

Review of Patient Satisfaction with Case Management*

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Introduction

Like many other countries, Korea has adopted case management(CM) in order to manage rapidly rising healthcare cost and to care for the increasing number of the elderly and people with chronic diseases in a cost-effective way. Case managers are intervening to tailor seamless healthcare services for patients with various conditions including clinical needs and available resources within and beyond the episode of care. Nurses are playing an important role as a case manager and are expected to develop CM practice in collaboration with other disciplines. At the same time, they are required to prove their value as a case manager by achieving goals of CM. One of the most important goals of CM is to improve patient satisfaction with care. Patient satisfaction influences compliance to treatment regimens, which is critical for better clinical outcomes. As a partner with healthcare providers, patients' active roles become essential in their care, and patient satisfaction has garnered growing attention as an important quality measure among various healthcare stakeholders. The level of patient satisfaction is likely to indicate the patients' acceptance of CM and provides evidence for decisions whether CM services need to be expanded. Case managers and nurse leaders need to know how patients perceive their experiences of care so as to identify areas for improving CM practice and

eventually quality of care.

In the previous studies measuring CM outcomes, patient satisfaction was most commonly measured. Also, the majority of them found that patients who received CM services were more satisfied than those who received traditional nursing care. Nevertheless, these satisfaction outcomes were often measured using traditional satisfaction questionnaires that were not developed or tested with a focus on CM(Laramee, Levinsky, Sargent, Ross, & Callas, 2003). Due to the lack of appropriate satisfaction questionnaires developed for use with CM, the satisfaction outcomes measured in CM studies may be less reliable and valid. Accordingly, this review intends to provide nurses with the current research evidence on measuring patient satisfaction with CM. Few satisfaction measurement tools can be directly used in the CM field, and thus this study purposes to identify the most relevant tools and methodological issues so that case managers can be better informed and prepared for evaluating patient satisfaction. Furthermore, because only a few satisfaction instruments are available in the field of CM, this study attempted to examine the potential benefits of using satisfaction outcomes from the Nursing Outcomes Classification (NOC, Moorhead, Johnson, & Maas, 2004) in CM practice. The NOC is one of the widely accepted nursing taxonomies and provides comprehensive lists of outcome indicators of various nursing interventions. This article aims to 1) review

Key words : Patient satisfaction, Case management, Outcome Assessment(Health Care)

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the concept of patient satisfaction, 2) discuss important issues for developing satisfaction questionnaires, 3) overview survey questionnaires that were designed to measure patient satisfaction with CM, and 4) examine if outcome indicators of the NOC can be utilized to develop satisfaction measurement tools specific to CM.

Method

To review methodological issues of and instruments for measuring patient satisfaction, the author conducted a search of relevant literature using MedLine and the Cumulative Index to Nursing and Allied Health Literatures(CINAHL) databases. Using the keyword *Case Management* and *Care Management* and the Subject Heading *Patient Satisfaction* and *Client Satisfaction*, nearly 300 articles(199 from Medline and 108 from CINAHL) were retrieved. Titles and abstracts were reviewed to select studies that measure patient satisfaction of CM as a major intervention. Articles were purposely selected to provide examples of patient satisfaction tools that were developed or modified specifically for evaluating CM.

Results

Concept of Patient Satisfaction

The concept of patient satisfaction has not been thoroughly investigated through an a priori approach(Hall & Dornan, 1988). While various definitions are found in the literature, patient satisfaction is often described as “perception and attitude” or as “an emotional and cognitive response” in the literature. Also, the majority of researchers defined patient satisfaction as the degree of congruence between patients' expectations of care and actual experiences of care(Eriksen, 1995; Greeneich, Long, & Miller, 1992; La Monica, Oberst, Madea, & Wolf, 1986; Risser, 1975), even though it is not clear if current satisfaction instruments have been developed following this definition. For example, nurse researcher Eriksen (1995, p. 71) states that “patient satisfaction with nursing care is the patient's subjective evaluation of the cognitive/emotional response that results from the intervention of the patient's expectations of nursing care and their perception of actual nurse behavior/characteristics”. The more discrepancy between patients' expectations and perceived actual care, the lower the

satisfaction, according to a study by Linder-Pelz(1982). Also, Risser(1975)'s study found that lower expectations were related to higher satisfaction. This notion of expectation is a complex blend of personality, previous experiences, social and cultural values, and a care environment(Ellmer & Olbrisch, 1983). However, a consensus of the relationship between expectations and satisfaction has not reached and needs further study.

Patient satisfaction is a multidimensional concept. For example, Ware and colleagues(Ware, Davies-Avery, & Stewart, 1978) identified eight dimensions of patient satisfaction from the literature in the late 1970s: 1) art of care, 2) technical quality of care, 3) accessibility/convenience, 4) finances, 5) physical environment, 6) availability, 7) efficacy/outcomes, and 8) continuity. Also, Risser(1975) concluded there are three dimensions to the evaluation of care, 1) trusting relationship, 2) technical-professional behaviors, and 3) educational relationship. Therefore, patient satisfaction should be evaluated in these multiple aspects instead of a single aspect.

One important debate on the concept of patient satisfaction is whether high satisfaction can be considered same as low dissatisfaction. The relationship between the concepts of satisfaction and dissatisfaction is ambiguous in the literature. Cryns, Nichols, Katz and Calkins(1989, p. 814) suggest a “two-factor structure of patient satisfaction”, and maintain that satisfaction is composed of different attitudes from those for dissatisfaction. The model uses four quadrants which are created by two axes of positive attitude and negative attitude with a continuum of low to high levels. Satisfaction is a combination of high positive and low negative attitudes while dissatisfaction is a combination of high negative and low positive attitudes. In general, however, a lack of conceptual clarity has primarily brought about difficulties when measuring patient satisfaction.

Issues of Patient Satisfaction Questionnaires

Surveys are predominantly used to measure satisfaction but have a risk of producing an incorrect measurement of satisfaction level. Measuring patient satisfaction using a survey involves a range of issues to consider through the entire process of surveying, as exemplified in <Table 1>. These strategies should be considered in advance to elicit a meaningful satisfaction score from patient surveys. While all of these methodological issues influence satisfaction levels, having

<Table 1> Issues to consider for patient satisfaction surveys

Setting and sharing the purpose of survey	Purposes: e.g., ongoing quality monitoring, evaluation of new services, or performance evaluation Participating groups: e.g., departments of CM, quality improvement, nursing administration, risk management, and public relations
Developing Survey Questionnaire	Patient characteristics including demographics and health status Satisfaction Items: content, indirect or direct approach, positive or negative wording, vocabulary and reading level (e.g., 6th grade level) Scales: e.g., Likert scale, Thurstone scale, visual analogue scale, evaluation rating scale (poor, fair, good, very good, excellent), face expression scale Scoring: e.g., mean score or summed score, weighted value of items, risk adjustment Psychometric property
Administrating and Analyzing Survey	Survey frequency: regular basis or anecdotal Timing of survey: e.g., during visit or hospitalization, weeks or months after discharge Sampling: e.g., representativeness, sample size Analysis depending on goals
Utilization of Satisfaction Outcomes	Feedback to care providers Integration to quality improvement process

a valid questionnaire is most important and challenging.

Satisfaction questionnaires are composed of items and scales. Questionnaire items are often developed through a comprehensive literature review, for example, studies about both patient satisfaction and CM. An in-depth interview with a group of patients may be used as well as subject-matter experts (case managers) in the instrument review process. Furthermore, a pilot test is always necessary with a target population to determine the psychometric properties and the feasibility of completing a questionnaire with patients.

● Direct or Indirect Approach

The survey items may be stated in either an indirect approach(objective method) or a direct approach(subjective method) in terms of satisfaction. The direct approach asks how satisfied patients are with care and care providers, while the indirect approach asks patients to report whether expected interventions or nursing behaviors occurred or not. For example, using the direct approach, a patient rates how satisfied (s)he is with the experience of medication education (subjective method). On the other hand, using the indirect approach, patients report whether or not a nurse told them about the possible side effects of a drug(objective method) and then patient satisfaction is inferred according to their experiences(Cleary & McNeil, 1988).

Some researchers recommend using an indirect approach because satisfaction is often influenced by various experiences unrelated to quality of care(Ware, Snyder, Wright, & Davies, 1983). However, patients' reports may not always be accurate or reliable because discrepancies between patients' reports and

care providers' answers have been found. For example, patients' report of time spent with the doctor was mostly incongruent with the doctor's evaluation of the same visit in a study by Linder-Pelz(1982). In addition, because an indirect approach is dependent on patients' memory, respondent burden for remembering details of their care experience may increase(La Monica et al., 1986). Also, others argue that since a survey intends to measure patients' subjective perceptions, a questionnaire should directly ask satisfaction rather than predict satisfaction(Cleary & McNeil, 1988; Hall & Dornan, 1988). In Hall & Dorman(1988)'s meta analysis of 221 satisfaction studies, each approach was used nearly 40% of the time among survey instruments, and a mixed approach was also found in others(20%). However, there was no evidence that satisfaction level was influenced depending on these different approaches and thus no preferred approach is suggested as a result of this meta analysis.

● Acquiescence Effect

Another issue arises when making statements of satisfaction items; for example, "clarity of information" can be written as both favorable and unfavorable statements. For this decision, the acquiescence effect, defined as "the tendency to agree to personality items as self-descriptive, independently of the particular content of the items"(Wiggins, 1980, p. 423), needs to be considered because it can interfere with the true satisfaction score. The acquiescence effect is reported to occur more often among patients who are older, less well educated, and in poorer health(Ross, Steward, & Sinacore, 1995). Mixed wording of both negative and positive statements has been

applied to control for the acquiescent bias. However, on the negative side mixed wording may confuse patients and lead them to answer incorrectly. The end result is that there is no one answer for wording items in a satisfaction questionnaire, and a decision should be made considering patient characteristics and through an interview with patients or a pilot test.

● Response Scale

A response scale needs to be selected considering sensitivity, potential for variability and its convenience of use(Ross et al., 1995). The Likert scale, for example, ranging from 'strongly agree' to 'strongly disagree' or from 'very satisfied' to 'very dissatisfied' is preferred in measuring attitudes(Lin & Kelly, 1995; Ware et al., 1983). The advantages of using Likert-type scales are 1) to smooth the process of completing a survey questions taking a relatively short time and 2) to shorten questionnaire pages by using a simple layout(Ware et al., 1983). The response choices of the Likert scale usually have five or more levels classified in satisfaction questionnaires. However, skewed high satisfaction levels are common and five levels may not be enough to discriminate meaningful differences in satisfaction. An evaluation rating scale ranging from excellent to poor may produce more varied and less skewed scores than the Likert scale(Ware & Hays, 1988), but no conclusion has been reached as yet.

● Confounding Variables

In satisfaction surveys, patient information needs to be gathered to interpret meaningful satisfaction scores. Because the level of satisfaction is associated with patient characteristics such as age, gender, and health status(Lin, 1996; Lumby & England, 2000; Megivern, Halm, & Jones, 1992), and patients participating in a survey are not homogeneous at each time, simply comparing crude satisfaction scores can be in vain (Turnbull & Hembree, 1996). Often older patients tend to be more satisfied with care than younger patients(Johansson, Oleni, & Fridlund, 2002), but other studies did not find this relationship(Megivern et al., 1992). For gender, women expressed higher levels of satisfaction than men(Lin, 1996), whereas no difference was found in other studies(Lumby & England, 2000; Megivern et al., 1992). Also, the better the patient's health status, the higher the level of satisfaction(Hall, Milburn, & Epstein, 1993).

Patients cared for by case managers are in most cases more vulnerable people such as the elderly, the disabled, and patients with chronic or catastrophic disease, and thus they are likely to be different from an average group of patients. These differences need to be taken into account before comparing satisfaction scores measured at different times and in different populations using the same questionnaire(Lin & Kelly, 1995). Unfortunately, few studies have controlled for these confounding factors in their satisfaction measurement, and no conclusion has been reached. Therefore, as a first step, it is suggested to include patients' demographic and health status in a satisfaction survey(Cleary & McNeil, 1988; Lin, 1996). This effort is necessary to better understand inconsistent satisfaction outcomes in diverse patient groups.

Questionnaires to Measure Patient Satisfaction with CM

A large number of patient satisfaction questionnaires have been developed in nursing since the 1950s(Abdellah & Levine, 1957). These questionnaires mostly measure the art of care, technical quality of care, physical environment, and efficacy but less often included domains such as accessibility/convenience, finances, availability, and continuity(Greeneich et al., 1992), although the latter four domains are closely related to CM services. In Hall and Doran(1988)'s meta analysis of 221 studies, access or availability was measured in only 27% of these studies, cost in 18%, and continuity in 6%. This indicates that many satisfaction questionnaires have limitations for use in evaluating CM as they are.

In the literature review, six studies were identified because they described instruments used to measure patient satisfaction with CM. They modified an existing satisfaction questionnaire or developed a new survey questionnaire to include specific attributes of CM, which is summarized in <Table 2>. The instruments were the Quality of Multidisciplinary Care Scale (Blegen, Reiter, Goode, & Murphy, 1995; Goode, 1995), Discharge Planning Satisfaction Survey(Finch & Linderbery, 1999), Client Satisfaction Questionnaire(CQS-8, global measure) and Opinion Questionnaire on Outpatient Services-26(OQOS-26, specific measure, Tempier, Pawliuk, Perreault, & Steiner, 2002), Patient/Family Care Coordination Survey(Barry, Davis, Meara, & Halvorson, 2002), and the CM Quality Questionnaire (CMQQ, Hadjistavropoulos, Sagan, Bierlein, & Lawson, 2003).

<Table 2> Survey Instruments measuring satisfaction with CM

Author (year)	Setting	Tool & subscales	Item and scale	Psychometric property
Blegen et al. (1995) Goode (1995)	Women who delivered by cesarean section	Quality of Multidisciplinary Care Scale Subscales: Technical quality, Communication, Interpersonal care, Outcomes of care, Participation in decisions, Satisfaction	21 items 5-point Likert Scale	Cronbach's alpha as a whole: .95 (Blegen et al.) & .94 (Goode) Construct validity
Finch & Linderbery (1999)	Arnot Ogden Medical Center in NY	Arnot Ogden Discharge Planning Satisfaction Survey Questions Subscales: Not reported	12 items including 1 open ended question Evaluation scale (Excellent, very good, satisfactory, poor, and unsatisfactory)	Not reported
Barry et al. (2002)	The Children's Hospital of Los Angeles	Patient/Family Care Coordination Survey Subscales: Availability/advocacy Education/empowerment General coordination of care	Not reported	Reported test of reliability but no data available
Tempier et al. (2002)	Psychiatry Outpatient of a university teaching hospital in Canada	Client Satisfaction Questionnaire (CQS-8, global measure) & Opinion Questionnaire on Outpatient Services-26 (OQOS-26, specific measure) Subscales: Therapist understanding, therapist interest and attitude, service accessibility, explanations of service and treatment, atmosphere and location, continuity of care	36 items including 2 open-ended questions 4-point Likert scale	Cronbach alpha = .90 (CQS-8) & .84 (OQOS-26)
Hadjistavropoulos et al. (2003)	Home care and long term care	CMQQ (CM Quality Questionnaire) Subscales: Accessibility, efficiency, assessment/coordination skill	30 items: both positive and negative wording 5-point Likert scale: 1 (strongly disagree) to 5 (strongly agree)	Cronbach's alpha = .95 (accessibility), .80 (efficiency), .93 (assessment/coordination) Face validity, Content validity, Concurrent validity, Discriminant validity

The subscales of these satisfaction questionnaires include not only general components such as technical quality, communication, interpersonal skills, and outcomes of care, but also specific attributes of CM such as assessment/coordination skills, participation in decisions, advocacy, empowerment, and continuity of care. These various subscales show that the concept of satisfaction is multi-dimensional but not agreed among the researchers. In addition, the number of items varies from 12 to 36.

Among these survey tools, the CM Quality Questionnaire (CMQQ) was the only one that was developed specifically for CM practice, while the other studies modified an existing tool. It has solid scientific rigor and used patients and families who were cared for by case managers in community care settings in its development (Hadjistavropoulos et al., 2003). This instrument measures three subscales of 1) accessibility, 2) efficiency, and 3) assessment/coordination skill, using 30 items on the five-point Likert scale. Both positive and negative wording was used to minimize the acquiescence effect. Cronbach's alpha for this instrument ranges from .80 to .95,

which is acceptable. Also, face and content validity of this instrument was supported by case managers. Concurrent validity was acceptable because the correlations between the CMQQ and Client Satisfaction Questionnaire-8 (CSQ-8) were high ranging from .61 to .85. The low correlations ranged from .10 to .25 between the CMQQ and SF-8 Health Survey, which supports discriminant validity. The CMQQ can be reliably used among patients cared for by case managers in home care or long term care settings. As the authors of this article suggested, more satisfaction questionnaires need to be developed in diverse CM settings.

Satisfaction Outcomes in the Nursing Outcomes Classification (NOC)

Greeneich et al. (1992) stressed the importance of the nursing taxonomy of patient satisfaction as a fundamental framework for both research and practice in measuring satisfaction in order to "(a) study specific dimensions of patient satisfaction in depth; (b) provide direction for measurement of patient

satisfaction with nursing care found across all clinical settings; and (c) evaluate future tools according to identified dimensions of patient satisfaction specific to nursing(p. 47)”. The NOC fits these purposes. The NOC has been built on scientific research findings, nurse experts' opinions, and empirical studies in multiple clinical sites and focuses on standardizing outcome measurement by creating a classification of outcomes for use with patients across the care continuum.

Each of the 330 outcomes in the 3rd edition of the NOC has a standardized label name and definition, a list of specific indicators and a measurement scale. Under Domain V: Perceived Health in the NOC taxonomy, there is the Class called Satisfaction with Care. This class contains 14 outcomes focused on measuring patient satisfaction. These outcomes contain 236 outcome indicators that use a five-point scale ranging from 1(Not at all satisfied) to 5(Completely satisfied). All 236 outcome indicators were examined for their relevance with attributes of CM and classified into three levels by the author: outcome indicators that are more emphasized in CM than general nursing care were marked with “+++,” and those relevant to both CM and nursing in the same degree were

marked with “+,” and those less emphasized in CM than traditional nursing care were marked with ‘+’. Also, these findings were reviewed by the NOC experts and nurse managers at the University of Iowa College of Nursing.

<Table 3> exemplifies the findings with Client Satisfaction: Access to Care Resources. About 40% of outcome indicators was more closely related to CM rather than traditional nursing care, and nearly 30% was relevant with both CM and usual nursing care, which is summarized in <Table 4>. It was found that outcome indicators under the same outcome of the NOC have different degrees of relevance. In the six of the 14 outcomes, a majority of outcome indicators are more relevant to CM rather than traditional nursing care: 1) Client Satisfaction: Continuity of Care, 2) Client Satisfaction: Cultural Needs Fulfillment, 3) Client Satisfaction: Psychological Care, 4) Client Satisfaction: Protection of Rights, 5) Client Satisfaction: Technical Aspects of Care, and 6) Client Satisfaction: Access to Care Resources. The other three outcomes are composed of mostly outcome indicators that are equally stressed in both CM and traditional nursing: 1) Client Satisfaction: Teaching, 2) Client Satisfaction: Communication, and 3) Client Satisfaction:

<Table 3> Example of relevant NOC satisfaction taxonomy to CM

Client Satisfaction: Access to Care Resources--3000

Domain-Perceived Health (V)	Care Recipient:
Class-Satisfaction with Care (e)	Data Source:
Scale(s)-Not at all satisfied to Completely satisfied (s)	
DEFINITION: Extent of positive perception of access to nursing staff, supplies, and equipment needed for care	
OUTCOME TARGET RATING:	Maintain at _____ Increase to _____
	Not at all satisfied Somewhat satisfied Moderately satisfied Very satisfied Completely satisfied
CLIENT SATISFACTION: ACCESS TO CARE RESOURCES OVERALL RATING	1 2 3 4 5
INDICATORS:	
300001	Availability of registered nurses ++
300002	Availability of assistive staff ++
300003	Availability of supplies needed for care +++
300004	Availability of equipment needed for care +++
300005	Informed of registered nurse and assistive staff responsible for care ++
300006	Access to registered nurse responsible for care ++
300007	Assistance with gaining access to other health care providers +++
300008	Assistance with contacting physician +++
300009	Coordination of health care resources +++
300010	Coordination of health care providers +++
300011	Wait times for getting an appointment ++
300012	Wait times to be seen at appointment ++
300013	Access to support group(s) +++

<Table 4> Number of NOC *Outcome Indicators* depending on the relevance to CM

NOC Outcomes	+++	++	+	Total
Client Satisfaction: Continuity of Care	20 (100%)	0 (0%)	0 (0%)	20
Client Satisfaction: Cultural Needs Fulfillment	13 (100%)	0 (0%)	0 (0%)	13
Client Satisfaction: Psychological Care	12 (75%)	4 (25%)	0 (0%)	16
Client Satisfaction: Protection of Rights	10 (66%)	4 (27%)	1 (7%)	15
Client Satisfaction: Technical Aspects of Care	9 (60%)	2 (13%)	4 (27%)	15
Client Satisfaction: Access to Care Resources	7 (54%)	6 (46%)	0 (0%)	13
Client Satisfaction: Teaching	4 (19%)	17 (81%)	0 (0%)	21
Client Satisfaction: Communication	8 (44%)	10 (56%)	0 (0%)	18
Client Satisfaction: Caring	4 (18%)	12 (55%)	6 (27%)	22
Client Satisfaction: Safety	5 (38%)	1 (8%)	7 (54%)	13
Client Satisfaction: Symptom Control	1 (7%)	6 (43%)	7 (50%)	14
Client Satisfaction: Functional Assistance	0 (0%)	2 (13%)	13 (87%)	15
Client Satisfaction: Physical Care	0 (0%)	0 (0%)	21 (100%)	21
Client Satisfaction: Physical Environment	0 (0%)	0 (0%)	20 (100%)	20
Total	93 (40%)	64 (27%)	79 (33%)	236 (100%)

+++, outcome indicators that are more relevant to CM than traditional nursing care

++, outcome indicators that are equally relevant to CM and to traditional nursing care

+, outcome indicators that are more relevant to traditional nursing care than CM

Caring. The rest of the five outcomes are more related to traditional nursing care than CM: 1) Client Satisfaction: Safety, 2) Client Satisfaction: Symptom Control, 3) Client Satisfaction: Functional Assistance, 4) Client Satisfaction: Physical Care, and 5) Client Satisfaction: Physical Environment.

However, this finding is only tentative and may change depending on CM definitions and models. Furthermore, these 14 NOC outcomes measuring patient satisfaction were not developed focusing on CM, and this grouping is not necessarily consistent with priority of CM practice. Although satisfaction outcome indicators in the NOC are unlikely to be used as they are, the NOC provides a pool of satisfaction questionnaire items for case managers in practice to easily refer. Nurse researchers and case managers may be able to use the NOC as guidance to develop survey items reflecting attributes of CM.

Conclusion

This review discussed several challenging but important issues of measuring patient satisfaction with CM. Although tools for measuring satisfaction with CM need to specifically address roles of case managers, many studies used general tools that were not validated in the CM field. With other common measurement issues, use of an unspecified tool in CM is likely to generate misleading outcomes and misidentify the value of CM as an approach to care. Therefore, instruments for evaluating patient satisfaction need to be tested whether they are sensitive to reflect CM services. This study found only five satisfaction measurement tools specifically designed for CM services. However, they vary in the types of subscales, questions, and measurement scales, and thus there is no standard tool to measure patient satisfaction with CM. One

standard satisfaction tool is unlikely to be used across the different models of CM programs. However, to utilize satisfaction scores for the improvement of CM performance, one or more ideal instruments need to be developed. Using standardized instruments, a comparison between different satisfaction scores becomes meaningful, which helps identify a room for improvements in CM practice. Whereas CM outcomes studies often measured patient satisfaction but often only as a part of a series of outcome measures, future studies are suggested to focus on patient satisfaction as a major outcome of CM, which is likely to increase opportunities for the use of CM specific measurement tools.

Literature review of satisfaction measurement revealed that there are different approaches in developing satisfaction survey questionnaires. Researchers need to better understand survey respondents and characteristics of interventions to decide the best way of asking survey questions. Surprisingly, the concept of satisfaction is not clearly defined, and different explanations of the concept exist in the literature. It is considered that a lack of theoretical and conceptual understanding of satisfaction brings about difficulties in developing satisfaction tools. Concept analysis of satisfaction needs to be conducted without delay.

The development of valid survey questionnaires is challenging, and resources are often limited in practice. The 14 client satisfaction outcomes from the NOC provide a comprehensive list of content items. They may not be directly used in CM, but be useful resources and easily adapted to satisfaction questionnaires in CM practice. Outcome indicators more relevant to CM than traditional nursing care were identified in this review. It may be important to continue to evaluate satisfaction instruments for their relevance to CM.

Measures of patient satisfaction are an integral indicator of an entire CM program. Healthcare leaders and case managers seem to agree the importance of measuring patient satisfaction. It is suggested that case managers and researchers put more efforts in order to develop a reliable and valid satisfaction measurement tool for use in CM practice. Nurses are an important workforce in CM, and thus they are expected to take a leadership role in CM practice. Accordingly, measuring outcomes of CM is one of the vital tasks of nurse case managers. They need to understand crucial issues of measuring patient satisfaction and find true satisfaction levels.

References

- Abdellah, F. G., & Levine, E. (1957). Developing a measure of patient and personnel satisfaction with nursing care. *Nurs Res*, 5(3), 100-108.
- Barry, T. L., Davis, D. J., Meara, J. G., & Halvorson, M. (2002). Case management: An evaluation at Childrens Hospital Los Angeles. *Nurs Econ*, 20(1), 22-27.
- Blegen, M. A., Reiter, R. C., Goode, C. J., & Murphy, R. R. (1995). Outcomes of hospital-based managed care: A multivariate analysis of cost and quality. *Obstet Gynecol*, 86(5), 809-814.
- Cleary, P. D., & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25(1), 25-36.
- Cryns, A. G., Nichols, R. C., Katz, L. A., & Calkins, E. (1989). The hierarchical structure of geriatric patient satisfaction: An Older Patient Satisfaction Scale designed for HMOs. *Med Care*, 27(8), 802-816.
- Ellmer, R., & Olbrisch, M. E. (1983). The contribution of a cultural perspective in understanding and evaluating client satisfaction. *Eval Program Plann*, 6(3-4), 275-281.
- Eriksen, L. R. (1995). Patient satisfaction with nursing care: Concept clarification. *J Nurs Meas*, 3(1), 59-76.
- Finch, G. L., & Linderberg, J. (1999). Improving patient satisfaction through unit-based team case management. *Continuum*, 19(2), 12-16.
- Goode, C. J. (1995). Impact of a CAREMAP and case management on patient satisfaction and staff satisfaction, collaboration, and autonomy. *Nurs Econ*, 13(6), 337-348.
- Greeneich, D. S., Long, C. O., & Miller, B. K. (1992). Patient satisfaction update: Research applied to practice. *Appl Nurs Res*, 5(1), 43-48.
- Hadjistavropoulos, H. D., Sagan, M., Bierlein, C., & Lawson, K. (2003). Development of a case management quality questionnaire. *Care Manag J*, 4(1), 8-17.
- Hall, J. A., & Dornan, M. C. (1988). Meta-analysis of satisfaction with medical care: Description of research domain and analysis of overall satisfaction levels. *Soc Sci Med*, 27(6), 637-644.
- Hall, J. A., Milburn, M. A., & Epstein, A. M. (1993). A causal model of health status and satisfaction with medical care. *Med Care*, 31(1), 84-94.
- Johansson, P., Oleni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care:

- A literature study. *Scand J Caring Sci*, 16(4), 337-344.
- La Monica, E. L., Oberst, M. T., Madea, A. R., & Wolf, R. M. (1986). Development of a patient satisfaction scale. *Res Nurs Health*, 9(1), 43-50.
- Laramee, A. S., Levinsky, S. K., Sargent, J., Ross, R., & Callas, P. (2003). Case management in a heterogeneous congestive heart failure population. *Arch Intern Med*, 163(7), 809-817.
- Lin, B., & Kelly, E. (1995). Methodological issues in patient satisfaction surveys. *Int J Health Care Qual Assur*, 8(6), 32-37.
- Lin, C. C. (1996). Patient satisfaction with nursing care as an outcome variable: Dilemmas for nursing evaluation researchers. *J Prof Nurs*, 12(4), 207-216.
- Linder-Pelz, S. (1982). Social psychological determinants of patient satisfaction: A test of five hypothesis. *Soc Sci Med*, 16(5), 583-589.
- Lumby, J., & England, K. (2000). Patient satisfaction with nursing care in a colorectal surgical population. *Int J Nurs Pract*, 6(3), 140-145.
- Megivern, K., Halm, M. A., & Jones, G. (1992). Measuring patient satisfaction as an outcome of nursing care. *J Nurs Care Qual*, 6(4), 9-24.
- Moorhead, S., Johnson, M., & Maas, M. (2004). *Nursing outcomes classification (NOC)* (3rd ed.). St. Louis, MO: Mosby.
- Risser, N. L. (1975). Development of an instrument to measure patient satisfaction with nurses and nursing care in primary care settings. *Nurs Res*, 24(1), 45-52.
- Ross, C. K., Steward, C. A., & Sinacore, J. M. (1995). A comparative study of seven measures of patient satisfaction. *Med Care*, 33(4), 392-406.
- Tempier, R., Pawliuk, N., Perreault, M., & Steiner, W. (2002). Satisfaction with clinical case management services of patients with long-term psychoses. *Community Ment Health J*, 38(1), 51-59.
- Turnbull, J. E., & Hembree, W. E. (1996). Consumer information, patient satisfaction surveys, and public reports. *Am J Med Qual*, 11(1), S42-45.
- Ware, J. E., Davies-Avery, A., & Stewart, A. L. (1978). The measurement and meaning of patient satisfaction. *Health Med Care Serv Rev*, 1(1), 1.
- Ware, J. E., & Hays, R. D. (1988). Methods for measuring patient satisfaction with specific medical encounters. *Med Care*, 26, 393-401.
- Ware, J. E., Snyder, M. K., Wright, W. R., & Davies, A. R. (1983). Defining and measuring patient satisfaction with medical care. *Eval Program Plann*, 6(3-4), 247-263.
- Wiggins, J. S. (1980). *Personality and prediction: Principles of personality assessment*. Reading, MA: Addison-Wesley.

사례관리 만족도 측정에 관한 고찰

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연구 목적: 사례 관리(CM) 환자 만족도 측정에 관한 연구 결과를 고찰하여 사례관리 실무에서 활용할 수 있는 근거를 제공하고자 한다. **연구 방법:** MedLine, CINAHL에서 주요용어로 *case management, care management*, 주제어로 *patient satisfaction, client satisfaction*을 이용해 문헌 검색을 실시하였다. **연구 결과:** 만족도에 대한 개념은 관련 연구가 매우 부족하며, 서로 다른 이론적 접근을 하고 있으므로 그 측정에 어려움이 있다. 신뢰할 만한 만족도 측정을 위해서는 설문 문항을 서술하는 여러 가지 방법들, 측정 척도의 종류, 만족도에 영향을 미치는 혼란변수들을 주의 깊게 고려하여야 한다. 만족도는 사례관리 연구에서 흔히 측정되는 성과이지만 대부분의 관련 연구에서 사례관리의 특징이 반영된 측정 도구를 사용하지 않고 있었다. 따라서 본 논문은 다섯 개의 사례관리 만족도 측정 도구를 제시하고 그 특징을 소개하였다. 또한, 간호성과분류체계(The Nursing Outcomes Classification)에 제시된 만족도 측정항목들 중 사례관리와 관련이 높은 약 40%의 항목들을 발견하였다. **결론:** 사례관리 만족도 측정 도구가 매우 부족하므로 표준 사례관리 측정도구 개발이 시급하다. 한편 사례관리사들은 만족도 측정에 대한 이해를 높이고 기존 연구 결과를 활용함으로써 보다 정확한 사례관리 만족도 평가가 이뤄지도록 노력해야 한다.

주요어 : 사례관리, 환자 만족도, 간호성과

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