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Implementation of a Patient Satisfaction Survey in a Federally Qualified Health Center

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IMPLEMENTATION OF A PATIENT SATISFACTION SURVEY IN A FEDERALLY QUALIFIED HEALTH CENTER

By

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Dedication

First I would like to thank my family and friends for their love and support throughout my doctoral program. You gave me strength, love and patience when I needed it most. To my love Jennifer, thank you for believing in me every step of the way.

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IMPLEMENTATION OF PATIENT SATISFACTION SURVEY AT A FEDERALLY

QUALIFIED HEALTH CENTER (FQHC)

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Abstract

Problem: Safety net FQHCs are typically challenged with initiating and sustaining standardized measurement of patient satisfaction. Baseline survey data establishing how patients rate their satisfaction at San Francisco General Hospital (SFGH) Urgent Care Center (UCC), a public safety net federally qualified health center, located in San Francisco, California is needed. Implementing an existing patient satisfaction survey instrument using a standardized method, with volunteer survey administrators, made this study unique and resulted in a higher rate of survey participation that any other method previously attempted. Survey results determine whether patients' needs and expectations were being met, adding value and allowing for comparison of performance internally over time. Standardizing and using the same measurement tool across facilities, also allows for external comparisons to other safety net FQHC settings.

Methods: Using a convenience sample, over a period of three months surveys in English were given in-person to patients after receiving care at an urgent care center. The surveys were offered through volunteers who had completed specific survey administration training. The publicly available survey instrument was developed by the Bureau of Primary Health Care (BPHC) Health Resources and Services Administration (HRSA). Minor modifications were to the survey instrument tailored for the SFGH UCC patient population. Quantitative answers were based on a 5-point Likert-like scale (5-Great, 4-Good, 3-OK, 2-Fair, 1-Poor). Outcomes included patient self-reported ratings on specific domains: Ease of Getting Care, Waiting, Care and Communication, Financials, Facility, Confidentiality and Overall satisfaction.

Results: A sample of patients (n=64) received care at SFGH UCC self-reported being generally satisfied with their experience. Patients were most satisfied with care and communication by Nurses and Medical Assistants (4.54), and Providers (4.48). Patients were least satisfied with the Financials (4.01) and Waiting Time (4.06). The age groups showed majority being 25 to 44

years old (46.8%) and 45 to 64 years old (37.1%). Hispanic respondents comprised the highest

proportion of any racial/ethnic group, followed by Black/African American and White (40.3%

Hispanic, 22.6% Black/African American, 19.4% White). The majority of patients (71%)

answered "yes" to SFGH UCC being their regular source of care. An independent groups t test

indicated no significant difference on overall satisfaction between patients who consider the

clinic as their regular source of care ($M = 4.24$, $SD = 0.71$) and patients who did not ($M = 4.15$,

$SD = 0.78$), $t(41) = 0.382$, $p = .705$. The narrative data was analyzed for common themes using

an inductive approach to content analysis.

Conclusion: The results of the analyses reported provide preliminary support for the value with

collecting patient satisfaction data, the need of establishing baseline data fro FQHC settings, and

the benefits of utilizing an existing and standardized survey tool. Additionally, this study adds to

the body of literature supporting the importance of measuring patient satisfaction unique to

FQHC settings, while utilizing standardized survey methods. Lessons from implementing a

patient satisfaction survey can guide other FQHCs with similar patient population settings who

wish to undertake or promote transformation using the BPHC HRSA patient satisfaction survey.

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For health care organizations, patient satisfaction has become an integral quality indicator, used in the decision making process to shape the delivery of care. Patient satisfaction is encompassed in the overall patient experience and focuses on the degree to which patients are content with care (Steinbruege & Giuliani, 2010). As patients become more involved in their own care, their role will be central to defining and judging the quality of care. As a result, patient assessment of care can be a key motivator behind organizational efforts to provide patient-centered care. The patient experience offers valuable metrics in determining how well an organization is able to provide quality care, where the impression of quality is reported directly from the consumer and not the provider (Press & Fullam, 2011). Patient satisfaction is a key metric when attempting to measure patient centered care (PCC) (Rathert, Wyrwich, & Boren, 2012).

Gathering data on a patient's satisfaction with their health care experience is important in assessing whether the quality of care is patient-centered (Zuckerman, Wong, Teleki, & Edgman-Levitan, 2012). The Institute of Medicine (IOM) emphasized the importance of "patient-centered" care as being one of six aims for improvement of health care (2001). Knowing whether interventions intended to improve patient-centeredness have achieved their goal is foundational when designing a health care delivery system (Epstein & Street, 2011).

PCC and its metric, patient satisfaction, is growing in importance (Shaller, 2007; Heidenreich, 2013) and will be at the core of health care systems which are committed to placing patients at the center of their own care, seeking new and better ways to engage with patients, and applying patient feedback for positive changes in care. The first step in making these improvements is to gather data and feedback from patients, which gives the health care systems appropriate direction on how to make care more patient-centered. Patient satisfaction data can

identify key areas for delivery system improvement and inform new, more patient-centered ways

of delivering services. Patient satisfaction data can also be used for comparing quality of care by

patients, providers, payers, policy makers and the general public (California association of public

hospitals and health systems [CAPH], 2014). The need for meaningful patient satisfaction data

can be a barrier for some health care settings, however data is needed to drive improvements

(Lyles et al., 2013) and is considered to be a necessary precursor to prioritize issues within a

health care system and to gauge success of improvement initiatives.

The Problem

In 2001, the Institute of Medicine (IOM) reported a significant gap that exists in health

care and listed six dimensions (safe, effective, patient-centered, timely, efficient and equitable)

that broadly focuses on how a health system can be reinvented to cultivate innovation and

improve the overall delivery of care (IOM, 2001). Since many safety net systems typically

operate under the pressure of narrow financial margins, increasing efficiency, reducing costs, and

improving quality are increasingly becoming core strategies to sustain the safety net health care

system's ability to innovate the development of measures for assessing quality of care (Coughlin,

Long, Peters, & Arguello, 2014). Safety net systems can include public hospitals and health

systems, health districts, community health centers and clinics, and for-profit and nonprofit

health care organizations that provide free or discounted care (Saviano, 2009).

In the competitive health care environment, safety net systems and their encompassed

health centers will be pressed to achieve advancements in these six dimensions to be better

equipped in meeting their patient's needs, expectations, and improving the patient experience

(Berwick, 2002; Lewin & Baxter, 2007). Patient-centered care is one of the 6 specific aims

targeted for improving health care quality and is intricately connected to the other five aims of

improvement. IOM (2001) defines patient-centered care as provided care that is respectful of and responsive to individual patient preferences, needs, and values.

Characterized as being more susceptible to experiencing greater challenges of cultivating innovation and improving the overall delivery of care, safety net clinics and health centers have historically been considered as providers of last resort who care for all patients, regardless of ability to pay for their care, and providing a disproportionate amount of hospital and community care to those who are uninsured or Medicaid beneficiaries (IOM, 2000; Murphy, Ko, Kizer, & Bindman, 2015). Given the unique challenges that exist in safety net clinics and health centers, promoting transparency of patient satisfaction information that enables patients to make informed decisions will be key when designing sustainable health care delivery systems (IOM, 2001).

Safety Net System

California's health care safety net is composed of an array of providers committed to delivering a broad range of health care services to medically underserved populations (Saviano, 2009). As a result of having a larger proportion of uncompensated care for the uninsured, most safety net systems experience negative operating margins (Neuhausen & Katz, 2012). To help off-set financial constraints, a certain segment of safety net health centers are distinguished by having distinct legislative mandates to provide health care services to the medically indigent as a condition of federal or state funding and/or reimbursement from public health programs and are reimbursed differently than other safety net providers (Saviano, 2009). Health centers designated as a Federally Qualified Health Centers (FQHCs) provide comprehensive, culturally competent health care services to medically underserved communities and are often located within the communities they serve (Lee, Hill, & McConville, 2012; Taylor, 2004). In addition,

FQHCs receive federal funding under the Health Center Program (Section 330 of the Public Health Service Act) to provide health care services to uninsured and underinsured populations in high need communities (Center for Healthcare Research & Transformation [CHRT], 2013; Health Resources and Services Administration [HRSA], n.d., b; Taylor, 2004).

To respond to the growing demand of health care services, investing in patient satisfaction in FQHCs will contribute by providing patient-centered data that ultimately improves the sustainability of safety net health care systems. In order to sustain financial viability, safety net hospitals will need to reposition themselves to compete effectively as a "provider of choice" versus being the provider of last resort in the post reform health care market place (Coughlin, et al., 2014). IOM (2001) offered recommendations that address the support of the safety net system and the need to measure accessible quality health care for the nation's most disadvantaged and underserved populations.

Appropriating resources towards patient satisfaction initiatives has the ability to drive improvements in the quality and efficiency of care as patient satisfaction measurement identifies opportunities for meeting the needs and preferences of patients (Press Ganey, 2012). One of the first foundational steps to measuring patient satisfaction is the establishment of consistent standardized data collection practices and analysis. Given the competitiveness of today's health care market, understanding patient preferences and how satisfied they are with health care services, particularly in an FQHC, should be considered a vital performance metric in the rapid changing safety net health care environment of today (Grantmakers in Health [GIH], 2012).

Performance Measurement

Given that FQHCs have a mission to improve the health status of underserved populations in their targeted community, FQHCs must also have quality improvement systems

that measure and document the effectiveness, performance, and quality of management and clinical services (CHRT, 2013). Without the standardization of how to measure patient satisfaction, it is difficult to fairly compare data within the same organization and to outside organizations. In addition to having standardized measurement of patient satisfaction, it is equally important to have timely administration of patient satisfaction surveys, analysis, and communication of results (Murphy, Ko, Kizer, & Bindman, 2015; Urden, 2002). Sustaining the process of collecting and reporting on patient satisfaction can contribute to the success of safety net FQHCs. By utilizing a standardized survey instrument tailored for FQHC settings, there is great opportunity for future partnerships amongst safety net health care systems that can lead to enhancements that will contribute to the movement of improving and sustaining an organizational culture that promotes a satisfying experience for their patients.

Purpose

The purpose of this project is to implement an existent patient satisfaction survey tool developed by the Bureau of Primary Health Care (BPHC) Health Resources and Services Administration (HRSA) to evaluate patient satisfaction in a FQHC utilizing a standardized method of administration to establish baseline satisfaction data. This project will provide an at-a-glance view of how patients self report satisfaction with their health care experience at an urban FQHC setting. When implementing a quality improvement patient satisfaction project in an urban FQHC setting, it is important to have insight and consideration for the challenges that exist when collecting and using patient satisfaction data (Shi, Lebrun-Harris, Parasuraman, Zhu, & Ngo-Metzger, 2013). These challenges include low literacy, cognitive impairment, and social disadvantages. Because FQHCs serve vulnerable patient populations that are at a greater risk of being impacted by cross-cultural communication barriers, it is important to be aware that the

existence of these risks can lead to less than optimal patient satisfaction scores (Shi, Stevens,

Lebrun, Faed, & Tsai, 2008).

Background

The adult Urgent Care Center (UCC) at San Francisco General Hospital (SFGH) is the

only designated FQHC on the hospital's campus that is primarily responsible for accepting new

patients that present on a walk-in and appointment basis. The UCC provides evaluation and

treatment for patients with non-emergent conditions. The center is a unique setting in that it

serves a wide variety of patient populations and functions as a safety net FQHC within a larger

safety net system throughout San Francisco. This results in patients being commonly referred

from multiple sources that include emergency departments, on-campus and off-campus

community health centers. With over 23,000 annual patient visits it is surprising that SFGH

UCC does not utilize standardized methods in how it collects and measures patient satisfaction

(San Francisco Department of Public Health [SFDPH], 2014). Because of the complexity of the

safety net system, standardization is key when assessing the quality of care. One of the main

rationales for seeking to standardize measurement of patient satisfaction data is to generate

baseline data that can be compared internally within the SFGH organization, with potential to

compare to similar FQHC settings in other safety net health care systems.

Theoretical Framework

Avedis Donabedian (1988b), an international leader in public health, was known for his

classic work on quality assessment. Donabedian's work around health care quality has provided

many key contributions to the fields of health services and quality of heath care. Donabedian's

quality assessment framework's main assumption is that all providers of care are committed to

delivering high-quality care. Donabedian (1988b) asserts that quality must be understood before

assessment can begin. In addition there also needs to be detailed information about the causal

linkages among structural attributes of the settings in which care occurs, the processes of care,

and the outcomes of care. Donabedian emphasized that quality assessment requires specification

of: 1) a set of phenomena that are usually attributes of either process or outcome; 2) a general

rule of what constitutes goodness; and 3) a precise numerical statement of what constitutes

acceptable or optimal goodness with respect to each of these phenomena (Donabedian, 1981).

Patient satisfaction is both a process and outcome of care. As a process, the experience

of care can have an impact on the patient's perception and response to interventions as they

occur in the clinical setting. As an outcome, satisfaction reflects the patient's evaluation of the

entire experience (Press & Fullam, 2011). Patient satisfaction also hinges on whether the service

experience meets consumer expectations. Since patients typically interact with personnel from

multiple departments each day, patients provide a unique perspective on the coordination of

services within a health care facility. Patients' comments in surveys can be a valuable method

for managers to evaluate the quality of care provided by their particular area of service (Tasso, et

al., 2002). By questioning patients, one can obtain information about overall satisfaction and

also about satisfaction with specific attributes of the interpersonal relationship, and the outcomes

of care.

The role of patient satisfaction metrics is pivotal in assessing the quality of care.

Measures of outcome can be considered valid indicators of the quality of care, with the patient

satisfaction outcome highlighting the relationship between expectations and what actually

occurred during and following the episode of care (Cleary & Mcneil, 1988). Donabedian's

quality assessment frame work divides health care into two domains: 1) Technical care is the

application of the science and technology of medicine, and of other health sciences, to the

management of a personal health problem; and 2) Interpersonal care is management of the social

and psychological interaction between the patient and health care provider (Donabedian, 1988b).

Patient satisfaction attributes that are part of the interpersonal care domain of quality assessment

can include but are not limited to: the setting, empathy, professionalism, courtesy and

communication by health care staff (Donabedian, 1988b). Patient satisfaction data generated

from patients can be used to monitor performances to determine whether satisfaction is within a

targeted range.

Donabedian (1996) also emphasized the need for a cultural change in organizations that

are designing quality assessment processes. Donabedian believed cultural change occurs through

the connection of external forces: such as governmental pressure, professional aspirations,

consumer demand, the play of market forces, and so on. When looking at FQHC settings,

initiating a cultural change where patient satisfaction is collected to demonstrate how patients

perceive health care services requires organizational support. With investment and appropriate

allocation of resources by safety net FQHCS, there is a greater chance for having credible

trustworthy data. This allows for the establishment of meaningful results and gives importance

to the manner in how results are presented (Donabedian, 1996).

Donabedian's assessment of quality framework has been a widely accepted method to

evaluate the main dimensions of health care quality (El Haj, Lamrini, & Rais, 2013). His work

in assessing quality supports the purpose of measuring patient satisfaction. Acting on the belief

that interpretation of quality data is needed to measure performance, this framework provides

structure for developing a patient satisfaction measurement system that utilizes standardized

survey collection methods (Donabedian, 1996). Sustainability is key to quality improvement

projects and requires determined persistence by stakeholders to administer a patient satisfaction

survey in a FQHC. Donabedian wrote that commitment to quality requires the application of reasonable methods and not necessarily methods that are elegantly constructed or costly (Donabedian, 1996). Applying such a concept fits appropriately to FQHC settings that commonly function with limited resources where costly robust patient satisfaction collection methods are less feasible.

Measuring patient satisfaction as a quality performance metric is a significant endeavor when designing patient-centered safety net FQHCs. Without measurement, it is challenging to determine productivity, efficiency, or arrive to reasonable conclusions on how to allocate resources (Donabedian, 1988a). From the perspective of quality of care, patient satisfaction is itself a desired outcome (Wyszewianski & Donabedian, 1981). Systematic efforts to improve the "quality" of health care services are often coupled with the challenges of measurement. Developing what to measure and how to measure quality outcomes such as patient satisfaction feedback helps with understanding a patient population's perception of quality (Davidoff, 2013). Patients play an integral role in defining what constitutes quality care by determining what values should be associated with different outcomes. However, it can be difficult in determining what defines quality interpersonal care, in principle, quality should meet socially defined norms for the ways that individuals interact (Cleary & McNeil, 1988).

Literature Review

Safety net FQHCs have significantly increased over the last 50 years, growing to over 1,100 as of 2011 with those health centers serving more than 8,000 rural and urban areas in the United States and territories (CHRT, 2013). Given the large complex networks of safety net health care systems in the United States, understanding how patient satisfaction data is collected in FQHCs has not been adequately researched. Few studies have been conducted on the

utilization of an existing patient satisfaction survey instrument tailored to the unique patient populations that seek health care services in safety net FQHCs. As a result very little is known about the experience of care among patients who are served by safety net health care systems responsible for delivering a significant level of health care to uninsured, Medicaid, or other vulnerable patients (IOM, 2000). Even though differences may exist in the utilization of survey instruments between patient experience of care and patient satisfaction, their similarities involve collecting patient feedback and related to patient-centered care.

The review of research involving the collection of patient satisfaction in safety net FQHCs, patient experience of care (PEC) research literature may be similarly applicable to FQHC settings. Keywords used for this search included: patient satisfaction, safety net, patient experience of care (PEC), survey, HRSA, and Federally qualified health center (FQHC).

The following literature review specifically focuses on (a) assessing the readiness of safety net FQHCs to measure quality outcomes such as patient satisfaction, (b) understanding the needs and challenges that exist for safety net FQHCs involving the collection of patient reported satisfaction data (c) assessing research that utilizes an existing patient satisfaction survey instrument appropriate for safety net FQHC settings. Three studies that addressed the importance of and ways to measure patient satisfaction within FQHC settings were critiqued. The qualitative research focused on innovation and transformation in California's safety net health care system, the efforts and challenges with patient experience of care in safety net systems. The quantitative research described how a patient satisfaction survey instrument developed and selected by the Health Resources and Services Administration is utilized in an FQHC setting. These articles were published in 2012 and 2013 and took place in both statewide and national safety net health care settings.

Critique of Literature

Innovation and transformation in California's safety net health care settings: An insider perspective. (Lyles et al., 2013) conducted a series of interviews of key leadership from both California's public hospital systems and FQHCs. With an expected increase in demand for health care, health systems will be challenged to attract and retain patients as well as compete with other organizations in providing quality patient experiences. Public hospitals and health centers being are the core of the safety net in California, and there is a growing need for new ideas that foster continuous improvements.

Study Design. This qualitative study utilized an interview process that was informed by grounded theory (Engward, 2013), without specified a priori hypotheses and was used to explore safety net leaders' perspectives on the unique opportunities and challenges for innovation. Leaders were first recruited from 2 statewide membership organizations, the California Association of Public Hospitals and Health Systems (CAPH), and its quality improvement affiliate, the California Healthcare Safety Net Institute (SNI). Together, both organizations represent 16 county and three University of California health care systems. In addition to hospital care, California's public hospital systems provide over 10 million outpatient visits each year in hundreds of primary and specialty care clinics. Leaders were also recruited from the Center for Care Innovations, a nonprofit organization that provides support to the majority of the 480 community health centers and their regional consortia in California. These health centers collectively provide primary care services to more than 4 million Californians, generating more than 15 million encounters a year.

Sampling. Purposive sampling was used to recruit leaders from these organizations for the interviews and snowball sampling techniques implemented during initial interviews. A semi-

structured interview guide was developed and focused on system-wide transformation and innovation with interviews being recorded and transcribed for analysis.

Analysis. The authors then conducted qualitative content analysis of the transcripts: first coding two interviews for major thematic content areas and then meeting to develop a coding framework before completing the analysis across all transcripts. The authors executed simultaneous data analysis and interviewing to complete additional iterations of the codebook as needed and held regular meetings to achieve consensus on the themes. Human subjects approval was received from the University of California San Francisco (UCSF) Committee on Human Research.

Results. There were 13 interviewees from public hospitals, with leadership roles ranging from chief executive, medical, quality, or nursing officers to innovation/transformation and ambulatory care directors. The majority themes were similar for both public hospital and clinic interviewees and were summarized in the following sections: strategic challenges, definition of innovation, existing innovations, innovation barriers, and supporting future innovation.

The need for meaningful data was cited as an essential barrier for some settings. Data to drive improvement was seen as a necessary precursor in being able to prioritize issues within the organization and to gauge success of new practices. There was also a common desire to improve the collection of more timely and actionable data as well as to increase internal capability for more sophisticated data interpretation because many of the systems have not lived up to expectations related to data reporting and analysis. With limited resources and complex patient populations, safety net settings have historically been at the forefront of innovations, but many of the innovative solutions need support for broader dissemination and implementation to become transformational.

Limitations. Limitations consisted of interviews being conducted within several safety net systems throughout California with leaders holding a shared perspective about innovation, which may limit the generalizability of the findings. However, because safety net systems have historically dealt with the managing of patients with limited budgets, the results of this study may be generalizable to other health care systems that are facing increased cost pressures as a result of the new health care landscape.

Patient experience of care in the safety net: Current efforts and challenges. (Zuckerman et al., 2012), assessed how California safety-net practices measure PEC and the barriers they encounter. The primary questions the study focused on were: 1) How do safety net organizations measure PEC; 2) How do they use PEC data to improve health care quality; and 3) What specific barriers exist to the collection and use of PEC in the safety net.

Study Design. To address the gap in measurement of patient self-reported measures such as patient satisfaction, the researchers conducted a qualitative study design based on semi-structured interviews with 34 representatives of 27 safety net health care organizations in California between September 2008 and March 2009. The interviewees were represented as key decision makers in collecting and evaluated patient reported data in their organizations. The advisory panel met in person or via telephone three times during the study period.

Sampling. Interview subjects were recruited from the safety-net organizations that served on the advisory panel. Purposive sampling was used to select a sample that maximized variation in clinic type, size, geographic location, and characteristics of the patient population, including age, gender, race, and ethnicity. Multiple contact attempts were made to minimize non-response bias. The advisory panel helped construct the interview guide with contained the following domains: 1) current patient reported experience data collection and analysis practices; 2) patient

experience related quality improvement initiatives and resources; 3) barriers to patient

experience data collection; and 4) familiarity with CAHPS surveys, widely-distributed, public -

domain surveys assessing patient reported survey data. The interview guide was largely based

on open-ended questions designed to establish each organization's data collection practices and

to elicit barriers to data collection. The project was approved by the Institutional Review Board

of Partners HealthCare and RAND (a non-profit research center based in Santa Monica).

Analysis. Interview transcripts were analyzed using Framework Analysis, an analytic

strategy used for applied or policy-relevant qualitative research, in which preexisting ideas

inform the initial analysis. During the interviews and focus groups, the researchers requested

copies of the patient experience survey instruments from participating organizations. All English

surveys (n=21) were analyzed for reading level using the Flesch-Kincaid Grade Level test.

Results. There were 22 interviewees representing safety-net provider organizations, and

two represented safety net health care organization coalitions. Over half of the interviewees

represented FQHCs with the remaining respondents representing clinics affiliated with public

hospitals. All of the organizations were found to measure patient reported feedback in some

fashion without consistency in the type of survey instrument or method in which the feedback

was obtained. Most organizations used self-administered survey instruments to collect data from

patients. Surveys were most often administered in the waiting room just prior to or immediately

after the visit. Three organizations reported using a computer kiosk system for in-clinic data

collection, and one organization used a vendor to conduct its surveys. One-half of the

organizations used homegrown surveys, not adapted from or based on existing, validated

instruments. Eight organizations modified an existing survey instrument to meet their data needs

of collecting patient feedback. Three organizations did not know the source of their instrument.

Interviewees from public hospital systems were the only subjects familiar with the CAHPS

group of surveys, a publicly-available survey, and none knew that CAHPS surveys could be used

in an outpatient setting. A significant finding showed that the most commonly adapted

instrument was the BPHC survey created by the HRSA (n.d., a), which four organizations used.

One organization used a proprietary vendor instrument. Survey characteristics were generally

one-to-two pages in length with a median of 19 Likert scale or "Yes/No" response options.

Approximately one-third of the surveys also collected information on patient demographics

and/or solicited open-ended responses.

The most common survey domains were communication, access to services, office staff,

and satisfaction/willingness to refer or recommend. About three quarters of the organizations in

the interview sample reported offering surveys in English and Spanish; only two clinics offered

the survey in Chinese, Korean, Khmer and Asian languages. Patient literacy was an important

consideration in survey design. Most clinics made modifications for patients with low literacy

levels by writing their surveys at a low reading level, adding pictograms, or supplying

interviewers in the office to orally conduct the survey with patients who could not read. Surveys

were written at a median level of 5th grade, and interviewees reported that periodic revisions of

the survey were made to target areas of service and patient care feedback.

Nearly all organizations analyzed their own data and generated reports without the use of

an external vendor or consultant. Organizations either allocated staff to perform data entry and

generate reports or used volunteers to collate survey results and enter data. Many did not use

formal statistical methods to compare results. Organizations regularly shared survey results with

their senior management and clinic staff. Some also used survey results to justify additional

funding for operational improvements or salary support for additional health care providers. Of

the organizations that did not share their data, most expressed interest in doing so and in learning from top performers.

The most common focus of quality improvement initiatives was on improving access to care and decreasing wait times in the office. Other areas targeted for improvement included interpreter services, customer service, cultural competency, and clinic amenities such as parking and cleanliness. Organizations often used patient reported data to evaluate the effectiveness of improvement work by collecting and comparing data before and after implementation.

Barriers consisted of reported skepticism by interviewees that grew from concerns about the quality of the survey instruments, mode of administration and methods used to analyze the data. Sub themes of barriers included lack of financial and staff resources to administer and analyze data. Lack of knowledge about the value in collecting patient reported data resulting in unfamiliarity with existing validated instruments and inadequate training in survey administration. Even with the reported barriers, most participants had an interest in validated survey instruments, in standard process for data collection and analysis, and in surveys that would allow them to compare data with other practices, particularly those that were tailored to the needs of the safety net population. There were also many practices reporting the need for surveys in languages other than English and Spanish, most commonly, in Asian languages or dialects with low literacy levels. Finally, since all modes of survey administration seemed to exclude certain groups of patients, many organizations accepted the fact that their assessment of patient feedback could not be inclusive of their entire patient population.

Limitations. This study had a number of limitations, with one being not employing representative sampling or population-level data. While the study's findings may represent a range of organizations' experiences with collecting patient reported feedback, it may not

represent experiences typical of all California safety net organizations. As a result, it was

undetermined if the reported barriers were the most frequent or the most important which would

suggest the importance of conducing additional survey-based research on a state-wide or national

level. Another limitation was that interviewees may have presented positive views of their

organizations in order to satisfy the interviewer or to make their organization appear to be better

in comparison to other organizations.

Improving wait times and patient satisfaction in primary care. Michael, Schaffer, Egan,

Little, & Pritchard, (2013) tested the hypothesis of using the Dartmouth Microsystem

Improvement Curriculum (DMIC) framework and the Plan-Do-Study-Act (PDSA) improvement

process to pilot a project intended to increase patient satisfaction by minimizing wait times in a

Florida county health department (CHD) Adult Primary Care Unit (APCU) practice. Although

this study was based on quality improvement, the importance of the study was the patient

satisfaction instrument and methodology on how it was administered to patients.

Patient satisfaction was explicitly defined in the study as: 1) patient satisfaction with

waiting room wait time; 2) patient satisfaction with exam room wait time; and 3) the likelihood

of referring friends and relatives to the practice as a proxy measure associated with overall

satisfaction and the likelihood of returning for care in the future.

Survey Instrument. This study utilized a patient satisfaction survey instrument

developed and selected by the BPHC HRSA for use in FQHCs. The survey is in the public

domain and was determined to be well suited for the study's quality improvement project given

the similarities of the safety net populations served by FQHCs. The survey instrument provides

anonymous collection of data and includes a total of 29 items in three response formats,

including items that allow for collection of data specifically relating to patient satisfaction. A

summary question asks patients to rate the likelihood of referring friends and relatives. Three

open-ended questions provide an opportunity for patients to comment on what they like best

about the practice, what they like least about the practice, what they like least about the practice,

and make suggestions for improvements. Cronbach's alpha was calculated for questions in the

Likert-scale category and the instrument was found to have high internal reliability (25 items; α

= .98)

Methodology. Patient satisfaction surveys were distributed at the point of care by a

study team member. Trained medical interpreters were available for non-English speaking

patients. The oral invitation to participate was guided by a standard script that covered all

relevant elements of informed consent. Study team members received information on the

informed consent process prior to interacting with patients. Written informed consent was not

required as no unique patient identifier information was collected and participation was

voluntary. Patients were able to return completed surveys via a secure lock box located in the

APCU checkout area or via mail using a stamped, self-addressed envelope.

Analysis. All data were entered into Microsoft Office Access databases that were created

for the purpose of managing patient wait time data and patient satisfaction data. The data were

subsequently imported into Microsoft Excel and analyzed using Excel. Two primary analyses

were conducted. The t-test was used to compare mean wait times prior to and following

implementation of the test of change intervention. Chi-square was used to examine and compare

patient satisfaction with waiting room and exam room wait times, as well as the likelihood of

referring friends and family, for the pre- and post- implementation periods. An alpha level of .05

was used for all statistical tests.

Results. Results of the Chi-square analysis of patient satisfaction scores in the waiting

room wait time, exam room wait time, and likelihood of referring friends/family categories were

summarized. The results were significant in the waiting room wait time category ($x^2 = 10.77$, *df*

= 4, p = .029) but were not significant for time spent in the waiting room or question asking

about likelihood of referring. Pareto chart analysis of the *fair* and *poor* responses to the 25

questions scored by patients using the Likert-type scale was performed. The results indicated

that when rank ordered in terms of magnitude key drivers of dissatisfaction among APCU

patients included waiting room wait time, exam room wait time, turnaround time for return of

phone calls, and time spent waiting for laboratory testing and results. The responses in these five

categories accounted for nearly 50% of all fair and poor ratings. A preliminary appraisal of

responses to the open-ended questions included on the patient satisfaction survey during the pre-

and post- implementation survey periods using the word search function in Microsoft Excel. The

results showed recurring patterns and themes with responses to the questions by patients.

Among the responses to the questions, "What do you like best about our center?" the following

themes emerged: (a) friendliness and care of nurses and support staff, (b) affordability, (c) co-

location of laboratory and pharmacy services, (d) clean and comfortable facilities, (e) quality of

care, and (f) location/convenience. In the "What do you like least about our center?" category,

emerging themes included (a) wait times, (b) telephone call back response times, (c) crowded

and noisy waiting room, (d) amount of time with provider, and (e) lack of specialty care and

mental health referral resources. Themes in the "suggestions for improvement" category include

(a) reducing wait times, (b) improving telephone response time, and (c) increasing the

availability of referral resources, including diagnostic imaging, specialty care, and mental health

services.

Using the DMIC framework and PDSA improvement process, significant reductions in the mean waiting room and exam room times along with a significant increase in patient satisfaction with waiting room wait time were achieved. No significant changes in patient satisfaction with exam room wait time or the likelihood of referring friends or family were identified.

Pilot results provide support for the utility of the PDSA model for improving wait times and patient satisfaction. It was found that PDSA cycles for both front-end and back-end processes will be required in order to achieve meaningful improvement in exam room wait times. Pareto chart evaluation of pre- and post- implementation patient satisfaction survey data supports the APCU team's plan to continue focusing on wait time improvements in subsequent PDSA cycles. The results of this study's pilot project provided support for the hypothesis that reducing waiting room wait time improves patient satisfaction. However, gains in the waiting room wait time category measures were not accompanied by significant changes in the reported likelihood that patients will refer friends and relatives to the practice. It was determined that the evaluation of the impact of further improvements in satisfaction measures in the waiting category, and those associated with other dimensions of care, should be included in the long-term performance improvement plan for the APCU. The study concluded that it exemplifies a model for conducting sequential repetitive tests of change over time that can lead to meaningful and sustained improvement in the delivery of care and practice performance in a variety of ambulatory care settings. The project conducted in this study demonstrated that their methodology and process framework can be replicated in similar outpatient settings. It was demonstrated that the conducting of patient surveys and using the results to improve the quality

of care are two different processes. The utility of patient surveys as a quality-improvement tool depends upon the successful completion of both these processes (Patwardhan & Spencer, 2012).

Limitations. Key study limitations included the use of a pre-experimental pretest/posttest design, convenience sampling strategy, and disadvantages associated with the use of the instrument include lack of historical comparison information on the instrument's psychometric properties. Although the wait time data collection instrument proved adequate, APCU and study team members identified opportunities for instrument improvement in future PDSA cycles.

Review Summary

The strength of this literature review is that it provides support to the gathering of baseline patient satisfaction data and provides examples on how to utilize an existing government sponsored survey instrument. Collecting baseline survey results through sustainable creative methods can contribute to generating quality meaningful data unique to urban FQHC settings. This literature review examined (a) the importance of creating new ideas to accelerate improvements in California's safety net health care settings, (b) how safety net systems measure patient's experience of care, and (c) how an existing patient satisfaction survey instrument can utilized in an FQHC setting.

A weakness of the review is that these studies were conducted in a limited number of public health safety net health care settings, however, each of the studies had findings that could be associated in identifying and creating opportunities for improving patient-centered care in similar outpatient health care settings. The use of patient surveys for quality improvement has become a common practice in the health-care industry, with patient satisfaction considered to be a link to organizational performance (Patwardhan & Spencer, 2012)

This review examined research conducted in California safety net health care systems and

Florida's county health department. The literature suggests the importance of measuring

patients' self-reports and ratings of their health experience. There are two approaches to

evaluating patient satisfaction – qualitative and quantitative. Each method has its own strengths

and weaknesses and answers specific questions. Careful consideration must be given to which

approach is appropriate for the given situation, or whether a combination of methods might be

more useful (Urden, 2002). Although patient-derived information is subjective, patient

satisfaction surveys can be used to provide an accurate assessment of the patient's experience.

Patient satisfaction surveys that ask patients to evaluate their experiences take into account

multiple aspects of care not captured by patient reports, such as: the empathy and compassion of

nurses, providers and staff; the affect, tone, and caring in the delivery of health care services; and

the quality of the information and explanations that accompany care (Drain & Clark, 2004).

Various process barriers have been identified in the research that can affect the outcome of

a survey with research showing that there can be differences in the response rate in different

demographic populations (Patwardhan & Spencer, 2012). For example, efforts are needed to

defray or decrease the costs of assessing patient feedback, especially since health centers bear the

cost largely unassisted. Safety net organizations could also benefit from messaging a targeted

educational campaign addressing existing instruments, data collection methodologies, and low-

cost analytic resources. Overcoming measurement barriers that are encountered in safety net

systems can help improve the quality of patient-centered care in safety-net organizations.

Valid patient feedback measurement tools in safety-net populations will allow safety-net

providers to better serve their patient populations, foster better practice environments, and

ultimately improve health care quality for the uninsured and underserved. Since safety net

FQHC patient populations and communities are of homogeneous nature, utilizing an existing government survey instrument is a start to collecting results that can be comparable state wide as well as nationally.

The literature favors the need for future work for measuring patient reported feedback to help drive continuous quality improvement work. As a start, there is a need to publicize baseline patient satisfaction results to identify FQHCs strengths and weaknesses. Significant future work will need to address how to generate patient satisfaction survey data utilizing simple, low cost methodology that can be applied to quality improvement initiatives in government settings such as safety net health care systems. Changing care processes, developing interventions based on feedback from surveys should utilize a survey that has been tested or applied in similar settings (Drain & Clark, 2004).

Even though disadvantages were associated with the use of the BPHC HRSA survey instrument such as the lack of historical and comparison information on the instrument's psychometric properties, Michael et al., (2013) reported that the Cronbach alpha for the survey's Likert-scale questions was found to have high internal reliability (25 items; a = .98). Utilizing a survey such as BPHC HRSA patient satisfaction survey instrument as a performance measurement tool, should complement other organization surveys used for quality improvement. Patient satisfaction scores should not be the only standard for a FQHC's standard for success and should also complement other quality outcomes of care (Kupfer & Bond, 2012).

Performance measurement is an important mechanism for improving quality (Murphy, et al., 2015). Initiating performance measurement initiatives such as administering patient satisfaction surveys can accelerate improvement work (IOM, 2005). As safety net systems enter a new era of public accountability, adequate investment into surveying patients should be a

priority. Building a sustainable designed system that measures experience from the patient's perspective using ratings will help position safety net institutions as a provider of choice (Murphy, et al., 2015) and not one of last resort. Considering cost and the fact that not all FQHCs report survey results, or partner with outside survey vendors, being creative and utilizing existing resources to assess their patient population's feedback is foundational to organizational success. The findings in this review can serve as a innovative map to drive the measurement of patient satisfaction utilizing an existing government developed survey instrument in a setting where the importance of patient feedback is imperative for FQHCs viability and ability to compete in the modern safety net health care environment.

Methods

Project Design

A descriptive cross-sectional survey design was conducted from October 2014 through December 2014. Surveys were administered to gauge the prevalence of satisfied adult patients who visited this public health Federally Qualified Health Center (FQHC). The design allows for a 'snapshot' of how patient satisfaction is associated with individual characteristics of the patient population (Levin, 2006). The survey was offered to patients' in-person upon completion of their health care visit when exiting the health center.

Setting

This study was conducted at San Francisco General Hospital and Trauma Center, an acute care safety net urban hospital that is vertically integrated with a community health network of primary care clinics serving the residents of San Francisco, California. The walk-in and appointment clinic is the hospital's adult UCC, which accepts patients from 8:00 AM until 9:00 PM five days a week and 8:00 AM until 4:00 PM on weekends and holidays. Patients are seen in

the UCC when they present directly for care, are referred from the emergency department, or referred from the hospital's network of community clinics. During the study period, 4,185 patients visited UCC for health care services.

Sample

This study used a convenience sample method of adult patients who registered to be seen at SFGH UCC and was conducted representing three main time periods during the health center's seven day a week operation: morning (08:00-11:59, afternoon (12-17:59), and evenings (18:00-22:00). Patient participants were asked to complete a survey that provides feedback of their experience at the health center. The patient's agreeing to complete a survey implied consent and was part of the informed consent process. Patients were asked a standardized script "We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time" (HRSA, n.d., a).

Intervention/Instrumentation

This study utilized an existing English patient satisfaction survey instrument developed and selected by BPHC HRSA (HRSA, n.d., a) for use in FQHCs with minor revisions listed. The survey is in the public domain and has been described in the literature to be well suited for this project given the similarities of the safety net populations served by FQHCs (Zuckerman et al., 2012; Michael, et al., 2013). Permission was not required by HRSA to alter existing tool. Several minor revisions were made to the survey. "Age" was changed to "age group" to capture age range and increase patient anonymity. The date of the survey and time of survey completion were added to categorize surveys by time of day and report results by quarter. With the Likert (1-5; Great-Poor) scale, pictograph figures that represent the scale were changed to faces to

improve clarity for UCC patient population asking to rate perceptions. Under the "Staff"

heading, "Dentist" was removed, and separate headings for "Confidentiality" and "Overall" was

added to separate the questions. The Yes/No question "Do you consider this center your regular

source of care?" was moved and listed separately.

The survey instrument provided anonymous collection of data and includes a total of 29

items in three response formats, including items that allow for collection of data specifically

relating to patient satisfaction. Quantitative survey questions were based on a Likert-like scale to

maintain consistency in reporting and analysis. Cronbach's alpha was calculated for questions in

the Likert-scale category and the instrument was found to have high internal reliability (Michael,

et al., 2013). A summary question asked patients to rate the likelihood of referring friends and

relatives. Similar to other health systems, utilizing an overall measure such as "likelihood to

refer" was utilized as an indirect measure of quality of care (Institute for Healthcare

Improvement [IHI], 2012). Three open-ended questions provided an opportunity for patients to

comment on what they like best about the practice, what they like least about the practice, what

they like least about the practice, and allows patients to make suggestions for improvements.

This HRSA standardized survey was designed to be a self-reported survey or completed with

assistance. The format of the standardized HRSA survey asked all respondents identical

questions, presented in the same order, with the same directions, prompts, and response formats.

This structure would ensure comparability where internal and external benchmarking can be

obtained (Urden, 2002).

Data Collection

Patient satisfaction surveys were distributed in-person at the health center by trained

volunteer assistants. The oral invitation to participate was guided by a written standard script

located at the top of each survey that covered all relevant elements of informed consent. Informed consent was implied by patient voluntary consent to take the survey. The volunteers were made available to assist with survey completion and to help minimize non-responses from patients during survey collection periods. Guidelines on how to administer the patient satisfaction survey to patients were followed by volunteer assistants to ensure consistency in the administration. Prior to administering surveys, volunteers were required to watch an instructional video on how to administer patient satisfaction surveys at SFGH UCC (Ballin, 2014). Following the script, the research assistants handed the survey to a patient at the end of their visit, and asked them to complete it prior to leaving the health center. After the patient completed the survey, it was immediately placed in a sealed folder without reading the responses. Patients were also able to return completed surveys via a secure lock box located in the health center's checkout area. Taking into account patients who declined to participate at UCC, a log was kept to record the quantity of non-responses during the sampling periods and used to calculate survey response rates.

Data Analysis Plan

Descriptive statistics were computed to reveal patient sample characteristics, describes study variables, and to calculate the means for survey categories and demographics. Aggregate means on major survey categories were used to understand relationships between variables. Demographics, Likert-scales and yes/no choice question results were analyzed using percentages for each category. Day of week and time of day survey periods were completed, analyzed and categorized by percentages. Qualitative data was analyzed using a content analysis approach. The initial coding for all qualitative responses were completed by one member of the research team and an organization patient experience representative familiar with the survey tool.

Together, they both reviewed and further refined the open-ended text into idea categories. These

idea categories were then combined into themes. All survey data were initially entered and

coded into IBM SPSS Statistics version 22.0 (2013).

Results

This study asked 146 patients at SFGH UCC to participate in completing a patient

satisfaction survey, 64 consented to participate. Response rates for the satisfaction survey data

collection period were 44% (64/146 respectively). The survey instrument used a Likert-scale (5

= Great, 4 = Good, 3 = Ok, 2 = Fair, 1 = Poor). There was representation for each day of the

week for survey completion with the greatest proportions completed on Wednesday (25%) and

Monday (23%). Of the three time periods, a greater proportion of surveys were completed

during 12:00 – 5:59 P.M. (55%) and 08:00 – 11:59 A.M. (43%). A frequency distribution of the

gender, age group and ethnicity characteristics of the sample population are summarized in Table

1.

Table 1

Frequency and Percent of Patient Gender, Age, and Ethnicity (n = 64)

Demographic	*n*	*%*
Gender		
Male	22	41.5
Female	31	58.5
Age Group		
18 to 24 years	9	14.5
25 to 44 years	29	46.8
45 to 64 years	23	37.1
Over 64 years	1	1.6

Ethnicity

Asian Pacific or other Pacific Islander	8	12.9
Black / African American	14	22.6
White	12	19.4
Hispanic	25	40.3
Other	3	4.8

Data are counts unless otherwise indicated. Data are taken from the HRSA BPHC Patient Satisfaction Survey. Numbers may not add up to 100% because of missing data for certain variables.

Characteristics of Patients

Table 1 shows the distribution of demographic characteristics among the overall sample of patients. Frequencies showed a greater proportion of female than male patients (58.5% female vs. 41.5% male). The age groups showed majority being 25 to 44 years old (46.8%) and 45 to 64 years old (37.1%). Hispanic respondents comprised the highest proportion of any racial/ethnic group, followed by Black/African American and White (40.3% Hispanic, 22.6% Black/African American, 19.4% White).

Mean Patient Satisfaction Score by Major Survey Category

The means and standard deviations of scores of the satisfaction scale for total sample by variable category is presented in Table 2. The table is organized in sequence of patient health center experience and follows flow of existing survey instrument. Patients were most satisfied with care and communication by Nurses and Medical Assistants (4.54), and Providers (4.48). Patients were least satisfied with the Financials (4.01) and Waiting Time (4.06).

Table 2

Mean and Standard Deviation Patient Satisfaction by Category of (n = 64)

Category	n	M	SD
Ease of Care	64	4.11	0.78
Waiting Time	63	4.06	1.54
Provider Satisfaction	62	4.48	0.75
Nurse MA Satisfaction	62	4.54	0.69
Other Staff Satisfaction	51	4.37	0.84
Financials	39	4.01	1.11
Facilities	56	4.16	0.75
Confidentiality	56	4.41	0.71
Overall	64	4.25	0.65

Regular Source of Care

Patients were asked if they considered the health center as their regular source of care (Table 3). Majority of patients answered "yes" to the health center being their regular source of care with 71.1% indicating that UCC is their regular source of care.

Table 3

Frequency and Percent of Regular Source of Care (n = 43)

Measure	n	%
Yes	32	71.1
No	11	24.4

Patient Satisfaction for Category by Regular Source of Care

Patients who considered UCC as their regular source of health care were shown to be most satisfied with the care and communication by providers, nurses, medical assistants and other staff. These patients were also more satisfied with waiting and facility environment

compared to patients who did not consider UCC as their regular source of health care (Table 4).

An independent samples t test was conducted to determine a significant difference between

regular source of care and overall satisfaction (Table 5). An independent groups t test indicated

no significant difference on overall satisfaction between patients who attended the clinic

regularly ($M = 4.24$, $SD = 0.71$) and patients who did not ($M = 4.15$, $SD = 0.78$), t (41) = 0.382,

$p = .705$.

Table 4

Mean and Standard Deviation of Patient Satisfaction for Category by Regular Source of Care (n = 64)

	Regular source of care			
	Yes		No	
Category	M	SD	M	SD
Ease of Care	4.05	0.75	3.89	1.12
Waiting Time	4.21	1.93	3.57	1.21
Provider Satisfaction	4.42	0.84	4.59	0.67
Nurse MA Satisfaction	4.52	0.71	4.73	0.65
Other Staff Satisfaction	4.35	0.91	4.45	0.82
Financials	3.89	1.14	3.93	1.37
Facilities	4.19	0.81	3.77	0.74
Confidentiality	4.55	0.57	4.09	1.04
Overall	4.24	0.71	4.15	0.78

Table 5

Mean, Standard Deviation, and Standard Error for Overall Satisfaction between Patients Who

Attend Regular (n = 43)

Regular Source of Care	n	M	SD	SE
Yes	32	4.24	0.71	0.13
No	11	4.15	0.78	0.23

Qualitative Response: Liked Best

An appraisal of responses to the open-ended questions included on the patient satisfaction

survey revealed a number of recurring patterns and themes. Among patient responses to the

question, "What do you like best about our center" (n=28) four themes emerged (Table 6).

Theme 1: Care and Communication depicted satisfaction with the care and communication by

providers, nurses, medical assistants and all other staff. Theme 2 was related to the overall UCC

system with patients listing efficiency of UCC processes and operations. Theme 3: Ease of

Getting Care, depicted positive patient feedback regarding the convenience and ability to be seen

in UCC. Theme 4: included respondents reporting positive experience in reference to the

waiting process with a respondent writing: "The waiting process is faster than previous

experiences".

Table 6

Frequency and Percent of Liked Best about Facility (n = 28)

Measure	n	%
Ease of getting care	4	14.3
Waiting	2	7.1

Staff	17	60.7
Overall	5	17.9

Qualitative Response: Liked Least

In response to the "What do you like least about our center?" question (Table 7), three themes emerged. Theme 1: Waiting, depicted negative experiences with the waiting process in UCC. One respondent wrote: "The time spent in the exam room waiting for a doctor was too long". Theme 2: Facility, included concerns about the neatness and cleanliness of the UCC environment and the building being outdated. One respondent wrote: "Modernize the facility and improve parking". Theme 3: Ease of Getting Care, depicted patient concerns of UCC not being conveniently located. A single response commented on Staff, one respondent wrote: "Front clerical staff needs cultural awareness training". Another single response was related to Confidentiality, one respondent wrote: "patients sitting in the waiting in the room can hear other patient's information when registering to be seen".

Table 7

Frequency and Percent of Liked Least about Facility (n = 16)

Measure	*n*	*%*
Ease of getting care	2	12.5
Waiting	7	43.8
Staff	1	6.3
Facility	5	31.3
Confidentiality	1	6.3

Qualitative Response: Suggestions

Responses to the "Suggestions for improvement" category (Table 8), two main themes emerged (n=10). Two themes received more than one response from patients. Theme 1: Waiting, received patient comments that indicated the waiting experience in UCC needs improvement and did not list specific examples. Theme 2: Overall System included patient suggestions of improving overall efficiency in UCC. One respondent wrote that the UCC should be more organized and did not list specific examples.

Table 8

Frequency and Percent of Suggestions for Improvement about Facility (n = 10)

Measure	n	%
Ease of getting care	1	10.0
Waiting	3	30.0
Staff	1	10.0
Facility	1	10.0
Confidentiality	1	10.0
Overall System	3	30.0

Discussion

With patient care experience measures now widely recognized as central to the comprehensive assessment of health care quality, and vital to efforts to advance the goal of patient-centered care, standardized data collection remains an important factor in the uptake of survey-based measures of ambulatory care quality. In general, patients at the health center were satisfied. Although patients used the full range of responses (1 to 5) to each of the 25 items, the means of item scores were relatively good, ranging from 4.01 to 4.54 (Figure 1). The results of

the analyses reported provide only preliminary support for the need to collect patient satisfaction

data and the importance of establishing baseline data utilizing standardized methodology and an

existing survey instrument. Even though the existing HRSA BPHC patient satisfaction survey

instrument is publicly available (Figure 2), the instrument has not been widely implemented in

other safety net FQHC settings similar to SFGH UCC to generate comparison baseline

satisfaction result data.

In 2009, a national study that utilized HRSA BPHC survey was conducted to obtain

representative data on the patients seeking services from all types of section 330-funded health

center programs. The purpose of the survey was to gather person-level data about the patients of

these programs and the services they obtain. The interviewing took place between September

and December 2009. Similar to this project, patients generally rate the care and communication

from providers and nurses and excellent & very good. The "waiting" category generally receives

the lowest score and is similarly consistent with the results in this project. Since the results

included patients of all ages from over 352 different health center sites nationally, there is

difficulty comparing patient satisfaction results from utilizing the HRSA BPHC patient survey

instrument as multiple surveys were used and generated results that are not comparable (BPHC,

2009). However, having publicly available results demonstrate the opportunities for FQHCs if

the same survey instrument was consistently used in similar adult patient populations as it allows

better understanding of their patient population, patient needs and patient satisfaction.

Limitations

This study is limited in that it was based on research conducted at a single safety net

FQHC and it obtained only a small representation of the patient population. Both may

jeopardize the generalization of the findings, however, the major purpose of this study was to

establish the implementation of an existing patient satisfaction survey instrument appropriate for

an adult FQHC setting and to generate baseline patient satisfaction data utilizing standardized

methodology that will allow for future comparisons of data both internally within the SFGH

organization and externally to other adult safety net FQHC settings. Key study limitations

include use of a convenience sampling strategy, and lack of historical information on the

psychometric properties of the patient satisfaction survey instrument. For generalization of the

findings, a more representative sample with better response rates will be required. Further

research is also needed to examine the psychometrics of this instrument for different safety net

FQHC settings.

Implication for Nursing Practice

Nursing plays a pivotal role in ensuring that patient expectations and obligations are met

in ways that fulfill a need, desire, or want. Maintaining healthy work environments with

adequate staffing is directly connected to having satisfied patients (Kutney-Lee et al., 2009).

With patients having more input in the quality of care received, patient dissatisfaction can affect

the viability of a health organization in this new era of health care delivery (Squires, 2012).

Effective communication and teamwork between the provider and the nurse is paramount for

optimistic patient outcomes and superior patient satisfaction scores. Patient satisfaction also has

implications for nurse managers and leaders.

The American Organization of Nurse Executives (AONE) listed guiding principles for

nursing leadership roles with the first three focused on redesigning care that is patient-centered,

standardizing processes through utilization of evidence-based practices to decrease variability,

and outcomes (2010a). This project is guided by all three principles and has the intent to inspire

further research utilizing the same survey instrument. Understanding of person, health and

environment drives nursing practice of caring for patients (AONE, 2010b). Nurses direct the

continual improvement of quality by knowing the actual measured performance in the context where the health professional is learning/practicing and the nature of the gaps, and what activities are necessary to close the gaps (AONE, 2010b).

Conclusion

A competitive health care market now requires nurse managers to focus on achieving excellent ratings to distinguish their organization or unit from others. Literature confirms that staff care and communication is a main attribute to patients rating their overall experience as "excellent". (Otani, Waterman, Boslaugh, Burroughs, & Dunagan, 2009). Results in the SFGH UCC are good at 4.25 and it will take astute nurse management and leadership to build on baseline data to generate future improvements. By applying IOM's (2010) future of nursing recommendations, this project exemplifies opportunities for nurses to lead and diffuse collaborative improvement efforts towards patient-centered care. Measuring patient satisfaction is a huge undertaking that begins a journey to valuing patient feedback. Being innovative by creating new ways to make improvements utilizing existing resources is the most reasonable in a FQHC setting and supports the viability of safety net health care systems in an increasingly competitive health care environment (Lewin & Baxter, 2007)

The results of this project provide additional support in favor of collecting patient reported feedback utilizing an existing survey instrument. It provides a model for administering standardized patient satisfaction surveys in future periods to compare to the baseline results generated from this project. Measuring patient satisfaction is key to establishing performance trends and identifying future areas for improvement. Finally, this project supports future research that relates to utilizing existing patient satisfaction survey instruments to generate base line results for FQHC safety net settings.

References

American Organization of Nurse Executives [AONE]. (2010a). Guiding Principles for Future

Patient Care Delivery. Retrieved from

http://www.aone.org/resources/PDFs/AONE_GP_Future_Patient_Care_Delivery_2010.p

df

American Organization of Nurse Executives [AONE]. (2010b). Guiding Principles for the role of

the nurse in future patient care delivery. Retrieved from

http://www.aone.org/resources/PDFs/AONE_GP_for_Role_of_Nurse_Future.pdf

Ballin, R. J. (2014). Conducting patient satisfaction surveys: SFGH Urgent Care. Retrieved from

https://m.youtube.com/watch?v=EBwJDcsR0A0

Berwick, D. M. (2002). A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs,*

21(3), 80-90.

Bureau of Primary Health Care. (2009). BPHC Patient Survey Results: National results &

Greater Baden Medical Services, Inc. Survey Responses. Retrieved from

http://www.gbms.org/pdfs/ID%20228.pdf

California Association of Public Hospitals and Health systems. (2014). Lessons for transforming

care in the safety net. Retrieved from http://caph.org/wp-content/uploads/2014/04/Data-

Collection-to-Improve-the-Patient-Experience-DSRIP-brief-April2014.pdf

Center for Healthcare Research & Transformation [CHRT]. (2013). Federally qualified health

centers: an overview. Retrieved from http://www.chrt.org/public-policy/policy-

papers/federally-qualified-health-centers-an-overview/

Cleary, P. D., & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry,*

25, 25-36.

Coughlin, T. A., Long, S. K., Peters, R., & Arguello, R. (2014). Strategies in 4 safety-net

    hospitals to adapt to the ACA. *The Kaiser Commission on Medicaid and the Uninsured,*

    1-14. Retrieved from http://kff.org/health-reform/issue-brief/strategies-in-4-safety-net-

    hospitals-to-adapt-to-the-aca/

Davidoff, D. F. (2013). Patient perspective: what would Donabedian say? *Internal Medicine*

    Journal, 109-110. http://dx.doi.org/doi:10.1111/imj.12301

Donabedian, A. (1981). Criteria, norms and standards of quality: What do they mean? *American*

    Journal of Public Health, 71, 409-412.

Donabedian, A. (1988a). Quality assessment and assurance: Unity of purpose, diversity of

    means. *Inquiry, 25,* 173-192.

Donabedian, A. (1988b). The quality of care: How can it be assessed? *Archives of Pathology &*

    Laboratory Medicine, 121, 1743-1748.

Donabedian, A. (1996). The effectiveness of quality assurance. *International Journal for Quality*

    in Health Care, 8, 401-407.

Drain, M., & Clark, P. A. (2004). Measuring experience from the patient's perspective:

    Implications for national initiatives. *Journal of Health Care Quality,* W4-6-W4-16.

El Haj, H. I., Lamrini, M., & Rais, N. (2013). Quality of care between Donabedian model and

    ISO9001V2008. *International Journal for Quality Research, 7,* 17-30.

Engward, H. (2013). Understanding grounded theory. *Nursing Standard, 28,* 37-41.

Epstein, R. M., & Street, Jr, R. L. (2011). The values and value of patient-centered care. *Annals*

    of Family Medicine, 9, 100-103.

Grantmakers in Health [GIH]. (2012). Safety net in the era of health reform: A new vision of

    care. Retrieved from

http://www.gih.org/files/FileDownloads/Safety_Net_in_Era_Health_Reform_no38_Marc

h_2012.pdf

Health Resources and Services Administration. (n.d., a). Health center patient satisfaction

survey. Retrieved from

http://bphc.hrsa.gov/policiesregulations/performancemeasures/patientsurvey/satisfactions

urvey.html

Health Resources and Services Administration. (n.d., b). What is a Health Center? Retrieved

from http://bphc.hrsa.gov/about/

Heidenreich, P. A. (2013). Time for a thorough evaluation of patient-centered care. *Circulation

Cardiovascular Quality and Outcomes, 6,* 2-4.

http://dx.doi.org/10.1161/CIRCOUTCOMES.112.970194

Institute for Healthcare Improvement. (2012). A guide to measuring the triple aim: Population

health, experience of care, and per capita cost. Retrieved from

http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx

Institute of Medicine. (2000). America's health care safety net. Retrieved from

http://iom.edu/~/media/Files/Report%20Files/2000/Americas-Health-Care-Safety-

Net/Insurance%20Safety%20Net%202000%20%20report%20brief.pdf

Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st

century. Retrieved from

http://www.iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-Quality-

Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

Institute of Medicine. (2005). Performance measurement: Accelerating improvement. Retrieved

from https://www.iom.edu/~/media/Files/Report%20Files/2005/Performance-

Measurment-Accelrating-

Improvement/ReportBriefPerformanceMeasurementAcceleratingImprovement.pdf

Institute of Medicine. (2010). The future of nursing: Leading change, advancing health.

Retrieved from https://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-

Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf

Kupfer, J. M., & Bond, E. U. (2012). Patient satisfaction and patient-centered care: necessary but

not equal. *Journal of American Medical Association, 308*, 139-140.

Kutney-Lee, A., Mchugh, M. D., Sloane, D. M., Cimiotti, J. P., Flynn, L., Neff, D. F., Aiken, L.

H. (2009). Nursing: A key to patient satisfaction. *Health Affairs, 28,* w669-w677,

http://dx.doi.org/10.1377/hlthaff.28.4.w669.

Lee, H., Hill, L., & McConville, S. (2012). Access to the health care safety net in California.

Public Policy Institute of California, 2-37. Retrieved from

http://www.ppic.org/content/pubs/report/R_1012HLR.pdf

Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry, 7*, 24-

25. http://dx.doi.org/10.1038/sj.ebd.6400375

Lewin, M. E., & Baxter, R. J. (2007). America's health care safety net: Revisiting the 2000 IOM

report. *Health Affairs, 26*, 1490-1494. http://dx.doi.org/10.1377/hlthaff.26.5.1490

Lyles, C. R., Aulakh, V., Jameson, W., Schillinger, D., Yee, H., & Sarkar, U. (2013). Innovation

and transformation in California's safety net health care settings: an insider perspective.

American Journal of Medical Quality. http://dx.doi.org/10.1177/1062860613507474

Michael, M., Schaffer, S. D., Egan, P. I., Little, B. B., & Pritchard, P. S. (2013). Improving wait

times and patient satisfaction in primary care. *Journal for Healthcare Quality, 35*, 50-60.

Murphy, J., Ko, M., Kizer, K. W., & Bindman, A. B. (2015). Safety net integration: A shared

strategy for becoming providers of choice. *Journal of Health Politics, Policy and Law*,

40, 404-418. http://dx.doi.org/10.12115/03616878-2882267

Neuhausen, K., & Katz, M. H. (2012). Patient satisfaction and safety-net hospitals. *Archives of*

Internal Medicine, *172*.

Otani, K., Waterman, B., Boslaugh, S., Burroughs, T. E., & Dunagan, W. C. (2009). Patient

Satisfaction: Focusing on "Excellent". *Journal of Healthcare Management*, *54*, 93-103.

Patwardhan, A., & Spencer, C. H. (2012). Are patient surveys valuable as a service-improvement

tool in health services? An overview. *Journal of Healthcare Leadership*, *4*, 33-46.

Press Ganey. (2012). Return on investment: Increasing profitability by improving patient

satisfaction. Retrieved from

http://www.pressganey.com/Documents/research/hospitals/ROI%20Resources/WhitePap

er_Profitability.pdf

Press, I., & Fullam, F. (2011). Patient satisfaction in pay for performance programs. *Quality*

Management in Health Care, 20, 110-115.

Rathert, C., Wyrwich, M. D., & Boren, S. A. (2012). Patient-centered care and outcomes: A

systematic review of the literature. *Medical Care Research and Review*, *70*, 351-379.

San Francisco Department of Public Health. (2014). San Francisco General Hospital and Trauma

Center Annual Report Fiscal Year 2013-2014. Retrieved from

https://www.sfdph.org/dph/files/hc/HCAgen/HCAgen2014/November%2018/SFGH%20

Annual%20Report%202013-14;%20final%20141113-1.pdf

Saviano, E. C. (2009). California's safety-net clinics: A primer. *California HealthCare*

    Foundation, 2-39. Retrieved from http://www.chcf.org/publications/2009/03/californias-

    safetynet-clinics-a-primer

Shaller, D. (2007). Patient-centered care: what does it take? Retrieved from

    http://www.commonwealthfund.org/usr_doc/shaller_patient-

    centeredcarewhatdoesittake_1067.pdf

Shi, L., Lebrun-Harris, L. A., Parasuraman, S. R., Zhu, J., & Ngo-Metzger, Q. (2013). The

    quality of primary care experienced by health center patients. *Journal of American Board*

    of Family Medicine, *26*, 768-777.

Shi, L., Stevens, G. D., Lebrun, L. A., Faed, P., & Tsai, J. (2008). Enhancing the measurement of

    health disparities for vulnerable populations. Retrieved from

    http://www.nursingcenter.com/lnc/pdfjournal?AID=819684&an=00124784-200811001-

    00008&Journal_ID=&Issue_ID=

Squires, S. (2012). Patient satisfaction: How to get it and how to keep it. *Nursing Management*,

    26-32. http://dx.doi.org/10.1097/01.NUMA.0000413094.39091.08

Steinbruegge, J., & Giuliani, G. (2010). Patient experience in California ambulatory care.

    California HealthCare Foundation, 2-19. Retrieved from

    http://www.chcf.org/publications/2010/12/patient-experience-in-california-ambulatory-

    care

Tasso, K., Behar-Horenstein, L. S., Aumiller, A., Gamble, K., Grimaudo, N., Guin, P., Ramey,

    B. (2002). Assessing patient satisfaction and quality of care through observation and

    interview. *Hospital Topics*, *80*, 4-10.

Taylor, J. (2004). The fundamentals of community health centers. Retrieved from

     http://www.nhpf.org/library/background-papers/BP_CHC_08-31-04.pdf

Urden, L. D. (2002). Patient satisfaction measurement. *Lippincott's Case Management*, *7*, 194-

     200.

Wyszewianski, L., & Donabedian, A. (1981). Equity in the distribution of quality of care.

     Medical Care, XIX, 28-56. http://dx.doi.org/Retrieved from

Zuckerman, K. E., Wong, A., Teleki, S., & Edgman-Levitan, S. (2012). Patient experience of

     care in the safety net: current efforts and challenges. *Journal of Ambulatory Care*
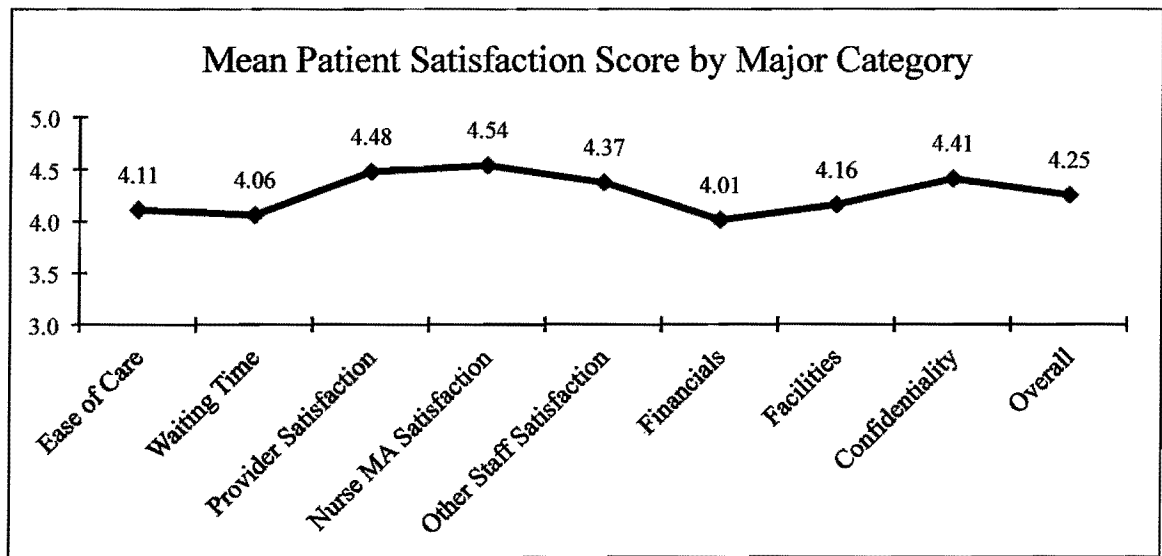
     Management, 35, 138-148.

Figure 1

Mean Patient Satisfaction Score by Major Category

Figure 2

Urgent Care Center (UCC)
Patient Satisfaction Survey

Today's Date: _____

Time of Survey Completion: _____

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Age Group: 18 to 24 ____
            25 to 44 ____
            45 to 64 ____
            Over 64 ____

Your Gender: Male ____ Female ____

Your Race/Ethnicity:
____ Asian
____ Pacific Islander
____ Black/African American
____ American Indian/Alaska Native
____ White (Not Hispanic or Latino)
____ Hispanic or Latino (All Races)
____ Unknown

Please circle how well you think we are doing in the following areas:	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
Ease of Getting Care					
Ability to get in to be seen	5	4	3	2	1
Hours Center is open	5	4	3	2	1
Convenience of Center's location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
Waiting					
Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Waiting for tests to be performed	5	4	3	2	1
Waiting for tests results	5	4	3	2	1
Staff					
Provider (Physician, Physician Assistant, Nurse Practitioner)					
Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1
Nurses and Medical Assistants					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1

Please circle the number for how well you think we are doing in the following areas	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
All Others					
Friendly and helpful to you	5	4	3	2	1
Able to answer your questions	5	4	3	2	1
Financials/Eligibility					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment/money	5	4	3	2	1
Facility					
Neat and clean building	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Facility privacy	5	4	3	2	1
Confidentiality					
Keeping my personal information private	5	4	3	2	1
Overall					
Likelihood of referring your friends and relatives to us	5	4	3	2	1

Continue on back…

Do you consider this center your regular source of care?   Yes _____   No _____

What do you like **BEST** about our Urgent Care Center?

_____

_____

What do you like **LEAST** about our Urgent Care Center?

_____

_____

Suggestions for improvement?

_____

_____

_____

Thank you so much for completing our Survey!