

PATIENT-CENTERED INTERACTIONS

Part 1: Measuring Patient Experience

June 2010 Transforming Safety Net Clinics into Patient-Centered Medical Homes

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The Safety Net Medical Home Initiative



Introduction

Patient-centered interactions are the active expression of patient-centered care. Patient-centered organizations respect patients’ values and preferences, engage them and their families in healthy behaviors, and expand care capacity to equitably serve patients and families of diverse cultures and with diverse needs. Patient-centered interactions imply more than providing excellent service; they have clinical impact as well. When primary care teams partner collaboratively with patients to help patients build their skills and confidence in better managing their health or chronic conditions, patients can demonstrate better health outcomes. Yet delivering patient-centered care can be challenging, and thus patients in many settings do not receive the optimal level of care. For example, a Commonwealth Fund survey of patients in five countries reported substantial gaps in doctor-patient communication, a key measure of patient-centeredness.¹

To effectively respond to patients’ values, preferences, and needs, and to improve their experience of care, patient-centered medical homes need feedback from patients and families on the care they deliver. However, in a recent study of the adoption of patient-centered care practices by physicians, only 36% of primary care physicians and 20% of specialists said they receive data based on patient surveys.²

This guide to measuring patient experience presents examples of how healthcare systems can use surveys, focus groups, and other methods of engaging patients and their families, to learn how to provide the care patients want and need, in ways they and their families can understand and use. Future additions will focus on expanding patients’ role in their health and health care, and on interventions that support self-management.

Change Concepts

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a patient-centered medical home (PCMH). Over the course of the “Transforming Safety Net Clinics into Patient-Centered Medical Homes Initiative” we will cover each of the Change Concepts in turn. An implementation guide will be prepared and made available for each concept. This implementation guide is focused on the Change Concept “Patient-Centered Interactions,” a foundational element of the medical home model, and one we think must be addressed before the others.

[Empanelment](#)

[Continuous and Team-Based Healing Relationships](#)

[Patient-Centered Interactions](#)

[Engaged Leadership](#)

[Quality Improvement \(QI\) Strategy](#)

[Enhanced Access](#)

[Care Coordination](#)

[Organized, Evidence-Based Care](#)

Message to Readers

SNMHI implementation guides are living documents. Updates will be issued as additional tools, resources, and best-practices are identified. This implementation guide, the first part in a series, provides an introduction to the first element of the Change Concept “Patient-Centered Interactions”:

- Respect patient and family values and expressed needs. It also provides an introduction to the third element of the Change Concept “Quality Improvement Strategy”:
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Transformative change relies upon knowledge sharing and transfer. The partner clinics and Regional Coordinating Centers participating in the SNMHI are members of a learning community working towards the shared goal of PCMH transformation. This learning community produces and tests ideas and actions for change. The Initiative celebrates the contributions and accomplishments of all its partner clinics and Regional Coordinating Centers and, in the spirit of collaborative learning, implementation guides often highlight their work. This guide includes resources from High Plains Community Health Center (Colorado) and CareOregon (Oregon).



Elements of Patient-Centered Interactions

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.

Assessing and Using Patient Experience Information

It is impossible to implement a medical home without an explicit focus on the patient. For care to be patient-centered, teams need to address interpersonal, organizational, and cultural factors in the practice. In PCMH practices:

- Physicians and staff respect and communicate well with patients. There is an interpersonal component to patient-centered interactions. Patients need to feel like respected partners in care. This happens by providing patients with access to information in a language and at a level they understand. It also means listening to patients and addressing their concerns. Patients need to trust their doctors and their care team to be competent and reliable care providers.
- The practice is designed to meet patients' needs and preferences. In addition to better communication techniques, practices need to structure their processes and systems to ensure they facilitate good patient care. This means ensuring patients can get in for an appointment when they need one, that they see linkages with important community resources, and that they don't face unnecessary barriers to care such as long wait times or day-time only office hours.
- The culture supports patients. Patient-centeredness means understanding that the patient is the real expert on his or her health and wellness. This acknowledgment necessitates that patients have an expanded role in decision-making and are encouraged and supported to manage their own illness through assistance in problem-solving and decision-making.

In order to begin addressing the interpersonal, system-level, and cultural aspects of patient-centeredness, it is essential to have an understanding of the wants and needs of patients and to incorporate those into decision-making and redesign efforts. There are a variety of ways to do this: some clinics incorporate patient representatives on their quality improvement teams; others regularly host focus groups; some informally ask patients about their ideas in the waiting room; and others regularly conduct patient surveys. This implementation guide will focus on the gathering and using of patient experience data as a starting point for bolstering patient-centered interactions.

Many safety-net providers, like Federally Qualified Health Centers (FQHCs), are required to regularly measure patient satisfaction. Patient satisfaction surveys are a good start for identifying areas for improvement, but there are some limitations to these measures. Specifically, satisfaction questions assess the match between a patient's expectation of care and whether that expectation was met. Because we know that patient expectations for their healthcare experience differ based on race, income, and insurance status, it is sometimes hard to interpret the findings that come from these surveys. For example, if 90% of patients are fairly to totally satisfied with wait time, does that tell you the wait time is okay? What if you independently find that the average wait time is several hours? Patient experience measures try to move away from asking if patients' expectations were met, and instead ask about what actually happened during the patient visit. Some commonly used patient experience tools are described in Figure 1. Incorporating more actionable patient experience questions into your work enables you to better understand your patients' needs and preferences.



Figure 1: Examples of Patient Experience Survey Tools

Tool Name	Description	Developed by/ Use	Pros	Cons	Copyright/Fee
1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Ambulatory Care	This commonly used patient experience tool was developed to assess patients’ general experiences with ambulatory care.	The Agency for Healthcare Research and Quality (AHRQ). Used primarily by health plans, but increasingly by other groups as well.	Publicly available, most commonly used patient experience measure. Research validates findings and some data are available about its use in underserved populations. Comparative data available.	Not specific to the PCMH model. Currently being updated so the content and focus are better aligned with the PCMH.	Publicly available for free: Click here
2. Primary Care Assessment Tool (PCAT)	Developed to assess if patients perceive the structures and process of primary care are in place. Primary care is defined in this tool as first contact care, person-focused care over time, comprehensive care and coordinated care.	Barbara Starfield and colleagues from the Johns Hopkins Bloomberg School of Public Health.	Specifically focused on the core characteristics of primary care. Research shows this tool is valid and primary care characteristics may be linked to improved health. Adult, child, facility, and physician versions in both short and long forms are available.	The short version is 12 pages long. Questions are specific to primary care, and may not include all of the elements worth measuring for the PCMH model.	Publicly available for free: Click here
3. Patient Activation Measure (PAM)	Developed to assess the knowledge, skills, and confidence of patients as self-managers of their health and health care.	Judy Hibbard and colleagues from the University of Oregon Not condition specific.	One of the few tools for assessing activation. Many versions available, including one that is only 11 questions.	Costs money to use. Narrow scope.	Must sign contract and pay licensing fee to use. Fees depend on the type of organization requesting its use and the purpose for which the results will be used. Click here

Figure 1: Examples of Patient Experience Survey Tools continued

Tool Name	Description	Developed by/ Use	Pros	Cons	Copyright/Fee
4. Patient Assessment of Chronic Illness Care (PACIC)	Developed to assess if patients' experience of their clinical care is congruent with the Chronic Care Model.	Russ Glasgow and colleagues at the MacColl Institute for Healthcare Innovation.	Made up of 20 questions, the PACIC corresponds to the Assessment of Chronic Illness Care (ACIC) that clinics may be familiar with through the Breakthrough Series Collaboratives. Research validates tool. Available in Danish, Dutch, Japanese, Spanish, and large print versions.	Focused on patients with chronic illness, although some have adapted the questions to be more general in nature.	Publicly available for free: Click here
5. Ambulatory Care Experience Survey (ACES)	General assessment of patients' experiences with individual physicians and practices.	Dana Safran and colleagues at Tufts University.	Like the CAHPS (which was based in large part on the ACES) this is a general questionnaire. Research validates its use down to the individual physician level. Measures both quality of interactions and organizational features of care.	Includes a few additional domains over the CAHPS, but not as widely used.	Publicly available for free: Click here
6. Primary Care Renewal Patient Experience of Care Survey	Developed to assess patient's experience of care as part of a "primary care renewal" redesign, similar to the PCMH model.	CareOregon, a Medicaid managed care plan for their multi-lingual FQHC partners.	Developed specifically for and used by safety net practices implementing the PCMH model. Also available in Spanish, Russian, Chinese and Vietnamese. Open-ended questions may be helpful for QI.	Not rigorously tested for validity.	For Technical Manual and Survey Instrument, contact Debra Read, Evaluation Practice Leader, at read@careoregon.org

Eliciting Patients' Experiences with Care in Diverse Populations

Special considerations are indicated when preparing to administer a patient survey in a socioeconomically, ethnically, and/or linguistically diverse population. This section of the guide briefly discusses a few of these considerations. Additional resources are provided in the bibliography on page 14.

Selecting a Survey

There are many good survey instruments available for eliciting patients' experiences with care (refer to Figure 1). Among these, there is no one best survey instrument, but there may be a survey best suited to your particular practice setting, patient population, and/or evaluation need. Choosing a survey should be based on a number of considerations. Here are a few factors to consider, focusing on issues that might arise in diverse patient populations:

- **Does the survey address domains of interest to you and relevant to your patients?** You should approach a survey with a set of evaluation domains in mind, e.g., access to care, timeliness of care, language barriers, access to interpreters, and perceived discrimination. Then you should check whether any of the available survey instruments include items or scales covering these domains. You may want to select items and scales from various surveys to make your own survey.
- **Is benchmarking data available?** You may want to know how your scores compare to the scores from other practices. Benchmarking data is frequently available for established surveys. If this interests you, check with the survey developers, or a local health plan that has used the survey, to see if they may be willing to share benchmarking data.
- **Has a survey been used in a comparable population?** It is best to choose a survey that has been used in a patient population similar to your own. Ideally, some of the validation research would also have been done in a population similar to your own.

- **Has the survey been translated into the languages you need?** Translating a survey is an expensive and time consuming process. If possible, use surveys that have translations in the language you need.

Translation

Translation for the purposes of measurement is a highly complex and expensive task that requires skilled professional translators and the involvement of the survey developers. Translations undertaken without the use of rigorous methods may produce misleading and invalid results. Whenever possible, use translations produced by the survey developer. Ask about how a translation was obtained and whether the translations have been evaluated.

Most surveys have been translated into common non-English languages used in the U.S. including Spanish and Chinese, but you may also need other languages. If a translation you need is not available, it is best to work with a reputable vendor to have a translation produced. A survey developer or foundation may be willing to share the costs. Here are a couple of sources for high quality translations:

- RAND Survey Research Group [Click here](#)
- Functional Assessment of Chronic Illness Therapy (FACIT) [Click here](#)
- University of Michigan, Survey Research Center [Click here](#)

For a very good overview of translation methods see: Eremencio S, Cella D, Arnold B. A comprehensive method for the translation and cross-cultural validation of health status questionnaires. *Evaluation and the Health Professions*, 2005; 28; 212-232.

Guidance from the Field: Translation

While formal translations have the best evidence for valid and reliable results, they sometimes don't make sense to non-English speakers. When contracting a formal translation of your survey materials, be sure to field-test the survey on a small group of patients to ensure that the formal translation is understandable and appropriate before distributing it widely.

Measurement and Measurement Bias

Most survey instruments consist of single-item measures and unidimensional multiple-item measures. Single-item measures are items such as “how would you rate your health,” where the response options range from 0 (worst health possible) to 10 (best health possible). This score can be used alone or in combination with other items to evaluate health. Multiple-item measures combine the scores from several items. For example, the CAHPS Health Plan measure for doctor communication consists of four items:

1. Doctor explained things clearly
2. Doctor listened carefully
3. Doctor respected your comments
4. Doctor spent enough time

Each item is administered with a 4-option response scale consisting of Never (1), Sometimes (2), Usually (3), and Always (4). To compute the summary score, each item score is linearly transformed to a 0-100 scale and then the item scores are averaged.

The most commonly reported psychometric properties of a measure are reliability and validity. The reliability of a measure is how consistently a scale measures a construct, while a valid measure measures what it is intended to measure and not something else. Keep in mind that a reliable measure may be consistent without necessarily being valid, e.g., a measurement instrument like a broken ruler may always under-measure a quantity by the same amount each time, but the resulting quantity is incorrect.

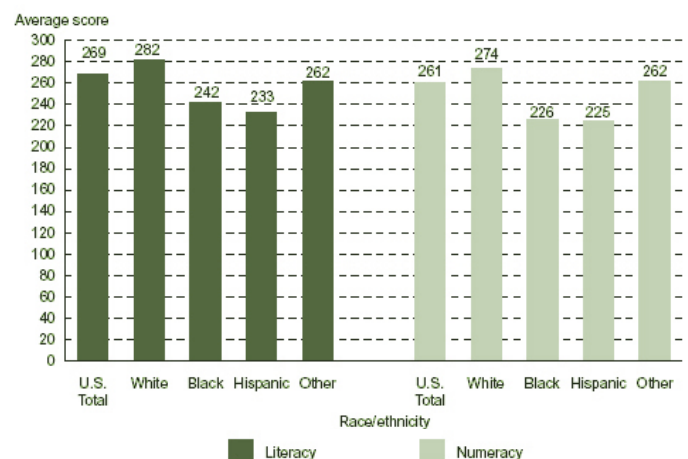
A special concern when selecting a survey for diverse communities and multiple languages is the concept of equivalence. Without equivalence, measures may not operate similarly in different segments of the population, and the results for different groups of respondents may not be comparable. Stewart et al. describe six levels of equivalence and the basic methods for addressing each type of equivalence.³ When you are selecting a survey, ask the survey developer whether it has been evaluated for equivalence in the groups of interest.

Literacy, Health Literacy, and Survey Readability

Providing valid responses to written surveys requires a degree of literacy. In many minority and underserved communities there are low levels of education and literacy. According to the National Assessment of Adult Literacy, 33% of the U.S. population has below basic literacy (no more than the most simple and concrete literacy skills) or basic literacy (can perform simple and everyday literacy activities). There are significant racial-ethnic disparities in literacy (refer to Figure 2).⁴ Minority patients may be less likely to respond to surveys and more likely to provide invalid responses due to lower average health literacy.

When choosing a survey, be sure to find out the reading level (readability) of the survey. Most surveys aim for a 6th to 8th grade reading level, though they sometimes exceed that level. The CAHPS survey, for example, has been assessed at the 7th grade reading level. Reading skills may be two or more grade levels lower than a patient’s self-reported education level. If the readability of a survey has not been assessed or is unavailable, you can easily do this using tools available in Microsoft Word® (Tools -> Options -> Spelling and Grammar -> Show Readability Statistics). Reading through the survey with a critical eye can also give you a sense of the readability level. Look for medical jargon, long sentences, multisyllabic words, stem and leaf question formats, and poor formatting, including small font size. All these factors make surveys less readable.

Figure 2: Average Literacy and Numeracy Scores of U.S. 16- to 65-year-olds, by Race/Ethnicity, 2003



**Literacy is a measure of reading ability. Numeracy is a measure of one’s ability to understand numbers and mathematics. Source: Calderón JL, Morales LS, Liu H, Hays RD. Variation in the readability of items within surveys. *Am J Med Qual.* 2006;21(1):49-56.

Mode of Administration

There are several modes of administering surveys, and each mode has strengths and limitations. Selecting the right survey mode for your project depends on a number of factors including: characteristics of your sample (i.e., education, socioeconomic status), types of questions asked (closed-ended versus open-ended), topics of questions (general topics versus sensitive topics), desired response rates, costs, and time frame. Various modes of survey administration include:

- Personal (face-to-face) interview
- Self-administered in the office
- Phone
- Mail
- Internet
- Mixed modes (eg. mail followed by phone; Internet followed by phone)

Various advantages and disadvantages of each method of survey administration are presented in Figure 3.

Figure 3: Comparison of Data Collection Methods

Variable	Self	Face-to-Face	Phone	Mail	Internet
Cost	Inexpensive	Costly	Moderate	Inexpensive	Inexpensive
Speed	Slow	Slow	Fast	Moderate	Fast
Response rate	Low to moderate	High	Moderate	Low to moderate	Low to moderate
Respondent burden	High	Low	Moderate	High	High
Control participation of others	Low	Variable	High	Unknown	Unknown
Length of questionnaire	Short	Long	Moderate	Short	Short
Sensitive questions	Best	Poor	Moderate	Best	Best
Lengthy answer choices	Poor	Best	Moderate	Poor	Poor
Open-ended responses	Poor	Best	Moderate	Poor	Poor
Survey complexity	Poor	Best	Good	Poor	Good to best
Low literacy	Poor	Best	Best	Poor	Poor to moderate
Possibility of interviewer bias	None	High	Moderate	None	None

The Internet is the newest and least studied mode of survey administration in minority populations. An important factor limiting the use of the Internet for survey administration in minority populations is the “Digital Divide.” The Digital Divide refers to the difference in access to and use of the Internet by age, socioeconomic status, race-ethnicity, and language preference.

Sampling Approaches

The sampling methodology you select should be matched to the purpose of your survey. In most cases, you will want a survey that produces results that are representative of your patient population, that is, that the responses provided by the individuals in your sample tell you something about your patient population. Sampling approaches that produce representative results are referred to as probability samples. By contrast, non-probability samples only provide information about the individuals included in your survey. Probability and non-probability samples can be further subdivided. Two examples of commonly used probability samples are random samples and stratified random samples.

- **Random Samples** are the purest form of probability samples. Each member of the target population has an equal and known chance of being selected for the survey. Individuals selected for the survey constitute the sample. An example of a random sample is 100 patients selected at random from among all patients seen in the practice.
- **Stratified Random Samples** are used when there are subgroups within the population that you want to ensure are incorporated into your sample. Stratification is the process of grouping members of the population into relatively homogeneous subgroups before sampling. Examples of strata are males and females, high and low-income earners, English and non-English speakers. The survey researcher first identifies the relevant strata and their actual representation in the population. Random sampling is then used to select a sufficient number of subjects from each stratum. "Sufficient" refers to a sample size large enough to be reasonably confident that the stratum represents the population.

Three examples of commonly used non-probability samples are quota samples, convenience samples, and snowball samples.

- **Quota Sampling** is the non-probability equivalent of stratified random sampling. Like stratified random sampling, the researcher first identifies the strata in the population. Then convenience sampling is used to select the required number of subjects from each stratum.
- **Convenience Sampling** is used in exploratory research where the researcher is interested in getting an inexpensive approximation of the truth. As the name implies, the sample is selected because they are convenient. Examples of convenience samples are persons in the waiting room or individuals leaving the hospital. With convenience sampling there is no guarantee that the patients in your sample are representative of those left out of your sample. In the case of waiting room samples, those not in the room may be avoiding care because of problems.
- **Snowball Sampling** is a special non-probability method used when it may be extremely difficult or cost prohibitive to locate respondents. Snowball sampling relies on referrals from initial subjects to generate additional subjects. While this technique can dramatically lower search costs, like convenience sampling, the respondents may not be representative.

Guidance from the Field: Convenience Sampling

Convenience sampling can be biased because it relies on patients engaged in care; for example, patients waiting for an appointment. This type of sampling can discount the voices of patients not engaged in care. Some clinics have found it helpful to call patients who miss an appointment and ask them if their absence was because of a problem with the care they received in the past, or a concern about their scheduled appointment (for example, not wanting to see a particular provider or inability to arrange for transportation). This information can help clinic staff better understand the reasons for missed appointments, and ensure that the concerns of patients not seen in the clinic are captured.

Response Rates

A good response rate ensures that the results of your survey are representative of the patient population. Low response rates result in biased samples when non-response is related to the outcome of interest. For example, if the sickest patients are less likely to respond, then the view represented in the survey responses are only those of well patients. Getting patients to respond to a survey can be difficult. Here are a few ideas for boosting your response rate:

- **Use the most current contact information available.** A major reason for low response rates is out-of-date or incorrect contact information. Find out when contact information is updated and set limits on how old contact information can be. Setting a standard to obtain current address and phone number with each patient contact is one way to ensure that the most recent contact information is available when needed.
- **If appropriate, use incentives.** Incentives increase response rates. Small (\$5-\$10), moderate (\$10-\$50), and large incentives (\$50 or more) all increase response rates for patient surveys.
- **Build trust.** In some communities, mistrust keeps individuals from participating in research projects, including surveys. Some strategies that help increase trust include partnering with other community-based organizations, community leaders, and faith-based organizations. Publicize your study in local media.
- **Use a mixed mode,** for example, mail and phone.
- **Prepare in advance.** If conducting a mail survey, send advance letters on letterhead and mail surveys in multiple languages.

Using Patient Experience Information to Transform Care

Patient surveys provide information about patients' satisfaction with, and experience of, care but from a level of remove that makes it difficult to apply the information to specific issues or questions you may have about care delivery. For instance, you may be working to make visits more efficient. Your team may have developed some proactive processes to have all the clinical information for the visit ready in advance, and now you are considering how to meet as many patient concerns as possible in a timely way. You wonder what would be the best method to elicit patients concerns before the visit. Would it be better to mail a visit prep form, have the reception staff offer the form when patients arrive, or for the medical assistant to spend a little more time asking about patients concerns when they are rooming them?

The answer to questions like these can provide real help in planning changes you make in visit flow, and can affect the quality of experience for patients and clinicians alike. The right answer could save a lot of time and make the visit more productive, but the right answer may take time to find out. And, of course, there is no right answer for every patient, but taking some time up-front to ask patients what is right for them is often the only way to find answers that work. Clinical teams that have become experts in asking patient input in care delivery changes typically use three methods to get the information they need:

1. Point-of-care data gathering at the time of the visit.
2. Patient and family focus groups.
3. Patient and family walkthroughs or walkabouts.^{5,6}

Point-of-Care Data

“Point-of-care” data is collected within or at the end of a visit, usually with a very brief written or even verbal question. It is used to find out patients’ experience when it is fresh in the mind, and usually focuses either on a specific area of interest to the team, or on the general experience of the patient during the visit. In our example of visit preparation, the medical assistant might give the patient a form asking their preferences when they begin the visit. It is helpful if the form is introduced by a team member. For example, “we are trying to make sure we get to as many of your concerns as possible in a visit. Would you be willing to complete this form about how that would work best for you?” They may also be completed anonymously, using a box for written responses. These questions can also be asked verbally. For example, the receptionist at checkout may simply ask, “On a scale of 1-10, how well did today’s visit meet your needs?” If the response is lower than optimal, the question might be followed by, “What one thing could we have done to improve your experience?”

Patient Focus Groups

Focus groups can be used to answer many types of questions about healthcare delivery, from casual feedback to more in-depth, multidimensional issues. Like telephone interviews, focus groups can also be advantageous when seeking information from a low literacy population and they allow patients and families to engage in a discussion about their care, rather than respond to written questions. Most systems have some experience with focus groups and many have considerable expertise, formally convening them to provide feedback on the larger goals and issues of the system. They are also of use when teams have a specific goal or question in mind. Ann Lewis, CEO of CareSouth Carolina, says that they find focus groups so useful that they have become adept at “pulling a focus group together whenever we need patient feedback.” It may be useful to pose one or more scenarios that help participants focus on the area of interest to the team. Stories or examples in the form of scenarios have a way of setting the stage quickly for responses and conversation. Holding focus groups more frequently allows repeated input, which can advise the team on practice changes at various

stages of design and implementation. At its most mature, the regular engagement of groups of patients to offer feedback on a particular area of interest to the team, or regular participation of patients and families on quality improvement teams, allows their development into a full fledged advisory group with in-depth expertise in that area.

Patient Walkabouts

One way to get feedback from patients and families on making care more patient-centered is an exercise which helps you explore care delivery through their eyes. A “walkabout” is an activity that can be used to obtain patient and family perspectives on any number of care delivery experiences as well as the more general experience of your setting, from the parking area to the patient materials in the waiting room to the receipt of information during an office visit. If you have patients and families who are experienced advisors within your program, ask them to participate in the activity. If not, invite several patients and families who receive care in your facility and who are willing to share their opinions. Walkabouts can be as broad as the experience of receiving care throughout the system, or as focused as evaluating the experience of having questions answered during a visit. Clinics have used walkabouts to explore:

- How patients and families are greeted.
- The processes of care and exchange of information in the administrative (e.g., billing, appointments) and ancillary areas (e.g., lab, pharmacy).
- The processes of care and exchange of information during a visit and exam.
- Patient forms and educational materials (or anything else they may receive or need to fill out as part of a visit).
- Characteristics of the physical environment (e.g., signage, artwork, color, lighting, visible equipment and arrangement of furnishings).
- Public materials (e.g., posters, magazines, announcements).

The idea is to accompany and record the perceptions of that care experience through the eyes of the patient. It is rare for a team to conduct a walkabout and not experience some ‘aha moment’ when their familiar environment and activities take on a whole new perspective. The team should collect evidence by

assigning one or more of the team to document the walkabout through:

- Digital photos, slides, or videotape.
- Notes from observation of simulated patient visit and exam.
- Patient forms and educational materials.
- Specific quotes or messages on posters or other announcements.

Thoughts on Collecting Patient Experience Data and Changing Care Processes

- It is very important to set realistic expectations for the amount of time and effort needed to see results in this work—we may have some frustration with the pace of change.
- One question that seems to show improvement within a relatively short timeframe is about sharing health information with patients. Asking a scaled response to “My healthcare provider explained things to me in a way that was easy to understand” has shown improvement when teachback or other health literacy interventions are used.
- Effective feedback comes from asking patients early and often. Don’t wait until you have a draft version of patient materials or a questionnaire before you ask for input. Bring patients in at the design level.
- Family members are an important part of the healthcare team as well, and offer valuable perspectives. Include them in care and in advisory capacities.



Related Change Concepts

As previously mentioned, patient-Centered Interactions is considered a foundational Change Concept because it must be mastered before practices can tackle most of the others. For example, providing organized, evidence-based care requires that practices understand what patients want and need from their medical interactions. And, developing continuous relationships with patients relies on both patients and providers feeling respected and engaged in the care relationship. Specific Change Concepts that rely on patient-centered interactions include:

- Empanelment
- Continuous, Team-Based Healing Relationships
- Enhanced Access
- Care Coordination
- Organized, Evidence-Based Care

To effectively manage the ongoing demands of assessing and understanding patient experience in the context of the Change Concept Patient-Centered Interactions, the following capabilities are needed:

- Engaged Leadership
- Quality Improvement Strategy

Additional Resources

Presentations and Media

- Knowledge Building Session: Patient-Centered Interactions Webinar (February 17, 2010). Moderator: Donna Daniel, PhD, Qualis Health; Panelists: Jay Brooke, CEO and Emily Montoya, Health Educator from High Plains Community Health Center (Lamar, CO); Laurie Francis, CEO from Community Health Partners, Inc. (Livingston, MT); Ann Lewis, Executive Director from Caresouth Carolina (Hartsville, SC); Leo Morales, MD, PhD from the Group Health Research Institute (Seattle, WA). Webinar recording and slides available at: [Click here](#)

Additional Resources on Patient-Centered Care

- **Patient-Centered Care Improvement Guide**, Picker Institute (2008)
- **Patient-Centered Care: What Does it Take?** (October 2007)
- **The Stoeckle Center of Massachusetts General Hospital:** [Click here](#)
- **New Health Partnership – Improving Care by Engaging Patients:** [Click here](#)

Additional Measurement Resources

- **CAHPS** [Click here](#)
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Healthcare organizations, public and private purchasers, consumers, and researchers use CAHPS results to: Assess the patient-centeredness of care; compare and report on performance; and improve quality of care.
- **CAHPS User Network** [Click here](#)
The CAHPS User Network is the principal source of CAHPS survey products, information about CAHPS-related products and services, technical assistance for survey users, and networking opportunities for users and researchers. The User Network is funded by the U.S. Agency for Healthcare Research and Quality (AHRQ) and administered by Westat.
- **MAPI Research Institute** [Click here](#)
MAPI Research Institute is a non-profit international health outcomes organization established to support and promote research in the field of Health-Related Quality of Life (HRQoL). The Institute has particular expertise in cultural adaptation and linguistic validation of questionnaires, helpful instrument pages, a widely distributed newsletter, and useful links.
- **Measurement Excellence Initiative**
The Measurement Excellence Initiative (MEI) is charged by the Veterans' Affairs (VA) Health Services Research and Development Service to serve as a resource for improving the overall quality of measurement in the health services research community.
- **Patient Satisfaction Questionnaire (PSQ III)** [Click here](#)
The Patient Satisfaction Questionnaire (PSQ), consisting of 80 items, was originally developed by Ware and his colleagues. The PSQ-III is a 50-item version that taps global satisfaction with medical care as well as satisfaction with six aspects of care: technical quality, interpersonal manner, communication, financial aspects of care, time spent with doctor, and accessibility of care. The questionnaire takes 9-12 minutes to complete.
- **Patient Satisfaction Questionnaire** [Click here](#)
The PSQ-18 is a short form version that retains many characteristics of its full-length counterpart, the PSQ-III. The PSQ sub-scales show acceptable internal consistency reliability. Furthermore, corresponding PSQ-18 and PSQ-III subscales are substantially correlate with one another. The PSQ-18 may be appropriate for use in situations where the need for brevity precludes administration of the full-length PSQ-III. The PSQ-18 takes approximately 3-4 minutes to complete.
- **Patient Satisfaction Survey** [Click here](#)
This patient satisfaction questionnaire was used to assess satisfaction with care and health-related quality of life of patients of the Unified Medical Group Association.
- **Measurement in a Multi-Ethnic Society.** Medical Care Special Issue. November 2006, Volume 44, Issue 11, Suppl 3.

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The following are websites, book chapters, and journal articles that provide more information about patient surveys for diverse populations.

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Mentor Site Examples

- **High Plains Community Health Center** in Lamar, CO has spent substantial time capturing patient experiences through survey tools and learning how to move this towards actionable improvements. For more information about their efforts please contact Jay Brooke, CEO, at jbrooke@highplainschc.net.
- **Community Health Partners, Inc.** in Livingston, MT, has redesigned its care delivery to fully integrate patient and family preferences, and extend care into the community. For more information about their efforts, please contact Laurie Francis, CEO, at francisl@chphealth.org.
- **CareSouth Carolina** serves eight federally designated medically underserved communities in rural South Carolina. CareSouth has been providing care that is built around the wants and needs of patients and dedicated to improving health outcomes for more than 20 years. For more information about their efforts please contact Ann Lewis, Executive Director, at annlewis@caresouth-carolina.com.

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About the Safety Net Medical Home Initiative

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh), representing 65 safety net practices across the U.S. The Initiative is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmf.org. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.

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