



## Patient Satisfaction with Hospital Care

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“... To see ourselves as others see us! It would from many a blunder free us.” When the poet Robert Burns wrote these lines in the 18<sup>th</sup> century, he unknowingly foretold the current practice of using patient satisfaction to measure health care services. Patient satisfaction has become a key measure by which quality of health care services is being evaluated. Many health care organiza-

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tions routinely collect and monitor these data for internal assessment. There is a growing movement to use these data to compare service quality among health care organizations. VHA is a leader in this movement. Several years ago, VHA established the National Customer Feedback Center to monitor patient satisfaction of veterans receiving their care in-house. Comparisons based on these data, however, inevitably raise questions about fairness. While patient satisfaction is viewed generally as a patient’s reaction to his/her actual encounter with a provider, there are concerns that certain demographic characteristics such as age; health status and race are associated. Also, certain intrinsic characteristics (i.e., teaching status and hospital size) may influence patient satisfaction.

Fair comparisons require some consideration of differences regarding demographic and institutional characteristics, but perhaps other factors need to be taken into consideration. A primary goal of patient satisfaction analyses is to motivate health care organizations to improve their care delivery; however, the underlying issues may be more complex.

HSR&D Management Decision and Research Center (MDRC) researchers (*G. Young, M. Meterko, and K. Desai, Patient Satisfaction with Hospital Care: Effects of*

*Demographic and Institutional Characteristics, scheduled for Medical Care publication, spring 2000*) used VHA patient satisfaction data to examine whether demographic and institutional characteristics influence patient satisfaction scores. By utilizing VHA’s unique database of patient satisfaction data collected from 135 hospitals, they examined the extent to which satisfaction scores are related to these characteristics.

Several patient-level and hospital-level characteristics were selected:

- Patient Satisfaction: summary scores from patient satisfaction questionnaire.
- Patient-Level Demographic Characteristics: age, health status, sex, race, and income.
- Hospital-Level Institutional Characteristics: hospital size, teaching status, and geographic location.

### Results

MDRC’s key findings indicate that:

- Advancing age is related to higher satisfaction scores.
- Better health status is related to higher satisfaction scores.
- Non-whites reported lower satisfaction scores.
- Large hospitals had lower satisfaction scores.

### Discussion

As comparisons of health care organizations based on patient satisfaction data become more common, increasing attention will be devoted to the fairness of these comparisons. MDRC researchers sought to identify patient-level and hospital-level characteristics that may need to be accounted for when comparing health care organizations.

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With respect to the patient-level characteristics, the results indicate that age, health status, and race had statistically significant effects on patients' satisfaction with their hospital care. It is not clear whether these relationships reflect differences in patient expectations and values or reflect actual differences in the way patients are treated. If health care organizations treat patients similarly, then the observed relationships suggest that patients' perceptions are influenced by the expectations and values they bring to the encounter with a provider. As for health status, patients who perceive themselves as healthy may be more satisfied with life generally and this attitude carries over to their specific encounters with providers. Race may serve as a substitute for attitudinal factors that influence different aspects of the health care experience and, subsequently, satisfaction scores. Individuals from different racial backgrounds may have different expectations regarding the behavior of clinicians. Racial and ethnic subgroups may differ in the degree of importance they attribute to various features of the care delivery process. Such differences may explain why a health care delivery system that seemingly behaves uniformly toward its customers might be judged differently by different subgroups. Alternatively, differences among racial subgroups may reflect real differences in the process and delivery of care. Perhaps a patient's race influences treatment decisions of physicians and reflects a subconscious bias.

Among the hospital-level characteristics, MDRC researchers found that only hospital size had a statistically significant effect on satisfaction scores. This points to the importance of combining demographic and institutional factors in examining determinants of patient satisfaction ratings.

### Implications

What are the implications of these results? On the one hand, they can be interpreted as justifying the need to account for differences in patient mix among health care organizations through statistical adjustment. On the other hand, statistical adjustment of these data may create a disincentive for health care organizations to customize their care. Donald M. Berwick, MD, a well-known health care quality improvement expert, states that the key to the success of world-class organizations is their ability to deliver what feels like individualized products and services. Instead of a "one size fits all" approach, these organizations practice what Berwick calls

"mass customization" and can readily identify the right "size" for any given customer. From this perspective, adjustment of satisfaction data serves as a potential barrier to the customization of health care services. In Dr. Berwick's words, to adjust for these factors "... is not getting closer to the needs of customers. It is ignoring them." This argument is particularly forceful when applied to race, given the obvious concern that there be no racial barriers to quality health care services.

Perhaps one way to resolve these competing viewpoints is to distinguish between short-term and long-term uses of patient satisfaction data. In the short term, consumers are making membership and purchasing decisions based on these data. In the long term, it is the use of these data in the pursuit of mass customization that will move health care in the direction of service excellence. Yet, is mass customization a reasonable goal? Might an attempt at identifying the real needs of customers be a more realistic goal and be related ultimately to higher satisfaction scores?

MDRC researchers conclude that much of the variation in patient satisfaction scores is not attributable to demographic or institutional characteristics. It appears that hospital managers and clinicians are in a position to affect patient satisfaction through improvements in care delivery. In order to improve care delivery, managers and clinicians need to know the desires of customers being served. ■

*Transition Watch* is a quarterly publication of the Office of Research and Development's Health Service Research and Development Service that highlights important information and learnings from the organizational change processes underway within the Veterans Health Administration. Special focus will be given particularly to findings from three organizational studies: the Service Line Implementation Study, the Facility Integration Study and the National Quality Improvement Study. The goal of *Transition Watch* is to provide timely and supportive feedback to VHA management throughout the change processes being studied as well as to draw on the change literature to assist managers in their decision making. For more information or to provide us with your questions or suggestions, please contact:

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# The Integration Scorecard: A Tool for Monitoring System Integration

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Many health care organizations today, in both VA and the private sector, strive to create integrated delivery systems. They expect an integrated approach to add value to their organizations — to enable them to provide higher quality care at lower costs while maintaining or improving the health and satisfaction of their patients.

Health care organizations also have ideas about how to structure an integrated system to achieve these expected benefits. Generically, an integrated delivery system is a network of organizations that provides or arranges to provide a coordinated continuum of services, and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served. In needing to integrate and coordinate care, integrated delivery systems require different relationships among components than traditional health care delivery systems.<sup>1</sup> Within this broad framework, there are many models, such as service lines, for structuring an integrated system.

So a health care organization has expectations about the benefits of an integrated delivery system, and it has ideas about how to structure the system to meet these expectations. But as it moves forward to create an integrated system, how does it know how well it is progressing? How does it know whether it is headed in the right direction or whether it needs mid-course corrections?

The leaders of the VA Upper Midwest Network (VISN 13) asked these questions in 1997 as they began to link their medical centers into an integrated delivery system. They asked the HSR&D Management Decision and Research Center (MDRC), through its Management Consultation Program, to help them monitor their progress toward system integration by developing an integration scorecard.

The central, and most challenging, component of the integration scorecard is measuring system integration — the extent to which the system is actually coordinated across operating units. To tap this component,

we worked with the Network 13 Integration Council to develop a survey that was administered to staff across the network. This article describes the survey process and presents selected findings to illustrate the type of information it provides to managers.

## Measuring system integration

The survey was designed to assess how frequently staff at all levels of the network had experiences that one would expect to find in an integrated system. The dimensions of experience represented in the survey were based both in Network 13 goals and in research on integrated delivery systems. Individual survey items were phrased to reflect personal experience whenever possible, so staff could respond easily. Staff were asked to estimate how often a situation had occurred in the last three months; for example, *Staff at other facilities in Network 13 cooperate when I need their assistance*. They rated frequency on a seven-point scale from almost never to almost always.

The survey was completed by 1042 staff between May and July 1999. These 1042 individuals represent 73% of the staff contacted, a very successful response rate. The survey sample was drawn to ensure that all facilities, service groupings and staff groups were well-represented.

- *Facilities* included all five VA medical centers in the Network.
- *Service groupings* includes the four Patient Service Lines (PSLs), Non-Service Line Clinical Staff, Integrated Services and Non-Service Line Administrative Staff. In facilities that have not implemented all four PSLs, for purposes of sampling, staff were assigned to the PSL they would be in if the PSL was implemented. Staff in services that are not expected to reorganize into service lines were assigned to one of the non-service line groupings.
- Within each service grouping and facility, staff were sampled from three *staff groups*: clinicians, general staff and managers. Each group received a version of the survey tailored to their personal experiences as much as possible.

<sup>1</sup> Gilles RR, Shortell SM, Young GJ, Best practices in managing organized delivery systems. *Hospitals & Health Services Administration*, 1997; 42(3): 299-321.

## The Integration Scorecard

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### Tracking progress on five dimensions

With the data collected from the survey, we used factor analysis and multi-trait analysis to reduce the large number of survey items to smaller sets of scales. The scales are clusters of items on which people gave similar responses. Creating scales has two advantages: by combining items, the results are more stable and because there are few of them, they are easier to interpret and it is easier to identify patterns than when working with the large number of individual items.

The analysis yielded five system integration scales. The scales are defined in terms of the features we would expect to find if the system were highly integrated. While these scales were built from the data, they also reflect dimensions that Network leaders have been working on.

### System Integration Scales

**Leadership:** System and facility leaders articulate clearly the system goals and objectives; staff understand their role in furthering those objectives and work together toward them.

**Staff cooperation:** Individual staff cooperate across facilities: I know whom to call when I need assistance, others are willing to help, we share the same goals and standards.

**Clinical coordination:** Patient care is well managed across facilities; reliable, timely patient data are provided across facilities.

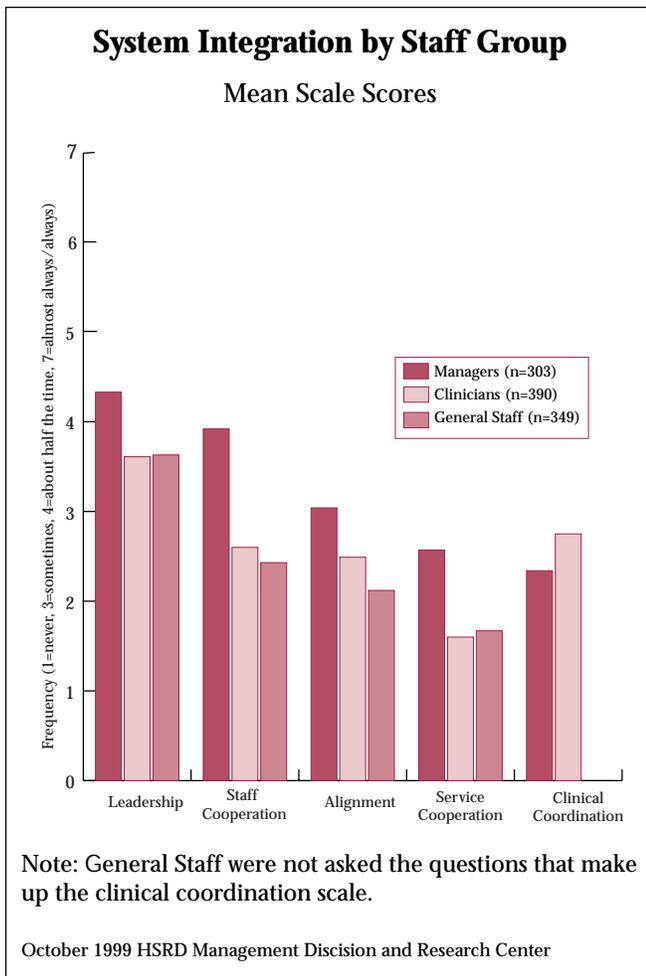
**Service cooperation:** Staff share problem solving, benchmark their performance, and coordinate administrative and support efforts across facilities.

**Alignment:** Facility leadership and priorities are aligned with network goals, yet local need and priorities do not get lost.

The graph shows Network 13 performance on these five scales from the perspective of managers, clinicians and general staff across the network. Comparable breakdowns were done for the five facilities and the seven service groupings. Higher scale scores indicate greater system integration. A score of 4.0 for example means that the average employee experiences the features described in that scale about half the time. Lower scores indicate that the features described in the scale definitions are rarely or never experienced.

The results of the survey can be used to inform a variety of decisions about system integration at the network level, the service-grouping level and the facility level. As examples of lessons that can be drawn from these results at the network level, we see that:

- **Leadership is the highest scoring scale (3.8).** The scale reflects both the extent to which network and facility leadership are clearly articulating the goals, objectives and strategic plans for the network, and the extent to which staff understand how their work furthers those goals. This scale seems appropriate as a possible leading indicator during this early phase of system integration since communicating the leadership’s vision and having it incorporated into staff work is an important starting point in changing an organization. At the same time, the score indicates that staff on average see the features in the scale occurring only about half the time, suggesting the need for continued efforts.



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## Service Lines—More Voices from the Field

Linda Pucci, MPH, Martin P. Charns, DBA

Over the Summer of 1999, the Service Line Project evaluation team conducted a third round of network and facility staff interviews. We heard how service lines are developing. In this issue, we share respondents' experiences, ideas, recommendations, and lessons learned in service line implementation.

### Changing Organizations

Large-scale organizational change is unsettling. Change brings a level of chaos and feelings of insecurity to those involved. Emotional reactions can overtake reason and blur perceptions. Old ideas fade away, replaced with new ways of relating within the organization. As one type of organizational change, implementing service lines involves these same feelings and forces. Service Lines shift the focus of the organization to its outputs (typically outputs are aligned with interventions, diseases, or segments of the population) instead of inputs like nursing service or social service that are inherent in traditional health care organizations. People and processes are turned upside down. One of the people we interviewed summed it up this way,

*“Implementing service lines is to disrupt people’s entire world view and work life. You cannot spend too much time with helping staff handle this.”*

Respondents related things common to all organizational change. They told us that change requires good working relationships with colleagues and a willingness to work out problems that would benefit patients. They emphasized planning as crucial. Staff involvement and communication are common themes.

*“The biggest challenge is the people, and if you can’t get a congenial process underway, you can’t make progress.”*

*“Communication is key, give as much information as possible. Be open to changes along the way and not be tied to a particular model.”*

*“The first victim of change is communication. [We] need greater effort at the level of middle management and the operational level.”*

*“[You] have to do a lot of talking, a lot of explaining. [You] need to take the threat out of the change process.”*

### Pace of Change

The pace of change is one aspect of the change process frequently mentioned. Although there was a slight difference of opinion, many of the interviewees felt that service lines transition ought to be slower than was mandated:

*“Plan it well—don’t rush into it. You need to tailor the model to the eccentricities of the facility.”*

*“We re-structured and implemented too rapidly. I would have spread change out over a couple of years. It [the pace] made many people uncomfortable and we lost good people.”*

*“We should have kept the task force together a little longer—or perhaps set up another group to go one layer deeper into the structure.”*

*“Give the VA staff time to put things in place—build the infrastructure—before communicating [the changes] to the Veterans.”*

*“Get a better appreciation of the needs and problems of all the care sites. Get to know the people there. Be sensitive to their needs. Find out what the real hang-ups are.”*

Some basic planning activities, such as job descriptions for the new service line managers, were often overlooked in the rapid transition, raising anxiety levels.

*“We did not change the job descriptions and this should be done early on. Job descriptions need to be in place before the service line is up and running.”*

*“We didn’t have key people in the best positions. Middle management was cut out.”*

*“It is difficult to pay attention to how people are impacted by the changes (SLs). We need to be better in assessing the toll of the change on personnel.”*

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### Stakeholders

The respondents indicated that more attention was essential to bringing stakeholders into the process. These people can make or break a new organization—Veterans Service Organizations and Unions often emerged as stakeholders.

*“Reach down in the organization and involve your stakeholders. Listen and understand what their concerns are.”*

*“Don’t forget the key stakeholders like the Veterans’ Service Organizations. Actively invoke input from all disciplines and all levels.”*

*“Invite labor in at the earliest possible moment. We made progress after labor began attending the ELC (Executive Leadership Council). Now we meet with the labor group before each ELC meeting.”*

*“Keep labor organizations involved in the process. They’ve slowed it down and I’m sure could have killed it entirely.”*

*“I would like to have labor issues resolved in a more timely fashion. This needs to be resolved at the national level.”*

*“We gave them [unions] the same information that we gave our senior management—the same amount and level as with any manager in the network. And they came to the same conclusion we did—that service lines served everyone’s best interests.”*

### Staff—a resource for change

Several of the people we interviewed stressed the need to make optimal use of internal skills, experience, and staff knowledge—educating them for the change.

*“Those who can best design a system are the people who are implementing it.”*

*“(We) need to keep significant contact with staff... Involve them in decisions as much as possible. They are important decision-makers. We need to establish and maintain more trust with staff.”*

*“Broaden the level of participation. We have gotten wonderful ideas from unexpected sources.”*

*“You have to educate the staff and alleviate their worries about the organizational structure and how it might change their duties.”*

Having established new roles and reporting relationships, respondents recognized measures that, at best, ought to have happened at an earlier stage. Suddenly, people thrown into managerial positions needed mentoring, administrative support and training while maintaining their professional identities. One respondent pointed out the need to:

*“Select care line managers, and particularly administrative assistants who have the appropriate managerial experience and knowledge.”*

Another, speaking about a primary care service line put it like this:

*“Given the environment in primary care, we could have been better at mentoring. We weren’t paying attention to the “canary in the coal mine” with regard to mollifying relationships with some staff.”*

### Supporting the new model

During our interviews, staff expressed great urgency for management training and support to help the new managers succeed. The respondents explained that information and data along with an appropriate infrastructure was a necessary decision-making resource for new managers.

*“Put time and money into educating people for new skills.”*

*“There was no additional administrative staff for our service lines when they were established. This put great strain on us. They (leadership) need to be more careful as they shift staff – try to place clerical staff and administrative support (staff) in the care lines.”*

*“We need to have better information systems to make it all possible.”*

*“The inadequacy of the databases makes it hard to move when things don’t keep up.”*

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*“Software was implemented that had not been tested. A horrible experience.”*

Some facilities established support systems addressing this necessity.

*“There is ongoing training on a monthly basis around working with the budget.”*

Many people openly expressed satisfaction that the change process was progressing as well as anticipated. Interviewees appeared exceptionally pleased with their improved involvement in clinical decisions, care practices, and above all, in staff hiring decisions. They spoke of increased patient satisfaction and their excitement about learning new things. Many were very philosophical about what they were going through and when asked what they would tell their colleagues said:

*“Never underestimate people’s capacity to learn. Set challenging expectations and coach people as needed so they can get there.”*

*“Get out there and find out what’s working.”*

*“The only way to gain control is to give up control. This is a difficult lesson for anyone who is a veteran of VA. I am convinced that if I said we needed to move the building 6 inches, within a week I would have a committee who would have figured out how to do it.”*

*“If you give people a chance to evolve it will work. You can’t dictate change.”*

*“You have a network of hospitals that need to work together—the magic of surviving today is the message that you can’t do it alone.” ■*

## The Integration Scorecard

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- **Service Cooperation is the lowest scoring scale (1.9).** On average, staff report that they only rarely see staff problem solving and benchmarking across facilities, or the coordination of administrative and support efforts. This appears to be an area that follows later in the integration process.
- **Managers tended to score higher on the system integration scales than clinicians or general staff** on all dimensions except clinical coordination. This indicates that managers see more evidence of integration than the other groups. On one hand, this is not surprising. Research has shown that in private-sector health care organizations, higher-level employees rate system integration higher than front-line employees. At the same time, it indicates that continued attention is needed to move integration efforts to front-line clinicians and general staff.
- As expected, **all dimensions show room for improvement.** The integration efforts in Network 13 are still in their early stages. The survey represents

a baseline measure for tracking system change. We would expect to see improvements over time.

Additional scale breakdowns by service groupings and facilities show leaders which ones have moved farthest and where additional efforts to promote integration might be most productive.

The Integration Survey currently provides Network 13 managers with a snapshot of their system integration. It gives them an overall indication of the extent to which the network is integrated, shows them which service lines and facilities are more integrated than others, and allows them to target the particular areas of integration highlighted by the scales. As Network 13 repeats the survey to measure the progress of integration over time, and as other networks also administer the Integration Survey to their staff, the survey data will increase in its usefulness. ■

*If you have questions about the Integration Scorecard please call Carol VanDeusen Lukas (700-839-5685) or Mark Meterko (700-839-4608) at the MDRC.*

## News You Can Use: A Potpourri of Recent Citations

Elaine C. Alligood, MLS

Here is a list of recent citations regarding patient satisfaction, integration, and service lines that we hope you will find useful. Check with your local VA Library Service for help in retrieving these articles if they are not immediately available.

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