Patient Health Satisfaction Survey in Connecticut Correctional Facilities

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Abstract
Although routine in the community, patient satisfaction surveys are relatively rare in correctional settings. This article describes the development of an instrument specifically adapted to the correctional environment and population, the statewide implementation of the survey, the initial results, and the quality improvement initiatives evolving from this effort.

Keywords
patient satisfaction, survey, care delivery, feedback, correctional health care

Introduction
As part of ongoing quality improvement initiatives, most community-based health care organizations routinely ask their patients to comment on the services they receive. The feedback received informs the organization about many key issues: perceptions of wait time; courtesy and respect shown to them by the staff; apparent knowledge and competence of the staff; and, critically, the degree to which the patients feel satisfied with the care they received. Although routine in the community, patient satisfaction surveys are relatively rare in correctional settings. One study in the literature was conducted in the Norwegian prison system (Bjørgaard, Rustad, & Kjelsberg, 2009). In that survey with over 1,000 responses, on a scale from 0 (worst, unsatisfied) to 4 (best, very satisfied), the satisfaction items ranged in general from 1.3 to 1.6. The authors reasonably concluded that the inmate-patient satisfaction with health care was low and that there was potential for quality improvement. In this article, we describe the development of an instrument specifically adapted to the correctional environment and population, the statewide implementation of the survey, the initial results, and the quality improvement initiatives evolving from this effort.

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Development and Planning

Correctional Managed Health Care (CMHC) is a division of the University of Connecticut Health Center that provides global health care to all sentenced and unsentenced inmates incarcerated under the supervision of the Connecticut Department of Correction (CDOC). During initial planning discussions, several potential barriers to conducting this survey or interpreting its findings were identified. How would implementation of a survey of this nature be received by CMHC health care staff, inmates, CDOC custodial staff, and even the community? How would allocation of staff to implement this survey be perceived? There also exists a community opinion that inmates already receive better health care than those in the private sector, especially those without insurance. How would the results of the survey be received if attitudes about inmate health care were potentially punitive? Concerns were raised regarding survey results from inmates housed in older facilities compared to those housed in the more modern facilities. The immediate physical environment in which health care is delivered could potentially impact one’s perception of quality and satisfaction. From the inmate’s perspective, would this survey be seen as a “threat” to take away existing services? Yet another potential concern was whether the inmates would think that the survey would be linked to an increase in their inmate co-pay for requested nonemergency services.

When health care staff were informed of the intent to implement an inmate-patient health satisfaction survey, initial responses varied. The comments ranged from very accepting of the survey concept to expressions of resentment, insult, threat, and cynicism. It was important for the success of this initial quality improvement endeavor that staff perceived this project as an opportunity to learn; substantial discussions to this effect were an important part of this process. CMHC health care administrators and health care staff were given ample opportunity to review the final survey questionnaire, ask questions, and generally express feelings. It was emphasized that this data collection would be a “snapshot” of a much larger picture and that existing avenues were already in place to begin addressing any findings that provided opportunities for improvement. Facility custodial staff were oriented to the survey concept through each warden’s chain of command. Planning sessions with the wardens and custodial staff addressed many of the same questions and perceptions raised by the health care staff. Subsequent to these interventions, all parties agreed that the survey was a good idea and assisted with plans for implementation.

Purpose of Inmate Health Satisfaction Survey

For this initial health care satisfaction survey, it was felt important to keep the process simple and easily understood to enhance acceptance. The primary purpose was to assess inmate-patient satisfaction with health care delivery in a correctional setting. Secondary goals included inmate-patient perceptions and expectations. In the CMHC survey design, the feedback process was clearly outlined prior to the implementation. There was no a priori sample size determined; the goal was to involve the maximum number of inmate-patients having health care encounters on the day of the survey.

Designing the Survey Tool

General reading materials for the CDOC inmate population are written for the fourth- to fifth-grade reading level. To increase acceptance and response rate, we decided to limit the CMHC survey to 10 questions. Responses were measured using a 3-point Likert-type scale. Cartoon images were chosen of a smile (representing “yes”), a question mark (representing “unsure”), and a frown (representing “no”). In selecting the questions for the health survey, the 2001 Institute of Medicine (IOM) report Crossing the Quality Chasm: A New Health System for the 21st Century was a fundamental source. The 10 questions were derived from both the IOM report and from a review of existing health
Figure 1. Correctional Managed Health Care inmate health survey.

satisfaction surveys (Carr-Hill, 1992; Figure 1). A Spanish version of the survey was available. No attempt was made in this quality improvement project to gather demographic data. The survey was designed to be anonymous.

**Implementation**

The introduction of the survey tool at CDOC facilities was scheduled for days when the maximum number of health services would be available at each of the 17 designated facilities. Surveys were conducted facility by facility over an 18-month period. Services included medical/mental health
prescriber encounters, nurse encounters, dental encounters, mental health staff encounters, laboratory services, counseling services, and/or pharmacy actions. Inmate-patients were approached following receipt of services or health care staff encounters. All participants were instructed not to write their name or identification number on the survey form (assuring anonymity) and asked to answer the questions honestly with no fear of reprisal. To encourage a sense of safety and anonymity, inmates were encouraged to place their written responses directly in a sealed collection box.

The cooperation of the correctional officer assigned to the health unit was of course paramount in making the project work. The surveyors were located at the exit to the health unit or directly outside the door to the health unit. A conscious decision was made not to use facility staff as surveyors to conduct this survey, thus reducing the potential for perceived bias or prejudice. It was intended that using staff deployed from the CMHC central office as surveyors would demonstrate an objective atmosphere.

The role of the surveyors was to explain the purpose of the survey and address any immediate concerns or fears. If necessary, surveyors could read the questions to inmates with known learning problems or who had not brought their reading glasses to the encounter. A Spanish interpreter was available if the written Spanish version of the survey was not adequate, for similar reasons as stated previously. Following data collection and review, surveyors provided feedback to facility staff. These feedback sessions included discussions about interpreting the data and understanding both inmate-patient perspectives and opportunities for improving the care delivery experience. From this discussion, quality improvement initiatives were developed. This feedback loop was intended to broaden as the number of facilities completing the survey increased. With each step, improving health care delivery was the primary focus, although we expected to learn a great deal about the functioning of CMHC as part of this endeavor.

Results

Process

Initially, when inmates were approached and offered the survey, there tended to be a reluctance to participate. Surveyors undertook the role of educators and public relations mediators. They verified the goal of improving health care delivery and the safe, anonymous nature of participating in the survey. As the program progressed from facility to facility, more and more inmates agreed to participate; knowledge about the presence of the surveyors in the medical units traveled throughout the system. Those inmate-patients opting not to participate in the survey did so with near uniform courtesy and did not discourage fellow inmates from participating. The custodial staff was instrumental in assisting with inmate participation, encouraging the inmates to use this tool as a “voice.” The survey was conducted at a time when the average statewide incarcerated population was approximately 17,100 in a total of 17 facilities. On average, 3,500 individuals were in active mental health treatment and an overlapping 4,000 individuals were in active medical care. Of those, 2,727 inmates (16% of the total population) participated in the survey: 2,469 males (15% of the male population) and 258 females (23% of the female population). The Spanish version of the study was used by 60 (2.2%) responders.

Satisfaction Data

Results are presented in Table 1, broken out by gender. There were no statistically significant differences for any item by gender or by facility type (for men) by \( \chi^2 \) analysis. In this initial evaluation, “yes” and “unsure” responses are combined. Table 2 includes the data broken out by detailed category (“yes,” “unsure,” and “no”).
Table 1. Combined Affirmative and Unsure Responses to Inmate-Patient Health Survey Questions (By Gender and Percentage).

<table>
<thead>
<tr>
<th>Inmate-Patient Health Survey Question</th>
<th>Males Total</th>
<th>Females Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>N</td>
<td>2,469</td>
<td>258</td>
<td>2,727</td>
</tr>
<tr>
<td>1. I am satisfied with the health care I receive in prison</td>
<td>43</td>
<td>44</td>
<td>43</td>
</tr>
<tr>
<td>2. If I have a health problem I can easily see health care staff</td>
<td>46</td>
<td>28</td>
<td>45</td>
</tr>
<tr>
<td>3. There was a short wait in the waiting area</td>
<td>54</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>4. The health care staff introduced themselves to me</td>
<td>46</td>
<td>58</td>
<td>48</td>
</tr>
<tr>
<td>5. My health care providers treat me in a friendly and courteous manner</td>
<td>64</td>
<td>72</td>
<td>65</td>
</tr>
<tr>
<td>6. The health care staff respect my privacy</td>
<td>79</td>
<td>77</td>
<td>79</td>
</tr>
<tr>
<td>7. The health care staff listens to me</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>8. Those who provide my health care know what they are doing</td>
<td>70</td>
<td>69</td>
<td>70</td>
</tr>
<tr>
<td>9. The health care staff explains what is wrong with me</td>
<td>56</td>
<td>66</td>
<td>57</td>
</tr>
<tr>
<td>10. I understand what I have to do to get better or take better care of myself</td>
<td>79</td>
<td>80</td>
<td>79</td>
</tr>
</tbody>
</table>

Table 2. Affirmative, Unsure, and Negative Responses to Inmate-Patient Health Survey Questions (By Gender and Percentage).

<table>
<thead>
<tr>
<th>Inmate-Patient Health Survey Question</th>
<th>Males Total</th>
<th>Females Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
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<tr>
<td></td>
<td>2,469</td>
<td>258</td>
<td>2,727</td>
</tr>
<tr>
<td></td>
<td>Y ? N</td>
<td>Y ? N</td>
<td>Y ? N</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I am satisfied with the health care I receive in prison</td>
<td>26  17</td>
<td>57  15</td>
<td>56</td>
</tr>
<tr>
<td>2. If I have a health problem I can easily see health care staff</td>
<td>29  17</td>
<td>54  19</td>
<td>72</td>
</tr>
<tr>
<td>3. There was a short wait in the waiting area</td>
<td>37  17</td>
<td>46  13</td>
<td>57</td>
</tr>
<tr>
<td>4. The health care staff introduced themselves to me</td>
<td>34  12</td>
<td>54  19</td>
<td>42</td>
</tr>
<tr>
<td>5. My health care providers treat me in a friendly and courteous manner</td>
<td>47  17</td>
<td>36  14</td>
<td>28</td>
</tr>
<tr>
<td>6. The health care staff respect my privacy</td>
<td>52  27</td>
<td>21  19</td>
<td>23</td>
</tr>
<tr>
<td>7. The health care staff listens to me</td>
<td>38  22</td>
<td>40  17</td>
<td>40</td>
</tr>
<tr>
<td>8. Those who provide my health care know what they are doing</td>
<td>31  19</td>
<td>30  17</td>
<td>31</td>
</tr>
<tr>
<td>9. The health care staff explains what is wrong with me</td>
<td>35  21</td>
<td>44  18</td>
<td>34</td>
</tr>
<tr>
<td>10. I understand what I have to do to get better or take better care of myself</td>
<td>61  21</td>
<td>21  19</td>
<td>20</td>
</tr>
</tbody>
</table>

Between 43% and 79% of our inmate-patients expressed satisfaction with their care. At the low end of satisfaction (43%) was the overall question (Question #1) stating, “I am satisfied with the health care I receive in prison.” On the other extreme, 79% expressed satisfaction with respect for privacy (Question #6) and knowledge of self-care (Question #10).

Staff Feedback

Some of the “feedback groups” felt the survey findings were better than they anticipated. Other staff felt some of the inmate answers had merit. They further acknowledged the credibility of the answers. All acknowledged that the survey concept and the responses were nonthreatening. No one voiced negative thoughts about repeating the process and even suggested ways to increase future participation.
During the feedback sessions, health care staff raised questions about the relationship of satisfaction possibly being influenced by the length of sentence (expressed belief: longer sentenced inmates more picky about care than those with shorter sentences), inmate age (expressed belief: older inmate patients more tolerant of waiting than younger patients), intensity of health care required (expressed belief: patients with chronic illnesses present with greater dissatisfaction than those with only minor ailments), and status of health at time of admission to the prison system (expressed belief: no attention to health care in the community and therefore no expectations of correctional care compared to community care).

Discussion

Access to Care

In prison, inmates often have access to health care not available to them in the community (Niveau, 2007). In Connecticut, inmates have access to health care at all times. In addition, nursing protocols provide for patient evaluation and use of over-the-counter medications for common nonacute complaints. Despite policies outlining the time frame to address inmate health requests, only 45% of the inmate-patients said that access was easy. From the feedback groups, there was discussion of male inmate transfers from one facility to another and the need for the inmate to re-request health attention. There was also discussion describing the steps involved to complete a "specialty appointment" after initial evaluation by a facility-based prescriber. The inmate responses to access of care were not unexpected. CMHC has been developing an automated scheduler system that will schedule and track the time between request and completion of service. At the time of the survey, individual facilities were being brought online with this program.

Waiting Time

Higher patient satisfaction has been shown to correlate with waiting times that are shorter than expected (Hedge, Trout, & Magnnsson, 2002). The longer the wait, the more apt the patient is to respond negatively to questions relating to satisfaction of care. Only 53% of our responding inmate-patients felt the time in the waiting room was "short." This correlated with only 43% expressing overall satisfaction with health care provided. Much of the "waiting" time, in practice, relates to the custodial schedule of the given facility. All individual housing unit activities and custodial programs impact the window of time for inmates to travel to the medical unit. To ensure that the inmate is seen by health care staff, getting the inmate within the physical confines of the health unit greatly ensures that the encounter will be completed. While waiting, occupied time feels shorter than unoccupied time (Welch, 2010). In the correctional facilities, there are no books, magazines, or other activities to focus the waiting inmate-patient. The main activity while waiting is conversations between inmates, if allowed by custodial staff. The chairs and benches are hard and time drags by. An actual brief waiting time can be perceived to be longer than the reality. The feedback groups clearly acknowledged that getting inmates down into the medical unit and readily available for their encounters helped ensure that the inmate would be seen. Custodial representatives present during the feedback sessions volunteered renewed commitment to tackling the problem.

Perceived Courtesy and Competence

Sixty-five percent of the inmates surveyed felt that health care staff treated them in a friendly and courteous manner. This survey result is somewhat contradictory to the fact that only 43% expressed satisfaction with the health care they received. There are several potential contributing elements to this apparent discrepancy. A caring attitude on the part of physicians and nurses has been repeatedly
linked with patient satisfaction (Chande, Bhende, & Davis, 1991; Schwartz & Overton, 1987; Vukimer, 2006). Focused interest expressed verbally and nonverbally by the health care provider not only conveys a caring attitude but may enhance the quality of the encounter. The feedback groups also reflected that respecting inmate patients as individuals was paramount to effective, satisfactory care provision. Perceived technical ability is another element that enters into this perception and it has been shown to correlate with positive patient perception (Mack, File, & Horwitz, 1995; Rhee & Bird, 1996). Inmate-patient responses to the question of perceived technical ability resulted in a data distribution distinctly different from other responses. Seventy percent of inmates surveyed responded affirmatively that they believed the clinician was technically competent. Finally, a perception on the part of the patient that the clinician failed to explain the patient’s condition/diagnosis and treatment plan is a frequent source of significant dissatisfaction and frustration (Carr-Hill, 1992; Locker & Dunt, 1978). In this sample, only 57% of the responders felt appropriate explanations were provided by health care staff. Feedback sessions resulted in recommendations for health care staff to provide inmate-patients with explanations of their health problem or need, proposed treatment options, and appropriate patient education. It was believed that these suggestions might reduce the number of sick call requests for the same problem and also increase adherence with treatment regimens.

Conclusion

Responses to survey questions can be made on the basis of emotional and cognitive factors. They may pertain to experiences or expectations; the responses may reflect particular unique experiences or cumulative representations developed over years. Further, patient satisfaction does not translate directly into health care outcomes: Unsatisfied patients may nevertheless be getting good health care. While all of these caveats may be relevant, the results of patient satisfaction surveys such as this are nevertheless very useful and informative, and large sample sizes tend to balance out individual issues. The data we have gathered here represent a first, foundational step to seeking input from inmate-patients about their perceptions of the health care they receive. The intent is to use this information to guide specific interventions and support broader attitudinal changes.

Corrective actions and quality improvement initiatives that are in place as a result of the survey include staff introductions to inmate-patients and enhanced efforts at explaining the issue and the health care intervention at the time of the interaction. An automated scheduling system is incrementally being introduced with the goal of more timely appointments. Also, facility-based working groups are developing productive uses for time spent waiting to be seen while at the clinic.

The field of quality improvement is predicated on using data to understand the current reality and to work toward improved processes and outcomes. Individual and composite data have been reviewed at all levels of CMHC and shared with the CDOC. It was agreed that several corrective actions could be implemented immediately with little or no cost. These included extensive discussions with staff in each facility about the survey results and recommended changes in practice to respond to opportunities to improve health care satisfaction. In another year, the plan is to repeat the inmate-patient satisfaction survey; the goal is to improve the results in each area to keep raising our own standards and the satisfaction of the inmate-patients we serve.

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Authors’ Note
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