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# Press Ganey Research Note
# Consumerism: Earning Patient Loyalty and Market Share

In a period of uncertainty and change, one clear imperative has emerged for every health care organization: earning and retaining patient loyalty. The reason is simple. Market share matters, regardless of the structure of contracts (fee-for-service vs. capitation) or actual reimbursement rates. Providers need patients if their organizations are to have any chance to be successful, and patients are becoming more active than ever in choosing where they receive their care.

Powerful economic trends are driving patients' increasing involvement in choosing care providers. The Affordable Care Act has led to the development of government and private exchanges, where a wide range of health insurance products are offered, including many with narrowed networks of providers. Middle class budgets are stretched, and people are struggling with health plan choices that cause them to question their care decisions: Are they willing to change physicians or hospitals, or do they stay with the providers they already know? Do they recommend their current providers to their friends and neighbors who are weighing their care options?

These decisions are being influenced by health insurance products, as well as the availability of information on the Internet, and also by mergers and affiliations that lead to new brands in new locations in many markets.

The good news is that patient loyalty and Likelihood to Recommend are driven by factors that are within the control of clinicians at all levels of health care—in the hospital, in emergency departments (ED) and in ambulatory offices. The better news is that the same themes drive patient loyalty across all of these settings. The best news is that these factors are completely consistent with values that inspire professional pride among physicians, nurses and other personnel.

## "Likelihood to Recommend" as a Loyalty Measure

Patients' Likelihood to Recommend health care providers is more than an expression of satisfaction with their care. This variable reflects the extent to which providers have met patients' needs—including their need for peace of mind resulting from compassionate and coordinated care and optimal clinical outcomes. They do not recommend providers to others because of the food, parking or lobby design. As will be discussed in this Press Ganey Research Note, patients recommend providers when the clinical personnel have earned their trust.

This distinction between meeting patients' expectations and meeting patients' needs is a critical one for competing in the new health care marketplace. Providers can meet patients' expectations for convenience, access and amenities, but patients may still suffer from unmet needs for communication, coordination and confidence in clinical outcomes. This difference explains why the term "patient satisfaction," which reflects expectations, is giving way to "patient experience," which reflects the more holistic and ambitious goal of meeting patients' needs.

The business imperative to improve patients' Likelihood to Recommend scores has long been obvious. High ratings are correlated with patients' probability of returning for additional care and likelihood of recommending services to others. But a relatively new insight is that patients' Likelihood to Recommend providers reflects the extent to which the providers have earned the patients' trust. Health care providers need to do all they can to prevent death and improve patients' physical health, but if they have not earned patients' trust and enhanced their peace of mind their work is incomplete.

## What Drives Patient Loyalty?

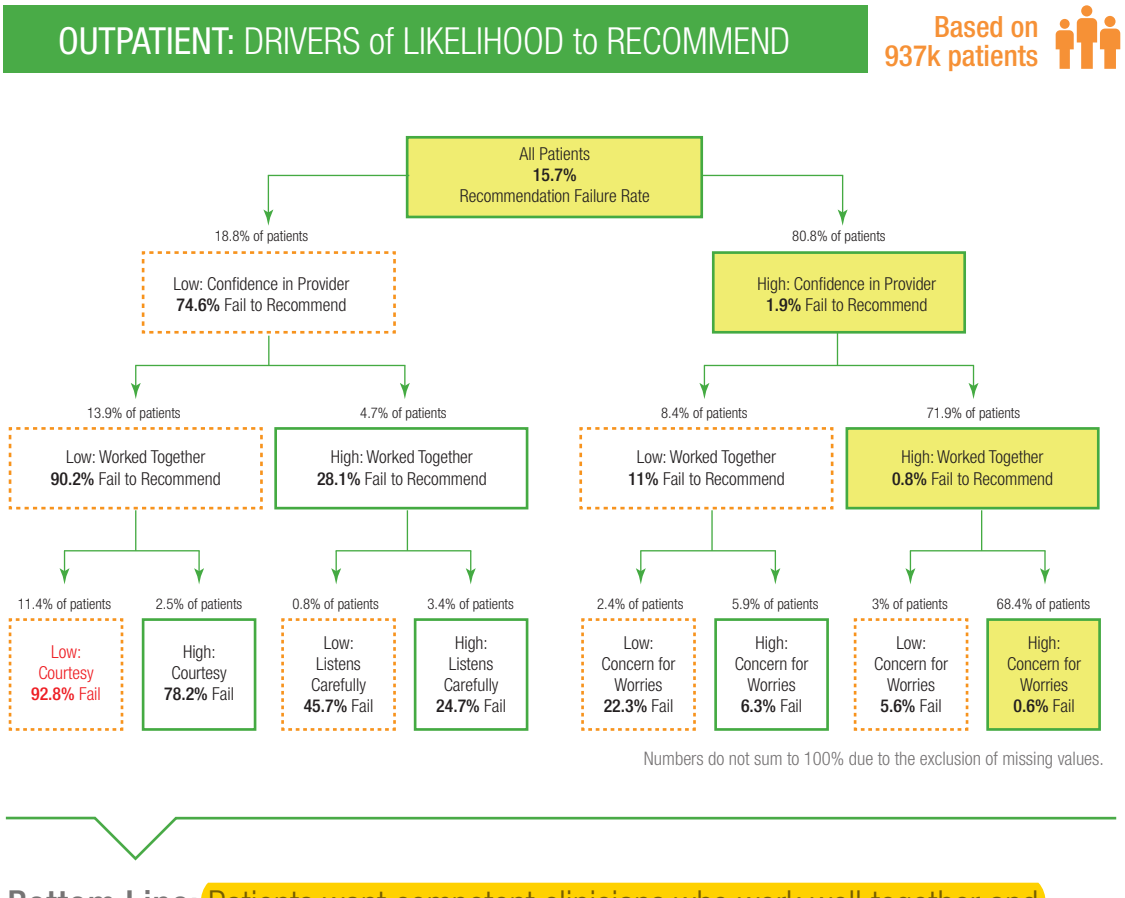
In this Press Ganey Research Note, we summarize analyses conducted in outpatient, inpatient and ED settings to identify the independent factors that drive patients' loyalty as measured by overall ratings of providers.

We use a statistical technique called recursive partitioning—a "nonparametric" technique (i.e., it does not assume that data have a bell-shaped curve distribution) that yields "trees." This method identifies the strongest driver of an outcome (e.g., Likelihood to Recommend) from every possible variable, divides the respondents into subsets, then determines the next strongest variable affecting each subset and so forth.

We use this methodology because it shows the relative importance of various factors, as well as the interactions among them (e.g., a variable that may be an important driver of the outcome in one subset but not others). The trees that result are considered to be more effective drivers of improvement than some alternative statistical methods, because providers can see not only whether they have differences in the outcome of interest, but why.

# Outpatient Loyalty

Figure 1




**Bottom Line:** Patients want competent clinicians who work well together and listen to them.

Figure 1 provides a visual representation of the tree analysis, indicating the patient experience domains that have the greatest influence on patients' Likelihood to Recommend their medical practice for outpatient care. We analyzed data from 937,000 patients and validated the analyses in other large datasets to confirm the robustness of the findings.

In the analysis, we identified the key drivers of "Recommendation Failure Rate," which is the percentage of patients who did not give a top rating on a five-point scale for their Likelihood to Recommend either the provider or the practice. Overall, 15.7% of patients were "not very likely" to recommend their physician or their medical practice to others.

We determined that the most important single variable driving Likelihood to Recommend is the confidence that a patient has in his or her clinician. The next most important variable is the patient's perception that the care team worked well together, followed by the perception that caregivers had concern for the patient's worries.

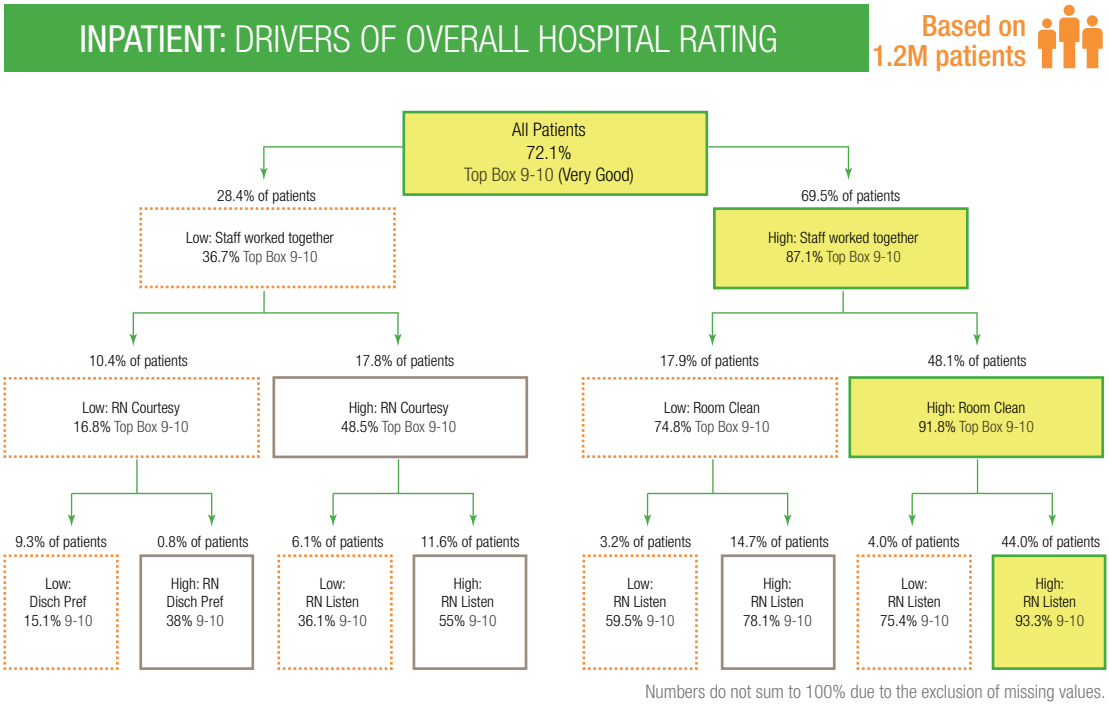
Of interest is the fact that considerations such as waiting time, convenience and amenities were not statistically important loyalty indicators. The implication is that, while patients would of course prefer to wait less and have greater convenience, their likelihood of recommending providers is driven by other factors.

We have also used this analytic methodology in a pediatric population (153,308 patients younger than 18 years old) and found essentially identical results.

Our analyses confirm that patients want good clinicians who are working well together and who are listening to them. In short, they want capable personnel who are delivering compassionate, connected care. Our data showed that even when confidence in clinicians is high, the Recommendation Failure Rate rose to 11% if patients perceived their care team didn't work well together and to 22.3% if they felt that the care team was not deeply concerned for their issues.

## Hospital Loyalty

Figure 2




Numbers do not sum to 100% due to the exclusion of missing values.

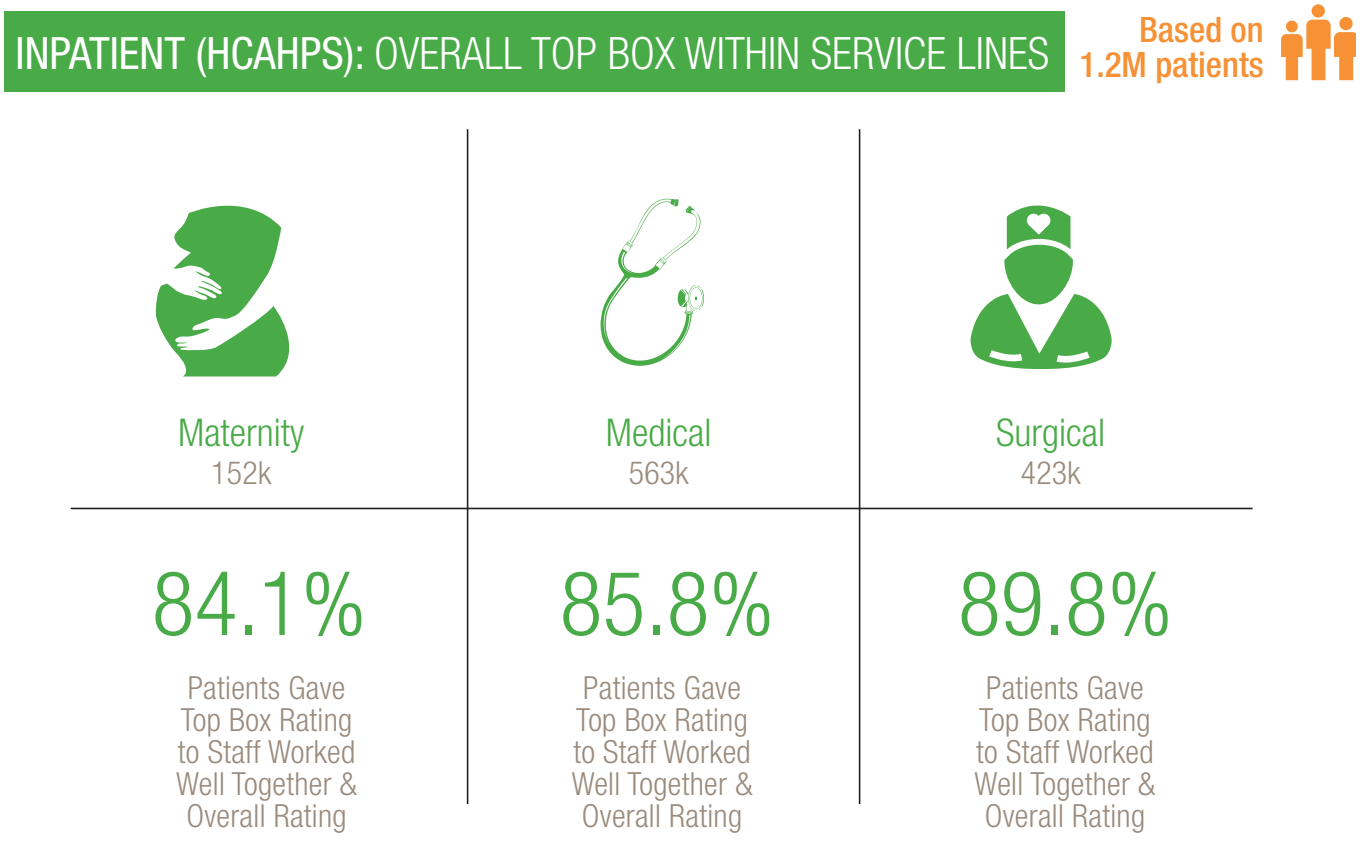
**Bottom Line:** Only after coordination meets patient expectations do other variables emerge as key drivers of Overall Hospital rating.

The same themes emerge from our analysis of patient experience data from patients who have been hospitalized. In the analysis in Figure 2, based on HCAHPS data, we identified the key drivers of top HCAHPS ratings for hospitals across all service lines. The perception that staff worked well together, in particular, demonstrated overarching importance. Specifically, 87.1% of patients who felt that staff worked well together gave the hospital high Overall ratings. In contrast, among patients who felt teamwork was disappointing, only 36.7% gave the hospital top ratings. Of interest is the fact that room cleanliness only emerged as a driver after care coordination expectations were met.

For insight into specific services lines, we expanded the tree for maternity, medical and surgical services and determined that care coordination (staff works well together) is the key differentiator across care settings, as shown in Figure 3. These data indicate that having "star" physicians is no guarantee of patient loyalty if those physicians are not working well as members of teams.

This research implies that coordination of care supersedes all other drivers. When patients felt that personnel worked well together and their care was coordinated, items such as cleanliness of the rooms emerged, followed on both sides of the tree by empathy on the part of nurses.

Figure 3




**Bottom Line:** Care coordination is the key differentiator across care settings.

## Emergency Department Loyalty

To the surprise of many, the same themes emerge from our analysis of Likelihood to Recommend data from ED patients. Because there has been so much concern regarding pain control—and possible overuse/underuse of opioid analgesics—and waiting time in the ED, we present an expanded set of analyses, which include only patients who were discharged home.

Figure 4 shows univariate analyses of a wide range of variables for correlation with Likelihood to Recommend the ED. When the multivariate analysis was performed, the most important variable was the extent to which patients felt that the staff cared about them.

Figure 4

**ED:** VARIABLES CORRELATED w/ LIKELIHOOD TO RECOMMEND

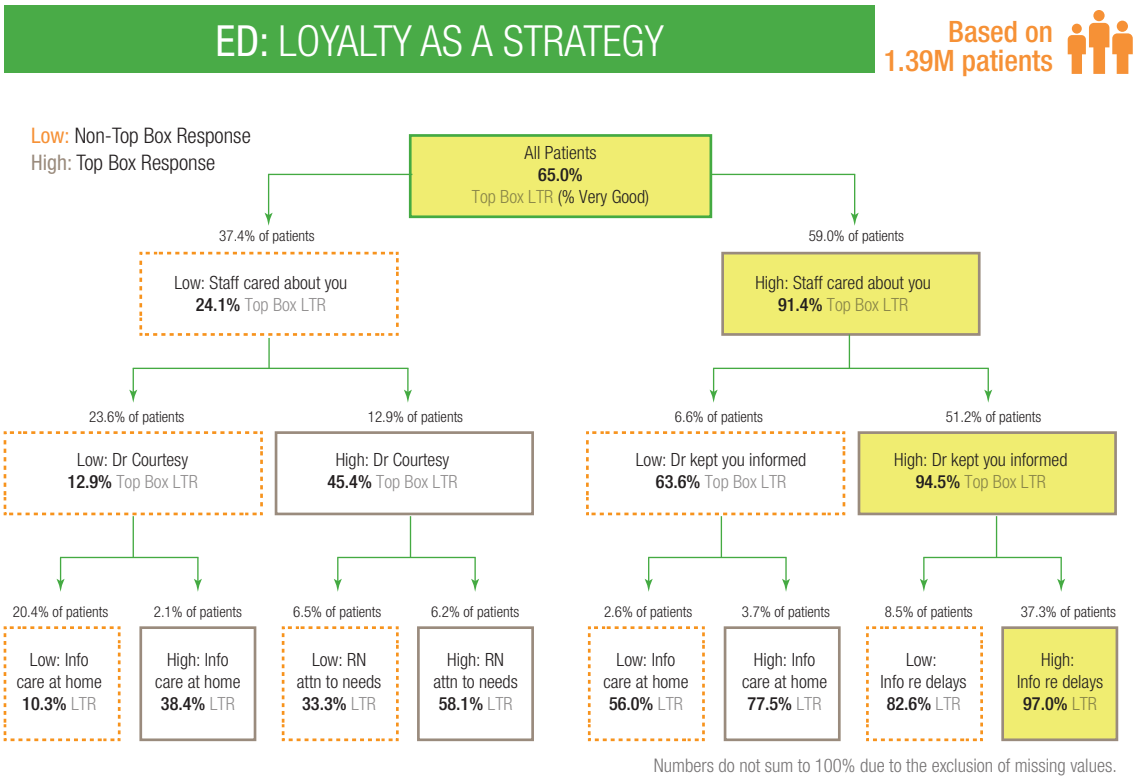
Based on 1.39M patients

| | |
|---|---|
| Staff cared about you as a person | 0.79 |
| Kept informed about delays | 0.72 |
| Pain controlled | 0.72 |
| Doctor's concern for your comfort | 0.72 |
| Doctor kept you informed | 0.71 |
| Staff kept family/friends informed | 0.71 |
| Nurses kept you informed | 0.71 |
| Information re: self care at home | 0.71 |
| Nurses attention to your needs | 0.70 |
| Doctor listened to you | 0.69 |
| Courtesy toward family or friends | 0.69 |
| Nurses listened to you | 0.68 |
| Courtesy of the doctor | 0.68 |
| Wait in treatment area to see doctor | 0.66 |

**Bottom Line:** Empathic care and communication are most highly valued by patients.

As Figure 5 shows, if patients gave high ratings for this variable, 91.4% were likely to recommend the ED, but if they did not feel that the staff was caring, only 24.1% were likely to recommend the facility—a deep hole from which recovery to high levels of recommendation would be unlikely.

Figure 5




**Bottom Line:** When ED patients feel staff is caring, and patients feel they are communicated with, pain management is not a factor.

If the staff was perceived as caring, the next important driver was how well the physician kept the patient informed about his or her care, followed by information about delays and follow-up care. On the other side of the tree, courtesy, coordination and communication were key factors.

Note that after these factors were taken into account, pain control ratings were not statistically important and did not enter the tree. Similarly, wait time did not matter after communication about delays and the rest of care were taken into account.

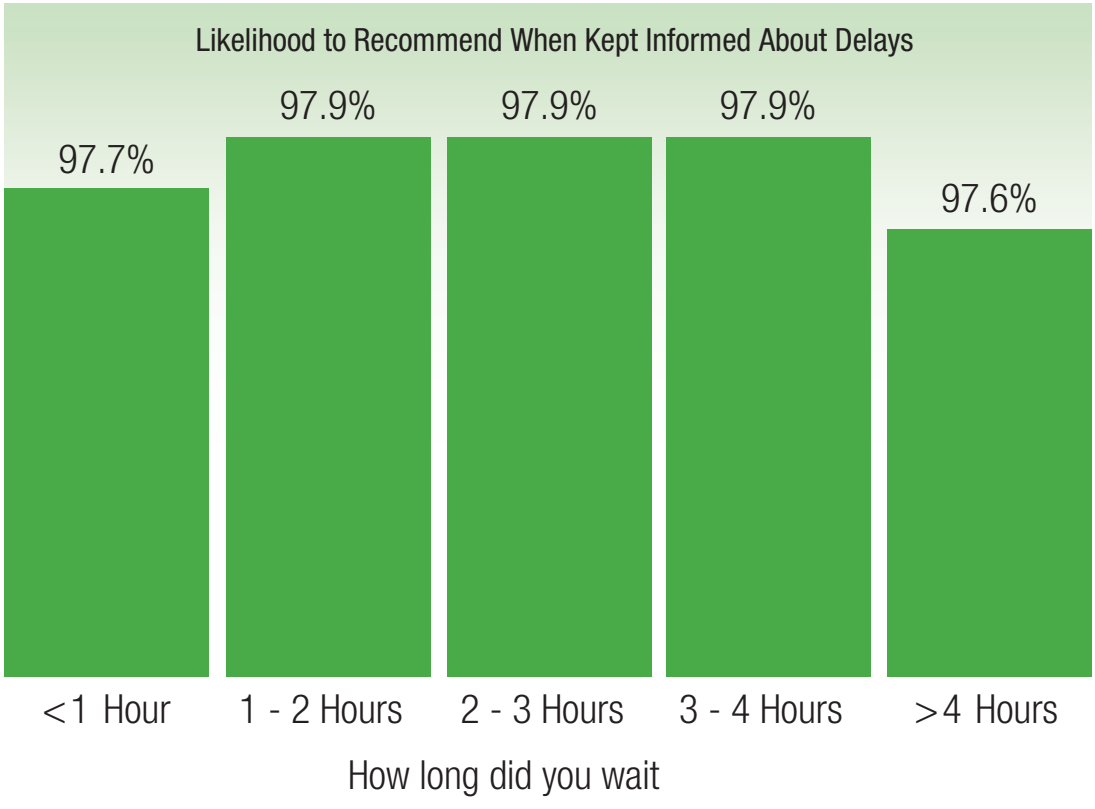
Figure 6 shows the relationship between communication and wait time, clearly demonstrating that communication is what matters. The height of each column reflects patients' Likelihood to Recommend the ED when they felt they were kept very well informed about delays in their care. Across the x-axis, patients are divided according to their perceived waiting time.

The findings indicate that when patients considered information about delays to be excellent, they were highly Likely to Recommend the ED even if they had waited several hours. In contrast, our analysis showed that when information flow was poor, patients were angry even if their stays were short.

Figure 6

**ED:** WAIT TIMES AND LIKELIHOOD TO RECOMMEND TOP BOX

Based on 1.39M patients




**Bottom Line:** Wait time is not a factor when communication about delays is very good.

## Patient Loyalty Strategies

These analyses indicate that similar themes dominate the extent to which patients feel their needs are being met in all settings. Patients want capable clinicians whose care is characterized by:

- Teamwork and coordination
- Empathy
- Communication with other clinicians and the patients themselves
- Courtesy

These variables are completely consistent with professional values of physicians, nurses and other personnel. Variables that clinicians often feel are beyond their control (such as wait times), irrelevant to quality (such as amenities) or potentially in conflict with high-quality care (such as pain control) simply did not emerge as drivers of Likelihood to Recommend after the primary factors noted above were taken into account. Indeed, these "other" factors were not close to having statistical importance.

## What strategies, then, are most likely to help organizations win patients' confidence and loyalty, market share and clinicians' engagement with their organization's goals?

### Here are some basic steps:

1. Develop a shared vision for patient care. The reduction of suffering by patients is a goal that everyone in health care embraces. The organizations that are engaging their clinicians most effectively are emphasizing that their overarching goal is improving clinical outcomes and reducing the anxiety, uncertainty and confusion that so often characterizes medical care.
2. Commit to measurement. If health care is to organize around meeting patients' needs and reducing their suffering, provider organizations must measure how they are doing. Electronic surveying is emerging as an efficient and rapid way to collect large amounts of data, enabling the development of meaningful analyses of individual clinicians, individual service lines and individual patient care units for hospitals.
3. Commit to accountability. With large amounts of data, feedback can be provided at the appropriate units of accountability, where real improvement can actually occur. Financial and non-financial incentives are being used in successful organizations for clinicians as well as non-clinical colleagues. One of the most effective tactics is provider-driven transparency, in which patient experience data, including all patient comments, are published by hospitals and physician groups.
4. Emphasize team care. "Closing the gaps" in quality used to mean that individual physicians made sure they had completed all the items on their individual checklists. While individual physician reliability is still important, health care is more complex today. Because so many personnel are involved in the care of patients of any complexity today, clinicians have to make coordination of care as high as any other priority.

5. Integrate excellence as a core value within your organization. If patients are to feel confidence in and stay loyal to a physician or to a hospital, they have to believe that they can trust everyone, not just the individual clinician to whom they may have bonded. An important tactic being used by successful organizations is "appreciative inquiry," in which the focus is not upon errors, but upon deconstructing cases in which care was excellent, and trying to make the interactions that led to excellent care happen as reliably as possible.

## Conclusion

Meeting patients' needs and earning their loyalty are strategic imperatives for the new health care marketplace. Rigorous statistical analyses across a range of health care settings have identified consistent themes that should characterize providers' care. These themes—coordination, communication and empathy—are completely consistent with clinicians' professional values. Improvement focused upon these areas is likely to lead to greater patient loyalty, enhanced market share and reduced turnover in personnel due to the pride in their work that results.

# Protecting Market Share in the Era of Reform:

## Understanding Patient Loyalty in the Medical Practice Segment

Implementation of the Affordable Care Act will broaden access to health care in most of the U.S., but this increased access will often occur via new insurance products that will provide incentives to patients to obtain care from limited networks of providers. Accordingly, patients are likely to reconsider the providers from which they choose to receive their care and contemplate moving to a new practice in order to reduce their personal health care costs.

The impact of new insurance product incentives will be magnified by the increased availability of public data on quality. Additionally, the likely result of provider transparency and choice will be considerable movement of patients among ambulatory medical practices. Already, front-line physicians are aware of growing numbers of patients who will have to move their care in the year ahead.

To help medical groups understand and reduce their vulnerability, Press Ganey has identified the risk factors that define patient subgroups with varying levels of loyalty to their physicians and medical practices. Based on these risk factors, Press Ganey developed and validated an algorithm that can be used by medical groups to benchmark their expected risk of patient attrition and to develop appropriate intervention strategies. This model can be used to profile individual clinicians, as well as entire medical practices, on their proportions of at-risk patients and focus efforts to enhance patient loyalty. This analysis suggests that coordination of care and demonstrating concern for the worries of patients represent key opportunities for physicians and their associated medical practices to improve patient care, while also enhancing patient loyalty and supporting financial viability.

### Overview

An analysis of one million patient records revealed that more than 15% of medical practice patients are in a high-risk category for defection from their current physician/practice. This cohort is defined as patients who were both:

- Not "very likely" to recommend their physician and
- Not "very likely" to recommend their medical practice to others

This segment of patients who are not satisfied with their care has historically attracted limited attention within organizations because many such patients are believed to remain with their current sources of care because of convenience or inertia. However, this cohort is of growing strategic interest as health care enters a period of unprecedented turmoil and uncertainty, during which medical practices must address the risk of losing market share.

Deeper analysis of this patient data reveals that the following variables are likely to be key determinants of patient loyalty for medical practices:

- Confidence in the care provider
- Coordination of care
- Concern care providers show for patients' questions and worries
- Listening
- Courtesy of care providers

A statistically robust algorithm based on these factors was developed to assess both medical practice and individual physician vulnerability of losing patients, and to guide efforts of enhancing overall patient loyalty.

## Key Findings

Using patient experience data from a sample of approximately one million patients treated in U.S. medical practices during the 12-month period from June 2012 – May 2013, Press Ganey's research team performed a decision tree analysis. Each node in the tree separates patients into groups with higher or lower levels of expected loyalty to the practice (see Appendix for more information on how loyalty was defined for these analyses). Overall, 15.7% of patients met criteria for being at-risk.

The decision-tree analysis identified the risk factors that were most important, i.e., the questions that split groups into subgroups with the greatest difference (high versus low) in rates of at-risk patients. The resulting risk stratification framework allows medical practices to consider the following series of questions:

1. How does my medical practice's rate of high-risk patients compare with benchmark data?
2. What are the most important determinants of patient loyalty, and how can they be used to define subgroups with different sources of vulnerability?
3. What factors do not seem to be important predictors of patient loyalty, after these risk factors have been taken into account?
4. How do individual physicians vary in their loyalty rates, and what factors might enable those with higher rates to improve?

The answers to these questions allow medical practices to assess their risk and focus their resources on high-impact issues—both at the practice level and at the individual caregiver level.

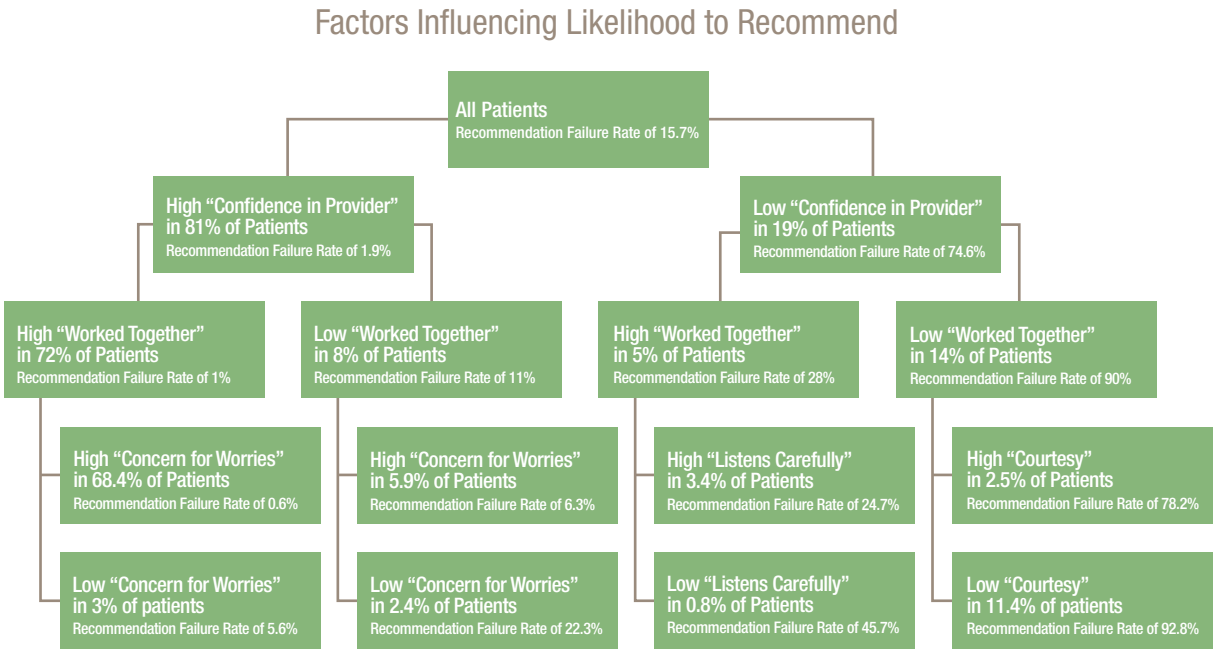
Press Ganey's analysis considered all elements of the Press Ganey Medical Practice Questionnaire and the Clinical and Group CAHPS (CGCAHPS) survey as potential risk factors, and the following questions emerged as the most statistically significant:

1. Confidence in Provider ("Your confidence in this care provider")
2. Coordination of Care ("How well the staff worked together to care for you")
3. Concern for Worries ("Concern the care provider showed for your questions or worries")
4. Listening ("During your most recent visit, did this provider listen carefully to you?")
5. Courtesy ("Friendliness/courtesy of the care provider")

While the surveys contain questions about all aspects of the patient experience and reference various staff roles, four of the five most important questions deal specifically with the care provider. (See Appendix for information on how the responses to these questions were analyzed.)

Press Ganey's analysis found that the most important predictor of patient loyalty was the patient's confidence in their care providers. The decision tree's first split is between the 81% of patients who expressed very strong confidence in their clinicians versus the 19% who did not. The rates of at-risk patients were 1.9% vs 74.6%, respectively. (Figure 1)

## Figure 1



Regardless of the level of confidence in the clinician, performance on Coordination of Care and Concern for Worries were important determinants of patient loyalty. More than two-thirds of all patients were in the lowest risk group, defined by positive answers on all these questions. Only 1% of these patients met the criteria for being at-risk. However, even among patients who said their confidence in their care provider was very good, one in 10 felt the coordination of their care was less than very good and had an 11% at-risk rate. Among these patients, those who rated "Concern for Worries" as lower than very good had an even higher at-risk rate of 22.3%. This rate was similar to the 24.7% at-risk rate among patients who did not have high confidence in their caregivers, but who thought positively about the coordination of care and the extent to which providers were listening carefully to them.

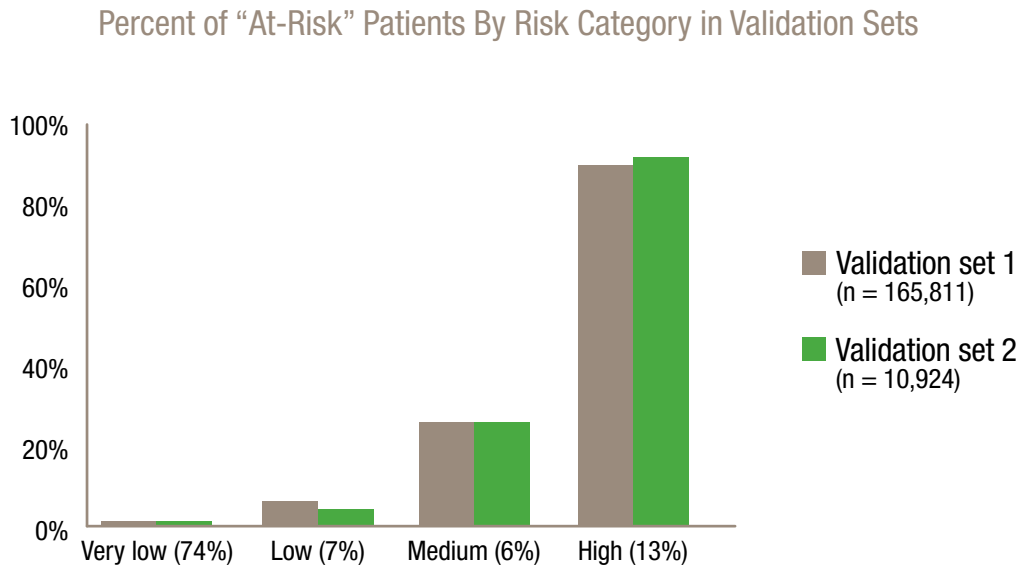
The eight nodes created by this decision tree can be separated into four risk groups: a Very Low Risk (<1%) group consisting of the first node only; a Low Risk (~5%) group, consisting of the next two nodes; a Medium Risk (22-48%) group, consisting of the next three nodes; and a High Risk group, consisting of the last two nodes. Table 1 shows the number of patients in each of these four strata. The percentage of the total population that fell into each group, and the percentage of patients in each group who were at risk.

Table 1

| Risk group | Number of patients 929,275 | % of all patients | % at-risk in group |
|---|---|---|---|
| Very low | 650,131 | 70% | 0.6% |
| Low | 84,597 | 9% | 6.1% |
| Medium | 62,493 | 7% | 26.4% |
| High | 132,054 | 14% | 90.2% |

The accuracy of this predictive model was confirmed in two separate tests. Figure 2 shows the percentages of at-risk patients in each of these four risk groups in two validation sets (i.e., data that were not used to develop the risk-stratification model). The first uses data from all practices for one month (June 2013). The second table shows the percentages from a sample of patients from a single practice, which demonstrates how single practice data can be expected to track closely with data from the overall sample, and thus, how variation from the benchmark is likely to be meaningful.

Figure 2

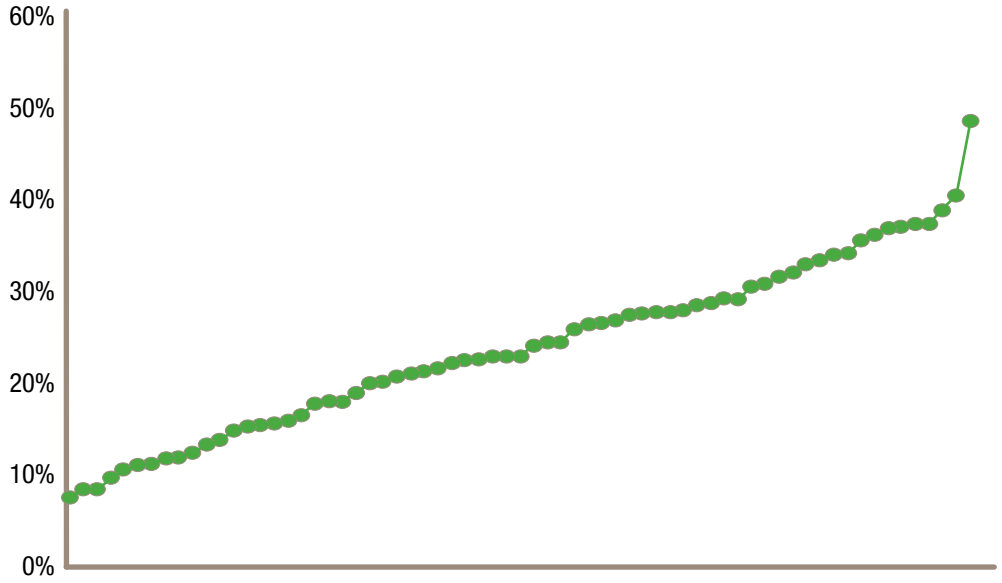



The percentages on the group labels on the X-axis indicate the percentage of patients who fell into each of the four categories in the larger validation set. In the validation sets, about 95% of vulnerable patients can be found among the 19% of patients who were in the Medium and High Risk groups. Accordingly, improvement efforts could be directed at the issues that define these risk groups and at physicians with higher-than-expected rates of patients in the "nodes" in these groups.

Further testing of this algorithm and risk-stratification framework demonstrate its potential utility for identifying individual clinicians with increased proportions of patients in medium- and high-risk strata. Figure 3 shows that, among all 67 internal medicine physicians in a single organization, the proportion of patients in these higher-risk groups ranged from 7% to 48%. The percentage of patients in the lowest-risk group—i.e., those with positive responses on all three questions—ranged from 88% to 42% for these individual physicians. Because this organization used Press Ganey's Census-Based Surveying, large samples (average size = 200 patients) were available for these physicians, and the findings are likely to be robust.

Figure 3

Proportion of Patients in Medium- and High-Risk Strata for Individual Physicians: Internal Medicine




Each data point represents proportion of medium- and high-risk patients for one physician (mean = 22.4%). Data are for all 67 internal medicine physicians in one organization. Mean number of surveys per MD = 200.

Similar variation existed within other specialty groups, and also between specialty groups. For example, in this organization, the overall percentage of patients who were at risk was 22% for internal medicine, but 36% for another large medical specialty.

## The Benefits of Improving Coordination of Care and Demonstrating Concern for Patients' Worries

The decision tree confirms the importance of having physicians who inspire confidence in patients and reinforces the potential value of appropriately bolstering patients' confidence in their caregivers of all type (Figure 1). But, this analysis also shows the powerful impact of patients' perceptions of care coordination and concern for their worries. Note that even when patients held high degrees of confidence in their care providers, lack of confidence in the coordination of their care raised their "at-risk" rates from 1% to 11%. At each level of the decision tree, lower patient confidence in these variables raised "at-risk" levels several-fold.

After these variables were taken into account, data on waiting time, convenience, ease of access and practice amenities—variables that are traditionally the focus of improvement efforts, as they are easily definable and actionable—were relatively less important predictors of patient loyalty. For example, among the roughly two-thirds of patients who had high levels of confidence in their caregiver and felt strongly positive about the coordination of their care and the extent to which their concerns were being heard, the at-risk rate was only 0.6%, and no variable could identify a high-risk subset of this population.

## Conclusion

For some medical practices, the challenging period ahead could result in a loss of patients and thus compromised business viability. But, this period will also provide opportunities to increase market share, retain patients, improve clinical outcomes and patient experience, and enhance clinician and employee satisfaction. This analysis presents a risk-stratification framework based on likelihood to recommend a practice and likelihood to recommend a physician. Lower levels of satisfaction on these questions—as well as commitment to both their individual caregivers and to their medical practice—suggest the strongest risk of defection.

With this algorithm and risk stratification system, provider organizations can estimate the size of their at-risk populations and compare them to benchmarks. Provider organizations can also evaluate whether they have higher-than-expected levels of adverse risk factors (e.g., communication from physicians to patients) in various patient segments. This system can help organizational leaders evaluate the potential return on investments aimed at improving adverse risk factors, which may include: Confidence in Provider; Coordination of Care; Concern for Worries; Listening; and Courtesy.

These analyses can be used to guide efforts of practices and individual physicians to better meet the needs of patients, thus minimizing the risk of market share loss as the market changes and new insurance products are introduced. Improvement efforts to reduce the proportions of patients who do not have confidence in their clinicians, do not believe that their care is well-coordinated or do not believe that their concerns are being heard are likely to have an additional important benefit: greater professional satisfaction and pride for caregivers.

## Appendix: Analytic Methods

Expected loyalty was defined on the basis of patients' responses to two separate questions asking them to rate their likelihood of recommending their care provider (generally, their physicians) and the medical practice to others. Patients who gave the highest of five possible responses ("Very Good") to one or both questions were considered to be at lower risk of leaving the practice. Patients who indicated that their likelihood of recommending was lower than "Very Good" for both the caregiver and the medical practice were considered at higher risk.

For analysis of potential risk factors for loyalty, responses to questions 1, 2, 3, and 5 as described in the text were considered positive if the patient answered "Very Good," the top response on a five point scale. Responses to #4 (Listening) were considered positive if the patient answered "Yes, definitely," as opposed to "Yes, somewhat" or "No."

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