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Monitoring Patient Satisfaction

by Marilyn C. Doss & John W. Waterbor, M.D., D.Ph.

Ten years ago patient satisfaction data were collected haphazardly, patient satisfaction monitoring systems were poorly established, and patient satisfaction results were not used for quality improvement initiatives. In fact, many health care providers questioned the need for a patient satisfaction monitoring system. For the most part, patient surveys were performed sporadically and only for marketing purposes or general curiosity. These surveys did not produce data that were reliable or valid, nor were the surveys specific to the patient care unit and clinical service. Because methodology was inconsistent, actual changes in quality could not be assessed. Clinicians and administrators did not take results seriously. Moreover, there was a pervasive attitude that patient survey data were of little value because the patient was not capable of evaluating care.

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Today the question is not whether to measure patient satisfaction, but how to measure it and how to use the data for quality improvement. Patients can, do, and should judge the quality of care and service they receive. Today's health care environment mandates that patient satisfaction data be scientifically collected and that the results be used for continuous quality improvement. Measurement and accountability, including the patient's perspective and evaluation of care, are here to stay.

Although clinicians still offer some resistance to the value and importance of patient satisfaction data, significant attitudinal changes have occurred. Health care providers now realize there are many compelling reasons to establish patient satisfaction monitoring systems, including:

- understanding patient needs and expectations
- using data for quality improvement
- engaging in internal and external benchmarking
- reinforcing outstanding employee performance
- meeting JCAHO accrediting standards
- positioning for managed care
- remaining competitive
- satisfying third-party payers.

WHAT TO MEASURE?

After understanding the reasons for collecting patient satisfaction data, a health care organization must decide what to measure. An important first step is to review the growing body of literature and hold focus groups of physicians, nurses, patients, and administrators.

Many providers usually assess the following attributes:

- technical competence of the care givers
- effectiveness of care givers' communication with patients and families
- effectiveness of patient education and discharge information
- relationships with physicians and nurses, including caring behavior, respect, and attention to patient needs, fears, and concerns
- patient comfort needs such as pain management and privacy
- the quality of "hotel services," including ease of access to the facility, admitting procedures, appearance of patient rooms, appeal of the food, and overall cleanliness of rooms and common areas.

Surveys specific to individual patient care units, clinical services, DRGs, or even physicians are superior to more general surveys because results can be used for internal benchmarking and quality improvement. Identifying successful

units or services, and finding out why they receive high scores, helps managers improve low scoring areas. The best practices of high scoring areas can be identified, analyzed, and imported to other units. If the data are to be specific to a patient care unit, clinical service, or physician, adequate sample sizes for each category are necessary for statistical analysis.

Reliability and validity of the data must be demonstrated through statistical testing and by comparisons with other sources of relevant data. Results should be stable and consistent. The survey must measure what it claims to measure. When bias and measurement error issues are addressed and explained in a straightforward manner, physicians, nurses, and administrators are more likely to accept the results.

IN-HOUSE OR OUTSIDE VENDOR?

The provider must decide whether to use an outside vendor or conduct the survey internally. If the expertise is available in-house, providers often prefer to develop their own monitoring systems. Some advantages of this approach include the ability to determine what to measure, the flexibility to add or drop survey items, on-site staff who are available and responsive to the needs and requests of those who use the satisfaction data, project staff participation in CQI committees and processes, and ease of linking patient satisfaction data with other hospital databases, such as staffing levels, patient acuity, or outcomes.

Using an outside vendor is preferable if comparisons to national norms or local competitors are desired. There are reputable vendors who follow sound survey research principles and who have large national and local databases. A vendor may be the best choice if internal expertise is unavailable and cost is not a major issue. Nevertheless, providers should still conduct the literature review and hold focus groups to help surveyors assess the vendor's methodologies and questionnaires. Many providers who conduct their own ongoing surveys may participate once or twice a year in comparative surveys.

Interviewing patients in the hospital or handing a survey to them as they leave is ineffective.

PHONE OR MAIL?

If providers decide to conduct their own survey, they must choose between a mail and telephone survey. Interviewing patients in the hospital or handing a survey to them as they leave is ineffective.

Supporters of telephone surveys claim higher response rates and more timely results than mail surveys. Be aware, however, that there is a downside to telephone surveys.

- They are more expensive than mail surveys.
- Respondents may find telephone surveys difficult to comprehend when items are long or complicated.
- They are difficult to administer when there are items with several response choices.
- The intrusion of a telephone call may anger patients, especially since calls must usually be made at night or on weekends.
- The telephone interviewer may introduce bias.
- Homes that do not have telephones are missed, and other homes may use answering machines to screen out unwanted calls.
- Often the response rate with telephone surveys is not much better than that of a well-conducted mail survey.
- Finally, telephone surveys tend to yield more positive results and show less variance in the range of responses. We need to go after negative responses.

Mail surveys are typically mailed seven to fourteen days after discharge. Some providers prefer mailing the survey to all patients, while others conduct random samples. A label attached to the survey encoded with date of discharge, patient care unit, clinical service, gender, age, payer class, and perhaps DRG or physician code allows for many important statistical analyses. Follow-up reminder letters or postcards and second wave survey mailings to nonresponders increase response rates significantly. Surveyors must become comfortable with a 33-50 percent response, provided that sound research principles are followed. The 80-90 percent response rates that are desired in some varieties of controlled, scientific studies are just not attainable with the typical mail survey.

Whatever the kind of survey chosen, excellent patient satisfaction monitoring systems:

- receive support from top administrators
- are reliable and valid
- provide indicators of statistical significance in order to distinguish meaningful from nonmeaningful differences

- use a systematic, formal, and scientific approach
- detect change and display trend data over time
- compare data at the unit, clinical service, or DRG levels
- identify issues that most affect patient satisfaction
- report data graphically
- report data regularly and in a timely fashion
- furnish data for positive feedback on a regular basis
- develop comparative and complementary databases
- continually assess, evaluate, and improve the system.

USING THE RESULTS

All levels of hospital management, clinical services, and staff should be made aware of patient satisfaction survey results. Internal publications can help to publicize overall findings.

Dealing with survey comments is a time-intensive activity; however, it is worth the investment. Although transcribing all comments may be too costly, surveys that cite specific employees should be copied before data entry and sent to respective employees and/or their supervisors. The positive citations can enhance employee morale.

Whoever is in charge of directing the patient satisfaction monitoring system should communicate with key data users to find out if the results seem meaningful, make sense, and are believable. The program director can help users interpret the results, identify dissatisfied patients and why they are dissatisfied, examine the implications and trends, and determine which events or activities explain changes. Negative citations require exploration and possible action. Because issues and functions of units and departments change, the survey instrument must be continuously evaluated and modified.

Quick and easy solutions to problems should be identified; success is reinforcing. Later, the program director can help units establish long-term goals to improve patient satisfaction. He or she can help determine target satisfaction scores and reasonable improvements in a given area. Not all units, services, or departments can reach or exceed the hospital mean in satisfaction scores because each differs in patient population, severity and type of illness, and department or unit function.

Finally, the project director can discourage the temptation to find excuses for low scores. High visibility of the patient satisfaction program and genuine support and commitment from the highest levels of administration and clinical practice help assure that physicians, nurses, and administrators will take results seriously and use the data. ■

The UAB Satisfaction Monitoring Process

The patient satisfaction monitoring system has been up and running at The University of Alabama at Birmingham since 1988. The project is housed in the office of the vice president for health affairs and tied to operations, not public relations.

Patient surveys are mailed four to seven days post discharge to all patients, with few exclusions (deaths or those transferred to nursing homes). A reminder postcard is mailed one week later.

Returned surveys are screened for comments. Signed surveys and those citing specific employees are sent to the appropriate manager, administrator, or physician, who may share the comments with the employee. Positive comments are placed in the personnel file. Negative comments are explored to determine facts and possible action. The appropriate nurse, physician, patient representative, or project director answers signed surveys by telephone or mail.

Reports are distributed quarterly to administrators, nursing directors, head nurses, physicians, patient representatives, and the project director. Results are also reported to the CQI Committee. The project director also serves on the CQI Committee. Meetings are held quarterly with managers and administrators to discuss results.

Because reports are prepared by patient unit and medical service, scores can be compared. The unit or service can be compared to itself and to the overall mean, including confidence intervals around the mean.

Quarterly trend reports are distributed to units, departments, and clinical services. Correlations, cross-tabulations, and other statistical analyses are performed and communicated every six months.

The program director visits patient care units to discuss the meaning of results, verify results, target areas for improvement, and answer questions.

Each year, the hospital participates in a local and national comparative study. The program director explores linkages with other databases and is instrumental in making sure satisfaction monitoring is assessed and improved annually.