What do Family Planning Staff Prioritize for Patient Experience Improvements? Findings From a Training Initiative in New York State

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Abstract
It is especially important for providers of sexual and reproductive healthcare services to deliver positive patient experiences, given the personal, preference-driven, and sensitive nature of these services. We facilitated a patient experience training initiative with 8 teams representing family planning agencies in New York State. Teams participated in onsite assessment activities, 4 individualized coaching calls, and 5 group virtual sessions. Teams reported regularly on their progress and changes made. Seven teams (88%) improved clinic flow and 4 teams (50%) increased access to appointments. Five teams (63%) each addressed staff satisfaction and internal communication, and 2 teams (25%) improved their first impressions with patients. Four teams (50%) enhanced the physical environment and 3 teams (38%) improved their website and virtual presence. When engaged in a process to collect data, identify opportunities for improvement, implement changes, and reflect on the progress of those changes—both individually and with peer agencies—all 8 teams successfully implemented system-level changes.

Keywords
clinician–patient relationship, environmental design, quality improvement, women’s health

Introduction
While it is important for all healthcare providers to strive to provide patients with a positive experience, the personal, preference-driven, and sensitive nature of family planning services gives added importance to patient experience for providers of these services (1). When individuals have a positive patient experience they are more likely to return and seek preventive and episodic healthcare services they need, which in turn reduces the likelihood of adverse health outcomes in the long run (2,3). Now more than ever there is an urgent need for ensuring clients have a trusted, regular, source of reproductive healthcare. It is especially important for safety net clinics, which deliver services regardless of a patient’s ability to pay and may be the only point of access in their communities, to provide an experience that supports patient retention and engagement in their care, contributing to improved health outcomes and health equity (2–6).

There are many factors that influence how a patient experiences a clinic visit which can be broadly categorized into 3 domains: the clinic’s systems, which affect how quickly and easily someone can make an appointment (eg, on the same day or the next day), whether a patient can make an appointment a time that is convenient to their schedule, and how long patients spend at the clinic, both in total and specifically the time spent waiting, a common source of frustration for patients; the interactions between staff and patients, such as the extent to which staff engender trust, provide culturally...
and linguistically appropriate care, demonstrate kindness and compassion and involve patients in decisions about their care while respecting their values and preferences; and the clinic environment, including whether the clinic’s online presence (eg, website, social media) is easy to understand and navigate, and the whether the physical clinic space is accessible, clean, safe, and comfortable (7–9). When systems, interactions, or environments do not support a positive patient experience, this can pose a barrier to patients accessing and receiving quality care.

It is, however, well known that changing clinic practices can be challenging. Many barriers can stand in the way of efforts to change policies and practices in clinical settings; these include lack of time, resources, leadership support, staff technical expertise, and competing priorities (10–12). On the other hand, factors that support change have also been documented, such as when there is strong evidence in support of a practice, an appropriate context for implementation, and facilitation support provided (13, 14).

As staff of the New York State Family Planning Training Center—an entity funded by The New York State Department of Health’s Bureau of Women, Infant, and Adolescent Health to provide training to state-funded family planning providers—we planned and facilitated an 8-month patient experience training initiative with family planning clinics between October 2020 and May 2021. Participating clinics received funding from the New York State Department of Health’s Comprehensive Family Planning and Reproductive Health Care Services Program, which provides accessible, confidential reproductive healthcare services to individuals of all genders and with priority given to low-income individuals and those without health insurance. The cost to the patient is calculated using a sliding fee scale, and in many cases, services are provided at no charge.15 In this paper, we explore the experiences of participating providers, including the opportunities for improvement they identified and what patient experience improvements they reported implementing in their clinics.

Method
Participating Agencies and Staff
We invited all 45 state-funded agencies to participate in a patient experience improvement initiative and 8 agencies (18%) elected to participate. These included 2 local health departments, 2 hospital-affiliated clinics, 3 reproductive healthcare specialty clinics, and 1 adolescent health-focused clinic. Four organizations were located in New York City. The range of agency type and geography of agencies that participated was representative of the broader network. We encouraged clinics to involve leadership, as well as administrative, clinical, and frontline staff. Clinic staff and agencies did not pay to participate, nor did they or their agencies receive any compensation to participate.

Initiative Design
We asked all teams to engage in a process that included: collecting patient experience data about their clinic, identifying opportunities for improvement unique to their setting, implementing change ideas, regularly assessing progress, and refining changes based on what was and was not working.

To start, we met with each team to identify their overarching goals for participating in the initiative; we then met every other month with each team for a coaching call, facilitated by the authors. Prior to each coaching call, we asked teams to collect patient experience data—both qualitative and quantitative—through various activities. To start, staff completed the Patient Experience Self-Assessment* to share their perspectives on opportunities to improve patient experience in their clinics; staff outside of the improvement teams were encouraged to respond to gather broad input. In subsequent months, teams conducted patient observations, assessments of the physical space and clinic website, and a staff satisfaction survey (see the Appendix), an activity added at the request of participating teams concerned about staff morale. We also asked all teams to collect and share patient satisfaction survey results in order to hear directly from patients about opportunities for improvement.

During coaching calls, we used a standard, semistructured coaching guide with a series of open-ended questions that encouraged participants to reflect on the data they collected during assessment activities and through the patient satisfaction survey, identify opportunities for improvement, explore change ideas for addressing newly identified opportunities for improvement, and share progress on change ideas identified previously. We introduced the Model for Improvement (MFI), developed and tested by the Associates in Process Improvement, as a framework to help participants think about improvement and returned to the framework several times during coaching calls.16 Returning to the MFI encouraged participants to focus on their stated patient experience goals and identify and test small changes using Plan-Do-Study-Act cycles in support of those goals. Each team maintained a written Patient Experience Improvement Plan, codeveloped with the authors, which teams updated during and between coaching calls with their progress and which was used to document the change ideas that teams chose to test and refine.

Every other month, all 8 teams came together for a virtual session to discuss implementation challenges and strategies. We recorded sessions and obtained transcriptions from a transcription service. During the final virtual session, each team verbally presented the changes they made and lessons learned.

To organize the flow of the initiative, we centered 3 domains for improvement: clinic systems, interactions, and environment. Each domain served as the overarching topic for 1 coaching call, a subset of activities, and a group virtual learning session. We selected these domains in order to help teams approach changes in stages rather than
Table 1. Schedule of Patient Experience Initiative Events.

| Month     | Description of activities                                                                 | Activities | Coaching call | Virtual session |
|-----------|------------------------------------------------------------------------------------------|------------|---------------|-----------------|
| Oct 2020  | Virtual session: Introduction to the patient experience initiative                         |            | √             | √               |
|           | Activities: Survey staff about perceived opportunities to improve patient experience     |            |               |                 |
| Nov 2020  | Virtual session: Challenges and strategies for improving clinic systems                   |            | √             |                 |
|           | Activities: View a video about patient experience; conduct clinic flow assessment; record observations of patients moving through the clinic |            |               |                 |
| Dec 2020  | Virtual session: Challenges and strategies for improving clinic systems                   |            |               | √               |
| Jan 2021  | Virtual session: Challenges and strategies for improving interactions                    |            | √             |                 |
|           | Activities: Watch a video about customer service skills; conduct staff satisfaction survey |            |               |                 |
| Feb 2021  | Virtual session: Challenges and strategies for improving interactions                    |            | √             |                 |
| Mar 2021  | Activities: Conduct assessments of the clinic’s physical space, website, and privacy protections |            |               |                 |
| Apr 2021  | Virtual session: Challenges and strategies for improving the environment                 |            |               | √               |
| May 2021  | Virtual session: Summary presentation of successes and lessons learned by each team      |            |               |                 |
|           | Endpoint assessment                                                                      |            |               |                 |

all at once, to help teams consider a range of potential change ideas rather than changes related to 1 specific area, and because they encompassed a wide range of drivers of patient experience represented in the literature (7–9).

Following the final virtual learning session, we conducted an endpoint assessment via an online survey (see the Appendix). In this assessment, participants were asked to describe the changes they made and their experiences with the initiative. To summarize the changes that clinics made during the initiative, the authors analyzed the transcription of the final learning session and endpoint assessment responses and coded these responses according to the 3 domains (systems, interactions, and environment). The authors then reviewed responses within each domain and coded based on subcategories that emerged within each domain. We provided certificates of participation to acknowledge the time participants committed to the initiative. An outline of the initiative is detailed in Table 1.

Results

Participation

Thirty-five individuals from the 8 agencies participated. Seven of the 8 teams attended all 5 virtual sessions; the 8th team attended 4 due to a scheduling conflict with the 5th session. All teams attended the 4 coaching calls, conducted the activities, implemented at least 2 changes in 2 different domains, and submitted an endpoint assessment.

Identified Opportunities for Improvement

Staff from all 8 agencies completed a Patient Experience Self-Assessment. The assessment was collected anonymously, aggregated by the authors, and shared back with each team in aggregate for discussion during coaching calls. In total, 81 individuals completed the assessments, representing an average of 10 people per team (range 4–17). The assessment asked staff to rate agreement with 15 statements according to how frequently staff observed them in their clinics (1 = never, 5 = always). The median rating of frequency as well as the range for each item is provided in Table 2. Across teams, staff indicated that patients waiting <10 min and getting in and out of the clinic in <45 min happened least frequently.

Drawing on the results of the Patient Experience Self-Assessment, as well as other data collection activities, teams identified changes to address opportunities for improvement. By the end of the 8-month initiative, teams collectively had identified opportunities for improvement and made changes in 7 categories related to the self-assessment measures within the 3 domains of systems, interactions, and the environment. Four teams made changes in all 3 domains; 4 teams made changes in 2 of the 3 domains. On average, each team made changes in 4 categories (range 2–7). More details about what staff identified as priorities to work on and what changes were made follow below and are summarized in Table 3.

Clinic Systems. Clinic Flow. Seven teams (88%) made changes to their clinic flow. Two teams adopted the practice of moving staff around patients in 1 room, rather than moving patients, in order to reduce time in transition and reduce opportunities for patients to get lost or confused during their visit. One team roomed patients immediately which meant patients skipped the waiting room entirely. Two teams stocked supplies (such as IUDs and implants, instruments, and swabs) in exam rooms, and one established a mobile cart with frequently used supplies (including testing kits, blood pressure cuff, sharps container, and instruction sheets) in order to keep staff in the room with patients longer, rather than looking for supplies. One team reduced paperwork by eliminating redundancy and unused questions on patient forms. One team restructured pregnancy testing services so nursing staff no longer needed to walk to and
from the laboratory to perform the tests. One team cross-trained staff so they could more consistently respond to patients’ needs and requests. Three teams (38%) reported that their clinic flow improvements resulted in decreased wait time for patients; the team that restructured their pregnancy testing services reported a wait time reduction of 15 min.

Appointment Systems and Availability. Four teams (50%) made changes to their appointment systems and availability. One team added evening hours. One team added the ability to make appointments via their website. One team implemented text reminders and obtained training for their clinician to insert and remove intrauterine devices so that patients could obtain that service with other reproductive healthcare needs. One team piloted “quick visits” so that patients could be seen faster and more patients could be seen during the day.

Patient and Staff Interactions. Staff Engagement. Five teams (63%) addressed staff satisfaction. All teams implemented a staff satisfaction survey during the initiative and 2 teams committed to implementing a staff satisfaction survey annually going forward. Two teams focused on management accountability; one manager was more intentional about following up on staff requests, and another made more of an effort to check in with clinic staff daily about their questions and concerns. Two teams improved staff recognition; one manager wrote personalized thank you cards to staff acknowledging their contributions, and the other team began sharing positive patient feedback at staff meetings.

Internal Communication. Five teams (63%) addressed internal communication. Three teams instituted regular staff meetings including 1 team that implemented virtual pre-shift huddles which they recorded for staff who started on later shifts. One team’s manager started meeting more regularly with other department heads, which broadened the scope of improvements they could implement. One team learned that staff were confused about a particular policy and they were able to clarify the policy, relieving a source of frustration among staff.

Communication With Patients. Two teams (25%) worked on improving their first impressions with patients. One team reinforced the need to practice customer service skills at the front desk. One team trained staff to ask and use correct patient pronouns.

Clinic Environment. Physical Environment. Four teams (50%) made changes to their physical spaces to make the clinic environment more welcoming and inviting. Two teams added posters for visual appeal and clear room labels and exit signs. One team posted pictures and bios of staff in the communal area to help patients become familiar with staff before their visit. One team added a white noise machine to provide needed privacy for patient–provider conversations and had their hallways freshly painted. One team worked with their IT department to get free Wi-Fi for patients in the waiting room.

Clinic Website. Three teams (38%) made changes to their website and virtual clinic presence. Two teams implemented updates to make their websites more user-friendly—using plain language and making it more intuitive to navigate. One team leveraged social media to promote their new online appointment system. One team met with their public affairs department to share the website assessment they conducted and, based on the results, they were able to hire an external marketing consultant to support them in search engine optimization.

| Table 2. Patient Experience Self-Assessment Results. |
|-----------------------------------------------|
| Patient experience self-assessment measure | Median rating (1 = never, 5 = always) | Range (n = 8) |
| Clinic systems | Patients can get an appointment to see a provider on the same or the next day. | 4.1 | 3.0–4.8 |
| | Patients do not have to wait more than 10 min before they are seen. | 3.4 | 3.0–4.3 |
| | Patients get in and out of the clinic in 45 min or less. | 3.4 | 2.3–4.2 |
| Average | 3.7 |
| Interactions | Staff make a welcoming statement to patients upon arrival. | 4.6 | 4.2–4.9 |
| | Staff use friendly words and tone of voice. | 4.6 | 4.3–5.0 |
| | Staff demonstrate empathy when a patient expresses difficult emotions. | 4.6 | 4.0–5.0 |
| | Staff use positive phrasing when communicating with patients. | 4.5 | 4.3–4.8 |
| | Staff use terms that patients understand when explaining medical procedures or devices. | 4.5 | 4.3–4.8 |
| | Staff offer options when a patient is having a difficult time understanding/complying with the clinic protocols. | 4.5 | 3.9–4.8 |
| Average | 4.5 |
| Environment | The clinic is well-maintained (equipment is in good shape, walls have a clean coat of paint/paper, magazines in the waiting room are replaced regularly, etc). | 4.1 | 3.3–4.9 |
| | The clinic is clean and uncluttered. | 4.3 | 3.8–4.8 |
| | Patients are able to move around the clinic without asking staff for directions. | 3.9 | 3.5–4.6 |
| Average | 4.2 |
| General assessment | Patients come to the clinic because we provide excellent care. | 4.5 | 4.0–4.9 |
| | Patients choose to come here even if they are insured. | 4.3 | 3.3–4.5 |
| Average | 4.4 |
Upon reflection, all 8 teams said they would recommend participation in this type of patient experience improvement initiative to others on their endpoint assessments. We provided space for teams to explain why they would or would not recommend the initiative; 4 teams volunteered that the initiative was valuable because it provided dedicated time and space to objectively step back, analyze systems and processes, and identify opportunities for improvement; 3 teams said that the initiative provided new ideas which helped them understand, foster buy-in for, and improve patient experience; and 1 team said that the initiative provided an “extra push” to make changes that had been of interest for a while.

When asked for recommendations for future improvement initiatives, 2 teams suggested providing more time to network with peer agencies (eg, through virtual breakout groups). Two teams suggested including an in-person meeting, which was originally planned but canceled due to the COVID-19 pandemic. One team said they liked the mix of coaching calls and interactive virtual sessions but suggested shortening it to 6 months as 8 months felt too long, and 1 team recommended a more detailed discussion of how to replicate improvements to other clinic sites managed by the agency. Two teams had no recommendations.

**Discussion**

When engaged in a process to collect data, identify opportunities for improvement, implement changes, and reflect on the progress of those changes—both individually and in coordination with peer agencies—all 8 teams successfully implemented system-level changes in their clinics. The most common area of focus was clinic flow which was identified as the area with the most room for improvement, since it was lowest-rated on the Patient Experience Self-Assessment. The second most common area of focus was staff engagement and internal communication. As the healthcare industry deals with high rates of staff turnover—as many as 4 in 10
primary care staff leave their healthcare system within 3 years—staff engagement is a concern at the forefront for many agencies.17 The literature suggests a strong link between staff engagement and patient experience. Interviews with healthcare staff indicate that staff who feel heard are more likely to be motivated and receptive to feedback, which in turn leads to improved care delivery; that being involved in quality improvement around patient-centeredness is motivating staff; and that improving patient experience can directly improve staff experience.18 Organizations successfully reduce staff turnover and increase employee productivity when they invest in employee well-being by strategically improving workplace conditions that are the root causes of stress.19 Satisfied employees intend to stay in their jobs longer.20 Thus, there is a positive feedback loop: focusing on patient experience improves staff satisfaction, and investing in staff well-being is a strategy for improving patient experience. While we did not include staff engagement measures on the Patient Experience Self-Assessment, the authors included a staff satisfaction survey as an activity at the request of teams during the initiative, further illustrating how important this topic was to participating teams.

On the other hand, improving interactions with patients was least likely to be an area of focus, and was rated highest by staff on the Patient Experience Self-Assessment. Future patient experience improvement initiatives may benefit from an increased emphasis on the impact of conscious and unconscious bias, and legacies of structural oppression, and in particular how these may influence the patient’s experience, including interactions with staff and the clinic overall. Providers may have benefited from more opportunities for self-reflection around the history of racism and coercion in reproductive and sexual health; strategies for approaching patients with cultural humility and applying strategies to mitigate the impact of personal biases; and strategies for providing family planning services that are adolescent-friendly, trauma-informed, and inclusive.

Additionally, while the 8 agencies that participated in the change initiative were broadly representative of the types of agencies and geography of the broader network of family planning agencies, since agencies opted into the initiative there is a risk of selection bias. Though we did not assess why agencies chose not to participate in the initiative, it is possible that agencies that did not participate had fewer resources to commit to improving patient experience, less leadership support for change, or more competing priorities, all of which would pose potential barriers to their success.

Conclusion

Based on the experiences of family planning staff in this initiative, we revised the Patient Experience Improvement Toolkit, which provides action steps and supportive resources for family planning agencies. Developed by the authors in their roles as training staff of the federally funded Reproductive Health National Training Center, the toolkit is in the public domain and free to use.21 We encourage staff at family planning and other safety net clinics to use the lessons learned from this initiative—including the data-driven process for improvement and change ideas generated by participating teams—to strive for a more positive patient experience in their settings.

Appendix: Data Collection Tools

Patient Experience Endpoint Assessment

These questions relate to your team’s experience during the Patient Experience Initiative. Your honest feedback is extremely helpful as we seek to improve future learning collaboratives.

1. Would you recommend participation in an initiative like this to others? Please explain.
2. Please describe any ways participation in this initiative resulted in improvements to your services.
3. What could have made this initiative better?
4. How can we support your agency to sustain or build on your successes going forward?
5. Any additional comments:

Staff Satisfaction Survey

Please tell us how you feel about your job. We value your opinion, and your responses will help us make improvements. This survey is anonymous. Thank you for your time.

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The management of this organization is supportive of me.
I receive the right amount of support and guidance from my direct supervisor.
I am provided with all training necessary for me to perform my job.
I have learned many new job skills in this position.
I feel encouraged by my supervisor to offer suggestions and improvements.
The management makes changes based on my suggestions and feedback.
I am appropriately recognized when I perform well in my regular work duties.
The organization’s rules make it easy for me to do a good job.
I am satisfied with my chances for promotion.
I have adequate opportunities to develop my professional skills.
I have an accurate written job description.
The amount of work I am expected to finish each week is reasonable.
My work assignments are always clearly explained to me.
My work is evaluated based on a fair system of performance standards.
My department provides all the equipment, supplies, and resources necessary for me
to perform my duties.
The buildings, grounds, and layout of this facility are adequate for me to perform my
duties.
My coworkers and I work well together.
I feel I can easily communicate with members from all levels of this organization.

| Strongly Disagree | Disagree | Agree | Strongly Agree |
|-------------------|---------|-------|---------------|

I would recommend this health facility to other workers as a good place to work.

How would you rate this health facility as a place to work on a scale of 1 (the worst) to 10 (the best)?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|
| Worst | | | | | | | | | Best |

I feel most appreciated at work when….
The thing I like most about my job is…
If I could change one thing about my job, it would be…

This tool includes the Satisfaction of Employees in Health Care instrument, used with
the permission of the authors.

Alpern R, Canavan ME, Thompson JT, et al (2013). Development of a brief instrument for assessing healthcare employee satisfaction in a low-income setting. *PLoS One* 8(11): e79053. https://doi.org/10.1371/journal.pone.0079053

Chang E, Cohen J, Koethe B, Smith K, Bir A. (2017). Measuring job satisfaction among healthcare staff in the United States: a confirmatory factor analysis of the Satisfaction of Employees in Health Care (SEHC) survey. *Int J Qual Health Care*. 29(2):262–268. doi: 10.1093/intqhc/mzx012. PMID: 28339641.

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**Notes**
* See table 2 for the measures assessed in the Patient Experience Self-Assessment.

**References**
1. Dehlendorf C, Henderson JT, Vittinghoff E, Steinauer J, Hessler D. Development of a patient-reported measure of the interpersonal quality of family planning care. Contraception. 2018;97(1):34-40. doi: 10.1016/j.contraception.2017.09.005
2. Safran D, Montgomery J, Chang H, Murphy J, Rogers W. Switching doctors: predictors of voluntary disenrollment from a primary physician’s practice. J Fam Pract. 2001;50(2):130-6. PMID: 11219560.
3. Browne A, Varcoe C, Wong S, et al. Closing the health equity gap: evidence-based strategies for primary health care organizations. Int J Equity Health. 2012;11:59. https://doi.org/10.1186/1475-9276-11-59
4. Street RJr., Makoul G, Arora N, Epstein R. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns. 2009;74(3):295-301. https://doi.org/10.1016/j.pec.2008.11.015
5. Stewart M, Brown J, Donner A, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49:796-804. PMID: 11032203.
6. Dehlendorf C, Akers A, Borroso S, et al. Evolving the preconception health framework: a call for reproductive and sexual health equity. Obstet Gynecol. 2021;137(2):234-9. https://doi.org/10.1097/aog.0000000000004255
7. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013;3:e001570. https://dx.doi.org/10.1136/bmjopen-2012-001570
8. Ahmed F, Burt J, Roland M. Measuring patient experience: concepts and methods. Patient. 2014;7:235-41. https://doi.org/10.1007/s40271-014-0060-5
9. What is patient experience? Agency for Healthcare Research and Quality [https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html](https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html) (accessed 6 June 2022)
10. Cowie J, Nicoll A, Dimova ED, et al. The barriers and facilitators influencing the sustainability of hospital-based interventions: a systematic review. BMC Health Serv Res. 2020;20:588. https://doi.org/10.1186/s12913-020-05434-9
11. Tappen RM, Wolf DG, Rahemi Z, et al. Barriers and facilitators to implementing a change initiative in long-term care using the INTERACT® quality improvement program. Health Care Manag (Frederick). 2017;36(3):219-30. doi:10.1097/HCM.000000000000168
12. Morris Z, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J R Soc Med. 2011;104(12):510-20. https://doi.org/10.1258/jrsm.2011.110180
13. Bauer M, Damschroder L, Hagedorn H, Smith J, Kilbourne A. An introduction to implementation science for the non-specialist. BMC Psychol. 2015;3(1):32. https://doi.org/10.1186/s40359-015-0089-9
14. Kawatu J, Clark M, Saul K, et al. Increasing access to single-visit contraception in urban health care settings: findings from a multisite learning collaborative. Contraception. 2022;108:25-31. https://doi.org/10.1016/j.contraception.2021.12.005
15. New York State Department of Health. Comprehensive Family Planning and Reproductive Health Care Services Program. [https://www.health.ny.gov/community/pregnancy/family_planning/](https://www.health.ny.gov/community/pregnancy/family_planning/) (accessed 21 March 2022).
16. Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational performance. 2nd ed. Jossey-Bass Publishers; 2009.
17. Willard-Grace R, Knox M, Huang B, Hammer H, Kivlahan C, Grumbach K. Burnout and health care workforce turnover. Ann Fam Med. 2019;17(1):36-41. https://doi.org/10.1370/afm.2338
18. Lcock L, Graham C, King J, et al. Understanding how frontline staff use patient experience data for service improvement: an exploratory case study evaluation. NIHR Journals Library; 2020.
19. Lovejoy M, Kelly E, Kubzansky L, Berkman L. Work redesign for the 21st century: promising strategies for enhancing worker well-being. Am J Public Health. 2021;111(10):1787-95. https://doi.org/10.2105/AJPH.2021.306283
20. Duffield C, Roche M, O’Brien-Pallas L, Catling-Paull C, King M. Staff satisfaction and retention and the role of the nursing unit manager. Collegian. 2009;16(1):11-7. https://doi.org/10.1016/j.colegn.2008.12.004
21. Reproductive Health National Training Center. Patient Experience Improvement Toolkit. [https://rhntc.org/resources/patient-experience-improvement-toolkit](https://rhntc.org/resources/patient-experience-improvement-toolkit) (accessed 12 May 2022).