



(Dis)Incentivizing Patient Satisfaction: A Departmental Study of an Incentives Program with Possible Bias against Women and UIM Physician Faculty

Sylk Sotto, EdD, MBA, MPS; Mike Ober, MD; and Mark Geraci, MD
Department of Medicine, Indiana University School of Medicine

ABSTRACT

The departmental study reviewed overall patient satisfaction and communication scores during a period in which quality related patient satisfaction financial incentives were offered to physician faculty.

Anecdotally, it appeared that women faculty were in the bottom quartile of patient satisfaction scores according to certain specialties. This led to remediation and potential income inequities that may have been related to patient bias and not actual physician performance. This concern prompted a deeper analysis into the department of medicine patient satisfaction data. This data was disaggregated based on gender, race/ethnicity, and by specialties under the Department of Medicine.

Results suggest that underrepresented faculty in medicine may obtain lower patient satisfaction scores, therefore furthering inequities.

BACKGROUND Quality – Patient Satisfaction Incentive

Provider patient satisfaction financial incentives were based on either 1) outpatient provider communication (composite score of 6 questions), or 2) overall outpatient rate (9 or 10).

The outpatient satisfaction component of the total quality incentive was weighted at a minimum of 30% of the total incentive payout. Scores < 30th percentile resulted in the entire loss of the quality incentive (\$10,000 maximum.)



MATERIALS and METHODS

Overall patient satisfaction and communication scores were obtained for 158 faculty members (38 women, 120 men) who had received a minimum of 30 patient satisfaction reviews. Scores ranged from 52.2% to 100%. Unpaired t tests and ANOVA were performed using Microsoft Excel Data Analysis Pack. Data were considered significant at the P < 0.05 level. In addition, single way ANOVA statistical analysis was performed in order to study differences amongst race/ethnic groups.

RESULTS

T test data results indicate no statistical significance amongst gender samples (Patient satisfaction P = 0.31; Communication Scores P =0.44). In addition, similar scores indicated no statistical significance amongst Department of Medicine specialties.

T-tests were also performed between African-American, Latino, Two or More races, and Asian groups individually compared to Whites. The results indicate a statistical significance amongst African American, Latino, and Asian groups (P=0.0046; P=0.0008; P=0.0055 respectively). There was a significant effect amongst African-American, Latino, Asian, Two or more Races and Whites for Patient Satisfaction scores at the P < 0.05 level [F(4,154)=2.77, p= 0.029].

LIMITATIONS

Future studies should look into larger sampling, patient populations served, patient-to-provider gender and race/ethnicity relation, and bias awareness of patients and physicians.



BACKGROUND

Indiana University School of Medicine

Established in 1903 with a single teaching hospital, Indiana University School of Medicine has grown into one of the nation's largest medical centers. The main campus has five hospitals: Eskenazi Health, the Roudebush Veterans Affairs (VA) Medical Center, and three Indiana University (IU) Health hospitals: Riley Hospital for Children, IU Health University Hospital and IU Health Methodist Hospital. More than 800 IUSM faculty physicians staff the hospitals and are members of Indiana University Health Physician practice plan (IUHP). IUSM has nine teaching campuses across the state of Indiana. The school currently educates the largest medical student body in the U.S., with more than 1,400 medical students; 1,000 residents staffed by 60 clinical departments & divisions.

The Department of Medicine has over 400 faculty physicians under IUHP. This study represents those at University Hospital and Methodist Hospital.

CONCLUSIONS

Our analysis demonstrates that patient satisfaction scores need to be carefully considered when incentivizing physician performance. Patient satisfaction is a unique experience and does not take into account the unconscious or firm biases that patients have prior to their physician visit. The impact of a potential patient's bias on a provider's survey results is very concerning, and needs to be taken into consideration in the development of financial incentives.

If patient satisfaction scores must be used to incentivize physicians, we suggest adjustment factors that would level the possible biases that may exist against women and URM physician faculty.

Update: This quality related patient satisfaction financial incentive has been discontinued by IUHP.

