



EUROPEP 2006

Revised Europep
instrument and user
manual

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SUMMARY

Background. The Europep instrument was developed by EquiP to represent patient views of general practice. It measures patient evaluations of a broad range of specific aspects of general practice care. The instrument has been used in many different countries, in some cases on a very large scale.

Aim. The aim was to revise the Europep instrument, if necessary, in the context of developments in European primary health care and experiences with the instrument in various countries.

Methods. An email discussion among contributors to this report led to an elaboration of the background of this revision and an outline for the revision process. In several rounds of proposals and responses consensus was achieved on the revision of the current Europep questionnaire.

Results. The box below describes the revised instrument.

Discussion. The English source version of the Europep 2006 instrument is ready for use. Although formal validation may be unnecessary, as all the changes were minor, the changes need to be translated into the various languages. It would be good to test the revised questionnaire before it is used on a large scale. Future work could focus on extending the instrument to cover new domains and topics.

EUROPEP 2006

What is your assessment of the general practitioner over the last 12 months with respect to:

1. Making you feel you have time during consultation *
2. Showing interest in your personal situation *
3. Making it easy for you to tell him or her about your problem
4. Involving you in decisions about your medical care
5. Listening to you
6. Keeping your records and data confidential
7. Providing quick relief of your symptoms *
8. Helping you to feel well so that you can perform your normal daily activities
9. Thoroughness of the approach to your problems *
10. Physical examination of you
11. Offering you services for preventing diseases (e.g. screening, health checks, immunisations)
12. Explaining the purpose of examinations, tests and treatments *
13. Telling you enough about your symptoms and/or illness *
14. Helping you deal with emotions related to your health status *
15. Helping understand why it is important to follow the GP's advice *
16. Knowing what has been done or told during previous contacts in the practice *
17. Preparing you for what to expect from specialists, hospital care or other care providers *

What is your assessment of the general practice over the last 12 months with respect to:

18. The helpfulness of the practice staff (other than the doctor) to you *
19. Getting an appointment to suit you?
20. Getting through to the practice on telephone?
21. Being able to talk to the general practitioner on the telephone *
22. Waiting time in the waiting room?
23. Providing quick services for urgent health problems?

* revised items

CHAPTER 1. BACKGROUND OF THE REVISION

1.1 Historical background

An international consortium of researchers and general practitioners developed the Europep instrument in the years 1995 - 1998. It was developed from the beginning as an international instrument for patient evaluations, using rigorous translation and validation procedures. We aimed at use for educational purposes in practices and regions as well as nationwide surveys and international comparisons. A series of studies were performed for its development, including an international study on patient priorities and studies to examine proto-versions of the questionnaire. The questionnaire is focused on evaluations of specific aspects of care (not: priorities, wishes, reports, experiences, satisfaction, utilities, etc.). Specific criteria were used for the final selection of items, which focused on coverage of domains of general practice, importance to patients, item-response, language problems, and discrimination (specific quantitative criteria were formulated). Providing effective feedback on Europep data was not explicitly addressed, but some countries have developed elaborated feedback procedures.

Since its development, the Europep instrument has been used in many local, regional and national projects. It was also part of new international projects, such as the EPA project on practice management (2002 - 2005). The contributors to this report provided the following examples of projects:

- Denmark: 56500 patients, 722 GPs, response 73%
- Italy: data from one project, n=983 (90% response, 25 GPs)
- Netherlands: data from one project, n=457 (13 practices)
- Germany: data from two projects, total n=1489
- Slovenia: data from two projects, total n=800
- Switzerland: data from three projects, total n=35709

1.2 Reasons for the revision

There was a mix of reasons to revise the instrument:

1. The experiences with the instrument in various countries has led to the identification of problems, needs, and ideas to adapt the current instrument. It was felt to be good to collect these experiences, as it is now ten years after the development of the instrument, and to consider what to change in the Europep questionnaire.

2. It was felt that the Europep questionnaire might not cover specific (new) aspects of general practice, because primary care has developed substantially in the last 10 years. The core group has identified a number of potential areas for possible new items (annex 3), but adding the idea of new items was not pursued in this report. This would require a new project.
3. A more flexible use of the Europep instrument was considered. In some situations a short form or core set of the Europep questionnaire may be needed, for instance if it is part of a longer questionnaire. Criteria for selecting items in the core version may be responsiveness for change, relevance of international comparison, etc. In addition, we might wish to create optional sub-sets of questions in addition to a core set, as this would allow more flexible use.
4. It was observed that a market for patient surveys has developed in Europe and other instruments have entered the field. Other questionnaires on patient views may be competitors in some situations, such as GPAQ / GPAS; CAHPS; Commonwealth; Picker.
We would like to include the strong components of these questionnaires in Europep, if possible.

1.3 Principles of the revision

1. A balance was sought between the wish to improve the instrument (e.g. better language) and the comparability of data over time and between countries. The comparability is enhanced by as few changes as possible in the language and structure of the instrument (words, type of questions, answering categories, answering scale, etc.).
2. The procedure for omitting items, adding items and making other changes had to be transparent and reproducible, similar to the original development of the Europep instrument. This implied that it was based on explicit criteria.
3. The Europep instrument has 23 items. At start of the revision process a rough indication of our revision was that we did not wish to omit more than a few items (<5 was mentioned).

4. International comparability is a key feature of the Europep questionnaire. Users can add country-specific items, which may be in the same format but which are not part of the Europep questionnaire.
5. Items can only be added if we manage to make appropriate translations (using the forward and backward translation procedure) and if we can perform a (small) survey study in several countries to test and validate the new items.
6. We will provide guidance on scoring and presentation of the data (e.g. how many missing values are allowed, how to calculate sum scores, etc.) – a users manual.
7. The final product should be attractive and easy to implement. Its aims should be clear.

1.4 Regulatory issues

The Europep instrument has been available in the public domain. This facilitates a large-scale use, which is positive, but which makes it difficult to coordinate further development and respond to inappropriate use of quality assessment instrument. Topas Europe Association will adopt Europep 2006. This is a non-profit association, ruled by its members, which has been established in 2005 under the Dutch law. It aims to stimulate and coordinate an appropriate development and use of quality assessment tools in general practice. Topas Europep Association will (among others) indicate what the appropriate version of instruments is; request registration and potentially a financial contribution by users. This will not be discussed in this report.

CHAPTER 2. REVISION PROCESS AND RESULTS

2.1 Items to be omitted or rephrased

Omitting or rephrasing items

Items could be omitted completely or replaced by a new item that is similar with respect to the content, but has some changes in the phrasing. Example: 'thoroughness of the approach to your problems' instead of 'thoroughness'. In principle, rephrasing implies that we create a new item, although we may accept minor revisions without saying that this is a new item. You may argue that any change, whatever small it is, creates a new item. We decided to consider small changes as acceptable, such as 'practice staff' instead of 'staff'.

As several countries could provide recent data based on the Europep instrument, we repeated the selection procedure that was used for the development of the Europep instrument. The following selection criteria were used:

- a Language: an item is omitted if there is a serious ambiguity or translation problem in any country, leading to misinterpretations; this is most relevant for countries, which have joined in after the original Europep study.
- b Item-response: an item is omitted if it has an unexpected response of lower than 30% in more than half of the countries. Some items are not applicable to many patients, but this does not imply that we omit these (annex 1, table 2).
- c Discrimination: an item is omitted (and may be added in a rephrased format) if more than 80% of the respondents used only one of the five answering categories in most (>80%) countries (which is also more conservative).

Originally, we also had criteria at the level of aspects of care:

* Coverage: all relevant aspects should be covered. The original five domains were not well supported by the factor analysis; this actually showed two domains, which could be labelled as 'physician behaviour' and 'practice management'. Some items are highly correlated, but this is considered in the creation of a short form and not in the omission of items. The reason is that items in the Europep instrument have a meaning by themselves, independent of the dimension in which they are.

* Importance: we have no recent internationally comparative data on importance, so this is not considered in the omission of items

Eight rounds of proposals and feedback were done in the core group over the email. Annex 1 provides a list of the language and interpretation problems, and proposed revisions, which were mentioned by members of the core group. The EPA project data on Europep data (collected in the period 2000 – 2005) were used for items 1b and 1c.

The final result was that we did not omit items, but achieved consensus on a number of minor rephrasings.

2.2 Changes in other parts of the questionnaire

Heading in the questionnaire

Currently: What is your opinion of the general practitioner and/or general practice over the last 12 months with respect to:

This issue was discussed as follows:

Belgium (Luc Seuntjens): discuss the possibility of changing ‘opinion’ into ‘score’?

Netherlands (Yvonne Engels): make two headings, one on GP and one on general practice.

Germany (Anja Klingenberg): 12 month is a short period and respondents ignore this > omit 12 months.

Slovenia (Janko Kersnik): no need for change in wording.

Switzerland (Beat Künzi): item 1 – 17 refers mainly to a single doctor whereas the remaining items refer to practice processes. Hence we prefer for the first part the current introduction and for the rest we suggest to rephrase “What was your personal experience in this practice with respect to ...”

UK (Glyn Elwyn): separate practitioner and practice (supported by Luc Seuntjens - Belgium, Richard Baker - UK; Peter Vedsted - Denmark).

Belgium: eventually change opinion into score as this is exactly what patients are asked to do (Denmark: does not like score); practices items are 6, 11, 18, 19, 20, 21, 22, and 23.

UK (Richard Baker): evaluation would be more accurate than opinion, but would potentially be more confusing to people with low language skills; perhaps assess/rate (Glyn: assess).

UK (Glyn Elwyn): the tense varies across items (past/present) and it is not clear whether the recent encounter or contacts in a period of time were referred to.

DK (response to previous comment): it should be contacts over time and past tense would suggest most recent encounter, which is not desirable.

We have decided to make two headings and replace 'opinion' by assessment:

- What is your assessment of the general practitioner over the last 12 months with respect to:
- What is your assessment of the general practice over the last 12 months with respect to:

Answering scale

Currently: Five point: Poor – Excellent (no labels in between) + not applicable/not relevant category.

It is important to base numbers for poor or excellent ratings on national standards, e.g. in Germany 1 will be excellent, whereas in Switzerland usually the higher the number the better..., hence 5 will be excellent. A change of the total numbers in the scale would require a new validation study, so it is proposed not to change. We accept that some countries make separate categories for 'not applicable' and 'not relevant' (Denmark). As part of the extension of Europep, we may consider different answering scales with possibly less ceiling effects (= proposal Denmark, implies a new validation study).

Item on overall evaluation

Such item was included in the first studies, but not in the actual Europep questionnaire. It will not be included in the revised questionnaire either.

But new user should be informed about the possibility to include overall evaluation items, also with an option for patients to comment on, i.e. to give concrete reasons for considering a change of doctor.

Changes in the introduction text

This can be adapted to the national situation and there was consensus that we do not wish to interfere with this.

2.3 EUROPEP 2006

The box below provides a final proposal for revision, which should not lead to new validation studies or formal translation procedures.

EUROPEP 2006

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1. Making you feel you have time during consultation *
2. Showing interest in your personal situation *
3. Making it easy for you to tell him or her about your problem
4. Involving you in decisions about your medical care
5. Listening to you
6. Keeping your records and data confidential
7. Providing quick relief of your symptoms *
8. Helping you to feel well so that you can perform your normal daily activities
9. Thoroughness of the approach to your problems *
10. Physical examination of you
11. Offering you services for preventing diseases (e.g. screening, health checks, immunisations)
12. Explaining the purpose of examinations, tests and treatments *
13. Telling you enough about your symptoms and/or illness *
14. Helping you deal with emotions related to your health status *
15. Helping understand why it is important to follow the GP's advice *
16. Knowing what has been done or told during previous contacts in the practice *
17. Preparing you for what to expect from specialists, hospital care or other care providers *

What is your assessment of the general practice over the last 12 months with respect to:

18. The helpfulness of the practice staff (other than the doctor) to you *
19. Getting an appointment to suit you?
20. Getting through to the practice on telephone?
21. Being able to talk to the general practitioner on the telephone *
22. Waiting time in the waiting room?

Providing quick services for urgent health problems?

* revised items

2.4 Short Form

Development of a short form

The short form is based on the original Europep questionnaire only, after exclusion of items that we have decided to omit. 'Do not know' and 'not relevant' answers are considered missing values. The (psycho/clini)metrics analyses were done: an explorative factor analysis (method PCA, based on covariance matrix, using eigen value > 1 as criterion, orthogonal rotation) on aggregated data. Step 2 is reliability analysis per domain. The short form is a proposal; you may wish to develop a different short form or only use the complete questionnaire, if you have specific aims. Ideally, it is tested empirically against the full version of Europep.

See annex 2 for results based on EPA data, n=12124. Factor analysis on the total datafile – ignoring the countries (PCA, varimax rotation, eigen value > 1 criterion) resulted in two factors, which might be labelled 'clinical management' and 'practice management' (60% variance explained). The skewness and factor loading (= correlation with underlying factor) provided little guidance to selection of items for a short form, as the differences between the items are small. If we take items with highest discrimination (% excellent under 50%) and best factor loading (0.70 or higher) we would select items 4, 8, 14, 15, 16, 17 within the domain clinical management. Within the domain practice management, we would select items 19, 20, 21, 22. This would result in the following 10 - item short form.

EUROPEP 2006.- SF 10

What is your assessment of the general practitioner over the last 12 months with respect to:

- 4 Involving you in decisions about your medical care
- 8 Helping you to feel well so that you can perform your normal daily activities
- 14 Helping you deal with emotions related to your health status
- 15 Helping understand why it is important to follow the GP's advice
- 16 Knowing what has been done or told during previous contacts in the practice
- 17 Preparing you for what to expect from specialists, hospital care or other care providers

What is your assessment of the general practice over the last 12 months with respect to:

- 19 Getting an appointment to suit you?
- 20 Getting through to the practice on telephone?
- 21 Being able to talk to the general practitioner on the telephone
- 22 Waiting time in the waiting room?

Criterion validity

For instance: relate a patient evaluation of waiting times with observed waiting times.

There was consensus that this was possible for only a few items. Another possibility is to compare Europep against a different validated questionnaire for patient evaluations, but this would require additional studies - these are currently not planned.

CHAPTER 3. USER MANUAL

3.1 General instructions

* The use of the Europep instrument is an example of survey research. Therefore all good methodological guidance regarding survey research applies to the use of the Europep instrument.

* While researchers are free to use, collect and analyse Europep data as they wish, a number of recommendations are made that provide a standard approach to the collection and analysis of Europep data.

3.2 Sampling procedures

* An appropriate sampling procedure is crucial for the validity of results. This requires, among others, a clear definition of the sampling frame (from which cases are sampled) and a sampling procedure that avoids bias (ideally, random sampling). Bias caused by the sampling procedure cannot be compensated for by larger sample sizes, a small but good sample may be preferable to a large but biased sample.

* Inclusion of more patients increases the power of the study and results in more accurate estimations (smaller confidence intervals). If figures are presented for specific practices or practitioners, it should be taken into account that the data are clustered. Statistical advice on appropriate power calculations may be needed. Some studies have suggested that a minimum of 60 respondents is needed per single-handed practice to allow for reliable figures at the level of practitioner. Lower numbers may be acceptable in educational feedback or scientific research, depending on the use. It is difficult to provide absolute figures for the sample size in studies, which use the Europep instrument. More patients need to be included to assess bigger practices with more doctors.

* The Europep instrument was not made for one particular sampling procedure. Many users have recruited patients among visitors of a general practice, but others have sampled patients from practice registers or population registers. Response rate is defined as the number of completed questionnaires divided by the total of questionnaires, which reached the target population. A low response rate could induce selection bias. Many studies with the

Europep instrument have achieved response rates of 70% or higher. It is recommended to strive for a response rate of at least 60% in the use of the Europep instrument.

* Sending reminders (in whatever format) can increase the response rate by about 10%. In many situations it is necessary to use reminders to achieve acceptable response rates.

3.3 Missing values

* Missing values are a problem for any study, which cannot fully be solved. Many users of the Europep instrument have regarded the category 'do not know/not applicable' as a missing value. It is recommended to use this approach as the standard procedure.

* In the calculation of scales (see items and scales) missing values are handled as follows. Patients are excluded if more than one third of the items in the scale were missing values (no answers or not applicable/not relevant). We do not favour imputation of missing values in scales.

3.4 Items and scales

* Each item in the Europep instrument has been developed to reflect a specific concept. In other words, different items are not necessarily repeated measures for an underlying concept. This implies that items can be presented and interpreted separately.

* Scales are aggregations of different items, which reflect an underlying concept (such as "practice management"). While the precise meaning of the individual items gets lost, the advantage of scales is that these are usually more accurate than individual items (smaller confidence intervals). It is suggested that the Europep instrument contains two scales: a general practitioner evaluation (item 1 - 17) and a general practice evaluation (item 18 - 23).

* While various methods for scaling may be acceptable, the following procedure is recommended as a standard for Europep users. Reliability analysis is used to verify the internal consistency (Cronbach's alpha) on each of the two scales in the Europep instrument. Raw scores are used for analysis; cases with missing values (see missing values) are excluded by listwise deletion. Alpha's should be above 0.70 (an arbitrary value), but are usually much higher.

* While different procedures for calculation of scale scores are acceptable, the following procedure is recommended as a standard for European users. Missing values have been defined and items are dichotomised according to 5 versus 1 - 4 (excellent versus less than excellent). The category excellent is coded as 1, while the other valid values are coded as 0. Then the mean value of the items in the scale is determined. For this purpose a new variable is defined, which is the aggregation of the selected items. The result is a scale score for each individual, which can be interpreted as a percentage.

Additionally benchmarks may be defined as e.g. the percentage of patients expressing "excellent" among the 25 percent (or 10 percent) of the best physicians for the pertinent item in a cohort (75th or 90th percentile rank).

3.5 Data-analysis and interpretation

* For educational purposes little more than presentation of frequency distributions may be needed. For comparison with other providers or patient groups potential confounders should be considered. The most obvious confounder in studies of patient views is patient age, although the absolute size of effect of age is small. It has been found that older patients have more positive views of the care received. It is therefore recommended to control for age in comparisons, certainly if they are used for accreditation, certification or public reporting.

* It is recommended to present all figures with 95% confidence intervals, certainly if they are used for accreditation, certification or public reporting. In many, if not all, applications data are clustered within practices or practitioners (different patients from the same practice/practitioner is included). This implies that random effects models should be used, for which external statistical advice may be required. Inappropriate statistics are most likely to overestimate differences and changes, because confidence intervals tend to be wider after correction for clustering.

* It is recommended to interpret results carefully if the response rate is low (e.g. lower than 60%). While the results may still be valuable for educational feedback and scientific research, they are probably less useful for accreditation, certification and public reporting.

CONCLUDING REMARKS

This report described the aims, process and result of the revision of the Europep instrument. The two logical next steps would be to get support from relevant bodies, such as EquiP, and to make valid translations and perform pilot tests in various countries. If the EUROPEP 2006 has been tested and accepted, it should become integrated in existing structures for quality projects as well as research and development. At an international level, Topas Europe Association could provide such structure. At national and regional levels, other structures are needed.

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Conflict of interest: Most contributors to this report have an interest in the use of the Europep instrument in their country in terms of acknowledge of their work, in some cases also financially.

International papers based on EUROPEP questionnaire

Grol R, Wensing M, Mainz J, Jung HP, Ferreira P, Hearnshaw H, Hjortdahl P, Olesen F, Reis S, Ribacke M, Szecsenyi J. Patients in Europe evaluate general practice care: an international comparison. *Br J Gen Pract* 2000;50:882-887.

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Bovier P, Künzi B, Stalder H. Qualité des soins en médecine de premier recours: « A l'écoute de nos patients ». *Rev Méd Suisse* 2006;2:2176-81 (www.revmed.ch).

Annex 1. Rephrasings based on ambiguity and language problems

1. Making you feel you had time during consultations? MAKING YOU FEEL YOU HAVE TIME DURING CONSULTATIONS	Denmark + Italy + Slovenia: enough time, otherwise difficult to evaluate [MW: not added, because it substantially changes the meaning and we had reasons in 1997 to avoid enough] UK (GE): past tense is use, different with most other items CH: making you feel you have time during consultations
2. Interest in your personal situation? SHOWING INTEREST IN YOUR PERSONAL SITUATION	UK: showing interest .. etc. DK: revision OK GE: revision OK CH: revision ok
3. Making it easy for you to tell him or her about your problem?	
4. Involving you in decisions about your medical care?	
5. Listening to you?	
6. Keeping your records and data confidential	ITALY: perhaps rephrase, because it is highly skewed, 80% answers that it is excellent. GERMANY: important, good experiences in EPA, but many patients write that they don't know DENMARK: in what situation – the practice, the waiting room, town ? – should be more precise – patient trust or practice organisation ? SLOVENIA: fine CH: ok, despite 73% excellent answers in overall cohort
7. Quick relief of your symptoms? PROVIDING QUICK RELIEF OF YOUR SYMPTOMS	GERMANY: doctors are unhappy with this, may be unrealistic; revision a bit better UK (RB): providing quick relief .. etc.; important issue, should not be dropped from the questionnaire UK (GE): may not be a very helpful item, assumes longitudinality in contacts DK + ITALY + SLOVENIA: revision OK
8. Helping you to feel well so that you can perform your normal daily activities?	SLOVENIA: difficult to accomplish in reality, add 'as much as possible' DENMARK: only for chronic patients – make it optional UK: important issue, should not be dropped
9. Thoroughness? THOROUGHNESS OF THE APPROACH TO YOUR PROBLEMS	UK: vague, refers to examination, treatment etc? perhaps: take a thorough approach to your problems DK + Italy + Slovenia: revision OK
10. Physical examination of you?	UK + SLOV: examining you thoroughly (MW: changes meaning substantially and induces overlap with item 9) DK: not just physical examination SLO: psychological component in item 2
11. Offering you services for preventing diseases (e.g. screening, health checks, immunisations)	UK: services is a cumbersome term, it implies special clinics or similar special arrangements ITALY: OK
12. Explaining the purpose of tests and treatments? EXPLAINING THE PURPOSE OF EXAMINATIONS, TESTS AND TREATMENTS	SLOVENIA: add: examinations DK: revision OK GE: revision OK
13. Telling you what you wanted to know about your symptoms and/or illness? TELLING YOU ENOUGH ABOUT YOUR SYMPTOMS AND/OR ILLNESS	DENMARK: telling enough about your symptoms. Patient may not always want to know the message, e.g. if it is a bad message. ITALY + Slovenia: revision OK
14. Helping you deal with emotional problems related to your health status? HELPING YOU DEAL WITH EMOTIONS RELATED TO YOUR HEALTH STATUS	BELGIUM: perhaps omit it, because it is not always relevant. SLOVENIA: add: and problems DENMARK: deal with emotions related to (revision OK) GE: revision OK
15. Helping you understand the importance of following his or her advice	BELGIUM: is rather abstract/omit 'you' SLOVENIA: add: advice for diagnostics and treatments + complicated and not always applicable

HELPING UNDERSTAND WHY IT IS IMPORTANT TO FOLLOW THE GP'S ADVICE	GERMANY: not always clear, sounds a bit paternalistic; perhaps helping you understand why it is important to follow advice UK: ... following the GP's advice DENMARK: important to get an evaluation of the GP's ability to create maximal adherence (revision OK?) GE: does not make sense in German, would not change the translation into German; OK if preferred by others ITALY: helping you understand why it is important to follow the GP's advice
16. Knowing what s/he had done or told you during previous contacts? KNOWING WHAT HAS BEEN DONE OR TOLD DURING PREVIOUS CONTACTS IN THE PRACTICE	BELGIUM: omit 'you', revised version: should be clearer SLOVENIA: knowing and understanding ...+ vague concept / agree with revision DENMARK: knowing what had been done during your previous contacts (not referring to a particular doctor, should include nurse contacts) UK: item should focus on DONE or TOLD, but not both GE: revision needs discussion, item has substantially changed – would like to keep the old item at any case ITALY: revision OK
17. Preparing you for what to expect from specialist or hospital care? PREPARING YOU FOR WHAT TO EXPECT FROM SPECIALISTS, HOSPITAL CARE OR OTHER CARE PROVIDERS	SLOVENIA: add: , when referred + not applicable in 70% of the patients / agree with revision DENMARK: or more general, when referred to other care providers... GE: revision needs discussion, would like to keep the old question ITALY: agree with revision
18. The helpfulness of the staff (other than the doctor)? THE HELPFULNESS OF THE PRACTICE STAFF (OTHER THAN THE DOCTOR) TO YOU	SLOVENIA: practice staff / agree with revision DENMARK: divide into helpfulness/service and competence GE: already translated as practice staff IT: helpfulness is part of staff competences, depends on what you want to evaluate
19. Getting an appointment to suit you?	SLOVENIA: .. to see the doctor to suit you + do we really need this DENMARK: we need this item
20. Getting through to the practice on telephone?	SLOVENIA: add (receptionist, nurse) + do we really need this DENMARK: .. to the receptionist (this refers to other aspects than the accessibility of practice and GP)
21. Being able to speak to the general practitioner on the telephone? BEING ABLE TO TALK TO THE GENERAL PRACTITIONER ON THE TELEPHONE	SLOVENIA: being able to get an advice from .../ agree with revision DENMARK: ... talk to ... (should not be part of the accessibility) GE: revision needs discussion, what is exactly evaluated? ITALY: talk sounds like chat / better to get advice about your health problem
22. Waiting time in the waiting room?	
23. Providing quick services for urgent health problems?	SLOVENIA add: not emergency care + perhaps different question needed

Annex 2. Metrics for short form

I. Clinical management

	Percentage excellent Skewness	Factor loading after orthogonal rotation	Item revised because of interpretation problems
1. Making you feel you had time during consultation?	57% -1.446	0.723	X
2. Interest in your personal situation?	56% -1.526	0.740	X
3. Making it easy for you to tell him or her about your problem?	55% -1.423	0.765	
4. Involving you in decisions about your medical care?	48.8% -1.249	0.760	
5. Listening to you?	62% -1.692	0.773	
6. Keeping your records and data confidential	64% -2.172	0.587	
7. Quick relief of your symptoms?	41% -1.020	0.644	X
8. Helping you to feel well so that you can perform your normal daily activities?	44% -1.153	0.715	
9. Thoroughness?	55% -1.432	0.750	X
10. Physical examination of you?	50% -1.343	0.714	
11. Offering you services for preventing diseases (e.g. screening, health checks, immunisations)	44% -1.296	0.647	
12. Explaining the purpose of tests and treatments?	51% -1.372	0.766	X
13. Telling you what you wanted to know about your symptoms and/or illness?	53% -1.362	0.765	X
14. Helping you deal with emotional problems related to your health status?	41% -1.235	0.771	X
15. Helping you understand the importance of following his or her advice	44% -1.141	0.756	X
16. Knowing what s/he had done or told you during previous contacts?	45% -1.177	0.719	X
17. Preparing you for what to expect from specialist or hospital care?	35% -1.220	0.718	X

2. Practice management

	Percentage excellent Skewness	Factor loading after orthogonal rotation	Item revised because of interpretation problems
18. The helpfulness of the staff (other than the doctor)?	56% - 1.726	0.650	X
19. Getting an appointment to suit you?	52% -1.557	0.800	
20. Getting through to the practice on telephone?	53% -1.587	0.787	
21. Being able to speak to the general practitioner on the telephone?	36% -1.328	0.738	X
22. Waiting time in the waiting room?	24% -0.638	0.705	
23. Providing quick services for urgent health problems?	49% -1.758	0.644	

Annex 3. Suggested areas for new questions

This annex lists the suggestions provided by the core group members, but it should not be seen as an exhaustive list. It is relevant for the extension of the Europep instrument (phase 3 in the working plan), but not for the revision of the Europep instrument itself (phase 2 in the working plan).

- * patient empowerment and self-management education
 - encouraging the self-management of your care
 - the helpfulness of the doctor and the staff to explain you how to manage (or cope or face) your disease
- * decision-making:
 - involvement in decision making
- * prescribing
 - medication/prescribing, including choice of medication, use of generic drugs, being involved in decisions on best medication etc.
 - ask regularly about prescription and non-prescription medicine / side effects
- * counseling
 - education /guidance on patient self-management, self-care, what you can do yourself to health
- * accessibility / continuity
 - accessibility of general practice care
 - GP / staff days off work or disability days, and health care use, including length of stay in hospital
 - opening hours of the practice
 - possibility to see the particular doctor you want to see
 - information on where to get medical treatment when the practice is closed
- * organisation in the practice
 - management of patients with chronic diseases
 - revision of professional roles and multidisciplinary collaboration
 - follow-up on diagnostic procedures and treatments
 - care from nurses and other non-medical staff
 - physician assistant taking care of you while in the practice
 - friendliness of the receptions /physician assistant
 - cooperation between doctor and staff
 - pleasantness of practice facilities
 - way the practice are involved in the patients' care
- * collaboration with other care providers outside the practice
 - organisation and how the patient evaluates the way the GP delivered the patient to other parts of the health care system and how the GP received the patient from the other health care sectors
 - referral process, delay, information etc.
 - the way the patient is transferred between health sectors (integrated care, care paths)
- * choice / possibilities
 - choice for different conditions – acute, chronic etc.
 - possibility to communicate with the doctor by email
 - possibility to have insight into own medical care records
- * other
 - ideas to improve practice in a proactive way (rather the retrospective evaluations)
 - trust
 - state of the practice (cleanness, periodicals, brochures, general impression)
 - special questions for parents accompanying little children
 - special questions for adolescents
 - medical knowledge and competence of the doctor
 - preventing from hearing confidential information about other patients
 - GP co-operatives for out-of-hours services