

Patient Satisfaction with Drug Treatment in Maryland: A Pilot Study

Final Report

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Examination of patient satisfaction is one area of interest in the CSAT initiative called the "Treatment Outcomes and Performance Pilot Study Enhancement" (TOPPS II). The general goal of TOPPS-II is to learn more about the long-term outcomes associated with publicly-funded drug treatment.

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Executive Summary

Background

The Center for Substance Abuse Research (CESAR) conducted a pilot study of patient satisfaction with drug treatment services in the State of Maryland. No uniform system of measuring patient satisfaction exists in Maryland, although several programs measure patient satisfaction for their own purposes. In this effort, an instrument and procedures to measure satisfaction were developed and assessed, survey results were examined, and the feasibility of continuing or expanding the study was evaluated. Five drug-free outpatient programs, three methadone maintenance programs, and one residential program participated. Two additional programs participated in a pre-pilot study.

Highlights

A one-page (front and back) patient satisfaction survey was developed, using a scale measure of satisfaction tested in the research literature and input from Program Advisors for each region of the State.

Survey administration procedures were drafted and then refined with the help of participating program staff. Two brief instruction guides were developed and utilized, and training sessions were held at each participating program.

Three hundred and eight surveys were received from patients in the five drug-free outpatient programs. Over half (54%) stated that they were “very satisfied” with the service received in an overall, general sense.

Four hundred and twelve surveys were received from the three methadone maintenance programs. Almost half (42%) stated that they were “very satisfied” with the service received in an overall, general sense.

The cooperativeness of the programs and their staff will likely be key considerations in assessing the feasibility of continuing or expanding studies of patient satisfaction in Maryland.

Introduction

Satisfaction with drug treatment services might be a key factor in retaining patients in programs. Longer stays in treatment have, in turn, been associated with successful treatment outcomes (Hubbard, et al., 1984; Gerstein and Johnson, 1999; French et al., 1991). Surprisingly little is known about the most appropriate methods by which to measure patient satisfaction. In Maryland, no uniform system of measuring patient satisfaction with drug treatment exists, although several programs do measure patient satisfaction for their own purposes. This pilot effort, therefore, started from the beginning- researching survey instruments, discerning the needs of the State, accommodating the needs of programs, and assessing the capacity of patient response (e.g., Will patients be able to read and understand the written survey? Will they complete the survey in the correct manner? Will they be willing to participate?). This report presents the findings from 720 surveys received from eight drug treatment programs in Maryland.

Goals & Objectives

The overall goal was to better understand the methodology involved in the measurement of patient satisfaction.

The specific objectives were to:

- Develop and assess an instrument to measure patient satisfaction in Maryland drug treatment programs.
- Develop and assess survey administration procedures.
- Report preliminary results from the data collected.
- Assess the feasibility of continuing or expanding the present patient satisfaction survey.

Methods

Designing an instrument to measure patient satisfaction

After reviewing the research literature on the measurement of patient satisfaction both in drug treatment and other health care fields, the Center for Substance Abuse Research (CESAR) staff recommended to the Alcohol and Drug Abuse Administration (ADAA) the use of the CSQ-8 (Patient Satisfaction Questionnaire-8 items) as a model for Maryland's patient satisfaction survey. The CSQ-8¹ is an eight-item scale, with responses on a Likert scale from one to four. A summary score is derived from the sum of all responses.

ADAA staff Program Advisors for each region of the State also contributed to the development of the survey instrument. The CSQ-8 was presented to this group, and their input was essential to the final development of the survey. Namely, they proposed additional questions that would be of interest to them regarding patient demographic information, primary means of payment for services, and cultural/gender sensitivity.

A protocol was reviewed and approved by both the University of Maryland and the DHMH Institutional Review Board. The survey instrument was pilot tested on two programs managed by a local County Health Department.

One program tested the instrument on its methadone patients, and one program tested the instrument on its drug-free outpatient patients. In general, the pilot test revealed that the survey instrument was functioning as intended, and a few minor changes were made to the form (i.e., asking for the age of the respondent rather than the date of birth, describing a sliding fee scale, and adding a pre-printed form identifier).

The final instrument, therefore, consisted of the CSQ-8 questions, 13 questions proposed by the ADAA regional representatives, and one question where respondents could provide additional comments.

¹ A description of how the CSQ-8 was developed and refined over the course of seven studies conducted by researchers at the University of California, San Francisco, can be found in: Nguyen, T.D., Attkisson, C.C., & Stegner, B.L. (1983). Assessment of patient satisfaction: development and refinement of a Service Evaluation Questionnaire. *Evaluation and Program Planning*, 6, 299-314.

In-house optical scanning (OpScan) technology was used to design and create the survey forms. When completed, the forms were scanned directly into the computer as an ASCII file and then imported into a database for analysis. A copy of the survey instrument can be found in Appendix A.

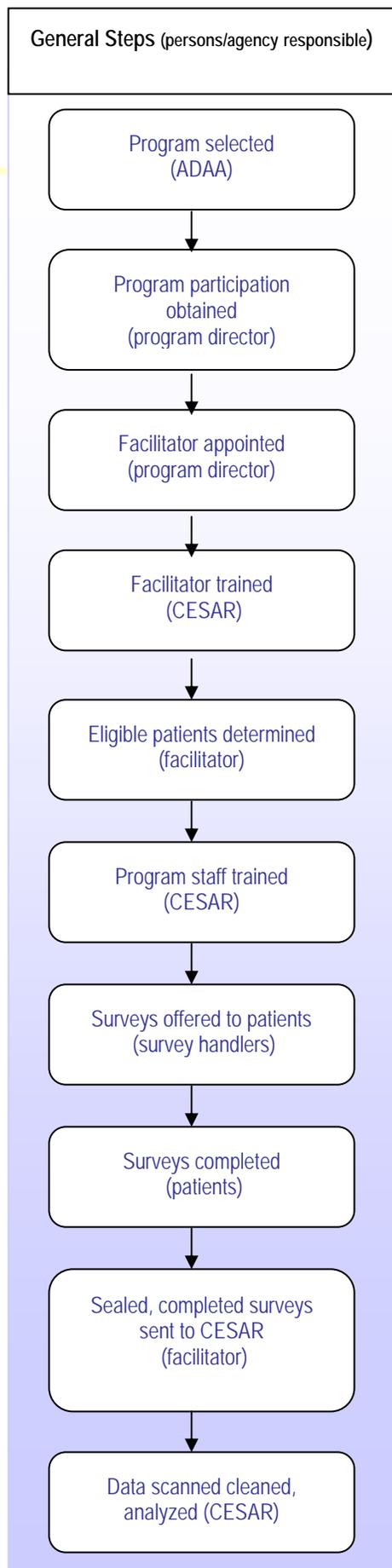
Designing procedures to measure patient satisfaction

To efficiently and accurately measure patient satisfaction, the following were considered.

- ✓ Designing a set of procedures that could eventually be implemented throughout the State with minimal burden of resources
- ✓ Minimizing burden on the programs, which are also often overextended in resources
- ✓ Minimizing the burden on patients
- ✓ Maintaining research integrity
- ✓ Maintaining patient confidentiality
- ✓ Encouraging active participation from programs, program staff, and patients
- ✓ Assessing the potential impact of patients who may have difficulty reading
- ✓ Assessing the potential impact of other reasons for non-participation.

To begin, CESAR staff drafted a set of procedures. The procedures were then discussed with program staff participating in the pre-pilot study of the survey instrument. As the pre-pilot phase progressed, procedures were revised, solidified, and written down as step-by-step instructions. Some of the more interesting findings of the pre-pilot phase were that:

- There was little resistance among patients to taking the survey, even though the patients were not compensated at all for their efforts. Several patients seemed happy just to be asked for their opinions and feedback.
- Much more resistance was found in gaining program participation, finding a helpful contact person to work with, and getting the counselors to distribute the surveys, even though the programs were offered an appreciation gift for their efforts.
- Very few of the eligible patients seemed unable to read the survey.



Data collection steps

1. Selecting drug treatment programs: Maryland's Alcohol and Drug Abuse Administration (ADAA) identified eight programs that were receiving any monies from the federal block grant to Maryland to participate in the pilot testing, five drug-free outpatient programs, two methadone programs, and one residential program. Results for the residential program are not presented in this report since only one was sampled. One more methadone program was added to the pilot study later at the request of a program director wanting another one of his programs to participate. The results in this report, therefore, reflect the views of patients from a convenience sample of five drug-free outpatient programs and three methadone maintenance programs. Program directors for each of the programs were asked for their participation in the study and for the name of a contact person who could coordinate the survey distribution in the program, a survey "facilitator." The facilitator worked with CESAR to develop program-specific plans.
2. Determining patient eligibility: To be eligible for participation in the survey, methadone maintenance treatment patients were required to be at least 18 years old and receiving treatment at that program for at least six months. For drug-free outpatient and residential patients, the requirements were that they be at least 18 years old and be receiving treatment for at least one month. The rationale for having a threshold for time in treatment stems from an attempt to capture patients who have been in treatment long enough to be able to make a fair judgment of the services, but not exclude patients who may drop out of treatment because of dissatisfaction with the services. The survey facilitator reviewed patient

records or coordinated the review of patient records to identify the eligible patients.

3. Training program staff on procedures: For the most part, the surveys were distributed to the eligible patients by the counselors who were already assigned to them, “survey handlers.” Detailed instructions of the whole survey distribution process were provided to the survey facilitators in the “Facilitator Guide” (Appendix B). CESAR staff also discussed the process with the facilitators and were available to answer any questions. Separate detailed instructions were provided to the survey handlers in the “Survey Handler Guide” (Appendix C). Also, CESAR staff held one training session at each of the sites for the survey handlers.
4. Offering the survey to the patient: Survey handlers read a statement to the patients about confidentiality and the voluntary nature of participation then offered the survey to the patient. If the patient accepted, the survey handler read instructions to the patient and handed him/her the survey, an opaque envelope, and a pencil.
5. Receiving completed surveys: After the patient completed the survey, he/she sealed it in the opaque envelope and dropped it in a locked box. The facilitator mailed the completed surveys in large self-addressed, stamped envelopes to CESAR for processing.
6. Cleaning the data: Once the data were received from the programs, CESAR staff reviewed each of the surveys for obvious incorrect markings (e.g., bubbles marked with ink instead of pencil, bubbles unmarked but answers were circled or otherwise indicated, two marks in one column indicating age). These were corrected before the forms were scanned into the computer. The scanned data were then read into SPSS and spot-checked against the forms.

Analyses

Analyses were performed separately for each modality. Comments made by the methadone maintenance patients in the pre-pilot suggested that several had similar concerns that were not mentioned by the drug-free outpatient patients. Further, the facilitators described many plausible reasons why patient satisfaction might be different for patients in the two modalities.

Descriptive information was generated for the patient population and their answers to the individual satisfaction questions. Bivariate ordinary least squares regression estimates were used to examine the association between patient characteristics and satisfaction scores.

The dependent variable for all bivariate models was a sum total of responses for eight satisfaction questions. The eight questions make up the CSQ-8. Each of the questions had four potential scaled responses (e.g., excellent, good, fair, poor). On the survey form, the eight questions were numbered 1, 2, 3, 4, 5, 6, 7, and 10:

- How would you rate the quality of service you have received?
- Did you get the kind of service you wanted?
- To what extent has our program met your needs?
- If a friend were in need of similar help, would you recommend our program to him or her?
- How satisfied are you with the amount of help you have received?
- Have the services you received helped you to deal more effectively with your problems?
- In an overall, general sense, how satisfied are you with the service you have received?
- If you were to seek help again, would you come back to our program?

When a question was not answered by the patient, a response was imputed by calculating the average score (rounded) of all valid responses for that question for each program where a response was missing. For example, if a patient from Program #6 skipped the second question, a value was still calculated for the second question by averaging the values of all the other responses in Program #6 for the second question and substituting that value for the missing one. Imputing values allows for the utilization of all available CSQ-8 data, and it is reasonable in this situation where the largest number of missing values for any one question was five across all programs.

Many of the responses that were not part of the CSQ-8 were used as independent variables. However, some of the response categories were collapsed. The response categories were mainly collapsed on the basis of how the data were distributed. Therefore, the response categories were sometimes collapsed differently for the drug-free outpatient analyses and for the methadone maintenance analyses. When data were missing on an independent variable, those cases were excluded from the regression analysis. One reason multivariate regression analyses were not attempted

was because of the wide range of missing values for the independent variables. The CSQ-8 satisfaction score was regressed onto each of the independent variables separately. Almost all of the independent variables were categorical. When the categorical variables were entered into a regression model, one reference group was selected, so that the other categories would be compared to the same reference group.

Finally, this report includes a discussion of some recurrent themes from the comment section.

Characteristics of Drug-free Outpatient Respondents (N=308)²

	n	%
Sex		
Male	212	69.7
Female	92	30.3
Race		
White	168	55.4
Black	109	36.0
Other	26	8.6
Age		
Younger than 25	51	16.9
25-34	84	27.8
35-44	111	36.8
45-54	42	13.9
55+	14	4.6
Weeks attending the program		
1-4 weeks	54	17.8
5-8 weeks	54	17.8
9-12 weeks	34	11.2
13-16 weeks	39	12.9
more than 16 weeks	122	40.3
Severity of drug/alcohol problem		
Not severe at all	47	15.5
A minor problem	57	18.8
Somewhat severe	111	36.5
Very severe	89	29.3
Source of referral to treatment		
Self, family, school, employer, other	44	14.3
Other treatment program	15	4.9
DWI/DUI	82	26.6
Probation	131	42.5
Other criminal justice	29	9.4
Primary method of payment		
Self/family funds	155	51.8
Private insurance	27	9.0
Public insurance	21	7.0
Don't pay for treatment	96	32.1
Sliding fee scale		
Yes	143	46.4
No	56	18.2
Don't know	102	33.1

² Because patients may have skipped questions, the counts may not sum to 308. The reported percent represents the percent of valid responses.

Satisfaction with Drug-free Outpatient Programs (N=308)³

1. How would you rate the quality of service you have received?	Count	Percent
Poor	2	0.7
Fair	18	5.9
Good	131	42.7
Excellent	156	50.8
2. Did you get the kind of service you wanted?		
No, definitely not	4	1.3
No, not really	14	4.6
Yes, generally	154	50.2
Yes, definitely	135	44.0
3. To what extent has our program met your needs?		
None of my needs have been met	6	2.0
Only a few of my needs have been met	22	7.2
Most of my needs have been met	163	53.1
Almost all of my needs have been met	116	37.8
4. If a friend were in need of similar help, would you recommend our program to him or her?		
No, definitely not	2	0.7
No, I don't think so	16	5.2
Yes, I think so	109	35.5
Yes, definitely	180	58.6

³ Because patients may have skipped questions, the counts may not sum to 308. The reported percent represents the percent of valid responses.

5. How satisfied are you with the amount of help you have received?	Count	Percent
Quite dissatisfied	18	5.9
Indifferent or mildly dissatisfied	20	6.5
Mostly satisfied	121	39.5
Very satisfied	147	48.0

6. Have the services you received helped you to deal more effectively with your drug/alcohol problem?		
No, they seemed to make things worse	4	1.3
No, they really didn't help	9	3.0
Yes, they helped somewhat	96	31.5
Yes, they helped a great deal	196	64.3

7. In an overall, general sense, how satisfied are you with the service you have received?		
Quite dissatisfied	4	1.3
Indifferent or mildly dissatisfied	14	4.6
Mostly satisfied	122	40.1
Very satisfied	164	53.9

8. In general, how satisfied are you with the comfort and attractiveness of our facility?		
Quite dissatisfied	14	4.6
Indifferent or mildly dissatisfied	17	5.6
Mostly satisfied	143	46.9
Very satisfied	131	43.0

9. In general, have the receptionists and secretaries seemed friendly and made you feel comfortable?		
No, often not	5	1.7
No, sometimes not	8	2.6
Yes, most of the time	76	25.1
Yes, definitely	214	70.6

10. If you were to seek help again, would you come back to our program?	Count	Percent
No, definitely not	3	1.0
No, I don't think so	16	5.3
Yes, I think so	115	37.8
Yes, definitely	170	55.9

Do you feel the services you received were sensitive to your cultural background?		No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely	Total
White	n	12	12	84	53	161
	%	7.5	7.5	52.2	32.9	100.0
Black	n	10	16	52	28	106
	%	9.4	15.1	49.1	26.4	100.0
Other	n	1	6	11	8	26
	%	3.8	23.1	42.3	30.8	100.0
Total	n	23	34	147	89	293
	%	7.8	11.6	50.2	30.4	100.0
Do you feel your treatment was sensitive to your needs as a woman or man?						
Male	n	10	22	117	59	208
	%	4.8	10.6	56.3	28.4	100.0
Female	n	3	4	37	47	91
	%	3.3	4.4	40.7	51.6	100.0
Total	n	13	26	154	106	299
	%	4.3	8.7	51.5	35.5	100.0

Characteristics Associated with Satisfaction: Drug-free Outpatient Patients

Independent Variables	n	%	standardized coefficient	significance
Sex				
Female	92	30	–	–
Male	212	70	-.086	.135
Race				
Non-white	135	45	–	–
White	168	55	-.164	.004
Age	–	–	.072	.210
Number of weeks in treatment				
16 weeks or less	181	60	–	–
More than 16 weeks	122	40	-.100	.083
Severity of drug/alcohol problem				
Not severe / a minor problem	104	34	–	–
Somewhat severe	111	37	.173	.007
Very severe	89	29	.326	.000
Source of referral to the program				
Self/family/school.../other Tx program	59	20	–	–
Probation	131	43	-.174	.024
DWI / other criminal justice	111	37	-.248	.001
Primary source of payment				
Private insurance	27	9	–	–
Self/family funds	155	52	.038	.713
Public insurance / no payment	117	39	.250	.015

The bivariate regression results point to a few patient characteristics that were significantly associated with the satisfaction score ($p < .05$). Briefly, patients who were not Caucasian, had a severe drug/alcohol problem, were voluntarily referred to treatment (not through the criminal justice system), or paid for treatment mainly through public funds, tended to be more satisfied with their treatment.

Qualitative Comments: Drug-free Outpatient Patients

Patients' comments about their programs seemed to be generally positive. Many said that they found their programs to be helpful and/or effective. Others used qualifiers to express that the program was effective *if* patients were willing to work with the program.

Several patients also wanted to praise specific staff members, especially counselors. There were also many positive comments about staff in general. Some of the more commonly used words or ideas about staff were "helpful," "well-trained," "professional," "understanding," and "supportive."

Among program elements that were thought to be helpful, one-on-one counseling was mentioned most frequently, and educational or informational components mentioned second most frequently.

Few people had something negative to say, and there did not seem to be any themes associated with negative comments. Two patients in treatment because of probation did not think that they needed treatment; this was the only repeated negative comment.

Characteristics of Methadone Maintenance Respondents (N=412)⁴

	n	%
Sex		
Male	189	46.8
Female	215	53.2
Race		
White	176	43.5
Black	213	52.6
Other	16	4.0
Age		
Younger than 25	9	2.3
25-34	75	18.8
35-44	150	37.7
45-54	142	35.7
55+	22	5.5
Severity of drug/alcohol problem		
Not severe at all	5	1.2
A minor problem	14	3.4
Somewhat severe	97	23.8
Very severe	292	71.6
Source of referral to treatment		
Self, family, school, employer, other	291	72.9
Other treatment program	78	19.5
DWI/DUI	0	0
Probation	25	6.3
Other criminal justice	5	1.3
Primary method of payment		
Self/family funds	233	57.7
Private insurance	70	17.3
Public insurance	94	23.3
Don't pay for treatment	7	1.7
Sliding fee scale		
Yes	239	59.6
No	70	17.5
Don't know	92	22.9

⁴ Because patients may have skipped questions, the counts may not sum to 412. The reported percent represents the percent of valid responses.

Satisfaction with Methadone Maintenance Programs (N=412)⁵

1. How would you rate the quality of service you have received?	Count	Percent
Poor	6	1.5
Fair	66	16.1
Good	204	49.8
Excellent	134	32.7
2. Did you get the kind of service you wanted?		
No, definitely not	4	1.0
No, not really	30	7.3
Yes, generally	246	60.0
Yes, definitely	130	31.7
3. To what extent has our program met your needs?		
None of my needs have been met	2	0.5
Only a few of my needs have been met	48	11.7
Most of my needs have been met	198	48.2
Almost all of my needs have been met	163	39.7
4. If a friend were in need of similar help, would you recommend our program to him or her?		
No, definitely not	3	0.7
No, I don't think so	21	5.1
Yes, I think so	130	31.7
Yes, definitely	256	62.4

⁵ Because patients may have skipped questions, the counts may not sum to 412. The reported percent represents the percent of valid responses.

5. How satisfied are you with the amount of help you have received?	Count	Percent
Quite dissatisfied	37	9.0
Indifferent or mildly dissatisfied	38	9.3
Mostly satisfied	178	43.5
Very satisfied	156	38.1
6. Have the services you received helped you to deal more effectively with your drug/alcohol problem?		
No, they seemed to make things worse	1	0.2
No, they really didn't help	5	1.2
Yes, they helped somewhat	118	29.0
Yes, they helped a great deal	283	69.5
7. In an overall, general sense, how satisfied are you with the service you have received?		
Quite dissatisfied	7	1.7
Indifferent or mildly dissatisfied	28	6.8
Mostly satisfied	202	49.4
Very satisfied	172	42.1
8. In general, how satisfied are you with the comfort and attractiveness of our facility?		
Quite dissatisfied	40	9.7
Indifferent or mildly dissatisfied	53	12.9
Mostly satisfied	198	48.2
Very satisfied	120	29.2
9. In general, have the receptionists and secretaries seemed friendly and made you feel comfortable?		
No, often not	6	1.5
No, sometimes not	41	10.0
Yes, most of the time	176	43.1
Yes, definitely	185	45.3

10. If you were to seek help again, would you come back to our program?	Count	Percent
No, definitely not	8	2.0
No, I don't think so	17	4.1
Yes, I think so	136	33.2
Yes, definitely	249	60.7

Do you feel the services you received were sensitive to your cultural background?		No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely	Total
White	n	8	15	84	67	174
	%	4.6	8.6	48.3	38.5	100.0
Black	n	15	35	118	43	211
	%	7.1	16.6	55.9	20.4	100.0
Other	n		1	11	4	16
	%		6.3	68.8	25.0	100.0
Total	n	23	51	213	114	401
	%	5.7	12.7	53.1	28.4	100.0

Do you feel your treatment was sensitive to your needs as a woman or man?		No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely	Total
Male	n	6	21	102	58	187
	%	3.2	11.2	54.5	31.0	100.0
Female	n	10	23	109	70	212
	%	4.7	10.8	51.4	33.0	100.0
Total	n	16	44	211	128	399
	%	4.0	11.0	52.9	32.1	100.0

Characteristics Associated with Satisfaction: Methadone Maintenance Patients

Independent Variables	n	%	standardized coefficient	significance
Sex				
Female	215	53.2	–	–
Male	189	46.8	-.056	.266
Race				
Non-white	229	56.5	–	–
White	176	43.5	.265	.000
Age	–	–	.036	.468
Severity of drug/alcohol problem				
Not severe to somewhat severe	116	28.4	–	–
Very severe	292	71.6	.244	.000
Source of referral to the program				
Other Tx prog / probation / other C.J.	108	27.1	–	–
Self, family, school, employer...	291	72.9	.084	.093
Primary source of payment				
Private ins. / public ins. / no payment	171	42.3	–	–
Self/family funds	233	57.7	-.021	.671

The bivariate regression results point to patient characteristics that were significantly associated with the satisfaction score ($p < .05$). Briefly, Caucasian patients and patients with very severe drug/alcohol problems tended to be more satisfied with the treatment services they received.

Qualitative Comments: Methadone Maintenance Patients

Similar to the drug-free outpatient patients, the most common theme found among the methadone maintenance patients' comments seemed to be general positive comments about the program. Many said that they found their programs to be helpful and/or effective. Others used qualifiers to express that the program was effective *if* patients were willing to work with the program.

Another commonly expressed idea was that patients liked their counselors. Program staff in general received many more positive comments than negative comments.

Four concerns were prevalent among the methadone maintenance respondents:

1. Expensive fees
2. Scheduling, especially regarding medication hours
3. Take home policies
4. Needing more help or services (with the opiate problem, with another drug problem, or in terms of ancillary services such as job training or childcare).

Alternatively, some patients specifically attributed their success in dealing with drug problems to being on methadone.

Lessons Learned

Cooperation of the programs

The primary benefit to programs for participating in this pilot study was probably the rapid feedback they would receive on patient satisfaction at their program. Each program that finished the survey distribution received copies of a brief report of its survey results. Programs were also offered to receive their survey results in batches as CESAR received them, but none of the programs requested this. Only a few of the participating programs expressed some interest in the results.

Among the ten programs involved in the patient satisfaction study (including the pre-pilot programs), there was wide variation in the level of cooperation exhibited by each program. Some programs responded quickly and provided a good contact person, but for others, it took several months for CESAR staff just to find a person who was willing to say whether the program would participate or not.

There are a variety of reasons why it may be difficult to gain the cooperation of programs in a patient satisfaction study. Some are speculated here:

1. The patient satisfaction survey is simply not a priority for the program, so calls may not be returned and no effort may be made to come to a decision.
2. The program may already be tight on staff resources and reluctant to put any more strain on the staff.
3. The program may be suspicious that the results could be used against it, especially in funding decisions.
4. Internal authority structures may be such that nobody feels that they have the authority or proper understanding to make a decision.
5. The potential costs may seem to outweigh the potential benefits, but the program may not want to say 'no' outright.
6. The program may already be distributing its own patient satisfaction survey.
7. The program might be hesitant to report the results.

Cooperation of the facilitator

Benefits to survey facilitators included:

1. Facilitators received a \$15 gift certificate for groceries.
2. If facilitators were counselors and spent more than 10 hours on the survey, they could request a letter from CESAR to receive training credit towards their license.
3. Facilitators received the standard report and were able to request additional analyses. These could be used to support the facilitator in his/her normal job responsibilities.

Among the ten programs there was also wide variation in the levels of cooperation of facilitators. Facilitators seemed to be key to the success of data collection at the programs. Programs that had facilitators who were responsive and enthusiastic about the study tended to complete the data collection process quickly and provide a good accounting of the survey distribution process. When facilitators were less enthusiastic, CESAR often had difficulties getting phone calls returned and obtaining data (e.g., the completed surveys, a count of the eligible patients, an assessment of what happened with the eligible patients, etc). Even when forms were received, they often required extra attention (e.g., counselors did not seem to offer patients pencils or convey the proper instructions, respondents did not seem to be part of the targeted group, etc.) Occasionally program directors volunteered themselves to serve as the survey facilitator, but usually the program directors appointed someone else to serve as the facilitator.

There are a variety of reasons why it may be difficult to gain the cooperation of facilitators in a patient satisfaction study. Some are speculated here:

1. They may already be overburdened with work.
2. They may not have the authority or resources to get the work done efficiently.
3. There may be poor communication between the facilitator and the people who appointed him/her to the task (e.g., regarding the survey distribution process, expectations, etc).

Cooperation of the survey handlers

The primary benefit to the survey handlers was a portion of the \$85 in grocery gift certificates to be allocated by the facilitator for the encouragement of good work in the survey distribution process.

Survey handlers were usually the counselors who were assigned to the eligible patients. CESAR did not work directly with the survey handlers except to provide a training session for them. Instead, their work was coordinated and supervised by the survey facilitator.

When survey handlers did not do their parts properly, many difficulties arose. For example, if survey handlers did not distribute the forms, the number of potential survey respondents declined. Also, the longer the survey handlers waited to distribute the surveys, the more likely patients would be discharged. If survey handlers did not keep track of the eligible patients for whom they were responsible, an accurate assessment of what happened with the eligible patients could not be made. If survey handlers did not provide pencils or give adequate instructions, completed survey forms had to be cleaned up. From the incomplete data CESAR received regarding the distribution of surveys to eligible patients, it seemed that despite the provision of appreciation gifts to the survey handlers, most of the loss in patient response rate was due to patients not being offered the survey at all. Very few patients actually refused to take the survey.

There are a variety of reasons why it may be difficult to gain the cooperation of survey handlers in a patient satisfaction study. Some are speculated here:

1. They may view it simply as extra work.
2. They may not want to burden the patients.
3. They may fear that they are being evaluated personally.
4. They may think that the survey results will influence program funding decisions.
5. They may procrastinate or forget.

Cooperation of patients

Completing the survey form may benefit the patients in that:

1. Patients are given the opportunity to openly express their opinions about their treatment with the protection of anonymity.
2. Patients may be able to influence program improvements through their feedback.

Across all the levels of cooperation, patients in general seemed to present the least resistance. Nevertheless, some obstacles to patient cooperation are speculated here:

1. They may not want to take the time to complete a survey (about 10 minutes).
2. They may regularly come late to appointments, so no time is available to take the survey.
3. They may be suspicious of the confidentiality of the survey.
4. They may not have an adequate level of literacy to understand the survey.

Feasibility of the survey instrument

Again, looking at the incomplete data CESAR received about the distribution of surveys to eligible patients, it seemed that only a small proportion of patients had reading difficulties. Therefore, a written survey would seem to be a feasible tool, and likely the most cost efficient tool, to measure patient satisfaction.

The patients seemed to understand the questions correctly. The only issues that seemed to arise from the questions were that: 1) a few respondents did not seem to like being asked about their race/ethnicity; 2) several patients were not able to indicate whether a sliding scale fee was used (income and number of dependents were taken into consideration for the treatment charge); and 3) probably because the sliding scale fee question was in the survey, more patients were prone to comment that income and

the number of dependents should be considered in the charge for treatment.

The patients also seemed to consider each question. For example, patients did not mark the first circle for each question or go through the survey marking by patterns that would give inconsistent answers.

OpScan technology may be optimal for this type of survey in that patients can quickly mark their choices right onto the form and the data can easily be scanned into the computer. While OpScan eliminates the need for keyed data entry, there is still a fair amount of labor involved. First, printing OpScan forms can be tedious—each sheet must be checked for proper printer alignment; after the first side is printed, the sheets usually need to be flattened under something heavy before printing the second side, to prevent the papers from jamming in the printer; on the second side, form numbers are assigned to each form; and once the second side is printed, each sheet must be checked again for proper printer alignment. Printer alignment can be inconsistent and require multiple adjustments for one batch. If the forms are being printed from a printer that is shared by other users, there is the additional difficulty of other users accidentally printing on the forms. Any printing mistakes that occur on the second side require the whole sheet to be discarded. Further, some treatment programs are not forthright to report the number of eligible patients they have, but instead will insist that they be provided with a certain number of forms, which is almost always much higher than the number of forms completed. Second, although there are instructions at the beginning of the survey on how to mark responses, some respondents do not follow the instructions—marking in pen, incorrectly marking the age, circling the entire response, drawing circles on the other side of the response, blacking out the entire response but not the circle, etc. The completed forms, therefore, need to be checked and corrected before scanning. Third, alterations to the form can sometimes be difficult because the computer application to create the forms is not well documented. Fourth, OpScan cannot read data that is not marked by the bubbles. Comments, for example, if they are to be assessed, must be keyed in manually.

OpScan, however, is quite sturdy in reading the data that it was designed to read. Sheets that have been folded or slightly ripped can often still be read. If respondents draw a checkmark in the circle rather than filling it in (or otherwise make a small mark or a light mark), the program usually reads the correct response. If respondents do not cleanly erase a response, but mark another one darker, the program usually reads the darker response. Stray marks rarely affect how the data is read.

Basic resources used in this study

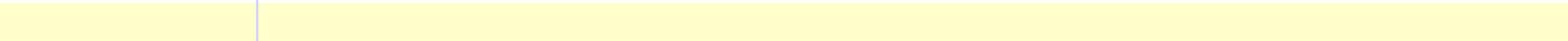
Equipment:

- NCS DesignExpert Software (to create OpScan forms)
- Scanner
- HP LaserJet Printer 8150N (older printers did not work as well)
- SPSS statistical software

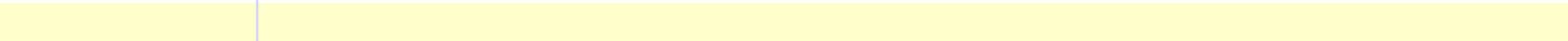
Supplies:

- NCS paper compatible with NCS DesignExpert
- Opaque 9"x 12" envelopes (brown or gray) in which patients sealed completed surveys
- One locked box per survey site with a slot for patients to drop completed surveys
- Number 2 pencils for each survey site
- Large self-addressed, stamped envelopes for facilitators to return completed surveys
- Giant grocery gift certificates- \$100 per program

Appendix A
Patient Satisfaction Survey Form



Appendix B
Facilitator Guide



Appendix C
Survey Handler Guide