ABSTRACT

During the past decade, the proliferation of managed care plans and the reduction of governmental reimbursement has seriously eroded hospital revenues.

As a result, hospitals are managing with less resources yet confronting more complex patient problems, particularly in the Emergency Department of the hospital.

Since the Emergency Department is frequently the major interface between the hospital and the community, it is essential that patients have a positive experience while obtaining care. This study explores the impact of a hospital-based volunteer program upon patient satisfaction within an Emergency Department and the implications for hospital administrators.

Patient Satisfaction Within an Emergency Department: The Impact of a Hospital Volunteer Program

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FACTORS INFLUENCING EMERGENCY DEPARTMENT TREATMENT

Frequently, the Emergency Department is the primary interface between the patient and the hospital. Decisions related to the need for emergency care, however, often circumvent the traditional physician-referral mechanisms and rely to a large extent upon self-referral. Wood and Cliff (1986) discovered that 42% of the patients in their survey did not consult with their private physicians based upon their perception of an immediate need for treatment and the potential absence of ancillary services in a private practice. In particular, patients who perceive a need for x-ray and laboratory procedures were less likely to consult with their private physicians.

Conversely, patient decisions related to the selection of one Emergency Department over another Emergency Department are significantly influenced by the proximity of care, physician affiliation, and previous satisfaction with care. While issues of access and physician affiliation strongly influence institutional selection, 35.3% of the patients in a study by McMillian, Younger, and DeWine (1985) cited previous satisfaction as a key consideration in the selection of an Emergency Department.

In a similar vein, Locker and Dunt (1978) contend that patient satisfaction also influences whether a person complies with a treatment and maintains a continuing relationship with a provider.

Patient satisfaction, however, may not necessarily be influenced by normative clinical and administrative criteria but rather by the extent to which the care conformed to the patient's expectation of care. Expectations are confirmed when a service is delivered as expected and disconfirmed when the service is less than expected. Frequently, it is the magnitude of the disconfirmation experience that results in satisfaction or dissatisfaction with a service or product (Churchill and Surpenant, 1982).

MANAGEMENT DILEMMAS IN THE PROVISION OF EMERGENCY SERVICES

Conflict is an inherent characteristic of emergency room operations. Clinical staff typically perceive their goals as the provision of sophisticated crisis-oriented services while patients often utilize emergency services as a substitute for a primary care visit (Katz, 1973). It is not surprising, therefore, that Smeltzer and Curtis (1986) in a random informal survey of eight hospitals reported waiting times ranging from

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one to four hours in duration with an average waiting time slightly above two hours.

In addition to lengthy waiting times, Lane and Evans identified impersonal attitudes of the emergency room staff and lack of information about patient status as key variables which affected satisfaction with service. Subsequent studies by McMillian, Younger, and DeWine (1986) suggest that communication provided to the patient and persons accompanying the patient is an often ignored dimension of care and may contribute to patient dissatisfaction.

IMPETUS FOR THE EMERGENCY ROOM VOLUNTEER PROGRAM

Statistics from the Emergency Department of Albert Einstein Medical Center in Philadelphia indicate that approximately 40,000 patients are treated on an annual basis. Usually, these patients are accompanied by two or three significant others which suggests that 120,000 to 160,000 individuals have direct contact with the department. Many of the patients receiving treatment are indigent individuals or recent immigrants who do not have a primary care physician. Consequently, the need for empathic and accurate communication between the clinical staff and patient is enhanced.

In order to address issues of communication involved in the delivery of emergency room services, a pilot program relying upon hospital and community volunteers was initiated in July of 1986. Essentially, the goals of the volunteer program focus upon increased communication between emergency room staff and patients (see Table I). Volunteers offer psychological support, interpret emergency room policies and procedures, and provide information on the process of care to patients and their families. In some cases, volunteers also assist with discharge functions for the patients.

Although the clinical staff and administration recognize the pivotal role performed by the volunteers, information related to the impact of volunteer activity upon patient satisfaction had not been evaluated. Since patient satisfaction is crucial not only to the preservation of a continuous relationship with a provider but also to the retention of a favorable image within the community for the department, further studies related to the impact of volunteer intervention upon patient satisfaction were initiated.

RESEARCH DESCRIPTION

In February, March, and April of 1988, a random telephone survey was conducted approximately one to two weeks after the patient visit to the Emergency Department. During this period, 75 patients were contacted and 66 patients completed interviews resulting in a response rate of 83%. Patient logs from the Volunteer Department were used to identify those patients in the experimental group who received volunteer services and a control group was developed utilizing emergency room logs which indicated the hours when the volunteers were not present.

Global satisfaction scores were adopted from the Larsen, Attkinson, and Hargreaves index which was designed to measure satisfaction within human service agencies (see Table II). Comparative health indices to measure patient satisfaction on a global basis are not as well represented in the health administration literature. In fact, few articles related to the quality of health services were published prior to 1960. Studies which were conducted emphasized structural measures which focused on the organization of the institution or process studies which validated the appropriateness of particular treatments in comparison to medical standards (Lebow, 1974). Partially, the absence of a global measure is due to institutional auspice and locus of service as well as the associated dilemma of measuring variations in medical practice patterns within the same environment (Lebow, 1974).

Although global measures are useful from a research perspective, their relevance is limited to the manager who may be interested in modification of specific attributes within the health delivery system. Typically, global measures amplify satisfaction with service while neglecting to measure the specific attributes which contributed to patient satisfaction. Consequently, intervention to rectify or expand specific facets of service is impeded (Locker and Dunt, 1978).

Recent studies have developed mea-

TABLE I

VOLUNTEER FUNCTIONS IN THE EMERGENCY DEPARTMENT

Administrative Functions

Provide explanation of waiting time to patients.
Explain the procedures in the Emergency Department to patients.
Escort patients to waiting areas or other hospital areas.
Provide periodic information about treatment to patients and family members.

Psychosocial Functions

Provide support to patients and families.
Initiate contact with family members or escorts.
Assist patients or families with refreshments or reading material.

Discharge Functions

Provide information about transportation.
Assist with transportation when requested by clinical staff.

TABLE II

GLOBAL SATISFACTION SCALE*

(1) To what extent did the Emergency Department meet your needs?

_____ Almost all of my needs have been met

_____ Most of my needs have been met

_____ Only a few of my needs have been met

_____ None of my needs have been met

(2) In an overall, general sense, how satisfied are you with the services you received?

_____ Very satisfied

_____ Mostly satisfied

_____ Indifferent or mildly satisfied

_____ Quite dissatisfied

(3) If you were to seek help again, would you come back to our emergency room?

_____ No, definitely not

_____ No, I don't think so

_____ Yes, I think so

_____ Yes, definitely

* Larsen, Attkinson and Hargreaves Index

sures to evaluate patient satisfaction in relation to specific attributes within the health delivery system. Many of these studies have focused on the clinical as well as the institutional variables which may potentially affect satisfaction (McMillian, Younger, and DeWine, 1986). Since institutional variables such as access and comprehensiveness of care are integral components of the Emergency Department experience, questions which assessed patient satisfaction with these variables as well as satisfaction with the quality of medical care were analyzed in the study (see Table III).

DISCUSSION OF RESULTS

Sixty-six surveys were evaluated in the study. Thirty-three interviews were obtained from individuals in the experimental group who received volunteer services, and thirty-three interviews were analyzed from participants in the control group. Initially, a t-test was conducted to measure differences in global satisfaction between the control and experimental groups.

Global satisfaction scores measured the extent to which the Emergency Department services met the patient's needs, patient satisfaction with the services which were provided, and the willingness of the patient to use Emergency Department services in the future. Significant differences in patient satisfaction between the experimental and control groups emerged ($t = 4.24$, $p < .05$) which suggests that volunteer intervention contributed to patient satisfaction as well as a tendency for patients to express a desire to use Emergency Department services in the future.

Further analysis to assess differences in patient satisfaction with the comprehensiveness, quality, and access to care was also conducted using a series of t-tests to measure differences in mean satisfaction

TABLE III

EMERGENCY SERVICE DELIVERY ATTRIBUTES

Sources of Satisfaction:
(Scale: 5 = high satisfaction; 1 = low satisfaction)

1. Access to Care:
   _____ signs posted to emergency room area
   _____ information requested upon arrival in emergency room
   _____ waiting time prior to treatment

2. Comprehensiveness of Care:
   _____ comfort of waiting area
   _____ cleanliness of waiting area
   _____ waiting time for x-ray, lab results, etc.
   _____ availability of facilities (bathrooms, cafeteria)

3. Quality of Care:
   _____ interest of medical staff and nursing staff in your condition
   _____ courtesy extended by clinical staff to you and family
   _____ explanation provided about treatment
   _____ quality of treatment which you received

scores between the two groups. Patients in the experimental group again demonstrated a higher level of satisfaction with the comprehensiveness of care provided by the institution ($t = 3.56$, $p < .05$). This finding is particularly interesting because these measures were designed to assess the patient's perception of the comfort and cleanliness of the waiting area, waiting time for ancillary services, and the availability of support services. Invariably, the communication provided by the volunteer appears to mitigate delays intrinsic in the provision of ancillary and support services and to minimize inconveniences which are inherent in most waiting areas of Emergency Departments of urban institutions.

Statistical differences related to the quality of health services delivered by the clinical staff also emerged between the control and experimental groups ($t = 5.66$, $p < .05$). Individuals in the experimental group expressed a higher level of satisfaction with the courtesy and interest of the medical staff and appeared more content with the explanations of treatment which they received from the medical staff.

Conversely, volunteers had virtually no impact upon patient satisfaction with access to health services. Patients in the control and experimental group expressed dissatisfaction with prolonged waiting periods for treatment in the Emergency Department. Although the mean satisfaction score for the experimental group (2.75) was slightly higher than that of the control group (2.5), this finding was not significant at the .05 level ($t = 1.25$) and indicates no difference in satisfaction between the two groups.

IMPLICATIONS FOR HEALTH MANAGERS

Due to the nature of emergency medicine, administrators may not be able to alleviate problems associated with extended waiting times. In most cases, those patients with critical symptoms will receive immediate treatment while those with less severe complaints will have to wait for care despite the best intentions of management. Since administrators may not be able to consistently influence this dimension of care, it is crucial that other components of the emergency room experience contribute to a satisfactory experience for the patient.

Patients continue to use services which meet their expectations, and they also tend to share their impressions about particular services with others in the community. Studies by Diener and Greysen (1978) confirmed that at least 34% of those dissatisfied with a product will communicate this information to other individuals. Consequently, administrators must be cognizant of the ultimate impact of patient satisfaction upon future referrals and image in the community.

In an era of declining revenues and professional shortages in hospitals, volunteer involvement can be instrumental to the preservation of patient satisfaction within an Emergency Department. Volunteers can not perform functions which are obviously within the domain of the health care professional. They can, however, document incidents which require further investigation or alert administrators to problems in service delivery. More importantly, they can humanize the health care system for the patient by interpreting the bureaucratic structure of the hospital or by offering psychological support during a crisis, functions which to a large extent enhance the satisfaction of a patient in the emergency room and contribute to a positive image for the hospital within the community.

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