



Universiteit  
Leiden  
The Netherlands

## **Patient satisfaction in innovating integrated care for older persons : towards care with personal value**

Poot, A.J.

### **Citation**

Poot, A. J. (2018, September 11). *Patient satisfaction in innovating integrated care for older persons : towards care with personal value*. Retrieved from <https://hdl.handle.net/1887/65501>

Version: Not Applicable (or Unknown)

License: [Licence agreement concerning inclusion of doctoral thesis in the Institutional Repository of the University of Leiden](#)

Downloaded from: <https://hdl.handle.net/1887/65501>

**Note:** To cite this publication please use the final published version (if applicable).

Cover Page



Universiteit Leiden



The handle <http://hdl.handle.net/1887/65501> holds various files of this Leiden University dissertation.

**Author:** Poot, A.J.

**Title:** Patient satisfaction in innovating integrated care for older persons : towards care with personal value

**Issue Date:** 2018-09-11



# Chapter 3

Changes in patient satisfaction related to their perceived health state during implementation of improved integrated care for older persons.

Antonius J. Poot<sup>1</sup>, Daisy M. Wopereis<sup>1</sup>, Wendy P.J. den Elzen<sup>1</sup>, Jacobijn Gussekloo<sup>1</sup>, Jeanet W. Blom<sup>1</sup>.

<sup>1</sup> Department of Public Health and Primary Care, Leiden University Medical Center, Leiden, The Netherlands.

*Submitted*



## **ABSTRACT**

### **Background**

Patient satisfaction with the general practitioner (GP) is lower in older persons with a higher level of complexity of health problems. This study investigates whether, in these older persons, changes in satisfaction with their GP, on receiving improved integrated care, is related to their perceived health state.

### **Methods and Findings**

Using the Integrated Systematic Care for Older People (ISCOPE) trial (aimed at improving person- centered integrated care) this study compared changes in satisfaction with the GP in older persons (aged  $\geq 75$  years) with a high level of complex health problems on receiving integrated care, stratified for perceived health state at baseline. Satisfaction with the GP was registered on a 5-point Likert scale. Perceived health state was estimated with the Older Persons and Informal Caregivers Survey-Composite End Point (TOPICS-CEP) at baseline, stratified into 33% percentiles. Differences in satisfaction change between the intervention and usual care/control groups (overall and stratified for perceived health state) are presented by percentages of 'very satisfied' participants and improving or deteriorating 1 or more points on the Likert scale.

At baseline, the intervention (n=151) and control group (n=603) were mainly female (75%) and living alone (62%); mean age was 83 years. Medical status, perceived health state and characteristics of participants were similar. Overall, satisfaction changes showed no significant difference between the intervention and control group during implementation (difference in % 'very satisfied' -4.5%,  $p=0.20$ ); after stratification for TOPICS-CEP the results were the same.

### **Conclusion**

In older persons with a high level of complexity of health problems, implementation of person- centered integrated healthcare did not influence their satisfaction with the GP, also not among those with the highest or lowest perceived health state.



## INTRODUCTION

Integrated and patient-centered care can be defined as: the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money. (19) This type of care is considered necessary and advantageous for patients with complex care needs. (2, 4, 10, 36) This applies particularly to older patients because of the higher level of complexity of their care needs, and their increasing absolute numbers and proportion in the general population. (19) Despite that the evidence concerning the (cost) effectiveness of integrated and person-centered care interventions remains unclear, there is strong consensus about the need for implementation amongst care providers and policymakers. (9, 20, 26)

In its 2006 policy paper on Integrated Care, the World Health Organization observed that the various stakeholders have different expectations of integrated care. In particular, patients expect integrated care to be seamless, smooth and easy to navigate. (19) Patient satisfaction is a complicated concept which partly reflects the realisation of these expectations. (21, 23, 37). In addition, satisfaction is influenced by patient characteristics such as age and gender, and also reflects communicative provider skills more than care characteristics or quality. (31, 38, 39)

Despite reservations concerning the meaning of patient satisfaction, it is argued that only the patient can determine whether his/her needs and expectations have been met. (20, 27) Therefore, no doubt exists about the relevance of perceptions and satisfaction of patients for the design and delivery of integrated care. (1, 9, 40, 41)

Our earlier study showed that, in older persons, patient *dissatisfaction* with general practitioner (GP) care increased with the complexity of health problems independently of age, gender and morbidity. (39) This raised the question whether the decreased satisfaction level was related more to the experienced health state of the patients themselves, or to the failure of the integration and patient-centeredness of the provided care to meet the expectations of this category of patients.

This study aims to address this question by investigating changes in the satisfaction of older patients during implementation of integrated and person-centered care in relation to their perceived health state. For this, we compared changes in general satisfaction with GP care between two groups of patients aged  $\geq 75$  years with a high level of complexity of care needs at baseline and at 12-month follow-up. One group received improved integrated and patient-centered care and another group received usual care. The analyses were stratified according to the perceived health state of the patients.

## METHODS

### Study design and participants

This study is embedded in the Integrated Systematic Care for Older People (ISCOPE) study. The Medical Ethical Committee of the Leiden University Medical Center approved the study. The study was registered in the Netherlands Trial Register (NTR1946).

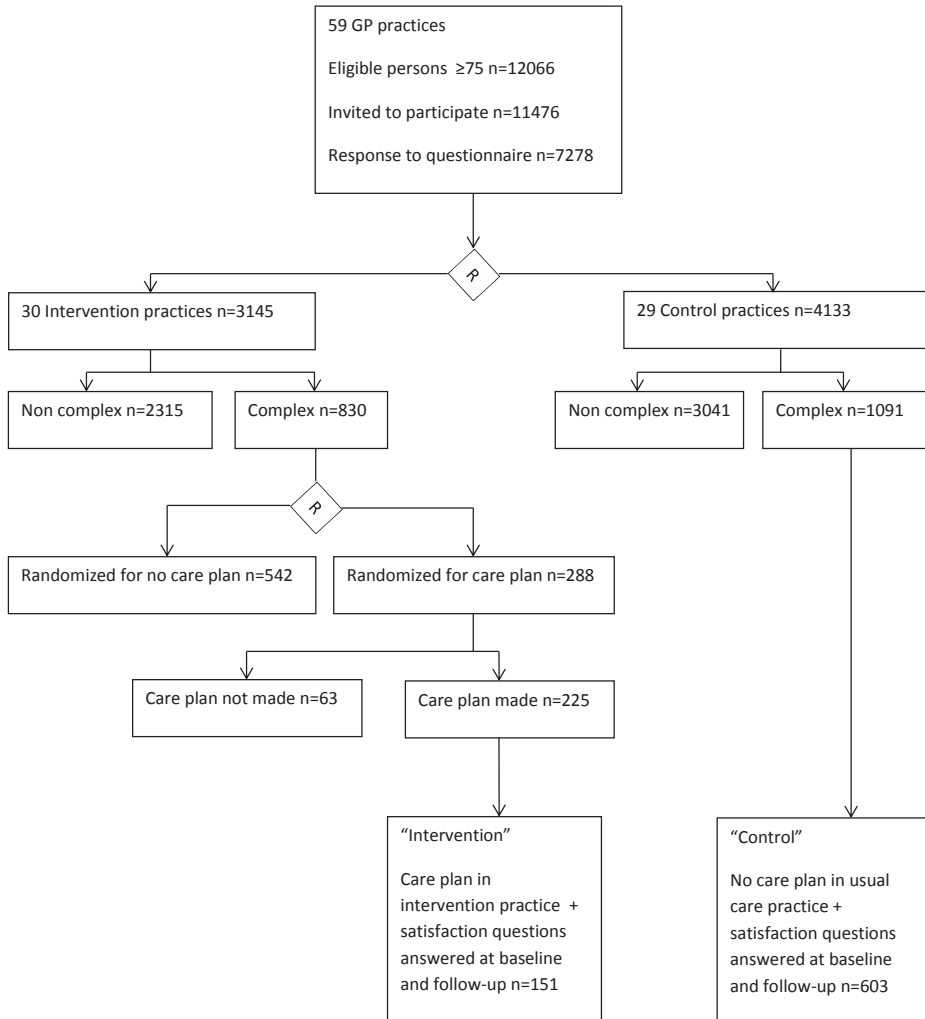
The ISCOPE study is a cluster randomized trial in which all persons aged  $\geq 75$  years in 59 general practices received a structured postal questionnaire with 21 questions on four health domains (functional, somatic, mental, social). (35) The 59 practices were randomized into 30 intervention and 29 control practices. In each of the intervention practices 10 patients with health problems in 3 or 4 domains were randomly selected in order to make a care plan.

For the present study, the intervention group included all respondents to the postal questionnaire with health problems in 3 and 4 domains who: i) received a care plan, ii) answered the satisfaction questions, and iii) for whom a perceived health state score could be calculated. The usual care (control) group included respondents to the postal questionnaire with health problems in 3 and 4 domains who: i) received usual care in a control practice, ii) answered the satisfaction questions, and iii) for whom a perceived health state score could be calculated (Fig. 1).

### Intervention

In the intervention practices, the GPs and practice nurses received training in making and performing a person-centered and integrated care plan for patients with complex problems. This 8-h training included: i) accessing and using resources, and ii) organizing person-centered, proactive, multidisciplinary care for older persons in primary care. In the intervention practices the GP or practice nurse made a care plan for a maximum of 10 randomly chosen patients with problems in 3 or 4 domains (Fig. 1).

The care plan process was started by the GP or practice nurse making an inventory of the problems experienced by the older person in the somatic, activities of daily living (ADL), as well as in social, psychological and communicative areas. The wishes and expectations of the older person about goals to be achieved were explored in a dialogue with the participant and their informal caregiver(s). Actions, evaluation items and moments were formulated based on this dialogue. Other care professionals were involved when suggested by the care plan. During the intervention, the GPs had the possibility to consult another GP with special post-graduate training in geriatric care in general practice. Patients in the intervention practices who received a care plan were compared with patients with similar complexity (i.e. problems in 3 or 4 domains) who received usual care in the control practices.



**Figure 1.** Flow chart

### Outcomes and follow-up

At baseline and at 1-year follow-up, participants were visited by a research nurse to measure characteristics and outcomes. These included demographics, healthcare utilization, morbidities, functional limitations, emotional wellbeing, pain experience, cognitive problems, social functioning, self-perceived health, self-perceived quality of life (QOL), and satisfaction with their care providers.

Satisfaction with GP care was measured by asking: *'How satisfied or dissatisfied are you about your GP practice?'* Responses were recorded on a 5-point Likert scale ranging from 'very satisfied', 'satisfied', 'neutral', 'dissatisfied' to 'very dissatisfied'. We chose to express the aggregated satisfaction response as the percentage 'very satisfied' and the percentage rising/



decreasing at least one category rather than a mean score, since the choice 'very satisfied' is the most meaningful and there is little effect size variation in the mean Likert score. (22, 25)

Experienced health state was quantified at baseline using the TOPICS-MDS CEP. This measure was developed as a combined end point (CEP) of **The Older Persons and Informal Caregivers Survey Minimal Data Set** (TOPICS-MDS) for the studies within the Dutch National Care for the Elderly Program, of which the ISCOPE study was part.(42, 43) The TOPICS-MDS CEP is an individual aggregation of the outcomes of all the used instruments indicating health and wellbeing, with a preference weight arrived at through a vignette study with a panel of older persons and informal caregivers.(44) For this, the instruments used are morbidity, functional limitations, emotional wellbeing, pain experience, cognitive functioning, self-perceived health and self-perceived QoL. It has been validated as a measure for evaluation of health state by older persons in various settings .(45) We used the TOPICS-CEP syntax to calculate the score for the individual participants in the ISCOPE intervention and control groups at baseline. The TOPICS-MDS CEP gives a score for perceived health state, ranging from 0 (worst possible perceived health state) to 10 (best possible perceived health state).

## STATISTICAL ANALYSIS

To characterize and compare the intervention and control groups at baseline the following were calculated: i) median age, ii) number of diseases, and iii) percentage of participants who were female, living alone and had completed a higher education. Also, median scores for the Groningen Activities Restriction Scale (GARS) and Mini-mental State Examination (MMSE) were calculated.

We defined two outcome measures as an expression of the change in satisfaction: i.e. we calculated between baseline and follow-up: 1) the change in percentage of participants who reported being 'very satisfied', and 2) the proportion of participants who showed an increase or decrease of 1 or more points on the Likert scale. The changes in satisfaction were compared between the intervention and usual care group, stratified for TOPICS-CEP; this was performed in three strata, each representing a third of the total group (i.e. low, middle and high TOPICS-CEP).

Differences between the groups were tested with a chi-square test for dichotomous variables and with a t-test or Mann-Witney U-test for continuous variables.

Analysis of the difference in overall satisfaction scores of the intervention and usual care groups at the follow-up measurement was adjusted for age, sex and clustering by practice using generalized estimating equation (for dichotomous outcomes) and linear mixed models for continuous outcomes. Values were calculated for the intervention and usual care groups, overall and per stratum of TOPICS-CEP.

## RESULTS

Sociodemographic, functional and medical characteristics, as well as perceived health state and satisfaction for the intervention and control group are presented in Table 1. Of all patients, 75% were female and 62% were living alone. Slightly more participants in the intervention group had completed a higher education (70.2% vs 61.0%  $p=0.05$ ) and the intervention group was younger than the control group (82.1 vs 83.2;  $p=0.04$ ). The groups showed no differences in gender, living situation, multi-morbidity, activity restriction and cognitive impairment. The perceived health state at baseline quantified by TOPICS-CEP showed no significant difference between the intervention and control group (both scoring between 6 and 7). Differences in the distribution over the five satisfaction categories were not significant ( $p=0.08$ ).

Changes of satisfaction (expressed in differences of % 'very satisfied') between the intervention and control group are shown in Table 2. Overall, at baseline 44.4% of respon-

**Table 1.** Sociodemographic, functional, medical characteristics, perceived health state and satisfaction of the participants at baseline for the intervention and control group.

	Intervention group n= 151	Control group n= 603	P
Age in years: median (IQR)	82.1 (78.5-85.8)	83.2 (79.5-87.2)	0.04
Gender (female) n (%)	112 (74.2)	452 (75.0)	0.84
Living alone n (%)	94 (62.3)	380 (61.5)	0.94
Higher education* n (%)	106 (70.2)	368 (61.0)	0.05
Multi-morbidity** median (IQR)	4.0 (3.0-5.0)	4.0 (3.0-6.0)	0.37
Activity restriction, <b>GARS</b> score: median (IQR)	33 (27-43.3)	35 (28-43.3)	0.21
Cognitive impairment, <b>MMSE</b> score: median (IQR)	28 (26-29)	28 (26-29)	0.89
Perceived health state, <b>TOPICS-CEP</b> score, 0=poor, 10=good: mean (SD)	6.79 (1.21)	6.66 (1.12)	0.13
Satisfaction with GP practice n (%)			
Very satisfied	676 (44.4)	193 (32.0)	0.08
Satisfied	66 (43.7)	311 (51.6)	
Neutral	13 (8.6)	71 (11.4)	
Dissatisfied	4 (2.6)	25 (4.1)	
Very dissatisfied	1 (0.7)	5 (0.8)	

\*Completed practical training/secondary vocational education/pre-university education/university or higher professional education.

\*\* Number of diseases/ailments

**GARS:** Groningen Activities Restriction Scale minimum of 18 and maximum of 72, with higher scores indicating greater limitation

**MMSE:** Mini-mental State Examination, maximum of 30 indicates no cognitive impairment and a score below 24 is considered indicative of dementia.

**TOPICS-CEP:** The Older Persons and Informal Caregivers Survey Composite End Point

dents in the intervention group were 'very satisfied' compared with 37.1% at follow-up, resulting in a difference of -7.3%. In the control group the difference was -2.8%, resulting in a difference in change of -4.5% (p-value 0.20, 95% CI -8.5;0.5). For the low, middle and high strata of TOPICS-CEP, the difference in change between the intervention and usual care group was -7.2% (p=0.16, 95% CI -14.8;0.4), -10% (p=0.99, 95% CI -19.0;-1.0) and +3.5%, respectively (p=0.24, 95% CI -1.4;8.4).

Similarly, the changes in satisfaction from baseline to follow-up between the intervention and control group are shown in Table 3; expressed as the percentage of respondents with a 1 or more point improvement or deterioration on the Likert scale. Overall, 27% of the intervention group improved 1 category or more in satisfaction vs. 25% in the control group (p=0.52); a deterioration of 1 category or more occurred in 17% vs. 20% (p=0.38), respectively. Similarly, in the low TOPICS CEP stratum, satisfaction improved in 26% in the intervention group vs. in 29% in the control group (p=0.93), and deterioration in 21% vs. in 22%, respectively (p=0.94). In the middle stratum, improvement was in 28% vs. in 23% (p=0.38), and deterioration in 13% vs. in 21% (p=0.18), respectively; and in the high stratum, improvement was in 25% vs. in 24% (p=0.96), and deterioration in 19% vs. in 18% (p=0.83), respectively.

**Table 2.** Changes in satisfaction about GP care over 1-year follow-up during implementation of integrated care in the intervention group compared to control (usual care) group, overall and stratified according to perceived health state (Older Persons and Informal Caregivers Survey Composite End Point; TOPICS-CEP). Respondents with Likert scale option 'very satisfied' about the GP practice.

	Intervention group			Control group			Difference in change between intervention and usual care	
	n=151			n=603			difference	p*
	Baseline	Follow-up	change	Baseline	Follow-up	change		
Overall								
Very satisfied n(%)	67 (44.4)	56 (37.1)	-7.3	193 (32.0)	176 (29.2)	-2.8	-4.5 (-8.5;0.5) <sup>#</sup>	0.20
TOPICS CEP strata								
Low 33%	16 (42.1)	13 (34.2)	-7.9	49 (25.8)	46 (24.2)	-0.7	-7.2 (-14.8;0.4) <sup>#</sup>	0.16
Middle 33%	29 (47.5)	22 (36.1)	-11.4	74 (34.9)	71 (33.5)	-1.4	-10.0 (-19.0;-1.0) <sup>#</sup>	0.99
High 33%	22 (42.3)	21 (40.4)	-1.9	70 (34.8)	59 (29.4)	-5.4	+3.5 (-1.4;8.4) <sup>#</sup>	0.24

\* GEE, corrected for baseline age, gender and cluster

<sup>#</sup> 95% Confidence Interval

**Table 3.** Changes in satisfaction about GP care over 1-year follow-up during implementation of integrated care in the intervention group compared to usual care (control), depending on perceived health state (Older Persons and Informal Caregivers Survey Composite End Point; TOPICS-CEP). Respondents with satisfaction improvement, deterioration or unchanged (on the Likert scale: 1 point or more increase, decrease or unchanged).

	TOPICS CEP strata										
	Overall		Low 33%			Middle 33%			High 33%		p
	Interv	Contr	Interv	Contr	P	Interv	Contr	Interv	Contr		
	n=151	n=603	n=38	n=19	n=61	n=21	n=52	n=201			
Improvement (>= 1 category increase) n(%)	40 (27)	153 (25)	10 (26)	55 (29)	17 (28)	49 (23)	13 (25)	49 (24)	0.52	0.96	
No change, n (%)	85 (56)	329 (55)	20 (53)	94 (50)	36 (59)	119 (56)	29 (56)	116 (58)	0.90	0.80	
Deterioration (<=-1 category decrease) n(%)	26 (17)	121 (20)	8 (21)	41 (22)	8 (13)	44 (21)	10 (19)	36 (18)	0.38	0.83	

Measured on Likert scale,

Interv = intervention

Contr = control (usual care)

## DISCUSSION

In this population of older persons with a high level of complexity of health problems, the satisfaction level did not differ after implementing person-centered integrated care as compared to usual care. Also, no relation was found between the levels of perceived health state and changes in satisfaction after implementation.

Not finding a marked effect on patient satisfaction after an intervention aimed at integrating and improving person-centered care for older persons is consistent with other studies. (28, 35, 38, 46) On the other hand, a relationship has been reported before between patient and care provider characteristics, and patient satisfaction. (29, 31) Particularly the interpersonal aspects of the care provider-patient interaction were found to be significant in relation to patient satisfaction. (47-49) However, we found no studies that further investigated the relation between the complexity of health problems, the perceived health state, and the satisfaction with care in older patients.

An earlier cross-sectional study found that the chance of *dissatisfaction* with the provided care increased with rising complexity of health problems. (39) However, the question remains whether this decreasing level of satisfaction was related mainly to the complexity of the health problems itself, or was also influenced by the perception of health state. In the aim to unravel this association, the present study focused on the perceived health state in older persons with a high level of complex problems. As expected, based on our earlier studies and literature, we found no significant effect on satisfaction after a change in the organization of care. Our finding that the various levels of perceived health state introduced no clear difference in change of satisfaction in the intervention vs. control group suggests that this is not an important modifier of patient satisfaction.

When regarding patient satisfaction as an indication of the fit of provided care, it should be taken into account that the level of complexity of health problems of the population influences patient satisfaction, and not the perceived health state. Therefore, the earlier found decreasing satisfaction with increasing complexity of health problems is more likely to be an indication of a patient-need versus care-organization discrepancy than of a negative state of mind of the patient.

### Strengths

A strength of this study is that it provides a quantitative impression of the development of satisfaction in real-life implementation of person-centered integrated primary care. The trial design accommodates the reality of implementing improved care next to usual care.

The study also offers extensive in-depth data on the health state of the specific group of older persons with complex care needs; by using the TOPICS-CEP all these data have

been combined and used. The TOPICS-CEP was developed and validated as an instrument to evaluate the quality of care for older persons and has since been validated for the concept 'perceived health state' in various populations. Being an aggregation of a number of clinical, functional and psychological study-instrument outcomes it has an area of overlap with concepts such as 'care need complexity', 'multi-morbidity' and 'frailty'. (50) However, being weighted by patient and informal caregiver preferences, with general wellbeing as a reference, it distinguishes itself from these other concepts. From a clinical viewpoint, we think that it provides a useful measure.

### **Limitations**

This study was performed in a population of older persons with self-reported problems in 3 and 4 out of 4 health domains. Therefore, it is a selected population of older persons with a high level of complexity of health problems with a decreased variation in experienced health state compared to the total population. Therefore, caution is required when generalizing these data to a population of older persons with a greater variation in level of complexity of health problems, as a greater variation in experienced health state may influence satisfaction to a differing extent.

The intervention of training GPs and practice nurses in making and performing person centred, proactive, multidisciplinary care can be seen as a step towards fully integrated care. There is however no measure for the degree of integration of care achieved. An assumption is therefore that a meaningful level of contrast in integration between intervention and control group was achieved. Differences in perceptions of the provided care in GPs between the two groups in the ISCOPE study suggests this assumption is legitimate.(35)

As the intervention group was younger and better educated than the control group at baseline some inclusion bias could have occurred. This possible bias was corrected for by not comparing the actual satisfaction levels, but the changes within the intervention and control group.

The Likert scale is widely used in the evaluation of patient satisfaction. However, quantifying change using Likert data can be done in various ways. Due to the predominance of the middle options around 'neutral' and 'satisfied', the mean or median scores show little variation. As 'very satisfied' can be considered a meaningful expression of patient satisfaction, we used the percentage of respondents choosing this option as a measure of satisfaction level. To compensate for this limitation, we used an increase and decrease of at least 1 point on the Likert scale as an alternative.



## **CONCLUSION AND IMPLICATIONS**

We conclude that in these older persons with a high level of complexity of health problems, the satisfaction of GP care does not change during implementation of improved person-centered integrated care. In this relationship, the perceived health state does not act as an additional modifier. Therefore, the absence of a change in satisfaction must be seen more in relation to the expected and experienced care by the older persons than to their perceived state of health.

## REFERENCES

1. Schrijvers G. *Integrated Care - Better and Cheaper*. Sutton, Surrey, UK: Reed Business Information; 2016. 292 p.
2. Christensen K, Doblhammer G, Rau R, Vaupel JW. Ageing populations: the challenges ahead. *Lancet*. 2009;374(9696):1196-208.
3. Gilburt H. Supporting integration through new roles and working across boundaries. The King's Fund [Internet]. 2016. Available from: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Supporting\\_integration\\_web.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Supporting_integration_web.pdf).
4. Callahan CM. Controversies Regarding Comprehensive Chronic Care: Coordinated Care: The Drug-Free Wonder Drug. *J Am Geriatr Soc*. 2015;63(9):1938-40.
5. Greaves F, Pappas Y, Bardsley M, Harris M, Curry N, Holder H, et al. Evaluation of complex integrated care programmes: the approach in North West London. *Int J Integr Care*. 2013;13:e006.
6. Harris M, Greaves F, Patterson S, Jones J, Pappas Y, Majeed A, et al. The North West London Integrated Care Pilot: innovative strategies to improve care coordination for older adults and people with diabetes. *J Ambul Care Manage*. 2012;35(3):216-25.
7. Oliver D, Foot C, Humphries R. Making our health and care systems fit for an ageing population. The King's Fund [Internet]. 2014. Available from: <http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population>.
8. Porter ME, Pabo EA, Lee TH. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff (Millwood)*. 2013;32(3):516-25.
9. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health affairs (Project Hope)*. 2008;27(3):759-69.
10. Wise J. Services for older people need major change, says report. *BMJ*. 2014;348:g1994.
11. Bastiaens H, Van RP, Pavlic DR, Raposo V, Baker R. Older people's preferences for involvement in their own care: a qualitative study in primary health care in 11 European countries. *Patient Educ Couns*. 2007;68(1):33-42.
12. al-Bashir MM, Armstrong D. Preferences of healthy and ill patients for style of general practitioner care: implications for workload and financial incentives under the new contract. *Br J Gen Pract*. 1991;41(342):6-8.
13. Nelson KM, Helfrich C, Sun H, Hebert PL, Liu CF, Dolan E, et al. Implementation of the patient-centered medical home in the Veterans Health Administration: associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. *JAMA Intern Med*. 2014;174(8):1350-8.
14. NHG-Standpunt Kernwaarden huisartsgeneeskunde: generalistisch, persoonsgericht en continu. Vastgesteld in de Algemene Ledenvergadering van het NHG op 9 juni 2011, (2011).
15. Moller H, Gildea C, Meechan D, Rubin G, Round T, Vedsted P. Use of the English urgent referral pathway for suspected cancer and mortality in patients with cancer: cohort study. *Bmj*. 2015;351:h5102.
16. Epstein RS, Sherwood LM. From outcomes research to disease management: a guide for the perplexed. *Annals of internal medicine*. 1996;124(9):832-7.
17. Sands KE. Patient-centred care: confessions of a pragmatist. *BMJ Qual Saf*. 2016.
18. Wright OR, Connelly LB, Capra S, Hendrikz J. Determinants of foodservice satisfaction for patients in geriatrics/rehabilitation and residents in residential aged care. *Health expectations : an international journal of public participation in health care and health policy*. 2013;16(3):251-65.
19. Waddington C, Egger D. *Integrated Health Services - What and why?* WHO [Internet]. 2008. Available from: [http://www.who.int/healthsystems/technical\\_brief\\_final.pdf](http://www.who.int/healthsystems/technical_brief_final.pdf).

20. UK Doh. Liberating the NHS: No decision about me, without me 2014 [updated 2014. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf).
21. Williams B. Patient satisfaction: a valid concept? *Soc Sci Med.* 1994;38(4):509-16.
22. Pascoe GC. Patient satisfaction in primary health care: a literature review and analysis. *Eval Program Plann.* 1983;6(3-4):185-210.
23. Sitzia J, Wood N. Patient satisfaction: a review of issues and concepts. *Soc Sci Med.* 1997;45(12):1829-43.
24. Coulter A, Collins A. Making shared decision-making a reality. No decision about me, without me. The King's Fund [Internet]. 2016. Available from: [http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf).
25. Collins K, O'Cathain A. The continuum of patient satisfaction—from satisfied to very satisfied. *Soc Sci Med.* 2003;57(12):2465-70.
26. C H, N W. Making integrated care happen at scale and pace: lessons from experience. London: The King's Fund 2013 [updated 2013. Available from: <http://www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace>.
27. Jaques H. Putting patients at the heart of quality. *BMJ.* 2012;344:e3164.
28. Chang JT, Hays RD, Shekelle PG, MacLean CH, Solomon DH, Reuben DB, et al. Patients' global ratings of their health care are not associated with the technical quality of their care. *Ann Intern Med.* 2006;144(9):665-72.
29. Heje HN, Vedsted P, Sokolowski I, Olesen F. Patient characteristics associated with differences in patients' evaluation of their general practitioner. *BMC Health Serv Res.* 2008;8:178.
30. Hall JA, Dornan MC. Patient sociodemographic characteristics as predictors of satisfaction with medical care: a meta-analysis. *Soc Sci Med.* 1990;30(7):811-8.
31. Salisbury C, Wallace M, Montgomery AA. Patients' experience and satisfaction in primary care: secondary analysis using multilevel modelling. *BMJ.* 2010;341:c5004.
32. Haggerty JL. Are measures of patient satisfaction hopelessly flawed? *BMJ.* 2010;341:c4783.
33. van Houwelingen AH, den Elzen WP, le Cessie S, Blom JW, Gussekloo J. Consequences of interaction of functional, somatic, mental and social problems in community-dwelling older people. *PLoS one.* 2015;10(4):e0121013.
34. P P. Crossing the quality chasm: a new health system for the 21st century. Redesigning health care with insights from the science of complex adaptive systems: Institute of Medicine;; 2001.
35. Blom J, den Elzen WP, van Houwelingen AH, Heijmans M, Stijnen T, Van den Hout W, et al. Effectiveness and cost-effectiveness of a proactive, goal-oriented, integrated care model in general practice for older people. A cluster randomised controlled trial: Integrated Systematic Care for older People—the ISCOPE study. *Age Ageing.* 2016;45(1):30-41.
36. James Lloyd SW. Integrated care. A guide for policy makers 2016 [updated 2016 14 June 2016. Available from: [http://www.ilcuk.org.uk/images/uploads/publication-pdfs/pdf\\_pdf\\_7.pdf](http://www.ilcuk.org.uk/images/uploads/publication-pdfs/pdf_pdf_7.pdf).
37. Williams B, Coyle J, Healy D. The meaning of patient satisfaction: an explanation of high reported levels. *Soc Sci Med.* 1998;47(9):1351-9.
38. Kupfer JM, Bond EU. Patient satisfaction and patient-centered care: necessary but not equal. *JAMA.* 2012;308(2):139-40.
39. Poot AJ, den Elzen WP, Blom JW, Gussekloo J. Level of satisfaction of older persons with their general practitioner and practice: role of complexity of health problems. *PLoS One.* 2014;9(4):e94326.
40. Berwick DM. What 'patient-centered' should mean: confessions of an extremist. *Health Aff (Millwood).* 2009;28(4):w555-w65.

41. Reckrey JM, Soriano TA, Hernandez CR, DeCherrie LV, Chavez S, Zhang M, et al. The team approach to home-based primary care: restructuring care to meet individual, program, and system needs. *J Am Geriatr Soc.* 2015;63(2):358-64.
42. Hofman CS, Makai P, Boter H, Buurman BM, de Craen AJ, Olde Rikkert MG, et al. Establishing a composite endpoint for measuring the effectiveness of geriatric interventions based on older persons' and informal caregivers' preference weights: a vignette study. *BMC Geriatr.* 2014;14:51.
43. The National Care for the Elderly Programme. The National Care for the Elderly Programme [Internet]. 2014 3/17/2015. Available from: <http://www.nationaalprogrammaouderenzorg.nl/english/the-national-care-for-the-elderly-programme/>.
44. Hofman CS, Makai P, Blom JW, Boter H, Buurman BM, Olde Rikkert MG, et al. Comparing the health state preferences of older persons, informal caregivers and healthcare professionals: a vignette study. *PloS one.* 2015;10(3):e0119197.
45. Hofman CS, Lutomski JE, Boter H, Buurman BM, de Craen AJ, Donders R, et al. Examining the construct and known-group validity of a composite endpoint for The Older Persons and Informal Caregivers Survey Minimum Data Set (TOPICS-MDS); A large-scale data sharing initiative. *PloS one.* 2017;12(3):e0173081.
46. Metzelthin SF, van RE, de Witte LP, Ambergen AW, Hobma SO, Sipers W, et al. Effectiveness of interdisciplinary primary care approach to reduce disability in community dwelling frail older people: cluster randomised controlled trial. *BMJ.* 2013;347:f5264.
47. Berkelmans PG, Berendsen AJ, Verhaak PF, van der Meer K. Characteristics of general practice care: what do senior citizens value? A qualitative study. *BMC Geriatr.* 2010;10:80.
48. Bowling A, Rowe G, McKee M. Patients' experiences of their healthcare in relation to their expectations and satisfaction: a population survey. *J R Soc Med.* 2013;106(4):143-9.
49. Butterworth JE, Campbell JL. Older patients and their GPs: shared decision making in enhancing trust. *Br J Gen Pract.* 2014;64(628):e709-e18.
50. Fried LP, Tangen CM, Walston J, Newman AB, Hirsch C, Gottdiener J, et al. Frailty in older adults: evidence for a phenotype. *The journals of gerontology Series A, Biological sciences and medical sciences.* 2001;56(3):M146-56.