USING FOCUS GROUPS TO ASSESS PRIMARY CARE PATIENTS' SATISFACTION

MIRIAM SCHWARZ
SUZANNE E. LANDIS
JOHN E. ROWE
CYNTHIA L. JANES
NAOMI PULLMAN
Mountain Area Health Education Center

The present report describes the use of patient focus groups by a primary health care facility. We review our rationale for using focus groups and the process we used to prepare for and conduct them. We then highlight the results and lessons learned through this experience. Focus groups can be an excellent method for primary care practices to assess the complexities of patient satisfaction issues and engage patients in the continuous quality improvement process. Focus groups can uncover unanticipated issues that surveys fail to identify. Our experience demonstrated that this benefit can be critical in identifying and prioritizing quality of care improvements and that focus group results can be used to make immediate improvements in the quality of care, even though this type of study is not intended to generalize.

AUTHORS' NOTE: The authors gratefully acknowledge the expertise and guidance provided by the Patient Satisfaction Improvement Team in developing and conducting the patient satisfaction focus groups. We wish to thank specifically team members June Trevor, M.S.W.; Beverly Berthelot; Joni Ellis, R.N.; and Roger Jensen, M.D.

EVALUATION & THE HEALTH PROFESSIONS, Vol. 23 No. 1, March 2000 58-71

Successfully improving quality depends on being able to understand customers' needs and expectations and then exceeding them. When the delivery of medical care meets or exceeds customers' needs and expectations, patients are more satisfied. And when patients are satisfied with the care they receive, (a) they are more likely to continue seeking care at that health care facility, (b) they perceive their quality of care to be high, (c) they are more likely to follow their providers' instructions, and (d) they may be viewed as having adequate access to care (Batchelor, Owens, Read, & Bloor, 1994; Bell, Krivich, & Boyd, 1997; Goldfield, 1996). Thus, patient satisfaction with medical care is an important concept to track over time.

Measuring satisfaction is complex and multidimensional. The most frequently used method of determining the degree to which patients are satisfied with the services they are receiving is the patient satisfaction survey. Unfortunately, survey results often fail to produce information that is useful for program improvement (Williams, Coyle, & Healy, 1998). One reason is that the information produced from surveys is not discriminating enough to be helpful. Satisfaction depends on the degree to which expectations have been met (Williams, 1994). Assessing only the level of satisfaction without assessing associated expectancies yields information that is limited in its ability to lead to service improvement: Patient satisfaction surveys fall into this category (Williams et al., 1998). A second issue is that providers may ask for satisfaction ratings about areas (e.g., friendliness of staff, quality of care, timeliness) that are not of greatest interest or importance to patients (McComas, Kosseim, & Macintosh, 1995). Third, the typical closed-ended, global survey may too narrowly frame the range of possible responses and may result in overestimates of satisfaction (Batchelor et al., 1994). A related issue is that surveys often do not give patients any real opportunity for input into how they would like to have services provided (Batchelor et al., 1994). Fourth, the written survey approach presents barriers to those patients who are less educated and literate, or for whom English is not the first language. The use of questionnaires may discriminate against these groups (McIver, 1991).

Valid feedback on what patients expect and value in a health care experience, how a health care facility measures those aspects of care (Batchelor et al., 1994; McComas et al., 1995; Williams et al., 1998), and what system changes patients would like to see (Nelson, 1993) would be more useful for service improvement. Patient focus groups can provide valuable feedback about what patients expect, and they are particularly effective in identifying factors patients find important (Ford, Bach, & Fottler, 1997; McComas et al., 1995). Because the questions are open-ended and amplification is invited, participants' experiences, opinions, and suggestions are likely to be heard and understood. The focus group setting communicates to patients that they will be listened to and that their input is valued.

Focus groups have been suggested as very helpful in the development and testing of new patient services (Smith, Scammon, & Beck, 1995), as well as the ongoing monitoring of existing services (Joint Commission on Accreditation of Health Care Organizations, 1995), but the emphasis in the literature is on using qualitative findings to develop more customized quantitative surveys. Ford and his colleagues (1997; Fottler, Ford, & Bach, 1997), in a comprehensive review of methods of measuring patient satisfaction, recommend that health care organizations new to measuring patient satisfaction begin with qualitative methods for issue identification, following up with quantitative methods. For example, McComas et al. (1995) used focus groups to identify aspects of care that were important to patients, then constructed a questionnaire that reflected these issues.

Hospitals and large managed care organizations have led the way in health care-related quality improvement efforts. A number of journal articles have reported on hospitals' and managed care organizations' use of focus groups to understand patients' perspectives (e.g., Nelson & Batalden, 1993; Nemeth, Hendricks, Salaway, & Garcia, 1998; Smith et al., 1995). Increasing competition for patients, increasing emphasis on satisfying customers' needs, and improving quality of care is resulting in more attention being paid to the expectancies and needs of patients (Nelson & Batalden, 1993). Most primary care practices do not regularly employ mechanisms for measuring patient satisfaction. The regular employment of systems for soliciting patient feedback through focus groups can provide critical information to primary care facilities that could lead such organizations to better meet customer needs while also meeting the facility's objectives (Smith et al., 1995).

Focus groups do have some drawbacks that are important to consider when determining the best approach for measuring patient satisfaction. Even with careful planning and a skilled research team, focus groups can be very expensive, time consuming, and labor intensive (Ford et al., 1997). Costs may include paying a skilled facilitator, finding a suitable location, providing incentives for attending, and helping with child care and transportation. Recruitment of participants and data analysis take time and are labor intensive. These issues must be addressed up front.

The present report describes the use of patient focus groups by a primary health care facility. We review our rationale for using focus groups and the process we used to prepare for and conduct them. We then highlight the results and lessons learned through this experience. We emphasize that the information obtained from patient focus groups can be used to make immediate changes that improve both satisfaction and quality of care.

BACKGROUND

The Mountain Area Health Education Center (MAHEC), located in Asheville, North Carolina, is an arm of the statewide Area Health Education Center network overseen by the University of North Carolina at Chapel Hill. Within MAHEC is housed a continuing medical education division providing programs for health professionals from a 16-county region of western North Carolina, a Women's Health Center providing ob-gyn medical care for women in the region, and a division of family medicine (DFM) in which is housed the Family Health Center (FHC), a family medicine practice. Both medical practices incorporate community practice-based residency programs. This work was based at the FHC, which has a staff of some 125 people, including nine full-time faculty physicians, two behavioral medicine faculty, and 24 community practice-based family practice residents.

The medical director of the FHC established an interdisciplinary Patient Satisfaction Improvement Team in the late fall of 1995. The team was charged with exploring patient satisfaction with the FHC to help guide the future development of the center. The team was central to the dat-gathering efforts of the DFM's fledgling continuous quality improvement (CQI) program. The team comprised physician faculty, business office staff, nursing staff, and CQI/research staff, all of whom were included to help develop and implement the team's data collection plans.

RATIONALE FOR USE OF FOCUS GROUPS

The team's objective was to obtain from patients themselves information on which specific action could be taken to improve existing services and to help devise additional services. Initially, the team considered conducting a written survey to elicit patient ratings about service delivery at the FHC. Our past experiences with written surveys had resulted in poor response rates because of the less educated and literate nature of key segments of the FHC patient population. Written surveys also produced superficial data of limited use in decision making. A key deficiency of written surveys and one-to-one interviews is that the structured questioning that is typically used relies on the interviewer's or surveyor's preconceived notion about what is really important to the respondent. Although we thought we knew what the key issues were, we wanted the flexibility to explore in depth with patients issues we had not anticipated. We also wanted to provide an environment in which patients would feel comfortable enough to discuss issues candidly with one another. For these reasons, the team chose to use focus groups.

PREPARING FOR THE FOCUS GROUPS

SELECTION OF TARGET GROUPS

Once it was agreed to gather data by conducting focus groups, the next step was to define the representation needed to successfully explore topics of interest to the FHC's major consumer groups. Four patient groups were defined: (a) pregnant women and families with children (this group would be of mixed payer status with Medicaid recipients included), (b) people with private insurance or with a health maintenance organization (HMO) up to age 65 who were working people and professionals, (c) people 65 and over, or with disabilities, who use Medicare, and (d) African Americans. Each of these groups was of particular interest to us, some because they represent large portions of our patient population, others because they are groups we need to attract to our practice. Because ours is a teaching practice within a family practice residency program, it is important for us to attract obstetric and pediatric patients to the FHC so that we can maintain a mix of patient types for our residents. Our practice comprises over 50% Medicare and Medicaid patients, so we wanted to be sure that they were well represented in the focus groups. The private insurance sector/HMO group was invited because of our interest in assuring that we were doing all we could to satisfy their needs. And finally, as part of an organization-wide effort to increase our diversity, an African American group was added because we had learned through other patient focus groups we were running elsewhere in MAHEC that some issues related to racism and discrimination had been brought up in an all-African American group that were not raised in the all-white groups.

RECRUITMENT OF PARTICIPANTS

Patients meeting one of the group definitions described above were recruited through faculty physicians, residents, and clinical staff. These sources were asked to recommend information-rich (Patton, 1990) patients who would be willing and able to air in a balanced way their likes and dislikes about being a patient at the center. We recognized the possibility of selection bias, but this was thought to be the most efficient, cost-effective means of recruiting patients.

Once potential participants were identified, their physicians were asked to recruit the patients in person if their next appointment was within the month. At the appointment, the physicians presented the patients with letters of invitation that provided details about the focus group. Patients who did not have an upcoming appointment scheduled were sent the letter of invitation in the mail. A follow-up phone call was made and, if the patient agreed, a flyer was sent that confirmed their participation and provided the details of the particular focus group session.

LOCATION AND INCENTIVES

The focus groups were held in the spring and summer of 1996 and were held away from the FHC to provide a neutral, confidential environment. The pregnant/families group was held at a centrally located church with day care facilities. Child care was provided for this group. A complete meal was provided for each group, and each participant was given a $10 gift certificate to a local grocery store. All groups were held at times of greatest convenience for participants; for example, they were held in the morning for the Medicare group, which was largely made up of retirees, and in the early evening for the working insured. Transportation (taxi service) was provided for several Medicare group members.

CONDUCTING THE FOCUS GROUPS

FOCUS GROUP STAFFING

The moderator for the four focus groups was an M.S.W. candidate at the University of North Carolina at Chapel Hill who, at the time, was serving an internship with MAHEC's Community Health Resource Services Department. She had been the project coordinator of the Madison Community Health Project in western North Carolina and had helped conduct numerous community-based focus groups. She had written about using focus groups as a research tool and had helped to conduct workshops on the subject. She was deemed an appropriate choice as moderator because of her extensive experience with focus groups, her neutrality, and her willingness to do this work free of charge. One staff person coordinated the recruitment of participants and logistics. She also took notes and handled audio recordings at each session. The CQI coordinator was present at three of the groups as an observer and also took notes. An African American staff member was recruited to serve as co-leader in the African American focus group.

FOCUS GROUP PROTOCOL

The focus group methods, introduction, ground rules, guidelines, questions, and prompts for specific topics of interest were developed in close collaboration with the Patient Satisfaction Improvement Team. We used Kreuger's (1994) *Focus Groups: A Practical Guide for Applied Research* as a guide. Our introduction included a statement on confidentiality. We assured participants that no names would be attached to our documentation. We obtained their verbal permission to tape-record the session, assuring them that we would erase the tape after the information was extracted from it. We also decided that we would consult with and seek permission from specific participants if we used direct quotes in our report that might render those patients identifiable.

PILOT FOCUS GROUP

A pilot group was organized that consisted of MAHEC employees from another building who were also FHC patients, to pretest the focus group questions and the process. Debriefing questions were designed for use with the MAHEC staff pilot group to solicit feedback about the process.

DESCRIPTION OF PARTICIPANTS

In total, 32 patients participated in the five focus groups. Most of the participants had been FHC patients for a considerable period of time (5 years or longer and, in some cases, 15 to 20 years). During the sessions, patients connected well and seemed to enjoy meeting and talking to one another, even exchanging telephone numbers. Many participants told us that they were surprised and honored to have been asked to be in a focus group and greatly appreciated the opportunity to contribute their ideas. Initial groups were scheduled to last an hour and a half, but with meals being served and the level of participation and involvement witnessed in the pilot group, subsequent sessions were scheduled for 2 hours.

PROCESS OF ANALYZING RESULTS

During the sessions, the moderator summarized key comments made by participants to verify accuracy and completeness. Participants were given a copy of the focus group questions and were encouraged to write down and submit anonymously in an envelope issues or concerns that they were not comfortable sharing with the rest of the group. Staff met immediately after each session to debrief, discuss the most important themes, noteworthy quotes, and unexpected findings; to compare themes with those from other groups; and to make any revisions to the process that might be needed for future groups.

Staff developed initial verbatim transcripts from tapes and field notes. Transcripts were mailed to participants for review and verification of accuracy. The moderator, note taker, and CQI coordinator then independently conducted content analysis of the raw data and identified emerging categories and themes. These independent findings were compared and consolidated into a final report, which included a description of the process and areas for improvement. Also included were patient recommendations for solutions. This report was circulated to all faculty, residents, and staff at the FHC through formal presentations and at group meetings. The Quality Council, which oversees the CQI process at the center, made recommendations based on the findings, as did faculty, residents, and staff.

Following the focus groups, participants were kept informed of the implementation process through memos from the DFM's director. The following fall, a phone survey was conducted with a sample of the participants to gauge whether they had noticed changes we had made and if new issues were emerging.

RESULTS

The interchange between patients was key in identifying unanticipated high-priority quality issues. For example, our practice regularly uses video cameras in exam rooms so that faculty can monitor the resident physician/patient encounter. Although we did not ask them about cameras, the patients raised questions about their use. There was confusion about when the cameras were on and what the role of the patient was in the use of the cameras. Our center policy was not being clearly communicated or understood by patients. Because this issue was raised spontaneously in four out of five groups and was an important issue of patient trust, priority was given to immediately implementing improvements. The information was passed on to the center's behavioral medicine team, which revised the consent statement provided to new patients. A procedure was developed to ensure that all new or returning patients being monitored by the camera understood and signed the form.

Another example of an important unanticipated concern was the issue of test results. When describing what they liked about the FHC, some patients expressed great satisfaction with the way test results were communicated, stating that they got all test results (both normal and abnormal) with ample physician comments/explanation. On hearing this, others shared their experiences with receiving test results, and these experiences varied widely. Of those who got their results, some were notified by phone calls, some by mail, and some were asked to call in to the office to hear results. Some patients received little or no explanation of their test results. Some obtained results long after they expected to get them. Others never learned of their results at all. Many patients in the groups expressed surprise and dismay on hearing that their experiences were so varied.

The discussion within the focus groups identified for us the wide variation in how we distributed test results to patients. These patients concurred that they wanted to be informed of both positive and negative test results in a reliable, predictable way. On learning of the patients' consensus and recommendations, providers acknowledged that the variation in reporting test results was a significant quality of care issue warranting immediate attention. A CQI team was formed to improve the process used to inform patients of their test results.

One of the major benefits of the patient focus groups was that we were able to use the results to make immediate improvements in the quality of care. Although focus group results are not to be generalized to the entire population, they can certainly point to systems issues that need attention and improvement. Kreuger (1998) notes,

> In a strict sense, one cannot generalize, but what we suggest is the concept of transferability. . . . Those who seek to use the results [should] look over the study; examine the procedures, methods, and analysis strategies and then decide the degree to which the [findings] might be applied to their situation. What may be transferred are the larger theoretical concepts, as opposed to the specific behaviors. (p. 70)

Concerns were raised in our focus groups that were so obviously fundamental to good service that additional verification was not needed: Implementation just made good common sense. Older patients and others with mobility problems brought up the heaviness of the front doors of the clinic. The doors were reworked. Mothers of infants described how hard it was to change diapers in a crowded waiting room or on a bathroom floor. A changing table was added to the women's restroom (expense prohibited placing one in the men's restroom). Our waiting room reading material was said to be limited in scope. Subscriptions to magazines that reflected the clinic's diverse patient population were ordered. Difficulty finding one's way around the clinic was raised. Directional signs were installed to guide patients to key clinic sites such as the lab. Telephone access to the clinic was problematic; phone lines were added to the phone system. Not all staff were identifying themselves to patients; name badges were issued to all employees, and the wearing of badges was strongly encouraged. Prescription refills were difficult to obtain; the phone system was redesigned, and refill phone lines were established. All of this information helped emphasize the importance of patient feedback in the quality improvement process and helped staff understand the need to include this kind of information in the process.

Other, more complex issues required additional research before further action was taken. Often, these topics were assigned to various CQI teams and committees for further investigation. Focus group participants had a number of recommendations for attracting more obstetric and pediatric patients to the clinic. Their comments were forwarded to the FHC Marketing Committee for further assessment, resulting in the establishment of childbirth classes at the facility. The issue of waiting times, both in the waiting room and the exam rooms, was raised in the focus groups, but the perceptions about them were inconsistent. For example, some felt that the FHC provided the ideal in wait times and were very satisfied. Others had occasional lengthy waits, but that was not their experience in general. Still others were satisfied with the wait time in the waiting room but felt the time in the exam room was excessive and wondered why they could not have remained in the waiting room. The information we received left us with an unclear picture of the level and focal point of concern. The Patient Satisfaction Improvement team subsequently conducted a targeted written patient survey on wait times, which provided broader input on details about actual and expected wait times. The results suggested general satisfaction with FHC wait times.

This was our practice's first venture into using focus groups as a means to collect patient data. We kept track of the time it took us to plan, conduct, and analyze data from four focus groups plus the pilot group. It took us a total of 267 hours to complete this work. This included 147 hours for planning (including Patient Satisfaction team meetings, literature reviews, research on focus groups through readings and workshops; design of focus group questions; preparation of the introduction and ground rules; participant recruitment; and logistics such as child care, food, incentives, and transportation); 100 hours for conducting the focus groups (setting up the sites, moderating the groups, taking notes, cleaning up, debriefing, developing initial transcripts, analyzing the data); and 20 hours for the final report (writing, editing, reviewing, copying, distributing, discussing). We estimated that if we were to repeat the same process again, the time needed for planning could be cut by 40% to 50% because we now had experience, a clear process, and prepared materials on our side.

Other than the time that the process took, there were some difficulties along the way. Identifying eligible patients who were likely to provide a balanced view of the practice without bias was challenging. It was anticipated that physicians and staff would be likely to select people who would have a tendency to say good things about us. Given the nature of our practice, where a 15% to 20% no-show rate is common and the literacy rate variable, and because of the large amount of time and expense expended on this project, we felt we could not rely on a random selection of patients, as half the people might not show, and the others might have little to say. We acknowledged that we were introducing a source of bias, but the information gained was useful in improving systems. We did try to include those who might be dissatisfied with some particular services or procedures, knowing that they would have important views and feedback for us. It was a challenge to coordinate the logistics of getting physicians to identify patients and inviting patients to participate. This added a considerable amount of time to the process.

Although our focus group research study was time consuming, this effort marked a turning point for our practice in using patient data to make quality improvements. For the first time in our practice's history, we collected and then followed up on patient satisfaction data in an organized, thorough manner. The richness of the resulting data proved exceptionally useful in making immediate, meaningful improvements to our practice. The focus group data also provided us direction for further needs assessments where the issues were more complex. Meeting with the patients in person and hearing them express themselves made us feel even more connected to them and heightened our commitment to respond to the issues they raised. The staff involved in the focus group study found the experience rewarding. We enjoyed listening to our patients, and we found their enthusiasm and level of involvement gratifying. All involved in the effort felt the time was well spent. Because of this experience, the practice decided to continue using focus groups as its primary means of collecting comprehensive and meaningful information on the status of patient satisfaction. We are now in the process of conducting our second focus group study.

CONCLUSION

Focus groups can be an excellent method for primary care practices to assess the complexities of patient satisfaction issues and engage patients in the CQI process. Focus groups can uncover unanticipated issues that surveys fail to identify. Our experience demonstrated that this benefit can be critical in identifying and prioritizing quality of care improvements and that focus group results can be used to make immediate improvements in the quality of care, even though this type of study is not intended to generalize.

REFERENCES

Batchelor, C., Owens, D. J., Read, M., & Bloor, M. (1994). Patient satisfaction studies: Methodology, management, and consumer evaluation. *International Journal of Health Care Quality Assurance*, *7*, 22-30.

Bell, R., Krivich, M. J., & Boyd, M. S. (1997). Charting patient satisfaction. *Marketing Health Services*, *17*, 22-29.

Ford, R. C., Bach, S. A., & Fottler, M. D. (1997). Methods of measuring patient satisfaction in health care organizations. *Health Care Management Review, 22*, 74-89.

Fottler, M. D., Ford, R. C., & Bach, S. A. (1997). Measuring patient satisfaction in health care organizations: Qualitative and quantitative approaches. *Best Practices and Benchmarking in Healthcare*, *2*, 227-239.

Goldfield, N. (1996). Collecting and using information from patients: A summary guide of recent practical research. *Managed Care Quarterly*, *4*, 39-48.

Joint Commission on Accreditation of Health Care Organizations. (1995). Using patient input in a cycle for performance improvement. *Joint Commission Journal on Quality Improvement*, *21*, 87-96.

Kreuger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.

Kreuger, R. A. (1998). *Analyzing and reporting focus group results*. Thousand Oaks, CA: Sage.

McComas, J., Kosseim, M., & Macintosh, D. (1995). Client-centered approach to develop a seating clinic satisfaction questionnaire: A qualitative study. *American Journal of Occupational Therapy*, *49*, 980-985.

McIver, S. (1991). An introduction to obtaining the views of users of health services. King’s Fund Centre for Health Services Development.

Nelson, E. C. (1993). Developing a patient measurement system for the future: An interview with Eugene C. Nelson, DSc, MPH. *Joint Commission Journal on Quality Improvement*, *19*, 368-373.

Nelson, E. C., & Batalden, P. B. (1993). Patient-based quality measurement systems. *Quality Management in Health Care*, *2*, 18-30.

Nemeth, L., Hendricks, H., Salaway, T., & Garcia, C. (1998). Integrating the patient's perspective: Patient pathway development across the enterprise. *Topics in Health Information Management*, *19*, 79-87.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Smith, J. A., Scammon, D. L., & Beck, S. L. (1995). Using patient focus groups for new patient services. *Joint Commission Journal on Quality Improvement*, *21*, 22-31.

Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science and Medicine*, *38*, 509-516.

Williams, B., Coyle, J., & Healy, D. (1998). The meaning of patient satisfaction: An explanation of high reported levels. *Social Science and Medicine*, *47*, 1351-1359.