

PERFORMANCE MEASUREMENT

# How U.S. Health Care Got Safer by Focusing on the Patient Experience

by Thomas H. Lee, MD

MAY 31, 2017



Before 1999 “performance” had a simple, unidimensional definition for health care leaders and their boards: It was shorthand for the CFO’s financial report, summarizing operating margins. In the years since, “performance” has become more complex, now including dozens or even hundreds of quality measures. “Numbers that numb” has become an all-too-common description for performance reports in many organizations.

Now, however, a unifying theory has emerged for how to improve performance for all these dimensions – safety, quality, experience, and financial. What is that theory, what is that driver, and what evidence supports it?

First, a few words about where we came from and how we got here. Before 1999 the assumption was that quality in health care was basically pretty good – and in any case was difficult if not impossible to measure. The financial health of the organization was the most important metric for management and governance to follow.

But 1999 was the year the Institute of Medicine (IOM) released “To Err Is Human,” the first line of which began, “Health care in the United States is not as safe as it should be...” The second sentence estimated that as many as 98,000 people die in hospitals each year as a result of preventable errors. Two years later, the follow-up IOM report, “Crossing the Quality Chasm,” reviewed other types of disappointing quality, including gaps in efficiency, effectiveness, timeliness, and patient-centeredness.

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Some IOM reports are quickly forgotten; these two changed the world. Health care providers (with forceful nudges from payers and regulators) began measuring and trying to

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improve multiple dimensions of quality, including reliability in use of evidence-based medicine, patient experience, and safety. The measures were never perfect. The work was difficult and disruptive. There are still plenty of opportunities for improvement in health care today, but the fact is that care is better, safer, and more efficient.

Some organizations have improved faster than others, and gains have been greatest in areas that were major focuses of leadership at many institutions (e.g., safety). That said, many organizations have made steady improvements in *multiple* types of performance. Is that a coincidence? Or are there organizations that have their acts together and are thus more effective at learning and improving?

The answer is increasingly clear: It is the latter. My colleagues and I have analyzed data on patient experience as well as publicly reported data on patient safety and business performance. We have found that these performance “outcomes” are correlated – that is, the organizations with better patient experience also have better safety records and report better financial margins. For example, the chart below shows rates of safety events – indicated by the Patient Safety for Selected Indicators (PSI 90) score, a composite measure – readmissions, length of stay, and hospital-acquired conditions (HAC score) for hospitals in the top and bottom quartiles of various areas of patient experience (nursing, physician care, and so on.) For every comparison, the clinical quality performance was better in the hospitals with the better patient experience performance.

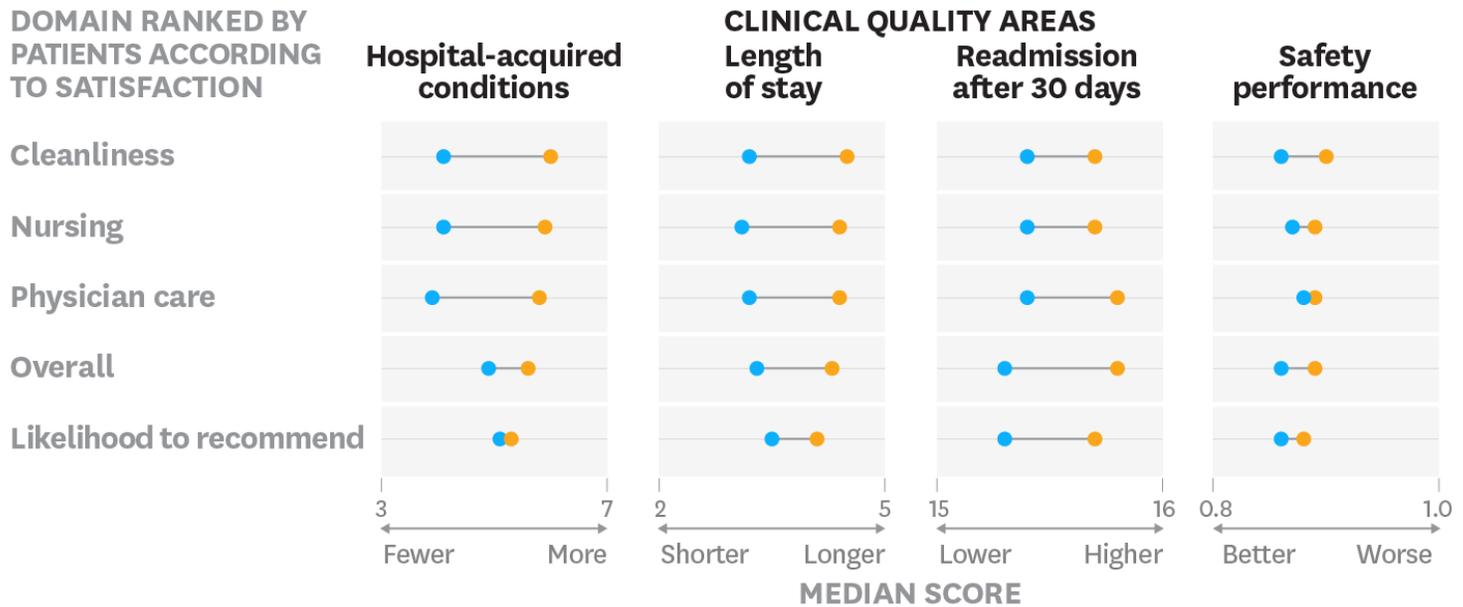
There is good news for chief financial officers, too, in these analyses. The hospitals with better safety and patient experience performance also had better financial performance. For example, the financial margins for the hospitals in the top quartile of patients’ likelihood to

## Linking Patient Experience and Clinical Quality

Hospitals that performed poorly across five patient-ranked domains also performed worse than top performers in four areas of clinical quality: hospital-acquired conditions, length of stay, rate of readmission, and safety performance.

**PATIENT RANKING**

- TOP QUARTILE
- BOTTOM QUARTILE



SOURCE PRESS GANEY, USING THE HCAHPS PATIENT SATISFACTION SURVEY

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recommend were 4.8 percentage points higher than those in the bottom quartile. I could summarize many, many comparisons in these types of performance data, but readers probably already have the idea. The performance outcomes that patients and providers want tend to track in the same direction.

But why? What is driving what? For example, does better patient experience drive shorter lengths of stay, or is it the other way around? Do the hospitals with better financial performance sit in markets with higher socioeconomic status, and thus have higher reimbursement and patients who are happier with their lives in general and are somehow less vulnerable to safety events? Or are there some common drivers of performance in general?

Our analyses suggest that it's the latter – and the common factor across various types of performance seems to be culture. My colleagues at Press Ganey recently completed an extensive series of analyses of data from client provider organizations on overall employee engagement, physician engagement, and a proxy for nurse engagement, the nursing composite measure derived from the Practice Environment Scale–Nursing Work Index. For each of these measures of engagement we examined associations with three different types of “outcomes” (patient experience, safety, and financial performance).

This work involved dozens of pair analyses that collectively show that organizations with greater engagement measured in all these ways have better performance measured in all these ways. Readers interested in seeing these analyses in greater detail can download the report without charge [here](#). The association between the various outcomes and the various measures of engagement is most consistent with the conclusion that engaged physicians, nurses, and other personnel – people who are proud of their organization, who believe it is committed to quality and safety, and who consider teamwork a core value – perform better. There are no randomized trials to prove it, but we believe this is the secret sauce.

My take is that these analyses provide comfort and direction for leaders who might be stressed and exasperated by the increasing number of performance measures relevant to their organizations. Yes, they are all important to someone, including subsets of their patients and their personnel, as well as the rest of society. But it is impossible to mount focused efforts on every one of them.

These analyses point to the power of focused, effective efforts aimed at enhancing the engagement of physicians, nurses, and other personnel, as indicated in the supporting chart. If they believe that the organization cares about quality and safety, and if core values include compassion for patients and teamwork, there is a good chance that better quality and financial performance will follow.



Thomas H. Lee, MD, is the chief medical officer at Press Ganey Associates. He is a practicing physician at Brigham and Women’s Hospital and on the faculty at Harvard Medical School, as well as the co-author of the HBR article Engaging Doctors in the Health Care Revolution and An Epidemic of Empathy in Health Care (McGraw-Hill 2015).

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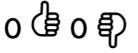
2 COMMENTS

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**Debbie Burbary** a day ago

As I work with data for quality improvement daily, we have seen improvement in EBC metrics. However, on a personal note, with a family member who has been a long term inpatient, in a highly recognized trauma one hospital, the patient experience does not reflect the results of the data. We have experienced some horrendous errors that thankfully have not been catastrophic in outcomes. Even with having been a strong voice as a patient advocate these errors continue to be an issue.

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