Patient experience measurement ignores mental health: Suggestions for healthcare organizations

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INCORPORATING MENTAL HEALTH ISSUES INTO PATIENT EXPERIENCE MANAGEMENT

The prevalence of mental illness in the USA is significant (Reeves et al., 2011). Mechanic (2014) estimates that ‘at any point in time, as many as 5–10% of the population has disorders that are serious and involve substantial impairment and a critical need for treatment and care’ (Mechanic, 2014, p. 1418), more than ever before. In any given year, nearly 40 million people in the USA (18%) experience an anxiety disorder, and 9.1% of the US adult population experience symptoms consistent with major depression (Substance Abuse and Mental Health Services Administration, 2014). Mental health issues are increasingly being identified and treated. For instance, the World Health Organization (WHO) has predicted that depression will be the second most prevalent cause of disability by 2020 (Ferrari et al., 2013) and the costs of mental health and substance abuse treatment are daunting, having exceeded $135 billion (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011).

Mental health disorders can be a clinically important comorbid condition, and have interactions with other health issues. More than 68% of adults with a mental disorder have at least one medical condition (Druss & Reisinger Walker, 2011). This is an important consideration because comorbidity is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs (Druss & Reisinger Walker, 2011). Additionally, medical disorders may lead to mental disorders, mental conditions may place a person at risk for certain medical disorders, and mental and medical disorders may share common risk factors (Druss & Reisinger Walker, 2011). Collaborative care models that use an interdisciplinary team have been shown to provide effective treatment for persons with comorbid physical and mental conditions. The most effective treatment models, however, are not in widespread use.

In today’s evolving and dynamic healthcare environment, measures and reimbursement hold the ability to drive strategies and behaviors. Thus, if mental health is not considered when developing reimbursement structures for ‘value-based purchasing,’ then it becomes marginalized and misunderstood. However, patient experience managers are just beginning to explicitly acknowledge mental health as a significant patient-level consideration. This is true, despite the recognition that positive patient experiences have been shown to be related to enhanced adherence to treatment, better clinical outcomes, improved patient safety, and lower resource utilization (Anhang Price et al., 2014).

The aims of this paper are to: (1) briefly capture the existing state of patient experience measures and management; (2) highlight the lack of incorporating mental health issues into patient experience measurement; (3) recommend more explicit acknowledgment and incorporation of mental health factors in patient experience measures and management; and to (4) outline how integrating mental health awareness and considerations into patient experience management provides the opportunity for improved processes, outcomes, and quality of life.
EXISTING STATE OF AFFAIRS

Recent policy changes and legislation that support parity in mental and behavioral health treatment may present ‘a turning point in the recognition of the centrality of mental health status and function for the nation’s health’ (Mechanic, 2014, p. 1416). However, much still needs to be done to properly treat those with behavioral or mental health issues. Additionally, mental and behavioral health concerns and illnesses are not being adequately measured when assessing and managing patients’ experiences when these individuals are being treated for medical disorders.

The current state of patient experience measurement and analysis for those with mental illness is quite poor. It is only included as a self-reported measure for all patients (‘In general, how would you rate your overall mental or emotional health?’), and most often is being analyzed as a control variable instead of being a variable of interest (independent variable or moderator). There is, however, a separate survey for behavioral and mental health issues, Experience of Care and Health Outcomes (ECHO), which includes the following mental health-related items (Agency for Healthcare Research and Quality, 2004):

15: ‘In the last 12 months, what effect has the counseling or treatment you got had on the quality of life?’
R1: ‘In general, how would you rate your recovery now?’

However, the ECHO instrument is not widely used, and data generated from the deployment of this instrument are not routinely integrated with other patient experience measures. There are significant issues in measuring and analyzing patient experience by mental health status. For instance, Home Health and Hospital versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey include this single item: ‘In general, how would you rate your overall mental or emotional health?’ The original instruments did not even include this item; it was added in 2013. The Clinician and Group CAHPS survey includes a set of items for mental or emotional health (Centers for Medicare & Medicaid Services, 2012b):

PCMH16: ‘Anyone in provider’s office asked if patient had felt sad, empty, or depressed.’
PCMH17: ‘Anyone in provider’s office asked if patient had felt sad, empty, or depressed.’
PCMH18: ‘Anyone in provider’s office talked with patient about personal problem, family problem, alcohol use, drug use, or a mental or emotional illness.’

As a result, analyses of patient perceptions of their care experience are predominantly statistically analyzed through inclusion of these self-reported patient measure(s) – a sub-optimal condition. It should be noted that CAHPS responses cannot, by regulation, be linked back to individual patient identifiers. Thus, it is difficult to include CAHPS measures in large patient-level datasets. CAHPS guidelines assert that organizations should ‘assign random, unique, de-identified patient identification number (Patient ID) to track each sampled patient’ (Centers for Medicare & Medicaid Services, 2012a), and that ‘this unique ID number should not be based on an existing identifier such as a Social Security number or a patient ID number. This number will be used only to track the respondents during data collection’ (Centers for Medicare & Medicaid Services, 2011).

What patient experience managers are left with is to methodologically treat mental illness as a confound variable that presents issues with data collection and analysis, rather than a variable of interest. In a very large national dataset of HC-AHPS responses, self-reported measures of overall health and mental/emotional health were only moderately correlated (0.56) (Costello, 2013). Furthermore, HHCAHPS instructions tell organizations that ‘an employee of a group home may serve as a proxy respondent for a sample patient who lives in the group home and who is physically or mentally incapable of responding to the survey’ (Centers for Medicare & Medicaid Services, 2014, p. 62).

What can be ascertained from self-reported mental health measures is that patients who report having both excellent mental/emotional health and overall health, rate their medical experience significantly higher than patients who rate both low/low (Costello, 2013). The implication is that patients rate their experience lower when they have underlying health issues, particularly mental health issues. Possible explanations for these findings may include:

1. Patients with mental health issues are actually receiving sub-optimal care
2. Patients with mental health disorders may have problems understanding the process and experience of their own care
3. Other possible explanations not yet identified.

Insight into this issue is provided by the finding that staff/nurse/physician communication is rated significantly lower by those patients who identified as having poor mental/emotional health (Costello, 2013).

MANAGING PATIENTS WITH MENTAL HEALTH ISSUES

Clinically, treating and managing patients with mental health issues suggests that patients experience very different care as a result of their conditions. Various treatment options include:

1. Isolation rooms
2. No treatment (other than medications) for mental health issues
3. Low-level staff as ‘sitters’ for one-to-one observation (e.g., persons who are on medical units after a suicide attempt)
4. Patients ignored if deemed to be ‘controlled’ by medication
5. Nurses and other healthcare providers avoiding contact with persons with mental illness because of stigma, fear, or lack of confidence or training.

Indeed, mental healthcare providers are often subjected to abuse by patients (Seager, 2014). Mental health treatment should be part of a plan that addresses underlying causes, and does not
simply marginalize its effects. For instance, analysis of patient surveys can provide insights into the extent to which mental health status is considered when discharge plans are developed. This would determine a patient’s level of ability to understand and comply with new health behaviors, to follow-up with future treatments/appointments (reduce no-shows), with the knowledge of the patient’s family, social networks, support systems, and likelihood to harm self or others.

What are the inherent issues with managing patient perceptions, satisfaction, and experience? In one widely used case study, after a ‘difficult’ patient with mental illness caused a ‘scene in the lobby,’ administrators ponder whether the clinic should ‘fire’ the patient, how it might impact their HCAHPS scores, and whether it was ‘fair’ to the clinic that they would be challenged by these ‘types’ of patients (Raman & Tucker, 2013). These questions, while they may be thought provoking, subvert emphases on mental health treatments relative to medical treatments, or even to business issues.

Patients with mental health issues are more likely to access health care through hospital emergency departments, the most expensive method of delivering health care (Costello, 2013). Many are seriously ill people with behavioral disorders, who are also homeless, some have substance abuse issues, and follow-up and adherence management is very difficult, if not impossible (Mechanic, 2014). ‘Even bringing together mental health, substance abuse, and medical care is demanding, and studies repeatedly show large neglect of general medical care among people with serious behavioural disorders’ (Mechanic, 2014, p. 1421). Moreover, ‘many patients with behavioral disorders are difficult to manage quickly, requiring careful evaluation, listening, and support’ (Mechanic, 2014, p. 1419), posing challenges that are not easily overcome (Shattell, McAllister, Hogan, & Thomas, 2006; Shattell, Starr, & Thomas, 2007). Clearly, new integrated care measures and models are needed.

**PROPOSED CHANGES**

Emanating from the issues explored here, we propose the following changes to patient experience measurement, analysis, and management. First, data collection, abstraction, and analyses should include multiple measures of mental health, not just self-report item(s). This would allow analysts to use mental health status not just as a control variable, but also as a variable of interest. As a result, important questions can be specified and explored, including how mental health moderates the relationship between care processes and patient perceptions of a patient’s experience. Patient experience managers can then assess patient experiences and perceptions concomitantly with mental health issues. Issues common to patients with similar mental/behavioral health issues can then be identified, with a mind toward gaining insights into how patients with mental health issues view domains including nurse communication, physician communication, discharge instructions and processes, home health care, and others.

Second, organizations should be allowed to tie medical records to survey responses without violating terms of confidentiality. Organizations should be held accountable to maintain confidentiality and to protect patients’ rights. This would bolster, not risk, efforts to better design and manage patient experiences to better accommodate patients with mental health issues. Specifically, healthcare organizations should:

1. Treat mental health concomitantly with physical health issues
2. Triage patients based on physical and mental health status
3. Consider the physical environments within healthcare centers when treating patients with mental health issues
4. Evaluate and alter discharge planning and processing to accommodate issues with ongoing treatment of mental and behavioral health concerns
5. Engage family, friends, and other caregivers in recognizing and treating mental health issues.

The potential impact on systems, providers, and patients is profound. Gaining a more nuanced, yet complete understanding of care experiences for those who have mental health disorders would allow healthcare organizations to better design patient facilities, service processes, and treatment protocols. As a result, improvements could be seen in process adherence, cost containment, and health outcomes. Improved patient experiences hold the potential to facilitate enhanced wellbeing and an enriched quality of life (Lee et al., 2013).

**CONCLUSIONS**

In this paper, we discussed the existing state of patient experience measures and management. We highlighted the lack of mental health issues in patient experience measurement and we recommended more explicit acknowledgment and incorporation of mental health factors in patient experience measures and management. Finally, we outlined how integrating mental health into patient experience management provides an opportunity for improved processes, outcomes, and quality of life for individuals with mental health concerns.

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**REFERENCES**


