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The CAHPS Ambulatory Care Improvement Guide

Practical Strategies for Improving Patient Experience

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DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

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Section 1: About the CAHPS Ambulatory Care Improvement Guide

The extensive and growing use of the CAHPS surveys in ambulatory settings has created a demand for practical strategies that health plans, medical groups, physician practices, and other organizations can use to improve patients' experiences with care. The CAHPS Ambulatory Care Improvement Guide is designed to help meet this need. It is aimed at executives, managers, physicians, and other staff who are responsible for assessing patient experience and improving the quality of health care services.

What are CAHPS surveys?

The Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The family of CAHPS surveys includes instruments designed to assess patient experience with health plans, physician practices, hospitals, and other providers of health care. All CAHPS surveys are standardized, which means that results can be compared by survey users across the country. As a result, these surveys enable providers to identify their strengths and weaknesses with respect to patient experience and evaluate their performance over time.

1.A. What Surveys Are Addressed by This Guide?

The guide is structured around the aspects of patient experience with health care assessed by two CAHPS surveys: the CAHPS Health Plan Survey and the CAHPS Clinician & Group Survey.

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. Since its launch by the Agency for Healthcare Research and Quality (AHRQ) in 1997, this survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans, including Medicare, Medicaid and commercial plans. To be accredited by the National Committee for Quality Assurance, health plans must submit the results of a modified version of the commercial questionnaire. The Centers for Medicare & Medicaid Services (CMS) also administers a version of the CAHPS Health Plan Survey designed for Medicare beneficiaries.

The CAHPS Clinician & Group Survey asks patients to evaluate their experience with health care providers and staff in doctors' offices. Since its release by AHRQ in 2007, this survey has been implemented by medical practices and groups, health systems, health plans, regional and community-based collaboratives, accreditation and certification organizations, and State and Federal agencies, including CMS.

The guide does not currently address the needs of organizations that use the CAHPS Hospital Survey (HCAHPS) or other CAHPS surveys. However, much of the guidance

about the prerequisites for effective quality improvement, the cyclical approach to implementing improvement strategies, and the process of analyzing performance issues is pertinent to all organizations seeking to improve patients' experiences with care.

1.B. What Can I Find in this Guide?

The CAHPS Ambulatory Care Improvement Guide has several parts:

- **Why Improve Patient Experience?** A compelling case for health care organizations to focus on improving their patients' experience with care.
- **Are You Ready to Improve?** An overview of behaviors common to health care organizations that have been effective in providing positive experiences with care.
- **Ways to Approach the Quality Improvement Process.** A walk through the basic steps of a CAHPS-related quality improvement initiative.
- **Determining Where to Focus Efforts to Improve Patient Experience.** A discussion of ways to analyze data from CAHPS surveys in order to identify opportunities to improve and various approaches to gathering additional information to help inform selection of strategies for improvement.
- **Strategies for Improving Patient Experience with Ambulatory Care.** Descriptions of strategies that health care organizations can implement in order to help improve consumers' and patients' experiences with care.

Each section includes brief lists of published studies, Web sites, books, and other resources that address the various issues discussed in the guide.

1.C. What Performance Issues Are Addressed in the Guide?

This guide suggests quality improvement strategies that can address a variety of performance issues assessed by CAHPS surveys of ambulatory care. Table 1-1 indicates which issues are addressed by the two surveys. Some topics are covered by "core" survey items, which are items that must be included in a given version of a survey in order for it to qualify as a CAHPS instrument. Other topics are addressed by supplemental CAHPS items that survey users could choose to add to their instruments. Some of these optional topics have already been incorporated into specific versions of a survey, such as CMS's Medicare Advantage Survey and Qualified Health Plan Enrollee Survey.

Table 1-1. Full list of topics addressed in the guide, organized by survey

	Health Plan Survey	Clinician & Group Survey
Access to care	C	C
Communication between patients and providers	C	C
Communication about costs of care	S	S
Coordination of care	S	C
Cultural competence	S	S
Customer service	C	C
Health plan information	S	
Health promotion/Education	S	S
Integration of behavioral health		S
Self-management		S
Shared decision-making	S	S

C=Core items
S=Supplemental items

For most of these topics, an organization's performance is reported for a composite measure, which combine the results for two or more closely related questions into one score. Table 1-2 lists the core composite measures from the Health Plan Survey and the Clinician & Group Survey.

Table 1-2. Core composite measures in the CAHPS Health Plan Survey and the CAHPS Clinician & Group Survey

	Health Plan Survey	Clinician & Group Survey
Core Topics		
Access to care	• Getting need care • Getting care quickly	• Getting timely appointments, care, and information
Communication between patients and providers	• How well doctors communicate	• How well providers communicate with patients
Care coordination		• Providers' use of information to coordinate patient care *(new to version 3.0)*
Customer service	• Health plan customer service	• Helpful, courteous, and respectful office staff

1.D. What Information Can I Find About Improvement Strategies?

The guide presents a variety of ideas for improving the patient's and consumer's experience of care organized by topic area (e.g., access, communication, customer service). The descriptions of the strategies are intended to give you enough information to determine whether the idea is pertinent to your organization and worth further investigation. Specifically, the summaries of each strategy cover the following questions:

- What are the problems shaping the patient's or member's experience with the health care organization?
- What is the practice that can help address this problem? What is its purpose? What benefits does it offer to patients, providers, and plans?
- How has it been implemented?
- What are the published results of an evaluation (if any)?
- What are some sources of additional information on the strategy?

1.E. How Do I Select a Strategy?

The strategies outlined in this guide represent a range of possible solutions. When you review your options, keep these considerations in mind:

- **Appropriateness for your organization:** Some strategies are more appropriate for health plans, while others are better suited to medical groups and physician practices. In some cases, the strategies are directed at both types of organizations, but one will have to take the lead.
- **Resources and time available:** Some strategies are easy and inexpensive to implement, while others are much more logistically complex and require a significant investment of money, resources, and time. If you find a strategy that seems appropriate but overwhelming, it's fine to "start small"—perhaps by tackling one component of the strategy, or even by stepping back to assess your organization's readiness for the change. You may also want to explore ways to stage the implementation of one or more strategies to make them more feasible.
- **How quickly you need to see results:** As you review your options, consider the immediate and long-term goals of your organization, as well as its constraints. Some strategies are likely to address the performance issue directly, while others may have an indirect impact. Some may allow you to see results right away, whereas others may take months or even years to make a measurable difference.

1.F. Who is Responsible for This Guide?

The CAHPS Ambulatory Care Improvement Guide was produced by a team of researchers associated with the Yale School of Public Health with funding from the Agency for Healthcare Research and Quality. It builds on the original CAHPS Improvement Guide released in 2003, which was developed with the support of the Centers for Medicare & Medicaid Services (CMS) for the benefit of Medicare health plans. Since that time, the Guide has been updated a few times, expanded to address the needs of different kinds of health plans and provider organizations, and transformed to be more accessible through the Web.

Section 2: Why Improve Patient Experience?

In the face of multiple priorities and limited resources, leaders of health care organizations may question the value of measuring and improving the patient's experience with care. Yet, powerful market and regulatory trends, combined with increasing evidence linking patient experience to important clinical and business outcomes, make a compelling case for improving patient experience as measured by CAHPS surveys.

2.A. Forces Driving the Need to Improve

Forces contributing to the growing imperative to improve patient experience include the public reporting of CAHPS survey scores as well as various initiatives to build measures of the patient experience into performance-based compensation systems, board certification and licensing, and practice recognition programs. A growing demand among patients for an enhanced service experience and greater participation in their health care is placing further pressure on health care systems to find ways to become more patient-centered.

Examples of prominent forces driving improvement efforts ***among health plans*** include the following:

- The Centers for Medicare & Medicaid Services (CMS) has been using several versions of the CAHPS Health Plan Survey since 1998 to measure the experiences of Medicare beneficiaries. These surveys are conducted annually with results reported publicly on the Medicare Plan Finder Web site. CAHPS survey results are combined with other quality measures in "star ratings" that take into account not only current levels of performance but also progress on improvement.
- The CAHPS Health Plan Survey is a mandatory part of health plan accreditation required by the National Committee for Quality Assurance (NCQA) for both commercial and Medicaid health plan product lines.
- A large number of States require the collection and reporting of the Medicaid version of the CAHPS Health Plan Survey as part of performance-based managed care contracts for Medicaid and Children's Health Insurance Program (CHIP) enrollees.
- Health plans offered in the new Federal and State-based Health Insurance Marketplaces conduct the Qualified Health Plan (QHP) Enrollee Survey, which is a version of the CAHPS Health Plan Survey. Results of the survey will be incorporated into the "star ratings" for QHPs and may be publicly reported on Marketplace Web sites.

Examples of forces driving improvement efforts ***among medical groups and physician practices*** include the following:

- The Patient Protection and Affordable Care Act of 2010 includes several new provisions for measuring and reporting patient experience of care:
- Health systems choosing to participate in the Medicare Shared Savings Program are required to use the CAHPS Survey for Accountable Care Organizations (ACOs). The results of the ACO CAHPS Survey (which builds upon the CG-CAHPS core survey) are used for public reporting on the Physician Compare website, as well as for calculating any "shared savings" to be earned by participating ACOs.
- Similarly, the Physician Quality Reporting System (PQRS) program administered by CMS includes a patient experience survey component using the CAHPS for PQRS Survey, which also builds upon the CG-CAHPS core survey. Requirements for using this survey are being phased in over time; eventually, all medical practices with two or more eligible professionals will be required to measure and report patient experience using the PQRS CAHPS Survey. These survey results are reported on the Physician Compare Web site and used with other performance measures to adjust Medicare fee-for-service (FFS) payments to all participating physicians.
- Starting in 2019, two new physician payment programs—a merit-based incentive payment system (MIPS) and eligible alternative payment models (APMs)—are likely to include some version of the CG-CAHPS Survey as part of the quality measurement formula used for payment. These programs were created under the Medicare Access and CHIP Reauthorization Act (MACRA).
- The National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home program includes optional recognition of patient experience. Physician practices seeking recognition are encouraged to use the CAHPS Clinician & Group Survey with the Patient-Centered Medical Home Item Set.
- Virtually all of the sixteen State and community-based multistakeholder organizations funded under the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) program included the measurement, reporting, and improvement of patient experience with primary care in their efforts to reform their local health care systems. While the AF4Q program concluded in 2015, many of these collaborative organizations are continuing their survey efforts, as are other regional collaboratives participating in the Network for Regional Healthcare Improvement (NRHI).

- The American Board of Medical Specialties (ABMS), which oversees the Maintenance of Certification (MOC) process that 24 medical specialties use to confirm physicians' qualifications every five years, continues to explore requiring medical boards to use patient experience measures to assess the communication skills and professionalism of physicians with direct patient care responsibilities.
- The National Priorities Partnership has articulated a goal of measuring and using patient experience in all care settings. Its Work Group on Patient and Family Engagement has specifically identified widespread implementation of the CAHPS Clinician & Group Survey in ambulatory settings as a top priority.
- Health plans (such as Blue Cross Blue Shield of Massachusetts and HealthPlus of Michigan) and multi-stakeholder organizations (such as California's Integrated Healthcare Association) are incorporating patient experience scores into provider pay-for-performance incentives.

2.B. The Clinical Case for Improving Patient Experience

Improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right. But good patient experience also is associated with important clinical processes and outcomes. For example:

- At both the practice and individual provider levels, patient experience positively correlates to processes of care for both prevention and disease management.[1] For example, diabetic patients demonstrate greater self-management skills and quality of life when they report positive interactions with their providers.[2]
- Patients' experiences with care, particularly communication with providers, correlate with adherence to medical advice and treatment plans. [3, 4, 5, 6] This is especially true among patients with chronic conditions, where a strong commitment from patients to work with their providers is essential for achieving positive results.[7]

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[1] Sequist TD, Schneider EC, Anastario M, et al. Quality monitoring of physicians: Linking patients' experiences of care to clinical quality and outcomes. *J Gen Intern Med* 2008;23(11):1784–90.

[2] Greenfield S, Kaplan HS, Ware JE Jr, et al. Patients' participation in medical care: Effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med* 1988;3:448-57.

[3] DiMatteo, MR. Enhancing patient adherence to medical recommendations. *JAMA* 1994;271(1):79-83.

[4] DiMatteo MR, Sherbourne CD, Hays RD, et al. Physicians' characteristics influence patients' adherence to medical treatment: Results from the Medical Outcomes Study. *Health Psychol* 1993;12(2):93-102.

[5] Safran DG, Taira DA, Rogers WH, et al. Linking primary care performance to outcomes of care. *J Fam Pract* 1998;47(3):213-20.

[6] Zolnierek KB, Dimatteo MR. Physician communication and patient adherence to treatment: A meta-analysis. *Med Care* 2009;47(8):826-834.

[7] Beach MC, Keruly J, Moore RD. Is the quality of the patient-provider relationship associated with better adherence and health outcomes for patients with HIV? *J Gen Intern Med* 2006;21(6):661-5.

- Patients with better care experiences often have better health outcomes.[8, 9] For example, studies of patients hospitalized for heart attack showed that patients with more positive reports about their experiences with care had better health outcomes a year after discharge.[10, 11]

Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency.

2.C. The Business Case for Improving Patient Experience

Patient experience is correlated with key financial indicators, making it good for business as well as for patients. For example:

- Good patient experience is associated with lower medical malpractice risk.[12, 13] A 2009 study found that for each drop in patient-reported scores along a five-step scale of "very good" to "very poor," the likelihood of a provider being named in a malpractice suit increased by 21.7 percent.[14]
- Efforts to improve patient experience also result in greater employee satisfaction, reducing turnover. Improving the experience of patients and families requires improving work processes and systems that enable clinicians and staff to provide more effective care. A focused endeavor to improve patient experience at one hospital resulted in a 47 percent reduction in employee turnover.[15]
- Patients keep or change providers based upon experience. Relationship quality is a major predictor of patient loyalty; one study found patients reporting the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships.[16]

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[8] Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. *Ann Intern Med* 1985;102(4):520-8.

[9] Stewart MA. Effective physician-patient communication and health outcomes: A review. *CMAJ* 1995;152(9):1423-33.

[10] Fremont AM, Clearly PD, Hargraves JL, et al. Patient-centered processes of care and long-term outcomes of acute myocardial infarction. *J Gen Intern Med* 2001;14:800-8.

[11] Meterko M, Wright S, Lin H, et al. Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. *Health Serv Res* 2010 Oct;45(5):1188-204.

[12] Levinson W, Roter DL, Mullooly JP, et al. Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;277:553-9.

[13] Hickson GBC, Clayton EW, Entman SS, et al. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA* 1994;272:1583-7.

[14] Fullam F, Garman AN, Johnson TJ, et al. The use of patient satisfaction surveys and alternate coding procedures to predict malpractice risk. *Med Care* 2009 May;47(5):1-7.

[15] Rave N, Geyer M, Reeder B, et al. Radical systems change: Innovative strategies to improve patient satisfaction. *J Ambul Care Manage* 2003;26(2):159-74.

[16] Safran DG, Montgomery JE, Chang H, et al. Switching doctors: Predictors of voluntary disenrollment from a primary physician's practice. *J Fam Pract* 2001;50(2):130-6.

Resources

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- Anhang Price R, Elliott MN, Zaslavsky AM, et al. Examining the role of patient experience surveys in measuring health care quality. *Med Care Res Rev* 2014;71(5) 522-54.
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Section 3: Are You Ready To Improve?

Improving CAHPS scores, i.e., the patient's experience of care, is a quality improvement challenge that is somewhat different from improving a clinical or technical process of care. This kind of transformational work requires new tools and often challenges many existing practices in your organization.

Before embarking on this kind of improvement initiative, it is helpful to perform a self-assessment to evaluate whether your organization approaches improvement in a manner that is associated with the successful implementation of CAHPS-related quality improvement (QI) programs. This is a valuable exercise because it takes time and effort to work through the QI process, i.e., to identify weaknesses, develop and apply solutions, and refine your strategies until they have a measurable and sustainable impact.

Read this section to learn about several behaviors common among organizations that are committed to and successful at improving their performance:

A. Cultivating and supporting QI leaders.
B. Organizing teams responsible for improving patient experience.
C. Training staff in QI concepts and techniques.
D. Paying attention to customer service.
E. Recognizing and rewarding success.

Once they become part of the organization's culture, these behaviors often play a large role in supporting and driving successful efforts to improve members' and patients' experiences with health care. If any are missing or inadequate in your organization, you may want to think about ways to introduce them. At the very least, recognize the impact of their absence on efforts to improve CAHPS performance and plan accordingly. You may, for example, need to devote resources to training team members in basic process improvement methods, or set aside time to educate and build support among physicians or board members.

3.A. Cultivating and Supporting QI Leaders

Many health care organizations are highly resistant to change. Employees are not encouraged to solve problems on their own, nor do they challenge the status quo. Most are accustomed to following standard operating procedures even when the policies and procedures may seem ineffective and outdated. Given the life and death issues confronted every day in most health care organizations, this risk-averse behavior is neither surprising nor hard to understand.

Because of this pervasive attitude, the search for better solutions and creative new approaches to long-standing problems requires strong and consistent encouragement and support. In order to achieve the goals of better performance on CAHPS measures,

health plans and ambulatory care providers must cultivate strong leaders throughout their organizations. Leaders are those who can communicate a compelling vision, motivate clinicians and other staff to lower their resistance to change, and effectively and willingly participate in the redesign of new systems of care. Ideally, all levels of staff in the organization should become adept at leading change, making changes, and managing change.

3.A.1. Sources of Leadership

Leadership for quality improvement (QI) can emanate from multiple sources: the board, the CEO and senior leadership team, and mid-level managers. Leaders may obtain their power from the authority of a title, through mastery of knowledge, or through the strength of personality or persuasive abilities.

Senior Leadership: Studies suggest that leadership from the top is a key factor in determining whether clinicians and others support and participate in QI efforts.[17] Senior leaders set the tone and establish the policies and organizational structure that can either strengthen or undermine QI efforts.

Mid-level Management: Because CAHPS surveys ask about multiple aspects of the care delivery process, the success of efforts to improve CAHPS scores often depends on the involvement—or at least cooperation—of clinicians, administrative managers, nurses, other clinicians, and practice staff. Medical group administrators and medical directors can also encourage cross-functional improvements in a group practice or ambulatory care site by selecting interdisciplinary team members and physicians with a special interest in QI.

The Board: Finally, strong board leadership can play a crucial role in QI. With the high turnover rates in plan and medical group senior executives, the board can help sustain a corporate culture focused on quality and provide "constancy of purpose."[17]

3.A.2. Attributes of Service-Oriented Leaders

Effective leaders maintain a focus on the needs of those they serve and their employees. Such leaders exhibit the characteristics listed in Table 3-1.

[17] Weiner BJ, Shortell SM, Alexander J. Promoting clinical involvement in hospital quality improvement efforts: The effects of top management, board, and physician leadership. *Health Serv Res* 1997;32(4):491-510.

Table 3-1. Characteristics of effective service-oriented leaders

Desired characteristics	Undesirable characteristics
Energetic, creative	Not…Stately, conservative
Participatory, caring	Not…Removed and elitist
Listening, coaching, and teaching	Not…Supervising and managing by command and control methods
Motivating by mission	Not…Motivating by fear
Leading by means of personally demonstrated values	Not…Relying on institutional policies that are meaningless or outdated

Source: Heskett JL, Jones TO, Loveman G, et al. Putting the service-profit chain to work. *Harv Bus Rev* 1994 March-April:64-74.

3.A.3. Key Tasks for Leaders at Every Level

Those who study effective leadership have identified ten practices that leaders at all levels can implement to produce and maintain an environment that emphasizes and encourages quality improvement:[18]

1. Link QI goals to the organization's mission and strategic plan (in other words, integrate improvement planning with business planning).
2. Establish and communicate the purpose of the organization.
3. Adopt and encourage a view of the organization as a system.
4. Use measurement and management's attention to keep the organization focused on the goals of QI efforts.
5. Allocate financial and other resources (e.g., staff) to QI endeavors.
6. Align incentives and performance appraisals to stimulate QI. (For example, create reward and recognition programs that reinforce the values and goals of the organization.)
7. Design and manage a system for gathering improvement information.

Learn More About Leadership

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- Lencioni P. The five dysfunctions of a team: A leadership fable. San Francisco: Jossey-Bass; 2002.
- Berwick DM. A primer on leading the improvement of systems. *Br Med J* 1996;312:619-22.

[18] Langley GJ, Nolan KM, Norman C, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass; 1996.

8. Remove barriers, which could be a function of finances, policies, system failures, internal politics, unsuitable attitudes, or legitimate concerns of personnel.
9. Become directly involved in continuous improvement projects, perhaps by managing individual and team improvement activities.
10. Market and advertise the QI work to the board, staff, and community through interpersonal communication, newsletters, and the media.

While some of these activities may be more appropriate for senior leaders, most can be applied throughout the health care organization.

3.B. Organizing for Quality Improvement

Organizations that are successful with their QI work typically develop an improvement team and set up a structure and process for how that team will work together in managing the improvement activities. Some organizations create highly formalized structures; in others, a small, informal group leads the QI effort. Your choices about team membership, roles, and meeting schedule should reflect what will work best for your organization and the people who will be involved.

3.B.1. Building an Implementation Team

The "right" team can play a major role in determining the success of a QI initiative. The key is to carefully select people with the right skill set and mindset for quality improvement: people who are opinion leaders, are respected by their peers, and have appropriate expertise for the purposes of the intervention.

- **Identify a leader for the team who can serve as the "champion" for the improvement initiative.**

  This person will not only be the key to energizing the team and keeping the work moving forward, but also a visible spokesperson for the initiative within the organization. The champion should be someone who is well respected professionally, has influence in the organization (formal or informal) that can help garner support for the work and overcome challenges, and has a passion for improving the experience of care for patients.

- **Choose people for the team who are enthusiastic about the chance to improve care, even if they lack some of the formal skills or responsibilities.**

  Sometimes QI leaders select staff for a team because of their titles or their clinical or administrative expertise, even though they are clearly not convinced that quality improvement is effective or that patients' experiences matter. These teams are rarely successful because they spend most of their time debating whether they should even be involved or they simply do not show up or do the work.

- **Recognize that there is no one "correct answer" for how a team should be organized.**

  A team may consist of only one or two people, especially in a smaller medical practice where each staff person may have multiple responsibilities. This approach is fine, as long as it is a conscious decision rather than an oversight. In larger organizations, effective performance improvement teams typically include:

  - A senior leader responsible for providing resources, removing barriers, and publicizing the work of the team through the organization.
  - A physician or nurse leader if the intervention involves any aspect of clinical care.
  - A team leader who is usually someone with administrative or clinical responsibility. This person could be a nurse, a practice manager, a pharmacist, or the supervisor of a call center, depending on the focus of the team.
  - A data analyst to track the performance measures and share them with the team and senior leader.
  - Other team members who represent the different disciplines or types of staff who own a "piece of the problem."

3.B.2. Establishing a Team Process and Structure

The team's job is to initiate the process of improving performance by assessing issues underlying performance problems, setting goals for improvements, developing a strategy and action plan for making changes, and then overseeing the implementation of those actions. During the early part of this work, the team members will be learning how to work together as a group. The leaders can reinforce the positive aspect of this (often messy) process by encouraging team members to

Learn More About Teams

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- Katzenbach J, Smith D. *The wisdom of teams: Creating the high-performance organization*. Boston: Harvard Business School Press; 1993.
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express their views, by listening carefully, and by helping them reach consensus on how the team can best carry out the work.

The team will have to make several decisions about managing its QI work:

- What is the role of the improvement team?
- How often will the team meet?
- What method will the team use to make decisions and achieve consensus on improvement strategies and actions?
- Should it create other committees for specific parts of the improvement work?
- How will the team interact with others who will be involved or affected by the changes they introduce? See the box below about engaging stakeholders.

Critical Task: Engaging Stakeholders Affected by Changes

Improvement teams must make the effort to understand the perspectives and concerns of the variety of people who will be involved in or affected by the improvements being made. Many improvement efforts have failed or been slowed because changes were implemented that were not acceptable to one or more stakeholder groups essential to success. On the other hand, some of the strongest efforts have been those that thoroughly engaged stakeholders and empowered them to contribute to achieving sustainable changes.

Leaders of improvement teams need to answer two questions regarding stakeholder involvement:

Who are the important stakeholders for this QI initiative?

Think broadly to identify the groups who may have an interest in the particular improvements you are pursuing. For most initiatives, stakeholders typically include patients, physicians, nurses, and administrative clerks. Depending on the specific services involved, they may also include pharmacists, health educators, therapists of various types, attorneys, staff in other departments in the organization, and representatives from external organizations.

How should these stakeholders be involved in the improvement process?

Ideally, your improvement team will include representatives of the stakeholder groups that are important for your initiative. You can engage front-line staff and other stakeholders throughout the implementation process by establishing mechanisms for open communication and regular opportunities to provide feedback on the process and related tools and practices.

For example, as you begin to develop ideas for changes, ask the people who will be implementing those changes for their suggestions. Then seek their feedback on proposed actions before you begin implementing them.

3.C. Training Staff in QI Concepts and Techniques

One requirement for successful quality improvement initiatives is a staff that is familiar with the reasoning that underlies these efforts and comfortable using the required tools and techniques. Many resources and educational programs are available to help organizations accomplish this. Here is a quick review of the kind of investment in training that you might want to make as you lead your health care organization down the path described in this guide.

3.C.1. Teaching the Rationale

Since training programs should address the "why" of QI as well as the "what" and the "how," you may want to start by educating clinical and administrative staff on the central precepts of QI and how it can benefit the organization and its members/patients. It can be especially useful to share information on how others have used this approach to improve patients' experiences with care and what their responses have been. Strategies to improve patient experience and engagement can also have an important effect on clinical outcomes and physician and staff satisfaction. (See box on right.)

Positive Outcomes Associated with Efforts to Improve Patient Satisfaction and Involvement

In the 1980s, Greenfield and Kaplan1 designed a randomized controlled trial to assess the impact of increased patient involvement in care. The patients were visiting a clinic that specialized in ulcer disease.

During a 20-minute session before their regularly scheduled visit, patients in the experimental group received help in reading their medical record and were coached to ask questions and negotiate medical decisions with their physicians. The intervention relied on a treatment algorithm as a guide. Patients in the control group received a standard educational session of equal length.

Six to eight weeks after the trial, patients in the experimental group reported fewer limitations in physical and role-related activities, preferred a more active role in medical decision-making, and were as satisfied with their care as the control group. Analysis of audiotapes of physician-patient interactions showed that patients in the experimental group were twice as effective as control patients in obtaining information from physicians.

Results of the intervention included the following:

- Increased involvement in the interaction with the physician
- Fewer limitations imposed by the disease on patients' functional ability
- Increased preference for active involvement in medical decision-making
- Improved patient and physician satisfaction with the encounter

Source: Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care. Effects on patient outcomes. *Ann Intern Med* 1985;102(4):520-8.

3.C.2. Teaching Concepts and Methods

Once assigned to CAHPS-related improvement teams, staff members will need basic training in specific QI concepts (such as microsystems, change concepts, small tests of change, and the diffusion of innovation) and methods. To learn about these concepts and methods, refer to "Section 4: Ways to Approach the Process of Quality Improvement." Teams that have had basic training in QI techniques, group work, and team building are usually able to achieve success much faster than teams that have had no previous training or experience. However, sometimes teams focus on the training as the "end goal," making it important to set clear aims for the success of any QI project at the outset.

Depending on their role in the team, many staff will also benefit from more advanced training in the effective use of statistical methods, graphic analysis, and multidisciplinary teams.

It is important to note that physicians are unlikely to be familiar with QI methods. While many professionals and managers receive some kind of QI training in their basic education, most physicians do not. Doctors are trained to succeed as individuals but not as members of a team, despite the reality that almost everything they aspire to accomplish is dependent on successful relationships with other staff and their patients.

"Nothing about medical school prepares a physician to take a leadership role with regard to changes in the system of care."

Berwick DM, Nolan TW. Physicians as leaders in improving health care: A new series in Annals of Internal Medicine. *Ann Intern Med* 1998;128(4):289-92.

Sources of Training on Quality Improvement

- America's Health Insurance Plans (AHIP)
- American Medical Group Association (AMGA)
- American Society for Quality
- Baldrige Performance Excellence Program
- Institute for Clinical Systems Improvement (ICSI)
- The Institute for Healthcare Improvement (IHI)
- Medical Group Management Association (MGMA)
- National Committee for Quality Assurance (NCQA)
- Virginia Mason Institute

3.D. Paying Attention to Customer Service

The ability of health plans and primary and specialty care practices to deliver high-quality clinical and administrative service to their members and patients depends in part on their understanding of basic customer service principles and their ability to integrate these principles into clinical settings. This section briefly reviews why excellent service is so critical and suggests some steps for achieving better service at the physician, group, and plan level.

3.D.1. Why Worry About Customer Service?

There are several reasons for health care organizations to pay attention to customer service:

- First, better service translates into higher satisfaction for the patient—and subsequently, for the employer who pays most of the bills.
- Second, as in any other service industry, a satisfied (and loyal) member or patient creates value over the course of a lifetime. In the context of health care, this value may manifest itself in the form of repeat visits, trusting relationships, and positive word-of-mouth. A dissatisfied member or patient, on the other hand, generates potential new costs. Patients who are not happy with their plan or clinician may not follow clinical advice, can develop worse outcomes, and are likely to share their negative stories with friends and family members.

"The impact of word-of-mouth on a customer's purchase decision was twice as important as corporate advertising."

Goodman J, Malech A, Marra T. Setting Priorities for Satisfaction Improvement. *Quality Review* 1987 Winter.

- Third, existing patients and members are an invaluable source of information that can help health care organizations understand how to improve what they do and reduce waste by eliminating services that are unnecessary or not valued.
- Finally, poor customer service raises the risk of a negative "grapevine effect." More than 50 percent of people who have a bad experience will not complain openly to the plan or the medical group. But research shows that nearly all (96%) are likely to tell at least 10 other people about their bad experiences.[19] Word-of-mouth reputation is important because studies continue to find that the most trusted sources of information for people choosing a health plan, medical group, doctor, or hospital are close family, friends, and work colleagues.

Health care organizations also need to pay attention to customer service because service quality and employee satisfaction go hand-in-hand. It is almost impossible to find high

[19] American Society for Quality. Basic Facts on Customer Complaint Behavior and the Impact of Service on the Bottom Line. *Competitive Advantage: ASQ Newsletter;* 1999.

employee satisfaction in organizations that have low patient satisfaction. And organizations that place a premium on customer service tend to have high employee satisfaction as well.

> *"Excellence is an art won by training and habituation. We are what we repeatedly do. Excellence, then, is not an act, but a habit."*
>
> Aristotle

Employees often are frustrated and angry about the same things that bother patients and members: chaotic work environments, poor systems, and ineffective training. No amount of money, signing bonuses, or other tools currently used to recruit hard-to-find staff will offset the negative impact of these problems on staff. The real cost of high turnover may not be the replacement costs of finding new staff but the expenses associated with lost organizational knowledge, lower productivity, and poor experiences for patients and members.

3.D.2. Advice on Achieving Better Customer Service

The most successful service organizations pay attention to the factors that ensure their success: investing in people with an aptitude for service, technology that supports front-line staff, training practices that incorporate well-designed experiences for the patient or member, and compensation linked to performance. In particular, they recognize that their staff value being able to achieve good results, and they equip the staff to meet the needs of members and patients. For health plans, this could mean developing information systems that allow staff to answer members' questions and settle claims quickly and easily; for provider organizations, it could mean providing the resources and materials that clinicians need to provide high-quality care in a compassionate, safe environment.

Experts on delivering superior customer service suggest that health care organizations adopt the following set of principles:[20]

- Hire service-savvy people.
- Establish high standards of customer service.
- Help staff hear the voice of the customer.
- Remove barriers so staff can serve customers.
- Reduce anxiety to increase satisfaction.
- Help staff cope better in a stressful atmosphere.
- Maintain your focus on service.

[20] Leebov W, Scott G, Olson L. *Achieving Impressive Customer Service: 7 Strategies for Healthcare Managers.* San Francisco: Jossey-Bass; 1998.

Resources About Improving Customer Service in Health Care

Many customer-service programs have been developed for companies outside of health care. Although the strategies are similar, Leebov and Scott have adapted this work for health care settings in ways that increase its credibility and buy-in, especially from clinical staff. Their books offer practical, step-by-step instructions about how to identify and solve customer service problems through the health care delivery system.

- Leebov W, Afriat S, Presha J. *Service savvy health care: One goal at a time.* Lincoln: Authors Choice Press; 2007.
- Leebov W, Scott G, Olson L. Achieving impressive customer service: 7 strategies for healthcare managers. San Francisco: Jossey-Bass; 1998.
- Leebov W, Scott G. Service and quality improvement: The customer satisfaction strategy for health care. Chicago: American Hospital Publishing, Inc.; 1994.

3.E. Recognizing and Rewarding Success

The pursuit of better performance benefits greatly from positive incentives, whether at the organizational level or the individual level. Rewards can be financial or non-financial, but what matters is that they are directly linked to either the effort to improve or, ideally, the actual improvement.

3.E.1. External Rewards

Over the past decade or so, the idea of rewarding health care organizations that exhibit good quality or a commitment to improving their performance has taken off, accelerated by various provisions under the Affordable Care Act. Initially, these rewards came in the form of public recognition. Some purchaser organizations point out high-performing health plans to consumers, while some health plans do the same with medical groups, practices, and even individual physicians to steer members to better performers.

Superior performance also receives public recognition through the growing use of health plan and provider organization "report cards." Many large employers, regional and state-based collaboratives, and government purchasers (such as Medicare and state Medicaid agencies) are producing Web-based reports with comparative information on the quality of health care organizations such as health plans, hospitals, and medical groups. Their goal is to provide consumers with better information for making health care decisions.

These public reports often highlight organizations that achieve better results than others on standardized measures such as CAHPS and HEDIS. While the impact of public reporting has not been extensively evaluated, there is some evidence that making

performance information public stimulates quality improvement activities in areas where performance is reported to be low.[21],[22]

More recently, purchasers and payers have explored ways of offering either increased market share or higher financial payments for good quality. Prominent examples include programs implemented by the California-based Integrated Healthcare Association and the Centers for Medicare & Medicaid Services:

- The Integrated Healthcare Association (IHA), a multi-stakeholder leadership group in California, administers a statewide "pay for performance" program. Through this program, health plans use common measures to evaluate the performance of their contracted physician groups serving commercial HMO enrollees, and develop individual bonus programs that pay significant financial incentives based on that performance.
- The Centers for Medicare & Medicaid Services has implemented several programs, some in the form of demonstrations, to reward health plans, accountable care organizations, hospitals, and physicians for both providing high quality care—including patient experience—and improving that care over time.

Learn more in "Health Policy Brief: Pay-for-Performance," *Health Affairs*, October 11, 2012.

3.E.2. Internal Rewards

External reward systems motivate the leadership and the staff of an organization to focus on quality. Internal reward systems pay close attention to the front-line staff and middle managers who do what is necessary to achieve the external rewards. Reward and recognition programs usually include formal programs, day-to-day feedback, and informal recognition programs.

"Creating loyalty means giving employees more for their labor than just a paycheck. Both research and personal experience tell us that people work for a sense of accomplishment and the recognition of others."

Gelinas L, Bohlen C. *Tomorrow's Workforce: A Strategic Approach*. VHA Research Series; 2002.

[21] Hibbard JH, Stockard J, Tusler M. Does publicizing hospital performance stimulate quality improvement efforts? *Health Aff (Millwood)* 2003;22(2): 84-94.

[22] Totten AM, Wagner J, Tiwari A, et al. Closing the Quality Gap: Revisiting the State of the Science (Vol. 5: Public Reporting as a Quality Improvement Strategy). Rockville (MD): Agency for Healthcare Research and Quality (US); 2012 Jul. (Evidence Reports/Technology Assessments, No. 208.5.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK99879/

3.E.2.a. Formal Programs

Examples of internal formal programs include:

- Staff recognition awards that focus on different behaviors, i.e., service excellence, clinical competence, teaching, and mentoring.
- Years of service awards: 5, 10, and 25 years.

3.E.2.b. Day-to-Day Feedback

Managers provide consistent and timely feedback to employees about their performance. Experts confirm that providing praise in a timely manner does have a positive effect on employee motivation and sense of belonging. Some organizations develop formal coaching programs to assist managers in coaching and providing feedback to their employees and peers.

3.E.2.c. Informal Recognition Programs

Many employees go above and beyond their assigned duties to assist patients, other staff, clinicians, and the community. It is important to encourage the recognition of these individuals for their customer service, teamwork, integrity, or overall positive attitude. Research indicates that informal recognition by managers is a key motivating factor for effective job performance.[23]

[23] McElroy J. Managing workplace commitment by putting people first. *Human Resource Management Review* 2001;11(3): 327-335.

Case Study: R.E.W.A.R.D.

One example of an informal program is called R.E.W.A.R.D., which stands for Recognition of Employees When Achievement & Responsibility is Displayed.

How to Recognize: Some organizations create a J.A.C.K. In-The-Box, where J.A.C.K. stands for Job Acknowledgement Care Kit. The JACK In-The-Box provides a number of rewards that can be used for instant recognition when situations "pop" up. These can include gift certificates, time off, extra vacation days, or other small tokens of appreciation scaled to fit the accomplishment.

Draw on your understanding of the person you want to recognize when selecting the recognition item. Some people like public recognition of their efforts; if you are not sure, ask the person what he or she would be comfortable with.

When to Recognize: There are no rules about how often recognition should take place. Ideally, recognition should take place as soon as possible, whenever you want to say "Thanks" or "Congratulations."

What to Recognize: People can be recognized for many things. Here are just a few:

- Exceptional job performance
- Excellent team work
- Outstanding customer service
- Extraordinary performance of regular duties in a particularly difficult circumstance
- Extremely good performance of regular duties over a long period of time
- A "Good Catch" (i.e., the person took the initiative to nip a problem in the bud or avoid a disaster)
- Active participation in projects
- Applying new skills and knowledge
- Meeting goals and targets
- Displaying commitment and loyalty to the organization
- Demonstrating innovation through new ideas and initiatives

3.E.3. Orientation

Orientation of new employees is the best place to begin the education about the culture of your organization. It is also an excellent way to highlight how the internal reward and recognition system is linked to the philosophy of care and organizational standards.

The objective of orientation should be to do the following:

- Instill a feeling of self-worth.
- Create a sense of belonging.
- Develop an attitude of pride and confidence in oneself and the organization.
- Spark a desire to succeed.
- Enhance the relationship between the employee and the organization.

3.E.4. Compensation and Benefits

Compensation and benefits can be designed to reinforce the desired behaviors and performance standards of the organization. Compensation levels can be linked to meeting service-oriented performance standards, coaching and mentoring goals for managers, and other indirect reward activities such as completing performance reviews on time.

"Most people can't sleep the night before their first day of a new job. They probably decided two weeks in advance what they'd wear. They can't wait to get started, meet new people, see everything, do great things. After all of the anticipation, their first day is usually a big yawn. They find themselves hidden away in a room somewhere filling out forms. What a mistake! First impressions are lasting."

Rosenbluth H. *The Customer Comes Second*. New York, NY: Harper Business; 2002.

Cafeteria-style benefit packages help meet the needs of a diverse work force without creating a sense of inequity in your workforce. Some organizations offer unusual benefits such as pet insurance, health club memberships, flexible spending accounts for medical and childcare expenses, and even home financing assistance and education.

3.E.5. Rewards That Go Beyond the Individual

Rewards can also be actions and changes that support the entire organization and help transform the culture. Examples include the following:

- Improve your systems to "make it easy to do the right thing" and improve quality of life for front-line staff.
- Make sure people have the aptitude, training, and the resources they need to do a job well done.
- Give star performers the opportunity to attend conferences of their choice and/or receive tuition reimbursement for courses that advance their expertise.
- Tell stories, create legends and celebrate "heroes."
- Help people get recognition internally and externally through presentations at meetings and conferences, newsletters, and local media.

- Recognize people personally for behavior consistent with the organization's stated philosophy and rules.
- Use thank you notes, voice mailboxes that allow patients to compliment staff, and public postings of thank-you letters from grateful patients and families.
- Be aggressive about the management of poor performers (i.e., staff who do not uphold the values and culture of excellence).
- Show respect for people. Start everything on time.
- Invite front-line staff to meet with senior management and the board routinely to improve communication and trust in management.

Learn more: Gelinas L, Bohlen C. *Tomorrow's Workforce: A Strategic Approach*, VHA Research Series; 2002.

Learn More About Improving and Transforming Organizations

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- Heskett JL, Jones TO, Loverman GW, et al. Putting the service-profit chain to work. *Harv Bus Rev* 1994 Mar-Apr;164-174.
- Institute of Medicine. *Crossing the Quality Chasm*. Washington, DC: National Academy Press; 2001.
- Kotter JP. Leading change: Why transformation efforts fail. *Harv Bus Rev* 1995;73(2):59-67.
- Langley G, Nolan K, et al. *The Improvement Guide*. San Francisco: Jossey Bass; 1996.
- Powell AE, Rushmer RK, Davies HTO. *A systematic narrative review of quality improvement models in health care*. Social Dimensions of Health Institute at The Universities of Dundee and St Andrews, February 2009. Available at: http://www.healthcareimprovementscotland.org/previous_resources/hta_report/health_care_improvement_models.aspx. Accessed July 2015.
- Tucker F, Gaither S, Zivan M, et al. How to measure yourself against the best. *Harv Bus Rev* January/February 1987:8-10.

Section 4: Ways to Approach the Quality Improvement Process

Health care delivery systems that are working to improve patient experience can face daunting challenges, reflecting the need to align changes in behavior and practices across multiple levels and areas of the organization. But the process of planning, testing, and eventually spreading those changes does not have to be overwhelming. Health care organizations can take advantage of established principles and approaches to quality improvement, which are already familiar to the many providers involved in clinical quality improvement (QI).

This section of the Guide suggests a way to use the concept of microsystems to focus the QI process on the locus of responsibility for patient experience, provides an overview of the process of quality improvement, discusses a few well-known models of quality improvement, and presents a few tools and techniques that organizations can use to address various aspects of patient experience.

Three Tips for Facilitating the Quality Improvement Process

Place a priority on encouraging communication, engagement, and participation for all of the stakeholders affected by the QI process. Learn what is most important to the people who make up the microsystem and look for ways to help them embrace the changes and begin to take ownership of them.

Start your implementation of improvements with small-scale demonstrations, which are easier to manage than large-scale changes. Small-scale demonstrations or small tests of change also allow you to refine the new processes, demonstrate their impact on practices and outcomes, and build increased support by stakeholders.

Keep in mind and remind others that QI is an iterative process. You will be making frequent corrections along the way as you learn from experience with each step and identify other actions to add to your strategy.

4.A. Focusing on Microsystems

One useful way for health plans and medical groups to approach the process of improvement is to think of the organization as a system, or more specifically, as a collection of interrelated "microsystems." The term "microsystems" refers to the multiple small units of caregivers, administrators, and other staff who produce the "products" of health care—i.e., who deliver care and services on a daily basis.

The concept of microsystems in health care organizations stems from research findings indicating that the most successful of the large service corporations maintain a strong focus on the small, functional units who carry out the core activities that

involve interaction with customers.[24] In the context of health care, a microsystem could be:[25]

- A core team of health professionals.
- Staff who work together on a regular basis to provide care to discrete subpopulations of patients.
- A work area or department with the same clinical and business aims, linked processes, shared information environment and shared performance outcomes.

Examples of microsystems include a team of primary care providers, a group of lab technicians, or the staff of a call center. In the patient-centered medical home model, a microsystem could be the patient's care team accountable for coordination of the patient's services that address prevention, acute care, and chronic care.[26]

The goal of the microsystem approach is to foster an emphasis on small, replicable, functional service systems that enable staff to provide efficient, excellent clinical and patient-centered care to patients.[27] To develop and refine such systems, health care organizations start by defining the smallest measurable cluster of activities.

Once the microsystems have been identified, a practice or plan can select the best teams and/or microsystem sites to test and implement new ideas for improving work processes and evaluating improvement.[28] To provide high-quality care, the microsystem's services need to be effective, timely, and efficient for all patients,[27] and preferably designed in partnership with patients and their families. Measurement and performance feedback must be part of the microsystem's principles to learn and improve.[29]

If a quality improvement intervention is successful for a microsystem, it can then be scaled to other microsystems or the broader organization. However, for successful scalability, organizations should adopt a framework for spread that will work within their structure and culture.

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[24] Quinn J, Baruch J, Zien K. *Innovative Explosion: Using Intellect and Software to Revolutionize Growth Strategies.* New York: Free Press; 1997.

[25] Berwick DM. A user's manual for the IOM's 'Quality Chasm' report. Health Aff (Millwood) 2002;21(3): 80-90.

[26] AHRQ Patient Centered Medical Home Research Center.

[27] Wasson J, Godfrey M, Nelson E, et al. Microsystems in health care: Part 4. Planning patient-centered care. Jt Comm J Qual Patient 2003 May; 29(5):227-37(11).

[28] Pronovost P, Weast B. Implementing and validating a comprehensive unit-based safety program. J Patient Saf 2005 Mar;1(1):33-40.

[29] Batalden PB, Nelson EC, Edwards WH, et al. Microsystems in health care: Part 9. Developing small clinical units to attain peak performance. Jt Comm J Qual Saf 2003 Nov;29(11):575-85.

4.B. Understanding and Implementing the Improvement Cycle

Although QI models vary in approach and methods, a basic underlying principle is that QI is a continuous activity, not a one-time thing. As you implement changes, there will always be issues to address and challenges to manage; things are never perfect. You can learn from your experiences and then use those lessons to shift strategy and try new interventions, as needed, so you continually move incrementally toward your improvement goals.

The fundamental approach that serves as the basis for most process improvement models is known as the PDSA cycle, which stands for Plan, Do, Study, Act. As illustrated in Figure 4-1, this cycle is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a product or process. Underlying the concept of PDSA is the idea that microsystems and systems are made up of interdependent, interacting elements that are unpredictable and nonlinear in operation. Therefore, small changes can have large effects on the system.

Figure 4-1. Plan-Do-Study-Act Cycle

The cycle has four parts:

- **Plan**. This step involves identifying a goal or purpose, formulating an intervention or theory for change, defining success metrics and putting a plan into action.
- **Do**. This is the step in which the components of the plan are implemented.
- **Study**. This step involves monitoring outcomes to test the validity of the plan for signs of progress and success, or problems and areas for improvement. Short-cycle, small-scale tests, coupled with analysis of test results, are helpful because microsystems or teams can learn from these tests before they implement actions more broadly.[30, 31]
- **Act**. This step closes the cycle, integrating the learning generated by the entire process, which can be used to adjust the goal, change methods, or even reformulate an intervention or improvement initiative altogether.

The PDSA cycle involves all staff in assessing problems and suggesting and testing potential solutions. This bottom-up approach increases the likelihood that staff will embrace the changes, a key requirement for successful QI.[32]

When you are ready to apply the PDSA cycle to improve performance on CAHPS scores, you will need to decide on your goals, strategies, and actions, and then move forward in implementing them and monitoring your improvement progress. You may repeat this cycle several times, implementing one or more interventions on a small scale first, and then expanding to broader actions based on lessons from the earlier cycles.

4.B.1. Plan: Develop Goals and Action Plan

This section discusses four key steps in the planning stage of a PDSA cycle as part of a CAHPS-related quality improvement process:

- Establish improvement goals.
- Identify possible strategies.
- Choose specific interventions to implement.
- Prepare a written action plan.

[30] Berwick DM. Developing and testing changes in the delivery of care. Ann Intern Med 1998;128(8):651-6.

[31] Iles V, Sutherland K. Organizational change: A review for health care managers, professionals and researchers. London: NCCSDO; 2001.

[32] Greenhalgh T, Robert G, Bate P, et al. How to Spread Good Ideas: a systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organization. London: NCCSDO; 2004.

4.B.1.a. Establish Improvement Goals

The team's first task is to establish an aim or goal for the improvement work. By setting this goal, you will be better able to clearly communicate your objectives to all of the sectors in your organization that you might need to support or help implement the intervention.

The goal should reflect the specific aspects of CAHPS-related performance that the team is targeting. It should also be measurable and feasible. One of the limitations of an *annual* CAHPS survey as a measurement tool is the lag time between the implementation of changes, the impact on people's experiences, and the assessment of that impact. For that reason, the team needs to define both ultimate goals as well as incremental objectives that can be used to gauge short-term progress. After defining your ultimate goals, ask "What is the gap between our current state and our goals?" Make of list of those gaps and use them to make SMART (specific, measurable, achievable, realistic, and time bound) incremental objectives.

For example, a team concerned about improving performance on the "Getting Timely Appointments, Care, and Information" composite measure in the Clinician & Group Survey may set a 1-year goal of a two percent increase in its composite score. At the same time, it could specify goals for the number of days it takes to get an appointment for non-urgent and urgent visits. Similarly, a team focusing on overall ratings may set goals for complaint rates for the health plan as a whole or for individual medical groups and then review those rates monthly.

4.B.1.b. Identify Possible Strategies

With objectives in place, the next task of the team is to identify possible interventions and select one that seems promising. Keep in mind that all improvement requires making a change, but not all changes lead to improvement.

Section 6 of this Guide presents a number of different strategies that health care organizations can use to improve different aspects of their CAHPS performance. In addition, you may want to consult several case studies of health care organizations that have implemented strategies to improve performance on CAHPS scores.

These sources of improvement ideas offer an excellent starting point, but they are by no means comprehensive. There are many other sources for new ideas or different ways of doing things both within and outside of health care. Consequently, improvement teams should make an effort to develop and maintain systematic ways of identifying effective solutions.

New ideas and innovative solutions can be found:

- At conferences or workshops.
- In the academic literature, the media, and/or the popular press.
- Through the identification of benchmark practices in health care as well as other industries, i.e., noncompetitive benchmarks.
- Through patients and their families—whether through direct interviews and focus groups, as partners on quality improvement teams, or as members of Patient and Family Advisory Councils.
- In the Agency for Healthcare Research and Quality's searchable clearinghouse of health care innovations.

"Ideas for change can come from a variety of sources: critical thinking about the current system, creative thinking, observing the process, a hunch, an idea from the scientific literature, or an insight gained from a completely different situation. A change concept is a general idea with proven merit and sound scientific or logical foundation that can stimulate specific ideas for changes that lead to improvement."

Plsek P. Innovative thinking for the improvement of medical systems. Ann Intern Med 1999;131:438-44. Available at http://annals.org/article.aspx?articleid=712942. Accessed July 27, 2015.

One useful way to develop and learn innovative approaches is to visit other health care organizations. Resistant or hesitant staff members are often "unfrozen" by visiting another highly respected site that has successfully implemented a similar project. You can also visit a company outside of the health care industry to get new ideas. Some health plans, for example, have learned how to improve their call center operations by sending staff to visit mail-order catalog houses or brokerage firms. The Cleveland Clinic has required every doctor and senior administrator to make one "innovation site visit" a year to learn about different approaches that can be brought home and tested.

4.B.1.c. Choose Specific Interventions To Implement

To decide which new ideas or benchmark practices to implement, the improvement team needs to consider several factors:

- **Compatibility with the organization and local culture.** Serving Cuban coffee in the waiting room of the clinics of a Miami medical group may be very patient-friendly, for example, but it is not likely to be viewed with the same enthusiasm by patients in Arizona or Massachusetts.
- **Technical merit.** The ideas that are most likely to be adopted are those that provide significant advantages over existing practices for both patients and providers—whether in the form of increased efficiency, higher patient and

employee satisfaction, or improved outcomes. All improvement efforts ultimately have to answer the question: "What's in it for me?"

- **Fit with the problem.** The best intervention will be one that suits the specific problem you need to address (or can be tailored as needed). To ensure a good fit, the improvement team should seek input from both affected staff as well as patients or members. If you ignore either source of information in your planning, you may choose an intervention that will not fix the real problem.

Depending on the nature of the intervention, you may want to break it down into a set of related but discrete changes. For example, if the team decides to implement a new specialist referral process, you could begin by making changes to the procedures used to communicate with the specialist's office. The communication process with the health plan might then be the target of a separate change.

4.B.1.d. Prepare a Written Action Plan

Although there is no one "correct" way to write an action plan for your organization or facility, it is important to have some form of written document that states your goals, lists your overall strategies to achieve those goals, and then delineates the specific actions you will take to implement the interventions you have selected to address the identified problems. One way to organize the action plan is to review the following key questions as a team and document your answers:

1. What areas do you want to focus on for improvement?
2. What are your goals?
3. What initiative(s) will you implement? Describe the specific actions briefly.
4. Who will be affected, and how?
5. Who can lead the initiative? Identify a leader and/or champion to manage the project.
6. What resources will be needed?
7. What are possible barriers, and how can they be overcome?
8. How will you measure progress and success? Specify the measures you plan to use to monitor progress in achieving the desired changes to organizational processes and CAHPS scores. Read more about measures below.
9. What is the timeline? Record your planned start and end dates for the action.
10. How will you share your action plan?

It also helps to lay out the calendar for all actions in a Gantt chart format, so you can verify that the timing of sets of actions makes sense and is feasible to complete with the staff you have available.

4.B.2. Do: Select Measures to Monitor Progress

When a team establishes its goal, it typically specifies one or more performance metrics to assess whether a change actually leads to improvement. These measures should be clearly linked both to the larger goal and to the intervention itself. For example, if the goal is to speed specialist referrals, you could measure the time it takes to get a response from the specialist's office or an approval from the health plan.

4.B.2.a. Tips on Selecting Measures

Choose measures that allow you to track each of three steps in the improvement process:

- Test the acceptance and/or adherence to new or revised practices.
- Examine how and how much the new practices are affecting the delivery of patient-centered care.
- Assess how much patient experience of care is improving.

Communicate with staff about why the measures are being collected and how these data will help improve their quality of work life and the patient's experience.

Seek a feasible number of measures that address the most important aspects of the improvements you are trying to achieve. Too many measures could create a burden on the staff, leading to loss of attention due to information overload; too few measures may omit tracking of important aspects of the changes you are making.

Resources on Measurement

- Institute for Healthcare Improvement. Science of Improvement: Establishing Measures.
- Carey RG, Lloyd RC. *Measuring Quality Improvement in Healthcare: A Guide to Statistical Process Control Applications*. New York: American Society for Quality; 1995.
- Wheeler D. *Understanding Variation: Keys to Managing Chaos*. Knoxville, TN: Statistical Process Controls, Inc.; 1993.
- American Board of Internal Medicine (ABIM) Foundation. *Putting Quality Into Practice video series*. This series shows the perspectives of physicians who have adopted quality measurement and improvement tools. The doctors speak candidly about why they decided to measure their performance, and how the information empowered them to improve the care they provide to patients.

4.B.2.b. Producing Visual Displays

Once you have established practical measures, you will be able to produce visual displays of your performance over time by tracking the metric on control or run charts. Control

and run charts are helpful tools for regularly assessing the impact of process improvement and redesign efforts: monthly, weekly, or even daily. In contrast to tables of aggregated data (or summary statistics), which present an overall picture of performance at a given point in time, run and control charts offer an ongoing record of the impact of process changes over time.

A run chart can show different data collection points plotted over time for a specific survey question, e.g., an item about patients' ability to reach the practice by phone. By measuring and tracking results to this question at regular and frequent time intervals, managers can discern how process improvement interventions relate to changes in survey results. If an intervention appears to have positive results, it can be continued and sustained; if not, it can be modified or discontinued.

Dashboard reports are another way to display performance. A dashboard report presents important data in summary form in order to make it easier to identify gap in performance and trend performance against goals. Dashboards can be a useful method for sharing consistent information across multiple levels of an organization. For example, the Massachusetts General Physicians Organization (MGPO) prepares quarterly leadership dashboards with benchmarks and targets, where relevant, at a summary level across clinical services, at the clinical service level, and at the practice level.[33]

4.B.3. Do and Study: Test and Refine Actions on a Small Scale

Once you have selected interventions, the next stage of the cycle is to develop and test specific changes. It helps to think of this stage as a number of "mini-cycles" within the larger improvement cycle, in the sense that the microsystem or team is likely to go through multiple iterations of testing and refining before the specific changes add up to a real intervention.

Small-scale tests of the interventions you wish to implement help refine improvements by incorporating small modifications over time. Conducting these small tests of change within a microsystem can be very powerful:

- They allow for incremental modifications of interventions to fix problems, which helps the larger implementation run smoothly.
- Failures are low-risk because you have not tried to change the entire culture.
- You create enthusiasm and positive "word-of-mouth" for early successes.
- It is easier to accumulate evidence for implementation when people are engaged in making something work rather than focused on the "failure analysis."

[33] Agency for Healthcare Research and Quality. How Two Provider Groups Are Using the CAHPS® Clinician & Group Survey for Quality Improvement. CAHPS Issue Brief. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/reports-and-case-studies/cgcahps-webcast-brief-2014.pdf. Accessed on May 17, 2017.

Most improvement strategies require some adaptation to the culture of the organization. Patient-centered improvement strategies have to consider the needs of patients and their families as well as the staff. Moreover, front-line staff will frequently resist new ideas if they are not allowed to modify them and test their own ideas.

4.B.4. Act: Expand Implementation to Reach Sustainable Improvement

Building off of the development and testing of specific changes, the final stage of the PDSA cycle involve adopting the intervention and evaluating it against the goals of the improvement project and the measures established for tracking improvement progress. For example:

- Did the intervention succeed in reducing the time required to see a specialist?
- Are members and patients reporting better experiences with regards to getting care quickly?

This part of the improvement cycle is really the ongoing work of health care and where your teams will spend most of their time. There are no set rules about how long this part of the cycle takes. It depends in part on how frequently you monitor your CAHPS scores and other quality measures.

It is important not to let the work go on too long without ongoing measurement in order to make sure you are making progress toward achieving your aims. Most monitoring takes place on a monthly or quarterly basis. The team can use data on the impact of the intervention to see if it is making progress towards the goals and to determine whether to conduct a new set of analyses of its CAHPS performance. The purpose of this effort is to get some sense of what worked, what did not work, and what further or new interventions may be needed. To the extent that the improvement initiative was successful, the team must also think about ways to sustain and spread the improvements over time.

Resources on Sustaining and Spreading Improvements

- Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin C. A Framework for Spread: From Local Improvements to System-Wide Change. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006. (Available at http://www.ihi.org/resources/Pages/IHIWhitePapers/AFrameworkforSpreadWhitePaper.aspx)
- Nolan KM, Schall MA. A framework for spread. In Nolan KM, Schall MW, editors: Spreading Improvement Across Your Health Care Organization. Oak Brook, IL: Joint Commission Resources, 2007,1–24.
- Øvretveit J. Implementing, sustaining, and spreading quality improvement. In The Joint Commission: From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed. Oak Brook, IL: Joint Commission Resources, 2012, 159–176.

4.B.4.a. Identify and Deal with Barriers

As part of its work, the team will need to take a hard look at the psychological, physical, and procedural barriers it has to address in order to accomplish its aim. Barriers to improvement come in many guises. Psychological barriers such as fear of change, fear of failure, grief over loss of familiar processes, or fear of loss of control or power can be significant impediments to overcome. Other common barriers include the following:

- Lack of basic management expertise.
- Lack of training in customer service, quality improvement methods, or clinical areas such as doctor-patient communication.
- Inadequate staffing levels.
- Poor information technology systems.
- Outdated or misguided organizational policies. For example, many organizations are so concerned about violating HIPAA regulations that they do not want to give information to a patient about *their own care* for fear of violating patient confidentiality.

Despite the serious nature of some of these barriers, few are large enough to bring a project to a halt. Typically, they are cited as excuses for two of the fundamental barriers to change: the fear of new ways of doing things and the fear of failure.

Anticipating How the Improvement Process Affects Staff

An improvement process often requires significant changes in people's attitudes and behaviors, often requiring staff to give up their old standards and practices and adopt new ones. As a result, you can expect pushback from some staff as you introduce new processes and habits.

Many staff will "get it" early and pitch in enthusiastically. But introducing and reinforcing changes in behavior that "stick" in the form of sustainable practices will take some work and time to succeed. Over time, as less enthusiastic staff see positive progress, they too will become more engaged and supportive.

When you succeed, the payoff is significant, with benefits not only for patients but also for clinicians and staff. Many organizations have found that job satisfaction for their staff rises with improved patient experiences because the new, better practices usually reduce frustrating inefficiencies in the system that created extra work for staff.

Learn More: Aligning Forces for Quality. The Center for Health Care Quality at the George Washington University Medical Center School of Public Health and Health Services. *Good for Health, Good for Business: The Case for Measuring Patient Experience of Care*. 2012. Available at http://forces4quality.org/case-patient-experience.

4.B.4.b. Identify and Cultivate Facilitators

The team also needs to identify factors that could facilitate their work. Facilitators can include financial or nonfinancial incentives, such as gain sharing for staff if a specific target is met or better quality of life for the staff when a problem is fixed. Other facilitators include picking an aim that is part of the organization's strategic plan or one that will improve other goals the staff care about, such as clinical outcomes.

Sometimes, the facilitator is the ability of a change to help achieve secondary goals. For example, improvements in doctor-patient communication may decrease medication errors, or the development of shared care plans may improve clinical outcomes and reduce no-shows for appointments or procedures.

4.B.4.c. Harness Social Interaction to Spur Adoption of Innovations

Research on the diffusion of innovation has found that social interaction plays a crucial role. Most people do not evaluate the merits of an innovation on the basis of scientific studies; they depend on the subjective evaluations of "early adopters" and model their behaviors after people they respect and trust.[34] For that reason, choosing the right team members and opinion leaders (i.e., people within an organization who informally influence the actions and beliefs of others) is critical to efforts to diffuse innovation.

Depending on the project, you may want to try to identify the opinion leaders that would be helpful to involve (assuming they are open to change and new ideas). Interpersonal communication works best when the people communicating the message are respected opinion leaders within the same staff group whose behavior they are trying to change. For example, an innovation to change the behavior of receptionists will often move quickly if it is led by a respected receptionist or office manager. But this person would probably not be as effective at getting physicians in a medical group to change their communication style with patients.

Ask people whose opinion they respect. Who do they follow when they have adopted new clinical or improvement practices? Who do your staff look to when they want advice or information about the organization?

4.B.4.d. Communicate Internally

One important step that is often neglected is the communication of successes throughout the organization—to organizational leaders as well as clinical and administrative staff. By discussing successful projects, the team helps to reinforce the culture of quality improvement, build credibility for the intervention, reward those involved, and foster the spread of effective innovations.

[34] Rogers E. *Diffusion of innovation*. New York: The Free Press; 1995.

The organization's leaders can also:

- Use media and interpersonal communication to promote the work of specific improvement teams.
- Highlight successful innovations in staff newsletters and in staff and board meetings.
- Reinforce the importance of the project by sitting in on improvement team meetings or visiting the practice site or unit involved in the project.

A related practice is the communication of changes beyond the walls of the organization to members or patients. By telling people about innovative practices—whether through newsletters, emails, office computer screensavers, member Web sites, or handouts in the office—you can raise the standard of expectations.

Learn About Encouraging Innovation

- Blakeney B, Carleton P, McCarthy C, Coakley E. Unlocking the Power of Innovation. *OJIN: The Online Journal of Issues in Nursing*. 2009 May 31;14(No. 2, Manuscript 1). Accessible at http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No2May09/Innovation.html. This article describes innovative methods and highlights specific examples of organizational structures that support innovations within health care organizations.
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- Langley GJ, Nolan KM, Norman C, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass; 1996.
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- Plsek PE. Innovative thinking for the improvement of medical systems. Ann Intern Med 1999;131(6): 438-44.
- Plsek PE. Thinking differently. Available at: National Health Services Institute for Innovation and Improvement. http://www.institute.nhs.uk/building_capability/new_model_for_transforming_the_nhs/thinking_differently_guide.html. Accessed May 28, 2015.
- Rogers E. Diffusion of innovations. 5th ed. New York City: Free Press, 2003.

4.C. An Overview of Improvement Models

To succeed in improving patients' experiences, it is important to use a systematic, structured approach that gives feedback on your progress. If your organization has already adopted an established quality improvement model, you will be able to apply its system and methods to improve patient experience and your organization's CAHPS survey scores. If not, you can learn about and adapt one of the models described below to pursue improvements:

- The Institute for Healthcare Improvement's Model for Improvement
- Lean
- Six Sigma

Established QI models share several common features, including:

- Emphasis on leadership to hold people accountable, communicate the vision and strategy, and eliminate cultural and other barriers to improvement.
- Clear goals.
- Use of measurement and analysis to identify issues and guide decisions.
- Emphasis on stakeholders as participants and audiences for the improvement processes.
- Use of structured, iterative processes to implement improvement interventions.
- Use of many of the same tools to support analysis and implementation.
- Monitoring of front-line clinical activity through observations and the collection and reporting of process data as feedback on the effect of changes or to track the progress of the implementation process.
- Transparent metrics.

As you work with any QI method, the key is to carefully choose strategies that have the best chance to improve how your organization interacts with patients.

4.C.1. The Model for Improvement

The Institute for Healthcare Improvement (IHI) Model for Improvement is a simple, yet powerful model that focuses on setting aims and selecting or developing measures to indicate if a change resulted in improvement. At the heart of the Model for Improvement is the Plan-Do-Study-Act (PDSA) cycle (see Figure 4-1).

The first part of the Model for Improvement is based on a "trial and learning" approach using rapid cycle improvement (RCI; see box on right.). During this first part, a QI team guides development of its strategy and action plan by answering the following questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

In the second part of the model, the QI team uses RCI and the PDSA cycle to implement its action plan with small-scale interventions introduced rapidly to test the changes, learns from these tests, and then modifies the intervention for implementation in another cycle.

What Is Rapid Cycle Improvement (RCI)?

RCI is a practical and real-time approach that involves testing interventions on a small scale (e.g., one physician), permitting experimentation, and discarding unsuccessful tests. Numerous small cycles of change can successfully accumulate into large effects. For example, a medical practice could improve quality by working on a series of cumulative and linked PDSA cycles in different aspects of care at the same time, e.g., medication use, diagnostic testing, and patient scheduling. RCI also limits measurement to what is sufficient to track progress.

4.C.2. Lean

Lean, which is sometimes referred to as the Toyota Production System, is a tool used by businesses to streamline manufacturing and production processes. The main emphasis of Lean is on cutting out unnecessary and wasteful steps in the creation of a product or the delivery of a service so that only steps that directly add value are taken. One core principle of Lean is the need to provide what the internal or external customer wants, i.e., to provide "value" to the customer, with minimal wasted time, effort, and cost. Another is that any part of a process that does not add value is simply removed from the equation, leaving a highly streamlined and profitable process that will flow smoothly and efficiently, creating additional capacity and hence enhanced performance. In health care, Lean "thinking" involves a clear understanding of the process under review, including every step involved, eliminating unnecessary steps, and basing the redesigned process on the "pull" needs of the patient.[35]

Lean uses a technique called Value Stream Mapping (VSM). In VSM, a QI team creates a visual map of each step in the flow of the current process. To do that, the team will have to discuss and agree on the current process's sequential steps from beginning to end. VSM is extremely useful for mapping the steps that a patient will take when visiting a clinician's office. Another example would be mapping the flow of a medication

[35] ASHP Foundation. Clinical Microsystems. Transformational Framework for Lean Thinking. Accessible at http://www.ashpfoundation.org/lean/.

prescription, fill, and dispense. Using this technique, QI teams can find steps in the process that result in waste, poor flow, low value, and/or errors.

The next step in Lean is to do 5S organization. During 5S workplace organization, team members systematically review each environment to

1. Sort,
2. Simplify (set in order),
3. Standardize,
4. Sweep/shine, and
5. Initiate self-controls that will sustain the order of standardization.

The purpose of 5S is to improve space organization and to eliminate the time or "motion waste" of "searching" for things or getting prepared to work. VSM coupled with 5S are proven tools to create processes that are "leaner," offer more value to those involved in the process, and increase the success rate of sustained process improvement.

In a Lean culture, the focus is on interdisciplinary teams, where leaders are coaches and enablers. There is a strong patient focus and decisions are data and process driven. Rewards accrue to the team or group; however, the focus remains on the customer's needs and expectations. For example, from the patient perspective, a process with value would include no unnecessary delays in access to care, error-free process, no long wait times, and a satisfactory outcome. From the provider perspective, a process with value would result in readily available charts, equipment, labs and essential patient data.

Examples of Organizations Using Lean

Three Federally Qualified Health Centers applied Lean techniques to improve the patient visit process. In May 2009, Altarum Institute launched partnerships with three FQHCs in Virginia, Michigan, and Maine through the Community Health Center Innovation Mission Project. The goal of this project was to apply innovative systems change methods to strengthen FQHC operations.

Over an approximately 18-month period, Altarum and its FQHC partners worked together to improve operations using the Lean principles, tools, and techniques. Staff members across the three organizations reported that the use of Lean enabled them to identify and make positive changes to several processes and workflows. Many of the improvements perceived by the staff are interrelated. The standardization of a complex, time-consuming process, for example, may have had ripple effect leading to improved patient flow, communication, and collaboration; the provision of safer and better quality care; and enhanced patient access to care. Read the full report.

Virginia Mason Medical Center used Lean concepts to redesign their entire organization. In ambulatory care, these principles have improved preventive screenings, communication with patients, coordination of care, and care management of patients with chronic conditions. Read about Mistake-Proofing Primary Care.

4.C.3. Six Sigma

The essential goal of Six Sigma is to eliminate defects and waste, thereby improving quality and efficiency, by streamlining and improving all business processes. A sigma rating indicates the percentage of defect-free products created by a process. A six sigma process is one in which 99.99966% of all production opportunities are expected to be free of defects. While it was first designed for use in manufacturing and became central to General Electric's business strategy in 1995, the health care industry uses Six Sigma to increasing the reliability of the process of delivering health care services.

Six Sigma seeks to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimizing variability in processes. It uses a set of quality management methods and creates a special infrastructure of people within the organization who are experts in these methods ("Champions," "Black Belts," "Green Belts," "Yellow Belts," etc.).

A key focus of Six Sigma is the use of statistical tools and analysis to identify and correct the root causes of variation. As a roadmap for problem solving and process improvement, Six Sigma uses the DMAIC Methodology: Define, Measure, Analyze, Improve, Control. Additional information about DMAIC can be found at https://www.dmaictools.com/.[36]

[36] American Society for Quality. The Define Measure Analyze Improve Control (DMAIC) Process. Accessed at http://asq.org/learn-about-quality/six-sigma/overview/dmaic.html on May 20,2015.

Learn About Lean and Six Sigma in Health Care Settings

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- Butler G, Caldwell C, Poston N. Lean-six sigma for healthcare: A senior leader guide to improving cost and throughput. Milwaukee: American Society for Quality; 2009.
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- Jones, D., Ian Taylor, Marc Baker, Alan Mitchell Making Hospitals Work: How to improve patient care while saving everyone's time and hospitals' resources, 2011.
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- Stamatis DH. Essentials for the improvement of healthcare using lean & six sigma. Boca Raton: Taylor & Francis Group, LLC; 2011
- Zidel, Thomas. A Lean Guide to Transforming Healthcare: How to Implement Lean Principles in Hospitals, Medical Offices, Clinics, and Other Healthcare Organizations, 2006.

4.D. Tools to Enhance Quality Improvement Initiatives

This section summarizes two strategies that can support health care organizations in implementing a model of quality improvement.

4.D.1. The Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®)

For many health care organizations, one of the biggest challenges to improvement is getting a team of highly trained and busy professionals to work together effectively. TeamSTEPPS is an evidence-based training program designed to improve quality and safety by enhancing communication and teamwork skills among health care professionals. The program was developed jointly by the Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ).

TeamSTEPPS teaches techniques to improve team structure, communication, leadership, understanding of what is happening ("situation monitoring"), and mutual support among team members. Together, these factors have a strong influence on quality improvement and quality of care. Organizations can also use TeamSTEPPS to "coach coaches" or "train the trainer."

While TeamSTEPPS was originally designed for the hospital setting, AHRQ also offers a primary care version of TeamSTEPPS training in which the core concepts of the program were adapted to reflect the environment of primary care office-based teams.

4.D.2. Practice Facilitators

Another common challenge for physician practices is not having the expertise, time, or capacity to focus on designing and implementing a quality improvement program. To help overcome that problem, organizations can seek help from practice facilitators (PFs), sometimes referred to as quality improvement coaches or practice enhancement assistants.

PFs are full or part-time personnel hired or contracted to help medical practices evaluate and build organizational capacity for continuous quality improvement. The functions of a PF can include:

- Analyzing and evaluating performance, customer/patient feedback, or patient experience surveys.
- Recommending changes and supporting internal teams with implementation.
- Training clinicians and staff in quality improvement methods.
- Team building.
- Disseminating best practices and innovative ideas.
- Providing specific materials and resources (flow charts, computer training, etc.).

PFs can also assist with enhancing communication and technology, promoting adherence to best practices, and creating the capacity to participate in and benefit from research.

Learn About Practice Facilitators

- Geonnotti K, Taylor EF, Peikes D, et al. *Engaging primary care practices in quality improvement: Strategies for practice facilitators*. Rockville (MD): Agency for Healthcare Research and Quality. 2015 Mar. AHRQ Publication No. 15-0015-EF. Accessible at: http://pcmh.ahrq.gov/sites/default/files/attachments/QI-strategies-practices.pdf.
- Case studies of exemplar primary care practice facilitation training programs
- AHRQ Health Care Innovations Exchange. Practice enhancement assistants improve quality of care in primary care practices. August 13, 2014.

Section 5: Determining Where to Focus Efforts to Improve Patient Experience

To identify opportunities to improve patient experience and determine where to direct your resources, you can start by reviewing your CAHPS survey results in combination with other forms of patient feedback, both quantitative and qualitative. You can then use a variety of qualitative methods to confirm and gather further insights into specific problems, identify possible solutions, and monitor progress. Because some qualitative methods are easier and less expensive to implement than surveys, they can be used more frequently to provide ongoing feedback valuable to clinicians, administrators, and staff.

This section covers four ways to figure out which aspects of patient experience could and should be improved:

- Analyze CAHPS survey results to understand your organization's performance.
- Analyze other sources of data for related information.
- Evaluate the process of care delivery.
- Gather input from stakeholders.

Once you have identified the aspects of patient experience for which you want to develop improvement activities, you will have to decide where exactly to focus your resources. Considerations include how widespread the problem is, how different your score is from others (i.e., the size of the opportunity to improve), the nature of current improvement activities, and the importance of the issue based on other forms of patient feedback.

5.A. Analyze CAHPS Survey Results

Once you have results from a CAHPS survey in hand, you can start by seeing where your scores appear low relative to other composite measures in the survey. You can then conduct different kinds of analyses to identify your organization's relative strengths and weaknesses:

- Compare your CAHPS scores to benchmarks.
- Compare your current CAHPS scores to past performance.
- Assess which aspects of performance are most relevant to your members or patients.

Each kind of analysis provides a different perspective on performance. In some cases, you may be able to obtain sufficient information from using just one or two of these methods.

5.A.1. Compare Your CAHPS Scores to Benchmarks

One way to get the information you need to identify specific problem areas, formulate an improvement plan, and select appropriate strategies is to compare your performance to others. To do that, you need to identify benchmarks or comparative data that are appropriate and relevant for your organization. A benchmark could be a regional or national average, the average score for the same type of organization, or a "stretch goal," such as the score achieved by the top performers. Your benchmark choices should be guided by your business strategy and improvement goals.

Major sources of comparative benchmarks include:

- **CAHPS Database** (for both the Clinician & Group Survey and the Health Plan Survey (for Medicaid, CHIP, and Medicare plans))
- **National Committee for Quality Assurance's (NCQA) Quality Compass** (Health Plan Survey)
- **Centers for Medicare & Medicaid Services** (Health Plan Survey for Medicare only)

Other sources include:

- **Your survey vendor**. Many vendors offer access to comparison norms for their clients.
- **Community-level data**. Depending on the nature of quality measurement activities in your State or region, you may have access to benchmarks specifically for local providers. For example, several multi-stakeholder collaborative organizations gather and report comparative CAHPS results at the clinic site or individual physician level. (Learn about regional health improvement collaboratives).

What is the CAHPS Database?

The CAHPS Database is a voluntary initiative sponsored by the Agency for Healthcare Research and Quality (AHRQ) that enables survey users to compare their own results to relevant benchmarks such as overall and regional averages. In addition to a public online reporting system that presents summary-level de-identified comparative data, survey users that submit data to the CAHPS Database have access to a Private Feedback Report in Excel.

The CAHPS Database presents several views of comparison data, including percentiles, top box scores, and full frequency distributions. Using the online reporting system, a practice site submitting its CG-CAHPS Survey results to the CAHPS Database can compare its scores to selected benchmarks for each composite and item.

When comparing your results to a benchmark, keep in mind that the benchmark provides only a relative comparison. Even though your results may be better than the average score, for example, you may believe there is room for improvement in a particular area in an absolute sense. In fact, there may be some aspects of patient experience measured by the CAHPS survey that even the highest scoring sites could improve on.

There are many ways to analyze your CAHPS results in comparison to benchmarks or other reference points. There is no "right" approach, and the selection of methods for data scoring and presentation will depend on both the benchmarks you choose to use and the level of detail needed by your audience. Following are several examples of different approaches for comparing CAHPS survey results to benchmarks. These examples draw on survey results from the Clinician & Group Survey but apply as well to the Health Plan Survey.

Understanding Scores for CAHPS Survey Results

The CAHPS Analysis Program, often referred to as the CAHPS Macro, uses the survey results to calculate two types of scores. First, it calculates the percent of respondents in each of the response categories for a CAHPS composite or question. Those percentages are called **proportional scores**. The proportional score for the best possible response option (e.g., "always" or "yes, definitely") is referred to as a "**top box**" score.

The CAHPS macro then calculates a **mean** for the CAHPS composite or question. To do that, the response scales are first converted to numerical values. For example, the 4-point response scale of "always", "usually", "sometimes,", and "never" is translated into the values of 4, 3, 2, and 1, respectively. The mean value is then calculated across the four numerical values for each question. The mean score for a composite is computed by taking the average across the mean scores for the items that are included in the composite measure.

5.A.1.a. Comparing Mean Scores

The simplest place to start is to compare the organization's mean scores for the CG-CAHPS composite and rating measures with the average mean score for comparable entities (e.g., other physician practices, medical groups, or health plans), as illustrated in Figure 5-1. As can be seen in this example, a practice site's mean score for the Provider Communication composite measure (3.64) is significantly higher than the mean for the medical group (3.44), yet its mean score for the Provider Rating (8.21) is significantly lower than the mean for the group (8.74). The site is not significantly different from the group on the other two composites. The horizontal lines for each composite in the "Comparison to the Group Mean" column show the minimum site score and the maximum site score within that group.

Figure 5-1. Comparison of Mean Scores for a Practice Site and a Medical Group

CG-CAHPS Composite Measures	Comparison to Group Mean	Site Mean	Group Mean
	1 2 3 4		
Access to Care		3.08	3.04
Provider Communication		3.64	3.44
Helpful/Courteous Staff		3.28	3.24
	0 1 2 3 4 5 6 7 8 9 10		
Provider Rating		8.21	8.74

● Not significantly different from the group mean
▲ Significantly higher than the group mean
▼ Significantly lower than the group mean

For the purposes of comparing composite measures and rating items that have different response categories, Figure 5-2 shows the same data with the mean scores normalized to a 0-100 scale. (Learn about normalizing scores in the box below.)

Figure 5-2. Comparison of Practice Site Normalized Mean Scores to Group Normalized Mean Scores

CG-CAHPS Composite Measures	Comparison to Group Normalized Mean	Site Normalized Mean	Group Normalized Mean
	0 20 40 60 80 100		
Access to Care		77%	76%
Provider Communication		91%	86%
Helpful/Courteous Staff		82%	81%
Provider Rating		82%	87%

● Not significantly different from the group mean
▲ Significantly higher than the group mean
▼ Significantly lower than the group mean

What Does It Mean to Normalize a Score?

Normalizing is a way to transform all scores to the same scale, typically 0 to 100. It is done to ease comparison across items and composites that use different response scales.

To transform the scores, one would first transform the response values at the respondent level from 0-100 using the following formula:

> **Normalized Score** = 100*(Respondent's selected response value – Minimum response value on scale) / (Maximum response value – Minimum response value)

For example, the responses on a four-point scale would be normalized as follows:

Response Option	Normalized Response
1	0.00
2	33.33
3	66.67
4	100.00

5.A.1.b. Comparing "Top Box" Scores to Benchmarks

Another option is to compare the percent of responses in the best possible category for a survey question or composite measure (i.e., the "top box" score) to one or more benchmarks. The CAHPS Database uses this method in one of the displays included in its online reporting system.

Figure 5-3 illustrates a comparison of scores for a sample medical group on the CAHPS Database Submitter's Site for the Access composite measure ("Getting Timely Appointments, Care, and Information") and its individual items in the Clinician & Group Survey 2.0. The medical group scores (in the shaded column) are compared to the overall average of scores in the CAHPS Database and to selected percentile scores. (See the box below for an explanation of percentile scores.)

Table 5-1. Comparison of Sample Medical Group Top Box Scores to the Mean Top Box Score (CAHPS Database Overall) and Selected National Percentiles

Composite/Item	Selected Group/Site	CAHPS DB Overall	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Getting Timely Appointments, Care, and Information	58%	59%	73%	66%	59%	52%
Got appointment for urgent care as soon as needed	64%	64%	81%	74%	66%	58%
Got appointment for check-up or routine care as soon as needed	69%	68%	83%	77%	71%	63%
Got answer to phone question during regular office hours on same day	53%	59%	78%	69%	60%	52%
Got answer to phone question after hours as soon as needed	63%	59%	80%	68%	58%	48%
Wait time to be seen within 15 minutes of appointment time	41%	43%	61%	52%	43%	33%

Source: CAHPS Database Submitter's Site for the CAHPS Clinician & Group Survey 2.0

What Are Percentile Scores?

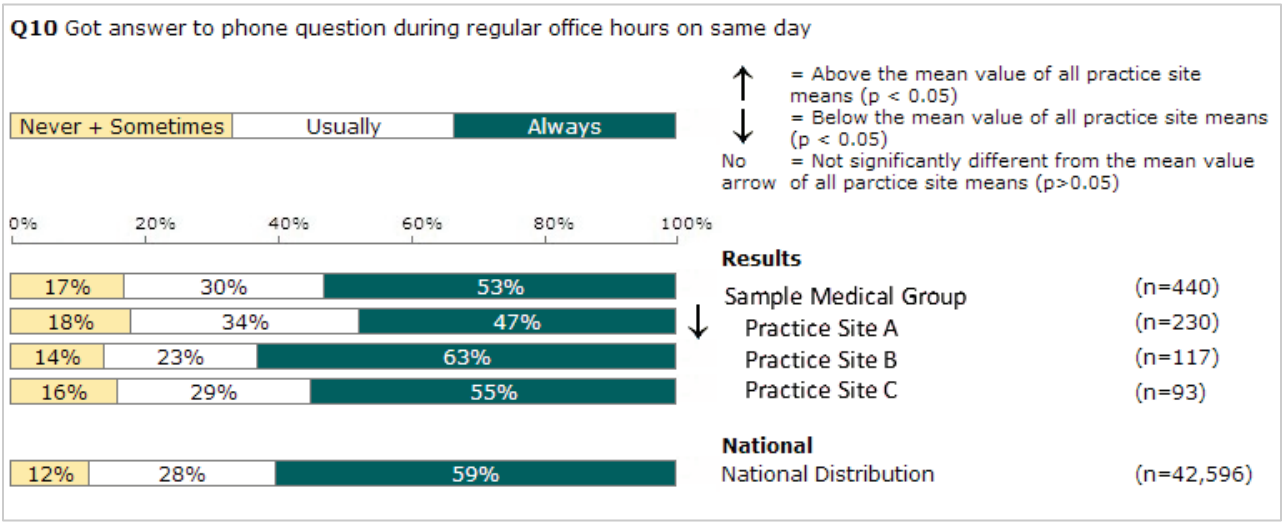
Percentiles provide useful information about the distribution of scores across all of the organizations (e.g., practice sites or health plans) included in a benchmark. To calculate percentile scores, the scores for all participating organizations are ranked in order from low to high. The percentile (e.g., 90th percentile, 25th percentile) indicates the percentage of organizations that scored at or below a particular survey score. For example, the score shown for the 75th percentile is the score where 75 percent of the sites or plans scored the same or lower and 25 percent scored higher.

To compare your scores, look for the highest percentile where your score exceeds the percentile score. For example, in Table 5-1, the group's top box score for the question, "Got answer to phone question after hours" is 63%. This score is higher than the 50th percentile score of 58%, which means that this group scored higher than 50 percent of the groups in the CAHPS Database.

By comparing your organization's top box score for a composite measure and its items to the mean top box score (CAHPS DB Overall) and the percentile scores, you can determine where your organization can improve. For example, the sample comparison in Table 5-1 shows that the medical group's scores for the Access composite measure and its items are roughly in line with the mean score, with the exception of the item, "Got answer to phone question during regular office hours on same day." The medical group's top box score of 53% for this question is close to the national 25th percentile score of 52%, suggesting the need to investigate factors that may be influencing this lower score.

One way to identify what is driving a relatively low score for a large organization is to look at the scores for its components. By calculating benchmark scores for a large organization, such as a health plan, health system, or medical group, you can see how entities within the organization compare to each other. For example, if the medical group in the example above submitted data to the CAHPS Database for several practice sites, the group and its practices could see a display of bar charts showing the full distribution of scores for each practice site. As illustrated in Figure 5-3, among the sample medical group's three practice sites, Practice Site A has the lowest top box score for the question related to getting an answer to a phone question during regular office hours on the same day. In addition, the down arrow indicates that the mean score for Practice Site A is below the average for all practice sites included in the CAHPS Database, calculated at the 0.05 significance level. This type of comparison would allow the medical group to pinpoint improvement opportunities at particular practice sites.

Figure 5-3. Comparison of Practice Site Scores to Medical Group Scores



Source: CAHPS Database

For more information on using the CAHPS Database to compare CAHPS results for both health plan and medical groups, explore the CAHPS Database Online Reporting System.

For more information on the pros and cons of different scoring and comparison methods for CG-CAHPS Survey results, read:

- *Aggregating and Analyzing CAHPS Clinician & Group Survey Results: A Decision Guide*
- *Developing a Public Report for the CAHPS Clinician & Group Survey: A Decision Guide*

5.A.2. Compare Your Current CAHPS Scores to Past Performance

If you have collected CAHPS survey results more than once, another useful way to identify opportunities for improvement is to look at past performance. Comparing your current scores to previous scores can be valuable for:

- Detecting areas where your performance is improving, declining, or holding steady.
- Increasing your confidence that the scores reveal a true picture of performance and are not just a snapshot of performance at a single point in time.

Figures 5-4 and 5-5 present two sample displays to examine CAHPS data over time. In Figure 5-4, bar graphs show trends in "top box" scores from 2010-2014 for the four Health Plan Survey composite measures and two rating items.

Figure 5-4. Bar Graph Example for Trends in Top Box Scores for the Health Plan Survey, 2010 - 2014

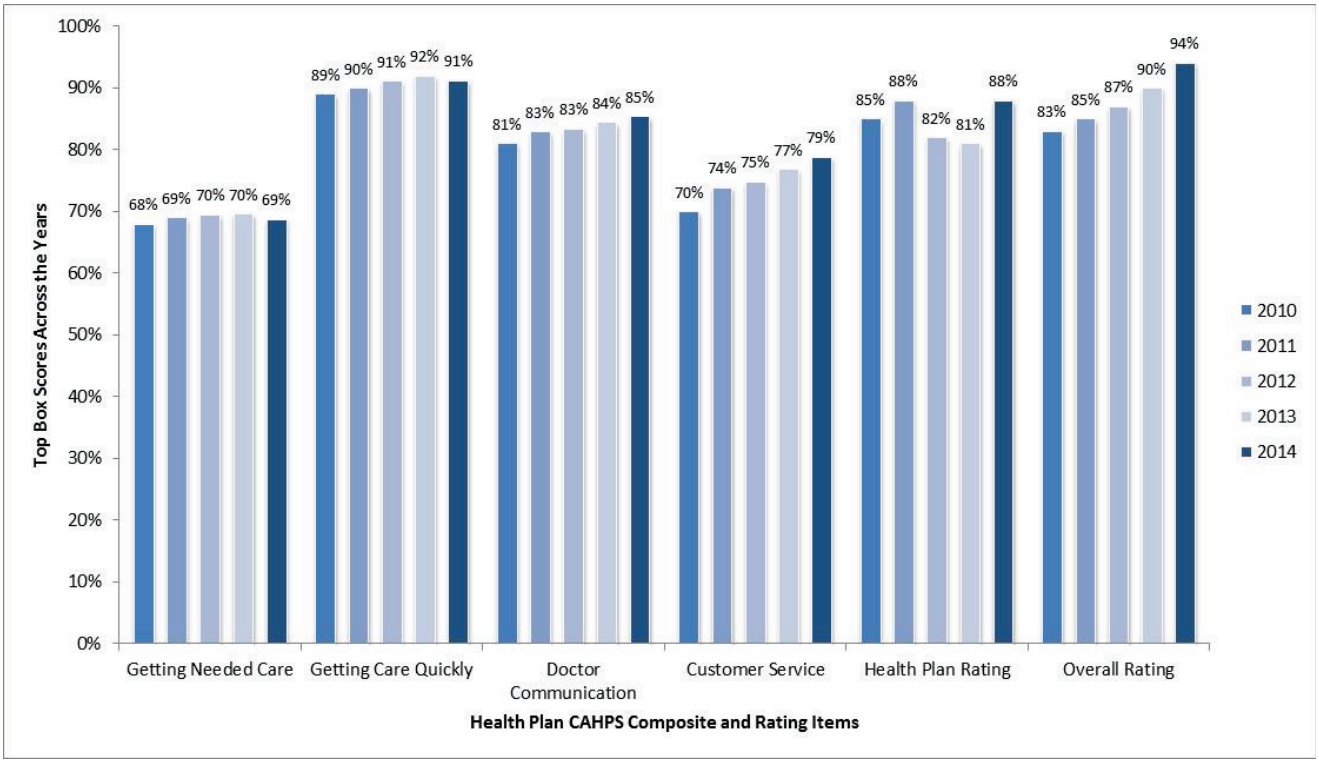
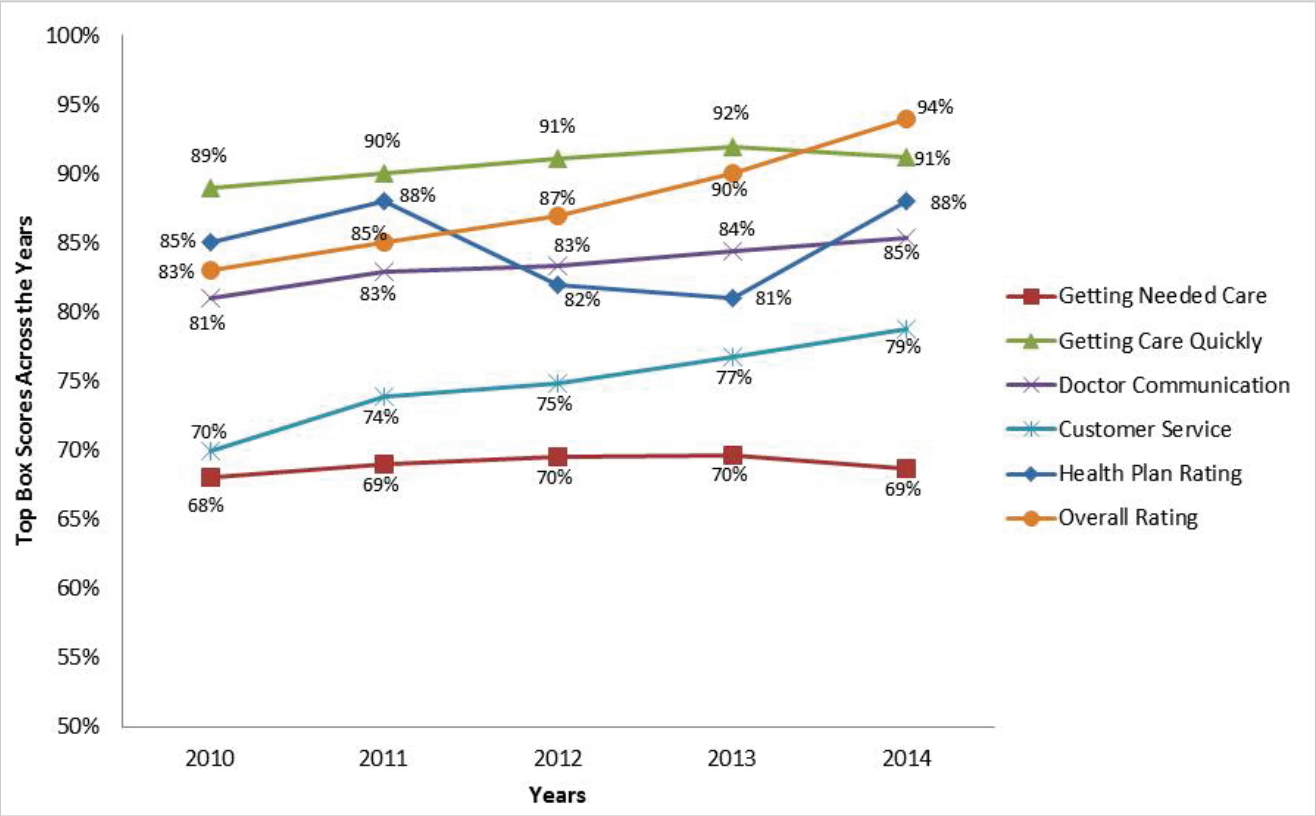


Figure 5-5 shows the same data using line charts to plot the trends over time. With the line charts, it was necessary to alter the y-axis so that it starts at 50% and goes to 100%. Because most of the scores clustered within 30 percentage points of each other, this change to the axis makes it easier to see the differences in scores across the measures.

Figure 5-5. Line Graph Example for Trends in Top Box Scores for the Health Plan Survey, 2010 - 2014



5.A.3. Assess Which Aspects of Patient Experience Are Most Important to Your Members or Patients

Another method you can use to help determine what specific issues to focus on for improvement involves identifying the factors that are most important to members or patients. This analysis of the "importance" of topics in the CAHPS survey—sometimes referred to as a "key driver" analysis—requires an assessment of how strongly a score for a particular question or composite measure is associated with patients' or enrollees' overall rating of their health plan or medical practice. This type of analysis can be conducted with data from multiple groups, sites, or plans.

The statistic commonly used to assess such associations is called a correlation coefficient, which can range from –1.0 to +1.0 (see box below for information about interpreting this statistic). There are several methods for calculating correlations; the method that is recommended for CAHPS scores is the Spearman correlation, but other methods may also be useful.

Interpreting the Correlation Coefficient

- **If the correlation coefficient is between zero and 1,** the overall rating (e.g., how would you rate your care?) has a positive relationship with the score for a question (e.g., how often did your personal doctor explain things in a way that was easy to understand?) or composite measure (e.g., Doctor Communication). This means that the rating increases as the score increases. The higher the value of the coefficient, the stronger the relationship.
- **If the correlation coefficient is 1.0,** the rating and the question or composite measure are perfectly related, i.e., measuring the same concept.
- **If the correlation coefficient is zero,** the rating and the question or composite measure are independent, i.e., not related.
- **If the correlation coefficient is between 0 and -1,** the rating is inversely related to the question or composite measure, which means that the rating decreases when the score increases. This is unusual in a CAHPS survey unless the response options are reversed, in that "never" is the most desired response.

The following examples illustrate the results of a key driver analysis for the Health Plan Survey and the Clinician & Group Survey. These correlations do not necessarily apply to your implementation of a CAHPS survey; it is important to analyze your own data for such correlations because they can be different for each sample.

5.A.3.a. Correlation Coefficients for the CAHPS Health Plan Survey

Table 5-2 below presents Spearman correlations between the Health Plan Survey composite measures and the overall ratings of doctor, care, plan, and specialist. As has been found in previous analyses, the strongest relationship was between the Doctor Communication composite and the Doctor Rating.

Table 5-2. Correlations between top box scores for composite measures and overall ratings in the Health Plan Survey

Composite measure	Doctor rating	Care rating	Plan rating	Specialist rating
Getting needed care	0.53	0.68	0.57	0.43
Getting care quickly	0.48	0.61	0.48	0.31
How well doctors communicate	0.69	0.67	0.44	0.39
Customer service	0.28	0.49	0.61	0.20

Note: All correlations are statistically significant ($p < .001$). Data for analyses came 122 health plans that administered the Health Plan Adult Medicaid Survey.

5.A.3.b. Correlation Coefficients for the CAHPS Clinician & Group Survey

Table 5-3 presents Spearman correlations between the composite measures from the Clinician & Group Survey 2.0 with supplemental Patient-Centered Medical Home (PCMH) items and the overall rating of the provider. Consistent with the example of the Health Plan Survey above, the data indicate a very strong association between the Provider Communication composite and the Provider Rating and strong but slightly smaller relationships between Access to Care and Office Staff scores and the Provider Rating. The correlations for the three PCMH supplemental composites are much lower than those for the core composites.

Table 5-3. Correlations between top box composite scores and the provider rating in the Clinician & Group Survey

Composite measure	Provider rating
Getting timely appointments, care, and information	0.61
How well doctors communicate with patients	0.87
Office Staff: Helpful, courteous, and respectful office staff	0.66
Talking with you about taking care of your own health (PCMH)	0.38
Attention to your mental or emotional health (PCMH)	0.17
Talking about medication decisions (PCMH)	0.52

Note: All correlations are statistically significant ($p < .01$). Data for analyses came from 714 practice sites that administered the Clinician & Group PCMH Survey 2.0.

5.A.3.c. Creating a Priority Matrix

One very useful way to hone in on areas for improvement is to plot a "priority matrix" that graphically displays relative performance on the composite measures along with the relative "importance" of the composite measure as it relates to an overall rating of care.

Using an example based on the CG-CAHPS survey with PCMH supplemental items (shown in Figure 5-6), a priority matrix plots the following two variables:

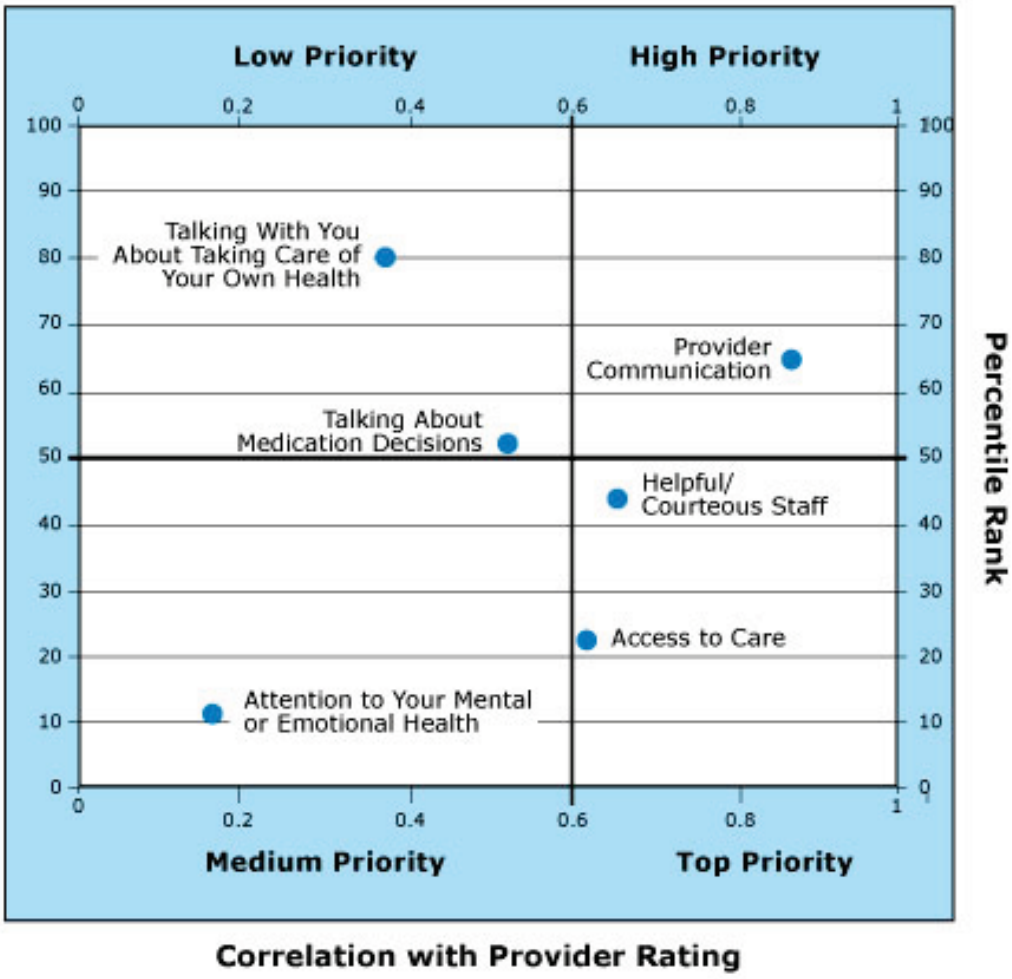
Relative *Performance* on the Y-Axis. On the Y-axis, the chart displays where the practice site's scores stand in relation to all other practices included in the survey. That is, scores below the "50" line denote measures for which the practice's performance is below the 50th percentile, and those above the 50 line denote measures for which the practice's performance is above the 50th percentile.

Relative *Importance* on the X-Axis. On the X-axis, the chart shows the relationship between each survey measure and patients' overall rating of the provider, as measured by the correlation coefficient discussed above. The further to the right a measure is on the chart, the more strongly it is associated with the provider rating. The vertical line at 0.6 illustrates one way to differentiate higher and lower correlations, as correlations at or above 0.6 signify a strong association.

Combining these two pieces of information into a matrix, as shown in Figure 5-6, can help you identify priority areas for improvement in the practice. For example, measures in the bottom right quadrant reflect those that should probably be the highest priorities for improvement in that they are both important to patients (as revealed by high correlations with patients' rating of the provider) and areas in which the practice performed below the 50th percentile. The other quadrants convey similar information about how the practice performed on each aspect of care and the relative importance of this area to patients. Note that Figure 5-6 is an illustrative example; where you choose to place the lines to form the quadrants should be based on your own goals and priorities.

These kinds of analyses and graphical representations of relationships are not difficult to do, but they do require time and access to analytical support. Many survey vendors are capable of providing these services as part of the CAHPS data collection and reporting process.

Figure 5-6. Priority Matrix for a Sample Practice Site



5.B. Analyze Other Sources of Information for Related Information

Once you have compared your CAHPS scores to your previous scores and/or relevant benchmarks (e.g., national, regional, or other comparison group of interest), you may want to review related information to confirm your findings and identify steps you could take to improve patient experience. Sources of information that could be helpful for this purpose include complaints and compliments, patients' comments, and administrative data.

Health plans and providers typically have access to or can easily gather various types of administrative data that you can "mine" to determine which performance issues may be affecting your CAHPS scores. Examples of sources of administrative data include:

- Telephone logs
- Employee work hours
- Visit appointment records

The types of data you choose to use for further analysis will depend on the issues you identified when examining your CAHPS results. For example, if you are interested in improving patients' experiences in getting appointments when needed, you could:

- Examine visit appointment records to assess missed appointments.
- Analyze telephone logs to assess how many dropped calls or failed appointment queries occurred.
- Analyze visit appointment records to determine the amount of time between scheduling an appointment and the actual appointment date.
- Search your complaint records and tabulate the number of complaints received about appointment problems.

5.C. Evaluate the Process of Care Delivery

If it is not clear why you are doing well on some CAHPS survey measures and not so well on others, you may need more detailed information to help you identify actions that can improve patient experience in specific areas. To get that information, you need to go beyond the survey results to do some additional analyses targeted at one or more specific topics addressed by the survey items or composites. The purpose of these analyses is to "drill down" to find very specific, underlying performance problems that are actionable—i.e., that you can change through quality improvement activities.

Consider a clinical practice whose score for the Access composite "Getting timely appointments, care, and information" is lower than average. An initial analysis of this practice's survey scores may find that a key driver of the composite score was a low score on this survey question: *"When you made an appointment for a check-up or routine care, how often did you get an appointment as soon as you thought you needed?"*

Why might patients be having trouble getting a timely appointment for check-ups or routine care? Various operational issues in the practice could contribute to this problem:

- The physicians may not be available sufficient hours to handle all the patients served by the practice.
- Problems in scheduling appointments may have a seasonal pattern related to when physicians take vacations or are otherwise not available.
- Routine appointments may be bumped frequently by last-minute emergency visits.
- Limitations of office hours may make it difficult to find visit times that are convenient for patients.
- The staff working on the appointment calendar may not be interacting well with patients to identify their needs and priorities.

This section uses this example to explore several tools and techniques you can use to examine the underlying causes of performance problems revealed by survey results. Although some of these approaches were developed for use in industrial settings, they apply equally well to health care.

- Root cause analysis
- Process mapping
- Process observation (including shadowing)
- Walkthroughs
- Small-scale surveys

5.C.1. Root Cause Analysis

Root cause analysis, also called "5 Whys," is a method for identifying the root causes of a problem and determining the relationship among different root causes. Repeatedly asking the question "Why" peels away the layers of issues to uncover the fundamental source of a problem. You may find that you will need to ask "why" fewer or more times than five to reach a conclusion. This tool, which does not involve a statistical hypothesis or analysis, is most useful when problems involve human factors or interactions.

Use the following steps to complete a root cause analysis:

Step 1: Write down the specific problem. Articulating the issue in writing helps you formalize the problem and describe it completely. It also helps everyone on the improvement team focus on the same problem.

> *Example of a problem:* A medical practice has received low CAHPS scores for the item on getting an appointment scheduled as soon as patients would like. It also is receiving a large number of complaints from patients on this issue.

Step 2: Ask why the problem happens and write the answer down below the problem.

> *Why? (#1):* There are not sufficient times available on the calendar for scheduling the number of patients calling in a timely manner.

Step 3: If the answer you just provided does not identify the root cause of the problem that you wrote down in step 1, **ask why again** and write that answer down.

> *Why? (#2):* The practice only has office hours 4 days a week and is not open on Saturdays.

Step 4: Loop back to step 3 until the team is in agreement that the problem's root cause is identified.

> *Why? (#3):* The physicians in the practice are not willing to work on Saturdays, and many of them are not always available to see patients for all of the weekday hours.

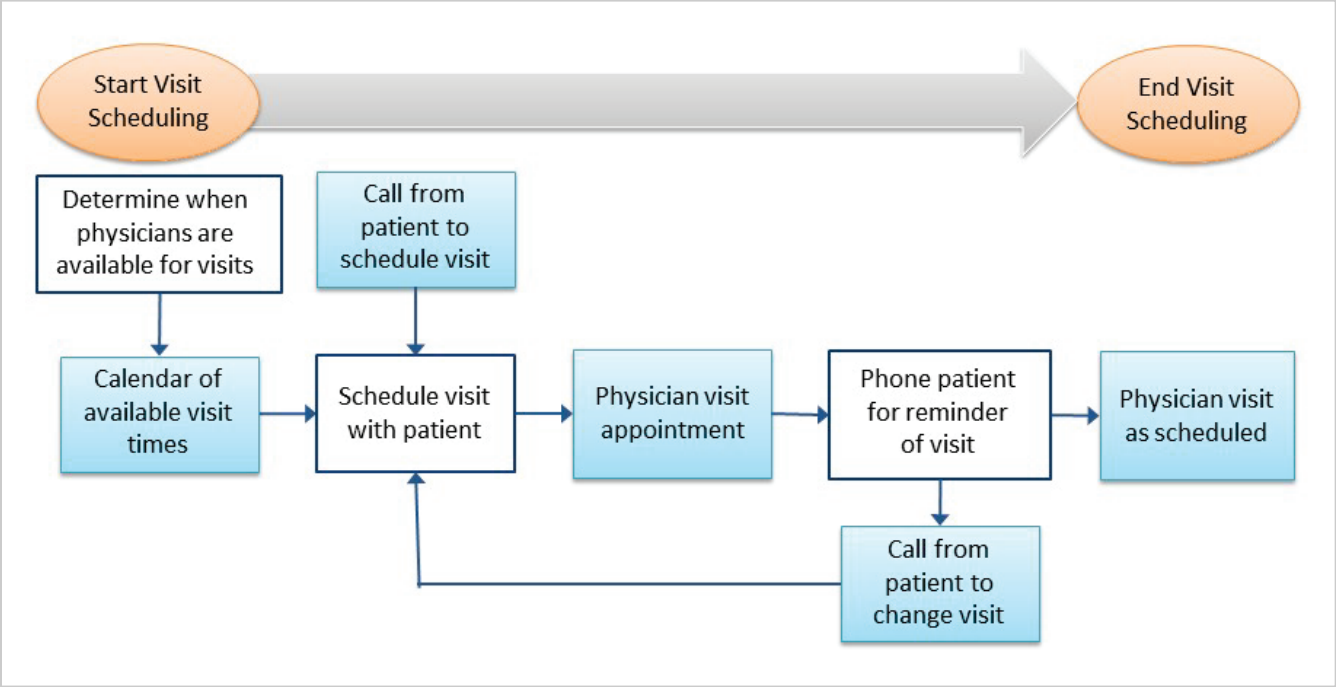
5.C.2. Process Mapping

To figure out how to improve a process, it helps to map it. A process map is a picture or flow chart showing the steps involved in transforming the inputs into the outputs of the process. For example, the practice in the example above would list each step involved in scheduling appointments for routine care. The chart seen in Figure 5-7 shows a simple process map for an appointment process in a medical practice. It includes:

- The process steps (best described using nouns [blue boxes]),
- The activities between the steps (best described using verbs [white boxes]), and
- For each activity, the inputs and outputs involved (arrows).[37]

[37] Cousins M. *Follow the Map 2003*. Available at: http://saferpak.com/process_mapping_art2.htm. Accessed on August 2010.

Figure 5-7. Process map of a physician visit appointment



You can choose from a variety of formats for preparing your process map. But within any given process map, use consistent symbols for each type of process component, such as process steps, activities, and decision steps. This will support clear communication among participants as you develop and work with the process map to guide improvement decisions. Learn more about developing this kind of picture.

Process mapping can address two aspects of process improvement:

- Developing an initial understanding of how things are done currently. It is critical to start by depicting the process the way it really works, not the way you think it should work.
- Examining and testing alternative changes to improve the process.

For best results, this method needs to be accurate and fast; it should also involve a high degree of staff ownership as well as input from patients or enrollees who can provide their perspective on what really happens.

5.C.2.a. Steps in Developing a Process Map

- **Start with the big picture.** Draw a macro-level process first, after which you may want to develop other diagrams with increased levels of detail. For example, you could develop a more detailed process map of the "Call from patient to schedule a visit" to understand the steps a patient goes through with your phone system to make an appointment.
- **Observe the current process.** Walk through the current process, observing it in actual operation. (Read about walkthroughs and shadowing below.)
- **Record the process steps you observed.** Document the steps as they actually occur. Start by writing the steps separately on index cards or sticky notes.
- **Arrange the sequence of steps.** Lay out the cards or sticky notes exactly as you observed the steps. Using cards lets you rearrange the steps without erasing and redrawing and prevents you from discarding ideas simply because it is too much work to redraw the diagram.
- **Draw the final process map.** Depict the process exactly as you observed, recorded, and arranged the sequence of steps.

5.C.2.b. Common Weaknesses of Process Maps

Take steps to avoid and correct for these common pitfalls that can interfere with your interpretation and full understanding of the process.

- Those working on the map may have drawn it for the process as they envision it, not as it really is.
- People may be reluctant to depict the obviously illogical parts of the process for fear they will be asked to explain why things have been working that way.
- Rework loops are either not seen or not documented because people assume rework is small and inevitable.
- The people drawing the map do not really know how the process works.

Resources for Process Maps

- Cousins M. *Follow the Map; 2003*. Available at: http://saferpak.com/process_mapping_art2.htm. Accessed August 2010.
- *Basic Tools for Quality Improvement: Flowchart*. Available at: http://saferpak.com/flowchart_articles/howto_flowchart.pdf. Accessed August 2010.
- Damelio R. *The basics of process mapping*. Quality Resources; 2007.
- Galloway D. *Mapping work processes*. ASQ Quality Press, 1994.

5.C.3. Process Observation

Process observation is a way of confirming exactly what is happening during any particular process. It allows you to gather useful information about almost any process, activity, or human behaviors that you can use to refine your process map as well as to help uncover issues that are compromising the effectiveness of the process.

Often you will not be able to observe all relevant activities by people, location, or over time, so you can observe only a sample of activities. If you sample, consider how important it is to have a probability sample, which would allow you to generalize to the entire process.

5.C.3.a. Methods of Observation

To choose an observation method, start by answering these questions:

- What do you want to learn from the observation?
- What will the users/stakeholders view as credible and useful information?

You may use either structured or unstructured observation methods, depending on the type of information you want to collect.

- **Structured observation** looks for certain things that have already been identified and can be tracked in a preset guide, checklist, or rating scales. This method generates quantitative data from frequency counts, rankings, and ratings.

Questions and Answers About Process Observation

When is observation most useful?
Observation is useful when:

- You want direct information on a process.
- You are trying to understand an ongoing process.
- Physical evidence, products, or outcomes of a process can be seen readily.
- Written or other data collection procedures seem inappropriate.

Who should do the observing? Your observers should be neutral parties. They should not be someone who has day-to-day contact with people in the process being observed. The observer must pay close attention to capture details well. He or she will also need to discern what is important in the process being observed and help to interpret the meaning of what was observed. Once the observation is complete, you may want to verify it by either having the observer go back to collect more information or asking others to do additional observation to validate the findings.

Should the observer be open about what he or she is doing?
Observations may be either overt or covert, depending on the situation and the purpose of the assessment. Covert observation is helpful because people often behave differently when they know they are being observed. But if you use covert observation, take care that neither the observation nor the resulting report will harm the people being observed.

- **Unstructured observation** looks at what is happening in a process or activity without confining the observer to preset items. The observed activities are recorded during the observation period, which produces qualitative data.

5.C.3.b. Observation Tools

Several types of tools are available to record observation data. Choose your recording methods—alone or in combination—based on your observation design.

- **Observation guides.** These printed forms provide space for recording observations, which allows for the consistent collection of information across observers or sites. The more detailed you make the guide, the easier it will be to tally results, but the less flexibility it will provide for recording findings.
- **Recording sheets or checklists.** These forms are used to record observation in either yes/no or rating scale formats. They are used when observations are looking for specific items or activities that are easily identified.
- **Field notes.** This tool is the least structured way to record observations. When the observer sees or hears something of import, he or she records it in a narrative, descriptive style, typically in a notebook. Observations should be accompanied by the date, location, and relevant contextual information.
- **Pictures or videos.** The observer can also record pictures or videos, which can be analyzed later and used to illustrate points in a report.

Shadowing the Care Process

Shadowing is a low-cost method for health care organizations to view firsthand how each step of the care process is experienced by patients and families. It can be performed by individuals with only minimal training—including volunteers, summer interns, college students, patient advocates—and is best conducted by those unfamiliar with the care experience in order to bring a fresh and unbiased perspective to the process being observed.

Shadowing starts at the very beginning of the care experience, such as in the parking lot of an ambulatory clinic visit, and follows the patient and/or family member through every "touch point" encountered, from entry to the practice to the end of the visit. Shadowers document the care experience in a field journal, take notes, and are encouraged to engage patients and families in a dialogue about their impressions of and ideas for improving the care experience.

Resources for Process Observation

- Taylor-Powell E, Steele S. *Collecting Evaluation Data: Direct Observation*, G3658-5, University of Wisconsin-Cooperative Extension. Available at: http://learningstore.uwex.edu/assets/pdfs/G3658-5.PDF. Accessed August 11, 2010.
- Nicolson S, Shipstead SG. *Through the looking glass. Observations in the early childhood classroom*. 3rd ed. Upper Saddle River: Merrill Prentice Hall; 2002.

5.C.4. Small-Scale Surveys

A small-scale survey can be used to drill down on the experience behind CAHPS scores or to survey staff about barriers they encounter when trying to schedule patients. You can conduct a small-scale survey with a convenience sample of as few as 10 individuals and usually no more than 100; examples of a convenience sample include:

- All patients who visit a specific clinic on a given day.
- All patients who report a problem scheduling appointments.
- Staff who participated in a specific training exercise.

These kinds of surveys are useful in that they provide information that you can act on or help you to understand what kinds of experiences may be driving your CAHPS scores. For example, one large health system took advantage of its marketing department's online opinion panel to survey 1,000 clinic patients about what "helpfulness" meant to them and what office staff could do to be more helpful.[38] However, it is important to recognize that the results of small-scale surveys are not generalizable to your patient population because they are not based on a scientific sample. That is, they reflect only the experience of the patients you surveyed, who are not representative of your total patient population.

Resources for Small-Scale Surveys

- Fowler FJ. *Survey research methods*. 4th ed. Thousand Oaks: Sage Publications; 2009.
- Gillham B. *Small-scale social survey methods*. London: Continuum International; 2008.

5.D. Gather Input from Stakeholders

Your analysis of performance issues can benefit from good information on the views, experiences, needs, and motivations of the various stakeholders who are involved in or affected by the processes you're addressing. To help identify and examine the causes of your performance problem, consider contacting the relevant stakeholders to find out what they know, how they feel about issues, and their ideas for improvement. Different

[38] Agency for Healthcare Research and Quality. How Two Provider Groups Are Using the CAHPS® Clinician & Group Survey for Quality Improvement. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/reports-and-case-studies/cgcahps-webcast-brief-2014.pdf. Accessed on July 21, 2015.

stakeholders have unique perspectives that you need to consider together to understand the full dynamics involved in delivering and receiving health care and how those dynamics influence patients' experiences with care.

5.D.1. Overview of the Process of Gathering Stakeholder Input

Imagine that an initial analysis of the practice with poor performance on the access composite found that a key driver of the composite score was a low score on this CAHPS question: "*When you made an appointment for a check-up or routine care, how often did you get an appointment as soon as you needed?*" What can you learn from stakeholders about the problems with timely appointments for care and how to fix those problems?

Step 1: Working as a team, identify the groups that are key stakeholders for the CAHPS performance issue you're addressing. Stakeholders can include patients and their family members, physicians, nurses, other clinical personnel, clerical staff, managers of the health care organization, and staff of other involved organizations. You should include groups who are involved in the process (such as nurses) as well as others who are affected by it (such as patients), since both would be affected by any changes you make during quality improvement work. For example, for a problem related to the appointment process, stakeholders may include:

- The physicians in the practice
- The patients who are getting appointments for care
- The office staff who handle the appointment process
- Nursing staff who initiate the office visit with patients
- The office manager who supervises the practice operation

People on the "front line" of care typically have the best understanding of what works well and what doesn't because they live with it every day. However, front-line caregivers sometimes become so accustomed to working in a "broken" system that they accept some problems as inevitable ("just the way it is") when the problems can—and should—be fixed.

Step 2: Develop a list of the topics you want to discuss with the stakeholder groups to learn:

- How the process works
- What they think is wrong with it
- How they think it needs to be improved

Step 3: Use qualitative data collection methods to gather information from people in each of your stakeholder groups. (Read about these methods below.) The exact methods you choose to use will depend on which types of stakeholders you will be talking with, and whether you want to have group discussions or talk separately with individuals.

Step 4: Summarize your findings. With feedback from all your stakeholder groups on each of the topics, you can compare responses to find similarities and differences in views and concerns across the groups.

Step 5: Use the information from the stakeholders to refine your process map and your list of possible issues affecting performance. You can also use this information to help guide strategies and actions for improving performance on the CAHPS measures.

5.D.2. Techniques for Gathering Feedback From Stakeholders

Techniques you can use to gather information from stakeholders on their experiences and views of performance problems include:

- Focus groups
- Semi-structured interviews
- Walkthroughs
- Patient and family advisory councils
- Patient Partners on improvement teams

5.D.2.a. Focus Groups

A focus group is a moderator-led discussion among staff and/or patients that is designed to collect more precise information about a specific problem and new ideas for improvement strategies. This approach allows for in-depth exploration of the drivers of dissatisfaction and can provide excellent ideas for reengineering services.

In addition, videotapes of focus groups can be very effective at changing the attitudes and beliefs of staff members because the participants' stories often bring to life the emotional impact of excellent service as well as service failures.

When conducting a focus group, the moderator uses a written topic guide to ensure that the group addresses all key topics in the discussion; another person usually serves as a note taker. The moderator typically uses various techniques during the discussion so that everyone in the group has a chance to speak and discussion among group members takes place. Examples of these techniques include going around the table to ask each person to give their views on a topic

Resources for Focus Groups

- Krueger RA, Casey MA. *Focus groups: a practical guide for applied research*. Thousand Oaks: Sage Publications; 2000.
- Bader GE, Rossi CA. *Focus groups: a step-by-step guide*. 3rd ed. San Diego: The Bader Group; 2001.

being discussed and specifically asking people who have not said much for their opinions.

5.D.2.b. Semi-Structured Interviews

In contrast to focus groups, interviews allow you to collect a great deal of rich, detailed information on the experience of an individual. They also offer greater flexibility in terms of the order in which topics are discussed. Interviews are also useful when you want to:

- Collect information that is not influenced by the opinions of others in a group discussion.
- Collect information from staff that is not influenced by the presence of supervisors or managers.

Semi-structured interviews are conducted one-on-one or in groups of no more than three people. The interviewer typically uses a topic guide and is accompanied by a note taker.

Resource for Semi-Structured Interviews

- Lindloff TR, Taylor BC. *Qualitative communication research methods*. 2nd ed. Thousand Oaks: Sage Publications; 2002.

5.D.2.c. Walkthroughs

A walkthrough recreates for clinicians and staff the emotional and physical experiences of being a patient or family member. It is an easy way to give members of your organization the patient's perspective and the fastest way to identify system, flow, and attitude problems. Walkthroughs provide a different perspective and bring to light rules and procedures that may have outlived their usefulness.

How a Walkthrough Works

During a walkthrough, one staff member plays the role of the patient and another accompanies him or her as the family member. They go through a clinic, service, or procedure exactly as a patient and family do. They do everything patients and families are asked to do and they abide by the same rules. They do this openly, not as a mystery patient, and throughout the process ask staff members a series of questions to encourage reflection on the processes or systems of care and to identify improvement opportunities.

The staff conducting the walkthrough take notes to document what they see and how they feel during the process. They then share these notes with the leadership of the organization and quality improvement teams to help develop improvement plans. For many who do this, it is the first time they have ever entered their clinics, procedure rooms, or labs as the patient and family do. Clinicians are routinely surprised about how easy it is to hear staff comments about patients from public areas and waiting rooms. Walkthroughs usually turn up many problems with flow, signage, and wasteful procedures and policies that can be fixed almost immediately.

A walkthrough is similar to shadowing (discussed in *Process Observation*), where a staff member asks permission to accompany a patient through the visit and take notes on the patient's experience. Since shadowing does not require taking a slot away from a real patient, it can be useful in settings where visits are at a premium.

Tips on Conducting a Walkthrough

- **Let the staff know in advance that you will be doing this walkthrough.** As a result of this warning, they will probably be on their best behavior. However, experience suggests that it is far better to have them part of the process than to go behind their backs. Ask them not to give you special treatment.
- **Go through the experience just as the patient and family member would.** Call in advance, if the patient would have to. Get dropped off or find a place to park. Try to act as if you have never been there before. Follow the signs. Tell the clerk that you are simulating a patient's experience and that you want to go through whatever a normal patient would have to do (e.g., the check-in process). Actually fill out the forms if there are ones to fill out. Find out how long a patient would typically wait and sit in the waiting room for that amount of time. Wait your turn. Do the same in the examining room. If a patient would undress, you should undress. If a patient does a peak flow meter, you should too. Ask each health care provider to treat you as if you were a real patient. If you are doing a walkthrough of the cardiac catheterization service, hold the sandbags on your leg the required amount of time.
- **As you go through the process, try to put yourself in the patient's (or family member's) position.** Look around as they might. What are they thinking? How do they feel at this moment?
- **At each step, ask the staff to tell you what changes (other than hiring new staff) would make the experience better for the patient and what would make it better for the staff.** Write down their ideas as well as your own, and also write down your feelings. As you do the walkthrough, think about how you would answer the following questions and ask the staff you interact with to answer them when you can:
    - What made you mad today?
    - What took too long?
    - What caused complaints today?
    - What cost too much?
    - What was wasted?
    - What was too complicated?
    - What involved too many people or too many steps?
    - What did you have to do that was just plain silly?

- **Finally, between the two of you (patient and family member), make a list of any issues you identified and any improvements that could be made.** Keep track of the things that can be fixed the next day versus problems that will take longer to remedy.

5.D.2.d. Patient and Family Advisory Councils

You can obtain feedback as well as improvement ideas from patients and families through strategies that engage their participation on an ongoing basis. A Patient and Family Advisory Council is one of the most effective strategies for involving families and patients in the design of care and ensuring that those on the receiving end of health care have a voice in the organization's decision-making process.

A patient and family advisory council can help overcome a common problem that most organizations face when they begin to develop patient-and family-centered processes: They do not have the direct experience of illness or the health care system. Consequently, health care professionals often approach the design process from their own perspective, not the patients' or families'. Improvement committees with the best of intentions may disagree about who understands the needs of the family and patient best. But family members and patients rarely understand professional turf boundaries. Their suggestions are usually inexpensive, straightforward, and easy to implement because they are not bound by the usual rules and sensitivities.

Council responsibilities may include input into or involvement in:

- Program development, implementation, and evaluation;
- Planning for major renovation or the design of a new building or services;
- Staff selection and training;
- Marketing the plan's or practice's services;
- Participation in staff orientation and in-service training programs; and
- Design of new materials or tools that support the doctor-patient relationship.

While councils can play many roles they do not function as boards, nor do they have fiduciary responsibility for the organization.

Tips for Starting a Patient and Family Advisory Council

- **Recruitment:** You can start with members that are recommended by staff. Look for people who:
  - Can listen and respect different opinions.
  - Are supportive of the institution's mission.
  - Are constructive with their input. Staff members will frequently describe good council members as people who know how to provide "constructive critiques."
  - Are comfortable speaking to groups and in front of professionals.
- **Size:** Depending on the size of the organization, most councils have between 12 and 30 patient or family members and 3 or 4 members from the staff of the organization.
- **Time commitment**: The council members are usually asked to commit to one 2- to 3-hour meeting a month, usually over dinner, and participation on one committee. Most councils start off with one-year terms for all members to allow for graceful departures in case a member is not well suited for the council.

Resources for Patient and Family Advisory Councils

- Webster PD, Johnson B. *Developing and Sustaining a Patient and Family Advisory Council*. Bethesda, MD: Institute for Patient- and Family-Centered Care; 2000.
- *Advancing the Practice of Patient- and Family-Centered Care in Primary Care and Other Ambulatory Settings*. Bethesda, MD: Institute for Patient- and Family-Centered Care. 2016. Available at http://www.ipfcc.org/resources/GettingStarted-AmbulatoryCare.pdf

5.D.2.e. Patient Partners on Improvement Teams

You can take the strategy of engaging patients in the process of care design and improvement one step further by embedding patients as active partners working together with clinicians and staff on quality improvement teams. This approach, referred to as Patient Partners, recognizes that true patient-centered transformation of care cannot be achieved without enlisting the active involvement of patients in the redesign process. Including patient partners as members of practice improvement teams brings the patient voice and perspective directly into the hard and sometimes messy work of process redesign, and can be an enlightening and rewarding experience for patients, clinicians, and staff alike.

Example: Patient Partners in Humboldt County, California

The Patient Partners strategy was pioneered by the Aligning Forces Humboldt program in Humboldt County, California, one of sixteen community alliances in the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) program. The Patient Partners program grew out of the alliance's Primary Care Renewal (PCR) collaborative, which was focused on the patient-centered medical home model. Collaborative leaders recognized that true patient-centered transformation of primary care could not be achieved without enlisting the active involvement of patients in the practice redesign process. Including Patient Partners as members of practice improvement teams therefore became a mandatory part of the collaborative process.

Improvement teams at each practice typically include at least one physician, nursing and office staff, and two Patient Partners. Patient Partners receive training for their role on practice improvement teams. Each team is assigned a practice coach from the Humboldt-Del Norte Independent Practice Association (IPA) to help plan and conduct team meetings and to assist in the improvement process. The practice teams meet individually on a regular basis and together at collaborative meetings.

Alliance staff meet separately with the Patient Partners prior to the full collaborative meetings to help prepare them to participate effectively and hold other meetings with just Patient Partners to refresh their training, debrief together, and share lessons learned. A case study evaluation of the program found strong evidence that engaging patients directly in the quality improvement process yielded many perceived benefits to the practices as well as to the patients involved.

Tips for Integrating Patient Partners on Improvement Teams

- Determine how often patients will attend improvement team meetings. Some practices have meetings twice a month and integrate patients into one of the meetings. This leaves one meeting to discuss business-related issues that the practice may not be ready to share with patients. However, this approach may also create discontinuity between meetings and make it difficult for patients to follow unless meeting agenda topics do not cross between meetings, which may be difficult to achieve.
- Select two or three patients that can commit to attend the QI team meetings regularly and can provide “constructive criticism” and input to the team. Practices implementing this approach typically ask patients to make at least a 1-year commitment to being a Patient Partner.

- Create an environment where the patients are encouraged to participate and share positive and negative thoughts and experiences.
- Provide some background and training in quality improvement (QI) for Patient Partners. While Patient Partners are experts at representing the patients' perspective of the practice, they may not be familiar with QI processes, interpreting standard QI data reports, and commonly used acronyms.
- In order to make the meeting time most productive, provide some advance preparation to the Patient Partners. Many practices that have integrated Patient Partners have received support from community collaborative organizations, such as special training sessions to help them prepare for their new roles.
- Give the Patient Partners the same kinds of tasks and activities that staff members would do. For example, Patient Partners can be valuable in doing walkthroughs and conducting interviews with other patients. Similarly, give Patient Partners the ability to add issues to the team's agenda. They may identify issues from the patient perspective that staff do not recognize as problems.

Resources for Patient Partners

- *Engaging Patients in Improving Ambulatory Care*. Washington, DC: Aligning Forces for Quality; 2013. http://www.rwjf.org/en/library/research/2013/03/engaging-patients-in-improving-ambulatory-care.html. Accessed July 10, 2015.
- Roseman D, Osborne-Stafsnes J, Amy CH, et al. Early lessons from four 'Aligning Forces For Quality' communities bolster the case for patient-centered care. *Health Aff* 2013;32(2):232-41.

Section 6: Strategies for Improving Patient Experience with Ambulatory Care

Overview of Strategies

The steps you take to assess patient experience with care in your organization and explore what is driving those experiences will enable the quality improvement team to identify opportunities to improve and establish goals. As discussed in Section 4 of this Guide, the next step in the quality improvement process is to identify possible strategies. Your team may have several ideas for improvement strategies based on its evaluations of care delivery processes and input from stakeholders. To supplement and help to organize those ideas, this section presents selected strategies for improving the experiences of patients and enrollees as measured by the CAHPS surveys.

The strategies are intended to address the various topics covered by CAHPS surveys of ambulatory care, with an emphasis on the three core survey domains of access to health care, communication, coordination of care, and customer service. Table 6-1 lists sixteen strategies you could consider and the survey topics they address. Appendix 6a provides a crosswalk of these topics and the measures derived from different CAHPS surveys (all of which are variations on the CAHPS Health Plan Survey or the CAHPS Clinician & Group Survey).

These strategies represent a range of possible solutions. Some are easy and inexpensive to implement, while others are more logistically complex and require a significant investment of money, time, and other resources. If your team wants to pursue a more intensive strategy, it can help to "start small" by breaking down the strategy into smaller components and tackling one component at a time. Also, some strategies may allow you to see results right away, while others may require time to make a measurable difference.

Finally, it is important to note that these strategies are directed at different audiences. Some strategies are aimed at physician practices and medical groups because they address aspects of care that happen in the doctor's office, such as access to care (e.g., scheduling appointments and receiving timely care and information), communication between providers and patients, interactions with office staff, shared decision making, and self-management support. Other strategies address experiences within the domain of health plans, such as member services, information to manage health care and costs, and health promotion and education. For some strategies, both health plans and provider groups have a role to play, even if one is more "responsible" than the other for an aspect of patient experience. Health plans, for example, can equip providers with the skills, tools, and information systems they can use to improve their communication with patients. Health plans can also play a very important role in motivating medical groups, practices, and individual physicians to improve patient experience. Appendix 6b discusses three ways in which health plans can harness reporting and purchasing strategies to focus attention on the experience of care.

Table 6-1. Improvement Strategies Organized by Topic

Strategy	Access to Care & Information	Communication with Patients	Coordination of Care	Customer Service	Health Promotion/ Education
Open Access Scheduling for Routine and Urgent Appointments (6.A)	X				
OpenNotes (6.C)	X	X	X		
Internet Access for Health Information and Advice (6.D)	X				X
Rapid Referral Programs (6.E)	X		X		
On-Demand Advice, Diagnosis, and Treatment for Minor Health Conditions (6.F)	X	X			
Training to Advance Physicians' Communication Skills (6.G)		X	X		X
Tools to Help Patients Communicate Their Needs (6.H)		X	X		
Shared Decision-Making (6.I)		X			X
Support Groups and Self-Care (6.J)					X
Cultivating Cultural Competence (6.K)		X			
Planned Visits (6.L)	X	X	X		
Group Visits (6.M)	X	X			X
Price Transparency (6.N)	X				
Service Recovery Programs (6.P)				X	
Standards for Customer Service (6.Q)				X	
Reminder Systems for Immunizations and Preventive Services (6.R)		X	X		X

Appendix 6a. Crosswalk of Patient Experience Domains and Survey Measures

The tables below list composite measures derived from the standard items in each survey, i.e., the items included by every user of that specific survey. Many other topics, including some of the domains in the left column, are covered by supplemental items that users can choose to add to their surveys. The tables do not include the global rating measures.

Table 6-2. Domains and Composite Measures in Current Versions of the CAHPS Clinician & Group Survey (as of Winter 2017)

Domains for Patient Experience	Clinician & Group Survey 3.0	CAHPS Survey for Accountable Care Organizations (ACOs)* **	CAHPS for Physician Quality Reporting System (PQRS) Survey **
Access to care	Getting Timely Appointments, Care, and Information	Getting Timely Care, Appointments, and Information (9 & 12) Between Visit Communication (12)	Getting Timely Care, Appointments, and Information Between Visit Communication
Communication	How Well Providers Communicate with Patients	How Well Providers Communicate (9 & 12)	How Well Providers Communicate
Office Staff	Helpful, Courteous, and Respectful Office Staff	Courteous and Helpful Office Staff (9 & 12)	Courteous and Helpful Office Staff
Coordination of care	Providers' Use of Information to Coordinate Patient Care	Care Coordination (12)	Care Coordination
Self-management	Talking with You About Taking Care of Your Own Health (from the Patient-Centered Medical Home Item Set)	Helping You Take Medications as Directed (12)	Helping You Take Medications as Directed
Shared decision making	(not included)	Shared Decision Making (9 & 12)	Shared Decision Making
Health promotion and education	(not included)	Health Promotion and Education (9 & 12)	Health Promotion and Education
Access to specialists	(not included)	Access to Specialists (9 & 12)	Access to Specialists
Cost of care	(not included)	Stewardship of Patient Resources (9 & 12)	Stewardship of Patient Resources

*** In 2016, CMS accepted results for two versions of the ACO Survey: ACO-9 and ACO-12.**
**** Health Status/Functional Status is not included as a composite measure for the purposes of this table because the questions are not asking about the patient's experience with care.**

Table 6-3. Domains and Measures in Current Versions of the CAHPS Health Plan Survey (as of Winter 2017)

Domains for Enrollee Experience	Health Plan Survey 5.0	Medicare Advantage CAHPS Survey	Qualified Health Plans (QHP) Enrollee Survey
Access to care	Getting Needed Care Getting Care Quickly	Getting Needed Care Getting Appointments and Care Quickly	Getting Needed Care Getting Care Quickly
Communication	How Well Doctors Communicate	Doctors Who Communicate Well	How Well Doctors Communicate
Customer Service	Health Plan Customer Service	Health Plan Information and Customer Service	Health Plan Customer Service
Coordination of Care	(not included)	Care Coordination	How Well Doctors Coordinate Care and Keep Patients Informed
Cultural Competence	(not included)	(not included)	Getting Information in a Needed Language or Format
Access to Information	(not included)	(not included)	Getting Information about the Health Plan and Cost of Care
Costs	(not included)	(not included)	Enrollee Experience with Costs

Appendix 6b. How Health Plans Can Drive Improvements at the Medical Group Level

Many of the measures in the CAHPS ambulatory surveys address issues outside of the direct control of health plans, because the locus of the care or service lies at the medical group or practice level. However, health plans can exert some influence on medical groups and individual physicians, encouraging and motivating them to improve the patient's experience in the doctor's office. The degree of influence a plan can exert depends in part on the structure of its relationship with its provider network. Health plans that own physician practices and/or employ physicians, and those that have an exclusive relationship with their contracted providers, tend to have more influence than those that account for only a small share of a medical group's patients.

This section outlines a few ways in which health plans can encourage medical groups and physician practices to take steps to improve patient experience:

- Public Reporting on Provider Performance
- Private Feedback on Provider Performance
- Value-Based Payments

6b.1. Public Reporting on Provider Performance

Public reporting on provider performance can help patients make more informed choices about which health systems, hospitals, medical groups, and individual physicians best meet their needs. In addition, making such information publicly available encourages providers to engage in quality improvement activities in areas where their performance lags.[39,40, 41,42,43]

[39] Fung CH, Lim Y, Mattke S, et al. Systematic review: the evidence that publishing patient care performance data improves quality of care. Ann Intern Med 2008;148:111-23.

[40] Lindenauer PK, Remus D, Roman S, et al. Public reporting and pay for performance in hospital quality improvement. N Engl J Med 2007;356:486-96.

[41] Elliot MN, Cohea CW, Lehrman WG, et al. Accelerating improvement and narrowing gaps: trends in patients' experiences with hospital care reflected in HCAHPS public reporting. Health Serv Res 2015 Apr. doi: 10.1111/1475-6773.12305. [Epub ahead of print]

[42] Alexander J A, Maeng D, Casalino LP, et al. Use of care management practices in small- and medium-sized physician groups: do public reporting of physician quality and financial incentives matter?. Health Serv Res 2013 48:376-97.

[43] Lamb GC, Smith MA, Weeks WB, et al. Publicly reported quality-of-care measures influenced Wisconsin physician groups to improve performance. Health Aff (Millwood) 2013 Mar;32(3):536-43.

Public Reporting Can Stimulate Improvement

Since initiating public reporting of patient survey scores and patient comments about physicians, the University of Utah Health Care has seen a significant increase in physician communication scores, from the 35th percentile in 2010 to the 90th percentile in 2014. Public reporting has also led to a doubling of website traffic.*

*Source: Embracing Transparency: Valuing Patients As Informed Consumers. Feb 2013. Article accessible at http://healthsciences.utah.edu/notes/postings/2013/01/020413patientsatisfaction.php#.WLBUsH9_yzw.

Working independently and in collaboration with other stakeholders (e.g., large employers, local purchasing coalitions, government purchasers), health plans have been active in developing public "report cards" on provider performance—primarily on the Web but sometimes in print. These reports provide comparative information on the performance of hospitals and medical groups on various measures of quality, including but not limited to CAHPS survey measures. By making these reports available, health plans encourage their members to pay attention to the quality of their providers and to select high-performing medical practices and physicians.[44] As part of these programs, health plans can also publicly recognize high-performing providers in their network.

The following examples describe health plan efforts to work with other stakeholders to develop and publicly report on patient experience with providers:

- The Wisconsin Collaborative for Healthcare Quality (WCHQ), a multi-stakeholder, voluntary consortium of Wisconsin health plans, health systems, medical groups, and hospitals, has been publicly reporting provider performance on quality measures since 2004. WCHQ's online Performance & Progress Report on clinics and medical groups shows scores for six composite measures from the CAHPS Clinician & Group Survey: "Getting Timely Appointments, Care, and Information," "How Well Providers Communicate," "Helpful, Courteous, and Respectful Office Staff," "Follow Up on Test Results," "Overall Provider Rating," and "Willingness to Recommend." For large medical groups, the results are broken down by specialty.[45]
- Massachusetts Health Quality Partners (MHQP) is a coalition of health plans, physicians, hospitals, purchasers, patient and public representatives, academics, and government agencies that has worked to improve the quality of health care services in Massachusetts. Among other activities, MHQP collects and publicly reports on the performance of over 500 physician practices on various quality

[44] Martino SC, Kanouse DE, Elliott MN, et al. A field experiment on the impact of physician-level performance data on consumers' choice of physician. Med Care 2012 Nov;50 Suppl:S65-73.

[45] The Wisconsin Collaborative for Healthcare Quality Performance and Progress Report is accessible at http://www.wchq.org/reporting/

metrics, including patient experience measures from MHQP's statewide Patient Experience Survey, which is based on the CAHPS Clinician & Group Survey.

Learn About Public Reporting of CAHPS Survey Results

For guidance on developing public reports of CAHPS Clinician & Group Survey results, refer to:

Developing a Public Report for the CAHPS Clinician & Group Survey: A Decision Guide. Prepared for the Aligning Forces for Quality program, Robert Wood Johnson Foundation. Oct 2013. Accessible at http://www.rwjf.org/en/library/research/2013/09/developing-a-public-report-for-the-cahps-clinician---group-surve.html

6b.2. Private Feedback on Provider Performance

As a substitute or complement to public performance reports, health plans can also feed useful information to health care providers—including administrative leaders and staff—through private reports that evaluate their performance on various aspects of quality, including patient experience. In some cases, health plans share private reports first, and then introduce public reports after providers become more comfortable with the assessment of quality and the methodology being used. Private reports often contain more detailed information than that available in public reports, thus helping providers to pinpoint more precisely those aspects of the patient experience that are in need of improvement. For example, private reports may include results for individual survey items as well as summaries of patients' complaints and feedback, thus providing insights into common problems that need to be addressed.[46]

Private reports also typically offer more detailed comparisons of individual provider and/or group performance to that of peers and other benchmarks, such as local, regional or national norms and "best-in-class" performance. This comparative data not only encourages a sense of competition among providers to improve, but also may stimulate conversations among doctors and other clinicians about ways to improve performance on patient experience and other quality measures.

Examples of health plan initiatives to compile and disseminate private reports to network providers that include CAHPS or other patient experience survey measures include the following:

[46] Gerteis M, Harrison T, James CV, et al. Getting behind the numbers: understanding patients' assessments of managed care. New York: The Commonwealth Fund; November 2000. Publication 428. Available at: http://www.commonwealthfund.org/publications/fund-reports/2000/dec/getting-behind-the-numbers--understanding-patients-assessments-of-managed-care

- In 2005, HealthPlus of Michigan (an independent health plan) began privately reporting detailed performance data from the CAHPS Clinician & Group Survey to PCPs that direct primary care for enrollees in the plan's commercial HMO product. In combination with information on best practices, this feedback helped to stimulate steady improvement in both CG-CAHPS and CAHPS Health Plan Survey scores over a 7-year period through 2012.[47]
- In addition to public reporting, Massachusetts Health Quality Partners distributes private reports to all medical practices that participate in the statewide Patient Experience Survey.
- In the public sector, the Centers for Medicare & Medicaid Services (CMS) provides each group practice participating in the CAHPS for PQRS Survey with survey results in an individualized, detailed report. These reports describe the content of the survey and include the group practice's scores on both the summary measures and individual questions in the survey, comparison scores and, where applicable, trend data showing how a practice's results from the previous reporting period compare to results from the current one. CMS provides a similar feedback report to convey results from the CAHPS Survey for ACOs to those organizations participating in the Medicare Shared Savings and Pioneer Programs.

Learn About Private Reporting of CAHPS Survey Results

Health plans interested in providing comparative benchmark performance data and percentile scores by specialty type and region can find such information through the AHRQ CAHPS Database.

Another useful resource is an AHRQ publication called Private Performance Feedback Reporting for Physicians: Guidance for Community Quality Collaboratives. This guide provides 13 specific recommendations on how to produce effective private performance feedback reports in parallel with public reporting efforts.

6b.3. Value-Based Payment

Health plan payments to providers can be a critical lever for creating incentives to providers to improve the patient experience. Many health plans have already implemented pay-for-performance (P4P) and other payment programs that financially reward the provision of "high-value" care—i.e., care that is high quality, cost-effective, and person-centered. Such value-based payment programs typically tie payment to performance on a wide array of quality and cost measures, including those that evaluate clinical processes, patient safety, utilization of health care resources, structural elements

[47] Unpublished presentation by Clifford Rowley, Director of Member Service and Satisfaction, HealthPlus of Michigan, to the Michigan Patient Experience of Care Initiative, January 16, 2013.

of care, clinical outcomes (e.g., readmissions, mortality, complications), and costs (e.g., total cost of care, cost per episode). By incorporating Clinician & Group Survey measures into these payment systems, health plans can create meaningful incentives for providers to improve the patient experience.[48,49]

For P4P and other value-based payment programs to be successful in stimulating improvement, health plans and providers must come to a mutual agreement on the size and structure of the incentives, and not hesitate to tie a meaningful portion of payments to performance on a manageable number of measures.[50,51,52]

Examples of value-based payment programs that incorporate patient experience measures include the following:

- Blue Cross Blue Shield of Massachusetts (BCBSMA) developed the Alternative Quality Contract (AQC) payment system, which pays providers a population-based, global budget combined with significant financial incentives tied to performance on a broad set of quality measures, including CAHPS measures. By its fourth year of operation, the AQC had led to cost savings of nearly 10% while simultaneously improving quality performance, including patient experience scores. BCBSMA is now using AQC with its new health insurance products so as to create significant incentives for members to choose high-value providers and make high-value care choices, which in turn has encouraged them to participate actively in discussions with health care providers about quality and value.[53]
- The Integrated Healthcare Association (IHA), a multi-stakeholder group in California that includes health plans, administers a statewide P4P program in which participating commercial HMOs use common measures to evaluate the performance of contracted physician groups and pay bonuses tied to that performance. Measures evaluate both clinical processes and patient experience.

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[48] Browne K, Roseman D, Shaller D, et al. Analysis & commentary. Measuring patient experience as a strategy for improving primary care. Health Aff (Millwood) 2010 May;29(5):921.

49 Damberg CL, Sorbero ME, et al. ASPE Research Report: Measuring Success in Health Care Value-Based Purchasing Programs. Summary and Recommendations. Available at http://aspe.hhs.gov/health/reports/2014/HealthCarePurchasing/rpt_vbp_summary.pdf

50 Arcadia. Pay-for-Performance (P4P) Strategies for Health Plans and Provider Networks: Building Collaboration through Technology, Shared Value, and Trust. 2013. Accessible at http://content.arcadiasolutions.com/hs-fs/hub/358257/file-793806811-pdf

[51] Ryan AM, Damberg CL. What can the past of pay-for-performance tell us about the future of Value-Based Purchasing in Medicare? Healthc (Amst) 2013 Jun;(1-2):42-9.

52 Kirschner K, Braspenning J, Jacobs JE, et al. Design choices made by target users for a pay-for-performance program in primary care: an action research approach. BMC Fam Pract 2012 Mar 27;13:25.

[53] More information can be found at Massachusetts Payment Reform Model: Results and Lessons, available at http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf and National Quality Strategy Webinar: Using Payment to Improve Health and Health Care Quality, available at http://www.ahrq.gov/workingforquality/nqs/webinar020415/webinar6.htm.

6.A. Open Access Scheduling for Routine and Urgent Appointments

6.A.1. The Problem

Most patients that they always or usually received care as soon as they needed it, but some respondents to the Clinician & Group Survey report that they *never or only sometimes* got appointments for the care they needed as soon as they needed to be seen—even in urgent cases. Table 6A-1 shows aggregated results from surveys fielded in 2016.

Table 6A-1. How often respondents got needed care: Percent answering never or sometimes

	2016 Adult 6-Month Survey 3.0	2016 Child 6-Month Survey 3.0	2016 Adult 12/6-Month Survey 2.0
Getting Timely Appointments, Care, and Information	10%	6%	15%
Got appointment for urgent care as soon as needed	10%	7%	12%
Got appointment for check-up or routine care as soon as needed	6%	6%	8%

Source: CAHPS Database Online Reporting System. Comparative data from the 2016 Clinician & Group Survey Database. Accessed July 27, 2017.

Studies have shown that inadequate access to a primary care provider remains a major source of patient dissatisfaction.[54] One study cited in *JAMA* confirms that patients are not getting the care they need when they need it:[55]

- In a survey of insured adults under 65, 27 percent of those with health problems reported difficulty gaining timely access to a clinician.
- From 1997 to 2001, the percentage of people reporting an inability to obtain a timely appointment rose from 23 percent to 33 percent.
- In 2001, 43 percent of adults with an urgent condition reported that they were sometimes unable to receive care as soon as they wanted.
- 28 percent of women in fair or poor health reported delaying care or failing to receive care because of an inability to obtain a timely physician appointment.

6.A.2. The Intervention

Open access—also known as advanced access and same-day scheduling—is a method of scheduling in which all patients can receive an appointment slot on the day they call, almost always with their personal physician. (Note: "Open access" sometimes refers to

[54] Forjuoh SN, Averitt WM, Cauthen DB, et al. Open-access appointment scheduling in family practice: Comparison of a demand prediction grid with actual appointments. *J Am Board Fam Pract* 2001;14(4):259-65.

[55] Murray M, Berwick DM. Advanced access: Reducing waiting and delays in primary care. *JAMA* 2003;289(8):1035-40.

the elimination of gatekeepers in HMOs so that patients have direct access to specialists. In this context, it refers only to same-day appointments.) Rather than booking each physician's time weeks or even months in advance, this model leaves about half of the day open; the other third is booked only with clinically necessary follow-up visits and appointments for patients who chose not to come on the day they called (typically no more than 25% percent of patients).

This model breaks away from the traditional approach of differentiating between urgent and routine appointments, which results in the routine visits being put off until a later date. Instead of triaging callers by clinical urgency, front-desk staff simply sort the demand for appointments by clinician. According to experts in the design and implementation of the model, it is effective in both managed care and fee-for-service environments.[56]

"It has one very simple yet challenging rule: Do today's work today."

Murray M, Tantau C. Same-day appointments: Exploding the access paradigm. *Fam Pract Manag* 2000;7(8):45-50.

In essence, the open access model applies the principles of queuing theory and industrial engineering in an effort to match the demand for appointment visits with the supply (i.e., the time of clinicians). It is based on the supposition that the problem is not lack of capacity but an imbalance between supply and demand.

6.A.3. Benefits of This Model

While the open access model has not yet been formally evaluated with systematic controlled studies,[57] anecdotal evidence points to several benefits of this approach:

- It enables practices to reduce or eliminate delays in patient care without adding resources. Better access to care typically results in higher levels of patient satisfaction; physician satisfaction also improves as long backlogs and angry patients are no longer a daily source of frustration.[58]
- In contrast to what many physicians anticipate, patient demand for appointments decreases, mostly because patients are more often able to see their own clinician.[55]
- The ability of patients to see their personal physician enhances continuity of care, which is associated with both better health care and higher patient satisfaction.
- Finally, medical practices often realize cost and efficiency savings. Because patients no longer have to deal with long waits, the number of "no-shows" is likely to decrease, so clinical time is used more efficiently. Also, less staff time is required to manage the no-shows and the backlog of patients.

[56] Murray M, Tantau C. Same-day appointments: Exploding the access paradigm. *Fam Pract Manag* 2000;7(8):45-50.

[57] Murray M, Bodenheimer T, Rittenhouse D, et al. Improving timely access to primary care: Case studies of the advanced access model. *JAMA* 2003;289(8):1042-6.

[58] Murray M, Tantau C. Must patients wait? *Jt Comm J Qual Improv* 1998;24(8):423-5.

6.A.4. Implementation of This Model

The literature on open access suggests that medical practices can implement this model in a few months by working through the following steps:

1. Measure supply and demand as precisely as possible.
2. Establish a test team of providers who are willing to try the system.
3. Reduce the backlog of appointments. This may take 6 to 8 weeks of extra work. To facilitate this difficult task, practices may want to set a target date and agree that visits will not be pre-scheduled beyond that date. Another useful recommendation is to apply the concept of "max packing." The idea is to reduce the demand for future visits by taking care of any upcoming preventive or screening needs whenever the patient comes in for a necessary visit—regardless of the reason for that visit.
4. Simplify the appointment types and make them all roughly the same length. One recommended tactic is to minimize complexity by limiting the practice to three appointment types:
    - Personal, where the patient is seeing his or her physician;
    - Team, where the patient is seeing someone else on the clinical team; and
    - Unestablished, where the patient does not yet have a specific physician.

    Appointment times can also be specified as either short or long, where a long appointment is roughly equivalent to two short ones.[56]
5. Develop a contingency plan for days (or parts of the day) when demand far outstrips the availability of physicians. This plan should identify who can supplement or substitute for each physician, if and when needed. Also, the group should be proactive about planning for those times when they can predict increases in demand, such as visits for school physicals or flu shots.
6. Reduce demand for one-on-one visits with patients. One helpful tactic is to identify and address sources of unnecessary visits based on outdated clinical protocols, such as routine follow-up visits for urinary tract infections or annual Pap smears. Another approach is to implement group visits to better manage care for patients with the same chronic condition. (To learn more, refer to the strategy called "Group Visits"). Finally, clinicians can use the phone and email effectively to address concerns that do not require a visit.
7. Once the practice is able to offer same-day appointments, assess its effectiveness by measuring appointment availability on a daily basis (e.g., third next available appointment). (For information on the specific measures that you can use to evaluate and monitor the model, refer to Murray M, Berwick DM. Advanced access: Reducing waiting and delays in primary care. *JAMA* 2003 Feb 26;289(8):1035-40.)

6.A.5. Challenges of This Model

While the implementation of open access scheduling may seem daunting, the primary barriers are psychological rather than logistical. For both clinicians and their staff, this approach seems unintuitive; it defies both their beliefs and their experiences with scheduling systems. Because routine and urgent requests are treated similarly, the model also forces them to abandon the solidly ingrained notion that routine care can wait. Finally, clinical and administrative staff are typically skeptical that existing resources can meet demand.[55]

That said, the logistical challenges should not be discounted. First, the model requires accurate data on the size of the patient population (for each doctor), the level of demand for visits, and the number of appointment slots available each day. In particular, it relies on the ability to accurately predict demand for same-day appointments.[59] But demand is hard to measure retrospectively because the number of past appointments is more a factor of the supply of clinical time than of the demand for services. Medical groups need to obtain this data prospectively, usually by tracking patients' calls for appointments as well as requests by clinicians for follow-up appointments. Some practices rely on mathematical models for predicting demand, with mixed success. Computer-based information systems that integrate billing and scheduling can be useful for providing the initial data input for such models.[59]

The second major challenge is reducing the backlog of appointments. To do this, the group may need to see more patients each day for 6 to 8 weeks.[60] A study of practices that had implemented open access scheduling found that all of them had trouble working down the backlog. Moreover, the task was especially difficult for larger organizations, especially when the model was introduced by management rather than by the physicians themselves. One contributing factor was that management recognized benefits in the form of reduced delays in appointment before the physicians saw benefits in the form of a less stressful workday.[55] Finally, there are some practices where the demand for appointments vastly exceeds the supply of clinical services. While the open access model can handle excess demand on a given day, no scheduling system works effectively if demand is greater than capacity on a permanent basis.

To overcome both the psychological and logistical barriers, medical groups may want to join a collaborative where they can learn from others dealing with the same issues, or hire a consultant who can guide them through the more challenging terrain.

6.A.6. Examples

In the late 1990s, HealthPartners of Bloomington, Minnesota, identified members' dissatisfaction with access to care as a major concern. CAHPS data indicated that access to appointments remained a source of frustration for patients; this finding was

[59] Forjuoh SN, Averitt WM, Cauthen DB, et al. Open-access appointment scheduling in family practice: Comparison of a demand prediction grid with actual appointments. *J Am Board Fam Pract* 2001;14(4):259-65.

[60] Murray M. Patient care: Access. *BMJ* 2000;320(7249):1594-6.

corroborated by complaints data (specifically, complaints related to access had been increasing over the past year and represented 51 percent of quality of care complaints) as well as a survey of satisfaction with behavioral health. In addition, an analysis of internal data found that appointment wait times had steadily increased over the course of the last several years.

In 1999, several HealthPartners' medical groups participated in "Action Groups" supported by the Institute for Clinical Systems Improvement (ICSI) in collaboration with IHI. Through the action groups, the teams learned about the Advanced Access model and received support in implementing it at some of the clinics within their medical groups.

Initial assessments revealed little progress in improving patients' experiences with appointment access, primarily because the clinics were struggling to overcome some of the challenges of this model—including the backlog reduction and the skepticism of clinical and other staff. However, over time, the clinics have made measurable progress, including a statistically significant increase in the percentage of respondents that were very satisfied with their ability to get an appointment at their clinic at a convenient time.[61]

Other examples of successful implementation of open access scheduling include the following:[58]

- **Kaiser Permanente in Roseville, Northern California.** This clinic—which was the site at which the open access strategy originated—succeeded in lowering the wait time for routine appointments from 55 days to 1 day in less than a year. It also increased the changes that a patient would see his or her own physician from 47 percent to 80 percent.
- **The Mayo Clinic's Primary Care Pediatric/Adolescent Medicine Team.** Implementation of an open access model resulted in a reduction of the wait time for routine appointments from 45 days to within 2 days. The strategy also succeeded in lowering the number of daily visits on average.
- **The Alaska Native Medical Center.** At this medical center, open access led to a drop in the wait time for routine appointments in family medicine and pediatrics from 30 days to 1 day. They were also able to increase the percentage of patients seeing their own physician from 28 percent to 75 percent.

[61] HealthPartners. Quality Improvement/Preventive Health Activity Summary: Improving Satisfaction with Appointment Access - Submission of HealthPartners to NCQA; 2003.

- **Fairview Red Wing Clinic, Red Wing, Minnesota.** In addition to reducing the wait time for routine appointments, this clinic succeeded in reducing the time required to cycle patients through the office from 75 minutes to 40 minutes. At the same time, it increased their time with physicians.

Read More About Open Access

- Murray M, Berwick DM. Advanced access: Reducing waiting and delays in primary care. *JAMA* 2003 Feb 26;289(8):1035-40.
- Murray M, Bodenheimer T, Rittenhouse D, et al. Improving timely access to primary care: Case studies of the advanced access model. *JAMA* 2003 Feb 26;289(8):1042-6.
- Murray M, Tantau C. Same-day appointments: Exploding the access paradigm. *Fam Pract Manag* 2000;7(8):45-50. Available at http://www.aafp.org/fpm/20000900/45same.html. Accessed April 28, 2008.
- NHS Institute for Innovation and Improvement. Demand and Capacity – A Comprehensive Guide. 2008. Available at http://webarchive.nationalarchives.gov.uk/20121108092621/http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/demand_and_capacity_-_a_comprehensive_guide.html Accessed on June 21, 2017.

Support in Implementing Open Access

For help in implementing this strategy, contact:

- The Institute for HealthCare Improvement (IHI)
  Phone: (617) 301-4800; Toll-Free: (866) 787-0831
- The Institute for Clinical Systems Improvement (ICSI)
  Phone: (952) 814-7060

For federally qualified community health centers and other primary care practices:

- Bureau of Primary Health Care
- Primary Care Development Corporation (PCDC)

6.C. OpenNotes

6.C.1. The Problem

For a long time, patients have been deliberately excluded from access to the medical records that contain clinical information about their health problems, resulting in an enforced health illiteracy supported by medical professionals. While consumers and some clinicians have encouraged the adoption of transparent health records, skeptics worried that shared notes may offend or confuse patients, erode trust, promote defensive medicine, and create more work for already overburdened clinicians.

In recent years, however, information technology (IT) has brought about dramatic changes, including new avenues for patient care and patient engagement. Electronic medical records are changing how clinicians record, retrieve, and exchange medical information about patients. At the same time, online resource centers and support services are changing how patients learn about their conditions and treatments and manage their own health problems.

On the legal front, the 1996 passage of the federal Health Insurance Portability and Accountability Act (HIPAA) had a pronounced twofold impact: It gave patients the right to review their medical records and to request that corrections and additions be made to the record.[62] Since then, the medical chart is no longer the sole purview of clinicians. Yet relatively few patients take advantage of their right. Reasons include a lack of awareness, reluctance to upset clinicians, and obstacles such as technical issues and misplaced security and privacy concerns on the part of care teams.

6.C.2. The Intervention

To address these issues, various health care organizations have come together in an initiative called OpenNotes to encourage doctors, nurses, and other clinicians to provide their patients with real-time, online access to clinical visit notes. OpenNotes originally began in 2010 as a demonstration and evaluation study in Boston, rural Pennsylvania, and Seattle with 105 volunteer primary care physicians (PCPs) and 19,000 patients. Since then, OpenNotes has expanded rapidly across the country.

In the original study, a secure email message automatically notified patients when a note was signed and invited them to review their doctors' notes after each visit and again before their next visit. These patients were registered portal users who had already taken advantage of online access to lab test results. With OpenNotes, they had access to their medical record notes for the first time.

[62] Esch T, Mejilla R, Anselmo M, et al. Engaging patients through open notes: an evaluation using mixed methods. BMJ Open 2016;6: e010034. doi:10.1136/ bmjopen-2015-010034.

Specifically, patients could read what their physicians recorded, including:

- Findings on physical examination
- Interpretations of these findings
- Conclusions about a patient's current condition
- Thoughts about future evaluation of the patient's condition
- Prognosis for the patient

6.C.3. Benefits

This transformative change in practice represents a major step in the movement toward greater transparency and patient engagement in health care.[63] Advocates believe that when OpenNotes become the standard of care, clinicians and patients will enjoy improved efficiency, communication, and experiences of care. The results from the one-year pilot for OpenNotes indicated that 80% of patients chose to read their notes and two-thirds reported clinically important benefits, like improved understanding of their medical condition.[64] These patients also felt more in control of their care and were more likely to take their medications as prescribed. Moreover, 86% of patients reported that the availability of clinical notes would determine their choice of a future practice or clinician and 99% of them wanted their current practice to continue offering this feature.

The OpenNotes study also made an impact on medication adherence. According to researchers at Geisinger Health System, more than two-thirds of patients who took medication during the study reported improved adherence to these medications.[65] The investigation demonstrated that patients being treated for high blood pressure who were offered OpenNotes were more likely to fill their prescriptions than those without OpenNotes.

Enabling patients to read and amend their chart enhanced opportunities to:

- Detect serious inaccuracies and avoid medical errors
- Share notes with other clinicians
- Reinforce the clinician's findings and recommendations discussed at a visit
- Clarify something the clinician said or did at the visit
- Improve patients' insights into clinicians' decision-making

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[63] Fostering Patient Engagement. Peterson Center on Healthcare. Available at http://petersonhealthcare.org/fostering-patient-engagement. Accessed 1/10/17.

[64] Mende S. The Next Phase of the OpenNotes Movement. Robert Wood Johnson Foundation. February 2, 2016. Available at http://www.rwjf.org/en/culture-of-health/2016/02/the_next_phase_ofth.html. Accessed 2/24/17.

[65] Wright E, Darer J, Tang X, Thompson J, Tusing L, Fossa A, Delbanco T, Ngo L, Walker J Sharing Physician Notes Through an Electronic Portal is Associated With Improved Medication Adherence: Quasi-Experimental Study J Med Internet Res 2015;17(10):e226

- Gradually accept and adjust to some diagnoses
- Motivate patients to comply with prescribed behavioral modifications
- Help patients prepare for office visits
- Dispel unfounded worries about what clinicians were finding or thinking
- Involve family and other caregivers in the patient's care

6.C.4. Implementation

For guidance on implementing OpenNotes, including materials for clinicians, patients, and researchers, please refer to the OpenNotes Toolkit.

6.C.5. Challenges

When considering the use of OpenNotes, clinicians have voiced concerns regarding the burden on their scarce time, the risk of misunderstandings, and the possibility of confusing patients:[66]

- **Additional time**: Additional calls, letters, and emails causing a drain on a physician's time was the biggest worry.
- **Misunderstanding doctor language**: Physicians worry that patients may not be familiar with the shorthand, abbreviations, and clinical terms that physicians often use in their notes. For example, a patient whose chart includes an unfamiliar reference to "congestive heart failure" might think it refers to an actual failure rather than a manageable heart condition.
- **Confusing or upsetting patients**: Some physicians worry that their patients may misconstrue the notes or draw inaccurate conclusions about their condition or prognosis. This could lead patients to feel fear, guilt, anger, depression, confusion, frustration, or hopelessness.

The study results found that these concerns were not borne out. For example, less than 8% of doctors reported taking more time to address patients' questions outside of scheduled visits, and less than 20% of doctors reported taking more time writing notes.[67] Despite some initial resistance from participating physicians who feared that the program would require more of their time, all agreed to continue with the program.

From the patient perspective, perhaps the biggest barrier to realizing the potential benefits of patient portals and OpenNotes is finding ways to ensure that all patients can access them.

[66] Esch T, Mejilla R, Anselmo M, et al. Engaging patients through open notes: an evaluation using mixed methods. BMJ Open 2016;6: e010034. doi:10.1136/ bmjopen-2015-010034.

[67] Mende S. The Next Phase of the OpenNotes Movement. Robert Wood Johnson Foundation. February 2, 2016. Available at http://www.rwjf.org/en/culture-of-health/2016/02/the_next_phase_ofth.html. Accessed 2/24/17.

Read More About OpenNotes

- OpenNotes: http://www.opennotes.org/
- Culture of Health: http://www.rwjf.org/en/culture-of-health/2016/02/the_next_phase_ofth.html
- Bell SK, Mejilla R, Anselmo M, et al. When doctors share visit notes with patients: a study of patient and doctor perceptions of documentation errors, safety opportunities and the patient-doctor relationship. BMJ Qual Saf. 2016 May 18. pii: bmjqs-2015-004697.
- Delbanco T, Walker J, Bell SK, et al. Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. Ann Intern Med. 2012 Oct 2;157(7):461-70.
- Esch T, Mejilla R, Anselmo M, et al. Engaging patients through open notes: an evaluation using mixed methods. BMJ Open 2016;6: e010034. doi:10.1136/bmjopen-2015-010034. Available at: http://bmjopen.bmj.com/content/6/1/e010034. Accessed 1/10/17.

6.D. Internet Access for Health Information and Advice

6.D.1. The Problem

Many health care consumers seek information about specific complaints, conditions or diseases, drugs, nutrition, and fitness.[68] For these people, getting information quickly is a large component of "getting care quickly."

In the past, patients and their families had to depend primarily on their physicians for this kind of information. In the last two decades, of course, the Internet has evolved into an amazing resource for those seeking health-related information. Studies disagree on the number of Americans using the Internet for this purpose. But there is little question that a large number of people are looking for information and advice on the Internet, and that the number is growing rapidly. A Harris Poll in 2011 estimates that three-quarters of all adults have looked for health information online.[69] According to a 2012 poll by the Pew Research Center's Internet and American Life Project, over a third of adults have used the Internet to diagnose themselves or someone else.[70]

However, the sheer volume often makes information on the Internet overwhelming, hard to navigate, and hard to validate. A search for health information can bring up thousands of sites. It is also hard for people to know whether a source of information is trustworthy. A Pew survey found that many seekers of health information on the Internet do not follow recommended guidelines for checking the reliability and timeliness of information: half reported that they check the date and source of information only occasionally, hardly ever, or never.[71]

6.D.2. The Intervention

A number of health plans and medical groups have been exploring ways to channel consumers and patients to useful and reliable sources of information on the Internet. This strategy is meant to help address the demand for immediate information and to build on and reinforce the relationship of trust that health care organizations have with patients and members. While information on the Internet should not be a substitute for direct communication with personal care providers, it is a useful way to augment information sources for patients, especially when direct access to clinicians is not available.

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[68] Kassirer JP. Patients, physicians, and the Internet. *Health Aff (Millwood)* 2000;19(6):115-23.

[69] The Harris Poll #98. Harris Interactive September 15, 2011. Available at http://www.harrisinteractive.com/NewsRoom/HarrisPolls/tabid/447/ctl/ReadCustom%20Default/mid/1508/ArticleId/863/Default.aspx. Accessed July 28, 2015.

[70] Fox S, Duggan M. Health Online 2013. Pew Research Center, Internet and American Life Project. January 15, 2013. Available at http://www.pewinternet.org/2013/01/15/health-online-2013/. Accessed July 28, 2015.

[71] Fox S, Rainie L. Vital decisions: How internet users decide what information to trust when they or their loved ones are sick 2002; Washington, DC, Pew Internet & American Life Project.

One way to do this is to expand your own Web site to include health information and relevant tools as well as links to related information. Another simpler approach is to tell patients or members about external sites that are reliable and could be helpful; this information could be provided during office visits, in printed materials, through patient portals, or in e-mails (which allow you to provide the address [URL] for the site).

There are literally thousands of sites on the Web that may be helpful to your members and patients, including patient-support networks (such as bulletin boards and patient chat rooms) and disease-specific sites sponsored by medical associations, patient groups, government agencies (such as NIH), and others. You can do your members and patients a huge favor by sifting through some of these sites for them and recommending only those that offer timely, reliable, and objective information.

You may also want to provide links to the following sites, which enable users to conduct their own research:

Guidance on Assessing Health-Related Web Sites

- National Institutes of Health, Office of Dietary Supplements. How To Evaluate Health Information on the Internet: Questions and Answers. Accessed on July 7, 2017.
- Medical Library Association. Find Good Health Information. Accessed on July 7, 2017.
- Medline Plus. Evaluating Health Information. Accessed on July 7, 2017.

- http://www.pubmed.gov: This site allows users to search MedLine, the bibliographic database of the National Library of Medicine (NLM).
- http://www.pubmedcentral.nih.gov: PubmedCentral offers access to the NLM's digital archive of life sciences journals.
- http://www.medlineplus.gov: MedLinePlus offers direct access to health-related information. It is sponsored by NLM and the National Institutes of Health (NIH).
- http://www.OncoLink.com: OncoLink provides free information on cancer to the public. It is sponsored by the Abramson Cancer Center of the University of Pennsylvania.
- http://www.webMD.com: WebMD offers general information on health and wellness topics as well as a variety of message boards.

6.D.3. Benefits of This Intervention

The benefits of Internet access to health information and advice include improved quality of care, timeliness (i.e., 24-hour access), and efficiency. At least one study has found shorter duration of office visits, more phone consultations, and fewer and shorter

hospitalizations due to an interactive, disease-specific networked computer system.[72] In addition, consumers may benefit from quality of life gains, including improved psychosocial support, improved information-seeking ability, and reduced emotional distress.[73]

For example, in a small pilot study where a family practice provided access to patient education Web sites during the office visit, researchers reported the following results after just one month:[74]

- 90 percent were more satisfied with their visit because of the availability of the information.
- 94 percent of users found the information helpful.
- 77 percent felt the information would make them change their health behavior.
- 90 percent said they would use the clinic's Internet access again.

6.D.4. Constraints on This Intervention

While increasing numbers of health care organizations are embracing the use of the Internet to provide access to health information, some have expressed concerns about confidentiality, legal and liability issues, and reimbursement. Others are waiting for stronger evidence that these applications improve clinician efficiency, satisfaction, or quality of care.[75] Moreover, health care organizations may be reluctant to invest in this kind of functionality because they are not sure how to evaluate the information technology needed to implement it or how to integrate it into existing information systems.

A final obstacle for some organizations is that they are not certain that this strategy makes sense for the populations they serve. One common concern is that members or patients may not have access to the Internet. While disparities in Internet access (often referred to as the "digital divide") have decreased in recent years, there are still some populations with limited or no experience with or access to the Internet—including seniors, people without a college education, people living in rural areas, people with disabilities, and people who prefer languages other than English.[76] To help overcome these constraints, some health care organizations are taking explicit steps to educate

[72] Gustafson DH, Hawkins R, Boberg E, et al. Impact of a patient-centered, computer-based health information/support system. *Am J Prev Med* 1999;16(1):1-9.

[73] Gustafson DH, Hawkins R, Pingree S, et al. Effect of computer support on younger women with breast cancer. *J Gen Intern Med* 2001; 16(7):435-45.

[74] Helwig AL, Lovelle A, Guse C, et al. An office-based Internet patient education system: A pilot study. *J Fam Pract* 1999;48(2):123-7.

[75] Eng TR. The eHealth Landscape: A Terrain Map of Emerging Information and Communication Technologies in Health and Health Care. Princeton, NJ, The Robert Wood Johnson Foundation, 2001.

[76] Rainie L. The State of Digital Divides. Presentation on Washington Post Live: "Bridging the Digital Divides." November 5, 2013. Available at http://www.pewinternet.org/2013/11/05/the-state-of-digital-divides-video-slides/. Accessed July 28, 2015.

members and patients on ways to get access to information on the Internet (e.g., through smart phones; through computers available in libraries and schools; or through family, caregivers, and intermediaries with direct access). A few are even providing access to Internet-based resources at their site (e.g., by installing devices in clinic waiting rooms). A related concern is that providing better access only addresses part of the problem. The other part relates to Web literacy: the inability of some people with Internet access to navigate the Web efficiently or process all the information it offers.

6.D.5. Examples

A Web search would yield many examples of health plans and medical groups directly providing health information and serving as portals to other sites. One example is Kaiser Permanente, where members who sign in have access to in-depth health information and can refill prescriptions, make appointments, learn about health classes, and get personalized health advice from a clinician. They can also research health conditions, take personal health assessments (e.g., disease risks, healthy lifestyle) and join online health discussions.[77]

Other examples include the Web sites for Sharp HealthCare and the Mayo Clinic. These sites are excellent examples of providing specific information about the health care organizations—practices, hours, policies about appointment waiting times, access to medical records—as well as health information and condition-specific resources.

[77] Kaiser Permanente. Kaiser Permanente Online. https://healthy.kaiserpermanente.org/. Accessed July 7, 2017.

Resources About Health Information on the Internet

- Pew Internet and American Life Project
- Baker L, Wagner TH, Singer S, Bundorf MK. Use of the Internet and E-Mail for Health Care Information: Results From a National Survey *JAMA*. 2003;289:2400-2406.
- Diaz JA, Griffith RA, Ng JJ, et al. Patients' use of the Internet for medical information. *J Gen Intern Med* 2002 Mar;17(3):180-185(6).
- Fox S. Health Information Online. *Pew Internet and American Life Project*. 17 May 2005. Available at http://www.pewinternet.org/Reports/2005/Health-Information-Online.aspx. Accessed October 24, 2013.
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- Hargittai E. Second-Level Digital Divide: Differences in People's Online Skills. *First Monday* April 2002. 7(4). Available at http://firstmonday.org/issues/issue7_4/hargittai/index.html. Accessed April 29, 2008.
- Rainie L, Madden M., Boyce A, et al. The Ever-Shifting Internet Population: A new look at Internet access and the digital divide, Apr 16, 2003. Available at http://www.pewinternet.org/Reports/2003/The-EverShifting-Internet-Population-A-new-look-at-Internet-access-and-the-digital-divide.aspx. Accessed October 24, 2013.
- Sciamanna CN, Clark MA, Hoston TK, et al. Unmet Needs of Primary Care Patients in Using the Internet for Health-related Activities. *J Med Internet Res*. 2002 Dec 31;4(3): e19. Available at http://www.jmir.org/2002/3/e19/HTML. Accessed August 11, 2003.

6.E. Rapid Referral Programs

6.E.1. The Problem

Both the ease and the speed of the specialist referral process are major concerns for patients and their primary care providers (PCP). For patients, problems getting a referral are reason enough for dissatisfaction. Patients having trouble getting referrals reported the greatest level of distrust, lack of confidence, and dissatisfaction with their PCP.[78]

Compounding their frustration is the possibility of delays in care, which generates greater anxiety and contributes to a greater risk of adverse clinical outcomes. [79] This problem is especially salient for members with chronic illnesses, who typically require regular visits with one or more specialists.

In addition, patients unclear on the process or disconcerted by the wait often have little choice but to call their clinician's office to seek clarification and assistance, which can add to their frustration (and increases the workload for the office). Some patients end up seeking care elsewhere (e.g., emergency departments and urgent care clinics), and become "no-shows" for the eventual referral appointment.

> *"Patients are often informed that they will be 'referred' but have little or no influence on the process or knowledge about who they will be referred to or how long the expected wait will be."*
>
> Murray M. Reducing waits and delays in the referral process. *Fam Pract Manag* 2002;9(3):39-42.

Specialist referrals are a serious problem for some health plan members. In response to the following question "How often did you get an appointment to see a specialist as soon as you needed?," 22 percent of adult enrollees in Medicaid health plans responded "never" or "sometimes." [79]

While several factors contribute to complaints about specialist referrals, one common problem is that physicians' offices are not set up to handle the referral process efficiently. In particular, they are not communicating well with the specialists, the health plans, or their patients.

[78] Grumbach K, Selby JV, Damberg C, et al. Resolving the gatekeeper conundrum: What patients value in primary care and referrals to specialists. *JAMA* 1999;282(3):261-6.

[79] 2016 CAHPS Health Plan Survey Chartbook. Adult Medicaid Survey 5.0, 2016. Available at https://cahpsdatabase.ahrq.gov/CAHPSIDB/Public/about.aspx. Accessed on June 21, 2017.

6.E.2. Intervention #1: The Referral Agreement

Rapid referral programs include a host of strategies intended to reduce the delays associated with specialty referrals and increase satisfaction among patients and doctors. One useful approach is to improve communication between the PCP and the specialist through a referral agreement. The goals of a referral agreement include the following:

- Speeding the process by which a PCP makes a referral to a specialist.
- Reducing the amount of time between the initiation of a referral and the date of the patient's appointment with the specialist.
- Providing the PCP with decision support for the referral decision (typically in the form of guidelines.
- Improving the flow of information among the PCP, the specialist, and the patient.

When implemented effectively, this program should result in earlier diagnoses, reduced "no-show" rates at specialists, better patient outcomes, and greater patient satisfaction.

6.E.2.a. Key Elements

The referral agreements are meant to make the process more systematic and more responsive by helping PCPs make appropriate referral decisions and clarifying the expectations for information on both ends. In general, referral agreements require the following elements:[79]

- Joint development of guidelines by a small group of PCPs and specialists who are willing to think of themselves as creating a cohesive system of care. The purpose of the guidelines is to identify which clinical conditions the PCPs should manage themselves and which should be referred to the specialists.
- An explanation of the benefits to PCPs (e.g., shorter waiting times for patients, more timely and complete information from the specialist). While specialists may get fewer referrals, the benefits to them are more obvious: more effective care for patients, higher relative value units (RVUs), and more referred patients who have had a complete work-up.
- A referral process that involves the patient in decision making. This process should be designed to keep the patient informed, identify the work-up required before the specialist appointment, inspect the completeness of the work-up, and make sure that both the specialist and the PCP receive timely information. An electronic referral system can facilitate this process.
- An evaluation of the new referral process based on specific measures, such as waiting time for an appointment, physician compliance with the guidelines, and patient satisfaction with involvement in the referral process.

6.E.2.b. Example

An example of an electronic referral system can be found at The University Hospitals of Leicester, England, which have implemented a Web-based electronic referral system for cancer. While this project applies to the UK's National Health System, which clearly differs in many ways from the system of care in the U.S., it is still illustrative of the improvements that technology can make, in this instance by linking decision support with an electronic referral process.

When the clinician opens the Early Referrals Application (ERA), he or she chooses from among 12 different cancers, and then selects the electronic referral option. Once there, the physician is guided through a series of three screens:

- **Data entry:** This page collects the information needed for the decision support module (e.g., for breast cancer, it has a series of check boxes to describe lumps, skin changes, pain, etc.).
- **Recommendations:** Using the data entered in the first screen, this page indicates whether a referral is recommended and, if appropriate, the degree of urgency. If the physician chooses the "referral" button, the final screen appears.
- **Referral form:** This form captures the patient information needed by the specialist being given the referral. Because of the link to an electronic medical record system, much of the demographic information will already be inserted. When the physician adds additional comments or notes and clicks on "Email Referral," the form is sent to the referral hospital.

Learn more: University Hospitals of Leicester NHS. ERA – Early Referrals Application. Accessed July 7, 2017.

6.E.3. Intervention #2: The Referral Expert

Doctors and group practices that care for patients covered by multiple plans and insurers often expend a great deal of time and energy getting approvals from the plan/insurer for referrals to specialists, hospital admissions, tests, and procedures.[80] This task has become increasingly complex as the number of insurance products has grown, since each one has its own rules and requirements.

[80] Preston SH. Wrestling with the managed care octopus, Part 3. Get insurance authorizations faster. *Med Econ* 1999;76(9):117-8, 121-2, 124 passim.

One way to address this problem is for a group practice to develop a "referral expert"—in the form of a person, a computer system, or a combination of the two—that is responsible for tracking and managing each plan's requirements. This strategy helps to increase the speed of approvals, which has multiple benefits.

- For the patient, it can mean reduced or eliminated delays for referrals, tests, and procedures, which increases satisfaction with care.[81]
- For providers, health plans, and payers, quicker approvals save costs associated with the phone and paper-based approval processes,[82] as well as costs resulting from grievances and complaints.

A referral expert would expedite insurance authorization by doing the following:[83]

- Knowing which plans require authorizations.
- Staying abreast of changes in plan regulations.
- Knowing what actions to take when referrals are denied.

However, this intervention can be as simple as developing matrices (or ideally, a database) of referral requirements, co-pays, etc., for each insurance product and designating a person to keep the matrix or database up-to-date.

Other Interventions to Consider

In addition to becoming familiar with each plan's requirements, medical groups may want to explore other ideas for managing referrals more effectively, such as:

- Standardizing referral forms across multiple plans.
- Developing forms that specialists' offices can fill out so that the PCP has all the information needed to get preauthorization.
- Hiring a referral coordinator who can keep track of all referral requests and follow-up items, and facilitate communication with patients, specialists, and plans.

Learn more about these ideas: Spicer J. Making patient care easier under multiple managed care plans. *Fam Prac Manag* 1998 Feb;5(2):38-53. Available at: http://www.aafp.org/fpm/980200fm/spicer.html. Accessed July 7, 2017.

[81] Chan TC, Hayden SR, Schwartz B, et al. Patients' satisfaction when denied authorization for emergency department care by their managed care plan. *J Emerg Med* 1997;15(5):611-6.

[82] New England Healthcare EDI Network. *Progress Report: Reaping the Benefits of Administrative Simplification; 2002*. Available at: http://www.nehen.net. Accessed April 22, 2008.

[83] Preston SH. Wrestling with the managed care octopus, Part 3. Get insurance authorizations faster. *Med Econ* 1999;76(9):117-8, 121-2, 124 passim.

Learn More About Improving the Referral Process

- Murray M. Reducing waits and delays in the referral process. *Fam Prac Manag* 2002 Mar;9(3):39-42.
- Ghandi T, Sittig D, Franklin M, et al. Communication breakdown in the outpatient referral process. *J Gen Intern Med* 2000;15:626-31.
- Van Es GL. Improving the referral process: One group's experience with CQI. *Fam Prac Manag* 1997 May;4(5):51-4, 57.

6.F. On-Demand Advice, Diagnosis, and Treatment for Minor Health Conditions

6.F.1. The Problem

Individuals with non-urgent health problems typically have to schedule an in-person visit with a primary care physician (PCP)and then wait a day or more before traveling to an office for that appointment, often taking time away from work or other activities. Those who do not want to wait (or who experience problems during evening or overnight hours when physician offices are closed) often go to urgent care centers or emergency departments (EDs) in order to be seen right away.

Delays in waiting for this type of appointment will likely get worse in the future as the demand for office visits increases thanks to a combination of population growth, an aging population, and an influx of newly insured individuals. Based on one analysis of these factors, PCP visits are expected to rise from 462 million visits in 2008 to 565 million visits in 2025. This demand for care would require 52,000 more full-time equivalent PCPs by 2025 – an increase of 3 percent over the provider workforce available in 2010.[84]

Some of the patients who are visiting PCPs, urgent care centers, and EDs are dealing with relatively minor conditions that do not require an in-person visit or the services of a physician. Others are seeking advice that may or may not require a physician (e.g., digestion of a possibly toxic substance, high fever, medication queries). Many of these patients—particularly those used to receiving "on-demand" service in other sectors of the economy—would prefer to receive immediate or near-immediate advice and care. The rapid increase in the number of walk-in "retail" clinics operated by Walgreens, CVS, and others is indicative of the growing demand for immediate access to care for minor health problems. And some patients—particularly those familiar and comfortable with various information and communication technologies—do not mind receiving care virtually (e.g., by telephone, online, via video), which eliminates the need to schedule, wait for, and travel to an in-person appointment.

Health plans have a vested interest in helping members gain access to this type of immediate advice and care. Not only can it help to avoid unnecessary in-person visits to PCP offices, urgent care centers, and EDs, but it also has the potential to improve members' experiences with care, as reflected in the CAHPS Health Plan Survey's access measure.

[84] Peterson SM, Liaw WR, Phillips RL, et al. Projecting US primary care physician workforce needs: 2010-2025. Ann Fam Med 2012;10(6):503-9.

Opportunity To Improve Access to Immediate Care

Both the Adult and Child versions of the survey include the following question:

> "In the last 6 (*or 12*) months, did you (*or your child*) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?"

If the response is YES, then the next question asks:

> "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?"

As shown in the chart below, results from the CAHPS Health Plan Survey Database 2015[85] suggest that health plans can do a better job in providing access to immediate care when needed, particularly for Medicaid beneficiaries.

Table 6F-1. Results from the CAHPS Health Plan Survey Database 2015

	Survey item: Got urgent care for illness, injury or condition as soon as needed Response Frequency				Responses in 2015 Database
	Never	Sometimes	Usually	Always	(N)
Medicare Managed Care Health Plan Survey 4.0	2%	9%	21%	68%	50,687
Adult Medicaid Survey 5.0	3%	14%	21%	62%	24,151
Child Medicaid Survey 5.0	1%	9%	13%	77%	31,321

Analyses of survey results also indicate that, while the majority of adults are usually or always able to obtain urgent medical care when needed, the experience with timely access to care varies by race/ethnicity, age, income level, and health insurance status. For example, in 2010, only 71.7 percent of adults identifying as non-Hispanic other/multiple races indicated that they are usually or always able to get needed medical

[85] The results for the Medicaid sector were obtained from data collected by State Medicaid agencies and individual health plans from October 2014 through June 2015 submitted directly to the CAHPS Database. The 2015 database consists of submissions from 36 states, of which a total of 16 Medicaid State Agencies submitted data. The CAHPS Medicare Managed Care results were obtained from the Centers for Medicare & Medicaid Services (CMS) for survey participants who were enrolled in a managed care health plan.

care, compared to 84.0 percent for White non-Hispanics. The highest levels of access were reported by people age 65 and older and those in high-income families.[86]

6.F.2. The Intervention

Health plans can put in place a variety of programs designed to provide immediate, on-demand access to information, advice, diagnosis, and treatment related to non-urgent health conditions and problems.

Traditional 24-Hour Nurse Hotline (or Advice Line)

Most health plans offer a toll-free phone line available around-the-clock staffed by registered nurses (RNs) who assist members who have questions or need advice related to a health condition or problem. In addition to a regular phone line, plans also provide a separate number compatible with devices that enable deaf or mute individuals to communicate by phone.

Members can call the advice line any time they or a family member are having symptoms of an illness or medical problem, or they can call with general health questions. Using evidence-based algorithms or guidelines,[87] the RN quickly and accurately triages calls and directs the patient to the information he or she needs, which could include education on how to care for and manage the condition at home, a referral for an in-person physician visit, or immediate referral to an urgent care center or ED. (For example, any patient experiencing chest pain will be told to call 911 or go immediately to the ED.) The protocols embedded in guidelines and algorithms are typically conservative, guiding the patient to the appropriate level of care for their needs.

During non-urgent situations, the RN typically offers care management advice and health education related to the patient's health problem(s), with the goal of increasing the patient's confidence in managing his or her health conditions. For example, the RN can help in interpreting test results and in understanding and complying with the prescribed medication regimen and diet. The RN can also help members plan questions in preparation for an upcoming doctor's visit, and can serve as an additional channel for identifying, referring, and enrolling patients into the health plan's disease management, pregnancy, or similar programs. Lastly, nurse advice lines can assist members in finding in-network health care practitioners and facilities.

Many health plans have had 24-hour nurse advice lines in place for years. Plan leaders should routinely monitor the performance of these plans and, as necessary, make changes to improve them. For example, leaders of Molina Healthcare, a Medicaid managed care organization that covers 1.6 million medically underserved individuals in

[86] Carroll W, Rhoades J. *Access and Experiences Regarding Health Care: Estimates for the U.S. Civilian Noninstitutionalized Population Age 18 and Older, 2010*. Statistical Brief #406. May 2013. Agency for Healthcare Research and Quality, Rockville, MD.

[87] Silverstein S, Toomey H. How Nurse Advice Lines Can Help Hospitals and Providers Manage Population Health. *Becker's Hospital Review*. December 13, 2012.

10 states, reviewed usage patterns for its nurse advice line and found that relatively few Spanish-speaking members used the service. In response, Molina created a separate line known as TeleSalud to serve members who speak Spanish. Bilingual nurses (Spanish and English) staff the line, which has been marketed aggressively to Spanish-speaking members.[88] Learn more from AHRQ about TeleSalud.

Web- or Telemedicine-Based Diagnosis and Treatment of Minor Conditions

Some health plans are taking the concept of an "advice" line further by setting up programs explicitly designed to provide diagnosis and treatment of a select group of minor health conditions via virtual technologies, without the need for an in-person visit. In most cases, these services make use of a higher-level practitioner, typically a nurse practitioner (NP), physician assistant (PA), or physician.

For example, HealthPartners, a large integrated health plan and provider system serving residents of Minnesota, Wisconsin, and Michigan, offers an online "clinic" that diagnoses and treats roughly 40 minor health problems that can be safely handled without a face-to-face visit (e.g., pink eye, sinus infections). Members visit a Web site (virtuwell.com) where they interact with an expert system driven by sophisticated artificial intelligence to complete a thorough medical history of their symptoms, conditions, allergies, and medications. The system incorporates hundreds of built-in safety risk factors that automatically trigger a referral to an in-person visit whenever the patient-entered information suggests that one is required. Otherwise, a licensed NP or PA reviews the information and, in most cases, develops a protocol-based treatment plan, including a prescription if needed. Members receive an email or text notifying them that their treatment plan is ready, typically within 30 minutes of their having submitted the information. Occasionally, the NP or PA may feel that an in-person visit is warranted after his or her review, in which case a referral for a visit is provided. If desired, the member can ask to speak to the treating practitioner by phone.

The virtuwell service is covered by most insurers—including Medicare, which authorized coverage in 2011, making it the first online care service to receive such authorization. For those without insurance, a visit costs $40, including any follow-up calls.[89] Learn more from AHRQ about virtuwell.

In addition to online offerings, health plans can offer similar kinds of services via real-time video conferencing, which offers the advantage of allowing a practitioner to visually see and talk to the patient, including visual examination of areas of concern. For example, Anthem Blue Cross Blue Shield offers LiveHealth Online, which allows members to see a board-certified doctor within 10 minutes via a smart phone, tablet or webcam-enabled computer. The physician can offer medical advice and diagnose certain

[88] AHRQ Health Care Innovations Exchange. 24-Hour, Bilingual Nurse Line Provides Advice and Interpreter Services for Plan Members, Leading to Wiser Decisions and Cost Savings. Agency for Healthcare Research and Quality. July 2014.

[89] AHRQ Health Care Innovations Exchange. Online Clinic Enhances Access to and Reduces Costs of Care for Minor Health Problems, Generates Significant Time Savings and High Satisfaction Among Patients. Agency for Healthcare Research and Quality. November 2013.

minor health conditions (e.g., flu, cold, sinus infection, pink eye), including having a prescription sent to the member's pharmacy of choice if necessary.

6.F.3. Benefits

Both traditional nurse advice telephone lines and newer virtual services that diagnose and treat minor health conditions have been shown to provide benefits for both the plans that sponsor them and their members. These benefits include quicker access to care, cost savings (by getting patients to the right—often lower—level of care), better clinical outcomes, and high levels of member/patient satisfaction. For example:

- A 24-hour nurse hotline specifically designed for patients with chronic obstructive pulmonary disease was found to reduce hospital visits without causing any safety risks to patients.[90]
- A study evaluating over 20,000 calls to an advice line from individuals with symptoms suggesting the potential for appendicitis found that callers got care much more quickly than they would have had they not called the advice line, potentially reducing the morbidity associated with appendicitis.[91]
- A study of a nurse advice line in rural New Mexico found that it redirected callers away from unnecessary, expensive ED and urgent care visits to other less costly venues.[92]
- A survey of 278 patients who used Denver Health's nurse advice line found that over two-thirds of callers (68%) took actions that differed from their original plan, with many (46%) choosing to receive care in a less intense setting.[93]
- A study of 132,509 advice line callers found that 56% received advice that differed from their original plan of action, and that 57% complied with the nurse's advice. Compliant callers had $328 lower average healthcare expenditures during the post-call observation period than did non-compliant callers.[94]
- Since the launch of TeleSalud at Molina Healthcare, calls from Spanish-speaking members have increased significantly, leading to fewer ED visits and significant cost savings.[95]

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[90] Roberts MM, Leeder SR, Robinson TD. Nurse-led 24-h hotline for patients with chronic obstructive pulmonary disease reduces hospital use and is safe. Intern Med J 2008;38:334-40.

[91] North F, Odunukan O, Varkey P. The value of telephone triage for patients with appendicitis. J Telemed Telecare 2011;17(8):417-20.

[92] Bissell E, Fiorenzio C, Johnson A, et al. Effectiveness of a 24/7 nurse advice line in reducing non-emergency visits to the emergency room in rural New Mexico. J Investig Med 2010;58(1):126.

[93] Bogdan GM, Green JL, Swanson D, et al. Evaluating patient compliance with nurse advice line recommendations and the impact on healthcare costs. Am J Manag Care 2004 Aug;10(8):534-42.

[94] Navratil-Strawn JL, Ozminkowski RJ, Hartley SK. An economic analysis of a nurse-led telephone triage service. J Telemed Telecare 2014 Sep;20(6):330-8.

[95] AHRQ Health Care Innovations Exchange. 24-Hour, Bilingual Nurse Line Provides Advice and Interpreter Services for Plan Members, Leading to Wiser Decisions and Cost Savings. Agency for Healthcare Research and Quality. July 2014.

- During its first 2 years of operation, HealthPartners' virtuwell online clinic safely diagnosed and treated more than 40 percent of the roughly 96,000 individuals who accessed the system, with the remainder (who had conditions outside the scope of the service) receiving free suggestions for in-person care. Compared with face-to-face visits, virtuwell enhanced access to care, reduced costs, and saved users significant time. Those using the online clinic have reported very high levels of satisfaction, while physicians have generally supported the approach.[96]

6.F.4. Implementation

Health plans can develop and operate their own advice lines and virtual care programs using employed practitioners or contract for such services through vendors. Regardless of the approach taken, the following steps should be considered as ways to avoid or overcome potential implementation-related challenges:

- **Identify and address legal issues:** The provision of virtual care can raise legal issues related to state-specific statutes and regulations. Those offering virtual services must adhere to the statutes and regulations that apply to any provider, including being licensed in all states in which the program operates and adhering to state-specific corporate practice of medicine mandates, Internet prescribing and treatment statutes, scope-of-practice regulations, and physician supervision requirements. For example, some states require a clinician to have an existing face-to-face relationship with a patient before using telemedicine channels with that patient, and others require that a physician supervisor be located in the state.[97]
- **Invest in training**: RNs, NPs, PAs, and physicians involved in advice lines and virtual care services must be trained on how to use the systems and interact effectively with patients. With advice lines, for example, callers may not follow the nurse's advice.[98,99] A meta-analysis of 13 studies during 1990–2010 found that overall compliance with nurse advice averaged only 62%.[100] While more research is needed to clarify the degree to which noncompliance is attributable to poor communication by the nurse, training in active listening and motivational interviewing may help nurses make meaningful connections with callers over the

[96] AHRQ Health Care Innovations Exchange. Online Clinic Enhances Access to and Reduces Costs of Care for Minor Health Problems, Generates Significant Time Savings and High Satisfaction Among Patients. Agency for Healthcare Research and Quality. November 2013.

[97] AHRQ Health Care Innovations Exchange. Online Clinic Enhances Access to and Reduces Costs of Care for Minor Health Problems, Generates Significant Time Savings and High Satisfaction Among Patients. Agency for Healthcare Research and Quality. November 2013.

[98] De Coster C, Quan H, Elford R, et al. Follow-through after calling a nurse telephone advice line: a population-based study. Family Pract 2010;27(3):271-8.

[99] Blank L, Coster J, O'Cathain A, et al. The appropriateness of, and compliance with, telephone triage decisions: a systematic review and narrative synthesis. J Adv Nurs 2012;68(12):2610-21.

[100] Purc-Stephenson RJ, Thrasher C. Patient compliance with telephone triage recommendations: a meta-analytic review. Patient Educ Couns 2012 May;87(2):135-42.

phone.[101,102] Practitioners also need education and training on how to deal with patients who have potential substance abuse and/or mental health issues.

- **Market programs clearly, with a focus on the target audience**: The success of a health plan's advice lines and virtual care offerings is directly related to the marketing and promotion of the services. Mechanisms to market such services include physical materials (e.g., magnets, brochures, posters), mobile applications, direct mail, email, phone messages, and advertising on the plan's website. Materials should be targeted to the plan's member population, taking into consideration demographics and language. Leaders at Molina Healthcare, for example, invested in significant market targeted at Spanish-speaking members during the launch of TeleSalud; these efforts were instrumental in the advice line's attracting calls from Spanish-speaking members.[103]

  Promotional materials for any health plan service should also make it clear what the service specifically does and does not do. For example, members may be tempted to call the 24-hour nurse hotline for non-medical issues regarding coverage, claims, and/or referrals. The hotline's promotional material should clearly state that the nurse advisors cannot assist with these types of non-medical issues.

- **Review underlying guidelines and algorithms regularly**: The evidence-based guidelines and algorithms that underlie any advice line or virtual care system should be reviewed annually by a panel of credentialed physicians to determine if any revisions are needed due to changes in medical knowledge and clinical practice. As part of this effort, clinicians should listen to live or recorded patient-provider interactions to ensure that the algorithm- and/or guideline-based questions are being asked and answered as expected. If members or nurses consistently have difficulty with specific questions, the clinical team should take steps to make the questions clearer and the answers more consistent and reliable. Feedback should be gathered from practitioners and members related to any issues or problems that arise with the advice line and other virtual services.

- **Consider language and culture of target population**: As noted, advice lines and virtual services must cater to the demographics of the population being served. Consequently, as the leaders of Molina Healthcare discovered with their traditional nurse advice line, steps must be taken to ensure that staffing and marketing materials are tailored to the linguistic, racial, ethnic, and cultural profile of the target population.

[101] Williams B, Warren S, McKim R, et al. Caller self-care decisions following teletriage advice. J Clin Nurs 2012 Apr;21(7-8):1041-50.

[102] Johnson C, Wilhelmsson S, Börjeson S, Lindberg M. Improvement of communication and interpersonal competence in telenursing--development of a self-assessment tool. J Clin Nurs 2015 Jun;24(11-12):1489-501.

[103] AHRQ Health Care Innovations Exchange. 24-Hour, Bilingual Nurse Line Provides Advice and Interpreter Services for Plan Members, Leading to Wiser Decisions and Cost Savings. Agency for Healthcare Research and Quality. July 2014.

- **Ensure privacy and security**: Plans must meet all privacy- and security-related requirements and members will need assurances that advice lines and other virtual care programs safeguard their health information.
- **Minimize stress on practitioners**: Studies suggest that advice line nurses may be prone to significant stress, particularly those who work alone and/or on shifts with a high volume of calls.[104,105]

Read More About On-Demand Care

- Rise in on-demand health services reflects an appetite for change. Accenture Consulting. https://www.accenture.com/us-en/insight-highlights-health-rising-investment-healthcare-services. Accessed 10/20/16.
- Virtual health: The untapped opportunity to get the most out of healthcare. Accenture Consulting. https://www.accenture.com/us-en/insight-virtual-health. Accessed 10/20/16.
- The Rise of Virtual Healthcare. Market Strategies International. https://www.marketstrategies.com/blog/2016/07/the-rise-of-virtual-healthcare/. Accessed 10/20/16.
- Kim A, Lai J, Lamont E, et al. Virtual health care evaluated by UCSF and Stanford. UCSF School of Pharmacy. https://pharmacy.ucsf.edu/news/2015/08/virtual-health-care-evaluated-ucsf-stanford. Accessed 10/20/16.
- Pathipati AS, Azad TD, Jethwani K. Telemedical education: training digital natives in telemedicine. J Med Internet Res 2016 Jul;18(7):e193.

[104] Röing M, Holmström IK. Malpractice claims in Swedish telenursing: lessons learned from interviews with telenurses and managers. Nurs Res 2015 Jan-Feb;64(1):35-43.

[105] Allan JL, Farquharson B, Johnston DW, et al. Stress in telephone helpline nurses is associated with failures of concentration, attention and memory, and with more conservative referral decisions. Br J Psychol 2014 May;105(2):200-13.

6.G. Training to Advance Physicians' Communication Skills

6.G.1. The Problem

People rarely complain about the technical aspects of the health care they receive because—in the absence of an obvious error—patients are generally unable to judge technical competence. However, they and *only they* are well-equipped to judge the ability of clinicians to communicate with them effectively. Even though a clinician explains a diagnosis, test result, or treatment option to a patient, if the person walks away and does not understand the explanation, it has not been an effective communication.

Poor communication can have a serious impact on health outcomes. Patients may not provide the clinician with adequate information on their health or related concerns; they may not comply with the physician's orders—and in some cases, they may not even understand what they have been told. According to a study at the University of Kansas School of Medicine in Kansas City, patients' reports of their understanding of the post-discharge information and instructions they had received was significantly less than what their doctors perceived. For example, while the physicians thought that 89 percent of the patients understood the potential side effects of their medications, only 57 percent of patients said that they understood.[106]

In addition to affecting the patient's experience with health care, poor patient-physician communication has important consequences for medical practices. One study found that, in a three-year period, 20 percent of Massachusetts state employees voluntarily left their primary care physician because of the poor quality of their relationship, which was a function of trust, the patients' sense that the physician knew them, the level of communication, and personal interaction.[107] Poor communication is also a contributing factor in a majority of malpractice suits.[108]

"With patient characteristics and structural features of care taken into account, those with the poorest-quality physician-patient relationships in 1996 were 3 times more likely to leave the physician's practice over the ensuing 3 years than those with the highest-quality relationships."

Safran DG, Montgomery JE, Chang H, et al. Switching doctors: Predictors of voluntary disenrollment from a primary physician's practice. *J Fam Pract* 2001;50(2):130-6.

While the curriculums of most medical schools now include some form of training in communications skills,[106] this is a fairly recent phenomenon. Traditionally, medical

[106] Rogers C. Communications 101. Bulletin of the American Academy of Orthopaedic Surgeons 1999;47(5).

[107] Safran DG, Montgomery JE, Chang H, et al. Switching doctors: Predictors of voluntary disenrollment from a primary physician's practice. *J Fam Pract* 2001;50(2):130-6.

[108] Flaherty M. Good Communication Cuts Risk. *Physician's Financial News* 2002;20(2): s10-s11.

education has paid little attention to the skills that promote effective interactions with patients. Most practicing physicians have not been taught to appreciate the patient's experience of illness; nor do they learn how to partner with patients and serve as a coach or guide. As a result, they typically do not know how to communicate with patients in a way that maximizes understanding and involvement in decision making, lets the patient know that his or her concerns have been heard, and ensures that the care plan meets the needs of the patient.

6.G.2. The Intervention

To compensate for this deficiency in medical education, numerous health plans and medical groups are training clinicians in the communication skills they need—either through in-house programs or through communications programs offered by outside organizations. Most of these programs are optional, but a few organizations require the participation of all doctors. In some organizations, the program is mandatory only for those doctors who consistently receive low scores in this area.

The purpose of these programs is to improve providers' effectiveness as both managers of care and educators of patients. It is also believed that trained physicians may allocate a greater percent of clinic-visit time to patient education, leading to increased patient knowledge, better compliance with treatment, and improved health outcomes.

The most effective and efficient way of offering training in physician-patient communication is in the form of seminars or workshops where you can cover many strategies for improved communication in a relatively short period of time. Workshops may also use case studies to illustrate the importance of communication and suggest approaches to improving the physician-patient relationship.

For clinicians, workshops may serve multiple purposes, including increasing their understanding of the physician's roles, offering insight into the importance of connecting with patients, and increasing confidence in their interviewing skills. In addition to basic communication skills, the training can cover:

- History-taking skills
- Issues related to communicating across cultures
- Communicating with "problem" patients
- Interviewing techniques (including skills to help promote behavioral change)
- Empathic responses

Some programs also address weaknesses in written communications, which can be a serious problem for clinicians who use e-mail to communicate with some patients. Group Health Cooperative in Seattle, for example, offers a training curriculum on how to write e-mails to patients.

Training in behavioral change concepts can help physicians identify patients who are likely to be receptive to their advice and guidance. To help physicians better understand the process of behavioral change, some medical groups and health plans are teaching physicians about the Transtheoretical Model (see box below) and encouraging them to identify where patients are in these stages and to focus their educational efforts on patients who are ready to change.

If patients are precontemplative, physicians do not need to be spending much time convincing them to stop or start a new behavior. But if they are contemplative, then the time required to coach them about things they can do to adopt the desired behavior is well-spent.

Support in Improving Physician Communication

For help in implementing this strategy, consider the following resources:

Institute for Healthcare Communication, New Haven, CT
http://www.healthcarecomm.org
The Institute for Healthcare Communication (formerly the Bayer Institute) offers a variety of workshops to help clinicians develop and hone their communication skills. It also offers books, videos, and practical guides on how to improve communication.

American Academy on Communication in Healthcare, Chesterfield, MO
http://www.aachonline.org/
The American Academy on Communication in Healthcare (AACH) is an interdisciplinary group of medical educators and clinicians that share a common interest in patient-clinician communication and relationships, and psychosocial aspects of health care.

The Foundation for Medical Excellence, Portland, OR
http://www.tfme.org/
The Foundation for Medical Excellence is a non-profit foundation that sponsors a variety of educational programs and consulting services for licensed physicians. Its programs include education and research in physician-patient communication.

Motivational Interviewing Network of Trainers, Fairfax, VA
http://motivationalinterviewing.org/
The Motivational Interviewing Network of Trainers (MINT) is a non-profit organization that provides training, coaching, and consultation on the use of motivational interviews to promote behavior change.

A Model of Behavioral Change

The Transtheoretical Model lays out five unique "Stages of Change:"

- **Precontemplation** is the stage in which there is no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or under-aware that a problem exists.
- **Contemplation** is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.
- **Preparation** is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action in the past year.
- **Action** is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. Action involves the most overt behavioral changes and requires considerable commitment of time and energy.
- **Maintenance** is the stage in which people work to prevent relapse and consolidate the gains attained during action. For addictive behaviors, this stage extends from six months to an indeterminate period past the initial action.

A full explanation of this model can be found at *Cancer Prevention Research Center: Home of the Transtheoretical Model. Detailed Overview*. Available at: http://web.uri.edu/cprc/detailed-overview/. Accessed July 31, 2017.

6.G.3. Example

One of the best-known examples of an in-house program to inculcate strong communication skills in clinicians is the Thriving in a Busy Practice program developed by Terry Stein, MD, at Kaiser Permanente. This comprehensive communications curriculum strives to develop the ability of physicians to relate to patients effectively in both routine and difficult settings. In particular, it is intended to help physicians learn and practice techniques for dealing with difficult patient encounters. The workshops address the issues that typically confront primary care physicians as well as guidance pertinent for different specialists (such as emergency physicians).

Evaluations of this program have found a positive impact on the clinicians. One study found that clinicians reported improved confidence in their ability to conduct effective medical interviews and handle difficult situations. It also found that, after taking the course, fewer clinicians reported frustration with patient visits (specifically, the percent reporting frustration with 11 percent or more of patient visits fell from about half before

the course to about one-third afterwards).[109] However, the impact on patient satisfaction is not yet clear: One study found that the program had no impact, but noted that other factors may have influenced that finding.[110]

Read More About Improving Communication Skills

- American Medical Association. Section II: Resources Emphasizing Communication Skills. In: Cultural Competence Compendium. Chicago, IL; *American Medical Association* 1999: 89-106.
- Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A patient-based approach. *Ann Intern Med* 1999 May 18;130(10):829-34.
- Coulter A. The Autonomous Patient: Ending Paternalism in Medical Care. London: Nuffield Trust 2002.
- Jackson C. It Pays to Listen: The Importance of Doctor-Patient Communication. *Amer Med News* 2001 May 21.
- Nelson AM, Brown SW. *Improving Patient Satisfaction Now*. New York, NY: Aspen Publishers, Inc. 1997 April.
- Nigg CR, Burbank P, Padula C, et al. Stages of change across ten health risk behaviors for older adults. *Gerontologist* 1999;39:473-82.
- Prochaska JO, Norcross JC, DiClemente C. *Changing for Good*. New York, NY: William Morrow and Company, Inc.; 1994.
- Prochaska JO. Helping patients at every stage of change. *Behavioral Approaches to Addiction Journal* 1992;1(1):2-7.
- Ranier SB, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: A systematic review. *J Am Board Fam Pract* 2002;15(1):25-38.

[109] Stein TS, Kwan J. Thriving in a busy practice: Physician-patient communication training. *Eff Clin Pract* 1999;2(2):63-70. Available at: http://ecp.acponline.org/marapr99/thriving.pdf . Accessed July 7, 2017.

[110] Brown JB, Boles M, Mullooly J, et al. Effect of clinician communication skills training on patient satisfaction. A randomized, controlled trial. *Ann Intern Med* 1999;131(11):822-9.

6.H. Tools to Help Patients Communicate Their Needs

6.H.1. The Problem

Communication is a two-way street. While the communication skills of physicians and other providers certainly play a large role in shaping the patient's experience, that patient's ability to express herself clearly, process and interpret the information she receives, and act upon it (e.g., by changing behavior) also contributes to the experience of care.

One issue is that many, if not most, patients are just beginning to become comfortable with relationships with clinicians that are based on a partnership model rather than the traditional paternalistic model. This shift is especially difficult for older patients and people who do not speak English or who come from cultures where this kind of a relationship with a doctor is unheard of.

But even those who embrace the idea of working collaboratively with physicians may lack important communication skills, which can inadvertently undermine their interactions with the health care system. Beginning in childhood, people are socialized to restrain themselves with doctors, answering only what they have been asked. While this attitude is changing, it is still a big step for people to accept that their agenda is as important as the doctor's, and an even bigger one for them to learn how to satisfy that agenda while still respecting the clinician's constraints.

6.H.2. The Intervention

Health plans, medical groups, and physician practices can help patients improve their ability to share information with providers by suggesting or even giving them one or more simple and inexpensive communication tools. Patients who can communicate effectively with their clinicians tend to be more satisfied with their care, less likely to sue in case of an error, and more likely to experience improved health outcomes. [111] Their clinicians are likely to be more satisfied with their caregiving experience as well.

There are several ways to implement this strategy, including the four tactics discussed below:

- Record Sharing
- Patient Question Lists (a.k.a. Doc Talk Cards)
- Feed Forward
- Coached Care

[111] Stewart MA. Effective physician-patient communication and health outcomes: A review. *CMAJ* 1995;152(9):1423-33.

6.H.2.a. Record Sharing

Record sharing involves using the patient's medical record as a way to facilitate information sharing and generate discussion in the context of primary care. It typically consists of giving patients a copy of their physicians' progress notes (on paper or electronically) together with a glossary of terms. Access to this information enables patients to:

- better understand their condition and treatment plan,
- feel more in control of their health, and
- identify and correct inaccurate information.

Two factors may drive record sharing to become more commonplace: the HIPAA regulation that requires health care organizations to allow patients to review and amend their medical records, and the emergence of electronic medical records, which make it easier to share legible (and therefore less confusing) information.

Proponents believe that this intervention has the potential to increase compliance, improve patient safety, and enhance quality of care. Controlled studies indicate that the sharing of medical records has a consistently positive impact on doctor-patient communications, as well as modest benefits in other areas; with the exception of psychiatric patients, it appears to have little downside.[112] It has been found especially effective for patients with repeated visits, such as those with chronic conditions[113] and pregnant women.

6.H.2.b. Patient Question Lists (a.k.a. Doc Talk Cards)

Another tactic is to encourage patients to write down questions they wish to ask their doctor and bring the list to their visit; these lists are sometimes referred to as "Doc Talk" cards. Typically, patients are asked to generate two to five questions about their medical problems or their reason for the visit that they would like their physician to answer during the office visit. The cards are often designed to prompt patients for questions by listing topic areas such as symptoms and medications. These questions can be attached to the patient's chart for the physician's review. This intervention is simple, requires few resources, and is effective at generating communication and increasing patient satisfaction with their care.

[112] Ross SE, Lin CT. The effects of promoting patient access to medical records: A review. *J Am Med Inform Assoc* 2003;10(2):129-38.

[113] Maly RC, Bourque LB, Engelhardt RF. A randomized controlled trial of facilitating information giving to patients with chronic medical conditions: Effects on outcomes of care. *J Fam Pract* 1999;48(5):356-63.

One tactic is to provide a form on the Web that patients can print out prior to their visit. Some health plans and providers, for example, offer a form that suggests that patients write out answers to the following two questions and bring their response to the visit:

- What do I want to **tell** my doctor today?
- What do I want to **ask** my doctor today?

Patients can also use the form during the visit to write down what they and the doctor agreed the patient would do after the visit. Another approach is to maintain an ongoing record of health issues and concerns that the patient could share with his or her caregivers.

6.H.2.c. Feed Forward

The Feed Forward concept is part of a model developed by Eugene Nelson and John Wasson that aims to use information to improve the ability of the microsystem to deliver effective care that addresses the patient's needs. The basic idea is that, prior to a visit, each patient completes a questionnaire that asks about perceptions of the care received to date, functional health status, clinical health status, and health risk status. The clinical team can then use that information to design and deliver a treatment plan that is appropriate for that individual.

After the visit, the team collects similar information that can be used to redesign care for future patients (i.e., information for feedback). The model encompasses other steps as well, including a "prescription" that includes self-care assignments and tailored instructions.

Learn More About the Feed Forward Approach

- Nelson EC, Batalden PB, Homa K, et al. Microsystems in health care: Part 2. Creating a rich information environment. *Jt Comm J Qual Improv* 2003 Jan;29(1):5-15.
- Wasson JH, Stukel TA, Weiss JE, et al. A randomized trial of the use of patient self-assessment data to improve community practices. *Eff Clin Pract* 1999 Jan-Feb;2(1):1-10.

6.H.2.d. Coached Care

Coached Care programs are designed to prepare patients to be more effective participants in their care by teaching them how to ask the right questions, how to interrupt, and how to get their needs met in the encounter. Coaching sessions may also address common misconceptions regarding a condition. Its goals include:

- helping people become more assertive health care consumers,
- improving the quality of interpersonal care, and
- increasing patient involvement in treatment decisions.

The design of Coached Care programs varies from the inexpensive, where patients receive brochures prior to their visits that contain a list of common questions and other prompts, to more expensive programs involving individual coaching sessions between patients and designated clinic staff. For example, just prior to a doctor visit, a nurse may interview the patient, review the chart together, and generate a list of questions the patient has for the doctor. These more involved coaching programs require larger resources for staff training in Coached Care techniques in addition to financial coverage of staff time. While coaching sessions are usually performed in an office setting, they may also take place through e-mail or over the phone.

Coached care programs have been shown to improve both physiologic and functional outcomes.[114, 115] In addition, anecdotal evidence suggests that Coached Care programs enhance physician-patient communication without requiring an increase in visit length.[116]

Learn About the Effects of a Coached Care Program on Breast Cancer Care

- Sepucha KR, Belkora JK, Aviv C, et al. Improving the quality of decision making in breast cancer: Consultation planning template and consultation recording template. *Oncol Nurs Forum* 2003 Jan-Feb;30(1):99-106.
- Sepucha KR, Belkora JK, Mutchnick S, et al. Consultation planning to help breast cancer patients prepare for medical consultations: Effect on communication and satisfaction for patients and physicians. *J Clin Oncol* 2002 Jun;20(11):2695-700.
- Sepucha KR, Belkora JK, Tripathy D, et al. Building bridges between physicians and patients: Results of a pilot study examining new tools for collaborative decision making in breast cancer. *J Clin Oncol* 2000 Mar;18(6):1230-8.

[114] Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care. Effects on patient outcomes. *Ann Intern Med* 1985;102(4): 520-8.

[115] Greenfield S, Kaplan SH, Ware JE Jr., et al. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med* 1988;3(5): 448-57.

[116] Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care* 1989;27(3 Suppl): S110-27.

Free Materials to Help Patients Communicate

The Federal government offers several free documents that can be used to educate members and patients and prompt them to ask questions and take other steps to communicate more effectively. These materials can be ordered or downloaded from the Internet. Examples include the following:

- Questions To Ask Your Doctor. September 2012. Agency for Healthcare Research and Quality, Rockville, MD. Accessed on July 7, 2017.
- Next Steps After Your Diagnosis. Step 3: Talk With Your Doctor. June 2016. Agency for Healthcare Research and Quality, Rockville, MD. Accessed on July 7, 2017.
- Talking With Your Doctor: A Guide For Older People. National Institute on Aging, National Institutes of Health. NIH Publication No.16-AG3452, December 2016. Accessed on July 7, 2017.
- Five Steps to Safer Health Care: Patient Fact Sheet. October 2014. Agency for Healthcare Research and Quality, Rockville, MD. Accessed on July 7, 2017.

Books To Recommend to Patients

Clinicians can also support their patients by suggesting books that may help them communicate more effectively. Examples include:

- Clarke P, Evans SH. Surviving Modern Medicine: How to Get the Best from Doctors, Family, and Friends. Piscataway, NJ: Rutgers University Press; 1998.
- Keene N. Working With Your Doctor: Getting the Healthcare You Deserve. Patient-Centered Guides, 1998.
- Korsch BM, Harding C. The Intelligent Patient's Guide to the Doctor-Patient Relationship: Learning How to Talk So Your Doctor Will Listen. New York, NY: Oxford University Press; 1998.
- Oster N, Thomas L, Joseff D. Making Informed Medical Decisions: Where to Look and How to Use What You Find. Patient-Centered Guides, 2000.

6.I. Shared Decision-Making

6.I.1. The Problem

Although patients are far more informed about their care than they were even 20 or 30 years ago, some people express frustration and dissatisfaction because they do not feel like they have adequate (if any) input into the decisions that clinicians are making about their health and their lives. One element of this problem is that patients often do not know enough about their treatment options to make informed decisions. In particular, they may not understand the evidence base underlying the choices they are being offered.

Another contributing factor is that providers are not always supportive of patient involvement in the decision-making process. In some cases, clinicians are supportive of the concept but do not know how to make it happen.

Complicating the decision-making process is the fact that decisions related to preventive testing, diagnostic work-ups, and treatment options are often driven by physicians' preferences (which may be shaped by medical training, local norms, or personal experience) rather than scientific evidence. The resulting variations in care across the country are tremendous and well-documented. (For evidence of geographic variations, consult the Dartmouth Atlas.) However, the only preference driving variations should be that of the patient. This is a core principle behind shared decision-making.

6.I.2. The Intervention

Shared decision-making is a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health. It operates under two premises:

- First, consumers armed with good information can and will participate in the medical decision-making process by asking informed questions and expressing personal values and opinions about their conditions and treatment options.
- Second, clinicians will respect patients' goals and preferences and use them to guide recommendations and treatments.

While some critics of shared decision-making maintain that patients are not able or willing to make their own health care decisions, there is considerable evidence that patients want more information and greater involvement in decisions in partnership with their doctors.[117, 118, 119] The innovation of shared decision-making is the use of

[117] Deber RB, Kraetschmer N, Irvine J. What role do patients wish to play in treatment decision making? Arch Intern Med 1996;156(13): 1414-20.

[118] Guadagnoli E, Ward P. Patient participation in decision-making. Soc Sci Med 1998;47(3): 329-39.

[119] Coulter A. The Autonomous Patient: Ending Paternalism in Medical Care. London: Nuffield Trust; 2002.

evidence-based tools, known as patient decision aids, to inform patients and help them set their own goals and clarify their values.

6.I.3. Benefits of This Intervention

Improved quality of medical consultations has been found to have a positive effect on the quality of treatment decisions, the quality of patient-physician communication, and the satisfaction of both patients and physicians. Specifically, research on the impact of this intervention has found:

- Consumer participation can increase patient satisfaction and lead to better health outcomes.[120, 121, 122]
- Patients who are empowered to make decisions about their health that better reflect their personal preferences often experience more favorable health outcomes such as decreased anxiety, quicker recovery, and increased compliance with treatment regimens.[123]
- Greater consumer involvement in decision-making leads to lower demand for health care resources.[124]

Since this approach was first developed in the early 1980s, there has been considerable evidence gathered on the efficacy of patient decision aids. These tools increase knowledge, improve risk estimates, increase patient's involvement in decisions, and help clarify treatment preferences.[125] Research also suggests that the use of decision aids can increase the richness of discussions between physician and patient. In one study, both patients and physicians benefited from an increased level of understanding that allowed discussions to focus on the critical risk/benefit tradeoffs rather than simply describing treatment alternatives.[126]

[120] Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care. Effects on patient outcomes. Ann Intern Med 1985;102(4): 520-8.

[121] Greenfield S, Kaplan SH, Ware JE Jr., et al. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. J Gen Intern Med 1988;3(5): 448-57.

[122] Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med Care 1989;27(3 Suppl): S110-27.

[123] Guadagnoli E, Ward P. Patient participation in decision-making. Soc Sci Med 1998;47(3): 329-39.

[124] Devine EC, Cook TD. A meta-analytic analysis of effects of psychoeducational interventions on length of postsurgical hospital stay. Nurs Res 1983;32(5): 267-74.

[125] O'Connor AM, Stacey D, Légaré F, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev 2014 Jan 28(1).

[126] Onel E, Hamond C, Wasson JH, et al. Assessment of the feasibility and impact of shared decision making in prostate cancer. Urology 1998;51(1): 63-6.

6.I.4. Implementation of This Intervention

The aim of shared decision-making is to ensure that

- patients understand their options and the pros and cons of those options and
- patient's goals and treatment preferences are used to guide decisions.

A key step in shared decision-making is making sure that patients are fully informed about their medical condition and their options. Consumers have access to a variety of sources for such information, including physicians, friends and family, Web sites, and printed materials such as pamphlets and journal articles. Patient decision aids go beyond that kind of information to explain the issues fairly and clearly, highlighting the pros and cons of each option, and providing support for users to clarify and express their personal goals and preferences. Good decision aids, whether Web-, video- or paper-based, are balanced and do not encourage one treatment approach over the others. They can be used before, during and after visits for medical care,[127] and may be applied to a variety of medical conditions as well as general preventive medicine. Educational applications may also be used to prepare patients for various procedures or explain what they need to know after surgery.[128]

Resources for Decision-Making Tools

- Agency for Healthcare Research and Quality: The SHARE Approach
- Massachusetts General Hospital: Health Decision Sciences Center
- Healthwise
- Ottawa Hospital Research Institute: Patient Decision Aids

The challenge for patient decision aids is keeping pace with rapidly changing developments, including new treatment alternatives and new information concerning treatment efficacy and complications.[129] Keeping the decision aids up-to-date is a major enterprise.[130] International standards for the development of these types of patient decision aids provide guidance for developers as well as for potential users to evaluate the quality of available decision aids, including those developed by commercial companies.[131]

A related element of the shared decision-making model is that patients must take some responsibility for identifying and availing themselves of information and speaking up to

[127] O'Connor AM, Stacey D, Légaré F, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev 2014 Jan 28(1).

[128] Mechanic D. Issues in promoting health. Soc Sci Med 1999;48(6): 711-8.

[129] Onel E, Hamond C, Wasson JH, et al. Assessment of the feasibility and impact of shared decision making in prostate cancer. Urology 1998;51(1): 63-6.

[130] Mechanic D. Issues in promoting health. Soc Sci Med 1999;48(6):711-8.

[131] Joseph-Williams N, Newcombe R, Politi M, et al. Toward minimum standards for certifying patient decision aids: A modified Delphi consensus process. Med Decis Making 2013 Aug 20;34(6):699-710.

share their concerns, goals, and questions with their health care team. This may involve reviewing information before or after a visit, and perhaps completing an assessment of their understanding and goals. It may also involve working with a coach or attending a support group or educational program offered in the community.

Another important step in shared decision-making is for the clinician to involve the patient in the decision-making process. While the right of patients to be informed decision-makers is well accepted, it is not always well implemented.[132] Shared decision-making requires a "modification of the relationship between patient and provider and recognition of the ability of the patients to participate in making choices that affect their lives."[133] Thus, one key to success lies in training physicians and other members of the care team to:

- communicate about risks and benefits clearly,
- elicit patients' goal and treatment preferences, and
- respect patient's values, preferences, and expressed needs when making recommendations for care.[134]

Clinical decision support tools, such as risk calculators, can play a useful role in the shared decision-making process. It is also helpful to use a team approach to shared decision-making that involves nurses, health coaches, and case managers, so that informing patients and respecting their goals and preferences happens in all interactions.

A final element to consider is an assessment of the extent to which patients are meaningfully involved in decision-making for medical tests and treatments. Specifically, organizations implementing shared decision-making can follow-up with patients to determine whether they understood that they had options, how much the risks and benefits of each option was discussed, and whether their preferences were discussed. This kind of feedback can help to identify where the process of shared decision-making may be lacking and how it can be improved.

[132] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC, National Academy Press; 2001.

[133] Deber RB, Kraetschmer N, Irvine J. What role do patients wish to play in treatment decision making? Arch Intern Med 1996;156(13): 1414-20.

[134] Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. BMJ 1999;319(7212): 766-71.

Read More About Shared Decision-Making

- Barry MJ, Edgman-Levitan S. Shared decision making--pinnacle of patient-centered care. N Engl J Med 2012;366(9): 780-1.
- Elwyn G, Edwards A, Gwyn R, et al. Towards a feasible model for shared decision making: focus group study with general practice registrars. BMJ 1999;319: 753-6.
- Gerteis M, Edgman-Levitan S, Daley J. *Through the patient's eyes. Understanding and promoting patient-centered care*. San Francisco: Jossey-Bass; 1993.

6.J. Support Groups and Self-Care

6.J.1. The Problem

Patients often express dissatisfaction because they are not getting everything they need from the clinicians—but in many cases, what they need is not something that the clinicians can provide. While many physicians believe that they can (or should be able to) satisfy all of their patients' needs, including the need for self-care, this presumption is not realistic or helpful for them or their patients—particularly for those with chronic conditions.

Many communities offer multiple resources that serve patients looking for support, advice, better self-care knowledge and skills, and comfort. Rather than setting expectations they cannot meet, clinicians need to accept that this is a role better filled by others and help their patients connect with the outside resources they need.

6.J.2. The Intervention

Health plans, medical groups, and physician practices can play two important roles to counter this problem. First, they can manage the expectations of members and patients by helping them regard their doctors as coaches rather than all-knowing sages. Second, they can offer access to the kinds of educational, behavioral, and emotional resources and support they need. Tactics for providing this support include self-care programs and support groups.

- **Self-Care Programs:** Self-care programs are usually highly structured educational forums where patients with a chronic condition may learn about a variety of topics, including symptom management, nutrition, community resources, medications, managing emotions, and communication skills.[135,136] Self-care programs often teach skills that make people better able to manage their medical problems on their own, e.g., taking a blood pressure, giving injections, taking medications, and even performing diagnostic tests such as urine tests and blood glucose. Such programs are based on self-efficacy theory and emphasize problem solving, decision making, and confidence building.[136]
- **Support Groups:** Support groups may take the form of face-to-face meetings or on-line chat groups operating under the principle that patients can learn to take responsibility for the day-to-day management of their disease. They help people who have chronic health problems by teaching them how to do a better job of self-care, providing emotional support, or offering other kinds of concrete support, like getting groceries or providing transportation to and from medical

[135] Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial. *Med Care* 1999;37(1):5-14.

[136] Lorig KR, Sobel DS, Ritter PL, et al. Effect of a self-management program on patients with chronic disease. *Eff Clin Pract* 2001;4(6):256-62.

appointments. Other similar group interventions include survivor groups, 12-step programs, and psychoeducational groups for families of patients with chronic diseases.[137]

6.J.3. Benefits of These Interventions

The use of support groups and self-care programs can increase patients' knowledge about their disease and, in some cases, improve compliance with prescribed treatment. Additionally, these programs are beneficial to both patients and health facilities in that confident, knowledgeable patients practicing self-management have been shown to experience improved health status while utilizing fewer health care resources.[135, 138] Additional anecdotal evidence suggests that such programs can have a positive influence on long-term health outcomes.[139]

Studies of support groups formed for chronic arthritis, heart disease, stroke, and lung disease have shown that such groups have beneficial effects on mental and physical health as well as social functioning. Specifically, support groups were found to: [135, 139]

- Increase communication with physicians
- Improve self-reported health
- Make enhancements in social/role activities
- Reduce the need for hospitalizations

These studies did not detect short-term improvement in other factors such as pain and psychological well-being, but there is evidence of significant improvements of these factors over the long-term.

Inexpensive self-care programs and support groups appear to be responsible for significant cost savings. Evaluations of some of these programs have shown fewer hospitalizations and days spent in the hospital as patients become more confident in caring for themselves. Additionally, one study found a total health savings of ten times the cost of the self-care program.[135, 139]

6.J.4. Implementation of These Interventions

Trained lay persons can effectively moderate support groups and educate patients in self-care techniques; this person need not have the same condition as the patients. Such instructors have been found to be acceptable to both patients and health professionals and are an inexpensive staffing option for these programs.[135]

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[137] Mechanic D. Issues in promoting health. *Soc Sci Med* 1999;48(6):711-8.

[138] Bodenheimer T, Lorig K, Holman H, et al. Patient self-management of chronic disease in primary care. *JAMA* 2002;288(19):2469-75.

[139] Lorig KR, Mazonson PD, Holman HR. Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs. *Arthritis Rheum* 1993;36(4):439-46.

Additionally, many guidebooks are available that can serve as a text for self-care programs or as a topical guide for support group meetings. The book *Living a Healthy Life with Chronic Conditions* (see the box below for the full citation) has served these purposes for a variety of self-care programs.

Participants typically learn about self-care programs and support groups through referrals, fliers left in physicians' offices, and/or program announcements posted at senior citizen centers and in patient or member newsletters and Web sites. Additional cost savings could come from holding these meetings at the health care facility (if sufficient room is available) or at low-cost sites in the community, such as churches, senior centers, or public libraries.

Resources on Support Groups and Self-Care

Lorig K, Halsted H, Sobel D. *Living a healthy life with chronic conditions: Self-management of heart disease, arthritis, diabetes, depression, asthma, bronchitis, emphysema, and other physical and mental health conditions*. 4th ed. Boulder: Bull Publishing Company; 2012.

New Jersey Self-Help Group Clearinghouse, Dover, NJ 1-800-367-6274
http://www.njgroups.org/

6.K. Cultivating Cultural Competence

6.K.1. The Problem

Approximately 21 percent of the U.S. population speaks another language at home, and about 9 percent has limited English proficiency (LEP).[140] Many of these individuals come from racial and ethnic backgrounds that follow different cultural norms and customs related to health and health services. Often these individuals are unable to find information they can understand and use or to get care from providers who speak their native language and/or understand their norms and customs. As a result, when these individuals need services or care, they experience linguistic, cultural, and health literacy barriers that have a negative impact on their experience with care and health care outcomes.[141,142,143,144]

Relevant Questions on the CAHPS Health Plan Survey

Survey questions related to cultural competence are now part of the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) that the Centers for Medicare & Medicaid Services (CMS) is using to assess the performance of health plans offered through the State Health Insurance Marketplaces. This survey expands on the core Health Plan Survey to ask enrollees about –

- Access to interpreters when needed at a doctor's office or clinic.
- The availability of health plan forms in the respondent's preferred language.
- The availability of health plan forms in a needed format, such as large print or braille.

6.K.2. Interventions

The variety of strategies available to help health plans reduce linguistic, cultural, and health literacy barriers for their members include the following:

[140] Ryan C. Language use in the United States: 2011. American Community Survey Reports. United States Census Bureau; Aug 2013. Available at: https://www.census.gov/prod/2013pubs/acs-22.pdf.

[141] Ngo-Metzger Q, Sorkin DH, Phillips RS, et al. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007;22(Suppl 2):324-30.

[142] Weech-Maldonado R, Morales LS, Spritzer K, et al. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. Health Serv Res Jul 2001;36(3):575-94.

[143] Weech-Maldonado R, Morales LS, Elliott M, et al. Race/ethnicity, language, and patients' assessments of care in Medicaid managed care. Health Serv Res 2003 Jun;38(3):789-808.

[144] Weech-Maldonado R, Elliott MN, Morales LS, et al. Health plan effects on patient assessments of Medicaid managed care among racial/ethnic minorities. J Gen Intern Med 2004;19(2):136-45.

- Maintaining complete and accurate information on enrollees.
- Building a provider network to meet the community's linguistic and cultural needs.
- Training providers on cultural competency.
- Developing linguistically and culturally appropriate educational programs and materials.
- Regularly assessing cultural competence and addressing areas of underperformance.

6.K.2.a. Maintaining Complete and Accurate Information on Enrollees

The first step is to make sure that the organization has accurate and complete information on the race, ethnicity, and language preferences of its members. Having this information allows plan leaders to identify significant gaps between the linguistic and cultural make-up of its members and its provider network and to uncover specific areas where cultural competence may be lacking and/or ethnic and racial minorities are being underserved.

Many health care organizations are required by law to collect information on the race, ethnicity, and language needs of the individuals and populations served or eligible to be served. A handful of states have restrictions on how health plans and other organizations can collect this information. However, these restrictions generally apply to the application process, not to post-enrollment collection of information.

At a minimum, health plans should collect information on race, ethnicity, and preferred language through standard forms filled out by enrollees. These forms should be available in multiple languages and explain why the information is being collected—i.e., to identify and address cultural and linguistic barriers faced by members. Because these standard collection efforts may not yield complete information for all members, health plans can also:

- Pursue more proactive efforts to collect information as part of direct, routine interactions with enrollees.
- Use other sources as well to increase the completeness and accuracy of such information.

An example of a more proactive approach comes from Boston Medical Center's HealthNet Plan, a Medicaid plan that uses both direct and indirect data sources. In addition to gathering information on race, ethnicity, and preferred language through a health needs assessment filled out by members at enrollment, this plan—

- Trains customer service representatives and care managers to ask members to provide missing information during incoming and outbound telephone calls.

- Collects information from Medicaid application forms.
- Has a software program that uses U.S. census data to assess an individual's likely race and ethnicity based on their last name.

This program led to a significant increase in the proportion of members for whom the plan has this information.[145]

6.K.2.b. Building a Provider Network to Meet the Community's Linguistic and Cultural Needs

Once a plan has complete, accurate information on the race, ethnicity, and language preferences of its enrollees, the next step is to build a provider network that fits a similar profile. As part of the Healthcare Effectiveness Data and Information Set (HEDIS), plans routinely report on the number of practitioners and member services staff providing services to Medicaid and Medicare enrollees in languages other than English. They also track and report the availability of language interpretation services provided to Medicaid and Medicare enrollees.

To go beyond tracking, innovative plans put in place programs to match members with providers who can meet their cultural and linguistic preferences and needs. This approach involves systematically gathering and storing relevant information from providers about their cultural and linguistic profile. For example, CIGNA put in place a program to collect cultural and linguistic information from behavioral health practitioners, including gender, age, race/ethnicity, language(s) spoken, sexual orientation, religion, veteran status, substance abuse recovery status, and disabilities. CIGNA staff use a software system to search this information whenever a member requests a provider with particular characteristics, thus facilitating a cultural and linguistic match between provider and patient. Members of the plan can also search a Web-based directory to help them find practitioners that might be a good match. To make this program work, CIGNA actively recruits behavioral health practitioners that reflect the diversity of the local market (as determined by a review of local market characteristics using census and other data). Specific recruiting goals are set by language(s) spoken, racial/ethnic background, and religion.

This program led to a significant increase in the number of behavioral health practitioners with cultural backgrounds commonly requested by members, including African Americans (which rose by 80 percent over a five-year period), Spanish speakers (80 percent), and gays/lesbians (68 percent).

[145] AHRQ Health Care Innovations Exchange. Medicaid Health Plan Increases Collection of Race, Ethnicity, and Language Data by Using Direct and Indirect Sources, Including Genealogy Analyses of U.S. Census Data. Agency for Healthcare Research and Quality. July 2014.

Moreover, CIGNA found that its efforts to increase the diversity of its practitioner pool led to higher levels of satisfaction by members on several measures related to cultural competency, including:

- the percentage of respondents who believe that their practitioner meets their cultural, language, and specialty needs;
- the percentage of minority members expressing satisfaction with access to urgent and routine behavioral health care; and
- the percentage of members believing that their provider always/usually listens carefully.[146]

Health plans can also reward providers for contributing to the linguistic diversity of their networks. Kaiser Permanente Southern California, for example, created a Language Concordance Program that offers financial and other incentives for providers to achieve fluency certification in any of 21 designated languages commonly spoken by members. Physicians who already speak the language receive financial bonuses for passing the fluency certification test while those not yet fluent receive financial support for taking educational classes that help them become fluent. This program increased the number of Spanish-speaking physicians and the proportion of visits where physicians spoke the patient's preferred language (from 24.6 percent in

Health Plan Offers Nurse Advice Line in Spanish

Health plans can also take steps to ensure that their own services address their members' language needs. For example, Molina Healthcare, a Medicaid managed care organization, developed and aggressively marketed a 24-hour bilingual (English and Spanish) nurse advice line to better serve the 45 percent of members who prefer to communicate in Spanish. Eight bilingual registered nurses staff the line, which replaced a traditional advice line where nurses spoke only English. Callers who prefer to speak to someone in a different language can be connected to a separate language line for assistance. The plan also used linguistically appropriate marketing to promote use of the line to Spanish-speaking members.

After Molina introduced its bilingual nurse advice line, calls from Spanish-speaking members increased dramatically, from 2 to 60 percent of all calls.

Source: AHRQ Health Care Innovations Exchange. 24-Hour, Bilingual Nurse Line Provides Advice and Interpreter Services for Plan Members, Leading to Wiser Decisions and Cost Savings. Agency for Healthcare Research and Quality. July 2014.

[146] AHRQ Health Care Innovations Exchange. Insurer's Multifaceted Approach Facilitates Cultural and Linguistic Match Between Patient and Mental Health Provider, Leading to Higher Member Satisfaction. Agency for Healthcare Research and Quality. June 2014.

2008 to 45.0 percent in 2014). It was also associated with improved hypertension control among Spanish-speaking patients.[147]

6.K.2.c. Training Providers on Cultural Competency

Another strategy health plans can use is to sponsor training programs for providers to improve their cultural competency. For example:

- Aetna launched an initiative in 2002 to identify and address health disparities and improve health outcomes for African American and other minority members. Known as *The Racial and Ethnic Equality Initiative*, this program trains Aetna clinical staff and providers on cross-cultural communication (e.g., how to take a patient history, identify cultural issues, and discuss treatment options in a culturally sensitive manner).[148]
- Genesee Health Plan (GHP) partnered with Genesys Health System to develop a health navigator program for low-income residents to help patients adopt healthy behaviors. As part of this initiative, GHP provided cultural sensitivity training to prepare physicians and office staff to care for patients who had been without insurance coverage for many years. Part of the training focused on giving physicians a clear understanding of the social, cultural, and economic barriers this population faces, including multifaceted health needs that in many cases include untreated chronic conditions.[149]

Resources for Training Providers

- AHRQ Health Literacy Universal Precautions Toolkit, Second Edition. December 2015. Agency for Healthcare Research and Quality, Rockville, MD. This guide is targeted at physicians, but could be used by plans when working with providers on cultural competence. Tools 9 and 10 deal with addressing language differences and considering culture, customs, and beliefs.
- Quality Interactions: A Patient-Based Approach to Cross-Cultural Care. Available at www.qualityinteractions.com.

[147] AHRQ Health Care Innovations Exchange. Health Plan's Comprehensive Strategy Involving Physician Incentives and Targeted Recruitment Enhances Patient Access to Language-Concordant Physicians. Agency for Healthcare Research and Quality. August 2014.

[148] AHRQ Health Care Innovations Exchange. Culturally Competent Disease Management Improves Self-Monitoring and Blood Pressure Control in Hypertensive African Americans. Agency for Healthcare Research and Quality. March 2014.

[149] Klein S, McCarthy D. Genesys HealthWorks: Pursuing the Triple Aim Through a Primary Care-Based Delivery System, Integrated Self-Management Support, and Community Partnerships. The Commonwealth Fund. July 2010. Available at http://www.commonwealthfund.org/publications/case-studies/2010/jul/genesys-healthworks.

6.K.2.d. Developing Linguistically and Culturally Appropriate Educational Programs and Materials

To ensure access to information, most health plans recognize that they need to make basic forms and other commonly distributed written materials available to members in multiple languages. This step is particularly important for marketing materials that inform members of interpretation and other services available to those who speak limited or no English.

To maximize the impact of programs targeted at racial and ethnic minorities, plans can also develop written educational materials tailored to the cultural and linguistic needs of the target population. For example, as part of the Aetna program mentioned above, the health plan distributed written materials developed specifically for African Americans with hypertension. These materials included brochures on nutrition that were designed to be specifically relevant to African Americans, including diet and lifestyle tips that were consistent with the health needs and culture of the target population. One outcome of this program was more frequent self-monitoring and better blood pressure control.[150]

The same kind of culturally tailored approach can also be applied to in-person and virtual classes. For example, HealthPartners (an integrated Minnesota system that includes a large health plan) offers a diabetes outreach and educational program targeted to the large Ethiopian community in its market. Group classes are designed and structured in a culturally sensitive and tailored manner, incorporating elements in line with Ethiopian traditions and beliefs, including integration of a traditional meal, storytelling and visual learning, separate classes for men and women, and breaks for Muslim prayer times. Interpreters versed in predominant Ethiopian languages attend each session to provide translation services. Classes also feature culturally sensitive educational handouts that attendees can take home. This diabetes education program led to improved disease control among participants, increased patient engagement, and improved cultural sensitivity among staff.[151]

6.K.2.e. Regularly Assessing Cultural Competence and Addressing Areas of Underperformance

Health plans can conduct regular assessments of how well the plan and its providers are doing in offering culturally competent services. These assessments can be used to identify and address areas of underperformance in a timely and proactive manner.

[150] AHRQ Health Care Innovations Exchange. Culturally Competent Disease Management Improves Self-Monitoring and Blood Pressure Control in Hypertensive African Americans. Agency for Healthcare Research and Quality. March 2014.

[151] AHRQ Health Care Innovations Exchange. Clinics Offer Culturally Tailored Diabetes Education and Culturally Appropriate Care to Ethiopian Patients, Leading to More Engagement, Better Outcomes, and Reduction of Heath Disparities. Agency for Healthcare Research and Quality. January 2014.

Learn About Conducting a Self-Assessment

- Race Matters: Organizational Self-Assessment. The Annie E. Casey Foundation, Baltimore, MD. January 12, 2006. Available at http://www.aecf.org/resources/race-matters-organizational-self-assessment/.
- Cultural Competence Checklists. American Speech-Language-Hearing Association. 2010. Available at http://www.asha.org/practice/multicultural/self/.
- An Ethical Force Program™ Consensus Report. Improving Communication—Improving Care. How health care organizations can ensure effective, patient-centered communication with people from diverse populations. American Medical Association, 2006. Available at https://accrualnet.cancer.gov/sites/accrualnet.cancer.gov/files/conversation_files/pcc-consensus-report.pdf. (The Ethical Force Program™ was a collaborative project led by the Institute for Ethics at the American Medical Association.)

6.K.3. Benefits of These Interventions

In addition to contributing to better health outcomes for enrollees, these interventions can generate significant benefits for health plans:

- **Better information and patient-provider matching**. The strategies have led to more complete and accurate collection of enrollee information, along with an enhanced ability to match enrollees with providers who speak their language and understand their health-related cultural norms.
- **Better communication and overall experience**. An enhanced ability to connect enrollees/patients with providers who speak their language and understand their culture-related health beliefs and norms can lead to improvements in patient-provider communication and the overall experience of enrollees/patients. Studies show that—
    - Patients who have access to language-concordant physicians are more likely to report that their concerns and needs were addressed, more likely to bond with their providers, and more likely to highly rate their health care experience.[152,153]

[152] Ngo-Metzger Q, Sorkin DH, Phillips RS, et al. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007;22(Suppl 2):324-30.

[153] Fernandez A, Schillinger D, Grumbach K, et al. Physician language ability and cultural competence: an exploratory study of communication with Spanish-speaking patients. J Gen Intern Med. 2004;19(2):167-74.

- Education to provider groups that includes sensitivity training on race, ethnicity, culture, and language improves doctor-patient communication.[154]
- Having a more diverse workforce that is culturally competent improves enrollee trust in providers and understanding of health plan services and activities.[155]

[154] Wilkins V, Elliott MN, Richardson A, et al. The association between care experiences and parent ratings of care for different racial, ethnic, and language groups in a Medicaid population. Health Serv Res 2011 Jun;46(3):821-39.

[155] Siminoff LA, Graham GC, Gordon NH. Cancer communication patterns and the influence of patient characteristics: disparities in information-giving and affective behaviors. Patient Educ Couns 2006 Sept;62(3):355-60.

6.L. Planned Visits

6.L.1. The Problem

When patients with chronic illness report that their clinicians do not explain things well, they are often referring to inadequate support for, or training in, self-management of their illness. In many cases, clinical teams are not prepared to provide this kind of information during the patient's visit. Sometimes, the problem is that they are trying to fit it into an acute care visit, whether or not the reason for the visit is related to the chronic illness.[156] A study by RAND found that patients received adequate counseling and teaching (i.e., interventions known to be a "best practice" for certain conditions) only 18 percent of the time.[157]

> *"Too often, caring for chronic illness features an uninformed passive patient, interacting with an unprepared practice team, resulting in frustrating, inadequate encounters."*
>
> Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA 2002;288(14):1775-9.

6.L.2. The Intervention

One antidote to this problem is the planned visit, which is a component of the Chronic Care Model developed by Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation. The purpose of the visit is to ensure that the clinical team reviews the care for each patient with a chronic illness and is proactive in providing the patient with all the elements of evidence-based care for his or her condition, including training in self-management.

These visits are pre-scheduled one-on-one visits, 20 to 40 minutes in length. During the visit, the clinical team and the patient review the patient's progress and work on clinical and self-management topics. A typical visit might cover some challenging aspect of self-management, such as medication adherence. Other health professionals, such as pharmacists, nurses, and nutritionists, may also play a role by identifying appropriate patients, preparing for the visit, or participating with the primary care physician in the visit.

Planned visits can be used for:

- Specialty services
- One-on-one visits with the primary care provider
- Reviews of medications and adherence
- Psychosocial support[158]

[156] Kern, DH and Mainous AG III. Disease management for diabetes among family physicians and general internists: opportunism or planned care? Fam Med 2001;33(8): 621-5.

[157] McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. N Engl J Med 2003;348(26): 2635-45.

[158] Wagner E. System changes and interventions: delivery system design. Improving Chronic Illness Care. IHI National Forum, Orlando, FL; 2001.

6.L.3. Benefits of This Intervention

Because planned visits give clinicians and patients the opportunity to review and strengthen the patient's self-management of his or her chronic illness,[158] they can fill the gap left by acute care visits that—because of their focus on immediate symptoms—frequently allow little time for this kind of interaction.

Effective planned visits can lead to better clinical control of the illness (e.g., improvements in indicators such as blood pressure, cholesterol, HbA1c), reduce symptoms, improve overall health, and increase patients' sense of control over their health by providing them with ways to manage their own illness. They may also lead to fewer acute care visits, reduced costs, and greater patient satisfaction.

There is little literature on the effectiveness of planned visits because they are only one component of the Chronic Care Model. (Read about the chronic care model.) However, more general studies of the effects of follow-up visits for chronic illness found that they improve the management of disease. For example, one study found that children and adolescents with regular follow-up visits for diabetes had better glycemic control, fewer episodes of diabetic ketoacidosis, and reduced likelihood of developing retinopathy compared to children and adolescents with irregular follow up.[159]

6.L.4. Implementation of This Intervention

Based on experience with planned visits that focus on better medication management among patients 75 and older, the Improving Chronic Illness Care program at the Group Health Research Institute recommends the following steps to conducting planned visits:[159]

- Choose a patient population to focus on (e.g., diabetics, asthmatics, heart disease patients).
- Generate a list of patients at particular risk within the group. Patients at risk could include:
    - Those who are not adhering to their medications.
    - Those with clinical evidence of poor disease control.
    - Those who have not received important medications or other services indicated for their condition.
- Call patients and explain the need for a visit.
- Schedule the visit and instruct the patient to bring all medications.
- Prepare for the visit (e.g., attach patient summaries to the front of the chart; to identify the patient's concerns, prepare "Doc Talk" cards as described in "Tools to Help Patients Communicate Their Needs").

[159] Jacobson AM, Hauser ST, Willet J, et al. Consequences of irregular versus continuous medical follow-up in children and adolescents with insulin-dependent diabetes mellitus. J Pediatr 1997;131(5): 727-33.

- Reviews medications prior to the visit. (Physician consults with the pharmacy, if necessary.)
- At the visit:
    - Review the patient's concerns and questions.
    - Review the patient's clinical status and treatment.
    - Review medications; eliminate any unnecessary drugs and adjust remaining medications as necessary.
    - Discuss and resolve adherence issues with patient.
    - Collaboratively develop an action plan that the patient can and will follow.

Learn more in presentations produced by the Improving Chronic Illness Care program

Read More About Planned Visits

- Wagner E. System changes and interventions: Delivery system design. Improving Chronic Illness Care. IHI National Forum, Orlando, FL; 2001.
- Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA 2002;288(14):1775-9.
- Revere D, Dunbar PJ. Review of computer-generated outpatient health behavior interventions: Clinical encounters "in absentia." J Am Med Inform Assoc 2001;8(1):62-79.
- Kern DH, Mainous AG III. Disease management for diabetes among family physicians and general internists: Opportunism or planned care? Fam Med 2001;33(8):621-5.
- McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. N Engl J Med 2003;348(26):2635-45.

6.M. Group Visits

6.M.1. The Problem

Dissatisfaction with how providers communicate can arise when people need more attention, support, and information from the health system than they are getting. But in a typically brief office visit, clinicians do not have the time to cover everything the patient may need to know or to discuss all of their concerns (including problems with self-management.) As a result, the patient may feel that no one is listening or making the effort to explain things clearly. While the patient may be receiving various services, many of his or her needs are being missed.

This problem is particularly common for patients with chronic conditions, who are often struggling to understand how to control and live with their disease. A frequent consequence is that these patients become "high utilizers" of the health care system, particularly of emergency departments and urgent care centers—which tends to make them even less satisfied with their health care experience and more likely to have poor outcomes. These visits occur in part because the system of care does not provide patients with the tools, support, and information they need to manage their health problems adequately.

6.M.2. The Intervention

Group visits are an important component of the Chronic Care Model. In essence, they are a form of outpatient care that combines medical care, patient education, and patient empowerment in a group setting. In a group visit, patients with a common condition (such as diabetes) meet as a group under the guidance of one or more clinicians; participation in this group becomes part of their regular clinical treatment. This model dates back to at least 1990 when John Scott, M.D., of Kaiser Permanente Denver created the Cooperative Health Care Clinic (CHCC) for groups of 25 chronic care patients, 65 and older, who were high users of health care.[160]

6.M.3. Benefits of This Intervention

The benefits associated with group visits include:

- Reduced health care costs
- Greater patient and clinician satisfaction
- Patient empowerment
- Greater patient compliance
- Reduced repeat hospital admissions

[160] Lippman H. Making group visits work. Hippocrates 2000;14(7).

- Fewer emergency room and sub-specialist visits[161]

As a response to increased pressure for clinician productivity, this format can be an efficient way for patients to have face-to-face contact with their provider, get educational content, and learn from the experiences of fellow patients without overly taxing the clinician's time. These groups provide social and psychological support for the participants and help motivate them to follow their treatment plan and to take more responsibility for their own health.[161] The clinician is spared the repetition of delivering the same educational message to multiple patients in traditional one-on-one encounters,[162] while patients get to share valuable information and insights with one another about self-management and quality of life issues.

6.M.4. Implementation of This Intervention

There are several variations of the group visit concept. For example, in the model known as the drop-in group medical appointment (DIGMA), patients need not make prior appointments.[160]

The implementation of group visits is not complex, but it does require advance planning and preparation. A few considerations are worth mentioning:

- First, choose an appropriate condition. Group visits are best suited for chronic illnesses, such as asthma, diabetes, arthritis, and obesity.[162]
- Think carefully about which patients to invite. The goal is to identify patients who seem in need of better care, better advice on self-management, and more support. One way to do this is to focus on high-utilization patients, who can often be identified through pharmacy and billing records.
- Keep the group a manageable size, perhaps 10 to 16 patients.
- Pay attention to who is leading the group visit. Physician-led groups can be more effective at reducing no-shows than groups led by nurses or other mid-level clinicians. Also, it is important to avoid the impression that group visits are a way for physicians to avoid time with the patients.
- Be sure to get the permission of participants to share information about them in the meeting. Also, discuss the confidentiality of personal health information during the meeting itself.

[161] *Group Visit Starter Kit*. Improving Chronic Illness Care (ICIC). 2001 February. Available at http://www.improvingchroniccare.org/index.php?p=Critical_Tools&s=162. Accessed July 11, 2017.

[162] Masley S, Sokoloff J, Hawes C. Planning group visits for high-risk patients. Fam Pract Manag 2000;7(6):33-7.

The meeting might last 2 or more hours and generally follows this format:

- Introductions
- Educational mini-lecture or discussion
- A break during which clinicians conduct clinical work (e.g., review medication refill needs, check blood pressures, and other clinical measures)
- A discussion or question-and-answer period

They often end with clinicians meeting one-on-one with patients who were identified as needing extra follow-up.

Barriers to conducting group visits include privacy concerns, resistance from patients who do not want to participate in a group, and practical issues like adequate meeting space and available personnel. For many practices, the only space large enough to hold a group of people is the waiting room. Some medical groups get around this problem by conducting the group visits in the evenings; other organizations sometimes seek out space in the community that may be more accessible and familiar to their patients.

Learn more about implementing group visits:

- Eisenstat S, Lipps Siegel A, Carlson K, et al. Putting Group Visits Into Practice. John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital. 2012 January. Accessed July 11, 2017.
- Group Visit Starter Kit. Improving Chronic Illness Care. MacColl Center for Health Care Innovation at Group Health Center for Health Studies. 2001 February. Accessed July 11, 2017.

More resources are available in the Improving Chronic Illness Care (ICIC) Resource Library.

6.M.5. The Impact of this Intervention

Evaluations of group visits have found promising results:

- Randomized trials have shown that diabetic patients involved in group visits achieved better HbA1c levels than patients in a control group.[163] Other studies of group education in diabetes have also found that HbA1c levels in the intervention groups were better than those of control groups; they also found evidence of

[163] Trento M, Passera P, Tomalino M, et al. Group visits improve metabolic control in type 2 diabetes: a 2-year follow-up. Diabetes Care 2001;24(6): 995-1000.

improvements in patient self-care and satisfaction,[164] self-efficacy,[165] and body weight and non-fasting triglyceride levels.[166]

- In a study that compared a control group to a group of high users of HMO medical care who participated in group visits (all aged 65 and older with chronic conditions), the findings indicated that those in the intervention group were more satisfied with their care; had lower care costs; and had fewer ER visits, sub-specialist visits, and calls to physicians.

  Nurse contact (phone and in person) was higher among the group visit patients. Also, participating physicians were more satisfied with caring for older patients than comparison physicians who relied on standard one-to-one interactions with their patients.[167]

Read More About Group Visits

- Bronson D, Maxwell R. Shared Medical Appointments: Increasing Patient Access without Increasing Physician Hours. Cleveland Clinic Jour Med 2004;71(5):369-377.
- Houck S, Kilo C, Scott JC. Group Visits 101. Fam Pract Manag 2003 May. Available at http://www.aafp.org/fpm/20030500/66grou.html. Accessed June 2, 2008.
- Lippman H. Making group visits work. Hippocrates 2000;14(7).
- Masley S, Sokoloff J, Hawes C. Planning group visits for high-risk patients. Fam Pract Manag 2000;7(6):33-7.
- Noffsinger EB. *The ABCs of Group Visits: An Implementation Manual for Your Practice*. New York: Springer-Verlag New York. 2013.
- Noffsinger EB. *Running Group Visits in Your Practice*. New York: Springer-Verlag New York. 2009.
- Noffsinger EB. Use of Group Visits in the Treatment of the Chronically Ill. In *Chronic Disease Management*. Nuovo J (Ed.) New York: Springer-Verlag New York. 2007.

[164] Sadur CN, Moline N, Costa M, et al. Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. Diabetes Care 1999;22(12): 2011-7.

[165] Anderson RM, Funnell MM, Butler PM, et al. Patient empowerment. Results of a randomized controlled trial. Diabetes Care 1995;18(7): 943-9.

[166] Kronsbein P, Jörgens V, Mülhauser I, et al. Evaluation of a structured treatment and teaching programme on non-insulin-dependent diabetes. Lancet 1988; 2(8625): 1407-11.

[167] Beck A, Scott J, Williams P, et al. A randomized trial of group outpatient visits for chronically ill older HMO members: The Cooperative Health Care Clinic. J Am Geriatr Soc 1997;45(5):543-9.

6.N. Price Transparency

6.N.1. The Problem

The growth of health care cost-sharing in recent years—through increases in copayments, coinsurance, and deductibles—has made many consumers more concerned about paying for health care services. Yet a lack of usable information often prevents them from factoring in the cost of care when considering various diagnostic and treatment options and/or choosing among health care providers. Many providers do not even know the price of the services they offer (since each insurer has its own negotiated rates), and most do not know the prices of the tests and procedures they recommend and order for their patients.

In the past decade, the development and promotion of usable information about health care costs—generally referred to as price transparency—has emerged as a hot topic in State legislatures and corporate boardrooms.[168] Many States have enacted requirements related to price transparency.[169] At the same time, Federal agencies, private companies, and consumer advocates are pushing for various programs that aim to shed light on the costs of health care services, often as a complement to information already available on the quality of such services.

Many of these stakeholders recognize that the patients are unlikely to "shop" for urgent or emergent care and that they may be less price-sensitive about expensive services such as surgery where the cost exceeds their plan deductible and out-of-pocket maximum. As a result, the demand for price transparency tends to focus on non-urgent, routine procedures; procedures where patients have the time to explore alternatives (e.g., maternity care, elective surgeries); and prescription drugs with wide variations in pricing across providers.[170] Purchasers, policymakers, and consumer advocates share a belief that price-conscious consumers will seek out low-cost, high-quality providers once they are able to identify them and also that price transparency will stimulate providers to compete based on the value of the services they offer.

[168] Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System. Action Brief. Catalyst for Payment Reform. Available at https://www.catalyze.org/product/get-started-intro-transparency.

[169] de Brantes F, Delbanco S. Report Card on State Price Transparency Laws – July 2016. Catalyst for Payment Reform and Health Care Incentives Improvement Institute. Available at https://www.catalyze.org/product/2016-report-card/.

[170] Shaller D, Kanouse D, Schlesinger M. Context-based strategies for engaging consumers with public reports about health care providers. Med Care Res Rev 2014;71(5 Suppl):17S-37S.

Relevant Questions on the CAHPS Health Plan Survey

A few versions of the CAHPS Health Plan Survey include questions about the health plan's efforts to provide members with information about the costs of care. These questions focus on whether members can find out from the plan what they would have to pay for a particular service or product:

- How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?
- How often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

These survey questions about price transparency are part of:

- The CAHPS Health Plan Survey 5.0H – the HEDIS version administered for NCQA accreditation and reporting.
- The Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) – the version used by the Centers for Medicare & Medicaid Services (CMS) to assess members' experiences with the health plans offered through the State Health Insurance Marketplaces.

6.N.2. The Intervention

As a significant step toward greater price transparency for their members, health plans can offer access to searchable information on the costs of health care services on a public Website or through a members-only Website or tool. This approach is intended to help members:

- Anticipate and plan for their share of the costs.
- Consider costs before deciding on a particular service or choosing a specific provider.

Health plans that have implemented this strategy generally report provider-specific information on the average cost for physician services, inpatient and outpatient hospital care, medications, tests, and other common services. That cost reflects what the health plan pays plus the patient's share of the cost, whether as a copayment or coinsurance. Because consumers often equate high prices with high quality—despite no consistent evidence linking the two—this cost information is often paired with provider-specific quality data so that patients are able to find providers offering high-quality, low-cost care.

Sources of Cost Data

In addition to drawing from their own payment data, health plans can use data from external sources. Charge data for providers across the country are available from the Centers for Medicare & Medicaid Services (CMS). CMS publishes the Medicare Provider Utilization and Payment Data, which summarizes utilization and payments for procedures, services, and prescription drugs provided to Medicare beneficiaries by hospitals, physicians, and other suppliers. It includes "list prices" on initial submitted bills and the actual amount paid by Medicare.

Another option for external benchmarks and other data are the all-payer claims databases (APCD) that are being developed in a growing number of States. Learn more from the APCD Council.

For example, Blue Cross Blue Shield of North Carolina (BCBSNC) offers a Health Cost Estimator, a public, Web-based tool that provides cost estimates for health care procedures by individual provider. Based on BCBSNC claims data over a 12-month period, the tool reports the average total costs for the procedure, where total cost includes physician services, facility fees, anesthesia, drugs, and medical supplies. The costs that customers pay in the form of deductibles, copayments, and coinsurance are included in this average. However, the tool does not provide estimates of an individual patient's out-of-pocket (OOP) costs, which vary depending on the member's plan design.

An example of a tool that does offer patients information on their specific OOP costs comes from Geisinger Health System in Pennsylvania. Geisinger's MyEstimate® product offers estimates of patient-specific OOP costs for common ambulatory diagnostic services. By verifying the patient's insurance coverage in advance, the tool can factor in the plan's negotiated rates with the provider, along with the specific provisions for deductibles, coinsurance, copayments, and OOP maximums. The tool also provides information on any pre-authorization or primary care physician referral requirements. Geisinger Health System also provides access to comparative quality information by linking to reports published by The Joint Commission, the Pennsylvania Health Care Cost Containment Council, Pennsylvania Healthcare Alliance, and Geisinger Health Plan.[171]

[171] Geisinger's MyEstmate®: Examples of Price Transparency Tools. Healthcare Financial Management Association. Available at http://www.hfma.org/Content.aspx?id=22297.

Sharing Explanation of Benefits Online

In addition to providing cost information before services are provided, health plans can help members better understand the costs of care by revamping how they deliver the Explanation of Benefits (EOB) that is provided to members after they receive services. For each service, the EOB indicates the provider's charge, the plan's contracted "allowed amount" for that service, the amount the plan reimbursed the provider, and any non-covered charges.

One idea is to use the EOB to educate members about prices after the fact so as to make them more price conscious in the future. To that end, plans offer secure Web-based portals where members log in to see not only their personal health records, but also a list of all charges associated with the medical services they have received. In addition to sending the EOB in the mail, plans send notifications to members whenever a new EOB is ready for review online. The portal can also show the current status of any individual or family deductibles under the plan.

6.N.3. Benefits of This Intervention

By promoting price and quality transparency, health plans have the potential to support more cost-effective use of health care services by both patients and providers. Several studies have documented the impact of these programs. For example:

- Whaley and colleagues evaluated the impact of a Web-based price transparency tool that gave insured employees and their spouses and dependents access to estimated OOP costs for various procedures and office visits. Conducted between 2010 and 2013 with 18 self-insured employers, the study found that use of the tool was associated with lower total claims payments for common medical services, with the reductions being largest for advanced imaging services and smallest for office visits.[172]
- Wu and colleagues assessed the impact of a program in which insurers provided price information for elective advanced imaging procedures. They found that patients who could review information on price differences among MRI facilities and were able to choose different providers selected lower-priced providers. The study evaluated patients having at least one outpatient magnetic resonance imaging (MRI) scan in 2010 or 2012, comparing those enrolled in health plans that offered the program to enrollees of plans in similar geographic regions that did not. Providing cost information led to a $220 reduction in costs per test (18.7 percent) and to reduced use of hospital-based facilities (from 53 percent in 2010

[172] Whaley C, Schneider Chafen J, Pinkard S, et al. Association between availability of health service prices and payments for these services. JAMA 2014;312(16):1670-6. Available at http://jama.jamanetwork.com/article.aspx?articleid=1917438.

to 45 percent in 2012). The average cost of an MRI fell by $95 in places where prices were available, while it increased by $124 in areas where they were not.[173]

State Laws on Price Transparency

The National Conference of State Legislatures tracks State laws related to price transparency along with other initiatives that promote greater price transparency: Transparency and Disclosure of Health Costs and Provider Payments: State Actions.

The site provides access to the following:

- A summary of State legislation on pricing transparency and the disclosure of information on health costs.
- Examples of State websites that provide information on the price of health services.

[173] Wu SJ, Sylwestrzak G, Shah C, DeVries A. Price transparency for MRIs increased use of less costly providers and triggered provider competition. Health Aff 2014 Aug;33(8):1391-8.

6.P. Service Recovery Programs

6.P.1. The Problem

No matter how well you manage the customer service at your organization, problems are inevitable. Some may be serious, some may be minor, but they all play a role in shaping the member's or patient's perceptions of the organization and its responsiveness to their needs. Marketing researchers have found that the most satisfied customers are ones that have never experienced a serious problem or product defect. The next most satisfied customers are those who have experienced service difficulties—sometimes significant ones—that have been redressed by the organization. The least satisfied customers are those whose problems remain unsolved.

"When it comes to service recovery, there are three rules to keep in mind:
1. Do it right the first time.
2. Fix it properly if it ever fails.
3. Remember: There are no third chances."

Berry L. *Discovering the soul of service: The nine drivers of sustainable business success*. New York: Free Press; 1999.

For health plans, the number of people with outstanding customer service problems can be significant. In 2017, approximately 18% of members of Medicaid health plans and 13% of members of Medicare health plans reported "never" or "sometimes" when asked whether the plan's customer service gave them the information or help they needed.[174]

Most health plans and physician practices have some sense of the cost of replacing a lost member or patient. But many are not aware of how powerfully the "grapevine effect" can affect their reputations. Several marketing studies have confirmed that only 50 percent of unhappy customers will complain to the service organization, but 96 percent will tell at least nine or ten of their friends about their bad experience.

The "grapevine effect" can become an even more powerful force when your members and patients take advantage of the Internet to voice their complaints. Many Internet sites allow patients to evaluate their experiences with a doctor, group, or plan and post written comments online. Several health plans also publish ratings of patient experience as part of their online provider directories, and a few are starting to include anecdotal reports as well. Consider the influence that consumer ratings have on restaurants, books, and other products.

In the same way that it can be helpful to remember that some problems or difficulties will always be with us, it is important to acknowledge that complaints are inevitable. Health care organizations are caring for people who are almost always anxious and afraid, so the stakes are higher. What differentiates member- or patient-focused

[174] Results by Enrollee Population. Content last reviewed October 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/cahps/cahps-database/comparative-data/2017-health-plan-chartbook/results-enrollee-population.html. Accessed on November 2, 2017.

organizations from others is whether and how they handle these incidents to ensure that unhappy members or patients feel like their concerns have been addressed and that the organization values them.

6.P.2. The Intervention

Service recovery is the process used to "recover" dissatisfied or lost members or patients by identifying and fixing the problem or making amends for the failure in customer or clinical service. Excellent service recovery programs are an effective tool for retaining members or patients and improving their level of satisfaction. Good service recovery programs can turn frustrated, disgruntled, or even furious patients or members into loyal ones.

Service recovery is about restoring trust and confidence in your ability as an organization to "get it right." When members or patients repeatedly experience breakdowns in service, they begin to lose confidence in the care they receive. If you cannot get the small things right, how can they trust that you will do well with the complicated processes required to deliver high-quality care?

6.P.3. Implementing This Intervention

National experts in service recovery recommend a well-tested process for service recovery. This 6-step process details how to handle a range of problems from the mildly irritated to the malpractice case in the making.

1. Apologize/acknowledge.
2. Listen, empathize, and ask open questions.
3. Fix the problem quickly and fairly.
4. Offer atonement.
5. Follow up.
6. Remember your promises.

Service recovery can range from listening to an upset patient to giving free parking to patients who have to wait more than a specified time for their doctor visit. It can also mean providing solutions or making amends for problems that the patient created. Making sure that someone gets to see a doctor when they show up on the wrong day is an example of the kind of customer service patients never forget. Service recovery programs ensure that patients never hear, "I can't help you with this. It's against our policy."

According to Dr. Wendy Leebov, a national expert on service recovery in health care, service recovery is everybody's job. When people complain, they usually address those complaints to front-line staff—but these staff do not necessarily have the skills or the resources to fix "system issues" that are often the source of the problem. Managers and the executive leaders have responsibility for redesigning dysfunctional work processes and systems, or reassigning staff if needed.

Dr. Leebov suggests that the following five components must be in place to handle customer complaints and consistently impress your members and patients:

- Effective systems for inviting/encouraging customers to complain.
- Guidelines for staff and latitude to act and atone. (See the box at right.)
- Documentation and a feedback loop that channels problems revealed through service recovery into an improvement or problem elimination process.
- Clear protocols for handling customer complaints effectively.
- Staff skilled in service recovery: aware of protocols and able to listen non-defensively, empathize, handle emotion, solve problems, and follow through to closure. Read the axioms of service recovery in the box below for an overview of what employees need to understand about complaints and service recovery.

Learn more about the components of service recovery in Leebov W, Afriat S, Presha J. *Service savvy health care: One goal at a time*. Lincoln: Authors Choice Press; 2007.

Guidelines for Staff and Latitude to Act and Atone

Staff need to have the authority to make decisions about handling complaints autonomously so they can act quickly. Specifically, they need:

- Clarity about the extent of their authority to act on complaints without getting approval from managers.
- Defined courses of actions for most frequent complaints.
- Minimal red tape.
- A clear system of resource people, clear authority lines, and backup systems for dealing with difficult situations or those with financial, legal, or ethical implications.

The Axioms of Service Recovery

When problems with service do occur—and they will—your organization has to be prepared with a service recovery program that is designed to turn a disgruntled patient or member into a happy, loyal one. Based on previous work in this area, researchers have developed what they term the "axioms of service recovery."[1] The more your staff understand these axioms, the easier it will be for them to respond effortlessly and appropriately to service problems when they arise.

Axiom 1: All customers have basic expectations.

Researchers have found that these five categories of customer expectations account for 80 percent of the differences between high and low customer satisfaction.[2]

These factors are as follows:

- **Reliability** signals organizational competence and promotes confidence and trust in the organization or clinician. It is the most important of the five.
- **Assurance** involves reassurance that everything is going as it should or, if it isn't, that something will be done to remedy the problem quickly.
- **Tangibles** are the visible, concrete signs that influence the other expectations. When the furnace repair person shows up with dirty hands, no one is surprised. When the doctor walks in the room with a filthy white coat and dirty hands, something else is communicated quickly and convincingly to the patient. Old magazines in the waiting room, dirty bathrooms, and chaotic registration areas all suggest that an organization is not under control.
- **Empathy** conveys that you are listening and concerned about the experiences and care of your members and patients. When something happens to disrupt trust, reconnecting with the patient or member in a personal way that conveys you understand is critical to the service recovery process.
- **Responsiveness** refers to the expectation that things should happen in a timely fashion and that people should be kept informed about where they are in the process. The opposite of responsiveness is indifference and lack of communication. Solutions to problems need to be timely and responsive to the person's need.

(continued on next page)

[1] Zemke R, Bell CR. *Knock your socks off service recovery*. New York: American Management Association; 2000.
[2] Berry L, Zeithaml V, Parasuraman A. *Five imperatives for improving service quality*. Sloan Management Review 1990 Summer: 29-38.

The Axioms of Service Recovery (*continued*)

Axiom 2: Successful recovery is psychological as well as physical.

Perhaps the most important step in the recovery process is listening to the person and letting them vent their frustration and blow off steam. Letting the person tell their story and describe the impact of the failure is essential.

Axiom 3: Work in a spirit of partnership.

Involve the person in helping to solve the problem. However, this does not mean that the first question should be, "So what do you want me to do about it?" Work cooperatively to come up with a solution that makes the person feel like part of the problem solving and that acknowledges his or her needs.

Axiom 4: Customers react more strongly to "fairness mistakes" than "honest mistakes."

Research on service recovery indicates that the only effective solution when a person feels like they have been unfairly treated is extreme apology and atonement. When a situation like this occurs, the patient or member is a prime candidate for overt retaliation.[3] Communication about what went wrong and compensation or atonement are essential in these situations. From the patient safety movement, we know that a critical component of resolution in these kinds of situations is letting the person know that you and your organization will make sure this never happens to the patient or anyone else again.

Axiom 5: Effective recovery is a planned process.

In health care, certain problems are highly predictable. Surgeons get delayed in the operating room, flu season packs the appointment schedule, implementing a new call center system inevitably causes service glitches—but we often act like these problems are a surprise. Preparing your staff with solutions for predictable problems and teaching them how to offer and implement these solutions is essential. Even though you may have planned solutions in place, they must be offered in a very customer-sensitive way so that you do not leave people with the impression that the problem is common or your staff behave like robots.

Think about how you could translate these principles into planned protocols for the common problems your patients and members experience.

[3] Seiders K, Berry L. *Service fairness: What it is and why it matters. Academy of Management Executive* 1990;12(2):8-20.

Adapted with permission from: Zemke R, Bell CR. Knock Your Socks Off Service Recovery. New York: American Management Association; 2000.

Complaint management is also an important aspect of service recovery. Complaints can be a useful source of information about the organization; improvements in customer service depend on the organization's ability to elicit and monitor customers' complaints. In particular, service recovery cannot take place if the provider does not know that the member or patient is unhappy. Many people would rather "switch than fight," especially in a health care environment, where people fear that complaining could jeopardize the quality of the clinical care they receive. Also, minorities and people from underserved communities tend to avoid complaining, even though they may have significant problems with the delivery of care.[175, 176]

Health care organizations that are truly committed to improving the member's or patient's experience of care can make this commitment obvious to their staff and their members by encouraging complaints and offering members and patients multiple ways to give you feedback and help you improve your service. If you make it hard for members or patients to complain, you will continue to miss important service failures that shape your reputation in the community and the quality of care. There are many tools for cataloguing patient or member complaints that allow you to track the problems by CAHPS composite or other typologies that support linking the qualitative complaints to improvement activities.

As indicated in the table below about complaint management, good service recovery programs go beyond the "quick fix." They include a process for tracking problems and complaints to help identify the source of the problem so the right improvement can be put into place. Some complaints arise from experiences with a specific person in the service process, which reflects a training problem, while others are the result of system problems that require a totally different process to resolve. The tactic of assigning complaint letters received by the CEO to middle managers for resolution as if they all reflect a one-time event or an employee that needs disciplinary action is outdated, and will never result in permanent solutions to long-term problems. Many staff know immediately which situations or patients will end up in the CEO's office. Organizations with good customer service and service recovery programs are proactive and let the CEO, clinic manager, or chief medical officer know about these situations right away so that the person can be contacted *before* they have the time to file a formal complaint.

[175] Schneider EC, Zaslavsky AM, Landon BE, et al. National quality monitoring of Medicare health plans: the relationship between enrollees' reports and the quality of clinical care. Med Care 2001;39(12): 1313-25.

[176] Zaslavsky AM, Zaborski LB, Cleary PD. Factors affecting response rates to the Consumer Assessment of Health Plans Study survey. Med Care 2002;40(6): 485-99.

Learn more about complaint management in the table below.

Table 6P-1. How To Use Complaint Management as an Effective Service Recovery Tool

Complaint Management Process Step	Actions to Take
1. Encourage use of complaints as a QI tool	• Let your staff know that complaints are valued and essential for QI. • Display complaints in public areas to reinforce the value you place on them. • Make it easy for customers and staff to complain.
2. Establish a team of people to respond to complaints	• Include in the team people from the front lines as well as senior management. • Use this team to develop planned protocols for service recovery for your most common service failures.
3. Resolve customer problems quickly and effectively	• Commit the organization to resolving complaints quickly to avoid the waste of repeated contacts. • Train and empower frontline employees to resolve problems and give them the authority to fix problems on the spot.
4. Develop a complaint database	• Develop a computerized database that catalogs complaints by CAHPS composite or question. • Use the database to identify trends and generate regular reports to staff and management.
5. Commit to identifying failure points in the system	• Using complaint data, identify failure points that are root causes of low satisfaction. • Be proactive, not reactive; try to anticipate negative situations from occurring in the first place.
6. Track trends and use information to improve service processes	• Stop handling problems one at a time as if they have never occurred before.

Adapted from Bendall-Lyon D, Powers TL. The role of complaint management in the service recovery process. *Jt Comm J Qual Improv* 2001 May;27(5):278-86.

6.P.4. The Impact of Service Recovery Programs

Studies indicate that when customers' problems have been satisfactorily handled and resolved, their loyalty and plans to use the services again were within a few percentage points of those who had not experienced a problem.[177]

In other service industries, service recovery has proven to be cost-effective. Also, retention benefits the bottom line: Because of their word-of-mouth referrals and willingness to purchase ongoing services and premium products, customers retained over five years can be up to 377 more profitable than a "revolving door" customer who uses your services once.[178]

Read More About Service Recovery

- Berry L. Discovering the soul of service: The nine drivers of sustainable business success. New York: Free Press; 1999.
- Schweikhart SB, Strasser S, Kennedy MR. Service recovery in health services organizations. Hosp Health Serv Adm 1993 Spring;38(1):3-21.
- Zemke R, Bell C. Knock your socks off service recovery. New York: American Management Association; 2000.

[177] Goodman J, Malech A. Don't fix the product, fix the customer. *The Quality Review* 1988 Fall: 8-11.

[178] Reichheld F, Sasser E. Zero defections: Quality comes to service. *Harv Bus Rev* 1990 September-October;105.

6.Q. Standards for Customer Service

6.Q.1. The Problem

Achieving high levels of member satisfaction requires two ingredients:

- A deep knowledge of what constitutes high-quality service from the perspective of your members and patients.
- Service standards that clearly tell your staff what is expected of them in their interactions with members and patients.

However, while most of the accrediting organizations require such standards in their regulations, most health care organizations do not have a well-defined process for developing effective standards. One barrier is that setting standards takes time, although experts in this area argue that the absence of standards necessitates spending time on far more unpleasant activities, such as responding to complaints and managing unsatisfactory staff behavior.

Another problem with developing standards is that some of the behaviors are hard to describe. It can be challenging to describe what good and excellent service look like. Setting standards is also fundamentally about being accountable to high standards of service on a daily basis. That is a challenge in health care systems that are often deeply grounded in a culture of professional autonomy.

6.Q.2. The Intervention

Customer service standards are already embedded in many of the CAHPS survey questions. These questions were selected because they measure processes of care that patients and members use to define a "quality experience." However, that does not mean it will be easy to translate the questions into standards that your staff can measure and evaluate.

In some respects, standards are similar to "service guarantees"—a concept that frightens many health care employees because they do not trust that the systems they need to meet "guarantees" are in place. Organizations that maintain their focus on service often find that the standards evolve over time. As the organization gets better and better at meeting the needs of its patients, the staff are willing to raise the standards they commit to and trust that they will be able to deliver.

Examples of standards that some plans or groups have implemented include the following:

- 90 percent of patients who call for an appointment will receive one for the same day.
- Patients will wait 10 minutes or less in the reception area before being placed in an exam room.
- All telephone calls will be answered within three rings.

- All test results will be communicated in writing to the patient after an ambulatory care visit.

The box below provides an example of service standards for a pharmacy.

Example of Service Standards for a Pharmacy Department: Kaiser Permanente, Washington DC

Our department will abide by the following standards to guarantee caring and quality service is provided to our members and in-house customers.

Service Standards for our Members

- We will greet our members in a courteous and professional manner.
- We will listen effectively to our members' requests and promptly take the necessary actions to assist them.
- We will keep our members informed of unexpected delays in service.
- We will not engage in personal conversations while providing service to our members.
- We will call our members by name and will verify identity by means of address and/or ID card.
- We will inform our members of specific departmental procedures (e.g., refill line, last refill, mail order) to help them maximize pharmacy services.
- We will finish our encounters with our members in a courteous and professional way.
- We will respect our members' privacy and will not discuss member-related information in public.

Service Standards for our In-House Customers

- We will interact with our co-workers and company staff in a courteous and professional way.
- We will not discuss staff, organizational policies, problems, or medical care in public areas.
- We will be considerate, and we will cooperate and assist co-workers, staff, and other departments to guarantee quality service.

Telephone Etiquette

- We will answer the phone within four rings.
- We will provide our center location, our name, and our department and politely ask: "How may I help you?"
- We will listen to the caller's request and assist accordingly.
- We will direct the call to the person, department, or service needed to assist the caller.
- We will obtain the caller's permission before placing the caller on hold.
- We will end the call in a courteous and professional way.
- We will omit personal phone calls while on duty.

Leebov et al. describe a step-by step process to help set standards that everyone can abide by.[179] The steps are as follows:

- Work with staff and managers to resolve any mixed feelings or uncertainty about setting high standards and holding staff accountable.
- Help your team commit to aiming high and setting ambitious goals.
- Engage your customers and staff in identifying basic service behaviors that reflect impressive customer service.
- Use these guidelines to identify job-specific behaviors.
- Crystallize these behaviors into scripts and protocols. (Read about the use of talking points in the box below.)
- Design and institute measurable service standards that you expect your people to meet regularly.
- Set service targets—stretch goals—that will have a significant impact on customer satisfaction and that can become standards.
- Monitor performance.
- Hold yourself and your team accountable.

Although this process may require a big change in an organization's culture, it is very valuable. Without these kinds of standards in place, most organizations cannot sustain a meaningful focus on patient-centered improvements.

Learn more at: Leebov W, Scott G, Olson L. *Achieving impressive customer service: 7 strategies for the health care manager*. San Francisco: CreateSpace Independent Publishing Platform; 2012.

[179] Leebov W, Scott G, Olson L. *Achieving impressive customer service: 7 strategies for healthcare managers*. San Francisco: CreateSpace Independent Publishing Platform; 2012.

Incorporating "Talking Points" Into Everyday Interactions

Talking points or scripts ensure that everyone in the organization is delivering a positive message in a consistent way to your members and patients. These messages make sure that you are meeting your service standards and build these behaviors into predictable, daily routines. Work with your staff to develop the talking points and to help them understand that scripts are not intended to turn your staff into robots. Rather, they are reminders of the minimum that staff can do to create a positive experience for members and patients.

Once people become familiar with the design and intent of talking points, they often realize how helpful they are when dealing with frightened or upset patients. Simply put, scripting:

- Conveys the message of your culture: "This is how we do business around here."
- Puts words to your behaviors.
- Sets clear expectations for what is supposed to happen in encounters.

Here are some examples of how scripts can help to change communications:

Instead of…	***Say…***
"No, I don't have the time."	"Yes! I can help you in five minutes."
"We're short-staffed."	"We may be busy, but we're never too busy to help you!"
"I don't know."	"I think I can help you find the answer."
"It's the doctor's fault and I can't believe that happened."	"I'm sorry that happened. What can I do to help?"

Adapted from Best Practice Series: Scripting, Baptist Healthcare Leadership Institute; 2003.

Other examples of common and powerful talking points are:

- "How can I help you? I have the time."
- "How can I make this better for you?"
- "I'd like you to meet (Jane Doe), your doctor, nurse, etc. She will take excellent care of you."

When staff are resistant to using scripting, remind them that their personalities will always come through, yet they will be delivering a consistent message that reflects your organization's high standards. Reward employees who use scripting effectively and make it easy for people to remember the most common and important messages by putting them on the back of name badges or other convenient places.

Learn more: Best Practice Series: Scripting. Pensacola, FL: Baptist Healthcare Leadership Institute; 2003.

6.Q.3. Case Study

Based on an analysis of CAHPS data as well as other data, Harvard Pilgrim Health Care designed a set of interventions aimed at improving telephone access as measured by Average Speed to Answer (ASA) and Call Abandonment Rates. Some of the interventions also improved the consistency, clarity, and timeliness of responses to member inquiries and the availability of written member materials.

The plan implemented two types of interventions.

Interventions aimed at increasing self-service options for members:
The purpose of these interventions was to improve access and reduce call volume to Customer Service Representatives.

- Installed an Interactive Voice Response (IVR) system to enable members to get quick answers to the most frequently asked questions and to place the most common requests (e.g., new identification (ID) card, change of address, change of primary care provider (PCP)) without the intervention of a service rep. This system operates all day, every day. Through focus groups, members helped to design the IVR, which has been evaluated and fine-tuned over time.
- Installed an after-hours voice-mailbox so that members could leave an inquiry in the evening or over a weekend and receive a call back from a Customer Service Representative in the morning of the following business day.
- Developed and implemented Web-based FAQ (frequently asked questions) materials, downloadable member materials (e.g., benefit plan descriptions), online service requests (new ID cards, address and PCP changes), and email inquiries. The materials and requests are available around the clock, with service and inquiry responses within 24 hours.
- Developed a broader range of self-service options (e.g., change own address or PCP, see claims status, view prescription history, etc.).
- Implemented financial incentive program for Customer Service Representatives to promote the self-service options to members.

Interventions aimed at increasing the efficiency and responsiveness of Customer Service Representatives:

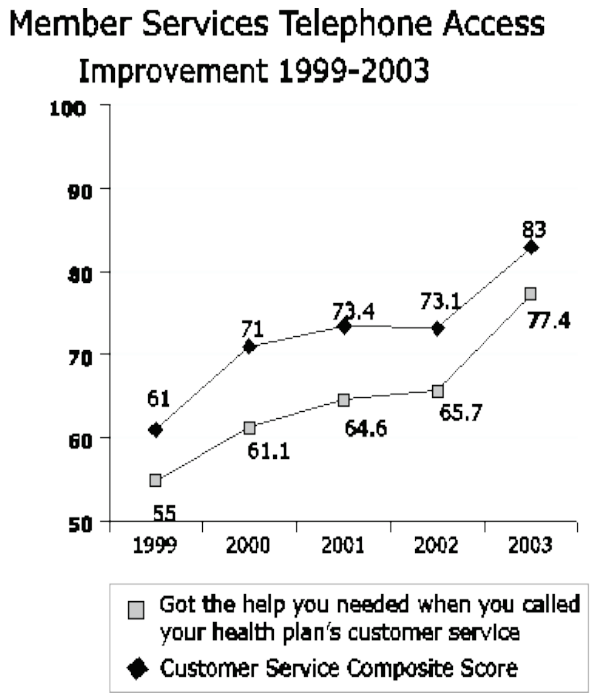
- Simplified and standardized product offerings and benefit policies.
- Installed an intranet-based reference system for service representatives to assure quick and consistent responses to member inquiries: fine-tuned it over time to provide quick links to frequently viewed pages.
- Increased manager and staff training and improved and streamlined staff resource materials.

- Improved internal communication and workflow between Customer Service and Claims departments to resolve members' inquiries about claims.
- Expanded hours of operation to 7:30 PM on Mondays and Wednesdays (peak volume days).
- Implemented a series of performance incentive programs for Customer Service Representatives that were tied to the goals of reducing ASA and Call Abandonment Rates.

Table 6Q-1. Results of Interventions at Harvard Pilgrim: *Performance on Internal Metrics*

	Current Goal	Q4 2000	Q4 2001	Q4 2002
Average Speed to Answer	30 seconds or less	67 seconds	47 seconds	28 seconds
Call Abandonment Rate	3% or less	5.6%	2.8%	1.5%

Figure 6Q-1. Results of Interventions at Harvard Pilgrim: *Performance on CAHPS Measures*



CAHPS Item (from Health Plan Survey 3.0): In the last 12 months, how much of a problem was it to get the help you needed when you called your health plan's customer service?

6.R. Reminder Systems for Immunizations and Preventive Services

6.R.1. The Problem

Many patients do not receive important immunizations and other preventive services and advice because they do not know to see their clinical team for these services, they forget to make appointments, and they miss scheduled appointments. One study of family practice clinics found that the rate of missed appointments ranged widely, from close to zero to more than 50 percent.[180]

The impact can be significant. Missed appointments contribute to discontinuity of care, reduce care opportunities for other patients, disrupt the patient-provider relationship, and add to health care costs.

The fact that vaccination rates for adults and children are below optimal levels supports this finding. According to the National Center for Health Statistics, in 2013:

- Less than 68 percent of adults 65 and over had had the influenza vaccine
- Less than 60 percent of adults 65 and over had been vaccinated against pneumonia.
- Only 70 percent of children aged 19-35 months had completed the full series of childhood vaccinations.[181]

Two common reasons for missed vaccinations are forgetting appointments and in the case of children, parents not knowing their child's immunization schedule.[182]

6.R.2. The Intervention

There are two useful strategies for tackling this problem:

- Reminder Systems for Patients
- Reminder Systems for Physicians

6.R.2.a. Reminder Systems for Patients

One way to tackle the inadequate delivery of preventive services is to institute reminder and recall systems for patients. Reminder systems notify patients a few days before their scheduled appointment, while recall systems contact patients who have missed appointments and encourage them to reschedule.

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[180] Hixon AL, Chapman RW, Nuovo J. Failure to keep clinic appointments: Implications for residency education and productivity. *Fam Med* 1999;31(9):627-30.

[181] National Center for Health Statistics. Health, United States, 2014. *With Special Feature on Adults Aged 55-64*. Hyattsville, MD: 2015. Available at http://www.cdc.gov/nchs/data/hus/hus14.pdf. Accessed on August 4, 2015.

[182] Alemi F, Alemagno SA, Goldhagen J, et al. Computer reminders improve on-time immunization rates. *Med Care* 1996;34(10 Suppl):OS45-51.

The benefits of reminder and recall systems include improved immunization rates, fewer missed appointments (no-shows), and more preventive care visits. The higher levels of preventive services are likely to reduce morbidity and mortality from preventable diseases. Also, as more patients come for their allotted appointments, the practice can increase its visit capacity and reduce its costs, particularly those associated with the inefficient use of clinician and staff time when slots are wasted.

Reminder systems have been in use for several decades, and except for the more sophisticated computerized phone reminder systems, are not complex either to initiate or to operate. Reminder and recall systems can work through a variety of mechanisms meant to prompt the patient, including phone calls (by clinic staff, by computer, through patient portals, or through centralized programs), e-mail, text, letters, and postcards.

Systems to reduce no-shows employ some additional techniques, including:

- Reducing perceived barriers (e.g., providing transportation)
- Providing information (such as pamphlets or videos) on the importance of regular preventive and health maintenance visits[183]

Reminder, Recall, and Outreach (RRO) programs are a more resource-intensive version of these systems and have been used effectively to improve immunization rates for hard-to-reach populations, such as inner-city minority children.[184]

The Costs of Patient Reminder Systems

Barriers to implementation include cost and lack of information about the variety of systems. Costs for immunization reminder programs vary widely; for example, the cost per additional child vaccinated ranges from $7 to $63. Studies have found that a letter reminder system can cost $10.50 per fully vaccinated child, whereas a comprehensive program of reminders and community outreach can cost $63 per child per year, with an estimated cost effectiveness of $316 per year per fully vaccinated child.[184]

The Impact of Patient Reminder Systems

Reminder and recall systems are effective at improving immunization rates in adults and children.[184] They also reduce the no-show rate for preventive services. Increases to immunization rates ranged from 5 to 20 percent in intervention groups compared to control groups. Effectiveness was shown for adult pneumococcus, tetanus, and influenza vaccines and for childhood vaccines, including the influenza vaccine. While all types of reminder systems were effective, telephone reminders were the most effective.

[183] Macharia WM, Leon G, Rowe BH, et al. An overview of interventions to improve compliance with appointment keeping for medical services. *JAMA* 1992;267(13):1813-7.

[184] Szilagyi PG, Bordley C, Vann JC, et al. Effect of patient reminder/recall interventions on immunization rates: A review. *JAMA* 2000;284(14):1820-7.

A review of studies of appointment reminder systems also found that they resulted in improvements.[183] The rates of kept appointments increased an average of:

- 40 percent for patient contracts.
- 120 percent for letters.
- 190 percent for phone calls and for orientation/information programs (e.g., videos and pamphlets).
- 660 percent for phone reminders for psychosocial appointments.

In a study comparing the effectiveness of different approaches to improve immunization and screening, patient reminder systems were the fifth most effective method, with an average improvement of 150 percent compared to control groups.[185] More effective were organizational change, provider reminders (see discussion below), patient financial incentives, and provider education. Less effective (but still more effective than no intervention) were patient education, provider financial incentives, and provider feedback.

6.R.2.b. Reminder Systems for Physicians

While physicians generally agree with preventive measures and guidelines, there is substantial evidence that physician compliance with such preventive measures is well below optimal.[186] Since most patient encounters revolve around treating acute illnesses and alleviating symptoms, preventive measures are often overlooked.[187] One way to improve compliance with such secondary tasks is to provide physicians with organized and processed data at key times.

Among physician reminders, the most prominent is the concurrent report, which offers the benefit of timeliness—i.e., it provides information to a physician at a time when she can act on it.[188] Such reports are commonly in the form of a computer-generated printout of suggested preventive procedures that is attached to the front of a patient's chart. A common computer reminder system reviews the records of patients coming for scheduled appointments and prints out the necessary procedures and tests in the "orders" section of the encounter form.[187]

[185] Stone EG, Morton SC, Hulscher ME, et al. Interventions that increase use of adult immunization and cancer screening services: a meta-analysis. *Ann Intern Med* 2002;136(9):641-51.

[186] Shea S, DuMouchel W, Bahamonde L. A meta-analysis of 16 randomized controlled trials to evaluate computer- based clinical reminder systems for preventive care in the ambulatory setting. *J Am Med Inform Assoc* 1996;3(6):399-409.

[187] Litzelman DK, Dittus RS, Miller ME, et al. Requiring physicians to respond to computerized reminders improves their compliance with preventive care protocols. *J Gen Intern Med* 1993;8(6):311-7.

[188] Murrey K O, Gottlieb KL, Schoenbaum SC. Implementing clinical guidelines: A quality management approach to reminder systems. *QRB Qual Rev Bull* 1992;18(12):423-33.

Other concurrent formats include tagged notes, stickers in patient charts, and cards given to patients to help them prompt physicians.[189] The type or location of the prompt does not seem to matter; that is, reminders at a variety of places in the medical chart (e.g., tagged progress note, computer monitor display) are equally as effective as a printout at the front of the patient medical record. All achieve 12 to 14 percent improvement.[189]

Other categories of reminders include:

- Intervisit reminders (i.e., a reminder sent to the physician after a visit when something is overdue)
- Registry reminders (e.g., an inter-visit reminder for a specific patient group, such as those with chronic condition)[188]

Implementation of Physician Reminder Systems

Prior to implementing physician reminder systems, the health care organization should address the following questions:

- Do the affected physicians believe that the services they are being reminded about are important?
- Do the physicians agree on the best approach to these issues?
- Do they agree on which steps of the process need the most support?
- Does the reminder system meet physicians' needs while also incorporating safeguards against process failures?

Failure to consider these questions is likely to undermine the success of the reminder system. It is important to note that significant rates of non-compliance with preventive procedures may indicate that there are fundamental problems with the underlying systems, which should be addressed before reminder systems are attempted.[188]

The Impact of Physician Reminder Systems

There is strong evidence from meta-analytic studies that physician reminder systems for preventive care are effective at increasing preventive procedures:[186, 189]

- Balas et al. reviewed 33 controlled studies and found that reminder systems led to an average improvement in six preventive procedures of 13 percent, ranging from 5.8 percent for Pap smear to 17.2 percent for pneumococcal vaccination. (The other four procedures were fecal occult blood test, mammogram, influenza vaccination, and tetanus vaccination.) Extrapolating these results nationwide, the researchers estimated that reminder systems could save 8,333 lives per year.[189]

[189] Balas E A, Weingarten S, Garb CT, et al. Improving preventive care by prompting physicians. *Arch Intern Med* 2000;160(3):301-8.

- Shea et al. reviewed 16 randomized controlled trials and found, for six preventive practices, an overall 77 percent increase in procedures when computerized reminder systems were used.[186]
- Litzelman et al. found a 19 percent relative difference in physician compliance with reminders on three procedures when physicians were required to actively respond to a prompt by indicating the action taken, compared to a reminder that required no active response.[187]

Read More About Reminder Systems

- American Academy of Pediatrics. AAP Immunization Resources: Immunization Reminder & Recall Systems. Updated May 2014. Accessed on November 2, 2017.
- Community Preventive Services Task Force. Guide to Community Preventive Services. Increasing cancer screening: provider reminder and recall systems. Updated February 2006. Available at https://www.thecommunityguide.org/topic/cancer Accessed on November 2, 2017.
- Community Preventive Services Task Force. Vaccination Programs: Client Reminder and Recall Systems. The Community Guide. Updated July 2015. Accessed on November 2, 2017.
- Reminder Systems and Strategies for Increasing Vaccination Rates. Centers for Disease Control and Prevention. Updated April 14, 2017. Accessed on November 2, 2017.
- Arditi C, Rège-Walther M, Wyatt JC, et al. Computer-generated reminders delivered on paper to healthcare professionals: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2012(12):CD001175.