Patient Satisfaction
In The Pediatric Emergency Department

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EB MEDICINE
Emergency Medicine Practice
Pediatric Emergency Medicine Practice
Guidelines Update
The Lifelong Learning and Self-Assessment Study Guide
Upon completion of this article, you should be able to:

1. Effectively use patient satisfaction surveys, patient/parent advisory groups, and customer service liaisons to monitor patients’ experience in the ED.

2. Effectively monitor your patients’ satisfaction to ensure that their needs are not overlooked, that negative perceptions of care are not created, and that initiatives are created to ensure effective, safe, efficient, timely, and equitable care.

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**Target Audience:** This enduring material is designed for emergency medicine physicians, physician assistants, nurse practitioners, and residents.

**Goals:** Upon reading this article, you should be able to: (1) recognize effective practices that endure patient satisfaction; (2) cite the reasons why patient satisfaction leads to better clinical care and higher levels of staff satisfaction; and (3) practice effective communication to ensure patient satisfaction.

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Many hospital emergency departments (EDs) now function as the gateway for all medical care, and with this increase in demand for service (not necessarily for emergency services) comes added strain on emergency clinicians, patients, and facilities. These conditions are clearly less than ideal for doctor/patient relations. Patient satisfaction is directly related to effective clinical care, litigation risk, staff satisfaction, and fiscal success. What follows is a discussion of the literature that is available on patient satisfaction scores and their relation to quality care, while offering examples of patient comments and physicians’ responses. This article will review the evidence on the importance of patient satisfaction and applicability of the existing data to pediatric emergency medicine, where appropriate.

In 2008, 33% of the comments made by patients or parents on Press Ganey™ surveys were negative. The shock value of critical comments and low patient satisfaction scores can generate a significant amount of concern in hospital leadership and a strong negative reaction from the targeted physicians, who may feel these comments are unwarranted by patients who, in their opinion, received excellent clinical and technical care. Here are some examples of the negative quotes that were received from patients:

- “Very bad experience - he flipped her over like she was a sack of flour and woke her out of her sleep and was not gentle putting the stick in her mouth to view her throat, and when I asked him to be more gentle he blandly ignored me.”
- “The doctor seemed rushed - I understand many were waiting for hours, but after hours it stinks to feel like the doctor's head and time is somewhere else - eye contact and 2 solid minutes would work! Seeing as the cost was over $1000!!!!!!! Even showing us the x-rays describing why he had pain with no break would have given all of us more peace of mind!”
- “The doctor was arrogant and rude. He did not even give any encouragement to make our daughter feel comfortable - he had no bedside manner and he made our daughter feel like she had done something wrong because of his manner - He has no ‘child-like’ disposition - why is he working with children?”
- “Didn’t feel ‘connected’ to ER doc. Didn’t seem busy in ER, but felt he needed to get somewhere else. MUMBLED FAST and hard to understand.”
- “Doctor was pretty ‘cold’ for working with children. Competent, but lacking bedside manner.”
- “Doctor was rude. She talked down to me. I have never in my life been spoken to so rude.”
- “Everything I talked to the Doctor about he contradicted me.”
- “Doctors should directly address the child so as to not make the child feel isolated or not a part of what is happening.”
- “Doctor had preconceived impression of my child’s condition therefore she didn’t appear to listen!”
- “The doctor we saw was very rushed and short with me and kept cutting me off mid-sentence. I did NOT appreciate that at all.”
- “The only thing I would recommend is for the doctor leaving for the evening to tell the parents that another doctor would be taking care of their child. I really liked the first doctor, but we didn’t know she had left until the next doctor came in our room.”

The Institute of Medicine (IOM) defines quality as the “degree to which healthcare services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” One of the 6 dimensions of quality listed in the IOM’s landmark document “Crossing the Quality Chasm” is patient-centered care. This term encompasses the partnership between practitioners, patients, and their families that ensures healthcare decisions respect the patient’s needs and preferences and provides the education and support patients need to make decisions and participate in their own care. As hospitals have adopted the concept of patient-centered care, the use of patient satisfaction surveys, patient/parent advisory groups, and customer service liaisons has become commonplace. Monitoring service quality (patient satisfaction) is essential to ensure that we do not overlook the needs of our patients or create negative perceptions of care as we implement initiatives to ensure effective, safe, efficient, timely, and equitable care.

Patient, Client, Or Customer?

It is important to elaborate on these terms before discussing patient satisfaction since the words “client” and “customer,” when used in relation to a patient, have a negative connotation for some clinicians. A “patient” is defined in the dictionary as a person who endures pain quietly, without complaint. Synonyms of the word include “suffering” and “victim.” This definition implies a sense of helplessness and dependency and may devalue the intrinsic autonomy of the individual to collaborate effectively with their physician in making healthcare decisions. It describes the individual as a passive participant in their own healthcare and shifts all the responsibility of care on to the physician.

There is a large subset of individuals who access healthcare for maintenance of chronic diseases and/or preventative care. These individuals would benefit from active participation in their care or the care of their loved ones. Unless they are educated consumers, they may receive suboptimal care. Starting in the 1950s, a number of articles, mainly from the realm of psychiatry, started referring to a subset of patients as “clients” (ie, people who seek the advice of a professional).
Most of these papers originate in the UK and Canada. Interestingly, a number of studies report that, when polled, 70% to 80% of individuals prefer the term “patient” and not “client.”

Over the last 50 to 60 years, healthcare has morphed into a business, medical care has become a commodity, and patients have become “customers” (ie, individuals purchasing a service). The empowerment of customers comes from the exchange of money and the ability to take their business elsewhere if they are not satisfied. In non-healthcare businesses, when customers want to purchase an item, they have some knowledge of what they are buying and some means of paying for the item. Patients presenting to the ED do not have to worry about payment prior to receiving service and may have no knowledge of their health condition, but the term “customer” allows them to have an absolute expectation of both service and positive outcome. The interaction created through a physician/customer relationship potentially undermines the physician/patient relationship and shifts empowerment to demanding service without necessarily a drive to become educated and actively involved in care. This leads to dissatisfaction in both the physician and customer. Compare this to the pilot on an airplane where the passengers are the pilot’s customers. Passengers do not question the pilot’s expertise on how to fly the plane or what route to take. The pilot makes those decisions, acknowledges the fact that the passengers have choices in carriers, and thanks them for choosing his carrier.

The healthcare professional providing care today may be the patient/client of tomorrow who, with appropriate intervention, may return to being the care provider of the future. We should treat our patients like we would want to be treated when we are patients. So, what do we call them? What’s wrong with “persons,” “individuals,” “humans,” “adults,” “children,” “men,” or “women?” Is that not what they truly have been, are, and always will be?

How Do Physicians Respond To Customer Service Feedback?

The role of patients as customers and the focus on patient satisfaction continues to be a controversial topic despite widespread use in healthcare. Below are actual responses by a pediatric emergency physician to a customer service representative who was asked to provide feedback on communication.

- “When did you last work a busy shift and save lives - under a tremendous amount of emotional, physical, and intellectual stress? ”
- “When was the last time you had to tell someone their child died?”
- “When did you last deal with an abusive patient that had over-utilized the ED to the tune of 20 visits in the last 12 months?”
- “How old are you and when did you graduate from kindergarten?”
- “Why should I value your opinion when you are the agent that cares less about patient care and more about patient perception and feelings?”
- “When was the last time you addressed quality issues rather than Press Ganey™ scores?”

These responses are likely an attempt to deflect responsibility and delegitimize criticism from parents/patients. It is interesting to note that the reaction pattern of physicians when confronted with poor customer service scores mirrors the 5 stages of grief identified by the noted psychiatrist Elizabeth Kubler-Ross:

- Denial: “These scores can’t be correct.” The methodology is questioned, based on small sample size and low response rates. While inner city hospital physicians claim that their poor uneducated patients do not appreciate the care provided, suburban hospital physicians claim that the high socio-economic class patients are demanding and upset when they don’t get what they want. Benchmark hospitals are questioned based on payer mix, volume, demographics, or acuity.
- Resentment: “These are patients, not customers.” “Our mission is to deliver high quality care.” “We save lives and are under a high amount of emotional, physical, and intellectual stress.”
- Depression: As overachievers, anything average or less is unacceptable to our psyche.
- Bargaining: The hospital is asked to increase the sample size to make the data statistically significant. They are asked to add admitted patients to the survey under the premise that they probably have higher satisfaction. Telephone surveys have low sample size and higher response rates. Mail surveys have high sample size, but low response rates. Physicians are usually convinced that the survey methodology in use is flawed, and they try to convince the hospital to change methodology or vendors.
- Acceptance: Physicians come to terms with the reality of patient satisfaction in today’s competitive healthcare market and develop a realization that patient satisfaction measures actually complement quality initiatives by ensuring that the needs of the patients are not ignored in our effort to become cost and flow efficient.

Reasons To Enhance Overall Patient Satisfaction

Patient Satisfaction And Effective Clinical Care

Medicine today is founded on the premise that progress in alleviating pain and suffering lies in technological advances. We only need to identify the correct gene to replace or produce the next effective
antibiotic to achieve our goals. The unintended consequence of this paradigm may be to dehumanize those who we are trying to help. When the process we employ to improve health alienates the patient we are treating, our effectiveness is diminished.

There is a growing body of evidence that shows that taking the time to listen, educate, discuss, and involve patients and parents in healthcare decisions improves outcomes and decreases inappropriate utilization. It appears that the vast majority of patients (and parents) first seek to have their negative emotional state addressed (fear of death, anxiety, stress, anger) and then to receive medical care. In contrast, the first priority of physicians is to respond to the physical symptoms and not to the patient’s or parents’ emotional needs.8 Investing time trying to understand the emotional needs and motivation for seeking medical care may do more for enhancing patient satisfaction than unnecessary medical interventions. Unsatisfied patients are less likely to fill their prescriptions, be compliant with therapy, or keep their follow-up appointment — ultimately resulting in reduction in treatment efficacy.9,10

Emergency physicians find themselves pressured to see more patients in a shorter time and within the constraints of resource limitations, while maintaining a high level of patient satisfaction. The good news is that high patient satisfaction scores and enhanced physician productivity may not be mutually exclusive — both can be improved simultaneously.11 Patient ratings of the time their physician spent with them during the ED visit were inversely associated with productivity, but there was no association between productivity and items that reflect physician communication like friendliness, explanations of problems, concern for worries, mutual decision making, and using understandable words. This suggests that physicians can increase productivity without compromising communication, which is a major concern of patients on satisfaction surveys.11

Patient Satisfaction And Litigation Risk
There is a clear association between patient satisfaction ratings and risk management episodes. Each 1-point decrease in score is associated with a 5% increase in the rate of risk management episodes.12,13 Negative physician behavior can have a profound effect on team dynamics and ultimately on the ability of the healthcare team to meet the medical and emotional needs of the patient. Barking, tuning out others, being passive-aggressive, and criticizing (either overtly or covertly) represent examples of disruptive physician behaviors. Patients who personally experience or observe a lack of emotional connection either start questioning every clinical decision (and are labeled “difficult patients”) or feel so demeaned and intimidated that they distance themselves from the care provided. A subsequent bad clinical outcome after such an experience puts the whole healthcare team at risk of litigation. Twenty percent of patients/parents cite “revenge” as a reason or justification to sue physicians – this reflects a loss of trust and anger about unexpected outcomes. Over a 5-year period in Florida, 6% of obstetricians accounted for 70% of all malpractice-related expenses for the specialty. When reviewed further, the technical competence of this group was at par with their colleagues, but on solicited surveys their patients were 3 times more likely to complain of poor communication and a feeling of not being valued. Almost 10% of the patients surveyed reported that at some point during their pregnancy, their doctor “yelled” at them.14

Unsolicited complaints to customer service representatives in hospitals are also a powerful proxy for litigation risk. The number of such complaints combined with the level of clinical activity (relative value units [RVUs] billed by physician) and the physicians’ specialty can be used to create a litigation risk score. This approach facilitates peer comparisons, identifies outliers, and can allow early intervention with behavior modification techniques.14-16 The importance of listening and “being nice” is not simply about marketing but also about protecting ourselves.

Patient Satisfaction And Staff Satisfaction
Collaboration and professionalism between physician colleagues and other staff members promotes teamwork, reduces error, and increases patient satisfaction.14-16 Physicians who disrupt the emotional ecosystem increase liability for themselves and their team members. When patients are satisfied, staff is usually also satisfied. At one hospital, when customer service scores increased, employee turnover decreased by 57%. What is good for the patients does, in fact, appear to be good for the caregivers and helps with retention and recruiting.17 Community reputation and patient loyalty drive employee loyalty and the likelihood that they will recommend their hospital for employment.

Patient Satisfaction And Fiscal Success
There is a strong financial driver for hospitals and physicians to promote patient satisfaction. The competition for pediatric patients continues to be strong, since most have some sort of public or private insurance. Three patient satisfaction indicators have a high correlation with fiscal success and patient recruiting. These are: a) overall satisfaction with care, b) patient’s likelihood to recommend, and c) patient’s likelihood to return.

In this competitive healthcare environment, community reputation and patient loyalty have a bigger fiscal impact than the technical and clinical skills of the providers.13 These factors influence not only consumer choice but also where referring physicians will send their patients to the hospital. Hospitals with
consistently high levels of patient satisfaction are also consistently the most fiscally successful. Despite being in a highly competitive market, a facility noted a 34% increase in admission rates over a 4-year period after launching a system-wide patient satisfaction improvement initiative. There was a 24% improvement in the scores for the question, “Likelihood of your recommending this hospital to others” as measured by the Press Ganey® inpatient survey. "The perception of care in the ED has a trickledown effect on the perception of care in the entire hospital, because the ED is the entry point into the hospital for over 50% of the patients. There is a clear correlation between satisfaction with the ED visit and accessing the resources of the healthcare system in the future.

Pay-for-performance measures are becoming the norm in adult medicine and are rapidly permeating into the pediatric healthcare market. Using this methodology, reimbursements for services are partially dependent on quality indicators (including customer service) developed by the subspecialty medical society. Private insurers currently utilize quality metrics, including patient satisfaction, as measures of performance and value, and they are now advancing pay-for-performance programs of their own. As all payers move toward reimbursement based on quality, organizations that do not move quickly to improve their performance will find themselves at a major competitive disadvantage. Consumers are paying an ever greater share of the cost of care and are just beginning to shop for value, pushed in part by some insurers’ use of tiers of providers based on their ability to deliver cost-effective care. Anecdotal evidence also suggests that more savvy patients are turning to Hospital Compare, the federal government’s public database of quality and patient satisfaction, when they need to choose a hospital for care.19

Fostering Patient-Centered Care in Medical Trainees

Our demonstrated interaction with patients will foster either positive or negative interactions with patients in future generations of physicians. A survey of students from 6 medical schools showed that 98% of the students reported witnessing unprofessional behavior by the teaching faculty. While “professionalism” has been regarded as a core value in medicine, descriptors used to characterize this competency are very abstract: altruism, excellence, duty, honor, integrity, and respect. These are difficult to translate into practice. Using patients, staff, faculty, and trainee-focused groups, Green et al defined professionalism in terms of tangible behaviors. Interestingly, 2 items which receive considerable attention in medical schools did not make the patients’ list of “professional” behaviors — “professional dress” and relationships with pharmaceutical companies. The patient group reported that a neat clean appearance is more important than physicians in shirt and tie. All groups rated good hand hygiene as a marker of professional behavior.20

Haidet et al utilized the “Patient-Practitioner Orientation Scale,” a validated instrument designed to measure individual preferences towards various aspects of the doctor-patient relationship. Total scores on the scale can range from patient-centered (egalitarian, whole person oriented) to disease- and doctor-centered (paternalistic, less attuned to psychosocial issues). Female students and first year students were more likely to have patient-centered attitudes. By the end of the third year, there was significant degradation in this attitude, as the students became more disease- and doctor-centered. The culture of medical schools (often termed the “hidden curriculum”) may actually foster greater disease- and doctor-centered attitudes at the expense of patient-centered attitudes.21-23 It is the duty of academic faculty to teach, foster, and exhibit patient-centered care to students and to provide early counseling for those students who do not perform to expectations. It is likely more effective to intervene at this point than to modify behaviors later in their careers.

Patient Satisfaction In Pediatric Emergency Medicine

There are a number of factors in emergency medicine that make it difficult to obtain the highest degree of patient satisfaction, and it is not surprising that when compared to other departments in the same hospital, ED scores on satisfaction surveys are typically lower.

Guaranteed access to care in emergency departments has lead to ED overcrowding, ambulance diversions, and increasing wait times. In this overburdened environment, success in improving or even maintaining patient satisfaction appears to be a daunting task.

Establishing a longitudinal and long-term relationship with a patient and parents is essential in developing trust and confidence. In emergency medicine, physicians have 10 to 15 minutes to achieve this goal. This is even more of a challenge when referring physicians create unrealistic expectations of the ED visit on ED throughput, medical management, subspecialty consult, or decision to admit. Managing these expectations without undermining the referring physician’s relationship with their patient while ensuring the highest quality of care is a fine balance that has to be achieved to gain patients’ or parents’ trust and confidence.

The experience in the ED may be affected by the involvement of other consultants and by movement
or delays experienced in other hospital departments (radiology, phlebotomy, laboratory, or inpatient) where extended care is provided or procedures are performed. Even in the ED, there are multiple contacts (technicians, registration clerks, nurses, respiratory therapists, students, and residents) that may affect overall satisfaction with care. This makes it more difficult to directly attribute the feedback from the survey instrument to the ED department or the ED clinician.

In the ED, it may be impossible to measure patient satisfaction in objective terms. For many patients, we cannot make a concrete diagnosis or elicit a cure or resolution of symptoms. The measures are by definition very subjective, and the questions asked and the responses received are susceptible to interpretation bias. The patient’s experience of care is not always in sync with the clinical efficacy of the care rendered. Patients may report great satisfaction even though poor clinical care was rendered, and they may report poor satisfaction with care when excellent clinical service was provided and lives were saved. In the emotionally charged environment of the emergency department, it is unrealistic to expect patient and parent perceptions of care to reliably correlate with accurate diagnoses and effective treatments.

If healthcare systems are to be responsive to a child’s needs, it is imperative to incorporate both the child’s and the parents’ perspectives of their care. Capturing a child’s perception poses special methodological challenges. Children are dependent on their parents for accessing health services, and most instruments for assessing patient satisfaction are geared towards obtaining the parents’ perspectives. A growing body of research shows poor concordance between the child and parent regarding health status items. A child’s sense of well-being and burden of symptoms is a better predictor of future healthcare needs than a diagnosis-based prediction by the physician or using the parent as a proxy for determining the child’s healthcare needs.

A child’s perception of pain, fear of the unknown, concerns about health, interactions with staff and physicians, and desire to please authority figures may lead to a totally different ED experience, when compared to their parent’s perceptions. This difference in perceptions is demonstrated in a study looking at parental perceptions compared to children’s reactions to physicians in face shields versus surgical masks. The parents thought that their children would be more comfortable with physicians wearing face shields, but the children thought that physicians wearing either type of covering would be fine; neither was frightening \((P < .0001)\). Children as young as 5 years of age can answer questions that measure pain and fear. Children who blame themselves for an injury resulting in a laceration experienced greater distress during laceration repair than children who attributed their injury to chance. Most children’s hospitals and even community EDs have created child friendly areas and utilized child-life experts to allay some of these anxieties. These studies and experiences suggest that our understanding of the child’s perspective may improve their ED experience as well as prevent sequelae that last beyond the ED visit. The next step is to ensure that we are meeting the child’s expectations by utilizing valid survey instruments.

Margaret et al compared overall satisfaction in the pediatric ED in English speaking families. The survey was administered to the child and the guardian/parent separately. The survey included self-reporting of pain, fear, and anxiety on arrival and departure from the ED as well as the child’s perception of their interaction with the doctor and other ED personnel. Patients who were ≥ 12 years to 17 years of age received a more detailed survey than those who were 5 years to < 12 years of age. Parents were asked similar questions. The perceived quality of interaction and adequacy of information correlated strongly with patient satisfaction in both parents and their children. Resolution of pain at discharge correlated with satisfaction in children but did not affect parental satisfaction. Parents were more satisfied if the times in the waiting and examination room prior to seeing the physician were short. Children did not seem to care about the perceived or actual length of wait times. The actual length of stay in the ED did not correlate with overall satisfaction. Overall, children were more satisfied than their parents. Interestingly, children’s pain resolution scores were significantly higher than their parents’ estimates. More studies are needed to validate these findings and to add appropriate questions to currently existing survey instruments that address the perspective of children.

### Sources Of Input

Input regarding care in the ED is provided through unsolicited sources or can be actively solicited via prospective survey instruments. Both of these will be discussed in detail.

### Unsolicited Patient Feedback

Filing a formal complaint to an institutional authority is a powerful avenue for patients and parents to express their opinions and concerns about the care received in the ED. These are rare events, occurring at a frequency of 1 to 2 complaints per 1000 ED visits. A multivariate analysis showed that white parents are 5 times more likely to submit formal complaints when compared to their African-American counterparts. Two studies reported the
breakdown of unsolicited complaints in emergency medicine.29,30 The majority of complaints were for concerns about the treatment received, communication issues, or billing concerns. In one study, 25% of the complaints were for misdiagnosis, but only 68% of these were justified. “Monday morning quarterbacking” by primary care physicians or a progression of illness may account for some of the unjustified complaints regarding misdiagnosis. The median number of complaints per report filed was 3. In 53% of these complaints, “communication” was cited as a major issue.

It is estimated that for every patient that complains, there are 20 who are dissatisfied and don’t complain. Of these, 90% do not return back to the institution. Furthermore, the average dissatisfied patient tells 25 others, amplifying the effect on the institution. It is 10 times more expensive to recruit new patients than to keep old ones.31

Solicited Patient Feedback

Early patient satisfaction surveys were rarely validated, were flawed by built-in bias, and had very low response rates.32 The past 20 years have seen improvement in this area with the development of survey instruments specific to the ED encounter that are better validated and standardized.17,33 In the last 5 years, there has been further consolidation of these efforts to ensure that questions on the survey instruments are standardized and meaningful and allow comparisons to be made between institutions.

In an effort to promote transparency in healthcare, the Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to develop and implement the “Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS – pronounced “H-caps”). The HCAHPS survey is a standardized survey instrument that dictates rigorous data collection methods and was developed to allow valid comparisons across hospitals locally, regionally, and nationally. Effective July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. Hospitals subject to IPPS that fail to report the required quality measures, which include the HCAHPS survey, may receive an annual payment update that is reduced by 2%. Critical Access Hospitals, which include pediatric hospitals, are excluded but may voluntarily participate in HCAHPS.34 Participating hospitals can use an approved survey vendor (the list is posted on the HCAHPS site)35 or collect their own data using a tool approved through CMS. The publically reported measures implemented by HCAHPS report on 6 measures that summarize nurse and doctor communication, pain and medicine management, and whether key information was provided at discharge. Cleanliness and quietness of the room and likelihood to recommend are also reported. These results are updated on the website quarterly.34 As of October 2009, 7 months after the start of public reporting, inpatient satisfaction scores had climbed more significantly than at any other point in the 24 years that Press GaneyTM has been tracking that data.19

Press Ganey Associates, Inc. remains the most widely used survey tool in pediatric EDs. National Research Corporation, The Myers Group, Professional Research Consultants, and Avatar are other large vendors. Patient responses are rated on a 5-point scale: Very Good (5), Good (4), Fair (3), Poor (2), and Very Poor (1). Most vendors use standard questions which have been tested and evaluated, represent issues that are of concern to the patients, and allow local regional and national comparisons. Questions can be added to the standard list to incorporate questions that may assess the impact of quality or other mission-driven initiatives. Emergency department patients are sampled using a list of discharged patients, ensuring that the distribution is equitable across all socio-economic demographics. Low scoring indicators in the ED that have a high correlation with “likelihood to recommend” have remained unchanged since 2007 and exemplify the need for humanistic rather than logistic improvements in emergency care. These include “being informed about delays,” “feeling cared for,” “being kept informed about treatment by staff,” “pain control,” “overall rating of care,” and “waiting time to see the doctor.”31

Commercial reports are extremely comprehensive and are organized into sections that allow personnel at all administrative levels as well as physicians and staff to review meaningful data that is pertinent to them, without being overwhelmed with too much information. The reports include trends in scores, statistical data, comparative data, customer characteristics, and detailed analysis that can drive down to demographic variables, time-of-day, and other visit characteristics. Detailed statistical analysis is available and can be used to demonstrate reliability and validity of the data to physicians. Statistical data includes mean, standard deviation, and 95% confidence interval (CI) at the overall, section, and question levels. The standard reports include overall, section, and question percentile rankings. These can be derived from the national database or an established peer group defined by the institution. Most institutions choose peer groups based on market competitors. In the case of pediatric EDs, competitors are usually local community hospitals, not other pediatric hospitals. “Top Box Analysis,” which is the percentage of questions answered as “very good,” is increasingly being used.
to identify areas of service recovery opportunity as well as to bust the myth that only dissatisfied customers return surveys. 

Most facilities use either mail or telephone surveys while some use a combination of both. Facilities with lower volumes can improve their response rates by following up a mail survey with a telephone call. The number of surveys sent to patients is limited by the relative cost of distributing the survey. Generally speaking, response rates for any type of survey depend heavily on getting the survey to the right person at the right time. For example, telephone surveys require that the respondent is home and available to talk, while mail surveys require that the survey gets to the right address and that the respondent competes and mails the survey. Studies are equivocal on which mode of administration produces the best response rate. A large variation in response rates is noted for telephone surveys (23%-42%) while a 33% response rate on mail surveys is typical. This variation may be based on demographic differences, underscoring the importance of clearly defining the population being studied and adjusting survey administration to accommodate for that.

### Telephone Surveys

The process of conducting telephone surveys is costly and labor intensive, so the population sampled is smaller than in mail surveys. There is a high rate of wrong or disconnected phone numbers impacting the response rate. In a study involving predominantly inner city patients (including parents of pediatric patients), female patients and those deemed “non-urgent” are significantly more likely to answer their phones than their counterparts. A telephone survey evaluated patient satisfaction 10 days post-visit and noted that “overall satisfaction” and “likelihood to recommend” were most closely related to the degree to which the patient felt that the ED personnel cared for them as a person and treated them with respect and dignity. The understandability of the discharge instructions was also a powerful predictor of patient satisfaction. Perception of safety, nursing skills, and bed-to-doctor times were also high predictors of overall patient satisfaction. Telephone surveys generally exclude patients without a phone number and cell phone only households. Of course, in this mode, the deaf and hard of hearing will be excluded as well. It is also noted that mean score on telephone surveys is consistently higher, especially when rating a caregiver. When telephone surveys are compared to mail surveys for the same parameters, a modal adjustment should be made. There are fewer “skipped” questions in telephone surveys, because the respondent can ask for clarification when they do not understand the question. There is a quicker turnaround time and, therefore, the chance to get information while it is still fresh in the patients’ minds. With telephone surveys, selection bias can occur for the following reasons. The homeless and low-income families may be poorly represented in the sample because they may not have access to a telephone. The deaf and hearing impaired may have difficulty understanding questions or decline an interview completely, leading to underrepresentation or misrepresentation on the surveys. Households that have replaced land lines with cell phones may decline a telephone survey, fearing a phone charge, also leading to underrepresentation in the final sampling.

### Mailed Surveys

Mailed surveys are cheaper to administer, so a larger percentage of the population can be sampled. The response rate is typically around 25% to 35%. This is the most common modality used around the country. These surveys use the same questions as telephone surveys but usually provide comment sections for customers to provide their feedback. Since patients/parents can complete these surveys at their convenience, they tend to write in more comments; however, the turnaround on these surveys is slower, with the majority being returned over a 4- to 6-week period. Patients who are functionally illiterate may not read well enough to respond to the survey. Patients for whom English is a second language are similarly disadvantage. Most vendors attempt to send surveys in the patient’s language of choice, but determining this is sometimes difficult.

### Other Tools

**Customer Service Liaisons:** Many hospitals now include a Service Excellence or Guest Services department to handle customer concerns and complaints. Service excellence employees have a background in customer service and are trained in service recovery methods. They function as patient and family advocates, acting as mediators in the resolution of conflict or concern. During peak ED volumes, they float through the ED, conducting family rounds, getting feedback on targeted customer service questions, and intervening to diffuse issues before they escalate. Their presence allows clinical staff to concentrate on providing clinical care instead of dealing with the complaints.

**Patient Rounds By ED Leadership Team:** Engaging ED nursing leadership is critical in driving a patient-focused culture. Emergency department leaders visit on patients at random times of the day asking targeted customer service related questions to determine whether expectations are being met. Leaders address any issues that arise and also provide immediate feedback (positive and negative) to the staff when appropriate. This process ensures that ED leaders...
are attuned to customer concerns and the needs of the ED, and it is key in demonstrating the hospital’s commitment to customer service.

**In-house Suggestion Card:** This tool is useful in getting real-time positive and negative feedback about the visit. This method is particularly useful since it is absolutely impossible to survey 100% of the ED patients seen. Providing customers with a voice regarding their experience shows how important their feedback is to the organization. This tool can also be used to recognize high performing physicians and coach low performing physicians and clinical staff.

**Customer Feedback Page:** A highly visible area on the organization’s public website for feedback can help to relay patient satisfaction concerns in a timely manner.

**Staff Reminders:** An embedded reminder to staff and physicians on the login page of the electronic medical record can keep staff members focused on patient satisfaction goals. (See Figure 1.)

**Discharge Callback Process:** This scripted tool is especially useful if a clinical team member completes the calls as a means to follow up with families regarding their visit and can answer any outstanding questions regarding discharge instructions. (See Figure 2.)

## Factors That Correlate With Patient Satisfaction

There has been an overall trend of increasing patient satisfaction scores with visits to the ED over the past 5 years, despite increasing ED volumes.¹

There are 5 major elements of the ED experience that correlate with patient satisfaction scores. These broadly encompass: a) timeliness of care, b) empathy, c) technical competence, d) information dispensation, and e) pain management.¹⁷ These are incorporated into the following discussion.

### Length Of Stay (LOS)

Despite all of the focus on ED throughput, only a minority of EDs are consistently achieving recommended wait times for all ED patients, and fewer than half of hospitals consistently admit their ED patients within 6 hours.⁴⁰ There is a clear correlation between overall poor patient satisfaction and prolonged turnaround times and increasing “left-without-being-seen” (LWBS) rates. To achieve success in reducing turnaround times and improving patient satisfaction...
satisfaction, it is important to focus on whole hospital throughput rather than expecting EDs to reduce times in isolation. Studies have validated that unless there is a reduction in ED boarders, it is impossible to reduce ED throughput.

Patients who spend more than 2 hours in the ED report less overall satisfaction with their visits than those who are there less than 2 hours. However, shortening wait time alone does not impact patient satisfaction as much as altering the patient’s/parents’ perceptions of wait times. Keeping patients updated of actual wait times may exacerbate concern with delays. Instead, providing updates on the reason for delay with an overestimated approximate wait time to be seen may engender more satisfaction, and the patient may be happier when released sooner than expected.

Educating patients on ED processes may also positively impact patient satisfaction. Studies show that an educational video on ED process had a positive impact, while a written educational intervention did not. Fifteen minute updates to patients by ED personnel had a positive impact on both perception of wait times as well as patient satisfaction.

Placement of patients in ED hallways and delays in transferring admitted patients to the floor or intensive care unit are significant predictors of lower “likelihood to recommend” and “overall satisfaction” scores. Both of these parameters predicted lower satisfaction with the entire hospitalization, demonstrating the trickledown effect of delays originating in the ED. A survey of admitted patients showed that they preferred boarding in inpatient hallways (64%) rather than in ED hallways (41%). A survey of parents in a pediatric ED showed that, while 30% had no preference, 59% preferred inpatient hallways and only 11% preferred ED hallways. The majority of pediatric patients prefer to remain at a children’s hospital despite crowded conditions. These findings should be considered when pediatric hospitals are developing strategies to improve patient satisfaction. For hospitals with a high rate of LWBS and ambulance diversions, it may be beneficial to put a physician at triage; however, one study showed that overall turnaround time was reduced by only 4%.

To help decrease turnaround times for discharged patients, it is helpful to institute an ED fast track to see the lowest acuity of patients. This can decrease ED length of stay for non-admitted patients without compromising the wait times and ED length of stay for other ED patients, and it can improve patient satisfaction in this population.

**Effective Communication**

On average, patients encounter 6 to 8 healthcare providers in rapid succession during their ED visit. They are unable to distinguish between registered nurses, nursing technicians, respiratory therapists, phlebotomists, and/or radiology technologists. They also have difficulty identifying who was the nurse and who was the physician. In teaching hospitals, it may be difficult to distinguish the various levels of learners from faculty. The “PHACES” study (Photo-

**Figure 2. Patient Callback Effect On Customer Service Scores**

Weekly customer service scores before and after implementing next day patient callbacks. Courtesy: Alson S. Inaba, MD and the Kapiolani Medical Center for Women & Children and Hawaii Pacific Health
graphs of Academic Clinicians and their Educational Status) concluded that using an information sheet with photographs of healthcare providers along with an explanation of their training improved recognition of the healthcare team members, acceptance of trainee involvement, and satisfaction with care delivered during the inpatient service.50 Parents expect healthcare providers to identify themselves by name and position and want to know when medical students are involved in care.51

In a pediatric ED study of mostly African-American mothers, 80% expected physicians to shake hands, but only 70% of residents and 66% of attendings shook hands. Eighty-eight percent of parents wanted to be addressed by their names, but only 14% of residents and 24% of attending physicians addressed them by name. All of the parents wanted the physicians to introduce themselves, but only 84% of residents and 93% of attendings introduced themselves. Attending physicians need to teach these small but important features and model them as well.52 In comparison, a primary care study showed that 78% of respondents expected physicians to shake their hand; 83% shook hands. Fifty percent wanted their first name to be used when physicians greet them; 50% of the physicians addressed the patient appropriately. Fifty-six percent wanted physicians to introduce themselves using their first and last names, and most of the physicians met this expectation.53

Most physicians cite inappropriate use of the ED as a source of frustration that leads to poor customer service scores. Insight into why parents come to the ED for non-emergent conditions may help reduce this frustration. Predictors of non-emergent use of EDs include single parenting, Hispanic race, inability to get a timely appointment with their primary care physician (PCP) (access to care issues), distrust of PCPs, and the inability to distinguish between emergent and non-emergent conditions. Parent working status also plays a big role, presumably because missing work to see a PCP could potentially result in termination. Over the last decade, there has been a rise in non-emergent use of the ED by parents who know their child does not have an emergency but are unable to get a timely appointment with their primary care doctor. Studies have found that some patients place greater trust in ED physicians compared to that of their PCP. In a decade, emergency clinicians have come a long way to gain this trust. This is probably because patient satisfaction measures have been in place in hospital-based settings longer than in the private sector.54-58

There is a direct correlation between doctor-patient communication and overall rating of satisfaction. This suggests that simple changes that physicians can make when talking with patients, such as asking patients for their opinions, letting them tell their stories, and encouraging them to ask questions, may have a substantial impact on patients’ quality of care ratings.59 Some of the characteristics demonstrating professionalism in physicians as identified by a patient focus group are as follows: good hygiene (washes hands, wears clean clothes), maintains the patient’s privacy, listens and answers questions from patients and families, takes a genuine interest in the patient’s health, communicates clearly and effectively, and is open to getting a second opinion. A physician with an empathic, caring attitude who addresses the patient’s expectations can at times override the negative effect on patient satisfaction of prolonged waiting times.60 Although pediatric ED patients may be too young to set expectations, it is important to assess the needs of the parents. Inquiring about their expectations allows them to be active participants in the care of their child and sends a powerful message that you care what they think.

The pursuit of equity in healthcare is a central objective of many healthcare systems. A fundamental step in identifying which populations are most at risk is to collect data on race, ethnicity, and English-language proficiency. A large body of research has documented disparities in access and quality of healthcare that are revealed when quality of care measures are stratified by race and language variables. The use of translators, even for low acuity conditions, is important when dealing with patients and parents who are non-English speakers. Non-English speakers tend to be less satisfied than English speakers and report more problems with care, communication, and testing.61

There may be a relationship between fewer interventions (tests, treatments, prescriptions) and lower patient satisfaction scores. In most cases, it appears that doing less leads to a negative perception of care. Stearns et al showed that prescribing antibiotics is associated with increased overall patient satisfaction.62 In contrast, Toma et al showed that satisfaction correlated more strongly with a physician’s interpersonal skills (communication) rather than whether the physician had met expectations about diagnostic and therapeutic interventions.63 As we promote effective care, we will need to utilize scripting, educate patients and their parents, and enhance physician communication skills to ensure that the perception of care continues to match expectations.

An inpatient survey showed a strong, consistently positive relationship between adequacy of discharge instructions given and overall patient satisfaction scores. Patients gave lower ratings to the quality of discharge instructions than to the overall quality of their hospital stay. In a pediatric ED, the use of a discharge facilitator had a positive impact on patient satisfaction scores when compared to
Hear: Listen to the patient – do not appear impatient – give them time to vent.

Empathize: Do not make excuses – acknowledge the emotion by name: “It’s very frustrating to have to wait so long.”

Acknowledge: Apologize, if appropriate – “Sorry you had such a bad experience, what can I do to make it better?”

Respond: “Here is what I can do to help.”

Thank: “Thanks for sharing your concern.”

Formalized training sessions for physicians in customer service have also been found to be helpful. Mayer et al demonstrated that a well-structured clinically-focused customer service training session for ED physicians and staff made a positive impact on decreasing patient complaints and increasing customer service scores. Emergency medicine staff and physicians attended an 8-hour training course that consisted of the following modules: basic customer service principles, recognition of patients, service industry benchmark leaders, stress recognition and management, communication skills, negotiating skills, empowerment, customer service proactivity, service transitions, service fail-safes, change management, and specific customer service core competencies. The core competencies included making the customer service “diagnosis” (in addition to the clinical diagnosis), providing the right treatment, negotiating agreement resolution of patient expectations, and building moments of truth into the clinical encounter.

Demographic Variables
Although more studies are needed to validate this, children appear to be more satisfied with ED level of service and pain management than their parents. Older adults are more satisfied than young adults. African-Americans are less satisfied than whites. In the primary care setting, African-American
patients rate their visits with physicians as less participatory than whites, unless there is doctor-patient race concordance. Improving cross-cultural communication between PCPs and patients and providing patients with access to a diverse group of physicians may lead to more patient involvement in care, higher levels of patient satisfaction, and better health outcomes.\(^{67,68,69}\) A study done in an inner-city ED with predominantly low income, uninsured, poorly educated, and African-American patients found demographic variables to be largely unrelated to overall patient satisfaction. Although uninsured patients showed a weak tendency to be less satisfied than insured patients, this difference was not statistically significant. These findings are significantly different from the data from other clinical settings, like inpatient or outpatient clinics. A review of unsolicited surveys showed that the parents of African-American children were less likely to complain than the parents of white children.\(^{30}\) Whether this difference is noted on solicited surveys has not been reported.

**Socioeconomic Status**

Most studies have found that individuals of lower socioeconomic status and less education tend to be less satisfied with their healthcare.\(^{70}\)

**Daily And Seasonal Variations**

Patients who arrive in the ED between 7:00 am and 3:00 pm report higher satisfaction than those who arrive in the evening or overnight hours.\(^{61}\) There is a cyclical pattern year to year where satisfaction dips in the spring months, possibly a carryover from the crowded EDs during the beginning of the year.\(^{1}\)

**Acuity**

When adjusted for perception of throughput times, acuity does not predict improved patient satisfaction.\(^{71}\) In a pediatric setting where a parent’s perception of their child’s level of acuity may be higher than actually assigned, the perception of wait times may be unrealistic and lead to dissatisfaction. This has not been studied in the literature.

**Pain Management**

Lack of pain control is one of the leading causes of dissatisfaction with ED care.\(^{1}\) Generally, it appears that pediatric EDs control pain well and parents are satisfied with pain management for their children.\(^{72}\) In 2008, Press Ganey\(^{TM}\) performed 1,399,047 surveys of patients and parents. “How well was your pain controlled?” was one of the 3 lowest scoring areas and continues to be an area where there is opportunity for improvement.

**Physician Gender**

In a primary care study, it was noted that patients of female physicians were more satisfied than those of male physicians, even after adjusting for patient characteristics, visit length, and physician practice style behaviors. This could be due in part to patients’ expectations about female physicians, presuming them to be more empathetic, nurturing, and responsive.\(^{73}\) It is important to note that patient ratings of physicians are based on multiple factors. In a primary care setting, patients treated by a physician for 1 year or less rated male physicians higher than female physicians. This gender difference disappeared after 1 year, but 2 physician personality traits - openness and conscientiousness - were associated with higher scores in lengthier patient-physician relationships.\(^{74}\) In another study, physician gender had no influence on patient satisfaction after adjusting for patient age and facility-level satisfaction. There was no significant interaction effect between patient gender and physician gender.\(^{75}\)

**Physicians In Training**

In a clinic setting, interns have lower scores than their faculty preceptors, but second, third, and fourth year students achieved scores similar to their faculty preceptor.\(^{76}\) Another study showed that non-surgical residents scored slightly higher than surgical residents. Orthopedics residents had the lowest scores. There was a decrease in resident scores at the beginning and end of the academic year (June and July). In comparison, faculty, nursing, and overall scores did not show this seasonal variation.\(^{77}\) Although parental knowledge regarding the relative roles of trainees is poor, parents generally are willing to have trainees involved in their child’s medical and surgical care, provided they are adequately supervised and that the parent is aware of their participation.\(^{51}\)

**Conclusion**

Whether we refer to them as patients, clients, or customers, it is clear that individuals seeking emergency care want to see physicians who not only have great technical skills but are also willing to listen and teach. In pediatric emergency medicine, more work needs to be done to elicit the perceptions of children and to ensure that we are meeting their needs, especially in relation to allaying fears and managing pain. In this day and age, to put blinders on and to continue to practice as we did 20 years ago is not possible. Information is at the parents’ fingertips. Use internet search engines to query your own name. You will be amazed at how many consumer sites are available for patients to rate your care.\(^{78}\) A myriad of sites are also available to consumers to learn about specific diseases and complaints. Be prepared to understand the parents’ fears and expec-
tations, and try to meet those needs in the ED. You will encounter a few parents with unreasonable and unrealistic expectations. With a little patience and tolerance, you will be able to satisfy most of your patients’ needs. Physicians are not expected to be perfect, but there is an expectation of professionalism. Of all the comments received by Press Ganey™ for ED services, 67% are positive, and 33% are negative.¹ (See Figure 5.) Here are some examples of improved patient feedback.

- “We were VERY impressed with our doctor. He took time to thoroughly discuss possible drug interactions. He seemed super knowledgeable and up-to-date. We see lots of doctors regularly. He is a standout.”
- “Although he was probably overwhelmed with patients, he didn’t rush when seeing my son and told me about all the possible options, tests, wait time, etc. He was awesome!”
- “The doctor was very concerned with everything - he was very thorough and we could tell that he really cared for my son’s well being.”
- “Fabulous MD; very concerned about the comfort of our baby and very gentle as well.”
- “I liked that the doctors took time to explain and even draw pictures of what was going on.”
- “Doctor listened - Very surprised when I compare this to other hospitals.”
- “The doctor was wonderful; he made me laugh and kept things light. I felt safe and comfortable with him.”
- “Both doctors treated my son with a lot of compassion & let me know before treating him the risk and rewards of doing the procedure before they went through with it.”
- “They acknowledged her as a little person and let her know what they were doing or about to do so that she wouldn’t be so scared of the unknown - Thanks. My daughter was comfortable with the entire experience because all persons dealing w/ her spoke directly to her.”
- “The doc was awesome! He explained everything in detail, even while performing my daughter’s procedure to keep us calm.”
- “The doctor had come in with the suture kit then got a beep. They had two traumas & I totally understand that. They kept us informed and made sure my son was comfortable while we waited.”
- “The doctor acted like we were the only ones

Figure 5. Customer Service Rankings After Multiple Initiatives

Sustained improvement in customer service percentile rankings after multiple initiatives including improvement in efficiency, dedicated fast track, leadership rounds, embedded reminders in the electronic medical records, and physician-nurse team assessments. Campus 1 is a private facility and campus 2 is a teaching facility where 50% of the patients are seen by residents or fellows. Courtesy: Children’s Healthcare of Atlanta
there. Even though her condition ended up being something embarrassing, the doctor treated us with dignity.”

- “We had a lot of questions and the doctor was pleased to listen and answer them.”
- “Everyone was wonderful. The MD made me feel comfortable. She even wore these cute sneakers that light up as she walks! My daughter instantly recognized them!”

References

42. Papa L, Seaberg DC, Rees E, et al. Does a waiting room video

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1. When confronted with poor customer service scores, physician response sometimes mirrors the 5 stages of grief identified by the noted psychiatrist Elizabeth Kubler-Ross. Which of the following is NOT one of those 5 stages?
   a. Denial
   b. Depression
   c. Rage
   d. Bargaining

2. Unsatisfied patients are less likely to fill their prescriptions, be compliant with therapy, or keep their follow-up appointment.
   a. True
   b. False

3. Which statement below describes the association between patient satisfaction ratings and risk management episodes?
   a. Each 1-point decrease in score is associated with a 5% increase in the rate of risk management episodes.
   b. Each 5-point decrease in score is associated with a 1% increase in the rate of risk management episodes.
   c. There is no clear association.
   d. Each 1-point increase in score is associated with a 5% decrease in the rate of risk management episodes.

4. Which of the following is not one of the 5 major elements of the ED experience that correlate with patient satisfaction scores?
   a. Timeliness of care
   b. Empathy
   c. Technical competence
   d. Cost of care

5. Keeping patients updated of actual wait times may exacerbate concern with delays.
   a. True
   b. False
Patient Satisfaction In The Pediatric ED

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Patient Satisfaction In The Pediatric ED

1. [a] [b] [c] [d]
2. [a] [b]
3. [a] [b] [c] [d]
4. [a] [b] [c] [d]
5. [a] [b]

Please indicate the number of hours spent of this activity if less than 4 hours: ________________________________

Enter the extent to which you agree with these statements. 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree

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2. _____ Adequate faculty disclosure was given.
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5. _____ I anticipate that this activity will improve outcomes for my patients.
6. _____ The following objectives were met: Effectively use patient satisfaction surveys, patient/parent advisory groups, and customer service liaisons to monitor your patients’ experience in the ED. Effectively monitor your patients’ satisfaction to ensure that their needs are not overlooked, that negative perceptions of care are not created, and that initiatives are created to ensure effective, safe, efficient, timely, and equitable care.
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