

DESCRIBING THE PATIENT CARE EXPERIENCE: QUALITY IMPROVEMENT IN  
FEDERALLY QUALIFIED HEALTH CENTERS IN ALASKA

By

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### **Abstract**

The purpose of this quality improvement project was to evaluate whether the quality assurance/performance improvement (QAPI) plan at a federally qualified health center (FQHC) provided a valid mechanism for assessing the overall patient experience or if implementing a multimodal approach to evaluating the patient experience provided a more accurate depiction on which to base operational decisions. The project used the Plan-Do-Study-Act (PDSA) framework to examine the efficacy of a multimodal approach to assessment of the patient care experience. The aims were to describe the patient care experience in a FQHC located in a small community in Alaska using a qualitative descriptive approach; and to examine the qualitative findings in relation to those derived from the aggregate FQHC survey data in order to make recommendations for a sustainable approach to evaluating the patient care experience in this FQHC environment. Provider relationships greatly influenced satisfaction and the perception of care. Participants long for a community clinic connection, to feel valued and connected to the FQHC and the community. Participants were satisfied with interagency coordination and communication, but struggled with understanding the inner workings of the health care system within the community. Participants were eager for community-based opportunities for learning and engagement. The results derived from the focus groups added important information in describing the patient care experience, supported the premise that a qualitative descriptive approach would add additional information not previously derived from the quantitative data, provided an opportunity to engage the community, and elicited a more accurate depiction of the care experience.

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## **Describing the Patient Care Experience: Quality Improvement in Federally Qualified Health Centers in Alaska**

The Community Health Center is a Federally Qualified Health Center (FQHC) in its third year of operation. As part of its strategic planning, a Quality Assurance Performance Improvement (QAPI) plan was developed which addresses establishing clear standards of patient care, evaluating the quality of care, improving future performance, and assessing/improving care process that directly affect patient outcomes (Human Resources and Services Administration (HRSA), 2015). As a part of the patient feedback/satisfaction mechanism, the FQHC began assessing patients' perceptions of their care in 2015. Three surveys were conducted in April, August, and December with response rates of 10%, 24%, and 18% respectively. Because the response rate was well below the optimal 50 to 60% (Reierson-Draugalis, Coons, & Plaza, 2008), it was uncertain whether results were representative of the consumers of the FQHC or whether inaccurate conclusions were drawn from this data secondary to nonresponse bias.

### **Purpose**

The purpose of this quality improvement project was to evaluate whether the quality assurance/performance improvement (QAPI) plan, in which patient satisfaction plays a pivotal role, provided a valid mechanism for assessing the overall patient experience or if implementing a multimodal approach to evaluate the patient experience provided a more accurate depiction on which to base operational decisions.

### **Background**

The Human Resources and Services Administration (HRSA) health center program provides comprehensive, primary care services to 22 million patients (U.S. Department of Health and Human Services (HHS), 2012a). Federally Qualified Health Centers (FQHC) provide care

to under-insured and under-served populations, such as minorities, homeless, or patients living in rural areas (HHS, 2012a). Health centers are required to provide comprehensive primary care, dental, and mental health services. Health Center funding is based on adopting an ongoing quality improvement and quality assurance plan that supports “accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent care” (HHS, 2012b, p. 1). Health centers are required to have a governing board comprised of a majority of consumers of care (HRSA, 2015). The purpose of a FQHC is to improve the health status of the community itself in addition to individuals within the community. FQHC are accountable to the community and actively involve community members in program development and organizational governance.

The Community Health Center opened in March 2014 in a medically underserved community in Alaska. Since its inception, the health center has offered a sliding scale fee structure to lower income patients who meet federal eligibility criteria. Comprehensive primary care services available include a team of physicians, nurse practitioners, physician assistants, nurses, and social workers; point of care (POC) lab testing; contract radiology and laboratory on-site; and physical therapy services off-site contracted through the local hospital. Dental and mental health services are contracted with local providers. The Board of Directors is comprised of no fewer than nine and no more than fifteen directors, currently the FQHC is comprised of 13 directors. At least 51% must be consumers of care at the health center. Although 90% of the board or their family members are consumers of care, employees are not allowed to be on the board, and board members cannot have an immediate family member simultaneously serving on the board. Directors are elected by the board and serve a three-year term (HRSA, 2015).

All Federally Qualified Health Centers are required to have a Quality Assurance Performance Improvement (QAPI) plan (HHS, 2012a). This plan is a data-driven, proactive approach to improving quality in healthcare. It involves all organizational levels to identify areas for improvement such as addressing gaps in systems and processes; developing and implementing improvement plans; and monitoring effectiveness of interventions (Centers for Medicare and Medicaid Services (CMS), 2014). As part of the comprehensive QAPI program over the last year, the health center conducted a series of patient satisfaction surveys to gain perspective on the patients' perception of the quality of care they were receiving. The surveys provided initial insight into the patients' perspective of their care. The health center developed a variation of the Consumer Assessment of Health Care Providers and Systems surveys (CAHPS). The CAHPS have been shown to be valid and reliable measures of the patient care experience (Dyer, Sorra, Smith, Cleary, & Hays, 2012).

The survey consists of 18 questions using a Likert scale (see Appendix A) to examine areas of interest including: (a) access to care (ease of scheduling, pleasantness of front desk staff, convenience of business hours, promptness in returning phone calls); (b) experience during the visit (speed of registration, courtesy of the staff, length of wait to treatment room, length of wait to see provider, friendliness of nursing staff, staff and providers treat me with respect and dignity); (c) the care provider (friendliness/courtesy of the provider, provider included you in decisions about treatment, provider was easy to understand, the instructions for follow-up care were helpful); and (d) overall assessment (overall friendliness of staff, overall care rating, likelihood of you recommending the center to others). To examine what the health center was doing well and what needed improvement two open-ended questions were added to the sections regarding access to care, the care provider and the overall assessment. A section with check

boxes inquiring about how patients heard about the health center: via radio, newspaper, social media, website, or other was included and an open ended section for any additional comments completed the survey.

The survey was provided to all patients who visited the health center for appointments during three two-week periods during April, August, and December 2015. Patients were encouraged by front office staff and clinical support staff to complete the survey. Patients were offered the choice of taking the survey at the end of their visit; taking the survey home and sending it back to the health center in a provided stamped envelope; or completing it online through the health center website. More than 95% of respondents chose to complete the questionnaire in the clinic following their visit using pen and paper, 2 to 5% completed surveys online, and only one person responded via mail. No phone interviews or follow-up calls were made to encourage participation. Of the 500 patients who were offered the opportunity to participate, 92 responded, an 18.4% response rate. Examination of the demographics revealed the sample was not representative of the patient population. Compilation of the data from the four domains: (a) access to care, (b) during your visit, (c) your care provider, and (d) overall assessment revealed that 90% of respondents were satisfied with the care they received. Although this information provided valuable feedback, in light of the low response rates, it was difficult to determine if the survey captured what was important to the clients and whether there was a difference between those who responded and those who did not.

To facilitate change and develop programs at the systems level, further exploration was needed to confirm the patient care experience was accurately depicted. A potential avenue for eliciting this information was through the use of a qualitative approach. The Community Health Center is in its infancy and to achieve the standard of providing quality, patient-centered care

examination of the QAPI program is needed to ensure the patients' perspective of care is incorporated as an active part of the health center development process.

### **Significance to Advanced Practice**

Research suggests that through improving patient satisfaction/experience we may improve patient outcomes (Browne, Roseman, Shaller, & Edgman-Levitan, 2010; Manary, Boulding, Staelin, & Glickman, 2013). By proactively collecting patient experience data, organizations have the opportunity to use the information gathered to better the perception of the quality of care the patients receive, to improve provider communication and performance, and to implement change at the systems and operational level (Aligning Forces for Quality (AF4Q), 2010; Browne et al., 2010). Positive patient experiences are in and of themselves beneficial, but positive effects extend beyond feelings. Patients who are satisfied with their experience correlate to healthier people with better outcomes especially in the areas of prevention and disease management (Aligning Forces for Quality, 2010; Manary et al., 2013). Chronic conditions also show improved outcomes when patients are satisfied and engaged with their providers (Manary et al., 2013). Patient satisfaction instills a level of personal responsibility, which leads to commitment, adherence, and action on the part of the patient, thereby improving outcomes (Browne et al., 2010; Manary et al., 2013). Measuring patient experience can also lead to improvements at the systems level (AF4Q, 2010). Areas of potential improvement include process times, efficiency in lab reports, and operating hours. It can also lead to insight into what types of providers the patients would like to see, affecting hiring and program development (AF4Q, 2010). Financial indicators such as patient loyalty and retention decrease malpractice cases (Browne et al., 2010). Finally, an increase in employee satisfaction is linked to better patient experiences (Browne et al., 2010; Rickert, 2014; Manary et al., 2013). Browne et al.

(2010) suggest that there needs to be “greater professional and policy support for the use of patient experience data” (p. 922). Understanding the patient perspective may help develop programs and systems that foster an active provider-patient relationship, which has been found to improve outcomes (Manary et al., 2013).

### **Aim of Project/Objective**

The project used the Plan-Do-Study-Act (PDSA) framework to examine the efficacy of a multimodal approach to assessment of the patient care experience. The aims were:

1. To describe the patient care experience in a FQHC located in a small community in Alaska using a qualitative descriptive approach; and
2. Examine the qualitative findings in relation to those derived from the aggregate FQHC survey data in order to make recommendations for a sustainable approach to evaluating the patient care experience in this FQHC environment.

### **Framework**

The PDSA quality improvement framework is based in scientific method and helps study a potential change before implementing it (see Figure 1). It starts with identifying a change that could lead to improvement, creating a plan to test the proposed change, carrying out the plan, and analyzing if the plan was effective (Langley, Nolan, Norman, & Provost, 2009). This project predicted that adding a qualitative descriptive approach to gather patient experience data would enhance the understanding of the patient care experience. A plan was formulated using focus groups to gain insight into the patient care experience. The outcomes analysis was designed to ascertain the effectiveness of the plan. The analyses examined the information derived from the focus groups in relation to the survey data to determine which approach provided the clearest

insight into the facets of the patient care experience. Finally, recommendations were made for modifications to the QAPI plan based on the analysis.



*Figure 1.* Plan-Do-Study-Act quality improvement framework. (Langley et al., 2009, The Plan-Do-Study-Act Cycle section, para. 1)

### Literature Review

Patient experience data has been shown to be valuable to the healthcare industry in both qualitative and quantitative studies (Doody, Slevin, & Taggert, 2012; Pieh-Holder, Callahan & Young, 2012). The use of patient experience data helps to “establish care that is culturally relevant, targets perceived barriers and incorporates and enhances coping strategies needed to increase accessibility and utilization of preventative and comprehensive healthcare services” (Pieh-Holder et al., 2012, p. 2). Multiple studies emphasize the importance of using qualitative research to explore a target population’s health behaviors and perception of care to gain insight into the target community’s priorities for effective community planning and improvement measures (Pieh-Holder et al., 2012; Stewart et al, 2000). It has been well documented that good

provider-patient communication and access to care leads to positive perception of care and higher perceived quality of care (Lebrum-Harris et al., 2013; Stewart et al., 2000).

Aysola, Werner, Keddem, SoRelle & Shea (2015) assert that patient perception of care received by the patient-centered medical home (PCMH) model is understudied. Upcoming guidelines within the FQHC grant system require the use of patient-reported experience and satisfaction in the evaluation of practice and provider performance (Aysola et al., 2015). Of the FQHCs that have been evaluated, patients report positive provider relationships and overall positive experience with care received within the PCMH model, which focuses on providing comprehensive, patient-centered, coordinated, accessible, quality, and safe health care services (Lebrum-Harris et al., 2013). Aysola et al. (2015) revealed the need to conduct more patient experience research to better understand what aspects of practice structure are related to positive patient experiences. Research emphasizes the role patient perspective can play in designing and redesigning primary care (Aysola et al., 2015). This study, among others, supports patient engagement and utilizing ongoing assessments of patient experience to achieve a deeper understanding of community needs and reveal quality improvement opportunities (AF4Q, 2010; Aysola et al., 2015; Cook et al., 2015). Systematic reviews of the literature support that positive patient experience has a positive association with clinical effectiveness, patient safety, better clinical outcomes, higher levels of adherence to treatment plans, better compliance with recommended preventative care (health promotion, screening services, and immunizations), and less healthcare utilization supporting its inclusion in the evaluation of quality health care (Doyle, Lennox, & Bell, 2013; Price et al., 2014).

Gathering patient experience data can be done effectively quantitatively, qualitatively or in combination (Browne, et al., 2010; Danielson, Tuler, Santos, Webler, & Chess, 2012;

Magiliv & Thomas, 2009; Ward, Bertrand & Brown, 1991). There are many advantages to using quantitative methods for data collection. Surveys are easy to administer and require no special training or skill to conduct (StatPac, 2014a). Surveys allow for rapid, easy access to larger sample sizes, across large demographic areas, and are affordable to administer (Danielson et al., 2012; StatPac, 2014a). They are more suitable for sensitive or highly private information as, typically, surveys are completed anonymously, which takes pressure off the respondents (Danielson et al., 2012). Survey information is repetitive and can be collected at regular intervals to track progress or program developments. Survey results are perceived to hold higher validity than other methods, since the researcher cannot influence the respondent (Danielson et al., 2012). Surveys are also familiar and easy to complete. Surveys are uniform and provide an excellent preliminary tool for conducting future studies to elicit more in-depth information (Danielson et al., 2012).

One of the major challenges in quantitative data collection is low response rates which leads to wider confidence intervals. This decreases validity and makes organizational change based on the results challenging (Danielson et al., StatPac, 2014b). Low response rates were evident in the health center survey cycles (April 10%, August 24%, and December 18%). Ninety percent of communication is visual (StatPac, 2014b); gestures and body language are lost with surveys. Another disadvantage is limited to no contact with participants, which leads to a feeling of impersonality (StatPac, 2014b). The researcher is inherently unable to probe and elicit deeper responses and clarify questions (StatPac, 2014b). Although survey data is generalizable across populations, the respondents may not represent the group attempting to be analyzed (StatPac, 2014b). For example, women tend to respond to surveys more frequently than men or those who have an interest in the topic may have higher response rates. This misrepresentation can skew

results. Unequal representation was also seen in the community survey results. The demographic of the health center is 53% female and 47% male. The respondents in the April survey was 75% female to 25% male, the July survey 71.4% female to 12% male, and the December survey was slightly more representative with 56.3% female to 43.8% male.

Qualitative analysis of patient satisfaction in community health centers provides a broad range of information from health care utilization to patient experience data (Danielson et al., 2012; Korn & Graubard, 1999). Focus groups facilitate in-depth discussions that allow for probing and the ability to gather insight as to why a person holds certain beliefs and attitudes (Jones & Carson-Cheng, 2013). Group interactions facilitate new ideas and thoughts through brainstorming. A group setting allows for feedback from multiple participants simultaneously (Doody, Slevin & Taggart, 2013b). The group setting also facilitates immediate follow-up on emerging ideas and thoughts for organizational change (Jones & Carson-Cheng, 2013).

Logistics can be a challenge as focus groups are intensive to organize. The moderator needs to be skilled and trained as not to distract from the responses of participants (Jones & Carson-Cheng, 2013). There is an inherent limit to the number of questions that can be asked during the focus group. The setting may positively or negatively influence opinions (Jones & Carson-Cheng, 2013). A skilled moderator must draw responses from all group members. Focus groups may be inappropriate for overly sensitive information, therefore, cannot be used for all topics or all populations (Ward et al., 1991). Conducting multiple separate groups is important to elicit feedback from different segments of the population. Results are limited to the group at hand and could lack validity when generalized to the population in its entirety (Danielson et al., 2012; Jones & Carson-Cheng, 2013).

After reviewing the literature, the case for gathering patient experience data through qualitative and quantitative methods is well supported. Newly developed federally qualified health centers can use patient experience data to engage patients to drive system development. Patient engagement and positive patient experiences may improve outcomes, save healthcare dollars, and support healthy communities (AF4Q, 2010; Browne et al., 2010).

## **Methods**

### **Project Design**

A qualitative descriptive approach was used to describe the experience of care at the health center and gain feedback for systems change. The Plan-Do-Study-Act quality improvement framework was used to examine whether the assessment of patient satisfaction/experience was best determined by a single survey approach or a multimodal approach of survey and qualitative data collection. Data collection was conducted using three focus groups. The specific aims of this project were:

1. To describe the patient care experience in a FQHC located in a small community in Alaska using a qualitative descriptive approach; and
2. Examine the qualitative findings in relation to those derived from the FQHC aggregate survey data in order to make recommendations for a sustainable approach to evaluating the patient care experience in this FQHC environment.

A meeting took place with the director of the health center to discuss this quality improvement project after which he consented to participate in the project and provided access to willing, eligible subjects. An agency support letter was obtained (Appendix B). After agency support was obtained, a meeting took place with the quality improvement committee to explain the project and offer opportunities for clarification.

### **Qualitative Descriptive Approach**

Qualitative description seeks to describe an event in everyday terms from the perspective of the person experiencing said event (Lambert & Lambert, 2012). The goal of the qualitative descriptive approach is to explore and describe an area of interest. The description of the area of interest may then be used to guide creation of an intervention that benefits the population being studied (Groves, Burns, & Gray, 2013; Magiliv & Thomas, 2009).

The FQHC opened in 2014 and serves a defined service area. It operates from 8:00 a.m. to 6:00 p.m. Monday through Friday. Initially, the clinic was staffed with temporary providers. During January through December of 2015, three providers were recruited and patient panels were finalized in the last six months. The community consists of both permanent residents and a transient summer population. The clinic provides both chronic disease management as well as management of acute illness.

### **Sample Selection and Criteria**

**Sample.** Purposive sampling (Groves et al., 2013) was used to recruit participants. In order to gain an understanding of the patient care experience, participants were selected based on the inclusion criteria and then asked to self-identify as having either a positive, neutral, or a negative experience. Participants who had a visit from December to May were recruited to capture the experience associated with a consistent provider as this has been shown to impact patient care experiences (AF4Q, 2010). Permanent residents of the service area were included as they comprise the majority of the patients seen during the winter months (the six month period preceding this project) and will be the consistent consumers of care at the FQHC. Sampling participants whom had at least one visit in the last six months reflected visits with consistent providers and facilitated feedback on the current care environment. The decision was made not

to exclude previous survey participants, as the focus of this project was to elicit more robust information, which may be elicited from survey or non-survey participants.

**Exclusion Criteria.** Non-English speaking by self-report at the time they established a relationship with the FQHC, patients under the age of 18, patients who had not had at least one visit from December to May at the FQHC, and non-residents of the service area, determined by zip code, were excluded.

**Inclusion Criteria.** English-speaking by self-report at the time they established a relationship with the FQHC adult patients 18 years or older, who had at least one visit from December to May at the FQHC were recruited to participate in describing their experience with care received at the health center and to elicit feedback related to organizational change.

**Recruitment.** To maintain confidentiality under the Health Insurance Portability and Accountability Act (HIPAA), clinic staff created a list of participants who met eligibility requirements using NextGen software, which categorized patients based on the inclusion criteria. This resulted in the identification of 550 potential participants. Provider teams reviewed the list and made initial recommendations for 100 participants who they believed potentially had positive, neutral, and negative experiences. Using the script provided (Appendix C) clinic staff contacted the first 100 prospective participants and invited them to participate. Of this group, 22 agreed. Once clinic staff created the list of participants willing to discuss the project with this investigator, the investigator conducted follow-up phone calls. The investigator confirmed eligibility and discussed the informed consent. The investigator then asked patients to self-identify their experience as positive, negative, or neutral. Participants were then assigned to the respective positive, negative, or neutral groups based on each participant's response. Only three participants identified as having a negative experience. Clinic staff contacted additional patients

from the NextGen list, but were unable to identify additional participants willing to speak with the investigator. In an attempt to broaden the voice of individuals who may provide a description of potential areas negatively impacting the patient care experience, participants who identified as neutral but leaned more toward the negative side were assigned to the negative group. Focus group meeting times were confirmed. A copy of the consent was available via email or US mail upon request, if the participant wanted to review it prior to the day of the focus group meeting. No participants requested an advanced copy. Ten-dollar coffee cards were given to each participant as a token of appreciation for their participation at the start of the focus group meetings.

The sample consisted of three focus groups ( $n=16$ ). There were six participants assigned to the positive perception group with one not attending the day of the focus group ( $n=5$ ). There were seven participants assigned to the neutral perception group with one not attending ( $n=6$ ). There were seven participants assigned to the negative perception group with two not attending ( $n=5$ ) the third group four of which had a neutral but erred more on the negative side and one with a negative perception. The small number of group members ensured that the group was large enough to elicit diverse responses, yet small enough that everyone had the chance to contribute (Jones & Carson-Cheng, 2013).

### **Human Subject Protection**

The Institutional Review Board (IRB) at the University of Alaska Anchorage (UAA) reviewed and approved the project. IRB application/approval number 899492-3. Participation in the focus groups was voluntary, and written informed consent for participation was obtained. Confidentiality was maintained through assigning the participants numbers and ensuring the transcripts were de-identified. Group confidentiality was emphasized during the consent

process, before the group and at the conclusion of the meetings. There was no physical risk to participants. Social risks did exist if confidentiality was breached. The groups were conducted in a small community, and internal confidentiality was key to minimizing this risk. The psychological risk associated with discussing the patient care experience for this project was minimal. If participants felt uncomfortable with a question they could choose not to participate in the question, no participants opted out of any questions. Participants were also offered the opportunity to leave at any time without fear of reprisal, no participants left prior to the conclusion of the group meetings. The nature of the topic area did not lend itself to overly sensitive information; again, confidentiality was stressed to help minimize this risk.

### **Data Collection**

A graduate level Family Nurse Practitioner student acted as the moderator and note taker during the focus groups. In order to prepare for the role the student attended a webinar through the University of Western Ontario to learn how to conduct focus groups. Two mock focus groups were conducted to further enhance her skills as a moderator. A script for the focus groups was created; it included introductory/welcome comments a discussion of the informed consent process; the questions to be explored; and a summary statement to conclude the groups (Appendix D). The script acted as a guide, so the formatting of the various groups remained consistent, reducing potential bias.

Focus groups are used in the behavioral and social sciences to explore phenomena and are widely accepted as a legitimate qualitative methodology (Doody et al., 2012). Focus groups are “useful in exploratory research where little is known about the topic under investigation” (Doody et al., 2012, p. 16). Focus groups are commonly used to identify problems with a new program and to learn how consumers discuss an area of interest. They are useful in helping to

develop future research tools (Doody et al., 2012). Focus groups can also be used to assist with the interpretation of previously obtained quantitative results, such as surveys (Doody et al. 2012) as in this case.

Participants were assigned to one of three focus groups of five to six participants based on their self-report of a positive, negative, or neutral care experience. Focus groups were conducted until informational redundancy was reached. Informational redundancy is defined as reaching a point in the analysis of the data that sampling more data will not lead to more information related to the question. Guidelines are lacking to support claims of informational redundancy, but experts in the field of qualitative research have agreed that typically two to three groups are sufficient (Lincoln & Guba, 1985). Three groups were conducted in this study. After the third group it became apparent that no new information was being revealed, achieving informational redundancy, therefore no further recruitment took place.

Prior to the focus group, each participant was called to discuss the informed consent and given opportunities to ask questions about the project. Prior to the start of the focus group the purpose and procedures of the project were reviewed with the participants and their desire to continue was confirmed. Each participant was asked to sign the previously discussed informed consent (Appendix E) and complete the optional demographic data form (Appendix F). A copy of the informed consent was provided to each participant at that time. Each group member was assigned a number and was asked to use the number in addressing the group. All transcripts were de-identified.

The group interview consisted of open-ended questions structured around the patient experience of care at the FQHC. The moderator used a semi-structured interview approach with open-ended questions to encourage and stimulate discussion (Doody et al., 2013b). The

interview guide (Appendix G) included follow-up and probing questions. The focus groups lasted approximately 60 to 70 minutes; approximately 15 additional minutes were required to complete the consent process. The sessions were digitally recorded using two digital recorders for back-up purposes and transcribed by the moderator. The focus group interview started with general questions. More specific questions were asked to clarify or augment the data; this helped the moderator facilitate progress and lead the group from start to finish (Jones & Carson-Cheng, 2013). The moderator created a safe and welcoming environment, remained neutral, and was respectful. Reflective journaling was used and after the first group, greater effort was exercised to ensure that each group member contributed equally to the discussion. No further adjustments were made after the second or third groups. Probing for meaning was achieved through building commonality and rapport and being comfortable with varied participant backgrounds (Doody et al., 2013b). Finally, the moderator used reflective listening techniques to keep the group on track and offer summary and reflection (Jones & Carson-Cheng, 2013). Field notes were also collected recording body language, preliminary thoughts, and interpretations. The moderator transcribed the focus group digital recordings verbatim soon after the group meetings. The transcripts were then compared to the recordings to verify the authenticity of the transcripts.

Focus groups were held at the Community Library's free multipurpose room; see library room use agreement (Appendix H). The location provided a neutral, familiar and unbiased setting. This room was private, which offered protection to participants, and provided a quiet space for recording purposes (Doody et al., 2013b). Light refreshments were provided.

### **Data Analysis**

Doody states "that effective analysis requires the researcher to generate rich data, familiarize herself with the data, to interpret the data" (Doody, Slevin, & Taggart, 2013a, p. 269).

The investigator listened to the interview tapes within 24 hours of the focus groups to become familiar with the content. The use of reflective journaling took shape through note taking after each focus group, reflecting on what went well and what improvements could be made. The moderator adjusted her emphasis in the opening comments on the importance of hearing from all participants and helped louder more vibrant participants allow time for quieter more reserved participants to share. The analysis started promptly and was completed in a timely fashion to ensure quality observation and data interpretation (Doody et al., 2013a). The digital recordings were transcribed to a word document by the moderator and saved to a zip drive. Field notes and observations were incorporated into the transcript timeline. The transcripts were coded using pen and paper. Standard codes were developed using descriptive coding which “classifies the data using terms that are close to the participants own words” (Groves et al., 2014, p. 283). Content analysis was used to create similar categories and develop themes. As themes emerged during the analysis, it became apparent that additional exploration was not required and follow-up focus groups were not necessary. Secure e-mail provided a mechanism by which the investigator’s project chair reviewed transcripts and provided analytic consultation. The emergent themes were the final product of the analysis (Doody et al., 2013a). Member checking was used at the conclusion of the preliminary analysis to assure accurate portrayal of participant feedback. Participants were asked to be involved in the member checking process at the conclusion of each focus group, one member of each group volunteered to participate. To confirm trustworthiness of the findings the list of themes and preliminary written findings were made available to one member of each group, they each agreed on the accuracy of the description. No adjustments were made to the findings or themes based on member checking.

After the analysis of the focus group data was completed, an examination of the qualitative findings in relation to the aggregate survey data was conducted in order to determine if survey data alone was sufficient or if focus group data added to the description of the care experience at the FQHC. This step contributed to development of recommendations as a part of the “act” phase of the PDSA framework to adjust the QAPI program at the FQHC.

### **Dissemination Plan**

The preliminary data was presented as a poster at the 2016 ANPA conference. At the request of the health center director a presentation of the preliminary findings was provided to the staff and Board of Directors. A final report will be submitted upon final project approval. The poster will also be displayed at the health center to promote patient engagement after final approval.

### **Data management**

All digital recordings are stored on zip drives. Two digital copies and one paper copy of the transcript exist and are secured in a combination safe at the student’s home. The transcripts have been de-identified to maintain privacy and confidentiality. The investigator has secured the informed consents. Numbers were randomly assigned to the participants and no record of the link between identified and the de-identified data has been maintained. The project chair and the investigator have access to the de-identified data. Secure e-mail provided a mechanism by which the investigator’s project chair reviewed transcripts and provided analytic consultation. The original transcripts, recordings, zip drives, and consent forms have been secured in a combination safe at the student’s home, upon completion of the project the data will be stored for a period of three years, then it will be destroyed.

## **Findings**

### **Introduction**

The purpose of this chapter is to describe the patient care experience in a federally qualified health center (FQHC) located in a small community in Alaska. A qualitative descriptive approach was used to explore the patient care experience in this federally qualified health center environment. The FQHC had been open for three years with stable providers becoming established in the last 18 months. For many who have long resided in the community the experience has been a challenging balancing act of navigating the health care system while receiving care from multiple, rotating providers, leaving them without the ability to establish a connection with anyone in particular until the last 18 months. For others, who are newer to the community, it has been an experience of instant connection to the health center, and an overall feeling of satisfaction with their care. All of the participants could recall their care experiences both past and present. The memories in this small community are long with many participants unable to share their current experience without reflecting upon their past. The quantitative survey data, collected by the FQHC, was also examined in relation to the qualitative findings to ascertain whether descriptive themes were represented in the survey.

### **Participants**

The FQHC generated a list of approximately 550 eligible participants using NextGen software. Based on input from clinical staff a list of approximately 100 participants was made and cross referenced with the NextGen list to ensure they met eligibility criteria. One clinical staff person then called from this list and made contact with 30 individuals, other recruitment

phone calls were not returned. Of the 30 individuals with whom the clinical staff spoke, 22 agreed to be contacted by the investigator for further information about the focus groups. After discussing the project with this investigator 20 agreed to participate. There was concern of having enough participants with a negative perception so clinic staff made repeat phone calls to participants that were identified by clinical staff as potentially having a negative perception. These recruitment phone calls were unsuccessful in recruiting additional negative participants. Participants were divided into three focus groups (see Table 1).

Table 1

*Focus Group Demographics (n=16)*

Variable	Category	Number of Participants	Percentage
Age (years)	30 to 39	4	25%
	40 to 49	3	19%
	50 to 59	3	19%
	60 to 69	4	25%
	70 to 79	1	6%
	>80	1	6%
Gender	Male	7	44%
	Female	9	56%
Perception	Positive	6	37.5%
	Neutral	5	31.3%
	Neutral-Negative	4	25%
	Negative	1	6.2%

There were six participants in the positive group with one participant not attending, seven participants in the neutral group with one not attending, and seven participants in the negative group with two not attending. There were sixteen adults ages 30 to 92 years of age who participated. There were nine females and seven male participants. All participants were 18 or

older, had at least one visit between December and May, spoke English by self-report, and lived in the service area. Of the participants who attended the focus groups, five participants identified as having a positive experience, six identified with a neutral experience, four identified with a neutral, but more negative experience, and one identified with a negative experience. Clinic staff were unable to recruit any additional participants with a negative perception from their list of eligible participants.

The facilitator engaged all participants, inviting them to contribute to each question. All participants were able to contribute and share their opinions. Although some group members shared more than others and some participated more actively through group agreement and gestures. One participant shared little and mainly echoed other participant's thoughts and stated agreement. Participants were randomly assigned a number (P1 to P16) to maintain confidentiality.

### **Themes**

The participants brought to light a variety of perspectives on their care experience. Many categories and subcategories emerged, but the overarching theme was a feeling of connectedness. That feeling of connectedness was further supported with subthemes of provider relationships, a community clinic connection, access to care, and interagency coordination and communication. Theme/subthemes are summarized with their major categories (see Table 2).

Table 2

*Theme and Subthemes*

Theme/Subthemes	Major Categories
Connectedness	
Provider Relationships	Consistency Shared Decision Making Provider Happiness The Personal Touch Results
Access to Care	Cost Availability
A Community Clinic Connection	
Interagency Coordination/Communication	

**Connectedness.** The past experiences of care within the community greatly influenced the initial perception of the FQHC. It was evident that prior to the FQHC, the primary care environment was tumultuous at best. Connectedness emerged as an important theme as participants repeatedly expressed this desire. The desire to feel connected and at ease with the providers came through with comments like “you need this connection to your primary care people” (P4) and “if I’m not comfortable with them, I’m not gonna tell them every aspect of what I’m feeling or what’s going on” (P14). Connectedness to the FQHC was also evident in statements such as “we ought to make an effort to make people feel like this is their clinic, that it belongs to them” (P4). Reinforcement of the desire to be connected came through in their suggestions for community engagement events such as clinic open houses and barbecues. Participants also discussed educational opportunities through health center driven community outreach. Both connectedness to the FQHC and to the providers emerged from the data and are explored in further detail below.

***Provider relationship.*** During the coding process the subtheme of provider relationship emerged. The categories that contributed to this subtheme were consistency, provider happiness, shared decision-making, the personal touch, and results. All groups, regardless of their perception of a positive, negative, or neutral experience, agreed that provider relationships greatly influenced satisfaction and the perception of their care experience. Participants verbalized the struggle of past experiences and the difficulty of being without consistent providers. P3 said, “I was elated when we got two doctors with the commitment to be here, that meant a lot really.” All groups repeatedly spoke about the availability of multiple providers so that patients could find a provider with whom they enjoyed working.

***Consistency.*** The need for a consistent provider they could connect with, share with, and feel known by was extremely influential in the participants’ experience. P12 expressed this need by saying, “the model of a rotating doctor wasn’t ideal, but the model of having community-based doctors seems to be ideal for most of the people here.” Most participants had found a provider they could trust and had built a relationship with. Consistency led to having a better rapport with providers. Participants visibly relaxed when they spoke about their providers knowing them. “It’s how they make you feel when you are in there, you know like you can talk to them” (P16) and “it starts early when you are sitting there waiting and brought in, it’s just continuous it seems to be a real effort to make you feel comfortable” (P4). The concern for keeping community based doctors was palpable. It was evident that conversation about losing consistent providers weighed heavily on the participants.

***Shared decision-making.*** Consistency helped to form grounded relationships between the provider and the participant. These relationships helped develop better rapport and facilitated open sharing of concerns and involvement in shared decision-making. This was evident with

statements like “I do feel like I do get involved in the decision making” (P16) and “these are the things we can do, what do you want to do...it’s letting me have a little control over what’s going on” (P12).

*Provider happiness.* The evolution of connection between providers and participants became evident when the analysis revealed the participants not only wanted to feel connected to their providers, but wanted their providers to feel happy and connected as well. The participants were no longer focused on what the providers could do for them, but what they perceived as important to the providers. The positive and neutral groups discussed providers being supported by the health center, so they had the ability to practice to their full potential. They showed concern with keeping providers happy so they would stay in the community through comments like, “we don’t want to have limiting things that would make these providers move on other than their own personal choice to move on” (P12).

*The personal touch.* Participants consistently described the importance of the personal touch. Statements such as “they know me” (P11) and “they recognize my voice” (P10) reflected the value of being treated as a person and not simply another patient. This personal touch took form in providers taking time to call them personally, feeling legitimate concern from providers during their visit, and the feeling of being known by providers and staff. P3 said,

I was impressed with the personalization really, obviously shows that they care, and that means a lot to the patient and I think it certainly helps your recovery a whole lot of whatever you are dealing with and makes it easier.

*Results.* Groups agreed that liking their provider is important, but getting results and resolution at the conclusion of their visit was equally important. Participants correlated this

category with getting prompt results related to testing, chronic and acute disease management outcomes, and becoming well. P6 described it as,

One side is the positive experience in terms of liking the visit, liking the provider to some extent, or feeling like you are treated like a human being, but that does no good if you are not better at the end, the results portion.

*Access to care.* All participants consistently spoke of issues with access to care. Major categories that emerged were availability and cost. An interesting thing that kept resurfacing was how past experiences cast a long shadow over initial perceptions of the health center. This was highlighted with statements like “I was very skeptical” (P1), “I was wondering what this was going to be, I was definitely on the skeptical side” (P3), and “the health clinic came into being because of all the problems we were having” (P4). It became evident that the primary care landscape had been a rocky, treacherous road for many patients in this small community. P16 added, “it’s been a back and forth, highs and lows.” As participants recounted how it used to be compared to what they have now it was apparent that the focus group environment helped them shed their previous experience of the past and recognize the present. There was contentment within the groups as they acknowledged that access to care has improved, “I’m really thankful for what is available now” (P1) and “they get you in, get you out and I like that” (P11).

*Availability.* Frustration with the lack of available hours outside the work week was evident across all groups. P10 stated, “we all seem to get sick on the weekends for some reason.” Equal frustration was voiced when the emergency department needed to be utilized because of lack of Saturday clinic hours. P14 stated, “I don’t want to take my son to the emergency room, but I can’t wait three days to get him in.”

Participants discussed that access to same day appointments was important to them. They appreciate this current service and would like it to continue. “I’d rather sit in the waiting room for half an hour knowing that they are taking care of somebody that needed to get in right then” (P14) and “I’ve been the person they squeezed in, I’ll wait longer, to keep that for the community” (P12).

They also identified the need for improved and expanded mental health services. Mental health services are currently contracted with a local agency, but access can be challenging. There was a wave of concern in the eyes of the group as participants discussed the difficulty and wait time of being seen for mental health services, this was described with comments like, “getting in to see somebody was very difficult...it took two months” (P1) and “the frustration of wanting some mental health assistance in the community and there being zero available, I haven’t been able to get in” (P2).

Frustrations arose about access to knowledge of available services. Participants often felt un-informed about what services the health center provides. There was a general feeling of confusion when participants further discussed the inner workings of the health center, its connection to the hospital and the services provided by each. P6 stated, “The clinic needs to do a better job on and the hospital needs to do a better job on is good PR to differentiate the services that are provided by each.” P16 echoed this by saying, “A lot of things people could ask for, that they are not getting, that they just don’t even know is available to them.”

Participants also expressed the lack of availability of specialty care such as OB/GYN, pediatrics, podiatrists, pain management, orthopedics, and colonoscopy services. All groups spoke about the need for a basic procedure clinic.

*Cost.* Cost emerged in relation to using the emergency department for non-emergent needs on the weekend or in the evenings. The stress of having a sick child, no access to primary care and concerns about cost came through in comments like, “I can’t afford to go to the ER, it would be really nice if they had a doctor on Saturday” (P16). Cost was also discussed as a significant stressor for patients. Downcast eyes and sullen shoulders accompanied comments like, “you never know what it’s going to cost, you have to go in, then they hit you with the bill.” (P14).

*A community clinic connection.* Participants showed genuine interest in learning about the health center through events like barbecues; meet the provider events; and clinic open houses. They were also interested in learning about the providers and the clinic through Facebook, the newspaper, and community outreach events. They echoed that these events would also foster a sense of community connectedness not only to the Health Center, but also to the providers. All participants echoed a need for connection, a need to understand, a need to be informed. Participants expressed appreciation for the opportunity to participate in the focus group meetings. Many participants echoed feelings of being surprised and pleased that the health center wanted to hear their opinion. P3 stated, “The act that you did this speaks to the community that you are interested in their opinion, and that counts for everything.” The group agreed. P3 said, “People need to know that you did it, that there are efforts being made to hear us, that’s important.”

*Interagency coordination/communication.* Another theme that emerged during the focus groups was interagency coordination/communication. Participants spoke of good communication between the hospital and clinic. P6 said,

One thing that has helped care is the close working relationship between the hospital and the clinic, being able to follow-up from an ER visit with the clinic is a benefit to the care that we or at least I, have been able to receive.

The participants had mostly positive things to say about communication between care entities including the pharmacy, hospital, and clinic. Opportunities for growth were identified with “follow-up on medication refills” (P13) and the “hospital and clinic being on the same electronic medical record” (P4) for greater ease in communication across care entities.

Participants attributed the ease of their out of town referrals to the work of the FQHC staff acknowledging that, “they did a really excellent job getting me out of town for my referrals” (P9) and that “the nurses were so wonderful following through, they took care of everything” (P10). Participants also noticed a better working relationship among staff within the clinic and added that it has improved care. P12 said, “I have noticed a more positive experience amongst the working staff.”

In summary, overall, participants reported that their care experience has improved since the FQHC started providing care in the community. All participants agreed that provider relationships greatly influenced satisfaction and the perception of their care experience. Participants long for a community clinic connection, they want to feel valued by and connected to the health center and the community. Participants were satisfied with interagency coordination and communication, but generally struggle with understanding the inner workings of the health care system within the community. They were eager for community-based opportunities for learning and engagement.

## Quantitative Data

The FQHC's analysis of the quantitative data is summarized in Table 3. Of the five hundred participants who were offered the surveys, ninety-two responded by completing a survey. Interval level data was obtained through the use of a Likert Scale (very poor, poor, fair, good and very good). Descriptive statistics were calculated for each Likert Scale item for each survey period. An overall mean was calculated from data gathered from three survey periods. Only one respondent marked a poor response (the instructions your provider gave you about follow-up care were helpful) to any question on the survey. The remainder of the responses fell into the categories of fair, good, or very good on the Likert Scale. The parent instrument, CAHPS Clinician & Group Surveys version: 12-month Survey with Patient Centered Medical Home (PCMH) items (Agency for Healthcare Research and Quality, 2016) is reliable and valid, however this instrument was developed from feedback and templates from other health centers and used only parts of the original. The reliability of this survey instrument was not established.

Table 3

### *Quantitative Results of the FQHC Survey*

Access to Care		April	August	December	Mean
Ease of scheduling your appointment	Fair	5.9%	0.0%	0.0%	2.0%
	Good	23.5%	4.7%	12.9%	13.7%
	Very Good	70.6%	95.3%	87.1%	84.3%
Pleasantness of person who scheduled your appointment	Fair	5.9%	0.0%	0.0%	2.0%
	Good	11.8%	2.3%	16.1%	10.1%
	Very Good	82.4%	97.7%	83.9%	88.0%
Convenience of our business hours	Fair	5.9%	2.3%	2.3%	3.5%
	Good	17.6%	11.6%	11.6%	13.6%
	Very Good	76.5%	86.0%	86.0%	82.8%
Our promptness in returning your phone calls	Fair	5.9%	2.4%	0.0%	2.8%
	Good	17.6%	4.9%	19.2%	13.9%
	Very Good	70.6%	92.7%	80.8%	81.4%

Table 3 (continued)

Do you have difficulty with transportation getting to your appointments	Yes	11.8%	0.0%	3.1%	5.0%
	No	88.2%	100.0%	96.9%	95.0%

During Your Visit

		April	August	December	Mean
Speed of the registration process	Fair	5.9%	0.0%	0.0%	2.0%
	Good	29.4%	16.3%	15.6%	20.4%
	Very Good	64.7%	83.7%	84.4%	77.6%
Courtesy of the staff in the registration Area	Fair	0.0%	2.3%	0.0%	0.8%
	Good	31.3%	4.7%	15.6%	17.2%
	Very Good	68.8%	93.0%	84.4%	82.1%
Length of wait before going into exam Room	Very Poor	5.9%	0.0%	0.0%	2.0%
	Poor	0.0%	0.0%	0.0%	0.0%
	Fair	0.0%	2.3%	3.1%	1.8%
	Good	41.2%	30.2%	31.3%	34.2%
	Very Good	52.9%	67.4%	65.6%	62.0%
Wait time in exam room before seeing a provider	Fair	11.8%	7.0%	0.0%	6.3%
	Good	23.5%	25.6%	46.9%	32.0%
	Very Good	58.8%	67.4%	53.1%	59.8%
Friendliness/courtesy of the nurse/assistant	Fair	0.0%	0.0%	0.0%	0.0%
	Good	29.4%	9.5%	15.6%	18.2%
	Very Good	70.6%	90.5%	84.4%	81.8%
Staff and providers treated me with respect and dignity	Fair	5.9%	0.0%	0.0%	2.0%
	Good	17.6%	4.7%	15.6%	12.6%
	Very Good	76.5%	95.3%	84.4%	85.4%

Your Care Provider

		April	August	December	Mean
Friendliness/courtesy of provider	Fair	0.0%	0.0%	0.0%	0.0%
	Good	5.9%	9.3%	12.5%	9.2%
	Very Good	94.1%	90.7%	87.5%	90.8%
The provider included you in decisions about your treatment	Fair	0.0%	2.3%	0.0%	0.8%
	Good	11.8%	7.0%	15.6%	11.5%
	Very Good	88.2%	90.7%	84.4%	87.8%
The provider was easy to understand	Poor	0.0%	2.3%	0.0%	0.8%
	Fair	0.0%	0.0%	0.0%	0.0%
	Good	11.8%	9.3%	12.5%	11.2%
	Very Good	88.2%	88.4%	87.5%	88.0%

Table 3 (continued)

The instructions the provider gave you about the follow-up care (if any) were helpful	Poor	0.0%	2.4%	0.0%	0.8%
	Fair	0.0%	0.0%	0.0%	0.0%
	Good	11.8%	7.3%	15.6%	11.6%
	Very Good	88.2%	90.2%	84.4%	87.6%
Overall Assessment					
		April	August	December	Mean
Overall friendliness of our staff	Fair	0.0%	0.0%	0.0%	0.0%
	Good	29.4%	14.6%	9.4%	17.8%
	Very Good	70.6%	85.4%	90.6%	82.2%
Overall rating of care received during your visit	Fair	0.0%	2.4%	0.0%	0.8%
	Good	12.5%	16.7%	12.5%	13.9%
	Very Good	87.5%	81.0%	87.5%	85.3%
Likelihood of you recommending our center to others	Fair	0.0%	2.3%	0.0%	0.8%
	Good	12.5%	16.7%	15.6%	14.9%
	Very Good	87.5%	81.0%	84.4%	84.3%
General Feedback					
		April	August	December	Mean
Where have you heard about us?	Radio	25.0%	6.1%	5.0%	12.0%
	Newspaper	25.0%	12.1%	10.0%	15.7%
	Friends/Family	66.7%	60.6%	65.0%	64.1%
	Social Media	8.3%	9.1%	5.0%	7.5%
	Website	0.0%	15.2%	10.0%	8.4%
	Other	25.0%	24.2%	30.0%	26.4%

The examination of the data collected through the survey process with that collected in the focus groups revealed some overlap with access to care, during your visit, and your care provider as participants discussed hours of operation, being treated with respect and dignity, and being included in decisions about their care. Interestingly, the qualitative data moved beyond the basics of friendliness, convenience, and wait times and captured the need for connectedness, the importance of interagency communication, the need for consistency with providers, the personal touch, results, cost, and availability.

### **Discussion**

The purpose of this quality improvement project was to describe the patient care experience in a FQHC located in a small community in Alaska using a qualitative descriptive approach. The findings were then examined in relation to those derived from the aggregate survey data to make recommendations for a sustainable approach for evaluating the patient care experience in this FQHC environment. The project was carried out using the Plan-Do-Study-Act framework. The “Plan” involved identification by the FQHC administration of potential shortcomings in the use of the quantitative survey approach to develop a clear understanding of the facets of the patient care experience specific to this community. Through collaborative discussions between the FQHC and this investigator a plan was developed to evaluate whether the quantitative survey included in the original Quality Assurance Performance Improvement (QAPI) plan provided adequate insight into these facets. Three focus groups were planned to explore the patient care experience. The “Do” involved recruiting participants, carrying out the focus group discussions and collecting the data. The data were “Studied” and analyzed to determine what revisions, if any, were needed to the QAPI plan. The “Act” involved developing recommendations for future cycles based on what was learned from the analysis. The evaluation revealed important similarities and differences.

### **Connectedness**

The overarching theme of connectedness permeated the focus group meetings; it encompassed the subthemes of provider relationships, access to care, a community clinic connection, and interagency coordination/communication. In the discussion groups, participants expressed a desire to be connected to the clinic, their providers, and the community. Interestingly, they wanted this to be a reciprocal relationship involving the providers, staff, and

the greater community. Fostering a sense of community connectedness for the clinic within the community and to the community members was very evident across all groups. Groups discussed community events like barbecues, educational events, clinic open houses and meet the provider events, which highlighted the desire to foster an environment that could facilitate this feeling of connection to the community for all involved parties. It was interesting that most participants verbalized how important this interconnectedness was in relation to their care experience. It was evident that past clinic environments, which lacked this feeling of connection, have greatly impacted this aspect of the patient care experience. The desire to be connected with their health care providers not only on the provider level but also on the community level was interesting; it was evident that the participants wanted the providers to feel welcomed and an integral part of the community as well. Participants who felt connected to the clinic were much more likely to describe their experience as positive. This facet was not evident in the quantitative survey but obviously was extremely important to the participants as it was discussed across all three focus groups. According to Doyle et al. (2013), patient perception of care affects overall patient satisfaction, outcomes, and the health of the community. It is imperative that we measure connectedness as it influences perception of care in this community.

**Provider relationships.** The qualitative analyses revealed that provider relationships were defined and shaped through consistency, shared decision-making, provider happiness, the personal touch, and results. The focus group environment helped participants emphasize the areas they attribute to a good provider relationship. Having a consistent provider to see, connect with, and feel known by was important to most participants. So important that when this feeling wasn't present some participants would either change providers or not share all their concerns with their providers. This has the potential to seriously affect the quality of care a provider is

able to offer. Patients felt comfortable sharing all aspects of their situation with providers who took the time to know them. Open sharing of concerns facilitates healthier patient-provider relationships and improves outcomes for patients, again facilitating a healthier community (Price et al., 2014). Provider happiness was emphasized across all groups again bringing to light the desire for a reciprocal positive patient-provider relationship. Participants had a desire for providers to be happy in their work environment so they would stay in the community to provide the consistent care participant's desire. The personal touch was important to participants; feeling known by staff fostered a feeling of trust and open sharing of concerns. Results were also important to patients; interestingly they were willing to go without a feeling of connection or being treated perfectly if they viewed the results of the visit as adequate. Being treated well was one thing, but getting the results, such as prompt testing, prompt results reporting, and prompt follow-up or referral, was most important, so much so that some participants stayed seeing providers they didn't necessarily like, but who delivered timely results.

Survey data revealed overall satisfaction with providers in the areas of friendliness, shared decision-making, being easy to understand, and follow-up instructions. Overlap existed with shared decision making, which helped to emphasize that participants place value on being part of decisions about their care. When participants did not feel included in the decision-making process some chose to change to providers who made them feel valued in the process. Interestingly the qualitative data gave voice to a much deeper meaning of the provider relationship, and it is imperative that it is more deeply explored as it is at the heart of a positive care experience in this community. The qualitative data went beyond friendliness and follow-up instructions and got to the heart of what patients perceive as qualities of a good provider relationship: (a) consistency; (b) being treated with respect; (c) being known by the provider; (d)

being involved in decisions about their care; and (e) results. These qualities were important and held meaning for this sample of participants regardless of the perception of a positive, negative or neutral care experience. When these qualities were not present it led to a more negative perception of care, when these qualities were evident participants tended to have a more positive perception of their care experience. Even though there was only one participant who self-identified with a negative perception of the health care center, upon analyses, it may still be stated that within the context of this study the qualities of a good provider relationship remained consistent regardless of perception. These qualities were identified by the positive, neutral, and negative groups as factors that affected patient provider relationships. This project supports the literature by Price et al. (2014) that patient-provider relationship influences patient satisfaction. The quantitative data gave brief insight into the provider relationship, but the qualitative data helped to enrich and expand upon the provider relationship as it relates to the experience of care.

**Access to care.** A topic area found in both the quantitative and qualitative data was access to care. Analysis of the qualitative data revealed overlap in the area of convenience of business hours but interestingly the information gathered was quite different from quantitative to qualitative. The survey data incorporated (a) ease of scheduling; (b) pleasantness of staff; (c) convenience of business hours; (d) promptness in returning phone calls; (e) transportation under the access to care domain. Overwhelmingly the survey respondents rated these areas as good or very good. But the focus group findings exposed a lack of availability outside the work week, which created a barrier to access to a primary provider. Patients were either forced to use the emergency department for care or delayed seeking care until the clinic was open, as there were no providers on-call after hours. This barrier to access was also evident in choosing not to use the emergency department because of cost. Using the Emergency Department (ED) separates

patients from their providers, decreases continuity of care, and causes a cost burden to the patient (Pines, Pines, Kellerman, Gillen, & Mehrotra, 2013). Participants placed value on and appreciated having access to same day appointments during clinic hours for acute care needs, further emphasizing a desire to have access to care and to their provider when possible.

The lack of available mental health services and the need for specialty clinics were also addressed as access to care concerns. All groups expressed concern about the lack of available mental health referrals; this led to patients seeking care outside the community or going without the mental health services they need and desire. Participants discussed that caring for mental health is equally as important as their physical health, and without this needed specialty, there is a significant barrier to the development of a healthy community. The qualitative data added greater depth and understanding to the challenges being faced by patients at the FQHC. This is consistent with the findings of Lebrum-Harris et al. (2013) and Stewart et al. (2000) who assert that adequate access to care leads to a positive care experience and the perception of higher quality care.

**Interagency coordination/communication.** There have been multiple transitions in the primary care environment in this community. Overall participants value the quality of care they are able to receive because of good interagency coordination/communication that occurs between the different care entities within the community. They appreciate and value the role the health center is playing in coordinating care both within the community and specialty referrals outside the community. Interestingly they still struggle with the inner workings of the health system within the community and how the health center and the hospital fit into the system. Although the hospital and health center have made efforts to communicate well, provide education, and facilitate the most recent transition, it appears there is still a lack of knowledge. Participants

were still not aware of how the health center advertised and were not knowledgeable of the expertise of the providers at the health center. The apparent lack of knowledge of available services either speaks to a lack of community engagement or lack of interagency engagement and visibility. It could also speak to consumers not being proactive in their care or not feeling empowered to be a part of the care process. The survey instrument did not address the topic area of interagency coordination/communication. The focus groups gave a platform for participants to voice this concern and seek out ways to alleviate this gap in knowledge. This speaks to the value and importance of community awareness and education of the health system as it relates the experience of care.

### **Trustworthiness and Rigor**

Trustworthiness was achieved by establishing credibility, dependability, and confirmability. Credibility is defined as confidence in the truth of the findings. It was achieved by using a wide range of informants and by building rapport with group participants to facilitate free giving of information (Lincoln & Guba, 1985). There was only one participant with a negative perception of the health center, it can be ascertained that the qualities that encompass a positive care experience remained consistent regardless of a positive or neutral perception of the health center, but it remains unclear whether more than the one participant with a negative perception would concur with the qualities. Although it appeared, informational redundancy was achieved from the data; this may not be the case as it was a blended group of neutral to negative and negative participants. Conducting multiple, separate groups was important to elicit feedback from different segments of the population (Danielson et al., 2012; Jones & Carson-Cheng, 2013). A wide range of informants was recruited and the moderator completed extensive work to prepare for conducting focus groups to build rapport and encourage giving of information.

Findings were also validated through member checking (Lincoln, 2000; Lincoln & Guba, 1985). Member checking was performed after thematic analyses were completed to assure accurate portrayal of the patient care experience in the FQHC helping to establish trustworthiness in the findings.

Dependability is defined by showing that the findings are consistent and could be repeated (Lincoln, 2000; Lincoln & Guba, 1985). Through detailed description of the method and data gathering dependability was achieved. Confirmability means that the participants shape the content and were not biased by the investigator acting as moderator. The investigator is a member of the community and a health care provider within the community. The investigator was aware of her historical knowledge of the community and its health care practice environment. Bias was reduced through self-awareness and the use of reflective journaling. The use of reflective journaling took shape through note taking after each focus group, reflecting on what went well and what improvements could be made. After the first group concluded, the moderator made stronger efforts to include all participants and not allow the groups to be dominated by participants who were louder, held stronger opinions, or mirrored the investigator's perceptions.

### **Strengths**

The gender distribution of the sample (43% male and 56% female) was representative of the demographics of the clinic population. Participants ranged in age from 30 to 92 offering insight into the perceptions of many different generations. The goals were met for the number of positive and neutral experience group members.

## Limitations

The study was not without limitations. Selection bias occurred through the use of purposive sampling techniques. Each decision that was made regarding inclusion and exclusion criteria was carefully examined and steps taken to reduce potential bias. Despite this approach potential bias can be identified. For example, the inclusion criteria excluded those participants who hadn't been seen in the last six months, this may have excluded many healthy 18-30 year olds who only obtain their annual visits between June and November. In the future, recruiting participants from within the last year may capture the 18-30 year olds that were missed with this cycle or other individuals who may only present to the clinic once during the calendar year. As a result of clinical staff reviewing the eligible participants list and making recommendations on individuals to contact two other types of selection bias were identified, pre-screening and exclusion. Pre-selection and exclusion bias can lead to a sample being collected in a way that some members of the population were less likely to be included. There were 500 participants that met eligibility requirements and only 100 were called based on pre-screening by staff and workload demand of staff making recruitment phone calls. Although not acknowledged, there may also have been some reticence by the contacting staff members to be persistent in contacting individuals they thought had a negative experience as the staff's preconception may have led them to believe it would be a negative interaction. This combination of pre-screening and exclusion bias could have led to the small number of participants with a negative perception. It also led to using a blended group of neutral to negative and negative participants thereby bringing question to the credibility of the data for the negative group and making it difficult to know if an adequate description of the patient care experience was formulated. It is difficult to ascertain what potential information we did not hear from this segment of the population or how

the provider directed pre-screening may have impacted the composition of the groups and unwittingly impacted findings. Organizational flaws or key components that effect satisfaction could have remained uncovered.

Ideally clinic staff would have gone back to the list of 500 eligible participants and contacted them based on the inclusion criteria alone to recruit more participants, but staff time constraints contributed to this limitation. Participants that were perceived to be dissatisfied and still obtained care at the clinic declined to participate or did not return recruitment phone calls. Being more persistent in recruiting additional participants until a larger number self-identified as having a negative perception may have added to the description of the patient care experience in the negative perception focus group and helped to more clearly describe the patient care experience overall. This could be accomplished through posting flyers at the office, local social establishments, and the clinic that delineate the purpose, explain inclusion/exclusion criteria, and mention the small incentive to participate. Follow-up phone calls, snowball sampling, or using existing social groups within the community could also lead to greater participation.

Ideally, each group would have consisted of only positive, neutral, and negative participants but recruitment of negative participants presented a challenge. Although the goals of the group sizes were met, there were a relatively small number of participants ( $n=16$ ) in the focus group discussions. The time commitment of the focus groups and the potential reluctance of participants in a small community to share disparate opinions could have led to the small number of participants. There were two participants who agreed to be contacted, but after review of the project elected not to participate. Four participants did not show up for their scheduled focus group times, decreasing the overall number of participants. Focus groups were held during the summer, which is a busy time of year in the community and may have contributed to the small

sample size. It may be beneficial to conduct groups during the winter months to elicit greater participation. The clinic patient population is comprised of 22% in the 1 to 18 age group, 65% are 19 to 64 years of age and 13% are 65 and over. Although there was a wide age range of participants in all focus groups, there were no participants under the age of 30. Obtaining data from participants under 30 could reveal a greater variety in perspective.

The moderator made every effort both in opening statements and during the groups to include all participants, and no participants appeared to be overwhelmed during the groups, but the louder more vibrant participants may have inhibited more soft-spoken members of the group. Many participants were familiar with each other and this might have affected their willingness to share opinions.

### **Recommendations**

The focus groups provided a more comprehensive description of the patient experience of care. Because of the valuable information revealed, it is recommended the health center add focus groups to their patient satisfaction assessment in the QAPI plan. This will continue to add to the understanding of the patient experience and present opportunities to enhance the care experience. Focus groups are time-consuming and may not be feasible to conduct with each quarterly patient experience/satisfaction survey cycle. Based on the challenges with recruitment during this project, it is recommended that the focus groups be conducted during either the first or fourth quarter. This time frame is recommended because it occurs during the winter months when patients may have more availability.

It is further recommended the FQHC incorporate strategies to improve return rates on the existing survey instruments. The U.S. Department of Health and Human Services (2010) recommends conducting follow-up calls during survey cycles to encourage participation. The

calls would need to be generic to ensure patients could choose to stay anonymous in their feedback.

It is recommended that the health center evaluate the reliability of the existing survey instrument. The parent instrument was proven to be reliable, with a reliability coefficient of 0.77 (Dyer et al., 2012), but the health center only used specific altered portions of the parent instrument. Instrument reliability is integral in assuring consistency in measuring the patient care experience.

Based on the data derived from the focus groups conducted during this project, adding a section to the existing instrument that addresses connectedness would also be beneficial. Connectedness was identified as an important facet of patient satisfaction in this community. This concept is not captured in the existing CAHPS instrument therefore it is recommended that the findings of this project be used to guide question development. It is recommended that additional questions follow the current Likert formatting. Suggested questions include: (a) feel a sense of connection to the health center; (b) feel the health center is connected to the community; (c) feel connected to your provider; and (d) feel known by your provider.

Focus groups have never been conducted in this community, and therefore no previous data exists for comparison. Recommendations for future cycles include repeating the focus groups with a larger sample for comparison with the results of this project. Larger sample size could increase the number of and variation in responses to gain a yet deeper understanding of the experience of care. Future cycles should focus on selecting participants by only calling from the generated list as to avoid influence from provider team input, as this is a source of pre-selection and exclusion bias. By reducing the potential for these forms of bias the sample may be collected in a more inclusive way, potentially generating a more representative sample, and

offering an opportunity to hear from participants whose voices were not heard during data collection, i.e, those with negative perception, those who held positive and neutral perceptions unknown to the providers, and those in the 18-30 age group. I would further recommend contracting with an outside entity to make the recruitment phone calls as this would eliminate any preconceptions about the potential participants, alleviate potential participants feeling pressured to participate through hearing from someone who knows them, and alleviate the workload burden of clinic staff members. It is unknown why there were no participants in the 18 to 30 age range. It is possible they were inadvertently excluded by the pre-screening or perhaps the recruitment strategy, timing of recruitment or other unidentified factor adversely affected their ability to participate. Future cycles should employ strategies to recruit in the 18 to 30 age range, to obtain data from this segment of the population. It is further recommended in the construction of the focus groups that the investigator continue to contact potential participants until the investigator has filled the focus groups with 10 participants who have self-identified as having positive, neutral or negative experiences. Not only would this reduce bias that may have affected this project, but would help ensure adequate numbers of participants were present. The opinions of those who have negative experiences or fall within the 18 to 30 age group are valuable and underrepresented in this sample. This insight may assist the FQHC in developing a strategic plan to improve the overall patient care experience.

In the area of access to care, recommendations include expanded clinic hours outside the 8:00 a.m. to 6:00 p.m. work week and the addition of Saturday clinic hours. If feasible, expanded clinic hours would be beneficial in alleviating the access to care concerns voiced by the participants. If expanded clinic hours are not physically or financially feasible considering weekend/after hours call may also be an avenue to alleviate access to care concerns. Seeking out

a better referral source or working more closely with the mental health service providers within the community to facilitate access to mental health services will be an integral step in moving the health of this community forward.

Community engagement events such as barbecues, meet the provider events and clinic open houses that are well advertised and marketed could help make the clinic more visible and provide the needed opportunities for outreach to help educate the patients about available services and provider expertise. It would also facilitate the sense of connection the participants so clearly expressed. Expanding the way the health center advertises through a more active Facebook page and more frequent use of community bulletins boards could also facilitate greater visibility and connection.

### **Conclusion**

The purpose of this quality improvement project was to evaluate whether the quality assurance/performance improvement (QAPI) plan at the health center, in which patient satisfaction plays a pivotal role, provides a valid mechanism for assessing the overall patient experience or if implementing a multimodal approach to evaluate the patient experience provides a more accurate depiction on which to base operational decisions. The aims were to describe the patient care experience using a qualitative descriptive approach and to examine the qualitative findings in relation to those derived from the survey data; first to determine whether the items on the quantitative survey captured the items of importance to the community and then to make recommendations for a sustainable approach to evaluating the patient care experience in this FQHC environment. The results derived from the focus groups added important information in describing the patient experience of care and support the premise that a qualitative descriptive approach would add additional information not previously derived from the quantitative data.

The use of qualitative data collection and analyses within the quality improvement program at this FQHC provided an opportunity to engage the community and elicited a more accurate depiction of the care experience. The findings of the focus groups expanded our thinking by shifting focus onto the participants and their connection to the community. The qualitative findings provided a more detailed, rich description of the patient experience of care and supported the addition of this data collection method to the QAPI program in this FQHC. This study supports the body of literature by Pich-Holder et al. (2012) and Stewart et al. (2013) encouraging the collection of patient experience data and the use of qualitative data collection in evaluating the patient experience of care.

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## Appendix A

### Survey Instrument



To help us provide you with the best health care experience possible, we are cordially inviting you to give us your feedback through this patient satisfaction survey. All surveys are anonymous and can be either mailed or dropped in the survey return box at the registration desk. You can also take the survey on our website,

[www.sewardhealthcenter.org](http://www.sewardhealthcenter.org).

#### GENERAL INFORMATION

1. Your Age: \_\_\_\_\_
2. Your Gender:  Female  Male
3. Your Zip Code: \_\_\_\_\_
4. Type of Payment:  Medicaid  Medicare  Self-Pay  Private Insurance

ACCESS TO CARE	Very Poor	Poor	Fair	Good	Very Good
1. Ease of scheduling your appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pleasantness of person who scheduled your appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Convenience of our business hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Our promptness in returning your phone calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have difficulty with transportation getting to your appointments?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

**What are we doing well in this area?**

---

**How can we improve in this area?**

DURING YOUR VISIT	Very Poor	Poor	Fair	Good	Very Good
1. Speed of the registration process	<input type="checkbox"/>				
2. Courtesy of the staff in the registration area	<input type="checkbox"/>				
3. Length of wait before going into exam room	<input type="checkbox"/>				
4. Wait time in exam room before seeing a provider	<input type="checkbox"/>				
5. Friendliness/courtesy of the nurse/assistant	<input type="checkbox"/>				
6. Staff and providers treated me with respect and dignity	<input type="checkbox"/>				

YOUR CARE PROVIDER	Very Poor	Poor	Fair	Good	Very Good
1. Friendliness/courtesy of the provider	<input type="checkbox"/>				
2. The provider included you in decisions about your treatment	<input type="checkbox"/>				
3. The provider was easy to understand	<input type="checkbox"/>				
4. The instructions the provider gave you about follow-up care (if any) were helpful	<input type="checkbox"/>				

**What are we doing well in this area?**

---

How can we improve in this area?

OVERALL ASSESSMENT	Very Poor	Poor	Fair	Good	Very Good
1. Overall friendliness of our staff	<input type="checkbox"/>				
2. Overall rating of care received during your visit	<input type="checkbox"/>				
3. Likelihood of you recommending our center to others	<input type="checkbox"/>				

**What are we doing well in this area?**

---

How can we improve in this area?

**GENERAL FEEDBACK**

Where have you heard about (check all that apply)

- Radio  Newspaper  Friends/Family  Social Media  Website  Other:

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Additional Comments:

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**Appendix B**  
**Agency Support Letter**

April 1, 2016

Attn: Institutional Review Board  
Office of Research and Graduate Studies  
University of Alaska Anchorage  
3211 Providence Drive  
Anchorage, AK 99508

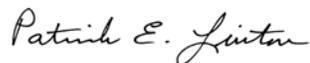
Dear IRB Members,

This letter certifies that Shawna Cooke RN has shared and discussed the study titled “Describing the Patient Care Experience: Quality Improvement Strategies in Federally Qualified Health Centers in Alaska” with me as well as the Quality Assurance Committee of the Board of Directors. The Community Health Center consents to focus group research being conducted to elicit patient experience with care at the health center.

This memo also confirms that Shawna Cooke has permission to conduct the above stated study at the Community Health Center for the purpose of fulfillment of requirements for the Masters in Nursing, Family Nurse Practitioner Program at University of Alaska Anchorage.

I do not have concerns about the proposed study based on multiple communications with Shawna Cooke the past five months. The health center supports the research plan and approves of the project, which includes recruitment of participants and data collection, through our agency.

Sincerely,



Patrick Linton, Executive Director  
Seward Community Health Center  
907-224-8505  
plinton@sewardhealthcenter.org

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## Appendix C

### Recruitment Script

Hello. My name is \_\_\_\_\_, I am calling from the Community Health Center. I am calling to let you know about an opportunity to participate in a quality improvement project about the patient care experience at the health center. Shawna Cooke, a resident of the community and student at the University of Alaska, Anchorage, is conducting the project. The project will consist of focus group interviews. Focus groups are interviews conducted with 3 to 10 participants and you will be asked questions related to your experience with patient care and discuss those experiences as a group. You have been contacted because you are at least 18 years old, identified yourself as English speaking and live in the service area. We feel your opinion of your care would be a valuable source of information to help us better understand how patients perceive the health care experience at the health center. Your decision to be contacted or not contacted will in no way impact the care you receive at the health center. If you agree to be contacted, I will be giving your contact information to Shawna and you can expect a follow-up call from her in the next few weeks. She will further explain the project and answer any questions you may have. Agreeing to be contacted by Shawna does not obligate you to participate in the project. Would you be interested in participating and getting more information from Shawna? Thank you for considering being a part of this important project.

## Appendix D

### Introduction

Hello. My name is Shawna Cooke; I am a student in the University of Alaska Anchorage Family Nurse Practitioner program. I would like to record our session today. Does anyone have an objection? **START BOTH RECORDERS**. I am here today to conduct a focus group to discuss your experience of care at the Community Health Center. The purpose of this quality improvement project is to evaluate whether the quality assurance/performance improvement (QAPI) plan which includes only patient experience surveys is a reliable way to obtain patient feedback or if using both surveys and focus groups would be a better way to evaluate the care experience. By conducting this focus group it involves you, the patients, in the care process and operational decision-making at the health center.

Focus groups are guided discussions, all participants are encouraged to respond and share. I am only here to help keep the conversation structured and flowing, not to participate. I will be moderating the discussion, observing and taking notes to help me remain true to the information you chose to share. I invited you all here to discuss your care experience at the Community Health Center. I will ask you several open-ended questions. Your personal opinions and your individual viewpoint are very important to me. There are no right or wrong answers. Please feel welcome to express yourself freely during the discussion.

I am going to read the informed consent to you now. (READ informed consent) Are there any questions? Go ahead and sign the consent, if you chose not to participate you can leave at this time. As stated in the informed consent the conversation will be digitally recorded. This is only for purposes of the project; I will listen to the tape, and transcribe it verbatim. No names or personal information will be used in the final report. I will secure the informed consents. Numbers will be randomly assigned to all of you and no record of the link between identified and the de-identified data will be maintained. My project chair and myself will have access to the de-identified data. Secure e-mail will provide a mechanism by which my project chair and I will review transcripts and provide analytic consultation. During the data analyses the information will be secured in a combination secured safe at the investigator's home, I will be the only one with access to the combination. Once the report is completed all information will be kept in a locked cabinet at UAA School of Nursing office for a period of three years and then be destroyed. You all signed an informed consent, which covers the things I just spoke about. Does anyone have questions about the process or the informed consent?

Some practical issues: the discussion will last for about 60 to 70 minutes. We will take a bathroom break before we start as to avoid interrupting the conversation. Please switch off your mobile phones. Like I said before everyone's opinions are very important, so please allow everyone to participate. You can address each other when expressing your opinion, but please use the number you have been assigned this is to maintain confidentiality. And please direct comments to each other, I am only here as a guide. Let's take a short break before we get started. Be back in 5 minutes. **STOP BOTH RECORDERS**

After return from break: I want to take a moment to stress the importance of confidentiality, the only way to ensure your confidentiality is if are willing to honor your fellow participants by doing the same. Please ensure the conversations we have here are kept private and do not share outside this group. Thank you.

To get started let's just briefly speak about yourself and tell us what motivated you to participate today. I will begin. (Go around the room and do introductions, then announce resumption of recording BOTH digital recorders)

Focus group questions will be asked to the group. Prompts and encouragement will be used to help clarify responses, encourage participation, and cover topic area.

At conclusion: This concludes my questions. Thank you for participating. I ask that you please respect and observe the confidentiality of the participants. (STOP Recording)

## Appendix E

### Consent Form

**Principal Investigator:**

Shawna Cooke, UAA School of Nursing  
Family Nurse Practitioner Tract  
University of Alaska Anchorage  
(605) 759-8524

**Faculty Advisor:**

Kathryn E. Sexson, PhD, FNP-BC  
Assistant Professor, School of Nursing  
University of Alaska Anchorage  
(907) 786-6412

**Description:**

You are invited to take part in a Master's student scholarly quality improvement project conducted by Shawna Cooke, a student in the Family Nurse Practitioner program at the University of Alaska Anchorage. The Community Health Center wants its patients to be a part of planning for the future. You are being asked to be involved in a project that hopes to make the health center better. Focus groups are group meetings with 3 to 10 people that come together to talk about the health center. You will be asked about the health center and the care you get at the center. The group meetings will last 60 to 70 minutes. The meeting will be recorded on a digital recording machine. It will then be written into a paper document. The last step will be a report of what is talked about in the meetings. The reason for this project is to decide the best way to get feedback from patients like you so the health center can make changes to benefit you and the rest of the community.

**Voluntary Nature of Participation:**

Being a part of the focus groups is voluntary. You are not required to be here. You are helping the community and the health center. If you feel uneasy or do not want to answer a question that is ok. You may choose to not answer that question. You may leave whenever you would like. Nothing will happen if you chose not to answer a question or if you chose to leave early. You only have to talk about things you feel good about sharing.

**Confidentiality:**

What you share during the group meeting will stay private. It is expected that all participants will respect and honor the confidentiality of the other participants by not disclosing specific information about what is discussed within the group, but it is possible that the information you provide may be discussed by one or more participants outside of the focus group. I will be turning the recording into a written document and no one else will have access to the recordings. The information and your words will be gathered in a way that you cannot be identified. The written document of the recording will be shared with my project chair so she may help me stay true to your words. All information will be placed on a zip drive and be stored in a safe place. Once the project is completed, all information will be stored in a locked cabinet at the UAA School of Nursing for a period of three years and then be destroyed. Any written work of the project will not name you or the community health center.

**Benefits and Risks:**

The goal of this project is to improve programs at the health center. Your participation and feedback will benefit the health center and the community. There is no physical risk in being a part of the groups. Social risks do exist if what is shared within the group is not kept private. It will be important that you keep what is talked about in the groups private. Because is a community we need to keep the information private to protect everyone in the group. Psychological risk is very small. We will be talking about healthcare and that can be difficult, but

the questions we are asking are not very personal. Again, if at any time you feel uncomfortable with any question, you may choose not to answer that question. You are also free to leave at anytime and nothing will happen to you.

**Compensation:**

You will receive a \$10 Resurrect Art Coffee card at the beginning of the meeting. This is just to say thank you for being here.

**Disclosures:** The Community Health Center knows about this project and is supportive of getting this information.

**Cellular Phones:** Cell phones will need to be off during the meetings.

**Contact People:**

If you have any questions about this project, please contact Shawna Cooke, Family Nurse Practitioner student, at (605)-759-8524 or my project advisor Dr. Kathryn Sexson, Family Nurse Practitioner at (907) 786-6412. If you have any questions or concerns about your rights as a participant, please contact Sharilyn Mumaw, UAA Research Integrity & Compliance Officer, at (907) 786-1099.

**Signature:**

By signing below, it means that you have read the consent and agree to stay here and be a part of the focus group. If you have any questions, please ask at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

**A copy of this consent form is available for you to keep.**

**Appendix F****Demographic Data**

This form is optional; you are not required to complete it. This data is being collected to ensure the sample is representative of the population being studied.

\_\_\_\_\_ Male      \_\_\_\_\_ Female

\_\_\_\_\_ Age

## Appendix G

### Interview Guide

1. What do you think about the quality of care you receive at the health center?
  - a. In your mind, what determines the quality of care and the quality of experience that you receive?
2. What, for you, is the most important part about the care you receive?
  - a. Provider
  - b. Accessibility
  - c. Being treated with respect
  - d. Or something else
3. What is your perception of the health center overall and of the programs and services it provides?
4. In your opinion how could the programs be improved?
5. Would you like to say anything else about the health center?

**Appendix H**  
**Room Use Agreement**

Hi Shawna,

Your room use agreement has been approved and initialed by staff.

Thank you,

Annie Martin

**Seward Community Library & Museum**

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