

**Quality Healthcare Network  
Networking for Better Practices Series 2003/2004**

**THE PATIENT EXPERIENCE IN REHABILITATION:  
BEYOND THE DATA**

**Hosted by St. John's Rehabilitation Hospital  
March 9th, 2004**

On March 9<sup>th</sup>, 2004, the Quality Healthcare Network provided yet another amazing opportunity for participants to learn about the innovative initiatives taking place across the rehabilitation sector. Hosted by St. John's Rehabilitation Hospital, the session *The Patient Experience in Rehabilitation: Beyond the Data* was attended by members from hospitals, community care access centres, service provider organizations, and consulting firms. During this session, participants learned about various collaborative projects that were aimed at defining the patient's rehabilitation experience.

Complimentary to the power point presentations that are available on the Quality Healthcare Network's website, this report provides a summary of the speaker's presentations and the discussions that followed.

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## **MEASURING CLIENT PERSPECTIVES IN REHABILITATION: A New Outpatient Satisfaction Survey**

*Heather Dawson, St. John's Rehabilitation Hospital  
Sarah Sharpe, Toronto Rehab Institute*

The informal partnership that evolved between St. John's Rehabilitation Hospital (SJRH) and Toronto Rehab Institute (TRI) over the years was facilitated by the similarities among the hospital's strategic directions, commitments, and clinical services. Although their results from in-patient satisfaction surveys were often compared, no such data was available for similar comparisons with out-patient rehabilitation satisfaction measures. Given the significant amount of out-patient rehabilitation discharges and the limited amount of information to support decision-making, a commitment to work collaboratively on this initiative was supported. A project was soon launched between the two hospitals, with the aim of identifying and implementing a satisfaction survey for rehabilitation patients.

### **Joint Initiative Process Model & Template for Survey Design: Plan-Do-Study-Act**

#### ***Plan***

A significant amount of planning was undertaken in the first few months of the project. One of the first activities was the establishment of the joint task force with representation from front-line staff to senior management. The goal of the project, the anticipated benefits and outcomes, and the roles and responsibilities for each hospital were defined.

#### **Project Goal:**

*To work together to create an outpatient rehabilitation satisfaction tool that is reliable and valid; economically feasible; generalizable across a range of outpatient populations; results in timely reports to assess services for improvement.*

## **Do**

Following a review of the literature and existing tools, as well as staff feedback, it soon became apparent that an adequate tool did not exist. To guide the development of a new outpatient rehabilitation satisfaction tool, a set of survey design principles were identified.

A one page (double-sided) survey was created, using a five-point Likert scale with visual (facial pictures), written (words), and numerical cues. The survey has several open-ended questions, and additional comments can be provided for each question. Existing questions (e.g. from in-patient surveys) were used where possible to maximize comparison with other surveys results. Furthermore, the survey has “drill down” capabilities and the results can be tailored to different audiences within the organization.

Feedback on the initial survey was obtained from clinicians, managers and directors to examine the overall design, feasibility, content, and wording of the survey. Focus groups with patients were also conducted at both hospitals to validate the content and the wording of the survey, and to explore whether the appropriate dimensions (i.e. those most important to patients and their families) were captured in the survey.

Following several modifications to the survey, a pilot study was conducted to test its reliability properties. A total of 120 packages (with 2 surveys per package) were distributed to patients prior to their discharge. The first survey was completed on-site and the second (identical) survey was completed two weeks later and mailed back. The first set of surveys (on site) had a response rate of 84% and the second set (mail back) had a response rate of 49%.

## **Study**

One of the less anticipated outcomes of the survey was the high percentage of patients that provided additional comments in the survey. Results also revealed significant language barriers (e.g. number of patients that could not read English), and approximately 85% of the respondents answered “not applicable” to the cultural awareness question. Based on these findings, the task force made several modifications to the survey, including the omission of the “not applicable” option on the cultural awareness question, and the development of a “translation sleeve” to enable the translation of the survey in five other languages.

## **Act**

The survey was implemented across all outpatient programs and clinics at both hospitals in September 2003. To minimize potential bias in responses, the surveys are distributed by non-clinical staff or volunteers when possible just prior to the patient’s discharge, Numerical results from the survey are then scanned and analyzed using SPSS software and excel databases, and qualitative

comments are captured with the Radical Logic software<sup>1</sup>. Reports are provided on a trimester-basis.

## **Project Success and Next Steps**

The establishment of a common goal and the trust that had developed between the two hospitals strongly contributed to the success of the project. The identification of the roles and responsibilities at the onset of the project also promoted the sharing of information and of resources, and the identification of targeted steps and outcomes (e.g. using PDSA cycles) enabled the project to proceed according to plan. Moving forward, the two hospitals will begin to share the results of the survey and will identify best practice opportunities. Although the logistics are to be determined, the use of the survey in acute care and non-hospital settings will be promoted, as well as the inclusion of the data results in the provincial Hospital Report.

In 2003, TRI and SJRH were both awarded the 3M Health Care Quality Team Award in recognition of their collaborative effort in the development of the outpatient rehabilitation satisfaction survey.

## **THE CLIENT-CENTRED REHABILITATION QUESTIONNAIRE: Development and Pilot Testing**

*Cheryl Cott, ACREU, University of Toronto*

*Gary Teare, Toronto Rehabilitation Institute*

The Client-Centred Rehabilitation Questionnaire (CCRQ) was developed as a result of the collaborative initiative between the University of Toronto, Toronto Rehabilitation Institute (TRI) and the Arthritis Society. This initiative was driven by the Client-Centred Rehabilitation Research Program, which was funded by the Ministry of Health and Long Term Care, Rehabilitation Reform Policy Branch.

### **Client-Centred Rehabilitation Research Program**

Following the release of the provincial report “Managing the Seams” in the year 2000, the concept of client-centred care in rehabilitation was flagged; as such, the research program was initiated to achieve the following key objectives:

1. *What is client-centred rehabilitation?*
2. *How will we know when we see it?*
3. *How will we measure it?*

A literature review of the various definitions and focus groups with previous rehabilitation clients were conducted to understand the core themes of client-centred rehabilitation. Patients explained that they wanted 1) to be seen as

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<sup>1</sup> Radical Logic is utilized at TRI only, and sorts the comments by themes.

people with needs and with strengths that can be brought into their program; 2) to be involved in setting meaningful goals; and 3) to further involve their families in their rehabilitation. Staff also acknowledged the need to:

- 1) further educate patients and their family in order to empower them in their rehabilitation program,
- 2) enable their patients to decide when their goals have been met.
- 3) provide more emotional support to their patients,
- 4) maximize the patient's transition into the community.

The results suggested that client-centred rehabilitation was a philosophy or an approach at two levels: not only must it be experienced at the patient's level, but it must also permeate throughout the organization. As such, client-centred rehabilitation was defined as: *a philosophy or approach to the delivery of rehabilitation services that reflects the needs of individuals and groups of patients.*

This definition was also characterized by eight client-level domains:

- client participating in decision-making and goal setting
- client-centred education
- evaluation of client outcomes from the clients' perspective
- effective communication
- family involvement
- flexibility
- coordination and continuity.

### **Measuring Client-Centred Rehabilitation**

The next challenge was to identify a way to measure client-centred rehabilitation. Following a review of existing tools, it was determined that a new one would need to be developed. The CCRQ working group panel was formed with clinicians and researchers from TRI, SJRH, and the Arthritis Society, to guide the development of a new measurement tool. A preliminary questionnaire with 40 items (i.e. approximately five questions for each of the eight domains) was developed, and where possible, questions from other surveys were used. Items were scored using a five point Likert response scale.

Interviews with clients were held to explore whether the questions were properly formulated (e.g. did patients interpret the question correctly?). Based on the feedback received, two items were dropped and three questions were revised. For some questions (e.g. those pertaining to families), the rating option of "not applicable" was later added. The revised 38-item CCRQ questionnaire was then piloted to determine its feasibility, scale development, and psychometric properties<sup>2</sup>.

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<sup>2</sup> Additional information of the pilot's properties is outlined in the power point presentation.

A total of 1560 surveys were mailed to discharged patients from TRI and SJRH in July 2001, and a second wave of surveys was mailed again in August to non-respondents. A response rate of 64% with appropriate gender and age representation was obtained. Highlights of the findings include:

- strong test-retest reliability was achieved
- respondents were less likely to strongly agree with negative items
- four items had the most missing responses or not applicable responses (family involvement, information about community services, spiritual/cultural needs, and help to the bathroom)
- the four items with too much missing data and one additional item that was repetitive of another item were dropped
- the factor analysis did not find strong evidence of several different factors or dimensions ; rather responses indicated that the items tap a generalized “patient perception of their rehabilitation experience”
- summary indicators of dimensions of client-centredness of rehabilitation were nevertheless created based on a combination of the results of factor analysis and the original grouping of the items into dimensions during initial instrument design. These indicators are moderately-to-strongly inter-correlated.

Since the completion of the CCRQ pilot, portions of the survey have been used with the recent Hospital Report. It is interesting to note that the results from the Hospital Report were similar to those from the pilot. As they begin to plan for the next use of the survey, modifications to the pilot will continue to be made.

## **PUTTING SENSE TO IT ALL: A Framework for Interpretation**

*Vannessa Blount, NRC+Picker Group Canada*

*Shahzia Adatia, St. John's Rehabilitation Hospital*

*Elaine Aimone, Toronto Rehabilitation Institute*

The following presentation occurred in three parts to provide an illustration of how survey results can be used for decision-making and for prioritizing action plans.

### **Part 1: Measuring and Improving the Most Important Aspects of the Patient Experience, NRC+Picker Group Canada**

The presentation began with an overview of the key attributes of the NRC+Picker Group surveys. Similar to the in-patients used by many hospitals across the province, NRC+Picker Group Canada (which merged with Smaller World Communications) has recently begun providing surveys for the rehabilitation

sector. The survey was developed based on the eight components from the CCRQ, and questions pertaining to their doctor, nurses, therapists, and overall impressions were also added. Survey results can be provided on a quarterly, biannually or annually basis to each hospital through the use of on-line reports (referred to as “Ideas” report), and the majority of the results are portrayed graphically through the use of graphs, control charts and tables.

A demonstration of an Idea report was provided to illustrate the different features of the on-line (Idea) report. Some of the key features include:

- highest % positive scores
- lowest % positive scores
- priority matrix
- Performance across time
- Comparisons with provincial average
- Comparisons with High Performers
- Verbatim comments

Once a on-line report is received, the “Action Plan” worksheet (refer to appendix 1) can be used to assist the user in understanding the results and to identify one or two improvement opportunities to focus on.

## **Part 2: Identifying Areas of Improvement-An example of how to use the data to drive QI efforts, St. John’s Rehabilitation Hospital (SJRH)**

The section of the presented provided an illustration of the process SJRH used to identify and prioritize opportunities for improvement based on the information in the on-line Idea report. The following steps characterized this process:

### *Step 1: Completing the action worksheet*

There are eight different items on the action worksheet; using the information in the Idea report, the worksheet is completed with a minimum of two survey questions.

### *Step 2: Selecting 2-3 key priorities:*

Once the worksheet is completed, the top two or three priorities are filtered based on the following criteria: the number of “yes” responses; the presence of statistically significant differences; and the magnitude of the percentage difference.

### *Step 3: Analyzing qualitative data of the two-three priorities*

The verbatim comments provided in the Idea report assists to further understand the key issues. Comments are filtered by 1) type (positive, negative, both, neutral); 2) code - “family/friends”; and 3) program area - e.g. musculoskeletal.

#### *Step 4: Confirming priorities with trend data*

Control charts are then used to determine whether the results are due to simple variation vs. special cause variation (e.g. whether action is required immediately).

#### *Step 5: Analyzing for key themes*

The last step involves analyzing the lowest ranked percentage positive scores (one of the sections of the Idea report) to identify key themes. In the example provided during the presentation, six of the ten lowest ranked percentage positive scores were in the dimension of “continuity and transition”. This information can then be used to direct action plans based on the top key priority area(s). For example, the two priorities that were identified using the action worksheet were:

- My family and friends received information that they wanted when they needed it
- I had to repeat the same information to the different program staff.

Using the key theme identified in step 5 (continuity and transition), it became apparent that the area of discharge planning, and more specifically the type/amount of information provided to patients and their families at the time of discharge, would need to be addressed. A new process was then initiated to begin identifying improvement strategies.

### **Part 3: An interactive example about where to focus efforts to improve service and next steps, Toronto Rehabilitation Institute (TRI)**

To illustrate how TRI used the results to drive improvement efforts, an example was provided using the results from its recent Complex Continuing Care (CCC) family satisfaction survey and applying it to the action worksheet.

The process began with the following questions:

- What do we think are important issues?*
  - are there clinical issue that keeps surfacing?*
  - what are the most important issues to our patients?*
- What are the low scores?*
  - Based on year to year trends*
  - Based on Peer Comparison*
- Are the verbatim comments helpful? Do they suggest a need for improvement?*
- Can we validate the survey results with clients and staff?*

These questions assisted in creating awareness of general improvement opportunities. The next step was the completion of the action worksheet, and the following two survey items were identified as likely areas for improvement: 1) staff follow up with requests and 2) staff keeping you informed.

Following the completion of the worksheet, the next step was to validate and to understand the survey findings. Although the verbatim comments of the report were reviewed, additional means were required to gain a deeper understanding of the underlying issues. Focus groups were therefore held with patients and their families, and a series of staff discussions were also conducted to further explore these two themes.

The last steps were the identification of the AIM statement and corresponding measures. In the example provided, the AIM statement was defined as: *to improve staff follow-up with family questions/concerns in CCC that can't be resolved immediately*. A balanced set of measures (cost measures, clients' perspectives, process measures and clinical outcomes) was also identified. With these components in place (AIM statements and measures), a Plan-Do-Study-Act (PDSA) cycle to address the issue was ready to be initiated.

## **Conclusion**

The session provided participants with a wonderful overview of the initiatives that have taken place over the past few years to further define client-centre rehabilitation and to identify ways in which it can be measured. Moving forward, it is anticipated that the tools and surveys developed will be further distributed and utilized to a much greater extent across the sector.