OUTDATED SATISFACTION METRICS EXCLUDE THE FINANCIAL EXPERIENCE

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I recently read with great interest that Avery Comarow, director of *U.S. News & World Report's* Best Hospitals and other healthcare rankings, recently retired after 31 years with the organization.[1]

As I reflected on this news, I found myself asking: Is it time to retire traditional patient satisfaction metrics?

First, we owe Mr. Comarow a huge debt of gratitude for persevering, in the absence of tangible data, and driving one of the most critical hospital evaluations historically available in the market. Patients, practitioners, administrators and those of us who support the industry have become dependent upon these rankings for all sorts of reasons.

In the absence of quantifiable data tying the clinical and the financial experiences together, we have all leaned on these rankings to try and determine who is providing truly world-class patient financial satisfaction. *U.S News & World Report* and Mr. Comarow have done a tremendous job of providing a framework for us to build on as consumerism evolves and patients take a more active role in both the clinical and the financial.

And that brings me to my second observation. Perhaps it is time to look at a different way to capture, quantify and embrace patient financial satisfaction in the age of consumerism. In this blog, I'll look at some of the reasons why it is not just desirable, but necessary, for hospitals to consider the financial experience of the consumer in the same context as clinical care.

I'd like to first take a moment to call attention to the profound lack of data available on one aspect of patient satisfaction—that is, financial satisfaction. It's become the elephant in the room at so many high-level hospital meetings. Patient satisfaction scores are still quoted with no one pointing out the obvious gap: How happy patients are with their financial experience is really largely unknown. Our recent **market study** found that the vast majority of hospitals are doing nothing at all to measure the financial experience. Those same hospitals are doubtlessly investing considerable resources in measuring the clinical care that's delivered, and in improving their patient experience in general. But the patient satisfaction metrics that have been relied on for decades don't focus on the financial experience. Hospitals

have only part of the patient experience story, and that means opportunities for improvement go unaddressed. That's something that would never be tolerated with deficiencies in clinical care.

There is just no other area of hospital operations that is so vital to the organization, yet so little understood. Virtually every other aspect of a hospital visit is an open book, with clinical care the obvious example. It's hard to even talk about clinical practice today without using the term "evidence-based." I'd venture to say it's literally not possible to have an informed discussion about patient outcomes without using this term. That's because it is so well understood that the hospital's entire mission—all of the services the hospital provides for the community—is rooted in evidence-based care. Patients' health and well-being depend on it, first and foremost. But so does the hospital's reputation in the community, the ability to recruit the best clinicians, the ability to attract new patients and even the ability to defend itself in the event of medical malpractice allegations. To provide evidence-based care, the hospital, of course, has to track and measure outcomes. For a single surgical patient, a dizzying array of metrics are tracked. It requires a significant amount of resources (and with every hospital doing more with less, that's something that speaks volumes about its perceived importance.) But no one would ever suggest it was a waste of time or money to pay attention to clinical outcomes.

But it doesn't stop with clinical care. Hospitals have data on virtually every aspect of their operations. They have data on employee engagement, race and ethnicity, length of stay, the percentage of self-patients converted to Medicaid, physician burnout, employee turnover, and the list goes on and on. Hospitals collect more data than possibly any other type of organization, and that's only growing.

But as for how satisfied patients are with their financial experience—which is one of the key determining factors in whether a hospital will succeed in the marketplace—there is virtually no data whatsoever. How can this be?

To fully understand this problem, let's take a look at the history of patient satisfaction metrics now used by U.S. hospitals. According to Press Ganey, patient satisfaction was top of mind for many hospital administrators as far back as 1984, but most had no way to measure or improve it. Dr. Irwin Press partnered with Dr. Rod Ganey to create the first scientifically valid survey.[2] Hospitals have relied on these scores ever since. These metrics served a purpose at a certain point in time, but something important has changed. Until recently, the typical patient with insurance gave little thought to finances because there was simply no reason to—not for the patient or the hospital. Little or no money was collected from patients in most cases, and certainly not upfront. When the vast majority of revenue came from insurers, it made sense to down play the financial experience. Why risk dissatisfaction by bringing up the money or collections, when there was so little for the hospital to gain? For all intents and purposes, there was no Patient Financial Experience. Patients simply went to the closest hospital and their insurance paid the bill. Increasing liability for patients means two things: One, hospitals have to get the Financial Experience right, because revenue is at stake. Second, hospitals can no longer count on patients choosing them just because they're closest. All patients, even those with insurance (and in some cases, especially those with insurance who have high-deductible plans) are having financial experiences when they seek health care.

And as with all health care experiences, they will be satisfied or they will be dissatisfied (and our **market study** revealed that most are the latter.)

Gone are the days when business decisions in healthcare might have been made on a whim, somebody's gut instinct, or based on a particular person's biases or management style. That wouldn't fly today, when virtually everything in healthcare is decided based on data. But why not the financial experience? If the revenue cycle does not have good data on the financial experience, and is forced to rely on general satisfaction metrics that do not really speak to the area (and that's exactly what our clients tell us is occurring), is it any surprise that the department is going to be at a distinct disadvantage in the marketplace?

Faced with narrowing profit margins and multiple factors threatening financial viability, hospitals are closing their doors in record numbers. Yet hospitals persist in outdated approaches to measuring satisfaction, without data on financial satisfaction. This drives operational changes that are not data-driven--and therefore, not in the organization's best financial interest.

It's time for a new approach. The Patient Financial Experience needs to be seen for what it is—an important aspect of satisfaction in dire need of quantification. Looking at it as anything less is introducing more financial risk to already fiscally-stressed hospitals which can ill afford it. Ignoring the financial experience is not modern, it's not 21st-century healthcare, and it's not what patients want.

And don't patients deserve financial care from hospitals? If there's any doubt, look no further than the growing body of research tying financial burdens with poor health. One recent study found that cancer patients with financial stress had worse health care-related quality of life, increased risks of depression and a higher frequency of worrying about cancer recurrence. [3] It's really not surprising, but it's completely unacceptable, that patients are literally worried sick over their health care bills.

If we in the industry do not take heed of this and look at patients holistically, with evidence-based assessments of the financial experience, we're not doing right by patients. Because that is not what patients themselves do. Patients do not experience clinical care one way, and financial care another way. For them, it's all one experience. There are no silos in human beings who seek health care services.

This tells us something profound. It's something many revenue cycle leaders have long suspected but had no numbers to prove: A bad financial experience clouds patients' perception of their entire experience—even including clinical care. The patient may have a great clinical outcome, but an unpleasant financial interaction affects their overall satisfaction. What does this mean? It means it's time for a better way that meets the needs of both patients and hospitals. Healthcare is notoriously slow to change, but hospitals have made this kind of change before. The motivation came when Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data was tied to reimbursement. Imagine hospital leaders sending out a memo saying, "Please disregard HCAHPS. It will be business as usual here and the hospital

will simply absorb the lost revenue stemming from our poor satisfaction scores." It sounds outrageous, but that's exactly what is happening with the Patient Financial Experience. If there's one thing we know, it's that a poor financial experience is a sure path to lost revenue. We have the data to prove it. Do a poor job at this and a certain percentage of patients will simply go elsewhere. Loss of trust means lost revenue, both short-term and long-term.

Is it time for a new approach? The fact is, it's long overdue. And for hospitals who get it right—the ones able to score the financial experience--it's a differentiator.

To learn more how you can approach the financial experience differently, check out our eBook **Are Patients Breaking Up With You and You Don't Know Why?**

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