CLIENT EXPERIENCE SURVEY

Service-Seeking Clients

Middlesex-London Health Unit Overall Results

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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Service-Seeking Clients

Project Sponsor

Heather Lokko
Chief Nursing Officer & Director, Healthy Start Division

Initial Project Team

Christine Brignall
Program Evaluator

Angela Armstrong
Program Assistant

Meena Ume
Health Promoter

Brenda Marchuk
Community Nursing Specialist

Jordan Banninga
Manager, Program Planning & Evaluation

Current Project Team

Michelle Sangster Bouck
Project Evaluator

Angela Armstrong
Program Assistant

Brooke Clark
Community Nursing Specialist

Jordan Banninga
Manager, Program Planning & Evaluation

Management Advisory Committee for Phase One Planning

Mary Lou Albanese
Manager, Infectious Disease Control

David Pavletic
Manager, Food Safety and Healthy Environments

Donna Kosmack
Manager, Southwest Tobacco Control Area Network

Sean Bertleff
Manager, Emergency Preparedness

Deb Shugar
Manager, Reproductive Health

Darrell Jutzi
Manager, Child Health

Tracey Gordon
Manager, Vaccine Preventable Diseases

Acknowledgements

Carolynne Gabriel
Librarian

Bernie Lueske
Data Analyst

Client Experience Survey

Service-seeking Clients - MLHU Overall Results

Background

In 2019, The Algoma Client Centred Care Tool (ACCCT)[i] was implemented as the data collection tool for measuring service-seeking[1] clients' experience as part of the MLHU strategic initiative for *Client and Community Confidence*. The selection of this tool was made specifically for service-seeking clients by the Program Evaluator and Community Health Nursing Specialist leading the project work, in consultation with the project's Management Advisory Committee. There was recognition of the strong alignment between the measurement of adherence to client-centred principles in the ACCCT and the MLHU values for client experience. This alignment would provide the MLHU with an understanding of service-seeking clients' experience. The purpose of this survey was to determine the extent to which public health staff in service-seeking programs were delivering client-centred care. This tool provides an opportunity to monitor service-seeking clients' experiences over time.

Relationship between the client-centred care and client outcomes

The ACCCT is based on the work of Carl Dunst and Carole Trivette and their model of family-centred care.[ii] Their research found that client-centred practice was an important determinant of self-efficacy beliefs, and self-efficacy beliefs were in turn an important determinant of health outcomes.[ii] At its essence, this survey tool measures how much staff follow client-centred principles when delivering care.

Methods

The service-seeking interventions in which this survey was implemented included: Home Visiting, Group Programs, Telephone Support and Drop-In from the Healthy Start Division, Children and Adult Dental Clinics from the Healthy Living Division, and the Immunization Clinic, Sexual Health Clinic, Family Planning Clinic, Needle Exchange, and Outreach interventions in the Environmental Health and Infectious Disease Division. For each intervention, staff and managers were responsible for setting up their data collection process. In most cases, staff and managers choose to use paper surveys, although on-line surveys were used in some interventions. A five-dollar grocery gift card[2] was distributed in the paper survey package or sent to on-line respondents that provided their contact information as an honourarium. In some areas, administrative assistants distributed the survey package, whereas in other areas the survey was distributed by the service provider.

Clients were eligible to complete the survey if they were 16 years of age or older and spoke English or French. Parents completed the survey for children under the age of 16. With some interventions, there were other specific eligibility criteria to ensure inclusion of service-seeking clients. Non-English and non-French speaking clients will be included in a future phase. This report includes the overall health unit results, with the aggregated survey results from all service-seeking interventions. Analysis followed the suggested program evaluation protocol by Dunst and colleagues.[iii]

[1] Service-seeking clients include those that independently pursue and consent to our programs and services. Their engagement is optional.

[2] Five dollars cash was used instead of a gift card for Outreach clients.

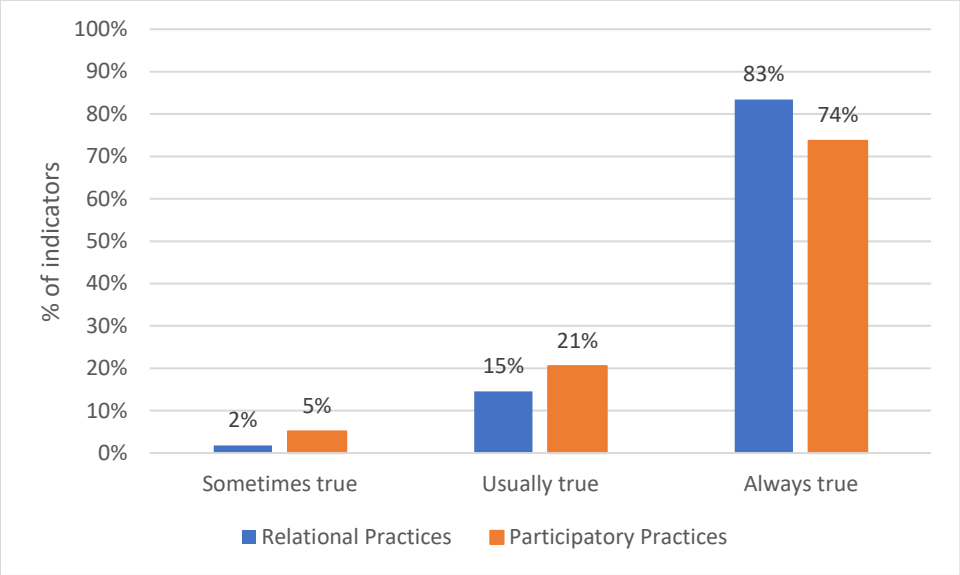
Results

In total, 1181 client survey responses were collected from January to November 2019. The survey measured client-centred practice (relational practice and participatory practice), self-efficacy, program loyalty and social validity. Participant demographics were also measured. In the results below, the measures are defined, aggregated results are presented, and brief interpretation notes are included.

Client-centred principles

Client-centred principles have been defined along two dimensions: relational and participatory practices. **Relational practices** are behaviors associated with good clinical practice and include active listening, compassion, empathy, respect and positive beliefs about clients' strengths and capabilities. **Participatory practices** are behaviours that involve clients in the decision-making. Participatory practice is individualized, flexible and responsive to family concerns and priorities.

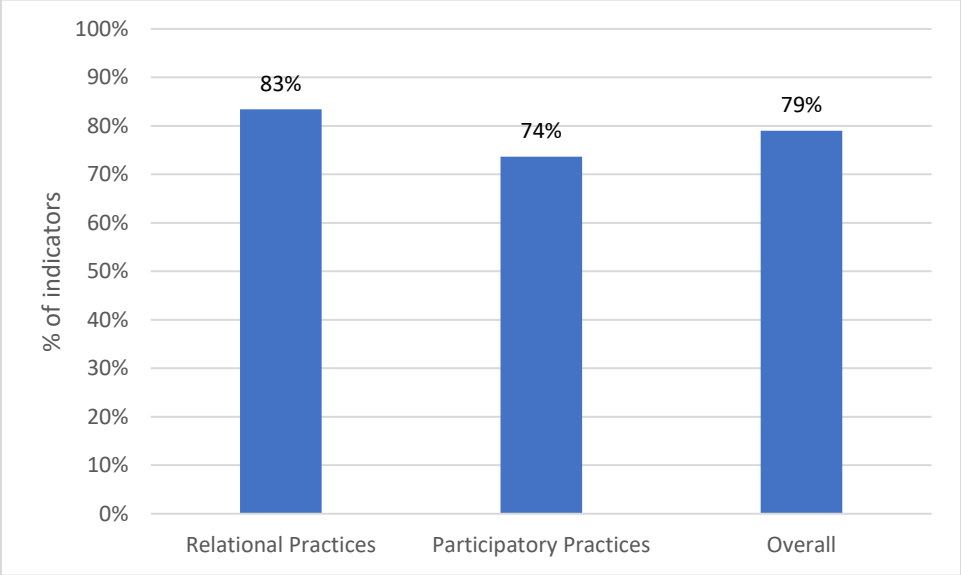
Figure 1: Percentage of indicators by rating for the client-centred principles of relational and participatory practices (n=1181).



Interpretation Notes – Figure 1

- Figure 1 presents the percentage of indicators given different ratings on the scales for relational and participatory practices for all participants taken together.
- Almost all responses to the relational and participatory practice items were rated "usually true" or "always true".
- Not all ratings are included on the chart due to the very small number of responses in the lowest ratings of "not at all true" and "rarely true."
- Typically, relational practices score higher than participatory practices. However, participatory practices are the types of capacity-building experiences that have empowering effects for clients and can have greater impact on health outcomes[ii].
- Individual item scores for the five relational practice items and the five participatory practice items are included in Appendix B.

Figure 2: Staff adherence to client-centred principles of relational and participatory practices (n=1181).



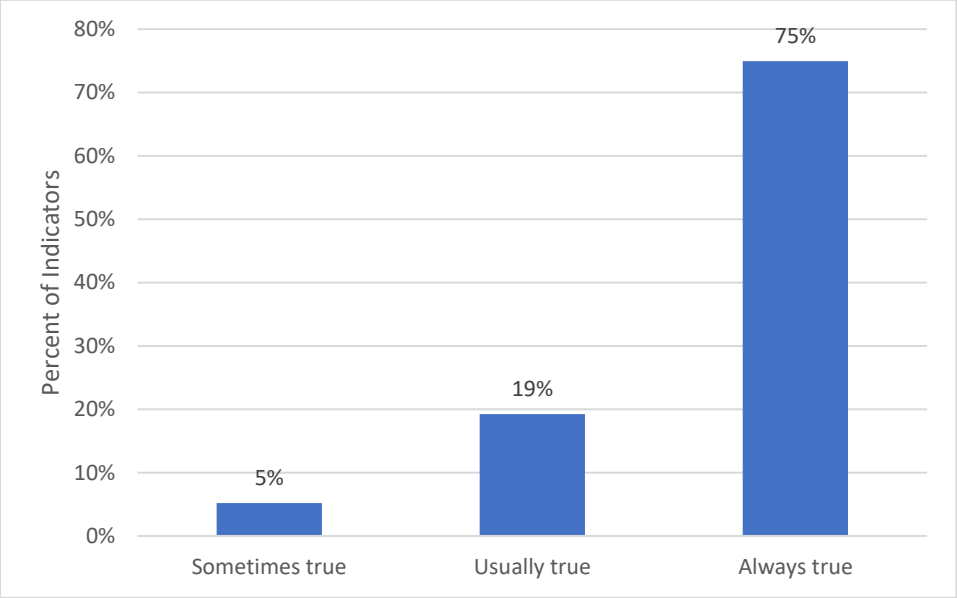
Interpretation Notes – Figure 2

- Figure 2 presents staff adherence to client-centred principles of relational and participatory practices as well as an overall score.
- These adherence scores have been calculated by determining the percentage of indicators receiving the highest rating of 5 or "always true" for all clients taken together following the evaluation protocol described by Dunst et al.[iii]
- Dunst and Trivette have indicated that programs should aim for scores of 85% adherence to client-centred principles. They established this as the liberal criteria to claim that adherence to client-centred principles has been attained. In some cases, they have applied the more stringent criteria of 90% adherence. This level of adherence is consistent with consumer loyalty research that indicates most indicators must receive the highest rating[ii]. In their technical manual describing their evaluation work with Family Support Programs in North Carolina, relational and participatory scores often ranged from 60% to 90%. In some years, participatory measures in some locations were under 40%[ii].
- There are structural aspects of programs that demonstrate differences in adherence scores. Typically, one-on-one interventions delivered in the home score higher than group programs offered in a community setting[ii]. These differences are expected; however, each intervention type can try to improve upon their baseline results and work towards the established benchmark over time.
- Adherence to client-centred care practices can be difficult to attain and maintain. Consistent attention to the principles of relational and participatory practices is required[ii]. Routine collection of this data, along with reflection and action planning about how these approaches may be effectively applied in day-to-day interactions, can support efforts to achieve client-centred practice.

Self-efficacy

Self-efficacy is the belief that an individual can take control; a measure of one's own beliefs about executing a course of action to produce a desired result. These questions ask participants to indicate the extent to which they can take control of the assistance, supports and resources provided to accomplish the desired tasks. According to the work of Dunst and Trivette, as the extent to which staff deliver client-centred care increases, self-efficacy scores should also increase. Furthermore, the desired health outcomes should also improve.[ii]

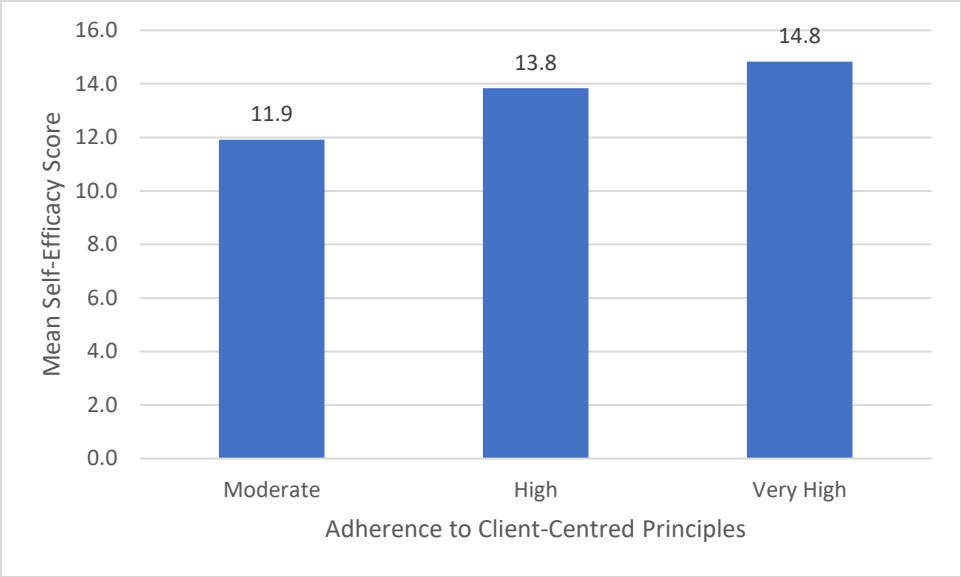
Figure 3: Percentage of indicators by rating for the self-efficacy scale (n=1181).



Interpretation Notes – Figure 3

- Figure 2 presents the percentage of indicators given different ratings on the self-efficacy scale for all participants together[ii].
- If clients feel a sense of empowerment, the largest percentages of indicators should receive the highest rating of "always true".
- Not all ratings are included on the chart due to very small percentages in the lowest ratings of "not at all true" and "rarely true." Therefore, the percentages do not add up to 100.
- Self-efficacy measures will be monitored for improvement over time.
- Individual item scores for the three self-efficacy questions are included in Appendix B.

Figure 4: Mean self-efficacy score by level of adherence to client-centred principles (n=1066)



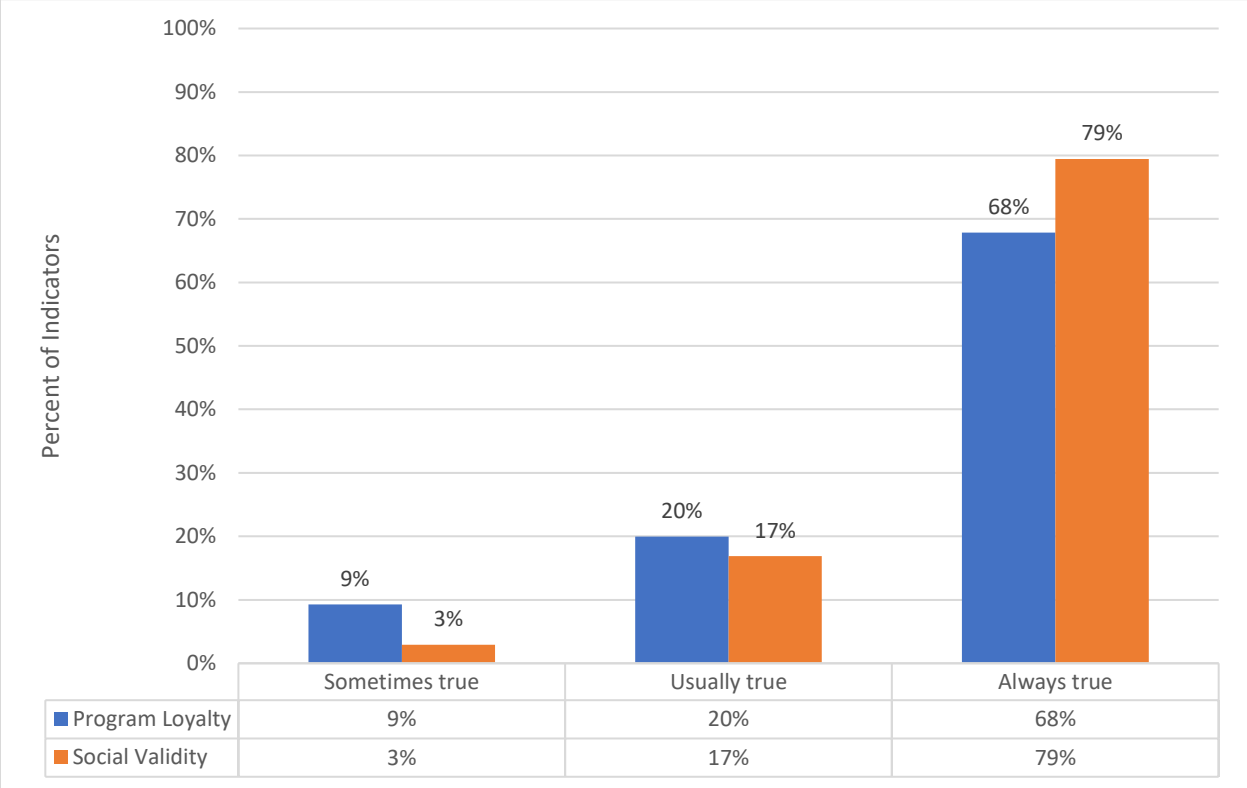
Interpretation Notes – Figure 4

- Figure 3 graphically presents the relationship between client-centred care and self-efficacy beliefs.
- In this figure, program participants were divided into different groups according to their client-centred care ratings and then the mean self-efficacy belief score for each group was calculated[ii].
- Clients in the "Very High" category scored 5 on all 10 client-centred measures, therefore having a client-centred care score of 50 (n=521). The 'High" category was every client that scored 43-49 which represents a rating of reaching the set benchmark of 85% (n=412). Clients in the moderate category scored 29-42, representing a rating below the benchmark (n=133).
- The maximum self-efficacy belief score is 15.
- According to the theory of Dunst and Trivette, the group with the highest adherence scores should have the highest self-efficacy score. This figure shows that this is indeed the case with the MLHU data. This is a simple way of checking to see if client-centred practices are influencing self-efficacy beliefs in the expected direction.
- Only clients that answered all 10 client-centred care questions were included in this analysis (n=1066).

Program Loyalty and Social Validity

Program loyalty is the degree to which clients desire interactions with the staff, have a positive attitude toward the staff, and consider the staff to be helpful when the need for support arises. Social validity is the degree to which clients feel their involvement with the organization is worthwhile. According to the work of Dunst and Trivette, as the extent to which staff deliver client-centred care increases, self-program loyalty should also increase.

Figure 5: Percentage of indicators by rating for program loyalty and social validity (n=1181).



	Sometimes true	Usually true	Always true
Program Loyalty	9%	20%	68%
Social Validity	3%	17%	79%

Interpretation Notes - Figure 4

- Figure 4 presents the percentage of indicators given different ratings on the program loyalty and social validity questions for all participants together[ii].
- If clients desire interactions with staff (program loyalty) and feel their involvement with MLHU is worthwhile (social validity), the largest percentages of indicators should receive the highest rating of “always true”.
- Not all ratings are included on the chart due to very small percentages in the lowest ratings of “not at all true” and “rarely true.” Therefore, the percentages do not add up to 100.
- Program loyalty and social validity measures will be monitored for improvement over time.
- Individual item scores for program loyalty and social validity questions are included in Appendix B.

Qualitative Comments

At the end of the survey tools, survey participants had the opportunity to provide any comments. Approximately, one-quarter of respondents provided comments, and an overwhelming majority of comments were positive. Many participants remarked on the friendly, caring and informative staff.

> *Great service. Thankful it was provided. The nurses were amazing. Very helpful.*
>
> *We really appreciated the service and staff! Professional, helpful and kind!*

There was no consistency across the few negative comments received about client experience. One participant expressed frustration in having to answer sensitive questions multiple times because staff didn't read the information provided. Another indicated the information provided was not consistent across staff members. A third participant brought attention to assumptions that can be made by some staff members.

> *'When you get married and pregnant' - question statement on behalf of public health - suggests shaming for those unmarried and pregnant. Also had no idea if I was married or not.*

In other cases, the negative comments received did not reflect the client experience, rather the client's desires for the program structure (e.g. disappointment when program cancelled, requests to expand services). There were a few suggestions for the survey tool itself including a suggestion to add a "not-applicable" option to each question.

Participant Characteristics

Survey participant characteristics are detailed in Figure 5 and Table 1 below. Table 1 presents the participant demographics including age, gender, ethnicity and place of birth across the whole sample. Figure 5 presents the length of involvement that survey participants had in their specific intervention. The length of involvement varied across the participants and this is not surprising given the varied interventions included in this survey.

Figure 5: Survey respondents' length of involvement in intervention (n=1181)

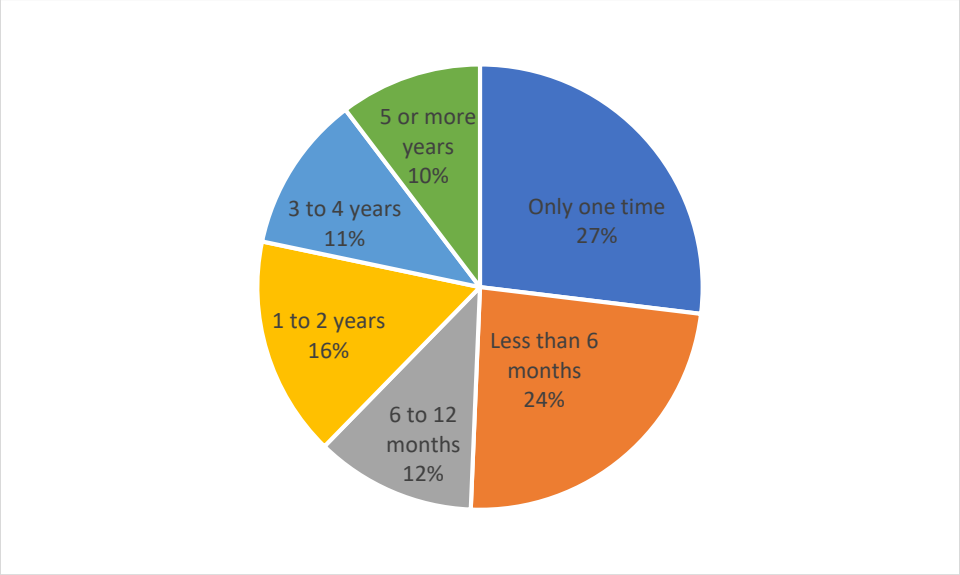


Table 1: Participant Demographics (n=1181)		
Age	Less than 20 years	7% (88)
	20 to 24 years	11% (132)
	25 to 29 years	20% (236)
	30 to 39 years	39% (455)
	40 to 49 years	12% (143)
	50 to 59 years	5% (64)
	60 or more years	1% (17)
	No Response	4% (46)
Gender	Female	71% (836)
	Male	25% (300)
	Other	1% (7)
	No Response	3% (38)
Ethnicity	Asian – East	4% (43)
	Asian – South	5% (61)
	Asian – South East	2% (20)
	Black -African	1% (14)
	Black - Caribbean	1% (14)
	Black - North American	0.5% (6)
	First Nations	4% (45)
	Metis	0.5% (6)
	Latin American	5% (62)
	Middle Eastern	7% (83)
	White European	20% (235)
	White North American	41% (480)
	Mixed Heritage	3% (34)
	Other	1% (14)
	No Response	5% (64)
Place of Birth	Born in Canada	68% (806)
	Born Outside Canada	28% (330)
	No Response	4% (45)
Years in Canada	< 5 years	26% (86)
For those Born Outside Canada	> 5 years	50% (165)
(n=330)	No response	24% (79)

Discussion

The intent of implementing the ACCCT, which monitors staff adherence to client-centred practice, with the service-seeking programs was to have a measure of client experience at MLHU. Aggregated together, our service-seeking interventions are close to achieving the established benchmark for relational practices, and more work is required to reach the benchmark for participatory practices. That said, it appears that the benchmarks established by the research of Dunst and Trivette for relational and participatory practices are fair and challenging for the service-seeking interventions at MLHU. Typically, relational practices score higher than participatory practices.[ii] Nevertheless, participatory practices are the types of capacity-building experiences that are more likely to have empowering effects for clients.[ii]

Another notable result is that adherence to client-centred practices appear to be influencing self-efficacy beliefs in the expected direction. The research of Dunst and Trivette has shown that adhering to client-centred principles impacts self-efficacy, which in turn impacts the health outcomes trying to be achieved. The higher MLHU clients rated staff adherence with client-centred principles, the higher their self-efficacy scores. Additional actions to support adherence to client-centred principles, and specifically participatory practices, by MLHU staff could improve client self-efficacy and overall health outcomes.

From this experience of implementing the ACCCT, there are additional baseline measures of program validity and social validity which can also be monitored over time. Full benefit of the results will be realized at the level of individual intervention where staff and managers can see their results and identify ways to strengthen adherence to client-centred principles and practices. Indeed, just the process of measuring and discussing the results with staff and managers can bring attention to these client-centred principles.

Limitations

There are several limitations to the data collected that may impact the final scores and interpretation of findings:

Response rate

Methods used did not allow for calculation of response rates. In team debriefings following data collection, some areas estimated that a significant number of clients declined to complete the survey (e.g. Immunization Clinic) whereas other areas indicated the response rate was very high (e.g. Home Visiting). Knowing response rates can help us understand the quality of data collected. For example, low response rates indicate there could be selection bias in the responses. The inability to calculate response rates also makes it impossible to evaluate the effectiveness of providing a five-dollar gift card as an honourarium.

Bias

In many programs, the staff members providing the service were responsible for asking clients to participate in the survey, which can result in staff consciously or unconsciously selecting which clients to ask to participate. In debriefings with staff, it was acknowledged that this selection bias was sometimes taking place. Survey implementation appeared to be more efficient and with less selection bias in settings where clinical assistants/administrative staff were responsible for distributing surveys to clients. Other types of bias may also have been present (e.g. seasonal bias, social desirability bias). The bias introduced into this sample likely elevates the client-centred scores.

Question wording

The question "How often do you use this program/ service?" experienced a high percentage of "other" responses that were difficult to categorize. As a result, this question was eliminated from the analysis. In our debriefings with staff following data collection, this same question was highlighted as difficult to answer given the episodic nature of many of the programs.

Next Steps and Recommendations for Future Data Collection:

At this stage, managers and staff will be reviewing results and developing action plans for their specific areas, with the support of the Community Health Nursing Specialist. Action plans will be developed collaboratively, and managers and directors will be responsible for ensuring action plan implementation. It is challenging to institutionalize program practices related to client-centred principles as there are many factors that can disrupt staff intentions including new staff members, setting changes, new knowledge, and changes to policy.[ii] It is suggested that planned actions increase staff attention to these principles.[ii]

Routine collection of this data ensures there is a match between perceived and actual client-centred service delivery and allows for timely actions to be organized.[ii] In recognition of the value in routine data collection and monitoring to bring attention to client-centred practices, recommendations for future data collection are outlined below.

Recommendation 1: Move towards intervention reporting

The results from the survey are most useful to staff and managers at the intervention level. When results for a division or program area with multiple interventions are combined, intervention staff are unable to directly determine how clients perceive their services. There are privacy concerns in programs with a small number of staff members, but it is hoped that overtime, staff members will recognize the value in this tool monitoring their adherence to client-centred practices.

Recommendation 2: Develop a more consistent process to implement the survey

There was significant variation in how surveys were implemented creating opportunities for selection bias, delays in data collection and inability to calculate response rates. Debriefings with staff also suggested that the data collection process can be made more efficient with reduced confusion by selection of one type of survey method. Opportunities to facilitate routine data collection should be explored (e.g. random selection of participants from electronic client record, increased involvement of administrative staff and decreased involvement of service delivery staff) that can decrease selection bias and ensure response rates can be calculated.

Recommendation 3: Revisit sample size and quotas

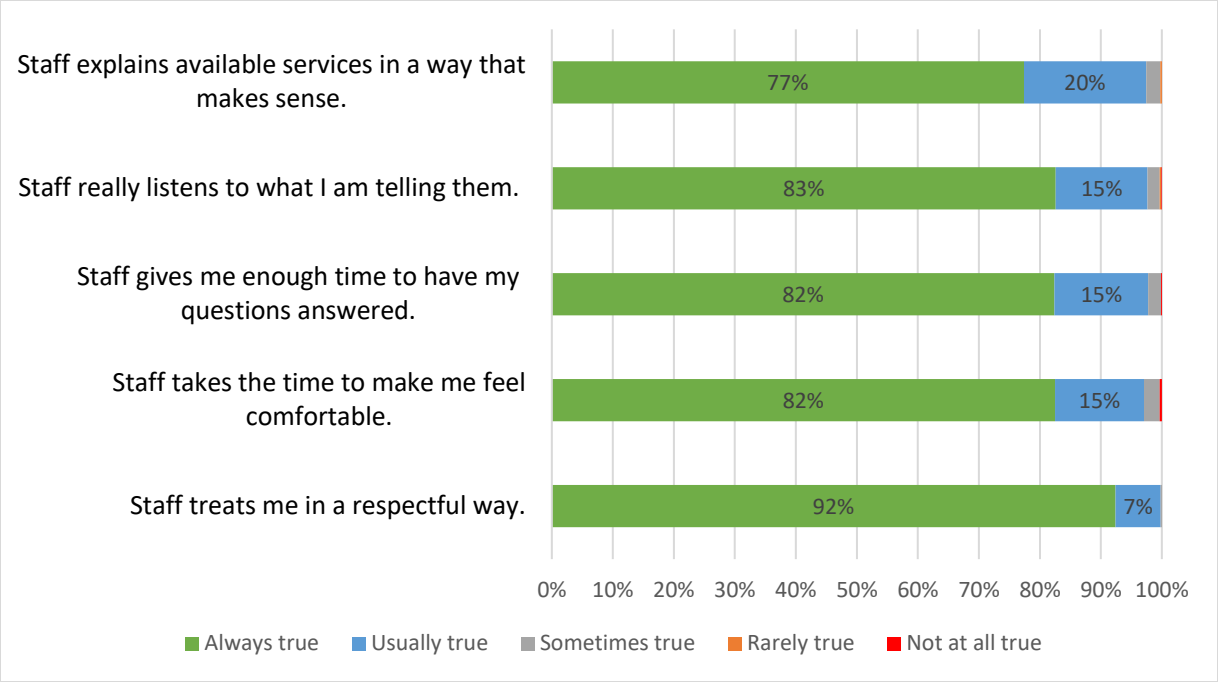
The sample size calculations for program/intervention reporting should be based on the actual number of clients seen by that program over a specified period (e.g. one year). This will require client population estimates and sample size calculations to be completed for each individual intervention.

Appendix A

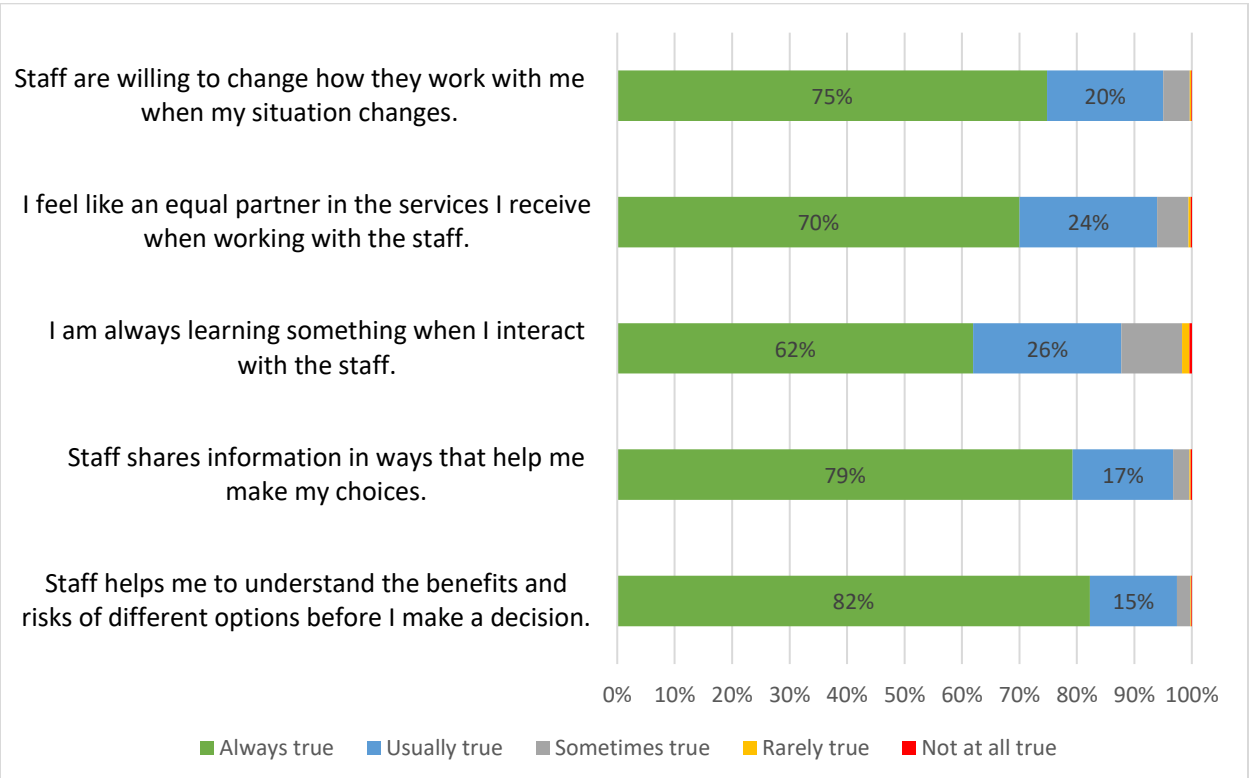
Adherence to client-centred practices

Below are charts with the individual item scores for both relational and participatory practices.

Relational Practices



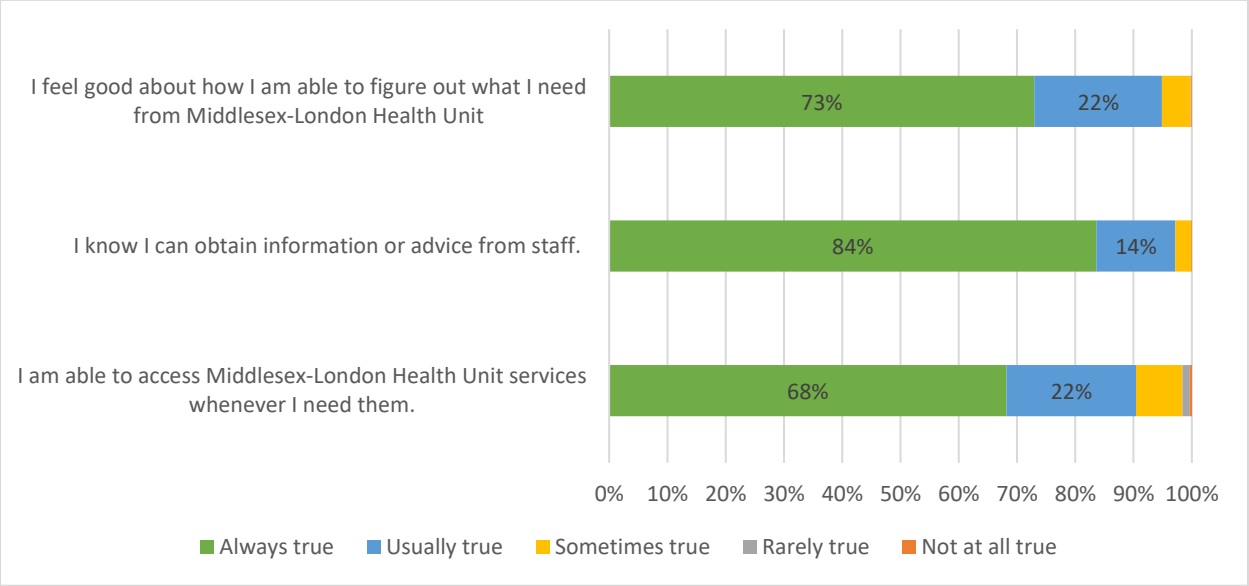
Participatory Practices



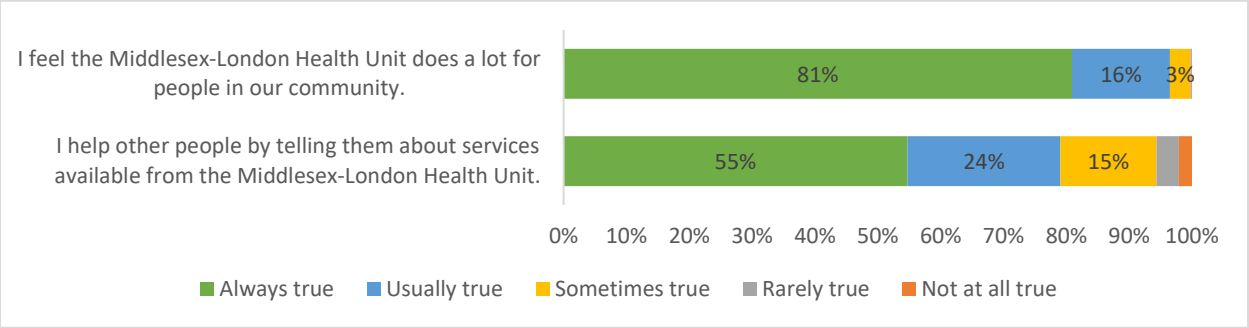
Appendix B

Below are charts with the individual item scores for self-efficacy, program loyalty and social validity

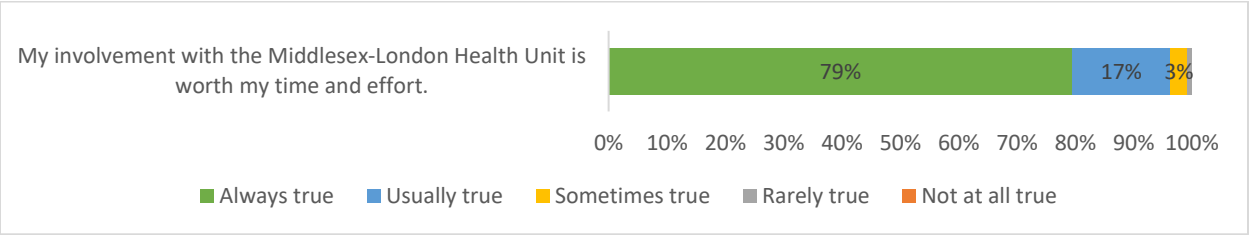
Self-efficacy



Program Loyalty



Social Validity



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References

[i] Boston, S., Zimmerman, G., Trivette, C. M., & Dunst, C. J. (2013). Algoma Client-Centred Care Tool: An evaluation scale for assessing staff use of client-centred practices. *Practical Evaluation Reports*, *5*(2), 1-12.

[ii] Dunst, C.J., & Trivette, C.M. (2005). Measuring and Evaluating Family Support Program Quality. Winterberry Press Monograph Series. Asheville, NC: Winterberry Press.

[iii] Dunst, C.J., Trivette, C.M., & Hamby, D.W. (2006). Family Support Program Quality and Parent, Family and Child Benefits. Winterberry Press Monograph Series. Asheville, NC: Winterberry Press.