6.6 ± 2.3	6.4 ± 2.3	6.2 ± 2.4	6.0 ± 2.4	6.5 ± 2.1	6.5 ± 2.1
Patient and family advisory council, N (%)	102 (23)	10 (15)	73 (30)	38 (18)	11 (22)	54 (31)	0 (0)
On a scale of 1-10, how successful was this intervention? Mean ± SD	6.0 ± 2.0	6.7 ± 1.6	6.0 ± 1.9	5.6 ± 2.3	6.7 ± 1.7	6.2 ± 1.9	N/A
Provider observation and coaching, N (%)	120 (27)	23 (34)	69 (28)	61 (29)	16 (32)	44 (25)	1 (10)
On a scale of 1-10, how successful was this intervention? Mean ± SD	6.4 ± 2.1	6.2 ± 2.0	6.2 ± 2.1	6.3 ± 2.1	5.9 ± 2.2	6.7 ± 2.1	N/A
Financial incentives to improve patient experience, N (%)	98 (22)	16 (24)	49 (20)	67 (32)	8 (16)	26 (15)	0 (0)
On a scale of 1-10, how successful was this intervention? Mean ± SD	4.7 ± 2.3	5.3 ± 2.5	4.4 ± 2.1	4.6 ± 2.4	5.1 ± 2.1	4.6 ± 2.4	N/A
Others[b], N (%)	20 (4)	2 (3)	11 (4)	10 (5)	1 (2)	6 (3)	1 (10)
On a scale of 1-10, how successful was this intervention? Mean ± SD	6.9 ± 3.0	2.5 ± 2.1	6.3 ± 2.3	5.8 ± 2.7	N/A	6.2 ± 3.0	N/A
Not applicable, N (%)	47 (10)	8 (12)	27 (11)	14 (7)	5 (10)	18 (10)	2 (20)

Abbreviations: IHI, Institute for Healthcare Improvement; HCAHPS, Hospital Consumer Assessment of Healthcare Providers and Systems; NA, not applicable.

[a]Respondents could be listed in more than one column; accordingly, the total may exceed 100%.

[b]Examples include interdisciplinary team rounding or meetings, patient call backs, thank you cards, white boards in patient rooms, quiet time on units, patient navigators, IHI "What Matters Most" program.

Table 3. Themes Derived From Free Text SHM Patient Experience Survey Question "What Does Patient Experience Meant to You?"

Question	Theme	Quotation
What does patient experience mean to you?	Holistic	"the lived experience of people who are hospitalized, including their relationships, reactions to the hospital environment, interaction with medical and psychosocial interventions, traumatic or healing stimuli in the context of medical care"
	Experience/perceptions of care	"The patient's overall impression of the care at our hospital. (Using the very broadest definition of the word 'care.') For many patients, their impression of their care seems less influenced by technical/medical factors, and more by interpersonal factors like provider-patient communication (i.e. feeling valued/listened to, having an opportunity to ask questions about the plan etc.)"
	Patient at the center	"Patient experience is the story of the entire patient and includes his history, his hospital stay, and his discharge planning. It includes his family, his feelings, and the multidisciplinary team."
	Quality of care/ perceptions of quality	"Patient interpretation of the quality of their medical care in multiple domains – physically, emotionally, intellectually, financially"
	Satisfaction	"patient being overall satisfied and content with the care being provided to them and understanding what and why certain things were done along with professional ancillary staff to make the stay comfortable"

Qualitative Results

Meaning of Patient Experience

Themes derived from the first question, "What does patient experience mean to you," include the idea that patient experience is holistic, should keep the patient at the center, and reflects both the experience and perceptions of the patient's medical care and quality of care (Table 3).

Challenges

Themes that emerged from the questions exploring challenges to improving patient experience, "Overall, for your hospitalist group, and at the institution-level," had some overlapping opinions, in addition to unique themes for the group or institution. Included in the overlapping opinions are patient factors such as unrealistic expectations or acuity of illness and physician time or workload constraints (Table 4). Unique themes include lack of meaningful data (overall), provider buy-in and heterogeneity in provider background (hospitalist group), and institutional challenges such as limited private rooms, lack of parking, and inconsistent commitment in improving patient experience.

Resources That Would Be Helpful for Patient Experience Work

Themes derived from the question about what resources would be helpful centered around education and tools, including educational materials or training, communication tools, and coaching or mentoring (Supplemental Appendix Table 2). Along with training and tools, robust feedback data and an established Patient and Family Advisory Council or patient experience office emerged as themes from the comments.

Discussion

Based on the survey respondents' answers, the most important findings of this study are (a) institutions have set patient experience as a high priority, (b) while multiple interventions have been deployed at institutions, respondents did not feel that they were overly successful, (c) qualitatively, respondents had fairly strong opinions about patient experience and initiatives to improve it (both positive and negative), and (d) resources that respondents stated were given toward improving patient experience rarely matched with the concerns that were raised by respondents.

Despite the concept of patient experience having been utilized as a measure for value-based performance for almost a decade (3,5,9), spawning numerous institutional initiatives and awareness of the concept, our study found that hospitalists have different definitions of patient experience and mixed feelings about the initiatives to improve it. Wolf et al found that while there was not consistency in the definition of what patient experience means, there was alignment around central themes seen as critical to patient experience, including emotional and physical lived experience, personal interactions spanning across the continuum, shaped by the organization/culture, and the importance of partnership/patient involvement (18). Society of Hospital Medicine defines "patient experience" as "everything we say and do that affects our patients' thoughts, feelings, and well-being" (19). To add to the confusion, patient satisfaction and experience are often mistakenly interchanged with patient experience differing from patient satisfaction in that patient experience captures the patient's perspective on care rather than superficial efforts aimed at making patients "happy" (1).

While hospitalists are well-positioned to influence patient experience in the inpatient setting, our survey results show that the hospitalist respondents perceive numerous barriers that impact patient experience that are often external to the provider, such as environment, multiple competing tasks, and insufficient staffing. Our results also highlight that respondents are seemingly ambivalent to the successfulness of the various initiatives implemented to improve patient experience.

Table 4. Themes Derived From Free Text SHM Patient Experience Survey Questions Regarding Challenges.

Question	Theme	Quotation
What do you perceive are the challenges to improving patient experience overall?	Physician time/workload	"Time restraints. Patient/Provider ratio. If time is inadequate to interact with the patient and family to the degree needed to fully answer their questions and concerns, they WILL be dissatisfied."
	Patient unrealistic expectations	"Clearly setting expectations/ communicating plan and timeframes Difficulty visualizing testing times, knowing timing of consultant recommendations and visits to help with setting expectations"
	Uncontrollable/ environmental hospital or facility factors	"A patient's rating of their experience weeks after they experience it is quite complex and relies on many factors, many which we can't control. patients may have different expectations for different institutions One negative encounter with one provider can change a patient's perception of their overall experience (the challenge of using 'top box')"
	Data not meaningful	"It is a complicated issue with many factors that go into it and very poor and unreliable metrics to measure patient satisfaction"
What do you perceive are the challenges to improving patient experience for your hospitalist group?	Time/workload	"Resources and time. In a busy group with many ongoing projects and ever growing clinical responsibilities it may be difficult to re-align priorities for providers."
		"Rising census, we are being asked to see more and more patients which allows for less time for patient interaction."
	Provider buy-in/awareness	"Achieving buy in from providers that this is important for our patients and needs commitment despite their concerns about creating more work for them"
	Provider heterogeneity	"Teaching doctors of different cultural background and personalities to communicate with a huge variety of patient types in terms of gender, culture, language etc."
	Scheduling/staffing challenges	"Understaffing. Everyone wants better outcomes, but administration doesn't want to pay for the staff to make it happen. Instead they stretch the physicians and nurses, etc. to the breaking point. Of course the patient is going to be unhappy when the call bell is on for 20 minutes (I would be also), but how can you expect a nurse or aid to get there quickly when they are on a 6:1 ratio on a progressive care floor."
What do you perceive are the challenges to improving patient experience at your institution?	Patient factors – challenging patients, acuity, expectations	"Large group, very sick and complicated patients, multiple providers and subspecialists see patients concurrently"
	Administration buy-in, or competing institutional priorities	"Patient experience like many initiatives seems to wax/wane in terms of importance to the hospital system. This lack of consistent drive allows a mediocre approach. The lack of rapid, accurate data does not facilitate adjustment/correction."
	Cost/resources	"Poor structure to foster physician-nurse collaboration and innovation. Restrictive operational finances."
	Physical plant or amenities	"Limited space, limited private rooms, long holds in ED due to lack of rooms, high census for each Hospitalist"
		"Limitations of the physical plant – location, parking, amenities, appearance, capacity."

Studies have shown that many factors impact patient experience of care in particular as measured by HCAHPS, such as nurse staffing levels, physician staffing levels, and teaching status (11,14). Even well-known tactics to improve patient experience have variable results including physician communication coaching and training and feedback (12,20–23). The original goals of the current HCAHPS survey was to provide patients with useful information for more informed decisions on hospital choice and also give hospitals incentives to improve care through public reporting. A recent survey of patient experience leaders indicated that these leaders do not feel the current HCAHPS survey has accomplished its original goals, with 61% of leaders giving a rating of a 5 or 6 on a 10-point scale (24), which may also lead to further frustration with efforts to improve patient experience. Additionally, this report highlighted the need for revising the current HCAHPS survey given falling response rates, adding additional topics such as teamwork and efficiency, addressing literacy levels, and assessing additional factors that may influence patient experience (24).

Most respondents noted that their institutions have prioritized patient experience and have actively implemented interventions. Previous work has identified factors that drive organizations' patient experience efforts including

government-mandated surveys (ie, HCAHPS) and leadership's desire to provide a better experience (2). Roadblocks that were identified included competing organization priorities and cultural resistance to doing things differently. They also found the most important factors in achieving a positive patient experience were highly engaged staff/employees (2). Birkelien developed a framework for improving patient experience in hospitals with key aspects of the framework being (a) patient and provider communication; (b) patient engagement; (c) information transparency; (d) accessible organization; (e) empathetic hospital environment; and (f) quality outcomes and value (25). While noble in nature, points 1 to 5 were mentioned as potential barriers by survey respondents to effectively being able to improve patient experience, including high patient census, lack of transparent processes, and issues with patient access to key services in a timely fashion. Despite the barriers that were recognized by survey respondents mentioned above, interdisciplinary resource allocation, learning modules with role play, and business cards with faces on them were thought to be helpful in improving patient experience.

We found that 26% of respondents are receiving individualized HCAHPS data and 22% reported receiving financial incentives to improve it. While HCAHPS has been designed to measure hospital-level performance, this survey highlights the concern that was raised by Tefera et al that "some hospitals may be disaggregating raw HCAHPS data to compare, assess, and incentivize individual physicians, nurses, and other hospital staff" (26). While HCAHPS was not meant to be disaggregated, there may be some inherent value for institution-specific study to drive hypothesis generation and performance improvement while recognizing that at present there are inherent weaknesses in the data. Additional research into the validity of individual and group scores is needed. As more research regarding patient experience accrues, a better understanding of statistical approaches, study design, and significance of findings pertaining to HCAHPS will be key. At present, there are no clear best practices. While some data suggest that financial incentives at the group level result in improved HCAHPS scores (27), incentivizing individual HCAHPS scores needs further study until more is known how this practice affects behavior, morale, and whether it drives the outcomes being sought. Attribution to an individual hospitalist will continue to prove challenging given patients are often exposed to multiple different providers while hospitalized (28).

Our study has several strengths. First, this study sought to understand hospitalist perspectives on patient experience and included hospitalists from approximately 200 institutions across the country. We have included perspectives from highly clinical hospitalists to those in leadership roles, with both a qualitative and a quantitative approach. Our study also has several weaknesses. Because our study was sent to both members and nonmembers of the SHM, and recipients of the survey could forward it to others, we do not have an estimate of the nonresponders to the survey. Respondents could have been from the same institution; thus, we cannot report precisely how many institutions were included in this survey. Additionally, there could be an inherent bias in those who decided to respond to the survey versus those who did not.

Conclusion

The majority of respondents in a national survey indicated that improving patient experience is a priority; however, there are many different initiatives in place with perceived variable success in improving patient experience. Additional research is needed to understand how experience initiatives can achieve value for both patients and care providers such as hospitalists.

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Supplemental Material

Supplemental material for this article is available online.

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