How to Improve Patient Satisfaction When Patients Are Already Satisfied: A Continuous Process-Improvement Approach

DAN FRIESNER, DONNA NEUFELDER, JANET RAISOR, and CARL S. BOZMAN

Abstract. The authors present a methodology that measures improvement in customer satisfaction scores when those scores are already high and the production process is slow and thus does not generate a large amount of useful data in any given time period. The authors used these techniques with data from a mid-sized rehabilitation institute affiliated with a regional, nonprofit medical center. Thus, this article functions as a case study, the findings of which may be applicable to a large number of other healthcare providers that share both the mission and challenges faced by this facility. The methodology focused on 2 factors: use of the unique characteristics of panel data to overcome the paucity of observations and a dynamic benchmarking approach to track process variability over time. By focusing on these factors, the authors identify some additional areas for process improvement despite the institute’s past operational success.

Keywords: benchmarking, customer satisfaction surveys, process improvement, rehabilitation

Over the past decade, process improvement has become one of the prominent issues facing healthcare practitioners. As consumers, third-party payers, and regulators have increased pressure on healthcare providers to simultaneously demonstrate both clinical effectiveness and efficiency, these providers have relied more and more on traditional, business-oriented process-improvement tools to justify current practices and identify areas for improvement.

One important process-improvement tool is the customer satisfaction survey. This survey provides managers with important information about how customers perceive and value a company’s products. A patient’s satisfaction simply reflects the extent to which his or her expectations have been met or exceeded. In healthcare, customer satisfaction surveys are traditionally given to patients on the completion of treatment to identify patient perceptions of (a) the value of the outcome of treatment (e.g., Does the patient feel better?), (b) the tools and facilities practitioners used in the treatment (e.g., Was the facility clean and state-of-the-art? Was the practitioner clinically experienced in his or her field?), and (c) the process by which that treatment took place (e.g., Was the patient treated with respect and in a timely manner?). In Donabedian’s (1980, 1988) framework, the first survey area measures patient perceptions about the outcome aspects of the quality of healthcare, the second measures the perceived structural components of quality, and the latter measures patient perceptions of the process components of healthcare quality.

Satisfaction measurement is important for three fundamental reasons (Nelson et al. 1992; Powers and Bendall-Lyon 2003). First, high levels of patient satisfaction with healthcare services lower the cost associated with new client acquisition.
Positive word of mouth from previous patients, for example, can encourage other people to use a particular healthcare provider. Second, satisfied patients are more easily retained, and the value of an existing client usually increases with tenure. As a result, patient satisfaction is a leading indicator of future financial performance. Last, the quality of customer care can only be enhanced when caregivers are aware of how well they perform on key patient criteria. In all three cases, the implication is that a small change in customer satisfaction disproportionately impacts not only a firm’s revenue stream, but also the quality of care it is able to provide in the future.

Many customer satisfaction surveys (including those in healthcare) ask respondents to identify their perceptions on a scale. The interval used in our analysis ranged from 1 to 10, although other scales (e.g., 1–5, 1–7) are also commonly used (Oliver 1980; Singh 1991; Dube and Morgan 1996). Higher values indicate stronger (usually positive) responses, whereas lower values indicate weaker (usually negative) responses. Management’s goal is to adjust the production process to elicit as high (or in a few cases where the survey asks what patients did not like, as low) a mean customer satisfaction score as possible.

For many organizations, obtaining a relatively high mean customer satisfaction score (for example, a 9 out of 10) is extremely difficult. As a result, most process-improvement initiatives for customer satisfaction do not look beyond this goal. A select number of organizations, however, do achieve high mean scores. This accomplishment is problematic in itself because the continuous process-improvement and customer satisfaction literature argues that firms should continuously look to improve patient satisfaction, regardless of the mean satisfaction score (Nelson et al. 1992; Aquilano, Chase, and Davis 1995; Powers and Bendall-Lyon 2003). The problem is not that the production process cannot be modified to increase customer satisfaction, but rather how to measure the gains in customer satisfaction from existing benchmarks. Because mean scores are already high, any performance improvement initiative, even if highly successful, will increase mean satisfaction scores by only a small amount. Thus, it becomes more difficult to determine (ex post) the magnitude of the initiative’s impact on customer satisfaction.

Quality control literature argues that in such cases, the focus should not be on the mean score, but rather on the variance (or standard deviation) of satisfaction scores (Aquilano, Chase, and Davis 1995). That is, emphasis should be placed on maintaining the high mean satisfaction score while reducing variation in customer responses. This emphasis, in turn, indicates the appropriateness of constructing control charts to measure process variation. Again, this strategy is problematic, particularly in healthcare industries such as rehabilitation in which the production process is notoriously slow and only a few outputs are produced in each time period. As a result, traditional quality control techniques may not be a viable approach.

In this article, we present a methodology that measures improvement in customer satisfaction scores when those scores are already high and the production process is slow. Our methodology uses a nonstatistical benchmarking framework: It does not formally require the use of hypothesis tests. However, providers with fewer data limitations can easily incorporate more advanced statistical procedures (including hypothesis tests) into this methodology. We apply these techniques by using data from a mid-sized rehabilitation institute that is affiliated with a regional, nonprofit medical center. Thus, this article acts as a case study whose findings may be applicable to a large number of other healthcare providers that share both the mission and challenges faced by this facility.

We proceed in four sections. First, we describe the data used in our study, some characteristics of the data that make it applicable to this problem, and some of the data’s limitations. Next, we describe our empirical methodology for analyzing the data. The third and fourth sections contain our empirical results. We conclude the article by discussing our findings and providing some suggestions for organizations that may face similar problems.

Data

The data utilized in our study come from a rehabilitation institute that is affiliated with a major, nonprofit medical center. The center offers a wide array of specialized and general healthcare services, including physical, occupational, and speech therapy services. It is located in a mid-sized, midwestern community with a population of approximately 130,000 and a surrounding metropolitan population of approximately 300,000. The center experiences competition from another similarly sized, nonprofit medical center in the same community.
The rehabilitation institute offers a wide array of inpatient and outpatient therapy services. Inpatient services are offered at its 50-bed inpatient facility, whereas outpatient services are provided at one of three sites strategically located throughout the community and one assisted living site. For simplicity, we refer to these outpatient sites by their location and/or function: north, east, south, and assisted living. Most therapy sessions average 45 minutes in length, though a few sessions are as short as 30 minutes and as long as 60 minutes.

Our dataset covers the time period between January and July 2005. During this 7-month interval, all individuals concluding outpatient treatment at the medical center were asked to complete a 13-question patient satisfaction survey. Items covered on the survey were designed to capture Donabedian’s (1980, 1988) process, structure, and outcome components of quality. For example, the survey questions asked patients to evaluate (a) the cleanliness of the facility, (b) the convenience of the facility’s parking, (c) the ease of the registration process, (d) perceptions of the staff’s skill, (e) perceptions of staff concern for the patient’s well-being, and (f) an overall perception of the quality of care offered. Respondents were asked to rate the facility using a scale of 1 to 10, where 1 was the minimum score and 10 was the maximum. A copy of the survey instrument is provided in the Appendix.

The medical center’s administration collects this data and provides monthly feedback to each department through interdepartmental e-mail and at staff meetings. In addition to disseminating this information, the center’s administration requires that each department use these scores as a continuous process-improvement tool. That is, each department is required to set a benchmark for each question on the survey and make changes in the department’s operations that allow it to meet or exceed these goals. The rehabilitation institute’s goal is to consistently have a mean score of 9 or higher for each item on the survey, both over time and for each of its four outpatient sites.

Table 1 provides some descriptive statistics for the rehabilitation institute, where the data generating these metrics are aggregated over time and location. This table shows some interesting trends. First, the mean patient satisfaction scores are all high, indicating that the rehabilitation institute’s staff does a relatively good job of meeting its goal. Standard deviations and coefficients of variation, on aggregate, are low, implying that the institute’s staff is not only performing admirably on average, but also maintaining low process variability.

These statistics simultaneously reflect desirable patient outcomes and pose an interesting dilemma. As mentioned earlier, the institute’s staff must not only be concerned with maintaining high patient satisfaction levels, but also continue to improve on what has already been accomplished. Unfortunately, because mean scores on the survey are already high (i.e., 9 out of 10) and exhibit limited variability, it is difficult to accurately and precisely measure performance-improvement gains using mean values. And because therapy is a slow process, there are only a small number of respondents, and that low level of response is especially problematic when the staff wishes to disaggregate the data by question, site, and time.

The data in Table 1 were aggregated across four facilities and seven time periods, yielding between 143 and 180 observations per question. If the numbers of respondents at each facility per month were equal across facilities, the information in Table 1 would indicate that the number of respondents per facility per month ranges between approximately 5 and 7. In reality, this is not the case, as the south and north sites typically have higher patient loads than do the remaining sites. As a result, the unequal number of respondents per site and month exacerbate the small sample problem and make process improvements even more challenging for those sites with fewer respondents. In the next section, we describe a simple technique that this provider used to document areas for process improvement given these data limitations.

**Empirical Methodology**

Several considerations guided our data analysis. First, despite the fact that mean patient satisfaction scores were high, the staff believed that any process-improvement initiative should nonetheless directly include mean values. Alternative measures should also be constructed, but mean values provide an intuitive (and, in the staff’s view, necessary) benchmark against which any new measures should be compared. Moreover, any additional measures used in the analysis should be small in number, simple to calculate, and easily interpreted to be clearly and concisely communicated to the institute’s staff. Otherwise, such measures become meaningless because the staff may be unwilling or unable to implement performance-improvement
initiatives on the basis of those metrics (Neufelder, Raisor, and Friesner 2002).

A second consideration is that the data are multidimensional. In particular, the data are collected over 13 questions, four sites, and seven time periods. The institute’s staff is primarily interested in benchmarking performance over time but has a secondary interest in benchmarking by question and location. Finally, there is a paucity of observations by location and, to a lesser extent, by question in each time period. This lack of data precludes the use of traditional quality control methods and more advanced diagnostics such as regression analysis.

To address the lack of observations by location, we adopted a methodology to aggregate the data into categories with a larger number of observations. Given the three-dimensional nature of this data and the needs of the institute’s staff, we aggregated the data in two distinct but related ways and thus conducted two different analyses.\(^3\)

First, for each time period and survey question, we approximated the mean, standard deviation, and coefficient of variation across individual patient responses from all four facilities. These approximations were calculated using a weighted average of mean patient satisfaction scores for which the weights were based on the proportion of total responses provided in each facility. As a result, this data set examined average responses to each of the 13 questions over time. The benefit of this approach was that the resulting mean, standard deviation, and coefficient of variation statistics were based on average values but were (approximately) summary statistics for the underlying observations in the data set. The cost of this approach was that we lost any heterogeneity by location.

Second, for each time period and facility, we aggregated mean responses across questions in the survey. That is, each facility’s mean patient responses were aggregated across each of the 13 questions in the survey, yielding a two-dimensional panel over time and location. As before, we used this methodology to calculate a mean, standard deviation, and coefficient of variation for each location and time period. This ensured that each observation (by facility and month) was based on at least 13 observations. The drawback to this approach was that each of the 13 observations was in itself a mean value, which made data interpretation more cumbersome. For example, the mean score for a particular location in a given month is an average of mean values. Similarly, the standard deviation for a facility in a given month is a standard deviation of mean values (i.e., a standard error of the mean).

Given the need for parsimonious metrics, our empirical analysis relied on basic process-improvement

<table>
<thead>
<tr>
<th>Question</th>
<th>(n)</th>
<th>(M)</th>
<th>(SD)</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate 1. Facility</td>
<td>180</td>
<td>9.328</td>
<td>0.035</td>
<td>0.376</td>
</tr>
<tr>
<td>2. Convenience of parking</td>
<td>166</td>
<td>9.283</td>
<td>0.084</td>
<td>0.907</td>
</tr>
<tr>
<td>3. Convenience of the registration process</td>
<td>170</td>
<td>9.418</td>
<td>0.020</td>
<td>0.208</td>
</tr>
<tr>
<td>4. How well the staff anticipated your needs</td>
<td>178</td>
<td>9.697</td>
<td>0.011</td>
<td>0.113</td>
</tr>
<tr>
<td>5. Skill and expertise of staff</td>
<td>180</td>
<td>9.722</td>
<td>0.008</td>
<td>0.083</td>
</tr>
<tr>
<td>6. Explanation of medical condition and treatment by doctor or nurse practitioner</td>
<td>153</td>
<td>9.529</td>
<td>0.034</td>
<td>0.358</td>
</tr>
<tr>
<td>7. Explanation of tests, procedures, and treatment by clinical staff</td>
<td>176</td>
<td>9.631</td>
<td>0.010</td>
<td>0.105</td>
</tr>
<tr>
<td>8. Courtesy and concern from the physician</td>
<td>149</td>
<td>9.470</td>
<td>0.073</td>
<td>0.771</td>
</tr>
<tr>
<td>9. Concern for privacy</td>
<td>173</td>
<td>9.607</td>
<td>0.029</td>
<td>0.302</td>
</tr>
<tr>
<td>10. Patient involvement in decision making</td>
<td>164</td>
<td>9.543</td>
<td>0.070</td>
<td>0.736</td>
</tr>
<tr>
<td>11. Explanation of discharge or follow-up care instructions</td>
<td>157</td>
<td>9.516</td>
<td>0.135</td>
<td>1.424</td>
</tr>
<tr>
<td>12. Overall quality of care</td>
<td>178</td>
<td>9.725</td>
<td>0.016</td>
<td>0.160</td>
</tr>
<tr>
<td>13. Educational materials</td>
<td>143</td>
<td>9.566</td>
<td>0.033</td>
<td>0.344</td>
</tr>
</tbody>
</table>

*Note. Answers ranged from 1 (poor) to 10 (excellent).*
methodology. That is, we tracked process variability over time to identify areas where patient perceptions of service varied widely. In those cases, the process needed to be adjusted to reduce variation while maintaining high mean scores. One potential problem was that we did not have sufficient data to construct control charts or conduct hypothesis tests with a high degree of statistical power, the traditional means of analyzing process variability. Thus, we measured process variability in a slightly different way: using time-series charts of mean and standard deviation values to benchmark current outcomes against past outcomes. Not only is this approach consistent with the concept of process control (Aquilano, Chase, and Davis 1995), but also these charts were easier to construct and intuitively appealed to the institute's staff.

When interpreting these charts, we looked for several key phenomena. First, we expected mean values to be both stable and relatively high over time, and thus we looked for changes in mean patient satisfaction. For example, a particular category or survey question may consistently elicit a mean response rate over 9 on a 10-point scale. However, if this category, although exceeding the benchmark, is consistently lower than the other categories, then staff should still focus process-improvement efforts toward this measure of patient satisfaction. Evidence of seasonality or location-specific differences in mean scores was also of concern. When analyzing standard deviations, we looked for unusually high measures, as this would indicate high process variability. Seasonality and location-specific differences in process variability were also a cause for concern.

A Simple Analysis of the Data Aggregated by Survey Question and Time

Figures 1 and 2 show mean levels of response to each of the 13 questions in the survey over each month in 2005, and Figure 3 depicts the three questions whose mean response levels (over all 7 months) were highest and lowest, respectively. Several characteristics stand out. First, most questions evinced response rates of 90% or higher. However, several categories produced much higher mean satisfaction scores than did other categories. Response rates for Questions 1–3 were the lowest, carrying average values of approximately 9.3 to 9.4 on a 10-point scale. Concomitantly, Questions 5, 6, and 12 had the highest mean scores, with values of approximately 9.75 out of 10. Thus, on average, patients were marginally less satisfied with the facility, parking availability, and patient registration process, and more satisfied with the skill and expertise of the staff, how thoroughly the medical condition was explained by the staff, and the overall level of care. In Donabedian's (1980, 1988) framework, these results imply that process-improvement initiatives should focus more on the structural and process components of quality, as opposed to the outcome components.

Another characteristic was the trend in mean scores over time. Scores for all 13 questions tended to fluctuate early in 2005, leveled off between April and May, and increased thereafter. As a result, it is reasonable to conclude that progress was being made despite the fact that mean scores were already high.

Figures 4, 5, and 6 depict a similar trend in the standard deviation of scores across each of the 13 questions. Questions 1, 2, and 8 exhibited the most variation in satisfaction scores over time, whereas Questions 3, 4, and 5 exhibited the least amount of variation over time. Thus, people had more disparate opinions about the facility, parking availability, and physician courtesy than they did about the registration process, skill and experience of the staff, and how well the staff anticipated a patient's needs.

These figures reveal several other interesting trends. First, although Question 3 has one of the lowest mean values, it also has one of the lowest standard deviations. Thus, most patients felt similarly about the registration process. On the other hand, although the facility and parking (Questions 1 and 2) received relatively low mean scores, there was also a lack of consensus across patients about these issues.

After discussing the results with the institute's staff, we identified several plausible explanations for these findings. First, the registration process may have been perceived by patients as tedious, regardless of how the staff had refined the process. This perception could account for the relatively low mean score as well as the consistency of responses across patients. Additionally, patients of advanced age groups and more severe medical conditions may have needed to park closer to the facility, and space may have been inadequate for them, leading to lower satisfaction scores in these areas. However, for younger or more mobile patients, parking may not have been as large an issue.

A final issue in the study is the pattern of variability in each question over time. Clearly, scores
were much more volatile in February, April, and May for all of the questions in the survey. Alternatively, scores were lower in January, March, June, and July. This consistent pattern suggests that some general, causal factors influenced process variability over time. Perhaps this variability was weather related. In this climate, January through March is the coldest time frame, and June and July are the warmest months of the year. Colder weather and the accompanying icy conditions may have reduced some patients’ satisfaction with parking areas because of their greater difficulty in walking between the parking lot and the facility.

**A Simple Analysis of the Data by Location and Month**

We begin by examining the mean scores by location and month, illustrated in Figures 7, 8, and 9. Figure 7 presents mean patient satisfaction scores by facility, aggregated over month and survey question. Consistent with Table 1 (in which data are aggregated over location and month), the mean patient
satisfaction scores for all four locations exceeded their benchmarks. The north and south locations had the highest mean scores, followed by the east and assisted-living locations. It remains to be seen whether these trends were borne out when the data were disaggregated over time.

Figures 8 and 9 demonstrate that mean patient satisfaction scores varied by month and location. Mean scores, although high, do suggest some minor opportunities for process improvement. The north location exhibited consistently high mean values (M satisfaction > 95%, or 9.5 on a 10-point scale) over the time frame of the analysis. With the exception of 1 month (March), the south location also exhibited high mean values in excess of 90%, or an average of 9 on a 10-point scale. The east location exhibited high mean satisfaction scores, with the exception of 1 month (February); however, in that single month, satisfaction scores were well below the acceptable rate of 90%. Last, the assisted living location fell substantially below the 90% standard in 2 consecutive months.

One intriguing finding was that the assisted living, east, and south locations were below the 90%
threshold in different, but consecutive, months. This suggests, but in no way proves, that the likely causes of the fluctuation in mean patient satisfaction were temporary and location specific. Thus, although the staff should look for the root causes of these fluctuations, they may not warrant major changes in operations.

Given that the mean levels of patient satisfaction were relatively high, we also examined variability in patient satisfaction, as measured by the standard deviation. Figures 10 and 11 contain this data work. As in prior analyses, the north location exhibited stable variation over time. Moreover, the magnitude of the variation was very small, with standard deviations of approximately 0.2. The south location exhibited slightly higher and more disparate levels of variation, with a magnitude about 1.5 times that of the north location. However, the final two locations exhibited a tremendous amount of variation in patient satisfaction, with the east facility demonstrating the most volatility.

Unlike the mean satisfaction scores, the standard deviations for the east and assisted living facilities showed dynamic behavior, following the same
general pattern over time. This indicates the possibility that there may have been common causal factors that increased variability in patient satisfaction across these locations. Thus, the institute's staff may want to adjust current practices to reduce the effects of this common cause in satisfaction variability.

**Suggestions for Facilities with Similar Issues**

Patient satisfaction is a moving target that must be monitored and enhanced over time. Failure to do so ensures that rising patient expectations will go unmet or present new opportunities for competitors to exploit. Understanding the content and organization of patient expectations can allow any healthcare provider to respond proactively. Not only could a rehabilitation institute identify and respond to less than optimal levels of patient satisfaction, but they could also effectively influence the composition of future expectations. The ability of any organization to satisfy its customers—to meet or exceed their expectations—is
most easily realized when those expectations are managed so as to be consistent with the product and processes provided.

Our case study presents several recommendations for facilities facing problems similar to this rehabilitation institute’s. First, continuous process improvement is possible, even when the process in question is highly effective. In such cases, the focus on process improvement must be conducted in a relative, and not an absolute, sense. That is, even if mean scores are high, staff should focus on those scores that are the lowest relative to other measures, including any added measures that reflect important new dimensions of service. Additional consideration must also be given to the variation in those measures, not just mean values.

Second, process-improvement techniques can be applied to virtually any area of business operations, not just the production- and defect-rate metrics traditionally espoused in the operations management literature. Our analysis used patient
satisfaction scores following output rehabilitation, which are traditionally thought to measure the quality of care. However, because the quality of care is fundamentally tied to a healthcare provider’s output (e.g., Dor and Farley 1996), any measure of quality can be analyzed using process-improvement techniques.

Third, providers can implement process-improvement studies even when data are limited. The crucial issue is using the available data as effectively as possible. In our case, we had access to a small, three-dimensional panel over location, time, and survey question. This access allowed us to aggregate observations and obtain sufficient data to perform a simple analysis. If staff cannot aggregate data sufficiently to perform a traditional control chart analysis, they may need to find different, creative ways to measure the efficiency of production. In our case, we analyzed time-series charts of means and standard deviations over time. Should a rehabilitation provider’s staff feel uncomfortable in performing such an analysis, establishing a relationship with faculty at a local university who are skilled in statistical process

FIGURE 5. Bar charts of SD values of patient satisfaction scores for Questions (Q) 1–3 (A), 4–6 (B), 7–9 (C), and 10–13 (D), by month.
control and willing to assist staff in this undertaking may be a viable approach (Neufelder, Raisor, and Friesner 2002).

**Conclusions**

This article presents a case study of how a rehabilitation institute can use simple data analysis techniques to improve its production process, if the production process is slow and levels of patient satisfaction are already high. Our analysis revealed that even if the institute is successful at maintaining high customer satisfaction levels, some areas need further improvement. In particular, patient concerns with the institute’s parking facilities and registration process should be addressed.

Our study’s findings and the results of other similar investigations should be viewed with caution. As with any such empirical work, readers must recognize that every avenue we pursued to avoid data limitations ultimately created trade-offs. Although the trade-offs may be both unavoidable and necessary, staff must interpret any findings in light of these constraints. For example, by avoiding the use of control charts, our study lacked a
statistical foundation and must be considered a simple benchmarking exercise. Similarly, by aggregating data to increase the number of observations, we gave up some information (one dimension of the panel) to gain a different set of information (benchmarks of patient satisfaction and identities of areas for improvement). However, as long as a rehabilitation provider’s staff recognizes those limitations, these tools should provide a valuable means for documenting and implementing process-improvement initiatives.

**FIGURE 6.** Line graph of smallest (A) and largest (B) SD values for patient satisfaction score responses to survey questions (Q), by month.

1. For a discussion of this issue, see Neufelder, Raisor, Khayum, and Friesner (2003).
2. As data limitations are reduced and sample sizes increase, small differences in customer satisfaction scores (e.g., a change from a mean score of 9.3 to 9.4) are also more likely to be statistically significant and thus to necessitate the use of hypothesis tests.
3. We note in passing that one could also aggregate over time, looking at locations and survey questions. However, because one of the premises of this analysis was to document trends in performance, this option was not pursued.
4. We chose to focus on mean and standard deviation values separately, because mean patient satisfaction scores were
5. As mentioned in the introduction, larger datasets might also allow for the construction of meaningful hypothesis tests to examine whether these changes across time and location are, in fact, statistically significant.

6. This result may also be because of the small sample sizes in each facility, especially if these individuals gave disparate

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**FIGURE 7.** Bar chart of time-oriented $M$ patient satisfaction scores, by location.

**FIGURE 8.** Line graph of $M$ patient satisfaction scores, by location and time.
responses across each of the 13 questions in the survey that were not representative of the population.

7. As mentioned in Note 5, a similar analysis using coefficients of variation yielded virtually identical results.

FIGURE 9. Bar chart of $M$ satisfaction scores, by location and time.

FIGURE 10. Line graph of $SD$ of patient satisfaction, by location and time.

REFERENCES


APPENDIX
Sample Survey

The staff of _______ would like to extend its gratitude to you for choosing us to meet your needs. We strive to make _______ a center of excellence for our customers. We would appreciate your input by completing the questionnaire below and returning it. Thank you for your comments and your time.

<table>
<thead>
<tr>
<th>Please rate</th>
<th>Poor</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The facility (cleanliness, appearance, parking).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>2. The convenience of the parking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>3. The convenience of the registration process.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>4. How well the staff anticipated your needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>5. The skill and expertise of the staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>6. The explanation of your medical condition and treatment by the doctor or nurse practitioner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>7. The explanation of the tests, procedures and treatment provided by the clinical staff.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>8. The courtesy and concern for you from the physician who treated you.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>9. The staff’s concern for your confidentiality and privacy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>10. The opportunity to be involved in the decision making about your care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>11. The explanation of discharge or follow up care instructions and written materials.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>12. The overall quality of care you received today.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
<tr>
<td>13. The educational material you received including ease of reading, content and understandability.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10 N/A</td>
</tr>
</tbody>
</table>