California HealthCare Foundation

Patient Experience in California Ambulatory Care

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by

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About the Foundation

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Contents

I. Introduction and Background

During the past decade, significant activity and energy have been focused on improving the patient experience in California. Public reporting of patient experience data and pay-for-performance incentives commenced, and the Patient Assessment Survey (PAS) instrument used by most medical groups and independent practice associations (IPAs) in the state has shown consistent year-over-year increases. Even though available comparisons show that Californians' ratings of the ambulatory care experience lag behind ratings in other states, there are several physician organizations in the state that have consistently ranked above their peers in each year of public reporting.

In light of these activities and improvements, this paper describes the present landscape of ambulatory patient experience in California. It is based on a literature review and a series of in-depth interviews with medical groups and IPAs that have sustained high performance on PAS, as well as with ambulatory care organizations serving large safety-net patient populations. The paper provides background on the definition, importance, and measurement of the patient experience, and synthesizes common strategies and areas of focus among the interviewees. It also describes the unique approaches and challenges of safety-net organizations in improving the patient experience. Among the topics discussed in detail:

- Patient-centeredness as an organizational focus;
- Leadership commitment to providing excellent patient experience;
- Robust measurement of the patient experience, transparency and clarity in reporting and communicating results, and using data for improvement;
- Engagement of staff and providers in the promotion, design, and implementation of patient experience improvement projects;
- Effective reward, recognition, and accountability systems to acknowledge individuals who excel and to provide feedback and support to individuals who need help; and
- Use of strategies to improve access to care and to support providers and staff in adopting effective patient communication techniques.

What Is the Patient Experience?

The patient experience is the sum of a patient's interactions when accessing the health care system; it is also the patient's perceptions of those interactions.

A distinction can be made between "patient experience" and "patient satisfaction," which focuses more narrowly on how patients rate their experience. Patient experience surveys typically assess what patients actually did or did not experience in their interactions, while patient satisfaction surveys assess only patients' ratings of satisfaction with their care. For example, a patient satisfaction survey might ask how well the physician listened, on a scale from highly satisfying to not satisfying at all. A patient experience survey, on the other hand, might ask the patient how frequently the physician listened during visits made in the previous 12 months. In this paper, patient experience is used broadly to encompass patient satisfaction.

Importantly, the patient experience reflects the dimensions of care that are most important to patients.[1,2] These include:

- **Interpersonal interactions and communications.** The more responsive, informed, helpful, and respectful the interactions a patient and family have with clinicians and staff, the better the patient experience.
- **Access to care.** The smaller the wait, delay, or effort involved in obtaining what the patient or family perceives is needed, the better the patient experience.
- **Care coordination.** Care processes should enable providers and care settings to work together to provide seamless care. Examples include getting test results, obtaining access to a specialist, and coordination between the primary care physician and other providers. Care that is perceived as quick, easy, or smooth provides a better patient experience than care that is perceived as confusing or delayed.

Analysis of PAS data shows that questions related to physicians are most highly correlated with overall rating of care, followed by questions related to coordination of care, office staff interactions, and access.[3]

The concept of patient-centered care is closely related to patient experience. The Institute of Medicine outlines several dimensions of patient-centered care, including: respect for patients' values, preferences, and needs; coordination of care; physical comfort and emotional support; involvement of family and friends; and information, communication, and education. The goal is to "customize care to the specific needs and circumstances of each individual," making care respond to the person, not the person to the care.[4]

Research has shown that the patient experience has a direct, positive relationship with health care quality. Patients who rate their experience highly show greater adherence to treatment recommendations and have better health outcomes.[5–11] Patient experience also affects financial outcomes. High ratings improve patient loyalty, increase physician satisfaction and retention, and reduce malpractice risk.[12–23]

Measuring the Patient Experience

Measuring patient experience is useful because it identifies problems that can adversely affect quality and cost of care, such as gaps in coordination of care or delays in returning test results.

Methods for surveying patient experience include mail, phone, and point-of-care approaches. Surveys commonly used in California to assess ambulatory care include:

- The Patient Assessment Survey (PAS) is a standardized survey that measures and publicly reports patient experience results at the physician group level (groups may choose to increase their sample size to measure and report internally at the individual clinician level). It is administered through the California Cooperative Healthcare Reporting Initiative and results are publicly reported on the Office of the Patient Advocate Web site (www.opa.ca.gov). PAS also serves as the measurement tool to determine pay-for-performance payments for the patient experience domain;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey is a nationally validated survey similar to PAS; and[24]
- A variety of proprietary surveys offered by vendors such as the American Medical Group

Association, Avatar, MTC, Press Ganey, and SullivanLuallin.

Heightened Market Focus

Over the past few years, several initiatives and changes in California and nationally have focused attention on the patient experience.

In 1999, the National Committee for Quality Assurance began using the CAHPS Health Plan Survey to assess the health plan member experience of care, as part of the HEDIS criteria used for public reporting and accreditation. Although the survey measures the member (rather than patient) experience and reports at the health plan level, the survey tool includes questions related to access to care, provider ratings, and how well doctors communicate. As a result, health plans became interested in providing incentives and support to physician organizations in their networks to improve their ratings.

In 2002, California became one of the first states to publicly report patient experience results at the physician group level. This was initiated under the auspices of the California Cooperative Healthcare Reporting Initiative, a statewide collaborative of health plans, provider organizations, and purchasers.

Growing interest in developing a common set of measures for evaluating physician group performance and in using incentive payments based on those measures led to the launch of the Integrated Healthcare Association's Pay for Performance initiative. Through this initiative, physician groups in California receive incentive payments based on their performance in five domains, one of which is the patient experience as measured by PAS. The first payout year was 2004. In 2009, health plans paid out $52 million to 229 physician organizations based on performance in all five domains. Of that total, approximately $15.4 million was paid out for performance in patient experience measures.

The California Quality Collaborative, established by health plans and large employers groups to support improvement in organizations caring for commercially insured populations, has developed expertise in the steps and approaches that lead to improvement (see sidebar on page 5).

Finally, the medical home concept has contributed to the growing interest in patient-centeredness and patient experience. The patient-centered medical home, formalized in 2007 by several major primary care organizations, is defined as "an approach to providing comprehensive primary care… that facilitates partnerships between individual patients and their personal providers, and when appropriate, the patient's family."[25] Of the seven patient-centered medical home principles, three directly address the patient experience: whole-person orientation, care coordination, and enhanced access. The collection and reporting of patient experience data is included in the standards and guidelines set forth by the National Committee for Quality Assurance for a patient-centered medical home.[26]

California vs. National Performance

The limited available data show that Californians' ratings of the patient experience lag behind those of other states.[27] In an analysis conducted for the Pacific Business Group on Health (PBGH) comparing California patients' ratings on several CAHPS Clinician & Group Survey questions (getting appointments and health care when needed, how well doctors communicate, office staff courtesy and helpfulness, and overall ratings of doctors), California lags behind a national sample and, on nearly all questions, samples from two other states.[28]

Although imperfect, it is also possible to use questions related to patient care on the CAHPS

Health Plan Survey to compare care experience ratings across states. Data from 2009 show that Californians rate their care experience lower than do patients in most other states, supporting the finding of the PBGH analysis. California scored between the 10th and 25th national percentiles on CAHPS composite ratings of access (getting needed care and getting care quickly) and physician relationship (how well doctors communicate and ratings of personal doctors). Ratings for specialists (specialists seen most often) and overall health care were slightly better—between the 25th and 50th percentiles.[29]

Within California, there is significant variation across physician groups. Based on 2009 PAS data, there is a 5- to 10-point range on key composite scores, suggesting that the highest-performing groups in California may be more competitive nationally.

Importantly, the patient experience in California has been steadily improving:

- CAHPS Health Plan Survey ratings on questions related to care increased relative to other states from 2007, when California was often below the 10th percentile, to 2009—although all scores remain below the 50th percentile nationally.[30]
- Research evaluating the impact of pay for performance, which was implemented in California in 2004, concluded: "In the context of statewide measurement, reporting, and performance-based financial incentives, patient care experiences significantly improved."[31] Physician-patient communication, care coordination, and office staff interaction all improved during the study period, from 2003 to 2006.
- The annual statewide PAS average ratings of all elements of the patient experience consistently increased from 2006 to 2010. These included ratings of access to care, physician-patient interactions, coordination of care, office staff, and overall rating of care.

Improving the Patient Experience: Lessons from the California Quality Collaborative

The elements of the patient experience most highly correlated with the overall rating of care are clinician-patient communication, access, and coordination of care. Fifteen groups participating in the California Quality Collaborative focused on these areas in yearlong intensive efforts that brought organizations together with expert faculty. Through this process, the collaborative identified key changes for practice sites and for organizations to improve the patient experience:

For practices and physicians:

- Negotiate the agenda with the patient at the start of each visit;
- Make a personal connection and demonstrate empathy through eye contact and empathic statements;
- Provide closure by summarizing next steps and an action plan;
- Notify patients of all test results, whether positive or negative;
- Review the patient chart prior to the visit;
- Handle more than one medical problem during the visit and extend return intervals when appropriate;
- Open same-day appointment slots; and
- Implement office "huddles" to monitor and manage patient flow on a daily basis.

For organizations to support practice sites:

- Provide ongoing feedback from patients to the sites through a patient experience survey and provide data at the physician level, at least quarterly;
- Provide training to physicians and staff to improve communication with patients;
- Provide a systematic approach to reporting lab results to patients and physicians; and
- Provide advanced access training to physician practices.

II. Medical Groups and IPAs

To identify practices and processes associated with high patient experience ratings, medical groups and IPAs with sustained high ratings were identified using PAS data from 2006 to 2009. The medical groups with sustained high performance had ratings above the 90th percentile on the "overall rating of care" question for at least three of the four years. A lower threshold was used to identify the IPAs, which had ratings above the 79th percentile on the same overall care question for all four years. The organizations represent a cross-section of size and geography (Table 1).[32] Structured interviews were conducted with leaders of these groups to obtain information about leadership practices, organizational processes, and initiatives to improve the patient experience.

Findings from these interviews are described below, along with their implications for physician groups and IPAs that want to improve their patient experience ratings. The findings are grouped into several themes that emerged from the interviews.

Patient-Centered Focus

All the medical group and IPA leaders interviewed spoke of a strong leadership commitment to patient-centered care. Many described this as a core value of the group. The patient-centered focus was articulated as "being the place to get care," "a place where patients come first," and a place where patients receive "a uniform experience wherever they go." Some interviewees spoke of a link between the patient experience and quality care ("patient satisfaction affects clinical quality" and "our goal is to provide patients with the highest quality care").

Most of the groups could identify a specific point when they started to improve the patient experience.

Table 1. Medical Groups and IPAs Interviewed

	TYPE	LOCATION	NUMBER OF PHYSICIANS	
			PRIMARY CARE	SPECIALISTS
Hill Physicians – San Francisco	IPA	San Francisco	234	774
Marin IPA	IPA	Marin and Sonoma counties	100	226
Palo Alto Medical Foundation	Medical group	Alameda, San Mateo, Santa Clara, and Santa Cruz counties	409	537
Scripps Clinic	Medical group	San Diego	118	340
Scripps Coastal Medical Group	Medical group	San Diego	110	5
Sharp Rees-Stealy	Medical group	San Diego	125	255
Sutter West Medical Group	Medical group	Davis, Woodland, Dixon, and Winters in Yolo County	42	28
Valley Care IPA	IPA	Santa Paula, Fillmore, and Ventura in Ventura County	24	286

The change was influenced by a number of factors, including: a decision by leadership; a merger with another group or larger system; public reporting; and pay-for-performance initiatives. Many of the leaders interviewed described a long-standing culture of using patient feedback to improve the patient experience.

Transparent Information

All of the leaders said their organizations measure the patient experience, communicate the results widely, and use the information to improve their performance.

Measurement and reporting. The medical group leaders survey patients using continuous sampling and report results at least monthly at both the site and department levels. All measure the patient experience at the individual provider level and most report these results quarterly, with a few reporting less frequently. All but one medical group report individual provider results in a blinded fashion.

Many of the leaders said they selected a survey tool based on its ability to provide:

- Reporting at site, department, and individual provider levels;
- Timely feedback, particularly the ability to access results on a real-time basis with an online reporting tool so managers can identify problems early or follow the impact of an improvement intervention; and
- Analysis of key areas to improve.

All of the medical groups interviewed use the Press Ganey survey. Leaders spontaneously described this survey's ability to report results frequently and to provide analysis and specific suggestions for improvement.

Two of the IPAs survey patients less frequently than do the medical groups, relying on the annual PAS or a combination of PAS and an internal survey. The third IPA, affiliated with a health system that uses Press Ganey to measure the patient experience, surveys and reports results quarterly.

Improvement. All of the medical groups and IPAs that were interviewed use survey results to guide improvement of the patient experience. One medical group initially directed its efforts toward improving employee satisfaction as the foundation for improving the patient experience (see "A Great Place to Work").

In the IPAs, results are typically reported first to the association's quality committee (or similar body), which identifies areas needing improvement and develops a strategy for addressing problems. For example, one IPA tracked patient dissatisfaction with coordination of care between the hospital and primary care providers. They responded to the

A Great Place to Work

Responding to low employee satisfaction scores, Scripps Health leadership decided to become a "Great Place to Work" and to improve the patient experience from that foundation. Focusing on issues identified in the employee satisfaction surveys, Scripps built consistent processes and infrastructure to support managers.

To engage employees, managers round daily and become involved in improvement activities, many of which focus on the patient experience. In one example of the employee engagement that resulted, front-line telephone staff developed their own behavioral standards to provide an exceptional patient experience and are audited on these behaviors. In another example, outstanding employees are trained in behavioral interviewing and conduct peer interviews of job candidates.

feedback by reducing the number of hospitalists used by the IPA and strengthening the relationship between the primary care physicians and the exclusively contracted hospitalists. The result was improvement in patient experience scores.

Recognizing how important access to care is for their patients, the medical groups have implemented strategies (variously called "advanced access," "open access," "same-day access," or "preferred access") to improve appointment access.[33–35] They typically monitor "third next available" (3NA) appointments and open more appointments when access is below targets. Notably, one medical group with only fair access when measured by 3NA has high patient experience scores for access because the staff responds to every patient request for a more timely appointment.

IPAs generally address access by auditing the number of days patients have to wait for urgent and routine new appointments among the practice sites. One IPA does a formal access analysis of one specialty every month and is careful to maintain good appointment access in every specialty when adding physicians to the network.

Communication. All of the medical groups said they communicate the importance of the patient experience and how the organization is performing through all available verbal and written methods, and that leadership plays a key role in this communication. Groups report patient experience results publicly at the work unit level (department or care site) using meetings, weekly emails, and posters. Some post monthly survey results so that patients can view them or publicly post positive comments to recognize staff.

Improving the patient experience is discussed as part of regular meetings and is on the agenda at quarterly and annual all-staff meetings. As one group leader stated, "There is not a meeting the medical director attends that does not address patient satisfaction."

The medical groups hold competitions to stimulate improvement in the patient experience, and special events recognize departments and staff whose ratings improve. Group leaders share unsatisfactory individual results or negative patient comments privately, usually with coaching to support behavior change.

The IPAs interviewed also share patient experience results widely, although their structure makes communication more challenging than for medical groups. Typically, a member of the IPA staff communicates results in person during practice visits and hard copies are sent by mail. Individual results are shared only with the physician; site results with patient comments are shared with both the physician and office manager. In one IPA, Press Ganey results are reported quarterly and are available to the physician or office manager at any time via a Web portal.

Staff and Provider Engagement and Training

Medical groups reported numerous ways that they engage staff in attaining service excellence. Team and staff meetings are used to discuss patient satisfaction at the work unit level. Action is taken where needed using the "small test of change" quality improvement methodology based on ideas from front-line staff. Several groups indicated they give their managers and staff autonomy to develop solutions to improve the care experience. Two leaders expressed a deep conviction that employee engagement and satisfaction are related to a positive patient experience.

In these medical groups, staff is engaged in many ways. Some examples:

- New employee orientation includes education about the patient experience and communication techniques that are meaningful to patients, such as body language;
- Ongoing training and skill development are held onsite to help staff maintain communication and service skills;
- Staff are involved in setting performance standards and clear expectations for their roles;
- Feedback from patients is provided verbatim to staff and solutions are discussed;
- Staff who provide exemplary service serve as peer interviewers of job applicants; and
- Friendly competitions to improve scores are held among sites or departments.

Both the medical groups and the IPAs offer robust programs to improve communication between staff and patients. The medical groups train staff to introduce themselves, keep patients informed about such things as wait times, and to use scripts—suggested words or language—for common interactions with patients. This training is provided in new employee orientation, training modules, and staff meetings.

IPA leaders said they focus on engaging office managers in improving the patient experience, including devoting time to patient communication techniques and issues on the agendas for office manager meetings. One IPA involved office managers in ensuring the successful rollout of an electronic health record. Another developed a program to engage office managers in improving patient care. Through this program, office managers meet regularly and learn how to improve the patient experience, discuss their practice's results, share successful strategies with other office managers, and are recognized and rewarded for improvements. At one IPA, office staff participate in a consultant-led communication training program every two years.

Ways to engage physicians were less notable and extensive, but included participation in monthly team meetings at the site level to review scores and develop improvements, and coaching by other physicians to enhance communication techniques.

The organizations interviewed also employed strategies to improve provider communication with patients. This is in keeping with the evidence that training can be developed to focus on physician communication behaviors valued by patients and that communication training can be effective.[36–44] Most of the medical groups and IPAs provide physician-patient communication support and training upon request and to physicians with low patient experience scores. Training is usually through individual coaching or shadowing; one organization routinely offers group training. Coaches are usually trained physicians. One medical group, for example, identified high-performing physicians, asked patients which communication practices set these physicians apart, and used the results to train other physicians.

Reward and Recognition

The high-scoring medical groups and IPAs reported using reward and recognition to motivate and involve staff. They reward work units that surpass patient experience improvement goals and recognize individuals who go above and beyond their job expectations to provide an exceptional patient experience. Creative activities include:

- Thank-you notes and emails from managers and senior leaders;
- "Above and beyond" awards, such as gift cards and movie tickets;
- Public recognition at staff meetings; and

- Department and site competitions with prizes for meeting goals.

Accountability

The medical groups that were interviewed all make clear that every person in the organization is responsible for providing an excellent patient experience. Staff members and physicians are hired for patient-centeredness and are then provided with behavioral service expectations, training to fulfill job requirements, feedback about individual and team performance, and coaching when improvement is needed. Managers are expected to meet patient experience goals, to provide feedback and coaching to individuals and teams, and to support improvement efforts that engage staff and physicians. Several group leaders noted that continuous feedback, transparent reporting, and conversations about the patient experience are strong cultural factors that hold everyone in the organization accountable.

The medical groups also use routine rounding on staff to engage all individuals, recognize high performers, and identify barriers.[45] When a leader or manager rounds on direct reports, the manager inquires about what is going well, which individuals should be recognized, whether each person has the tools and equipment they need to do their job, and what the staff would like the manager to know. Problems identified by staff are followed up and individual high performers are sent thank-you notes. In these ways, problems are identified and resolved early, and staff members feel valued by their managers.

One medical group has expanded rounding into a "walkabout" in which the senior physician leaders regularly visit each care site to discuss with the staff how things are going and follow up on issues that have been raised. One leader described the walkabout as "the single most useful thing we do."

In addition, many of the medical groups use "secret shopper" methods. One technique is to sit in the waiting room and observe interactions from the patient perspective. The shopper then provides feedback to staff on how well they are meeting standards.

Although accountability is less direct in IPAs than in medical groups, the IPAs that were interviewed see themselves as having an important role in quality improvement. They hold themselves accountable for helping the practices improve care. In fact, these highly rated associations view themselves as practice redesign IPAs rather than simply contracting IPAs.[46]

A study looking at market and organizational influences on physician performance on patient experience measures supports the observation that physicians belonging to integrated medical groups have higher ratings of physician communication and care coordination than physicians belonging to IPAs.[47] The study suggests that "organized care processes adopted by these groups may enhance patients' experiences."

Consultants

The medical groups reported using consultant expertise to help them improve the patient experience. They used Studer Group practices learned by engaging Studer Group consultants, attending Studer Group workshops, or using internal health system consultants who apply Studer principles. All reported currently using a consistent set of practices enumerated by Quint Studer in his book *Results That Last.*[48] Several groups reported also using other consultants to improve customer service or access.

The IPAs interviewed typically do not use consultants in the same manner, although one uses a consultant to conduct physician-patient and staff-patient communication training biannually.

Leader Commitment

Leaders in the highly rated medical groups are unrelenting in their commitment to achieving patient experience excellence. They see themselves as role models who set clear expectations, actively support and recognize individuals and teams that improve the patient experience, and are vigilant in keeping their organizations patient-centered. These leaders fulfill the description offered by J.L. Reinertsen over a decade ago, "The best physician leaders always behave as if they have a patient at their elbow and bring the patient's perspective into every conversation."[49]

The leaders indicated that they monitor the patient experience as closely as they monitor quality and financial performance and make course corrections or reinvigorate efforts as needed to achieve goals. In one organization, the senior management team meets every week to share success stories and spur innovation in the patient experience.

Leadership commitment is reflected in the commitment of resources. Many of the groups have leadership development programs, which further reinforce the culture of the organization, and all have internal coaches to help physicians whose patient experience ratings reflect unsatisfactory communication.

Within the IPAs, physician leaders typically work with the physicians in the practices. One IPA, in which the physicians are shareholders, functions more like a medical group in that the physicians all meet to discuss ways to improve patient care based on survey results. In the other IPAs interviewed, physician and IPA leaders communicate the importance of the patient experience while devoting significant effort to resolving physician concerns on issues such as ease of claims submission, relationships between primary care physicians and specialists, and availability of mental health consultation. The aim of these IPAs is to enhance the "practice experience" so that physicians can focus on the patient experience. For example, in one IPA, physician leaders visit primary care providers at least quarterly and visit specialists once or twice a year.

III. Safety-Net Organizations

In improving the patient experience, safety-net clinics, which provide health care services to medically underserved and uninsured populations, face many challenges that do not affect organizations that serve commercially insured populations. Most of California's safety-net clinics are operated by public agencies or receive federal or state funding and/or reimbursement.[50] Measuring the patient experience is difficult because safety-net organizations typically lack adequate resources to conduct patient surveys or to analyze data. Further, their patient populations generally have lower literacy rates, lower response rates to surveys, and often outdated contact information due to the difficulty many have maintaining an address or phone number.[51]

As a result, safety-net providers may not use the CAHPS Clinician & Group Survey or other patient experience surveys, choosing instead to administer their own surveys to collect data about the patient experience. Ratings of the patient experience for safety-net patients, therefore, cannot be compared within California or with other states.

In the absence of comparative data, safety-net organizations that are considered innovative or "ahead of the curve" in improving the patient experience were identified through discussions with an informal network of safety-net leaders and experts. This network has developed, in part, from participation in statewide collaboratives that support quality improvement in safety-net organizations.[52]

Structured interviews were conducted with selected leaders of the four identified safety-net organizations, including the leader of an organization in Colorado known nationally for its innovative improvement work, to obtain information about leadership practices, organizational processes, and initiatives to improve the patient experience (see Table 2).

Table 2. Safety-Net Organizations Interviewed

	TYPE	LOCATION	PATIENT POPULATION	PROVIDER PROFILE
Clinica Family Health Services	Federally qualified health center	Boulder, Denver, Lafayette and Thornton, Colorado	50% Uninsured 45% Medicaid 5% Medicare	34 physicians 34 nurse practitioners and physician assistants
Petaluma Health Center	Federally qualified health center	Petaluma in Sonoma County	50% Medicaid 25% Uninsured 15% Private insurance 10% Medicare	15 primary care providers
Innovative Care Clinic San Mateo Medical Center	County medical center	San Mateo in San Mateo County	33% Medicaid/Medicare 67% Uninsured	12 primary care providers
Department of Family and Community Medicine, University of California, Davis	Academic medical practice	Davis in Yolo County	43% Medicaid 26% Private insurance 26% Employees 5% Medicare	22 faculty 42 residents

Patient-Centered Focus

Like the leaders of the highly rated medical groups and IPAs, all safety-net leaders interviewed described a strong commitment to patient-centered care. Each organization had redesigned care using a patient-centered model. The leaders typically represented their work on the patient experience as part of a larger quality improvement approach to provide patient-centered care (see "Focus on the 'Big Six' Leads to Improvement"). For example, several leaders described the importance of good appointment access to improving health outcomes. They said that patients cannot close chronic disease care gaps or obtain preventive care if they have difficulty getting appointments. Same-day appointment access is especially important in safety-net populations because transportation, often a ride or bus fare, may only be available the day the patient calls.

This quality improvement mindset can be seen in the way the organizations embrace the concept of "small tests of change" or Plan-Do-Study-Act cycles. One leader said, "Our organization structure relies on testing cycles of change—it's not person-dependent, it's part of the culture." Another reported, "We collect patient experience data on a daily basis and share this data with our team huddles. This allows us to do 'fast track' interventions, allows the entire staff to see the results, and reinforces a culture of change."

In addition, the innovative safety-net organizations redesigned their delivery systems to achieve continuity of care and good appointment access by providing patient-centered, team-based care. Although the models differ in the composition of the care team, all focus on providing patients with continuity of care and same-day or next-day appointment access, with every member of the care team working at the top of their licenses.

Focus on the "Big Six" Leads to Improvement

Clinica Family Health Services, a community health center with multiple locations in Colorado, began work on clinical system redesign more than a decade ago as an offshoot of federally funded diabetes improvement work. Carolyn Shepherd, M.D., executive vice president of clinical affairs, recalled, "We set goals and told our diabetic patients to be seen by a provider every three months. But, because of inadequate access, patients could not get an appointment in time, or if they missed the appointment, they could not reschedule for another six weeks. So we stopped and focused on clinical system redesign."

Clinica has since worked on what the organization describes as the "Big Six" strategies:

1. Promoting continuity of care by assigning patients to a primary care provider and a pod with consistent administrative and medical assistant staffing. The organization measures how often patients are seen by their provider and pod.
2. Improving timely access to care by providing same-day or next-day scheduling. No-show rates and days wait for an appointment have both decreased over time.
3. Increasing office efficiency through team-based care and ensuring staff are working at the top of their licenses. For example, medical assistants give immunizations to children by standing order and front-desk staff support population management by reviewing registries and calling patients who need follow-up appointments.
4. Experimenting with alternative visit types. The organization offers more than 1,000 group visits for diabetes, ADHD, and prenatal care. To promote continuity, patients see the same educator or provider with the same patient cohort.
5. Integrating behavioral health services with primary care by co-locating a behavioral health professional in the pod.
6. Improving patient self-management through motivational interviewing and appropriate goal-setting with patients.

Transparent Information

The safety-net interviewees all collect data and use it for improvement, almost all using a home-grown survey. They collect and tabulate most data by hand although reports are automated whenever possible, and data are shared with leaders and improvement teams. Given the time and resource intensity of data collection, full-length surveys are completed only two to four times a year. The exception is the University of California, Davis Department of Family and Community Medicine, which, as part of the larger UC Davis Health System, uses an outside firm to conduct telephonic surveys in multiple languages and report results monthly at the department level.

Several of these organizations have developed creative ways to bring patients' voices to leaders and staff. One conducted a patient focus group and found the results so useful that the organization plans to conduct patient focus groups biannually. Another uses group visit evaluations to survey patients, or they conduct videotaped interviews with patients in their homes and share the videos with improvement committees.

Staff and Provider Engagement and Training

All the interviewed safety-net organizations said they actively engaged providers and staff in developing the new model of care. One leader explained, "We taught everyone quality improvement—the entire clinic was involved." As roles were redesigned, the organizations provided staff training and coaching to teams to ensure successful implementation of the new model of care. One organization created multiple workgroups with representation from all levels of staff; another asked staff what training they needed to be successful in their redesigned roles.

Two organizations credited their leadership's willingness to afford a level of autonomy to staff as a source of success. Leadership was described as encouraging staff to innovate and take risks, take time away to attend collaboratives, and incorporate improvement activities into their daily work.

Providers are trained in patient communication techniques through a variety of methods, including refresher courses and residency curricula. The organizations also cultivate internal trainers to coach colleagues, similar to the coaching approach used by medical groups and IPAs. They also discuss communication tips and techniques at new physician orientation and meetings reviewing patient experience results.

Communication training for staff is incorporated into their overall approach to patient-centered care. One safety-net organization, for example, conducted research and visited similar organizations to develop a training curriculum when it redesigned medical assistant, nursing, and administrative staff roles. The training helped ensure staff was effective communicating with patients in their new roles.

Reward and Recognition

Formal reward and recognition was used less frequently by the safety-net organizations. Only one described a program to recognize staff members for providing an exceptional patient experience: The Helping Hands Award initiative allows staff to nominate anyone for special recognition. Anyone who gets five nominations receives a $250 award.

Half of the safety-net leaders interviewed said their new model of care brought significant rewards in terms of improved provider and staff satisfaction. One leader noted, "All the numbers improved—patient and staff satisfaction. Our staff and provider turnover has really dropped; we're now able to retain our providers and employees."

Accountability

The safety-net innovators rely primarily on staff and provider engagement and dedication to motivate improvement efforts. To encourage accountability, they provide training to fulfill job requirements, develop clear job and role expectations, and give feedback on performance at the team or pod level.

Consultants

Instead of hiring consultants, the safety-net organizations participate in quality improvement collaboratives and workshops to access consultant expertise. All but one organization cited the Institute for Healthcare Improvement as a core source for learning improvement methods. Several organizations reported participating in collaboratives to improve access and redesign the patient visit.

Leader Commitment

The safety-net leaders believe that patient-centered care is essential and are committed to an organizational culture of quality improvement. They described sharing this commitment with a core group of leaders within their organization. "We have a shared vision," was a typical comment. In fact, the leaders of innovative organizations serving safety-net patients spontaneously described the crucial importance of such a shared commitment. Some described the importance of a significant leadership development experience (such as a conference, course, or fellowship) that gave the group a common perspective, language, and set of tools. Such experiences enabled them to work together to "spark change" and sustain it over time, they said.

IV. Conclusion

The steady improvement in Californians' ratings of the patient experience over the past several years is encouraging. Yet there is need for further improvement: Californians' ratings of the patient experience continue to be below average when compared with other states. The research and interviews on which this paper is based suggest several key components for sustaining high ratings of the patient experience over time:

- **Leadership commitment.** Leaders believe that the patient experience is integral to quality care and they speak, act, and make decisions based on what is best for patients.
- **Patient-centered focus.** The actions taken by individuals within the organization are based upon patient needs and preferences.
- **Transparent information, used for improvement.** The patient experience is measured regularly at the site, team, and provider levels; results are communicated widely and used to improve the patient experience.
- **Engagement.** Staff and providers are significantly engaged in the design and implementation of improvements in the patient experience.
- **Reward and recognition.** Individuals and teams who improve or excel are acknowledged and celebrated.
- **Accountability.** The organization identifies the roles of staff and physicians in providing an excellent patient experience and gives feedback and support to individuals and teams who need to improve.
- **Effective improvement strategies.** Work focuses on improving the elements that are most important to patients (for example, physician-patient communication, appointment access, and care coordination) and outside expertise is accessed as needed to guide efforts.

This list of leadership practices and organizational processes to achieve and sustain high patient experience ratings embodies the adage "simple, not easy." Unlike quality improvement initiatives, which involve discrete parts of an organization, the patient experience requires a holistic approach—all parts of the organization must deliver a good patient experience. Beginning with leadership commitment, without which improvement cannot occur, leaders can develop an organization that is highly rated by patients by instituting organizational processes that enable and motivate providers and staff to deliver patient-centered care.

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