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Client Satisfaction Survey for HIV/AIDS Dental Care Services: An Example from Rural Texas

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Client Satisfaction Survey for HIV/AIDS Dental Care Services: An Example from Rural Texas

Cover Page Footnote

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An Example from Rural Texas

Satisfaction of health care clients has emerged as an important measure of the quality of health care delivery, right alongside the more traditional health status measurements and quality of life indicators. For the purposes of this study, client satisfaction is defined as the degree to which a client's expectations for quality of services are met or satisfied. Interest in client satisfaction is attributed to several factors, including competition among service providers, influence of social sciences researchers, as well as emphasis on service quality, service completion and quality improvement (Brown, Sheehan, Sawyer, Raftos, & Smith, 1995; Knudston, 2000; Rosenthal & Shannon, 1997; Strug, Ottman, Kaye, Saltzberg, Walker, & Mendez, 2003). Health care organizations that solicit information about client satisfaction, including client concerns, are better prepared to make positive changes in the service delivery process. The importance of assessing client satisfaction is also supported by the relationship between client satisfaction and positive treatment outcomes, including clients' willingness to make important behavioral changes, stable relationships with health care providers, compliance with medical advice and treatment, keeping appointments, and improved health (Aharony & Strasser, 1993; Dansky & Colbert, 1996; Rosenthal & Shannon, 1997). It is important to note that client involvement in decision-making tends to be positively related to satisfaction and compliance with treatment (Auerbach, 2000; Auerbach, Penberthy, & Kiesler, 2003; Kiesler & Auerbach, 2003). Therefore, client satisfaction appears to be an important aspect of evaluating the delivery of health care services.

Whereas the topic of client satisfaction with health care services has received a fair amount of attention, studies that focus on individuals who are living with HIV/AIDS appear to

be less common. This is surprising given the chronic nature of HIV/AIDS and the need for active client involvement in long-term treatment. The importance of assessing client satisfaction in this population is supported by findings that doing so positively impacts the delivery of services to clients who are living with HIV/AIDS. For example, Tsisis, Tsoukas, and Deutsch (2000) identified the following positive outcomes: improving communication and building stronger relationships with clients, identifying the strengths and weaknesses of HIV programs from the clients' perspectives, and providing opportunities to focus quality improvement efforts. In terms of the importance of client satisfaction to treatment, Roberts (2002) found that clients who were satisfied with services were more likely to take their antiretroviral medications as prescribed. It is important to note that the stigma associated with HIV/AIDS may negatively impact client satisfaction, the client-provider relationship, client adherence to appointments, and the overall quality of care (Bodenlos, Grothe, Kendra, Whitehead, Copeland, & Brantley, 2004; Emler, 2007). Conversely, clients who hold positive regard for their health care providers are more likely to attend appointments (Bodenlos, Grothe, Whitehead, Konkle-Parker, Jones, & Brantley, 2007).

Whereas measuring client satisfaction is a beneficial practice, in many cases it is "easier said than done." For example, several studies have made it clear that client satisfaction should be approached as a multidimensional concept (Burke, Cook, Cohen, Wilson, Anastos, Young et al., 2003; Hsieh, 2009). When measuring client satisfaction in a clinic or hospital setting, the items should assess satisfaction with all of the providers/services the client has contact with, not just the physician (Bodenlos et al., 2004). It has also been suggested that clients tend to respond positively to client satisfaction surveys regardless of the actual quality of services. Potential reasons for this phenomenon include social desirability bias, acquiescent response set, instrument

reliability, and fear that their responses will not remain anonymous or confidential (Aharony & Strasser, 1993; Brown et al., 1995; Danksy & Colbert, 1996). Another common methodological challenge is nonresponse, especially among ethnic minorities (Aharony & Strasser, 1993; Fowler, Massagli, Weissman, Seage, Cleary, & Epstein, 1992; Rosenthal & Shannon, 1997). In fact, nonresponse may be an indicator of dissatisfaction with health care services and providers (Bell, Kravitz, Thom, Krupat, & Azari, 2001). Other factors that impact the quality of responses include the quality of the relationship between the provider and client, the client's ability to differentiate between expectations and actual experiences, provider's level of empathy, communication, access to services, and service coordination and continuity (Auerbach et al., 2004; Danksy & Colbert, 1996; Strug et al., 2003; Zapka, Palmer, Hargraves, Nerenz, Frazier, & Warner, 1995).

Despite the challenges to assessing client satisfaction, it is a necessary and beneficial endeavor. Collection of such information on a regular basis allows for the identification of patterns and changes in client satisfaction, which can be used to inform and evaluate organizational efforts to improve the quality of care. The purpose of this project was to develop a new instrument to determine the degree to which clients were satisfied with the services provided by Special Health Resources for Texas, Inc. (SHRT). Specifically, the instrument would be used annually to assess clients' satisfaction with services received under a Special Programs of National Significance (SPNS) dental and oral health grant, as well as all other services received through SHRT. The instrument development process was informed by a review of the literature related to HIV/AIDS service delivery, client satisfaction, and instrument development, as well as a pilot study. The article will discuss the results of the literature review, pilot study, and the first administration of the client satisfaction instrument.

Developing a Client Satisfaction Instrument

According to the literature, many factors should be considered when developing an instrument. First of all, developers must be familiar with the structural options. There are also choices to be made regarding integrating or distinguishing dimensions, phrasing of items, and formatting response options. Each of these has implications for the resulting psychometric qualities of the instrument. Developers must consider how the language they use in designing items might unintentionally express their own biases or suggest a lack of understanding about the sensitive nature of asking others to reveal controversial thoughts or feelings. Assessment instruments are inherently built to help make judgments, but not all of these are innocent or without consequence. In creating an instrument that, when scored, reveals sensitive, personal, or even unacceptable characteristics or views, developers must give careful consideration not only to the risks to those who eventually complete the instrument, but also to any potential harm that might come from others who determine whether a respondent's scores or answers are "good" or "bad."

More specifically to individuals dealing with HIV/AIDS, managing illness is often complicated by the challenges of ordinary daily life. Health care and social service providers helping them deal with challenges at home may find it hard to separate disruptions caused by everyday struggles from those resulting from the disease itself (Cohen, Nehring, Malm, & Harris, 1995). For example, Messick (2003) suggests that considering the vulnerabilities and strengths of future respondents requires reflection not only on their immediate reactions and circumstances, but also the broader social consequences of an instrument's administration and interpretation. In other words, we need to consider the potential uses of an instrument we design and weigh the benefits of designing such a tool against the risk that it will be misinterpreted or

used in harmful ways. Collectively, the literature discussed above illustrates thoughts and suggestions for guiding the development and use of an instrument. Next, a discussion will include the process of instrument development.

Development Process

Walter Hudson suggested that there were only two ways to know what was going on in the life of another: to watch or to ask (as cited in Spring, Abell, & Hudson, 2002). In the context of instrument development, this simple maxim translates into two primary formats: behavioral observation and self-reporting. The instrument developed for this study is guided primarily by the basic principles of self-reporting. It is believed that this structure is more relevant for individuals living with HIV/AIDS and is the best approach to determining service satisfaction. Ideally, instruments should be short and easy to understand, administer, score, and interpret (Bloom, Fischer, & Orme, 2006). No matter how elegant its design and thorough its conceptual foundation, if an instrument cannot be read and understood by its intended audience, it is useless. We must remember that the person completing this instrument is the most crucial player in the process. Consequently, respondents' ages, educational levels, ethnic or cultural identification, and developmental ability must all be considered in the wording and layout of an instrument. One basic consideration is readability.

The literature suggests that focus groups and expert panels are important tools in identifying the appropriateness of item wording. Expert panels are usually small groups composed of 6-10 members who understand the designer's methods or objectives and can provide feedback before the scale is subjected to a full-scale validation study or administered. Hence, it provides an early opportunity to identify and address concerns regarding length, content, structure, etc. The experts selected typically include persons from academia with

backgrounds in instrument development or the theories or models used in construct definition, social work practitioners with experience working with target problems or groups, and/or members of the target groups themselves (American Educational Research Association, 1999). Whatever their particular expertise, the criteria and procedures for selecting the members should be clearly described. Also, all members must be given clear instructions and encouraged to stay on task. The criteria and instructions serve to guide the panel's review of the instrument and their suggestions for improvement.

In terms of the specific items, developers typically choose to include Likert-type items in hopes that associating labels or categories with a numerical value will help respondents express their true feelings or thoughts (Springer et al., 2002). Responses to Likert-type items are chosen by the developer and organized in an ordinal pattern. Each item is assigned a numerical value that allows the item to be measured in the context of more or less (e.g., degree, magnitude or frequency). Likert-type items typically contain an odd number of response categories, with the most common number being 3, 5, and 7 point scales. There are a variety of opinions about the "best" number of responses, including whether there should be an odd or even number of responses. While a detailed discussion of this topic is outside the scope of article, the general rule is to use the minimum number of mutually exclusive categories required to cover the range of the concept. Exceeding the minimum number increases the likelihood of measurement related issues. Pairing Likert-type items with open-ended items can aid in understanding the responses to Likert-type items.

When developing an instrument, special attention must be given to demographic items. Developers should think carefully about what to include, the format in which responses are collected, and the sequencing and placement of specific items. Dillman (2007) proposes that

items with the most potential value to respondents be placed early in the package, the better to draw them in to the “conversation.” The cover letter should have prepared them for general topics, and they should find that “good faith” is being maintained by getting down to business accordingly. Designers should avoid beginning with a series of disjointed demographic questions, particularly if some are of an overly sensitive nature and may provoke deliberate misreporting. After respondents have become engaged with the task and convinced of its value, they may be more willing to answer sensitive questions (e.g., relating to HIV status or income). Often, these are best placed near the end of the instrument.

The final suggestion from the literature relates to implications for layout and content sequencing. Although the ordering of elements is critical, the graphic layout may be equally important to attracting and maintaining the respondents’ interest (Dillman, 2007). Numerous studies list the “do’s and don’ts” of graphic designs and have offered suggestions for best practices with text boxes, varying font sizes and intensities, “white space,” and other elements meant to make it as easy as possible for respondents to get (and stay) on task. Another principle is developing good items. What constitutes a good item? First, the language should be simple, straightforward, and appropriate for the reading level of the intended audience. Among the most important recommendations are making sure that instructions are clear, leaving no doubts as to what is being requested or how responses should be provided.

Pilot Study

The various components described in the previous section were considered when developing the instrument for this study. An important part of this process was the feedback provided by a panel of experts, which informed improvements in the instrument’s design and structure. The panel consisted of twelve social work educators, researchers and practitioners.

The panel members were chosen based on their knowledge of HIV/AIDS and/or instrument development. Several of them have engaged in research related to the treatment of individuals who have been diagnosed with HIV/AIDS. A group of fourteen senior social work field students also assisted with the review. Several of the students have experience working with individuals living with HIV/AIDS. Whereas it would have been preferable to administer the instrument to a small sample of the client population, time constraints for the project did not allow for such.

The survey was emailed to the panel of experts and given to the social work students during class. The panel and students were provided with criteria and instructions to guide their review and feedback. The criteria consisted of the following: 1) format of the survey, 2) clarity of questions, 3) content of survey, 4) edit words or phrases they feel could be eliminated or improved 5) comment on the overall set of items, 6) Likert scales, 7) each item is readable and understandable, 8) respondents' reaction to format and clarity of items, 9) selection and organization of demographics, and 10) demographic wording and location. The feedback from the experts and students was consistent across participants and extremely helpful. All of the participants offered suggestions regarding wording or phrases to enhance the clarity of the questions for better understanding and readability. Several suggested changes in the format, most of which related to item location and suggestions for additional items. Other participants offered constructive comments about the rating scale. Students from the senior class recommended adding additional space for comments from the participants. There was consensus among participants regarding the suitability of the instrument's format. Finally, participants agreed that the content of the instrument was relevant to and representative of the breadth of the construct of client satisfaction.

Method

Instrumentation

The development process described in the previous section yielded an instrument that measures satisfaction with services received from SHRT, as well as collecting information about demographic characteristics and social support. The instrument places particular emphasis on dental and oral health care services. The specific items are discussed in the results section.

Whereas content validity was established via the pilot study, it is important to note that neither empirical validity nor reliability have been established for this instrument.

Sampling and Subjects

SHRT's staff asked all of its dental clients, including those who were receiving services under the SPNS Dental/Oral Health Care grant, to participate in the study. All of clients were adults (18 years or older) and resided in SHRT's service region, which includes twenty-three northeast Texas counties and covers approximately 15,522 square miles. The service region is also comprised of the Tyler and Texarkana Health Service Delivery Areas (HSDA). The survey was provided to clients by SHRT staff during office visits that occurred between December 2009 and January 2010. Clients who did not have appointments during the time period were sent a survey via the U. S. Postal Service. All of the potential respondents were asked to complete the survey and return it via self-addressed postage paid envelope. Participants were not asked for identifying information and the surveys were not coded, which allowed participants anonymity.

Forty-one of the dental clients completed and returned the survey instrument (11.7% return rate). Of those, one instrument was incomplete and therefore not included in the data analysis. Of the remaining forty participants, 27.5% were males, 70% were females and 2.5% chose not to respond. Fifty percent of the participants were African American, 5% were

Latino/Hispanic, 50% were White/European and 2.5% chose not to respond. The average age of respondents was 43.13 (sd = 12.1) with a range of 21 to 67. In terms of clinic location, 72.5% of the respondents received services at SHRT's Longview facilities and 27.5% received services at the Tyler facility. None of the respondents received services at the Paris or Texarkana facilities. As for education, 10% of the respondents had less than a high school education, 20% had a high school education without a diploma, 15% had a high school diploma or GED, 7.5% completed a trade school or training program, 17.5% had some college without a degree, 15% had an associate degree, 2.5% had a bachelor degree, 10% had a graduate or professional degree, and 2.5% of the participants did not respond to this item. Given the size of SHRT's service region and differences in service availability, participants were also asked to identify their county of residence. Fifty percent of the respondents reside in Gregg County, 2.5% in Harrison, 2.5% in Hunt, 2.5% in Nacogdoches, 2.5% in Rusk, 20% in Smith, 5% in Upshur, and 15% of the participants chose not to respond to this item.

Limitations

Before presenting the results, it is important to point out the limitations resulting from the low return rate (11.7%). Of 350 potential participants, 40 chose to complete and return the instrument. The small sample impacted the use of inferential statistics to examine the data and prevented comparisons of subgroups within the sample. For example, comparisons among all four facilities could not be made because clients who received services in Paris and Texarkana chose not to participate. The lack of representation from various ethnic groups prevented comparisons among ethnic groups. Given that some studies have suggested ethnicity influences client satisfaction, such comparisons may have proven to be beneficial (Burke et al., 2003;

Emelt, 2007; Knudston, 2000; Macnee & McCabe, 2004). Finally, the sample is not representative of the overall client population, which prohibits generalizations to the population.

Results

As previously discussed, the instrument employed in this study was designed to assess dental clients' satisfaction with services received from SHRT during the past year. Although the emphasis is on dental services, it also collected information about other services, sources of support and demographic characteristics. The results for the quantitative and qualitative analyses are presented by item in the following subsections. In addition to examining the responses for all of the respondents, group comparisons were made based on location of services and gender. Comparisons based on ethnicity were not made due to the small sample size. Again, it is important that one remain mindful of the aforementioned limitations when reviewing the results.

Services Utilized in the Last Year

The services offered by SHRT and the percentage of respondents who reported utilizing them within them last year are as follows: Ambulatory Medical Care (27.5%), Ryan White Case Management (52.5%), Substance Abuse Case Management (30%), Prevention Case Management (17.5%), Mental Health Counseling (22.5%), Nutritional Counseling (17.5%), Housing Assistance (50%), Transportation Services (40%), Dental/Oral Health Care (100%), and Other (5%).

Satisfaction with Services

Participants were asked to rate each of the services they utilized within the last year. Ratings were based on the following 5 point Likert Scale: 1 = Very Satisfied, 2 = Satisfied, 3 = Neither Satisfied or Dissatisfied, 4 = Dissatisfied, 5 = Very Dissatisfied, 6 = Don't Know, and 7 = Service Not Used. The mean scores suggest that overall clients were satisfied with all of the

services (see Table 1). However, the standard deviation score for mental health counseling suggests some variance among responses. This appears to be reasonable given that SHRT has found it difficult to consistently provide mental health services to its clients. The standard deviation scores for the other services suggest consistency among participants' responses.

Table 1.

Satisfaction with Services

Service	N	mean	sd
Ambulatory Medical Care	14	1.57	.852
Ryan White Case Management	20	1.55	.759
Substance Abuse Case Management	14	1.50	.855
Prevention Case Management	8	1.38	.518
Mental Health Counseling	10	2.00	1.414
Nutritional Counseling	10	1.90	.994
Housing Assistance	21	1.29	.717
Transportation Services	17	1.35	.493
Dental/Oral Health Care	39	1.38	.877

Each of the items presented in Table 1 included a space to offer written comments. In terms of the broader category of satisfaction with services offered by SHRT, the primary themes centered on the respondents' concern about the decrease in availability of case management services and substance abuse groups, which they previously found helpful. In fact, the lack of group services was a common concern across many of the items on the instrument. The following comments serve to illustrate this point:

“Do not have any case manager..... (and) no (more) groups, why?”

“We no longer have groups so we can know (each other), and help other(s) in time.”

Additional themes for these items centered on dental services offered by the clinic and outside referrals made by staff. The majority of respondents reported being satisfied with the assistance received in these areas. Examples of such responses include: *“Very helpful and very nice”*, *“Keep up the good work”*, and *“The staff is always friendly and helpful.”*

Dental Services

Participants were asked about a variety of aspects of dental services, including where they received services and the number of visits in the last year. Twenty-nine (72.5%) of the respondents received services at the Longview facilities and 11 (27.5%) received services at the Tyler facility. Five of the respondents (12.5%) reported having full dentures and 8 (20%) reported having partial dentures. The average number of visits for each type of dental service provider are as follows: 2.76 visits with the dentist (sd = 2.66), 2.52 visits with the dental hygienist (sd = 1.35), 2.25 visits with the dental case manager (sd = 1.07), and 3.39 visits with the Ryan White Case Manager (sd = 2.77).

Participants were also asked to rate their satisfaction with specific aspects of the dental services. Ratings were based on the following 5 point Likert Scale: 1 = Very Satisfied, 2 = Satisfied, 3 = Neither Satisfied or Dissatisfied, 4 = Dissatisfied, 5 = Very Dissatisfied, and 6 = Don't Know. The results suggest that overall clients were satisfied with dental services and the standard deviations scores suggest consistency among participants' responses (see Table 2).

Table 2.Satisfaction with Dental Services

How satisfied were you with the...	n	mean	sd
availability of SHRT dentists in your area?	38	1.24	.542
length of time it took to schedule your dental appointment?	39	1.59	.880
time you waited to see the dentist with an appointment?	40	1.43	.636
time you waited to see the dentist without an appointment?	27	1.52	.935
service you received from the dental hygienist?	37	1.32	.626
quality of service you received at your last dental visit?	37	1.38	.721
assistance you received from the receptionist?	39	1.49	.756
management of your dental pain?	33	1.64	.929
change in your dental health?	31	1.71	1.01
level of hospitality you received at the dental office?	36	1.31	.624
overall dental and oral health services at SHRT?	37	1.30	.661

Each of the items presented in Table 2 included a space to provide narrative comments. The primary theme of responses regarding dental services centered on satisfaction with the level of patient care received from the dentist, dental hygienist, and auxiliary staff. Some of the comments from respondents in this category included:

“The dentist and the hygienist are very competent in the [sic] understanding of my needs and the illness.”

“The staff is always on top of my appointment”

“Everyone here is great and has done a great job providing care needs”.

“All dental services I have received are to the best standards possible. I am very pleased with the staff and services”.

“Everyone is very courteous.”

Despite the overall satisfaction with services, respondents mentioned the following concerns: minor scheduling issues, the need for more dental services in the region, and the difficulties associated with having to travel outside of the region for services. Some clients were also dissatisfied with the management of dental pain. For instance, one respondent offered the following comment: *“I think when having teeth pulled you should be able to get pain medicine. No one should have to feel pain.”*

Social Support

Participants were asked to identify the sources of social support they utilized on a regular basis. The sources of social support and percentage of clients who utilize them are as follows: significant other (17.5%), children (7.5%), immediate family (45%), extended family (17.5%), friends (37.5%), peer support groups (15%), church/Religious organization (32.5%), social organizations (17.5%), and other (10%).

Narrative Items

The instrument also included an open-ended question that solicited opinions from clients about things that could be done to improve services and provided a place for additional comments. The first item asked respondents to identify three things they felt would improve services to persons with HIV/AIDS in their community. The following themes were the most common: more primary care and specialized medical services, referrals for services (rental assistance, food assistance, and employment), client and community education (on the course of

the illness, preventative services, and nutrition), and support groups (self-esteem and substance abuse).

The second item asked respondents to offer additional comments that would help SHRT to better serve their clients. Themes in the comments for this item were similar to those expressed by the respondents in previous open-ended items. The primary theme was that of overall satisfaction with the services received from SHRT. Secondary themes centered on increasing services (dental, case management, and referrals) and timely prescriptions.

Discussion

The purpose of this study was to determine the degree to which SHRT's dental clients were satisfied with services. The data and results suggest that overall the participants are satisfied, and in many cases very satisfied, with services. The concerns mentioned tended to be centered on several common themes, including: the need for more dental, medical, mental health and case management services; absence of support and treatment groups; lack of community and client education; and improving referrals to outside services. However, when interpreting the results and the following discussion, one should remain mindful of the aforementioned limitations. It is also important to note that client satisfaction studies tend to produce overall positive results (Aharony & Strasser, 1993; Bell et al., 2001; Brown et al., 1995; Dansky & Colbert, 1996; Rosenthal & Shannon, 1997). The results of this study have implications service delivery, future evaluation efforts, and rural social work practice.

Service Delivery

The results suggest that the participants' overall perceptions of SHRT's services are, at the very least, satisfactory. Highlights include the professional demeanor and presentation of staff, overall quality of dental services, and clients' appreciation of SHRT and their efforts. On

the other hand, there are several common concerns related to service delivery, including assistance with referrals to services offered outside of SHRT and the lack of services (i.e., support groups, treatment groups, and specialized dental, medical, and mental health services). The need for group services is further indicated by the limited number of clients who reported utilizing social support on a regular basis. There appears to be a reasonable degree of concern regarding mental health services, but the low number of responses limited the authors' ability to further analyze the data.

Based on the results of the study and subsequent discussions with SHRT staff, the following suggestions for service delivery appear to be appropriate: 1) offering support and/or treatment group services to clients, 2) increasing the frequency and/or intensity of case management services, 3) enhancing community outreach and education efforts, and 4) increasing the availability of specialized dental, medical, and mental health services. In terms of addressing the need for specialized services, SHRT could enhance access to these services by developing collaborative relationships with local providers. SHRT may also benefit from evaluating their referral process to external services in order to increase its effectiveness and efficiency. When considering the above recommendations, it is important to remember that clients who receive services at the Paris and Texarkana facilities chose not to participate in the study. Given that these clients receive dental services at the Texarkana facility, it is possible that their perceptions would have varied from those clients who receive dental services at the Tyler and Longview facilities.

Future Evaluation Efforts

An evaluation process that yields useable results is an important aspect of achieving and maintaining quality service delivery. SHRT has made progress toward this goal by pursuing the

development of a client satisfaction instrument that is relevant to their services and clients. The instrument employed in this study represents an improvement over SHRT's previous instrument in that it treats satisfaction as a multidimensional concept. Seeking feedback about specific aspects of services, rather than limiting inquiries to overall satisfaction, is a preferable approach to evaluating client satisfaction (Bodenlos et al., 2004; Bodenlos et al., 2007; Burke et al., 2003; Dansky & Colbert, 1996; Hsieh, 2009). For example, SHRT's clients receive a variety of services and interact with numerous providers. A negative experience with one provider or service could significantly impact on overall satisfaction rating. On the other hand, specific items for each service would help identify specific strengths and concerns.

Approaching client satisfaction as multidimensional concept also requires one to consider other related factors, including demographic characteristics, health status, and mental health. The instrument developed for this study collects relevant demographic information, i.e., ethnicity, gender, age, education, and employment status. However, measures of health, mental health, and stigma were not included. Examination of their impact on client satisfaction may allow for a better understanding of client responses. For instance, evidence suggests that satisfaction declines as one's overall health declines (Dansky & Colbert, 1996). Depression has been linked to adherence with medical appointments and advice (Bodenlos et al., 2007). Assessing the degree of stigma related to a diagnosis of HIV/AIDS is important in that it is related to client satisfaction, compliance with medical recommendations and appointments (Bodenlos et al., 2007; Emelt, 2007). Stigma is also believed to decrease the response rate for client satisfaction surveys among those with HIV/AIDS (Bodenlos et al., 2004; Bodenlos et al., 2007; Emelt, 2007). Furthermore, the degree of stigma one experiences may be influenced by demographic characteristics, such as age and ethnicity (Emelt, 2007). Given the impact of

health, mental health and stigma upon satisfaction with services among clients who are living with HIV/AIDS, SHRT should consider collecting information on these factors.

In terms of the limitations of the current study, it is important to reconsider the sampling and data collection processes. The authors, in consultation with SHRT, chose to include all of the clients who were receiving dental services and to utilize an anonymous data collection process. The process was designed to minimize social desirability bias and encourage participation by addressing the common fears of identification and/or negative consequences for their feedback. The authors had originally planned for all of the potential participants to be provided with an instrument and return envelope when they visited the dental clinic. Unfortunately, the original time frame for the study was shortened to address agency time constraints. In an attempt to include all dental clients in the study, those who were not scheduled for a dental appointment during the revised time frame were mailed a survey and postage paid return envelope. In this case, the lower return rate associated with mail surveys was confounded by difficulties related to making initial and reminder contacts with a transient population via mail. Planning efforts for future studies should consider strategies to address barriers to obtaining an adequate return rate, including the transient nature of the population (makes it difficult to mail things to them and communicate in general), sporadic contact (inconsistency with appointments, follow-ups, etc.), medical frailty, limited access to internet and/or computer (prohibits use of web-based surveys), and the tendency of staff to emphasize service delivery with evaluation as a distant second.

Whereas one would hope that the low return rate was due to the sampling and data collection processes, there are alternative explanations. For instance, it is possible that those who chose not to respond did so as a result of negative experiences with services (Rosenthal &

Shannon, 1997). In this case, it would have been helpful to compare non-respondents to respondents. Such comparisons may have provided valuable insight regarding similarities and differences, as well as highlighted specific concerns to be considered in the improvement process. Employing a longitudinal research design would allow SHRT to make such comparisons, as well as identify the impact of related factors (e.g., health status, mental health, and stigma) upon individuals and groups over time (Aharony & Strasser, 1993; Rosenthal & Shannon, 1997). The obvious “catch” being this approach does not allow for anonymity, which may result in a lower return rate. Nonetheless, a design that allows for comparisons of respondents and non-respondents should be considered.

Rural Social Work Practice

There appears to be consensus that the prevalence of HIV/AIDS cases in the United States is increasing at higher rates in the South, compared to other regions (Reif, Gennotti, and Whetten 2006; Centers for Disease Control and Prevention, 2005). Given the prevalence of rural communities in the South, an increase in programs specifically tailored to those with HIV in rural populations is needed. Since persons affected with HIV/AIDS in rural populations face more barriers to healthcare than those in urbanized areas (Heckman, Somlai, Peters, Walker, Otto-Salaj, Galdabini, et al., 1998), the importance of client input in determining what services are provided is imperative. Additionally, it has been shown that clients with serious illnesses, such as cancer or AIDS, who perceive a sense of control over aspects of their treatment have a better ability to cope with symptoms of their illnesses (Taylor, Helgeson, Reed, & Skokan, 1991). With this sense of control, clients in rural areas may have higher levels of satisfaction with services and increased motivation to adhere to treatment. Clients who are satisfied with services may also be proactive in referring others to the program. Given the negative impact of

stigma upon decisions to seek and actively participate in services, this is of particular importance to HIV/AIDS service providers. Finally, the development process utilized in this study, as well as the instrument, may serve to inform similar efforts in rural social service agencies.

Conclusion

Understanding client satisfaction and related factors is a critical element of maintaining and improving the quality of services. The project described herein demonstrates the use of a collaborative process involving social work faculty and students, service providers, and clients to develop and administer a client satisfaction instrument. The process serves to demonstrate the principles and elements that are important to the development of a client satisfaction instrument. Whereas the results are not generalizable, the study is beneficial in that it serves to illustrate several key methodological challenges associated with administering such an instrument in rural settings. It is that authors' hope that the implications of the study, especially those regarding future evaluations, will assist SHRT and other rural social service organizations in their efforts to improve evaluation and service delivery.

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