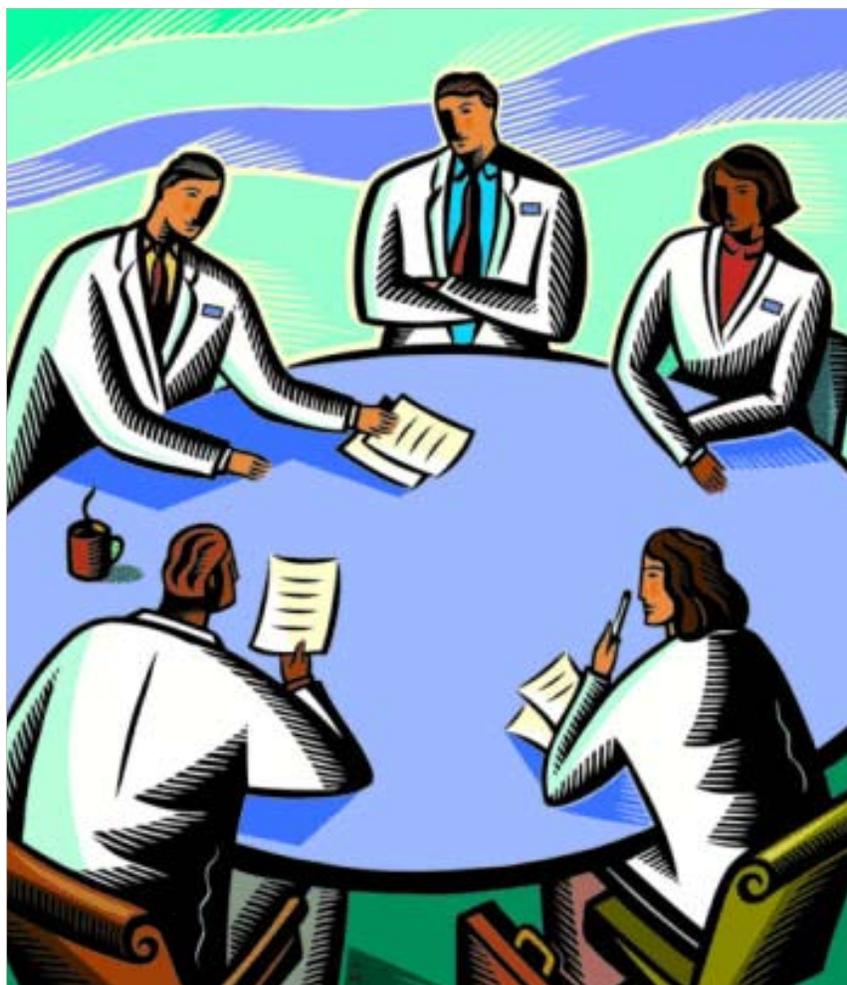




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Improving Patient Experience: A Hands-on Guide for Safety-Net Clinics

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Improving Patient Experience: A Hands-on Guide for Safety-Net Clinics

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by

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Introduction

IN JANUARY 2010, SAN FRANCISCO Health Plan (SFHP) launched two year-long learning collaboratives aimed at improving two key dimensions of the patient experience: timely access to care and provider/staff-patient communication. This paper offers the results of those collaboratives, and a step-by-step guide to assist safety-net clinics and small practices, and organizations working with them, in their efforts to improve patient experience.

Four community clinics participated in the access collaborative Optimizing the Primary Care Experience (OPCE), which focused primarily on improving access to primary care appointments.¹ This OPCE collaborative was led by Dr. Mark Murray and by Hunter Gatewood, manager of Quality and Performance Improvement at SFHP.

Five other community clinics participated in the second collaborative, Patient-Centered Communication (PCC), which focused on enhancing the provider/staff-patient relationship to help patients become partners in their health

care and to ensure that their most important concerns are addressed during their visits.² The PCC collaborative was led by the Institute for Healthcare Communication and by Tammy Fisher, SFHP's director of Quality and Performance Improvement.

A Guide for Clinics and Small Practices

The successful experience (see Summary of Process and Results, below) of the SFHP access and communication collaboratives has been synthesized here into a guide intended to help clinics and small practices, and organizations assisting them, with improving patient experience. There are four sections to the guide, presented in the order in which they are to be implemented:

- Step One: Identify Areas for Improvement
- Step Two: Prepare for Improvement
- Step Three: Make Improvements
- Step Four: Sustain and Spread Improvements

San Francisco Health Plan

SFHP is a licensed community health plan that provides affordable health care coverage to over 60,000 low- and moderate-income families in San Francisco. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and family planning services. Its members choose from over 2,300 primary care providers and specialists, six hospitals, and 200 pharmacies, in neighborhoods close to where the members live or work.

SFHP was created by the City and County of San Francisco to provide high quality medical care to the largest number of low-income San Francisco residents possible, while supporting San Francisco's community-minded doctors, clinics, and hospitals. SFHP was designed by and for the residents it serves, a diverse population that includes young adults, seniors, and people with disabilities.

SFHP also provides operational and quality improvement infrastructure for the ground-breaking health access program Healthy San Francisco, which serves another approximately 60,000 people who live and work in San Francisco and who do not qualify for or cannot afford health insurance coverage.

Each section presents an outline of the elements of that step in the process, a discussion of the SFHP clinics' experience of that step during the collaborative, and a summary of relevant lessons learned during the project.

Following the guide are three appendices of specific interventions: "Changes that Work to Improve the Patient Experience." These appendices offer concrete examples of changes to be made and specific ways to effect those changes for the three areas addressed by the collaboratives: in Appendix A, access to appointments; in Appendix B, communication between patients and providers; and in Appendix C, communication between patients and staff. A list of resources, for practices that want to learn more about and get started with improvement work, is offered in a final Appendix D.

Summary of Process and Results

THE NINE CLINICS IN THE TWO collaboratives attended two learning sessions, monthly teleconferences, and web-based seminars to learn the key changes for making improvements in access and communication. Clinics were taught to use the Model for Improvement, developed by Associates in Process Improvement and popularized in health care by the Institute for Healthcare Improvement (see Step Three: Make Improvements, below).³ The Model for Improvement helps clinics to test, implement, and spread changes shown to be effective in other communities but adapted, along with corresponding tools, to fit their unique clinic environments. A coach, experienced in quality improvement (QI) methodology and measurement, was assigned to each clinic to assist it in using the Model for Improvement to achieve measureable outcomes. Continuous measurement and feedback was central to both projects, allowing clinics to implement tests of change, use data to measure impact, and adjust the intervention as it was being implemented.

The access improvement clinics in OPCE used the count of days until the third-next available appointment (TNAA) as the measure for appointment access, and took the average for all providers as the value for the clinic overall.⁴ For the final project result, the average from the final four weeks' TNAA data was used to help account for TNAA variation week to week. For the communications clinics, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) visit point-of-care survey was used.⁵ This is a draft version of the CAHPS Clinician & Group Survey and asks respondents about experiences during their most

recent visit with a doctor (as opposed to all of their visits in the last 12 months with that doctor). The visit survey was implemented three times over the course of the project, with the third survey fielding period 10 months after the initial baseline period.

SFHP demonstrated that the combination of expert training and practice coaching could significantly improve measures of access and patient experience for the nine participating clinic sites. All OPCE (access) clinics cut wait times by more than 50%, even as their average panel size grew during the intervention year. All PCC (communication) sites showed improvement in patient satisfaction surveys. The staff at the clinic sites also reported benefits, such as improved morale, expanded QI skills, greater efficiency, and the ability to apply lessons learned to other projects. Staff members appreciated the opportunity to learn new skills and improve teamwork, and many patients noticed the positive change over the course of the intervention. As one patient commented, “Were you guys bought out or something? Something is really different here.”

Over the 12 months of the intervention, using the TNAA measure, all four OPCE clinics reduced their wait time for a regular primary care appointment by at least 50%. By the end of the program, two clinics saw delays reduced even more, while two others saw delays settle at a higher level than the shortest delay achieved during the collaborative. Final results for all four clinics were:

- Chinatown Public Health Center reduced delay by 81% (from 28 days to 5.3 days)
- Lyon-Martin Health Services reduced delay by 33% (from 12 days to 8 days)

- Maxine Hall Health Center reduced delay by 58% (from 44 days to 18.7 days)
- Southeast Health Center reduced delay by 38% (from 30 days to 18.6 days)

For the PCC collaborative, in the second (post-intervention round) fielding period, the five clinics showed improvement from baseline in all provider communication measures, staff communication, and global measures such as overall rating of provider and recommending clinic to family and friends. There were statistically significant ($p < 0.10$) improvements in four measures: doctor spends enough time, doctor's explanations are understandable, doctor provides easy-to-understand instructions, and clerks and receptionists are helpful.

Results from the third survey round (collected 10 months post baseline) demonstrated sustained improvements in most measures and a statistically significant improvement in willingness to recommend the clinic. Eight of 12 measures showed a positive absolute change from baseline, one remained flat, and three measures declined slightly. One measure, patient recommends clinic, scored "significantly higher," with an absolute increase of 3%, from 89.7% at baseline to 92.7%.

Step One: Identify Areas for Improvement

Outline of the Process

The SFHP collaboratives used the following steps to identify areas for improvement.

- Collect baseline data, including data from the patients' perspective:
 - Use standardized survey instruments that have been field-tested and, preferably, validated.
 - Administer the survey(s) using a standardized methodology such as point-of-care, mail, or Interactive Voice Response (for a discussion of alternative survey methodologies that might be used in a safety-net clinic setting, see *Developing and Testing a Survey Toolkit for Surveying Patients of Safety-Net Providers: Survey Implementation Report* [[www.chcf](http://www.chcf.org)] published simultaneously with this paper).
 - Use standardized measures to evaluate current performance (e.g., no-show rate, third next available appointment, provider continuity, CAHPS measures).
- Collect and analyze results at the most granular level possible, ideally for the provider/care team.

SFHP Collaboratives' Experience with the Process

SFHP used plan-wide CAHPS scores to identify areas for improvement. This led to a decision to establish targeted collaboratives on the plan's two lowest-scoring domains: provider-patient communication and timely access to care. Both areas are highly correlated with patients' overall rating of their care, and both are areas where SFHP scored below state

and national averages. Since there were no clinic-level patient experience results, the plan could not use CAHPS data to specifically target those clinics that might benefit more than others. Therefore, clinics were accepted into the project based on other criteria, including:

- Leadership commitment to the project:
 - Senior leader who would be part of the improvement team
 - Clinic commitment to providing sufficient and appropriate staff and other resources
- Team commitment to the project:
 - Specific project-dedicated QI team that would attend at least 50% of monthly conference calls and 100% of the day-long trainings
 - Team would participate in practice coaching with SFHP improvement advisors throughout the project
 - Team would report data at least monthly

Clinics participating in the communication collaborative used the standardized Clinician Group CAHPS survey (beta version of the visit-based survey), endorsed by the National Quality Forum, to collect baseline data on their patients' experiences using an in-office administration.⁶ This instrument was chosen because it has proven reliability among a wide variety of consumers. The five participating clinics used this survey at the point of care during three measurement periods: baseline, two months post-intervention, and 10 months post-intervention.

The fielding periods were about one month, within which clinics were instructed to provide the surveys to all patients. The goal was to receive 40 completed surveys per participating provider.

Clinic staff made a particular point of explaining to patients the purpose of the survey; for patients with low literacy levels, staff read the questions to them. To maximize responses and to accommodate the aggressive fielding schedule, each patient who completed the communication survey received two movie tickets. A locked collection box was used to preserve confidentiality. Providers' individual results were tallied and rolled up to the clinic level, and results were reviewed quarterly, with a training done by web-based seminar to explain each quarterly report.

Clinics in the access collaborative were not required to do a patient experience survey and instead collected data on a set of metrics using a standardized reporting tool. Measures included TNAA, provider continuity, no-show rate, and panel size.

Lessons Learned

Clinics measuring patient satisfaction started off with relatively high baseline CAHPS survey scores (low- to mid-90th percentile), which made it challenging to identify areas for improvement. However, the high scores may be attributable to two factors in addition to the high-quality relationships patients have with the clinics' providers: (1) The point-of-care methodology itself may result in falsely elevated scores; and (2) A number of questions in the visit-based CAHPS survey offered few response choices, limiting the ability to use the data to discriminate performance.⁷

In the immediate future, SFHP intends to use an interactive voice response or a mailed survey to collect data at baseline and post-intervention, as a way to improve accuracy in the assessment of patient experience. SFHP will also use the Clinician Group CAHPS survey's four-point scale, designed for less frequent measurements, to permit more varied responses from surveyed patients.

Step Two: Prepare for Improvement

Outline of the Process

- Establish an aim statement, with measurable goals and a clear timeline.
- Select changes identified as likely to improve selected measures.

SFHP Collaboratives' Experience with the Process

In each collaborative, clinics set an aim statement with very specific measures and goals based on their baseline results.

Establishing Aims

For access improvements, clinics were encouraged to reach a goal of no delay — referred to in the Mark Murray model as the Gold Standard Access Aim. This goal is to provide either a same-day appointment with the patient's own primary provider or team member, or with the primary provider on the next day that provider works in the clinic. Despite the difficulty of reaching this goal, it remains the aim for serious access improvement work. That is because many clinic organizations and/or individual clinics may not view as sufficiently worthwhile the hard work needed to reap the benefits of advanced access — lower no-show rates, improved patient satisfaction, improved continuity, improved staff and provider satisfaction, and decreased inefficiency — if they are only seeking to achieve a better-than-before delay (e.g., from 20 days to 10 days).

In the communication collaborative, clinics used the CAHPS-based measures to create their aims, then made those aims explicit in a formal statement

particular to each clinic. Here is an example from one clinic in the project:

At Silver Avenue Family Health Center, we put our patients first. It is important to us to make sure that every patient experiences a caring environment where they feel providers spend enough time with them. Also important to us is that the patient's time is respected by being seen in a timely manner. At Silver, we want our patients to feel good about our clinic and that they would recommend our clinic to their families and friends. Specifically, we aim to improve our performance in the following measures by March 2011:

- We will improve our score on the question "Provider spends enough time with you" from 94% to 96% or more.
- We will improve our score on the question "Visit started within 15 minutes of your appointment" from 86% to 90% or more.
- We will improve our score on the question "Would the patient recommend the clinic to family and friends" from 93% to 95% or more.

Selecting the Changes to Be Made

SFHP provided training to clinics using an adapted version of the Institute for Healthcare Improvement's Breakthrough Series collaborative.⁸ Each collaborative included two day-long training sessions for all clinic teams, monthly web-based seminars or teleconferences to teach new content and to allow clinics to share progress, weekly and monthly

reporting of measures, and biweekly meetings with a practice coach.

Specifically for the communication collaborative, the Institute for Healthcare Communication conducted two four-hour trainings, six weeks apart, that covered over 50 communication techniques; providers and other clinic staff received training in separate modules. The trainers emphasized agenda-setting, staff introductions to patients, an “ask-tell-ask” process, and eliciting patient self-diagnosis.

For the access project, the on-site sessions and web-based seminars covered access principles and changes, measures, the Model for Improvement, office efficiency, process mapping, and root cause analysis. Each clinic identified key changes it wanted to try to implement, based on what the improvement team learned in the trainings and through guidance from their coach. Coaching also helped clinics make sure the interventions they tried were directly related to the measures they wanted to improve.

Lessons Learned

It is crucial to involve the improvement team and clinic leadership when establishing the project’s aims. This helps ensure support and engagement from the beginning of the process. As a key part of developing the project aims, an understanding of baseline data should be shared with all members of the improvement team and clinic leadership. This will help create a clear vision that everyone supports when defining an aim statement and measures to evaluate progress made toward those aims. The aim statement spells out the first two questions in the Model for Improvement: “What do we want to accomplish?” and “How will we know that a change is an improvement?”

Similarly, it is important to let the people who will be making the changes select the measures on which the improvement team will focus. These measures should not only relate to things that need improvement for better patient care but also that are meaningful to the providers and other staff making the changes. Such direct involvement of staff and providers ensures that the changes will be meaningful for each of them on an individual level, and therefore that they will have the motivation to see those changes implemented and sustained.

Step Three: Make Improvements

Outline of the Process

The next question in the Model for Improvement is “What change can we make that will result in improvement?” Answering this involves examining the processes and tools to be used for making changes, including the following:

- Do small tests of change, using the Plan-Do-Study-Act (PDSA) Cycle, on all new interventions.
- Measure effectiveness of initial tests of change, using quick methods to collect data for each small-scale test (such as answering simple questions like “Did the patient find the agenda-setting form useful?”). These interim measures are intended to provide just enough information to decide what worked in the test and whether to keep going.
- Take notes on PDSA forms to keep track of what works and what does not, and use these notes to decide how to continue testing.
- Test separate change ideas in parallel to accelerate improvements.
- Once it has been decided that a test was successful and that the practice wants to implement the change for all patients by all involved staff and providers, observe the project measures data on run charts to see if the change improves performance across the whole clinic or practice.

SFHP Collaboratives’ Experience with the Process

In the communication collaborative, clinics initially tested specific changes with a few patients, using the following data-collection methods to obtain rapid feedback on whether the changes were resulting in improvement:

- Brief point-of-care survey (asking a few qualitative, open-ended questions specific to changes being tested)
- Brief point-of-care comment cards
- Exit interviews with patients directly following a visit
- Patient advisory boards to obtain patient input on changes and their effectiveness

In the access collaborative, clinics collected data on their measures monthly, using run charts to display data over time. Measurement was at the provider level with a roll-up to the clinic level. Each clinic was given an Excel reporting tool, developed by Mark Murray and Associates, for data entry and automatic calculation of run charts and graphs. Key project measures were:

- TNAA (number of days)
- Demand for visits (per-day number of requests for appointments)
- Supply of visits (appointment slots in the schedule)
- Activity (number of visits that actually occurred)

- Continuity of patients with their assigned providers
- No-show rate
- Panel size

For both projects, clinic staff filled out site satisfaction surveys quarterly as a way to measure how changes were affecting staff on a daily basis, and clinics received quarterly reports on these clinic site satisfaction scores. It should be noted that scores did not go up across the board during the course of the two projects. There may be several reasons for this, including the well-understood phenomenon that, before staff experience the benefits of a change, the disruption caused by the transition can lead to dissatisfaction.

An assigned coach checked in with each team biweekly for the first several months, and less often for some clinics as the projects progressed. Coaches held the first few meetings in person; most follow-up meetings were done telephonically or via web-based seminar. In addition, the coaches provided feedback on the monthly narrative reports, and helped teams interpret their data, summarizing what worked well and what could work better.

Lessons Learned

The Role of the Coach

Few of the participating clinics had expertise with QI methodology, so practice coaching as an adjunct to the collaborative learning sessions was critical in helping clinics make improvements. Specifically, the coaches were important in sustaining engagement of the team, especially the project manager and medical director, and in teaching clinics how to collect, interpret, and use their data to make decisions about changes. The coaches also helped teams stay diligent

about the “study” and “act” parts of the PDSA model, where the team discusses a change that has been tested and decides whether to continue testing or to implement that change as the new standard.

Thorough Training About Data

SFHP only had one online meeting about measurement itself and did no advance training about data management and interpretation. This turned out to be insufficient. Time should be spent up front teaching the whole team, not just those who express interest, about measurement, data management, and data interpretation through common improvement tools like run charts.

Extensive Teaching About PDSA

The PDSA model should not only be taught in an instructional presentation but also reinforced with the improvement teams as they do their first tests of change. In SFHP’s pilots, more time spent by coaches on PDSAs initially would have helped clinics get further faster in testing and implementing changes, and may have saved coaching time to be used for other team support and teaching.

Patient Comment Cards

Patient comment cards can be used in two important ways in patient experience improvement work: to gather data to decide what changes to try, and to provide immediate data where testing is underway through PDSA cycles.

A Survey with Sufficient Response Choices

The visit-based CAHPS survey that SFHP used has limited response choices. Patients were unable to express much variation in their answers, making it harder to discriminate changes in performance. In the pilot, the baseline scores were very high, leaving some providers unsure of where to focus their efforts

or even whether to believe the data. The Clinician and Groups CAHPS survey with a 12-month reference period, on the other hand, has more potential for identifying improvement needs, since this tool is fully validated and contains more response choices.

Survey Method Alternatives

In the communications pilot, high initial survey scores on many measures made it difficult to know where to focus improvement efforts. These scores may have been inflated by direct staff administration of the in-clinic survey, which research has found can contribute to skewed results with higher scores. A modified form of a point-of-care survey, such as one with independent rather than staff survey administrators, may address this problem; other methodologies, such as mail surveys, may also reduce response bias.

The Business Case

In order to gain leadership commitment to improvement in access, it is important to present the business case. A new emphasis on panel size rather than on scheduled visits can look risky to clinic CEOs and CFOs. They need to be shown how a full schedule does not necessarily result in a full day of visits, and how improving access can:

- Decrease the number of missed appointments
- Decrease the time clinicians spend doing work that is not billable
- Reduce staff turnover
- Reduce complaints from patients and families
- Avoid the unnecessarily long appointments and poorer clinical quality that come with poor patient-provider continuity

Step Four: Sustain and Spread Improvement

Outline of the Process

- Make patient experience a lens through which all staff and providers evaluate their success, which in many practices means having to change the culture.
- Communicate the goals and value of the improvement rather than merely its mechanics, and engage in that communication frequently, and to all levels of staff.
- Provide training and tools to equip staff to do things the new way.
- Measure patient experience regularly, sharing data with clinic providers and staff.
- Recognize and reward success.

SFHP Collaboratives' Experience with the Process

Progress made in a health care QI initiative is notoriously difficult to sustain after the project has concluded. Many safety-net clinics have developed the habit of lurching from grant to grant and project to project, instead of systematically testing and then integrating a change into daily clinic operations to sustain it over time. Clinics that achieve and sustain measurable improvement on clinical and operational measures are those with a data-driven culture of quality, where all staff are taught the basics of QI methodology, so that change does not depend on one champion or one grant.

In these two pilot programs, SFHP found that substantial time had to be invested by practice coaches in teaching QI basics, project management basics, and even the basics of effective interpersonal

communication. In response, SFHP collaborated with the San Francisco Community Clinic Consortium and the San Francisco Department of Public Health to launch the San Francisco Quality Culture Series, which provides a year-long training opportunity for clinic leadership teams in QI, project management, and change management. For a clinic joining any future SFHP-sponsored QI collaborative, SFHP will require that its leadership learn QI basics through the San Francisco Quality Culture Series or similar course.

Lessons Learned

Regular, Frequent Measurement

Measurement should be made and reported at least quarterly during intensive improvement efforts. A validated patient experience survey and defined methodology should be used, with trended data shared at the clinic level and statistically significant changes highlighted. Without clear measures of performance and ongoing improvement targets based on the results the clinic wants to achieve, it is impossible to know if the improvement process is having any impact. The measures are the map, and performance on those measures are the road signs.

Data Support

Many clinic improvement teams struggled with the need to collect and report on data, either because they felt “too busy” to measure things, or because there was a bias toward action over measurement. Clinic teams need substantial coaching on the reason for using data to drive improvements, as well as substantial support on how to collect and report

data quickly and efficiently, so that it becomes a part of daily work rather than just an annual report requirement. In this regard, training sessions for medical assistants and nurses in developing and interpreting run charts proved useful.

Celebrate Success

All too often a major change initiative just ends, leaving many providers and staff who worked on it wondering whether the goal was reached and, ultimately, what the point of the improvement efforts was. Patient experience QI is difficult work, and leaders and staff who engage in the work need recognition and closure as a project winds down. This allows teams not only to assess what they have achieved but also to shift their focus to what they want to improve next.

Framework for Sustainability and Spread

At the conclusion of the collaboratives, SFHP provided the clinics' improvement leaders with the following five-part framework for spread and sustainability, adapted from the work of Sarah Fraser and the Institute for Healthcare Improvement:⁹

- Specification of the changes to sustain (“Clarity dissolves resistance.”)
- Leadership action (“Attention is the currency of leadership.”)
- Ongoing communication on the changes to sustain
- Measurement
- Infrastructure (such as documentation to support the changes, ongoing training of new and current staff, and “knowledge management” to capture and spread new knowledge gained)

An event where changes that worked are shared may be a particularly positive climate in which attendees can begin or continue spread and sustainability planning. At the celebration luncheon for the two patient experience collaboratives, SFHP gathered improvement team leaders, medical directors, and other improvement leaders for a round-table discussion of their spread and sustainability plans and challenges.

Building on Success

Complementary improvement programs can build on each other, particularly by sharing key performance measures. For example, Strength in Numbers is an SFHP program that supports panel management through technical assistance and clinic incentives. Prior to the access collaborative, Strength in Numbers focused on clinical measures only. Now, SFHP requires all clinics in the Strength in Numbers program to report on two additional access measures that were critical in the access collaborative: TNAA and no-show rate. This is based on SFHP's belief that only by improving access can a higher level of performance in clinical quality be reached. (The clinics became supportive of these new access measures following much discussion regarding whether improvement leaders were not simply pushing clinics to do more work faster.) Similarly, SFHP has also included a patient experience survey requirement for its Practice Improvement Program, the SFHP version of a pay-for-performance program for its clinics and medical groups.

Appendix A. Changes that Work to Improve the Patient Experience: Improving Access to Appointments

The SFHP collaborative established a five-step foundation for improving access to appointments (adapted from Mark Murray and Associates):

1. Set access aim; consider the “gold standard” of no delay.
2. Measure delay using TNAA.
3. Measure the specifics of Demand, Supply, and Activity.
4. Empanel patients to a primary care provider (PCP).
5. Measure panel size and continuity with PCP.

CHANGE CONCEPT	CHANGES TO MAKE AND IMPORTANT MEASURES	COMMON SOLUTIONS
Match supply and demand daily and weekly	Measures: Supply, demand <ul style="list-style-type: none"> • Panel size (per provider or provider-based team) • Delay (days until TNAA) • Demand (appointments scheduled each day/ week) • Supply (available regular return appointments) • Activity (appointments completed in a day/week) 	<ul style="list-style-type: none"> • Assign different staff, based on role and interest, to gather different measures. • Discuss measures regularly in improvement team or general staff meetings so everyone knows what they mean and why they matter.
Reduce appointment backlog (existing providers add more capacity)	Measure: TNAA <ul style="list-style-type: none"> • Each provider agrees to see one to three more patients each day in the clinic. 	When patients call for appointments, they are offered these additional slots to avoid adding to the end of the line of appointments.
Simplify appointment types and times	<ul style="list-style-type: none"> • Eliminate visit types (one by one), to make schedule easier for patients to get in, and for staff to administer. • Separate registration and paperwork steps from the provider visit time (especially important for time-consuming visits, to help eliminate the need for special appointment types). 	<ul style="list-style-type: none"> • As access improves, eliminate “carve-outs” for next-day access or “urgent care.” • Eliminate different appointments, such as for “new” patients or “women’s health.” • Establish one “short” and one “long” appointment type. • Do registration by phone the day before. • Give patients an appointment time that reflects the time needed to do paperwork prior to seeing the provider.
Contingency planning	Measure: TNAA <ul style="list-style-type: none"> • Plan for supply contingencies (e.g., provider vacations, medical leaves). • Plan for demand contingencies (e.g., flu season, school sports physicals). 	<ul style="list-style-type: none"> • Have a plan for sharing work among providers when someone is out (e.g., who will do what for complex patients, who will cover urgent care needs of this panel). • Block a few days AFTER provider vacation, and make these appointments available during the days she is away, to minimize the delay that accumulates while she is gone. • Host drop-in hours for school sports physicals in late summer.

CHANGE CONCEPT	CHANGES TO MAKE AND IMPORTANT MEASURES	COMMON SOLUTIONS
Reduce demand for unnecessary visits	Measures: Internal and external demand <ul style="list-style-type: none"> • Extend visit intervals. • “Max-pack” visits: Handle urgent and preventive care tasks in one visit. • Vet schedules to eliminate non-necessary appointments. • Handle lab results and other information by phone, or with non-provider visits. 	<ul style="list-style-type: none"> • Extend visit intervals based on clinical guidelines. • Do phone visits/check-ins with patients to save them time and to minimize impact on provider schedule. • Do lab result notifications by phone. • If there are care teams, schedule patients with non-provider care team members. • Use group visits, including all-in-one chronic illness visits, and drop-in group medical appointments.
Optimize the care team	Measures: Cycle time, minutes behind for provider <ul style="list-style-type: none"> • Spread work across team members. • Break down visit delay-causing steps into actions: <ul style="list-style-type: none"> • Divide them up across all clinic staff. • Test different solutions and steps. • Standardize all appointment work. • Standardize all non-appointment work. 	<ul style="list-style-type: none"> • Establish a set process for handling patient forms, patient phone calls, refills, and other regular tasks, including the “who” for each step. • List all activities for one appointment, and decide as a team who can best handle each task and rearrange tasks accordingly. • Develop scripts for standard work, both in-person and phone.
Assign and manage patient panels	Measures: Panel capacity per provider FTE, continuity <ul style="list-style-type: none"> • Assign each patient to a specific provider. • Have each provider-based team see its own patients. • Monitor panel capacity monthly, by provider (use demand numbers). • Assign staff to partner with providers in regular care teams. 	<ul style="list-style-type: none"> • Use “four-cut” method to assign all patients. • Use supply numbers in the schedule template to establish panel capacity. • Analyze panel sizes monthly for each provider, to know who needs more/less. • Front desk staff ask “Who is your provider?” of all patients, steers them to their own.
Manage supply to maximize	Measures: Supply, activity, no-show rate <ul style="list-style-type: none"> • Schedule providers to fit what patients need. • Do not “park” patients in the schedule just to keep tabs on them. • Do not schedule far-future appointments for people who won’t/can’t keep them. 	<ul style="list-style-type: none"> • For patients who don’t need frequent return visits, or who fail to show, develop panel management tasks to keep track of them without parking them in the schedule. • Deploy provider supply to match demand patterns daily and weekly. • Do confirmation and troubleshooting calls with patients prior to visit. Help them attend.
Look before you book: “smart scheduling”	Measures: Daily and weekly demand <ul style="list-style-type: none"> • Pre-book appointments in a way that preserves same-day access. • Use data to see demand trends by day and by week. 	<ul style="list-style-type: none"> • Schedule future appointments in the morning, to allow travel time for same-day visits in late morning and afternoon. • Unless the patient needs a certain day, schedule future appointments as much as possible on the practice’s least busy days.

Appendix B. Changes that Work to Improve the Patient Experience: Improving Communication between Providers and Patients

CHANGES TO MAKE	EXAMPLES OF COMMON SOLUTIONS
<p>Make a warm, personal connection with the patient at the start of the visit.</p>	<ul style="list-style-type: none"> • Make eye contact, state the patient’s name (depending on culture and familiarity with patient, use first or last name), introduce yourself, and smile when welcoming the patient to his or her visit • To make the connection to the care team, your introduction may include “My Medical Assistant, Maria, mentioned that you wanted to discuss...”
<p>Negotiate the agenda with the patient at the start of the visit.</p>	<ul style="list-style-type: none"> • Ask what the patient wants to discuss during the visit. An agenda-setting form is helpful in asking patients to write down their concerns and the issues they wish to discuss with their provider. After, ask the patient “Is there anything else?” to make sure all concerns and issues are identified. • Prioritize the agenda with the patient, by asking something like “What’s the one thing you want to make sure happens before you leave today?”
<p>Use empathic statements throughout the visit.</p>	<ul style="list-style-type: none"> • Reflect: Convey your understanding of your patient’s experience (e.g., “You were caught between a rock and hard place.”). • Normalize: Let patients know that their feelings and actions are normal (e.g., “I think anyone would feel scared.”). <p>N.B. Self-disclosure should be used carefully; the key is to keep the patient’s experience as central.</p>
<p>Use “ask-tell-ask” technique.</p>	<ul style="list-style-type: none"> • Ask patients to describe their current understanding of the issue (e.g., “Can you tell me what your understanding of your asthma is?”) • Tell patients in straightforward language what you need to communicate (e.g., “I have some difficult news to share with you...”) • Ask patients what they understood about what you just said. Do not simply ask if they “understand”
<p>Elicit the patient’s self diagnosis.</p>	<ul style="list-style-type: none"> • Ask “What do you think is going on?” • Most patients make a self-diagnosis, and hearing them can help you appreciate the patients, address their concerns, and correct their understanding if necessary. • Agree on diagnosis and discuss any discrepancies between your diagnosis and that of the patient.
<p>Provide closure to the visit by summarizing next steps and an action plan.</p>	<ul style="list-style-type: none"> • Review diagnosis, treatment, patient self-care, and prognosis. • Review next steps: what will be done next and in future visits, calls, tests, test results, et al.
<p>Review the patient chart prior to the visit.</p>	<p>Remember something personal about the patient and mention that in the visit (e.g., “The last time you were here, I recall you were getting a new dog. How is it going?”)</p>

CHANGES TO MAKE	EXAMPLES OF COMMON SOLUTIONS
<p>Do daily huddles with members of the care team, to prepare the team to interact with that day's patients.</p>	<p>Huddles can address either the panel management needs for the day's appointment list, the basics of staffing and flow needs for the day, or both. A good huddle should start on time and be brief. (Many clinics do huddles standing up, a good way to keep it focused and brief.) There are many resources online to describe the why and how of primary care huddles.</p>
<p>Collect data from patients and staff frequently, to continuously measure the impact of changes and to engage others in trying changes.</p>	<p>Methods include:</p> <ul style="list-style-type: none"> • Patient exit interviews • Patient advisory boards • Comment cards

Appendix C. Changes that Work to Improve the Patient Experience: Improving Communication between Staff and Patients

CHANGES TO MAKE	EXAMPLES OF COMMON SOLUTIONS
<p>Make a warm, personal connection with the patient and family at the start of the visit.</p>	<ul style="list-style-type: none"> • Make eye contact, state the patient’s name (depending on culture and familiarity with patient, use first or last name), smile, and introduce yourself and the provider you are supporting (e.g., “Good morning Ms. Gonzales, I am Martha and I will be working with Dr. Ruiz. We will be taking care of you today.”) • When speaking, turn your body to face the patient; if escorting the patient, walk side by side.
<p>Appreciate the patient’s perspective. Help the patient feel heard and understood, and acknowledge his or her situation.</p>	<ul style="list-style-type: none"> • Keep the patient updated on wait times to see the provider, updating every 15 minutes. • Acknowledge how the patient may be feeling (e.g., “It must be frustrating to…”).
<p>Listen carefully and elicit the top concerns patients want to discuss with their provider by using an “agenda-setting form.”</p>	<ul style="list-style-type: none"> • Ask patients what they want to discuss during the visit and write it down on the agenda-setting form, or provide the form to the patients to complete in the waiting room and review it during triage, then summarize what you heard (e.g., “It sounds like you need…”). • Check back with the patient: “Have I got it right?” • Listen for confirmation from the patient.
<p>Respond to patients and families in helpful ways: use common language, offer possible solutions, and explain the process.</p>	<ul style="list-style-type: none"> • Use common language (e.g., “The room for your procedure is on the 2nd floor. Did you use the special soap we gave you at your last visit?”). • Offer solutions (e.g., “One option is to wait for your blood test now, and when it is ready you can go to the front of the line. Another option is to have you reschedule your appointment.”).
<p>Inspire confidence in patients, in their ability to contribute to their health and health care. Offer to help; find out what the patient knows, expects, and has tried; create choices; and look for the patient’s strengths.</p>	<p>“What is your understanding of your asthma?”</p>

Appendix D. Resources for Access and Communication Quality Improvement

General Resources

California Quality Collaborative

Offers several resources on improving the patient experience in communication, access, and care coordination, in addition to offering tools and resources for measurement

www.calquality.org

San Francisco Health Plan

- Spread and Sustainability Framework
- One-page Spread Planner
- One-page Sustainability Planner

www.sfhp.org

Improving Access to Appointments

Paul Bataldan, *Backlog Reduction Worksheet* (2003),

www.ihl.org.

Mark Murray, MD and Donald Berwick, MD, “Advanced Access: Reducing Wait Times and Delays in Primary Care,” *Journal of the American Medical Association* 289 no. 8 (February 26, 2003)

San Francisco Health Plan

- Phone triage script (Southeast Health Center, San Francisco)
- Six things needed for visit efficiency, flyer/poster reminder

www.sfhp.org

Improving Communication Between Providers and Patients, and Between Staff and Patients

Institute for Healthcare Communication

Trainers on communication techniques

www.healthcarecomm.org

Institute for Patient- and Family-Centered Care

www.ipfcc.org

San Francisco Health Plan

- Agenda-setting forms (in multiple languages) to help patients identify their most important concerns for their visit (from Mission Neighborhood Health Center, Family Health Center, and St. Anthony’s Free Medical Clinic)
- Discharge summary (from St. Anthony’s Free Medical Clinic), used to summarize the patient visit and describe next steps
- Placard with four icons to remind staff of four steps to improved patient interactions, created by SFHP to help clinic staff remember to smile, make eye contact, introduce themselves, and walk side by side with the patient
- Sample staff huddle script

www.sfhp.org

US Department of Health and Human Services Agency for Healthcare Research and Quality

Information about specific CAHPS-based surveys and improvement resources

www.cahps.ahrq.gov

Endnotes

1. The clinics that participated in the OPCE program were: Chinatown Public Health Center, Lyon-Martin Health Services, Maxine Hall Health Center, and Southeast Health Center.
2. The clinics that participated in the PCC collaborative were: Castro-Mission Health Center, Family Health Center at San Francisco General Hospital, Mission Neighborhood Health Center, St. Anthony Free Medical Clinic, and Silver Avenue Family Health Center.
3. For more information regarding the Model for Improvement, see www.ihl.org.
4. For more information regarding the usefulness of the TNAA measure, see www.ihl.org.
5. CAHPS surveys are produced by a coalition of public and private organizations with funding and administration by the U.S. Agency for Healthcare Research and Quality. For more information regarding CAHPS, see www.cahps.ahrq.gov.
6. See National Quality Forum, www.qualityforum.org.
7. M.P. Anastario et al., “A Randomized Trial Comparing Mail Versus In-Office Distribution of CAHPS Clinician and Group Survey,” *Health Services Research* (October 2010).
8. See Institute for Healthcare Improvement, www.ihl.org.
9. M.R. Massoud, et al., *A Framework for Spread: From Local Improvements to System-Wide Change*, Institute for Healthcare Improvement Innovation Series white paper (Cambridge, MA: Institute for Healthcare Improvement, 2006). See also Sarah Fraser materials at www.sfassociates.biz.



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