
Patient Satisfaction: Focusing on “Excellent”

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EXECUTIVE SUMMARY

In an emerging competitive market such as healthcare, managers should focus on achieving excellent ratings to distinguish their organization from others. When it comes to customer loyalty, “excellent” has a different meaning. Customers who are merely satisfied often do not come back. The purpose of this study was to find out what influences adult patients to rate their overall experience as “excellent.” The study used patient satisfaction data collected from one major academic hospital and four community hospitals.

After conducting a multiple logistic regression analysis, certain attributes were shown to be more likely than others to influence patients to rate their experiences as excellent. The study revealed that staff care is the most influential attribute, followed by nursing care. These two attributes are distinctively stronger drivers of overall satisfaction than are the other attributes studied (i.e., physician care, admission process, room, and food). Staff care and nursing care are under the control of healthcare managers. If improvements are needed, they can be accomplished through training programs such as total quality management or continuous quality improvement, through which staff employees and nurses learn to be sensitive to patients’ needs. Satisfying patients’ needs is the first step toward having loyal patients, so hospitals that strive to ensure their patients are completely satisfied are more likely to prosper.

For more information on the concepts in this article, please contact Dr. Otani at otanik@ipfw.edu. This study has been approved by the Institutional Review Board at Purdue University, Ref. #0710005884.

Most patient satisfaction studies use a Likert-type scale, with 5 indicating "excellent," 4 "very good," 3 "good," 2 "fair," and 1 "poor." This type of scale is often assumed to be an equal-interval scale, where "excellent" is one unit better than "very good," "very good" is one unit better than "good," and so forth. Many managers may think a "very good" rating is good enough. They may think the cost of improving the rating to "excellent" is too high. They may also think it is more cost effective to focus on unsatisfied patients. However, when it comes to customer loyalty, "excellent" has a different meaning from the other rating categories. Customers who are merely satisfied often do not come back (Jones and Sasser 1995; Stewart 1997; Carr 1999). In an emerging competitive market such as healthcare, managers should focus on achieving excellent ratings to distinguish their organization from others. The long-term survival of hospitals depends on loyal patients who come back or recommend the hospital to others.

Only patients who mark "excellent" are loyal patients and will support the long-term survival of the hospitals. Patients who are merely satisfied will move to another provider when they have an opportunity (Jones and Sasser 1995). Even though the cost of switching hospitals is quite high, patients have more choices now than they did in previous eras. Many patients are better educated and have access to more information via the Internet. The increasingly competitive nature of the healthcare market makes it more important than ever for healthcare organizations to focus on "excellent" patient satisfaction ratings.

Few studies specifically investigate "excellent" ratings in healthcare, despite the fact that there have been many patient satisfaction studies. First-generation patient satisfaction studies were aimed at identifying the demographic variables associated with patient satisfaction (Dansky and Brannon 1996). They analyzed patients' demographic backgrounds—such as age, gender, race, and education—and found correlations between these variables and patient satisfaction. Conflicting findings regarding these relationships have been observed, however. In addition, these variables are not modifiable, so healthcare managers could not use the findings to improve patient satisfaction. The next generation of studies focused on multidimensional constructs of patient satisfaction (Ware, Davies-Avery, and Stewart 1978; Ware, Snyder, and Wright 1976). They identified significant healthcare attributes related to overall patient satisfaction, including accessibility, availability of resources, continuity of care, efficacy of care, finances, humaneness, information giving or gathering, pleasantness of surroundings, and competence of providers. Subsequent studies used this multidimensional perspective and found that some healthcare attributes were stronger than others in increasing patient satisfaction. Thus, the authors of the studies argued that to increase overall patient satisfaction, healthcare providers should focus on improving the attributes that showed a strong rather than a weak influence.

Other researchers focused on measurement tools and used sophisticated statistical analyses to investigate the validity and reliability of patient satis-

faction questionnaires. These studies analyzed widely used Consumer Assessment of Health Plans (CAHPS®) data sets and confirmed their validity and reliability. However, because patients who completed the survey had not been randomly assigned to health plans or providers, study authors claimed that it was not reasonable to compare satisfaction levels across healthcare plans or providers without adjustment on patients' case mix (Marshall et al. 2001; Zaslavsky et al. 2000).

Recently, a new group of patient satisfaction studies has emerged. These studies combined psychological theories and quantitative models in patient satisfaction studies and found that patients do not simply average out their attribute reactions with weights to form their overall satisfaction. Rather, they are disproportionately influenced by a weaker attribute reaction (Otani et al. 2003; Otani, Harris, and Tierney 2003; Otani and Kurz 2004; Otani and Harris 2004; Otani, Kurz, and Harris 2005). Findings from these studies would allow healthcare managers to increase patients' satisfaction levels efficiently by identifying the specific attributes on which they should focus. However, simply increasing patient satisfaction levels is not the same as having patients mark "excellent."

Of course, one of the reasons for conducting patient satisfaction studies is that satisfied patients will likely come back (Ford, Bach, and Fottler 1997). However, there are other important reasons. First, satisfied patients tend to comply with prescribed medical treatments (Ford, Bach, and Fottler 1997; Eisenberg 1997; Williams 1994).

Because of the increase of chronic diseases, patients must adhere to the treatment regimen prescribed. Second, satisfied patients are less likely to "doctor shop" and will instead stay with the same provider (Ford, Bach, and Fottler 1997; Eisenberg 1997). When a patient changes physicians, he or she may be required to retake tests, which increases the patient's costs and may hurt the patient.

Third, patient satisfaction is now considered a key part of the healthcare quality improvement initiative (Nelson and Niederberger 1990; Shortell and Kaluzny 2000). While healthcare quality was once evaluated only by professionals, patient satisfaction (along with mortality, morbidity, and other factors) is now part of the healthcare outcomes dimension. Even though patient satisfaction is a subjective judgment, it is nonetheless a critical component in healthcare outcomes. Fourth, many managed care organizations use patient satisfaction data to determine reimbursement rates to healthcare providers, and many leading companies will not contract with health plans that do not require a patient satisfaction survey. Providers with positive patient satisfaction survey results may receive more financial incentives than providers with poor patient satisfaction survey results (Kongstvedt 2001).

METHODOLOGY

Data Collection

Data sets used in the study were provided by BJC HealthCare, a regional, integrated healthcare delivery system serving the St. Louis metropolitan area

as well as mid-Missouri and southern Illinois. Thirteen hospitals comprise the system, and five of these hospitals were included in this study. The eight excluded hospitals are different in size and location and do not maintain patients' demographic data for analysis. The Children's Hospital is a pediatric hospital and was excluded because most patients are younger than 20 years. The five hospitals included were one major academic hospital and four large community hospitals.

This study utilized a telephone-based survey of discharged patients. A national telephone survey company that specializes in patient satisfaction measurement conducted all interviews. For each hospital, the company drew a stratified random sample of patients from all candidate units. Patients were initially contacted 7 to 14 days post-discharge, and they were contacted until final disposition (e.g., completion, refusal, unable to reach) over the course of two weeks. Participants in the study ($n = 14,432$) were 20 years or older and were discharged from one of the five hospitals between January 2005 and November 2007. The response rate for the study period among the sample was 37 percent. Responders and nonresponders were compared regarding gender and age. No significant difference was found between the rates of male and female responders. Responders were older by 4.07 years than nonresponders, and it was statistically significant at $\alpha = 0.05$. However, this statistical difference may be partly the result of the large sample size.

Variables and Analysis

The survey collected information about the patients' ratings of their care. The

dependent variable was computed as a mean of three items: (1) Overall, how would you rate the quality of care and services received during this hospital stay? (2) How would you rate your willingness to recommend this hospital to family and friends? (3) How would you rate your willingness to return to this hospital? The answer choices for each item were "excellent," "very good," "good," "fair," and "poor." The coding in this survey was as follows: "excellent" = 5, "very good" = 4, "good" = 3, "fair" = 2, and "poor" = 1. After obtaining the mean score of the three items for each patient, the score of 5 was re-coded as 1 and all other scores were re-coded as 0. Thus, only cases where patients marked "excellent" on all three items were re-coded as 1.

The independent variables describe six attribute reactions to care: admission process, nursing care, physician care, staff care, food, and room. Each of the six construct variables included multiple questionnaire items in the survey that measured the same construct variable with the five-point, Likert-type scale. The reliability and validity of the survey instrument were evaluated and found to be quite strong in numerous studies that used a combination of principal component analysis, confirmatory factor analysis, and structural equation analysis (Burroughs et al. 1999; 2001). For each of the six independent variables, a composite index was created as the arithmetic mean of all items measuring the attribute. The descriptions, numbers of respondents, mean scores, and standard deviations of the items are shown in Table 1. The Cronbach's coefficient alpha was estimated to test the internal consistency of the items for each

TABLE 1
Descriptive Statistics of Survey Items and Composite Indexes

	N	Mean	S.D.	Description
<i>Admission Process</i>				
1	13,930	4.08	1.01	Promptness and efficiency of the admission or registration
2	13,990	4.27	.87	Courtesy and helpfulness at admission or registration
C.I.	14,169	4.17	.87	Composite index: Cronbach's $\alpha = .8165$
<i>Nursing Care</i>				
3	14,024	3.98	1.12	Responsiveness of the nurses when you called
4	13,831	4.23	.98	Helpfulness of the nurses to reduce or eliminate any pain
5	14,365	4.21	.97	Nurses' ability to communicate with you
6	14,271	4.16	.99	Nurses' ability to provide adequate instructions or explanations of your treatment or tests
C.I.	14,425	4.14	.90	Composite index: Cronbach's $\alpha = .9098$
<i>Physician Care</i>				
7	13,948	4.17	1.02	Availability of your doctor when needed
8	14,314	4.31	.94	Doctor's ability to communicate with you
9	14,279	4.30	.93	Doctor's ability to provide adequate instructions or explanations of your treatment or tests
10	14,174	4.31	.93	Doctor's involvement of you in decisions about your care
C.I.	14,409	4.26	.87	Composite index: Cronbach's $\alpha = .9284$
<i>Staff Care</i>				
11	14,239	4.19	.95	Staff's willingness to help if you had a question or concern
12	14,246	4.09	1.01	Responsiveness of the staff to your requests
13	14,360	4.23	.93	Courtesy and helpfulness of the staff
14	14,366	4.27	.92	Amount of dignity and respect shown by the staff
15	13,914	4.11	1.02	Clear and complete explanation provided by the staff about your medications and their side effects
16	14,081	4.15	.98	Clear and complete explanation provided by the staff about how to care for yourself at home
C.I.	14,294	4.17	.84	Composite index: Cronbach's $\alpha = .9300$
<i>Food</i>				
17	13,470	3.38	1.10	Rate the food that was delivered to your room
18	13,488	4.11	.94	Rate the courtesy and helpfulness of the staff serving the food
C.I.	13,660	3.74	.92	Composite index: Cronbach's $\alpha = .6147$

continued

TABLE 1 continued

	N	Mean	S.D.	Description
<i>Room</i>				
19	14,364	4.00	1.04	Rate the cleanliness of your room
20	13,131	4.10	.96	Rate the courtesy and helpfulness of the staff who cleaned your room
C.I.	13,644	4.03	.96	Composite index: Cronbach's α = .8663
<i>Dependent Variables</i>				
	14,395	4.16	.98	Overall, rate the quality of care and services received during this hospital stay
	14,350	4.32	.97	Rate your willingness to recommend this hospital to family and friends
	14,299	4.34	1.00	Rate your willingness to return to this hospital again
C.I.	14,428	4.27	0.90	Composite index: Cronbach's α = .9002

attribute. These results are also shown in Table 1.

The larger value of the alpha indicates that the items contribute to a reliable scale. Except for the food attribute, which only contained two items, all computed Cronbach's alpha values for this data set were larger than 0.80. This indicates good internal consistency. The control variables considered for analysis included age, gender, and race. Because the purpose of this study was to find patients who report only "excellent," multiple logistic regression analysis was used. The data were analyzed to predict which patients would potentially report their overall experience as "excellent."

RESULTS

The analysis of the five-hospital data set included 14,432 cases. The mean age was 58.29 years old, and the standard deviation was 17.21 years. There were

6,356 male patients and 8,076 female patients. The race composition was white: 9,055 or 73.91 percent, African American: 2,933 or 23.94 percent, Hispanic: 26 or 0.21 percent, Asian: 51 or 0.42 percent, and others: 187 or 1.53 percent.

For the logistic regression analysis, there were 5,532 patients in the "excellent" overall experience category and 8,896 patients in the "other" category. The logistic regression analysis was performed to measure the predictability of the "excellent" rating, controlling for age, gender, and race. A stepwise procedure was applied with a standard 0.05 entry criterion. The result of the multiple logistic regression analysis is shown in Table 2.

The logistic regression analysis with stepwise procedure selected admission process, nursing care, physician care, staff care, food, room, and age as

TABLE 2

Result of Multiple Logistic Regression Analysis with Dichotomous Overall Satisfaction as Dependent Variable

Independent Variable	Estimate	p Value	Odds Ratio	Odds Ratio (95% CI)
Intercept	-16.6235	< .0001	N/A	N/A
Admission	0.4864	< .0001	1.627	1.507, 1.755
Nursing care	1.0653	< .0001	2.902	2.582, 3.261
Physician care	0.5657	< .0001	1.761	1.606, 1.930
Staff care	1.1993	< .0001	3.318	2.879, 3.824
Food	0.1882	< .0001	1.207	1.130, 1.290
Room	0.3040	< .0001	1.355	1.261, 1.457
Age	-0.00807	< .0001	0.992	0.989, 0.995

significant predictors of the "excellent" rating of the overall experience. Two other variables—gender and race—were not selected by the model. Additional logistic regression analysis was done to force the inclusion of all independent and control variables, but the result (not shown here) was similar.

Among the six attribute reactions, staff care showed the largest point estimate of odds ratio (3.318), followed by nursing care (2.902), physician care (1.761), admission process (1.627), room (1.355), and food (1.207). A larger value of odds ratio indicated more weight to get to the "excellent" rating. Thus, staff care was more influential than nursing care to overall patient satisfaction. Among the six attributes, staff care and nursing care showed much larger odds ratios than others, indicating that those two attributes were the most influential. The only significant demographic predictor was age, which

was negatively related to overall satisfaction. Older people tended to give ratings other than "excellent" in the overall satisfaction category.

DISCUSSION

The purpose of this study was to find out what influences patients to rate their overall experience as "excellent." The results show that certain attributes are more influential than others in influencing patients to give an "excellent" rating. The most influential attribute is staff care, followed by nursing care, physician care, admission process, room, and food, in that order.

The examination of the 95 percent confidence intervals for all attributes revealed three distinctive groups of attributes. The first group includes staff care and nursing care, the second group includes physician care and admission process, and the third group includes room and food. Based on the confidence

interval overlaps, the impact of the first group (staff care and nursing care) is clearly stronger than that of the second group (physician care and admission process), and the impact of the second group is clearly stronger than that of the third group (room and food). In other words, staff care and nursing care have a greater influence on a patient's decision to give an "excellent" rating than physician care and admission process, and so on. This finding is generally consistent with previous studies. Also consistent with previous studies is the finding that room and food are less influential than other attributes (Otani et al. 2003). Considering the nature of a hospital stay, it makes sense for patients to put a higher value on staff and nursing care than on room and food.

The analysis also showed that even when patients mark "excellent" on each attribute, they do not always rate "excellent" on their overall satisfaction. Of the 14,432 patients included in this study, 1,077 patients marked "excellent" on all attributes. Among them, 998 patients (92.66 percent) gave an "excellent" rating on their overall satisfaction and 79 patients (7.34 percent) did not mark "excellent." These 79 patients were totally satisfied with each individual attribute, but their overall satisfaction was not "excellent." This apparent contradiction may reflect the inherent subjectivity of satisfaction with patient care, and it indicates that having all patients be totally satisfied with their overall hospital experience may be almost impossible.

Another interesting finding is that when patients marked "excellent" on staff care, regardless of how they rated the other attributes, most (81.47 per-

cent) marked "excellent" on overall satisfaction. For patients who rated nursing care as "excellent," 77.75 percent indicated their overall satisfaction was "excellent." The corresponding percentage for physician care is 66.51 percent; for admission process, 67.97 percent; for room, 70.66 percent; and for food, 70.94 percent. Hence, it is critical to make sure that patients mark "excellent" on staff care first. Only 13.26 percent of the patients who rated both staff care and nursing care as "excellent" did not mark "excellent" on their overall satisfaction. Among patients who marked staff care, nursing care, and physician care as "excellent," an even smaller percentage—11.66 percent—did not rate overall satisfaction as "excellent." These 13.26 percent and 11.66 percent are close to the 7.34 percent who marked "excellent" on all attributes but did not mark "excellent" on their overall satisfaction. These figures indicate that because it is not practical to reduce the number of patients who do not mark "excellent" to zero, it is reasonable for healthcare managers to strive for patients to mark "excellent" first on staff care and then on nursing care.

CONCLUSION

This study reveals that staff care is the most influential attribute to patients in rating their overall hospital experience as "excellent," with nursing care coming in as the second most influential. These two attributes are distinctively stronger drivers of overall satisfaction than other attributes. For healthcare organizations to survive in the competitive healthcare market, healthcare managers must have loyal customers who become repeat

customers and recommend the hospital to others. As advocates, these customers improve the prospects of the hospital's survival. Healthcare managers have to work hard toward earning patients' rating of "excellent" on their overall hospital experience.

As this study shows, staff care and nursing care are critical to boosting patients' overall hospital experience. Fortunately, these two attributes are under the control of healthcare managers. Many training programs are available that teach nurses, other caregivers, and support staff strategies and methods for meeting patients' needs and exceeding their expectations. Satisfying patients is the first step to ensuring a loyal base. In an increasingly competitive healthcare market, only those hospitals that strive to consistently deliver patient satisfaction will prosper.

Limitations and Suggestions

This study expands our understanding of patient satisfaction and provides useful information to healthcare managers. However, it has some limitations. First, because this is a cross-sectional study, it presents an association between attribute reactions and overall satisfaction but not a cause-and-effect relationship. Many patient satisfaction studies assume that patients combine salient attribute reactions to arrive at their overall satisfaction. However, an experimental or quasi-experimental study in which attributes are manipulated would demonstrate a clear cause-and-effect relationship between attribute reactions and overall patient satisfaction.

Second, although this study used a large data set from five hospitals, it

focused mainly on facilities located in the St. Louis metropolitan area. Thus, the generalizability of the results to other areas may be limited. Comparable studies in other areas would increase the generalizability of this study. Third, the response rate was 37 percent, a decent response rate when compared with that in other surveys. The responders and nonresponders were compared to find any significant differences between them. Although the analysis showed similarities in age and gender between the two groups, it is possible that nonresponders may combine attribute reactions with different weights to arrive at an overall experience rating of "excellent." A comparison of other variables between responders and nonresponders, such as health insurance status, severity of disease, and educational attainment, is encouraged.

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PRACTITIONER APPLICATION

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Parkview Health is an eight-hospital system in Northeast Indiana. We have measured patient satisfaction for many years. About five years ago, we began using a new patient satisfaction tool because its "top box" score was "excellent" as opposed to "very good." We had done considerable research that demonstrated patient loyalty

would increase significantly if patients perceived the overall quality of their care as "excellent" rather than "very good." This increase in loyalty is similar to what has been proven in research in other service areas, such as hotels, automobile dealerships, and restaurants. Only 20 percent of individuals who rate their service as "very good" will use that provider the next time service is needed, versus about 80 percent who will use the same provider if their prior experience was "excellent."

Parkview wants to be the best, not just average or even "very good." Competition is strong. Hospitals are improving their systems, processes, facilities, and workforces to provide higher quality care than ever before. At the same time, patients are becoming more discriminating in their selection of hospital providers and have higher expectations than ever before. Quality metrics, including patient satisfaction, are being made available to the public, and patients are using them to select hospitals. Providing excellent quality care to our patients would not only allow us to capture market share but also make coworkers feel positive about the work they are doing. Further, excellent quality patient care helps patients clinically by reducing their anxiety and improving their compliance with the care regimen.

The information presented in this article is supported by our own research, but the findings here go a step further: They provide hospitals with an understanding of those patient care attributes that correlate most strongly with achieving "excellent" ratings for overall quality of care or for the patient's likelihood to return. Currently, we receive "key drivers"—those questions or patient care attributes that correlate most strongly or have the greatest influence on the patient's overall satisfaction. However, as the authors point out, improving patient satisfaction is not our ultimate goal; we are after a rating of "excellent" that will lead to stronger patient loyalty.

Healthcare managers often struggle to find ways to improve their patient satisfaction scores. They know they are providing high-quality care, but they fail to achieve the standard of being in the top 10 percent of hospitals in overall quality of care. Typically, the difference is between receiving "very good" and receiving "excellent" rating. Anything we can do to help hospital managers understand what they can do to achieve "excellent" ratings and educate them about the psychology of patient perception of their care will be beneficial.