THE COMMONWEALTH FUND

Case Study

*High-Performing Health Care Organization* • December 2008

# Munson Medical Center: Constant Focus on Patient Satisfaction

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Commonwealth Fund pub. 1208

## Vital Signs

*Location:* Traverse City, Mich.

*Type:* Regional referral center; a member of Munson Healthcare, a nonprofit health care system. The largest hospital in northern Michigan, it serves patients in 24 primarily rural counties.

*Beds:* 391

*Distinction:* Top 5 percent of more than 700 large hospitals (300+ beds) in the portion of patients who gave a rating of 9 or 10 out of 10 when asked how they rate the hospital overall. Timeframe: October 2006 through June 2007. To be included, hospitals must have reported at least 300 surveys. See the Appendix for full methodology.

This case study describes the strategies and factors that appear to contribute to high patient satisfaction at Munson Medical Center. It is based on information obtained from interviews with key hospital personnel and materials provided by the hospital during July 2008.

## SUMMARY

By focusing on patient satisfaction and engaging frontline staff in improving care, Munson Medical Center has become one of the better large hospitals in the United States in terms of overall patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The following strategies and factors likely contribute to Munson's success:

- maintaining high nurse-to-patient ratios;
- fostering strong nurse–patient relationships;
- adopting acuity-adaptable care;
- identifying and responding to patients' individual needs; and
- tying managers' incentives to patient satisfaction.

## ORGANIZATION

Munson Medical Center is a 391-bed, nonprofit hospital in Traverse City, in a rural region in Michigan. The largest hospital in northern Michigan, it is the regional referral center for the northern part of Michigan's Lower Peninsula and the eastern part of the Upper Peninsula, serving residents in 24 counties. Tertiary care services include neurosurgery, trauma, neonatal ICU, and others. Munson also has a family practice residency and is a training site for five nursing schools. In addition to its main campus, Munson provides local specialty clinics in several communities throughout the area. It is a member of Munson Healthcare, a nonprofit health care system.

Munson has been tracking patients' satisfaction with their care through Press Ganey surveys for more than 10 years. It also closely monitors its HCAHPS results, particularly since the Centers for Medicare and Medicaid Services (CMS) began collecting these data.

James Fischer, M.S., M.B.A., R.N., vice president for patient services and chief nursing officer, says that Munson aims for every hospital unit to be in the top 10 percent nationwide in terms of patient satisfaction, as measured by Press Ganey and HCAHPS. The organization also aims to be in the top decile on CMS core measures of care processes, as well as in employee engagement as measured by a Press Ganey survey that Munson began using in the spring of 2007.

The hospital's senior management council and Board of Directors review patient satisfaction scores on a monthly basis. Munson has been intermittently in the top decile for the past decade, but there was some slippage several years ago that prompted the hospital to take action before scores eroded further. "For units not in the top decile, we establish incremental goals," Fischer says. "For units already there, we want them to stay there."

## STRATEGIES FOR SUCCESS

The following strategies and factors appear to contribute to patients' satisfaction with their care at Munson Medical Center.

### High Nurse-to-Patient Ratios and Shared Governance

Munson administrators regard having relatively high nurse-to-patient ratios as fundamental for ensuring patient satisfaction and good health outcomes.[1] "If nurses are spread too thin," says Fischer, "they won't be able to meet patient needs or establish relationships with patients and families." Recommendations for minimum nurse-to-patient ratios vary considerably, from one nurse per 10 patients (recommended by hospital associations) to one nurse per three patients (recommended by nurses' associations).[2] California, the only state to mandate nurse-to-patient ratios, requires minimum ratios of 1:5 in medical/surgical units, 1:2 in critical care units and ICUs, and 1:3 in step-down units.

Munson's nurse-to-patient ratios meet or surpass California's standards, and are maintained even though the state of Michigan does not mandate minimum nurse-to-patient ratios. They are:

- Medical/Surgical units – 1:4 during days and 1:4 or 1:5 during nights.
- Critical care units – 1:1 or 1:2.
- Step-down unit – 1:3.

Munson also practices "shared governance," whereby staff nurses participate in hospital decision-making and policymaking. Under this model, nurses are given greater authority and responsibility for patient care as well as greater control over their professional practices.[3] Fischer feeds ideas to nurses on ways to improve patient care from conferences, reports, and professional literature. Nurses then choose strategies and develop or adapt them for their units.

## Relationship-Based Care

Munson is in the process of implementing "relationship-based care," a model of care that emphasizes the importance of collaborative relationships.[4] It is focusing on strengthening three types of relationships:

- between care providers and their patients and families;
- among care providers; and
- between care providers and themselves (i.e., taking care of oneself).

Most important in terms of patient satisfaction, Munson works to build good relationships between providers—particularly nurses—and patients and families. A three-day workshop focuses on the three types of relationships. Though attendance is not mandatory, staff are strongly encouraged to attend and allocated time to do so. Staff are shown techniques for demonstrating their respect for patients; instead of prescribing ways to speak with patients, the teaching method relies on role-playing and education. Other training occurs at the unit level, at which a cross-section of staff meet regularly to develop plans to strengthen relationships on their units.

Further, a few simple procedures and tools help to build nurse–patient relationships. At the beginning of every shift, nurses spend three to five minutes at bedsides to establish rapport with patients, discuss the goals for the day (e.g., get out of bed two times and walk independently to the end of the hall), and elicit their priorities and concerns. Each room includes a dry-erase board on which nurses write their names, the names of the nurse assistants, goals for the day, and any special considerations. This serves as a visual reminder to patients of who is caring for them and how to contact someone if they need assistance.

Munson is also piloting a shift-to-shift bedside report. When nurses finish their shift, they give verbal reports to incoming nurses in front of patients and their families. The new nurse is introduced, patient goals and progress are reviewed, and the incoming nurse establishes or renews a connection with the patient and family. According to Fischer, patients and their families have said that they appreciate this process.

Munson uses initiatives such as an internal recognition system to promote staff morale. It is also encouraging staff to take care of themselves in order to provide good care to patients. Some units have relaxation rooms with massage recliners and soothing music to rejuvenate nurses, aides, therapists, and other staff.

## Acuity-Adaptable Care

Three years ago, Munson's Heart Center implemented on two floors the "acuity-adaptable" care delivery model, whereby a patient stays in the same room from admission through discharge. By eliminating most patient transfers, the model is intended to reduce medical errors, falls, missed treatments, and lost belongings and to improve staff and patient satisfaction, clinical outcomes, and efficiency. Staff members adjust the level of care as patients' needs change, providing critical care, step-down care, and/or regular care in specially designed "universal rooms." While this model entails cross-training of nurses to accommodate a range of acuity levels and a substantial investment in

### Munson's Acuity-Adaptable Care Room Design

Munson's Heart Center was built according to the acuity-adaptable care model in 2007. All of the rooms are private and have three zones to accommodate the needs of patients, families, and caregivers:

*The patient zone* is designed to be comfortable and soothing, and to enhance patients' privacy and dignity.
*The caregiver zone* includes workspace and storage for supplies.
*The family zone* incorporates sleeping accommodations, storage, a television, a desk, and internet access, enabling a family member or support person to stay with patients 24 hours a day. Studies show that family participation in care leads to better health outcomes.

Source: Positioning Munson as Michigan's Premier Heart Center, Munson Healthcare, p. A2. http://www.munsonhealthcare.org/munson/physicians/physicians_practice/pp_may_08.pdf.

equipment, it has been shown to enhance efficiency.[5] Hospital administrators are conducting a cost analysis of the model at Munson. The investment was about $3.8 million per unit. So far, patient satisfaction scores on the two units serving cardiac patients with universal rooms average 99 percent in the Press Ganey survey, as benchmarked against peer hospitals.

Private rooms are a key feature of the acuity-adaptable model and, according to Fischer, an important way to enhance patient satisfaction. Though the majority of Munson's rooms are semi-private (two patients), it has created 80 private rooms, each with a patient zone, caregiver zone, and a family zone (see text box). As Munson grows to meet demand (based on its increasing population base and referrals to the hospital), it hopes to increase the number of private, acuity-adaptable rooms.

### Identifying and Meeting Patient Needs

Munson has established protocols for inquiring about and responding to patients' individual needs and preferences. For example, an initial report sheet, completed upon admission, asks basic questions about how patients want to be referred to and their treatment preferences and priorities. Maternity unit nurses are encouraged to write personalized notes wishing new mothers success a week after their discharge.

Also, Munson is piloting in its general medical unit and stroke unit a "Quiet Time" from 2 p.m. to 4 p.m. every day, during which lights are dimmed and noises kept to a minimum. The goal is to promote rest by reducing the constant "hustle and bustle" of hospital stays—a simple modification that has been well received by patients and their families.

### Ongoing Measurement and Incentives

Munson's Board of Directors, senior management, and the rest of the management team receive monthly reports on Press Ganey surveys. Each month, the prior month's patient satisfaction scores and other performance indicators are reviewed on a unit-by-unit basis by administrators and frontline staff, and improvements or declines are investigated. Each hospital unit in turn creates a plan and goals for improving its scores. Unit managers have financial incentives to improve: about 20 percent of their annual bonus, which is an additional 7.5 percent of salary, is tied to meeting these goals.[6]

## RESULTS

Munson has just begun to focus on HCAHPS scores. Based on surveys from 2007, Munson performs better than the national average in nine of 10 domains of care (Table, page 5). Nevertheless, leaders acknowledge there is room for improvement, including opportunities to increase patient throughput and reduce waiting times in the outpatient area. They also believe that providing relationship-based care will help improve their scores by enabling them to meet the emotional needs of patients and families, communicate effectively, and show compassion and understanding about the inconveniences of hospitalization.

## LESSONS LEARNED

Munson leadership has learned some important lessons in its drive to improve patient satisfaction. Fischer stresses the following:

- always keep a focus on patient satisfaction;
- engage frontline staff in the process of improvement;
- measure, monitor, and give staff feedback on patient satisfaction on a frequent (e.g., monthly) and ongoing basis;
- share patient satisfaction scores and plans for improvement among administrators, managers, and staff; and
- maximize use and creation of private patient rooms.

## FOR MORE INFORMATION

For more information about Munson Medical Center, contact James Fischer, vice president, Patient Care Services, Munson Medical Center, jfischer@mhc.net.

Also see http://www.munsonhealthcare.org/locations/Munson/Munson.php/

## NOTES

[1] A review of nurse staffing literature and data for the Agency for Healthcare Research and Quality found that increased nurse staffing in hospitals is associated with lower hospital mortality and adverse events, and improved outcomes; it is also associated with improved patient safety in ICUs and for surgical patients (*Nurse Staffing and Quality of Patient Care*, prepared by Minnesota Evidence-based Practice Center, for Agency for Healthcare Research and Quality, AHRQ Publication No. 07-E005). Also see: J. Needleman, P. I. Buerhaus, M. Stewart et al., "Nurse Staffing in Hospitals: Is There a Business Case for Quality?" *Health Affairs,* Jan./Feb. 2006 25(1):204–11.

[2] Nurse-to-Patient Ratios: Research and Reality, NEPPC, Conference Report Series No. 05-1, July 2005. http://www.bos.frb.org/economic/neppc/conreports/2005/conreport051.pdf.

[3] For more information about the shared governance model, see: R. G. Hess, "From Bedside to Boardroom–Nursing Shared Governance," *Online Journal of Issues in Nursing,* Jan. 31, 2004 9(1):2; and M. K. Anthony, "Shared Governance Models: The Theory, Practice, and Evidence," *Online Journal of Issues in Nursing,* Jan. 31, 2004 9(1):7.

[4] For more information about relationship-based care, see M. Koloroutis, *Relationship Based Care,* Minneapolis: Creative Health Care Management, 2004.

[5] For more information about the acuity-adaptable care delivery model, see: K. K. Brown and D. Gallant, "Impacting Patient Outcomes Through Design: Acuity Adaptable Care/Universal Room Design," *Critical Care Nursing Quarterly,* Oct.-Dec. 2006 29(4):326–41; A. L. Hendrich, J. Fay, and A. K. Sorrells, "Effects of Acuity-Adaptable Rooms on Flow of Patients and Delivery of Care," *American Journal of Critical Care,* Jan. 2004 13(1):35–45; and Innovation Profile: *Acuity-Adaptable Inpatient Rooms Eliminate Most Patient Transfers, Leading to Enhanced Safety, Satisfaction, and Efficiency*, Health Care Innovations Exchange, Agency for Healthcare Research and Quality.

[6] Both hospital-wide and unit-specific factors are tied to annual bonuses. The major hospital-wide categories are positive work environment (employee engagement), quality (CMS core measures), customer perspective (patient satisfaction), financial performance, and growth (increases in volume). Examples of unit-based initiatives are decreasing the incidence of skin breakdown in a given area, implementing an electronic documentation system, or leading an organizational diabetes initiative.

**Table. Munson Medical Center HCAHPS Scores Compared with National Average, CY 2007**

| Percent of patients who reported that: | Munson | National Average |
|---|---|---|
| Their nurses "always" communicated well. | 79% | 74% |
| Their doctors "always" communicated well. | 81% | 80% |
| They "always" received help as soon as they wanted. | 72% | 63% |
| Their pain was "always" well controlled. | 70% | 68% |
| Staff "always" explained medicines before giving to them. | 61% | 59% |
| Their room and bathroom were "always" clean. | 71% | 70% |
| The area around their room was "always" quiet at night. | 45% | 56% |
| Yes, they were given information about what to do during their recovery at home. | 85% | 80% |
| Gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest). | 76% | 64% |
| Yes, they would definitely recommend the hospital. | 83% | 68% |

Source: Hospital Compare, 2008 (www.hospitalcompare.hhs.gov), based on surveys from patients with overnight hospital stays from January through December 2007.

## APPENDIX. SELECTION METHODOLOGY

Selection of hospitals for inclusion in this case study series is based on data voluntarily submitted by hospitals to the Centers for Medicare and Medicaid Services (CMS). Between October 2006 and June 2007, hospitals or their survey vendors sent a survey to a random sample of recently discharged patients, asking about aspects of their hospital experience. The survey instrument, called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), was developed with funding from the Agency for Healthcare Research and Quality. CMS posts the data on the Hospital Compare Web site (www.hospitalcompare.hhs.gov).

The survey contains several questions about nurse and physician communication, the physical environment, pain management, and whether the patient would recommend the hospital to family or friends. One question inquires about the patient's overall experience: "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?"

HCAHPS is a relatively new survey, and hospitals across the country are not yet achieving very high scores across all of the questions. Nevertheless, some hospitals are scoring significantly better than others. By profiling hospitals that score within the top 5 percent (among those that submitted at least 300 surveys) on the question concerning overall experience, this case study series attempts to present factors and strategies that might contribute to and/or improve patient satisfaction.

An initial list of top scorers among all hospitals submitting HCAHPS data contained a disproportionate number of very small, southern hospitals.[1] Concerned about the ability to generalize experiences and lessons and replicate strategies, we profiled one hospital from this list but chose to then examine high scorers among larger hospitals that were more diverse in region of the country, urban/suburban/rural setting, and teaching/nonteaching status. We thought that such diversity would provide lessons that would be useful to a broader range of U.S. hospitals.

Therefore, for this case study series, most hospitals were selected from among 736 large hospitals (300 or more beds) primarily based on their ranking in the percentage of survey respondents giving a 9 or 10 rating on the "overall" HCAHPS question. In the future, we will present case studies of hospitals of different sizes, ownership (e.g., public, private), and other peer groupings.

While high HCAHPS ranking was the primary criteria for selection in this series, the hospitals also had to meet the following criteria: ranked within the top half of hospitals in the U.S. on a composite of Health Quality Alliance process of care measures as reported to CMS; full accreditation by the Joint Commission; not an outlier in heart attack and/or heart failure mortality; no major recent violations or sanctions; and geographic diversity.

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1 Further examination and analysis may reveal reasons for this.

## About the Author

Sharon Silow-Carroll, M.B.A., M.S.W., is a health policy analyst with nearly 20 years of experience in health care research. She has specialized in health system reforms at the local, state, and national levels; strategies by hospitals to improve quality and patient-centered care; public–private partnerships to improve the performance of the health care system; and efforts to meet the needs of underserved populations. Prior to joining Health Management Associates as a principal, she was senior vice president at the Economic and Social Research Institute, where she directed and conducted research studies and authored numerous reports and articles on a range of health care issues.

## Acknowledgments

We wish to thank James Fischer, vice president, Patient Care Services, of Munson Medical Center for generously providing his time and sharing information, materials, and perspective.

*Editorial support was provided by Martha Hostetter.*

This study was based on publicly available information and self-reported data provided by the case study institution(s). The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund's case studies series is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund–sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.