Improving Behavioral Health Satisfaction Assessment: Measuring Patients' Perceptions

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Abstract: In order to focus on and improve key aspects of patient satisfaction in its behavioral health programs, Catholic Health East (CHE) enhanced its measurement methodology. In an effort to be consistent with the federal government's movement from measuring patient advocacy programs to measuring patients' perceptions, CHE transitioned to behavior-based questions. These questions give clear targets for program goals and initiatives by objectively measuring whether certain events and desired staff behaviors occurred during treatment, rather than subjectively ranking attributes of institution-defined service. Through this change in approach, CHE may better align its care and services with patients' wants and needs, as illustrated by four case examples.

Key Words
behavioral health
patient satisfaction
surveys

Catholic Health East (CHE) is a multi-institutional Catholic health system cosponsored by 15 religious congregations. Its facilities serve communities in 11 Eastern states, comprising 31 acute-care hospitals, 3 long-term acute-care hospitals, 45 freestanding and hospital-based long-term-care facilities, 5 continuing-care retirement communities, 19 home-health and hospice agencies, 7 behavioral health and rehabilitation facilities, and numerous ambulatory and community-based health services. With approximately 43,000 full-time employees, CHE is one of the nation's largest healthcare systems. Within its behavioral health programs, CHE surveys 17 inpatient and 22 outpatient psychiatric or chemical dependency programs. CHE behavioral health services include but are not limited to eating disorder treatment, partial-day programs, methadone treatment, art therapy, geropsychiatric services, and voluntary and involuntary psychiatric units.

As part of CHE's systemwide Values in Practice initiative—its commitment to living its values (Catholic Health East, 2002)—the Behavioral Health Quality Council convened a patient-satisfaction task force in February 2004 to research and discuss how to gain greater insight and better information from CHE's current patient survey. In June 2004 the task force recommended adopting a behavior-based approach to assessing, reporting, and acting upon improvement opportunities. Benefits to using a new survey instrument included

- accurately pinpointing opportunities for improvement by providing more targets with measurable results than were provided in CHE's existing tool
- measuring behaviors aligned with CHE's core values, quality of care, and patients' recommendations for CHE programs, in addition to capturing demographic data and optional narratives
- focusing on key dimensions of care consistent with the desires and needs of patients and their families
- improving the ability to identify opportunities for rewarding and recognizing staff
- positioning all CHE staff, regardless of service venue, to respond to the Centers for Medicare & Medicaid Services' preference for measuring patients' perception of care through the American Hospital Association's Hospital Consumer Assessment Health Plan Survey (HCAHPS) (Catholic Health East, 2004a).

CHE's task force, consisting of council members from four of CHE's individual behavioral health programs and CHE office staff, critically reviewed its existing survey (in use since October 2000) and revised its content to target improvement opportunities. In addition, the task force developed appropriate system- and program-level reports of findings, using a more robust methodology for calculating and presenting scores. Before implementing its new approach, the task force piloted its revised instrument in the four sites that had representatives on the task force in order to solicit feedback from management and frontline staff audiences, gain buy-in, and refine both the

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survey questions and the reporting protocol for use across all CHE behavioral-health patient populations, including inpatients, outpatients, general psychiatric patients, and those being treated for chemical dependency.

Adopting a New Philosophy

Consistent with CHE's intent to align desired behaviors with outcomes and to ensure that the new survey approach provide more targets with measurable results, the task force embraced Picker Institute research (n.d.) that emphasizes the need to answer four questions:

- What do patients want?
- What do patients value?
- What helps or hinders patients' ability to manage their health problems?
- What aspects of care are most important to patients and their families?

This research led the Picker Institute to identify the dimensions of care that are most important to patients and their family members and resulted in a unique approach that asks patients and family members to objectively report their experience with the care provided rather than simple satisfaction ratings.

Similar to approaches used by other external vendors (Agency for Healthcare Research and Quality, 2005), CHE's existing in-house survey instrument did not allow staff to easily identify targets for improvement. Measuring satisfaction from an institutional mindset that focused on hospitality-based attributes, the task force questioned whether it was collecting data most relevant to patients' needs and desires.

Although the survey instrument changed, the overall process of administering it did not. CHE's behavioral-health patient satisfaction is measured by its system office's in-house process. A single copyrighted survey is distributed quarterly by local practitioners to patients on-site, using an approved random sampling methodology that targets a 20% response rate or a minimum of 30 returned surveys per program (whichever is higher by service line) to ensure that findings are reliable and sufficient for statistical testing (Catholic Health East, 2004b). Individual sites subsequently transfer data from the completed surveys into a database developed by the system office. This local database is then forwarded to the system office, where it is entered into a comprehensive database for compilation, analysis, and report generation.

In the transition to the new instrument, the survey grew from one page with 14 questions to two pages with 19 questions (a copy of the new survey is available from Trenya Garner). The responses shifted from a subjective rating system (i.e., using a 5-point Likert scale of *poor* to *excellent*) to measure the extent to which a desired behavior occurred (**Figure 1**). Two of the 19 questions offer patients an opportunity to provide suggestions for changing the quality of service provided and to recommend staff members for reward and recognition. Demographic questions, which allow staff members to analyze the findings in light of the changing diverse populations served, gather information on date of service, gender, age, and type of service and include new questions asking for the patient's ethnic or racial background and name and telephone number; the survey also asks who completed the survey and whether the patient would like to be contacted by the staff.

The transition included a dramatic change in how findings are calculated and results are shared. Scores are now reported as the percentage of positive responses and reflect the percentage of patients who responded that a desired event or behavior occurred 100% of the time. Positive responses on the survey were

- Always
- Yes, definitely
- Yes, completely
- Excellent
- Very good
- Good.

Any other response is categorized as an opportunity for improvement or a less-than-optimal outcome or response (National Research Corporation, 2003). **Figure 2** shows an example of the new scoring methodology in which 60% of patients felt they would know how to react

Figure 1. Change in Question Type

Previous Survey	New Survey
How would you rate our ability to treat you with dignity and respect?	How often did staff treat you with courtesy and respect?
• Excellent • Very good • Good • Fair • Poor	• Never • Sometimes • Usually • Always

in the event of a crisis, and 40% of patients felt that caregivers were not providing them with complete vital information. This illustrates how staff may require additional education on relaying crisis information to patients, a useful target for quality improvement. Neutral responses to questions (e.g., "Did not express needs," "Chose no one to be involved") are removed from the denominator of the positive score equation because not all services are applicable to all persons.

The survey item regarding care received from treatment staff is modeled on one that appears on the HCAHPS and does not use a scoring methodology focused on positive responses. This item asks patients to rank the care they received from the treatment staff on a scale from 0 (*worst possible care*) to 10 (*best possible care*) and is the only question on the survey reported as a mean rating (Agency for Healthcare Research and Quality, 2005).

System- and program-level data findings are provided quarterly. The chi-square test is used to analyze statistically significant differences in scores at the 95% confidence interval. The system-level report is divided into three peer groups: general psychiatric inpatients, chemical dependency inpatients, and outpatients receiving all services. For each peer group, the system report consists of findings in two categories: how the overall quality was perceived ("rate the care you received") and whether the patient would "recommend [the facility] to family and friends" (see **Figure 3** for a sample of this report). Program-level reports provide much more robust information grouped into four thematic categories: care from treatment staff, patients' treatment and involvement in treatment plans, environment of care, and overall experience.

Additional points of reference on these reports include the program's previous score, the positive score percentage, the peer quarter score and statistical significance, the percentage of responses of *excellent*, and the percentage of responses of *probably yes*. Program-level reports also include positive scores for all attributes with program-specific key drivers of performance correlated to the question on overall quality for each thematic category. In addition, in order to promote local prioritization, questions are listed on a "Top 5 Key Drivers" report in program-specific descending order, according to the strength of the relationship to overall quality (**Figure 4**).

Figure 2. Example of New Scoring Methodology

Positive score equation = $\frac{\text{Number of positive responses}}{\text{Total number of responses}} \times 100$

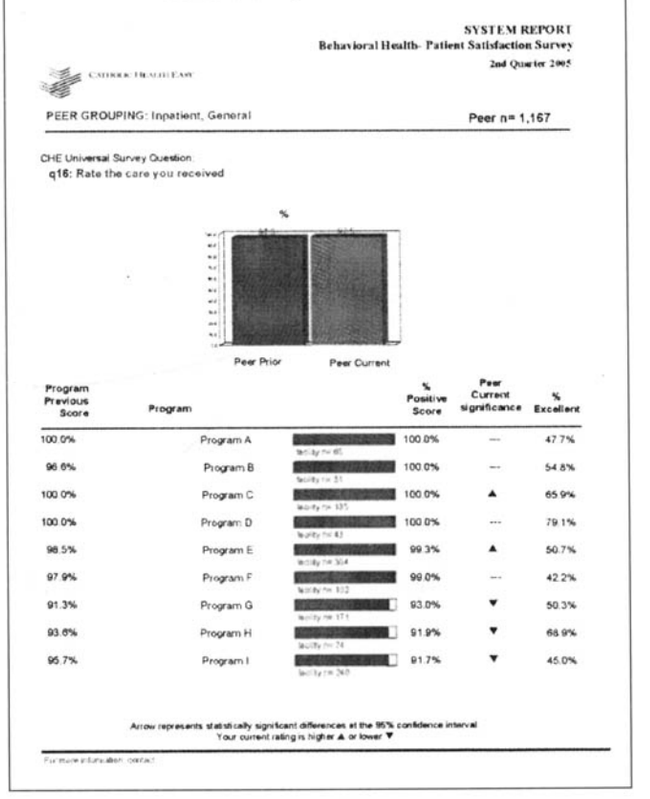
Survey Question: *Did staff tell you or those involved in your treatment what to do in case of a crisis?*

Distribution of scores for 10 respondents:

- 6 responses = *Yes, completely*
- 2 responses = *Yes, somewhat*
- 2 responses = *No*

***Positive score* = 60%.** Six out of 10 respondents answered *Yes, completely*, the only positive response. (6/10) x 100 = 60%

Figure 3. Patient Satisfaction Survey: General Inpatients


SYSTEM REPORT
Behavioral Health- Patient Satisfaction Survey
2nd Quarter 2005

PEER GROUPING: Inpatient, General — Peer n= 1,167

CHE Universal Survey Question
q16: Rate the care you received

%

Peer Prior | Peer Current

Program Previous Score	Program	% Positive Score	Peer Current significance	% Excellent
100.0%	Program A	100.0%	---	47.7%
96.6%	Program B	100.0%	---	54.8%
100.0%	Program C	100.0%	▲	65.9%
100.0%	Program D	100.0%	---	79.1%
98.5%	Program E	99.3%	▲	50.7%
97.9%	Program F	99.0%	---	42.2%
91.3%	Program G	93.0%	▼	50.3%
93.6%	Program H	91.9%	▼	68.9%
95.7%	Program I	91.7%	▼	45.0%

Arrow represents statistically significant differences at the 95% confidence interval
Your current rating is higher ▲ or lower ▼

Each CHE behavioral health program has embraced the importance of communicating patient-satisfaction findings as critical to continuous, focused improvement and a culture of service excellence. The following case examples illustrate how each program benefited from adopting the new survey approach, developed specific strategies to address identified opportunities, and created a mechanism for promoting change.

Figure 4. Top Five Key Drivers
(in Order of Highest Correlation to "Overall Care")

Program Previous Score		Question	% positive	Peer mean	Best Peer score
100.0%	q8	Staff help lessen physical pain	88.9%	76.2%	100.0%
80.0%	q12	Felt safe during treatment	95.0%	83.8%	100.0%
52.6%▲	q7	Enough say about treatment plan	90.0%	74.6%	97.5%
89.5%	q9	Staff explain purpose of any medicines	80.0%	83.8%	100.0%
57.9%	q17	Recommend to family and friends	75.0%	64.4%	87.2%

Case Study 1: Open Communication in Methadone Clinics

The communication process with staff and patients has been a key to success at three Catholic Health System (CHS) chemical-dependency outpatient units in Buffalo and Rochester, NY (CHS is a division within CHE). Program leaders incorporate real-time patient-satisfaction feedback into monthly committee meetings, focus groups, and direct conversations so that the information is shared with staff. Staff members use this information in weekly meetings with patients to acknowledge patients' concerns and provide status updates on progress made. The survey data show that this open communication model is very effective. The data show an upward trend in courtesy and respect; anecdotally, the clinical coordinator reported that patients perceive the information sharing as showing respect for them as partners in the treatment process.

Concurrent with both the transition to the new survey tool and CHS's commitment to practicing its values in its everyday relationships, key process-improvement changes related to patient satisfaction were made. With the standardization of survey delivery and distribution and with each program randomly sampling 30% of its patient population, the focus on communication continues; staff members receive booklets containing new standards of behavior and developing and implementing program-specific key words at key times (KWKT). KWKTs, or comfort words, ensure the alignment of staff actions and help patients, families, and visitors better understand staff behaviors (Catholic Health East, 2005). These include informing patients that their feedback is very helpful and that filling out the survey is time well spent. Further, staff members have committed to following up with every patient who desires to be contacted. Every patient comment is documented and presented to the staff in an effort to coach low performers and reward and recognize high performers.

These small changes to the patient-satisfaction survey process sparked CHS's chemical dependency services' initiative of redesigning their utilization review, quality improvement, and performance improvement processes (**Figure 5**). Championed by the assistant vice president of chemical dependency services, the department's goal is to help focus and streamline quality improvement efforts. Overall, program leaders feel that with information from the new survey and with the support of both CHE and CHS, they have been able to better allocate resources to achieve maximum results for patients.

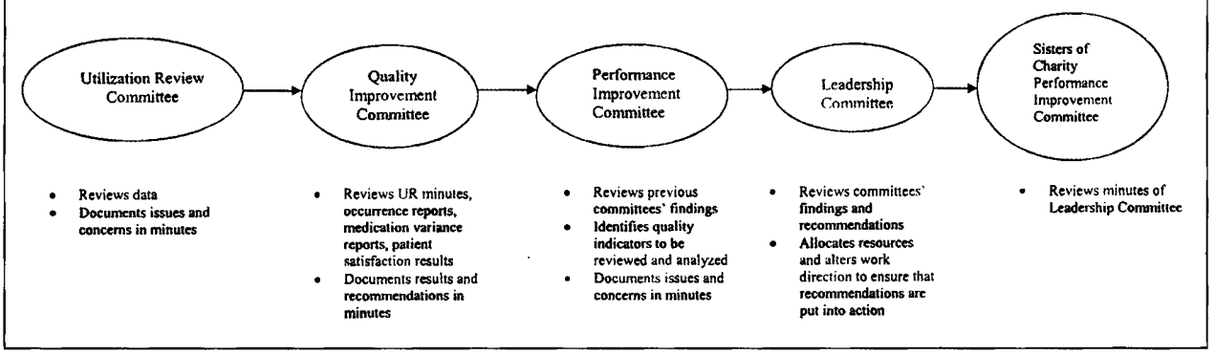
Case Study 2: Focus Efforts on Key Drivers

To improve scores at Providence Behavioral Health Hospital in Holyoke, MA, the performance improvement committee recommended that each program unit scoring below the CHE mean for overall quality focus on one of their key drivers to develop action plans for improvement. The adult psychiatric unit focused on the question "Did staff treat you with courtesy and respect?" which the facility's human rights officer also identified as an issue that ties directly to the core value of reverence for each person. As a result, sensitivity and cultural-diversity training is planned to help staff members develop improved communication skills for interacting with patients. The child and adolescent unit developed an action plan for crisis instructions, including

- completing a needs assessment with patients, families, and providers to identify ways to improve the discharge process
- planning discharges 48 hours in advance
- providing families with a discharge folder that includes the telephone numbers of crisis team members
- having clinicians available to help patients and families clarify questions and concerns they may have about the satisfaction survey.

Further, the drivers' alcohol education program developed an action plan focusing on the question "Did you feel safe during your

Figure 5. Catholic Health System Information Flow



treatment with us?" even though the scores have consistently been at 100%. Because of the gang population prevalent in this program, staff members constantly remind patients of the program's ground rules, such as "no cross-talking" and "agreeing to disagree," which are established up front and set the tone for future treatment. A strong message is repeatedly given throughout treatment on the importance of meeting treatment goals by being respectful. If rival gang members are patients in the program at the same time, all measures are taken to treat them in separate peer groups. Staff members and senior peers in the program also serve as role models of behaviors that demonstrate respect in order to rebuild the trust lost by some gang members early in life. This atmosphere allows all patients to feel safe, and the survey results allow staff to recognize when there is a need to strengthen, reinforce, or reevaluate its efforts.

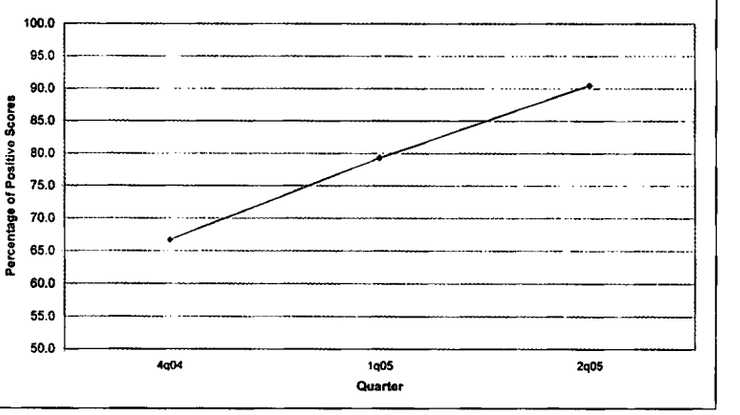
The facility realized time savings, more meaningful outcomes, and the ability to network with others as critical improvements resulting from the new process. Because CHE generates the reports, program staff members can focus on analyzing and acting upon the results, using the key-drivers report to further focus their efforts.

Case Study 3: Building on the Past to Realize the Future

The staff at St. Peter's Addiction Recovery Center (SPARC) in Albany, NY, found transitioning to a behavior-based patient satisfaction process to be relatively easy. A participant in CHE's patient-satisfaction initiative since its inception, the staff has refined its efforts over time. SPARC includes an 18-bed medically managed detox unit, a 40-bed inpatient rehabilitation unit, six outpatient treatment programs, and a men's community residence.

In 2004, because SPARC leaders wanted to improve their results, ambitious goals were set for several patient satisfaction attributes. In the fourth quarter of 2004, with the initial quarter results from the new survey, SPARC reassessed its previous goals and decided to focus on one major goal. Using the data, they identified "involvement of patients in their treatment plan" as an opportunity. To address this, the clinical care committee chartered a family involvement team in January 2005. Its primary responsibility is to examine the types of programs offered and increase family involvement in patient treatment. The team is also responsible for setting goals for the program and changing processes, as necessary. The data show that progress is being made (**Figure 6**). An increase in the number of family groups in which the patient and family receive treatment together is one of the program's major achievements.

Figure 6. SPARC Outpatient Program: "Enough Say About Treatment Plan"



Shifting to the behavior-based survey has provided results that SPARC leadership can use in a more focused approach to goal setting. Goals for 2006 include "increasing patient safety in the treatment facility" and "informing patients about their medications," with initiatives centering on achieving at least 90% *excellent* scores for safety and 80% *excellent* scores for information about medication.

Case Study 4: Committing to Excellence

The new survey's focus on overall quality has reinforced staff's commitment to caring and excellence at Mercy Hospital North Shore in Pittsburgh, PA. Shortly after a patient's admission, the clinical supervisor visits the patient to discuss and promote the facility's Excellence in Treatment and Satisfaction initiative. During this visit, patients are encouraged (in accordance with the program's goal of providing excellent service) to request to speak with a member of the management team anytime they believe their needs and issues are not being met. As a result, staff members have the opportunity to correct any issue immediately.

As part of the orientation process to the unit, each patient is given a patient handbook that includes a copy of the patient-satisfaction survey, an explanation of the process for completing it, and examples of what each question refers to in the treatment process. This information has also been incorporated into the morning community meetings to further emphasize the importance of quality and service.

Staff members' use of KWKTs further illustrates the importance of staff members behaving in a manner consistent with the organization's core values and providing excellent care by reinforcing the attributes measured by the survey tool. Throughout treatment, staff members ask patients, "Are you receiving excellent care?" and tell them, "Your responses assist staff in making any appropriate changes to the program as a result of your feedback."

Mercy's behavioral health quality improvement program incorporates the results of the surveys and comments into monthly meetings. Survey results are reviewed and discussed, and trends are charted. Both positive and negative comments are reviewed and addressed by the nurse manager, the manager of support services, and the chair of the department of psychiatry so that staff members identified as doing an exemplary job may be recognized and staff members whom patients perceived as not meeting their needs may be coached. Additionally, inpatient survey results are shared along the continuum of care with the Mercy behavioral health outpatient providers to show to staff and consumers the improvements realized in patient satisfaction and quality.

A New Focus, A New Energy

CHE's transition to a new survey instrument and reporting methodology was approached with enthusiasm and with a recognition of the importance of measuring what is most crucial. As with any change of this nature, successful implementation is dependent upon effectively communicating goals, objectives, and benefits and acknowledging the change's impact upon people.

Staff members have been reenergized by the transition because input from multiple key constituents was solicited, clearer expectations on key attributes of performance in a behavior-based approach were provided, and data offering opportunities for measurable improvement were made available. The staff has embraced the new instrument and become better equipped to make a difference in the lives of patients.

As CHE approaches its first anniversary of using the new tools, plans have been made to create subgroups focused upon systemwide top drivers of satisfaction most closely correlated to overall quality. These groups will be charged with developing model practices applicable across CHE behavioral health programs—reaffirming the commitment to learn from the data, listen to patients' voices, and capitalize on collective experiences.

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