By Wendy Ray, MPH

Improving the Quality of Service: The KPNW Experiment

This article was written in collaboration with Ron Potts, MD, and Alide Chase, RN, cosponsors and project designers of the KPNW Customer Service Collaborative.

In the mature, highly competitive Northwest US health care market, the Kaiser Permanente Northwest (KPNW) Region has adopted a central focus of exceeding members' expectations of health care services. This article introduces readers to the KPNW Customer Service Collaborative, an activity organized in 1999 to solidify service quality as a core value throughout the Region.

Introduction

Kaiser Permanente Northwest (KPNW) leadership is committed to creating a service-oriented culture that permeates all levels of the organization. Given that the highly competitive and mature managed care environment in the northern Willamette Valley and in Southwest Washington has virtually eliminated KPNW's historical price advantage, attention to meeting and exceeding members' expectations of the health care experience has become a central focus for the Region. More specifically, dimensions of the care experience as described by the Picker Institute (an organization that has spent many years exploring the experiences of patients who have been treated in a variety of clinical settings) provide the KPNW Region multiple opportunities to assess current activities and to improve on them.

"KPNW senior leaders recognize that a significant cultural shift is needed to understand these expectations and to organize services accordingly."

"Providing excellent customer service is no longer optional for us in Kaiser Permanente. Our members and customers expect to be treated with respect, honesty, and integrity. They also expect us to function as highly committed, customer-focused teams within our integrated health care system.

Working together, I am confident we can meet or exceed these expectations for service excellence."

Barbe West
Regional President, Kaiser Foundation Health Plan Northwest

"Improving service requires all members of the health care team to understand what our patients want and need, and communicate effectively among themselves about how to meet those needs. No one can sit on the sidelines; it requires the commitment of all."

Allan Weiland, MD
Regional Medical Director, Northwest Permanente, PC

KPNW senior leaders recognize that a significant cultural shift is needed to understand these expectations and to organize services accordingly. This recognition has led the leadership team to identify several organizational components that are necessary if KPNW is to be a leader in service excellence:

- *Knowledge* of what constitutes an excellent care experience;
- *Management modeling* in which senior and middle managers model excellent customer service behaviors;
- *Employee satisfaction and empowerment* in which employees are engaged, mobilized, and empowered to maximize their performance contributions and intrinsic work satisfaction;
- *Skills and competencies* in which senior leaders, middle managers, clinicians, and employees have the capability to provide excellent service;
- *Systems* such as training, recognition/reward, and care delivery systems in place to support service quality;
- *Strategy* for becoming an organization known for service excellence; and
- *Structure* to support benchmarking activities and sharing of ideas; and a compensation and incentive system that reinforces all of the above.

Historical Foundation for the KPNW Customer Service Collaborative

In 1998, the Institute for Healthcare Improvement (IHI)— an independent, nonprofit organization—invited 28 health care organizations to participate in a new, national collaboration titled "Improving Service in Health Care." KPNW participated in this collaboration, which challenged participating organizations to rapidly reshape customer service in areas important to customers. KPNW responded to the challenge by implementing a pilot project in one geographic area in the Region: the Salem Primary Care Service Area (PCSA). The Salem PCSA is one of six service areas within the Region and consists of two primary care medical offices, one specialty care medical office, and a centralized call center. Salem is located 50 miles south of Portland and serves approximately 48,000 members.

The support provided by the IHI Collaborative and the substantial attention given to improving customer

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service in Salem led to major improvements in customer service in the Salem PCSA. From August 1998 to November 1998, the Salem PCSA achieved a statistically significant increase in *overall satisfaction* (72.6% to 81.8%, p = 0.01); the percentage of *patients paneled* with a primary care provider (PCP) increased from 57% to 63%; the percentage of *patient visits with the patient's PCP* increased from 64% to 70%; and *member concerns* decreased by 31%. In addition, a nine-question employee satisfaction survey was distributed to KP clinicians, nurses, and receptionists in the Salem PCSA in April 1998 (before the start of the Collaborative), and again in November 1998; responses to six questions on that survey showed statistically significant improvement in employee satisfaction between April and November.

These successes led to formation of the KPNW Customer Service Collaborative, whose ambitious goals were 1) to increase overall customer satisfaction with service in the inpatient and ambulatory care settings by 30%; and 2) to increase by 50% employees' and physicians' ability to provide excellent customer service as perceived by the employees and physicians.

Formation of the KPNW Customer Service Collaborative

Modeled after the IHI Collaborative, the KPNW Customer Service Collaborative was designed to begin addressing the organizational components necessary for service excellence and to shift the organizational culture toward recognizing service quality as a core value. The Customer Service Collaborative is based on the premise that continuous learning drives continuous improvement. In February 1999, multidisciplinary health care teams were invited to explore ways to listen and learn from customers; to design small, site-specific improvements; and to rapidly adjust activities on the basis of customer feedback. Participation in the Collaborative was voluntary so that success within the Region would stimulate other teams to improve their customer service also.

Structure and Operational Model Used by the KPNW Customer Service Collaborative

Of the 16 applications received, 13 multidisciplinary teams were selected from primary, specialty, and inpatient care service areas to participate in the Customer Service Collaborative. All but two of these were naturally occurring work teams. Teams were selected on the basis of their excitement about improving customer service.

A strong organizational structure was created to support the teams' work in improving customer service (Figure 1). In addition to the team co-leaders (one physician and one RN), each team is supported by:

- Local operational leaders who address barriers, provide needed resources, and reinforce change at the local level;
- One senior leader, who removes barriers to team progress and reinforces change at the organizational level; and
- A process consultant and a measurement consultant, who provide fundamental skills and tools for effectively implementing change.

In addition, all Collaborative teams were encouraged to meet on a weekly basis. Most teams had a core group (5-7 multidisciplinary team members) who met every week for one to two hours over the lunch hour and then met with the other members of the patient care module once per month at a regularly scheduled module meeting.

Planning and Measuring Improvement Using a Rapid-Cycle Approach

The Collaborative teams were encouraged to use a simple yet powerful accelerated improvement model, as described in *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*[1] (Figure 2). This rapid-cycle, "trial and learning" approach to improvement is an adaptation of continuous quality improvement (CQI) methods designed to

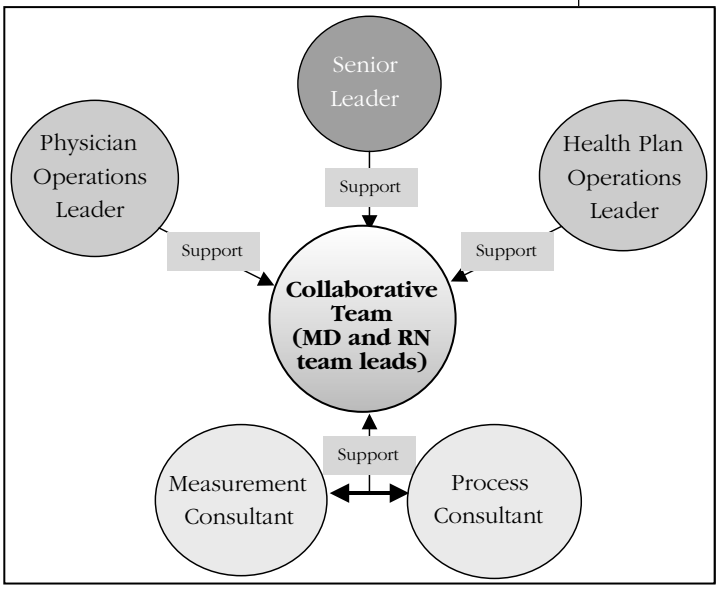

Figure 1. Organizational support structure for KPNW Customer Service Collaborative.

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both shorten turnaround times and make incremental changes at an accelerated pace. This approach has also been identified as the "quality in daily work" approach, in which clinicians and employees monitor their own performance and adjust it accordingly.

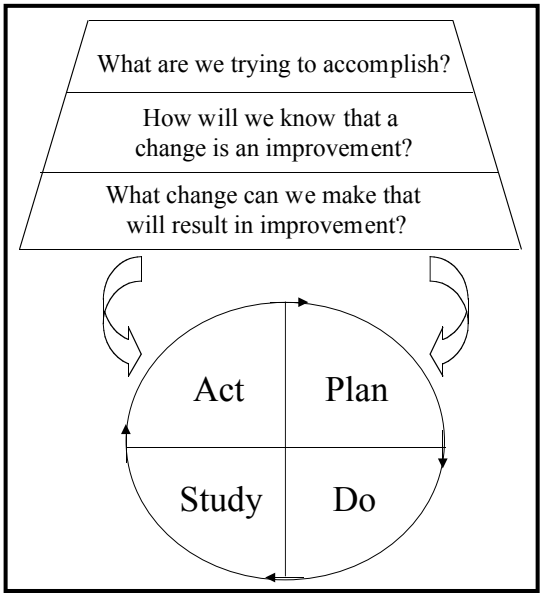

Figure 2. Model for planning and measuring rapid-cycle improvement. (Reproduced by permission of the author and publisher from Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass Publishers; 1996. p.10. (The Jossey-Bass business & management series).)

"These dimensions of care helped to ensure that the Collaborative teams' work toward improving customer service would make a difference to patients."

Figure 3. KPNW Customer Service Collaborative Web site, designed and implemented as a vehicle for team communication.

In the rapid-cycle improvement approach used by the Customer Service Collaborative, teams were continuously encouraged to try activities on a small scale by using the Plan-Do-Study-Act (PDSA) cycle,[1] which teaches teams to try a small-scale change (for example, trying an activity with only one or two physicians using one or two examination rooms; or trying the activity with the next three patients). After observing the consequences of the activity, the team modifies the change on the basis of what is learned. If the cycle is successful as shown by appropriate measures, the next cycle may test the same change on a larger scale or under different circumstances (eg, on a different time of day or day of the week). If test results are unsuccessful, the team can try a different improvement activity and thus not waste time and resources on an unsuccessful activity.

Before solidifying aims or goals for the Collaborative, the teams were encouraged to look at customer service from the perspective of patients. On the basis of responses from many focus groups, customer interviews, and national surveys, the Picker Institute (Boston, Massachusetts) identified eight "dimensions" of care that are especially critical from the patient's perspective.[2] These dimensions of care helped to ensure that the Collaborative teams' work toward improving customer service would make a difference to patients.

Measurements in the Collaborative are derived from results of locally administered surveys distributed by each team to members when they come into the office for a visit. Members return the completed surveys in confidential drop boxes before leaving the building. The surveys include six questions that are standardized to enable comparison across teams and three to six questions selected by each team to measure team-specific improvement activities.

At the start of the Collaborative, teams were supplied with a computer and a customized data entry and analysis program to enable teams to track their survey results frequently and independently.

Shared Learnings

In addition to three one-day conferences offered throughout the nine-month Collaborative, teams were continuously linked through a KPNW Customer Service Intranet site (Figure 3) that offered a wealth of current information to participating teams and outside observers and served as a vehicle for team communication. One team increased involvement among the Collaborative's entire patient care module by posting to the Web site all customer service

meeting minutes, member satisfaction survey results, employee satisfaction survey results, direct patient and employee quotes, tributes to exceptional employees, team photographs, and all customer service improvement activities.

Activities Designed to Improve Service

With the assistance of the Collaborative support structure and regular team meetings devoted to customer service, all Collaborative teams have been actively pursuing their aims. To date, more than 100 customer service improvement activities are underway. Categorizing these improvement activities into Picker dimensions of care has clearly shown that most of these activities are clustered in two of the Picker dimensions: the *Access* dimension and the *Information and Education* dimension (Figure 4). Two other dimensions—*Emotional Support* and *Respect for Patient Preferences*—may be considered more subjective because they involve somewhat ambiguous aspects of the delivery system. The five Picker dimensions of care include *Access*; *Respect for Patient Preferences*; *Continuity and Coordination of Care*; *Information and Education*; and *Emotional Support*.

• *Access to Care*: Patients want access to care and therefore become frustrated by the barriers they often encounter (eg, telephone triage or voice mail systems, scheduling difficulties, overzealous "gatekeepers," or restrictions imposed by the managed care system).[2]

• *Respect for Patient Preferences*: Patients describe feeling a sense of anonymity and loss of identity in hospital and clinic settings and a strong need to be recognized and treated with dignity and respect as individuals. They also express worry about how their sickness or treatment might affect their lives, and they want to be both informed about and involved in medical decisions.[2]

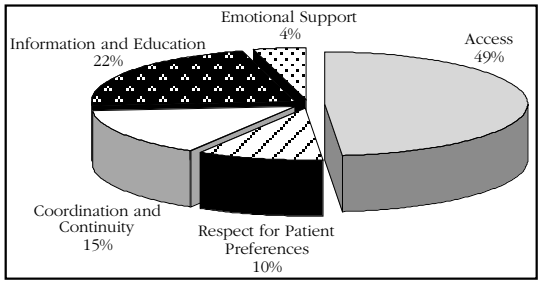

Figure 4. Service improvement activities as emphasized by KPNW Customer Service Collaborative and categorized according to the five Picker dimensions of care.

• *Continuity and Coordination*: Patients have a unique vantage point on the process of care. Their perceptions of the competence and efficiency of their caregivers are shaped, in large part, by how well clinical care, ancillary and support services, and "frontline" care are coordinated. Patients often do not understand institutional and functional boundaries and have difficulty navigating the health care delivery system effectively.[2]

• *Information and Education*: Patients often express the fear that information is being withheld from them or that they are not being completely or honestly informed about their illness or prognosis. In particular, they emphasize the need for information about their clinical status, progress, and prognosis; information about the processes of care; and information that helps them manage by themselves away from the clinical setting.[2]

• *Emotional Support*: The fears and anxieties provoked by illness can be as debilitating as its physical effects. In particular, patients express anxiety about their illness and fears about possible outcomes or long-term prognoses; worries about the effect of their illness on their ability to care for themselves or for their dependents; and concerns about the costs of medical care or the implications of the illness on their family's income.

Table 1 summarizes some KPNW Collaborative improvement activities included within each dimension of care. The critical key to all the improvement activities is use of the rapid-cycle methodology.

"To date, more than 100 customer service improvement activities are underway."

Early Findings of the KPNW Customer Service Collaborative

Tests for statistically significant differences in continuous and categorical data were done using *t* tests and χ^2 tests, respectively, at the 95% confidence level. All analyses were done using SAS (SAS Institute, Cary, NC) software.

Patient Surveys Distributed by the Collaborative Teams

On the Collaborative surveys administered by teams at the point of service, three of the five standardized survey questions have shown statistically significant improvement from April 1999 to July 1999 (Table 2). Significant improvement has been seen in patients' satisfaction with the interest and attention shown to them by nurses and medical assistants ($p = 0.0001$), satisfaction with how well the provider listened ($p = 0.0001$), and overall satisfaction with their medical care experi-

Table 1. KPNW Customer Service Collaborative improvement activities grouped by Picker dimensions of care	
Dimension of care	**Associated activity**
Access	Provide clear instructions on use of mail-order prescription service
	Provide information on estimated wait times at check-in
	Acknowledge lengthy patient wait times
	Ensure that nurses/medical assistants work to keep clinicians on schedule
	Reduce wait times by shifting staff to reception desk at peak check-in times
	Assign all members to PCP patient panels
	Have patients fill out previsit interview form ("Doc Talk") listing reasons for visit (saves Medical Assistant time and informs clinicians of patient expectations)
	Call select patients to identify any medical needs that can be met by telephone
	Provide patients espresso vouchers, co-pay waivers, or other form of apology for excessive waits
	Provide pagers to patients who will have excessive waits
	Enhance comfort in waiting rooms (eg, by providing toys, current magazines, newspapers, copies of KP *Healthwise Handbook*, television, videos, crayons, paper, telephones, water, coffee, writing tables, computer ports, fish displays)
	Provide supervised play areas in waiting rooms for children
	Read to children in pediatric waiting areas
	Shift waits from examination rooms to waiting rooms
	Modify schedules to better serve Urgent Care and walk-in patients
	Modify schedules to increase patients' ability to see PCPs
	Assign selected appointment types to nurses and physical therapists
	Encourage use of KP *Healthwise Handbook* and *KP Online*
	Use central team e-mail account to enable patients to reach any team member
	Distribute team brochures with clinician pictures and biographical information to patients not yet assigned to PCP panels
	Expand schedules so appointments can be made further in advance
Respect for patient preferences	Personally contact every patient who has expressed a concern
	Enhance computerized medical record by including personalized patient information such as nicknames used by patients
	Address all patients by their preferred name, pronounced correctly
	Ensure that nurses/medical assistants/other clinicians/receptionists wear nametags and introduce themselves to all patients
	Ensure that nurses/medical assistants/other clinicians/receptionists participate in communication workshops
	Ask all patients if their needs were met
Continuity and coordination of care	Make sure all collaborative teams work together to coordinate patient care
	Have teams work with Emergicenter to coordinate care at walk-in and Urgent Care appointments
	Have teams work with regional Call Center to improve customer service
	Have medical assistants schedule follow-up appointments for patients
	Have medical assistants verbally review clinician instructions and next steps at end of visit
	Place computerized medical record workstations in examination rooms
Information and education	At check-in, give patients written suggestions for making the most of their next appointment
	Customize information given on computerized After-Visit Summaries
	Increase use of computerized After-Visit Summaries
	Consolidate and standardize information given to patients
	Update posters placed in examination room
	Provide information packets to patients while they are in the hospital
	Give patients a written explanation of laboratory test results in nontechnical terms
	Redesign radiology prep sheets as necessary to be shorter and easier to understand
	Provide welcome package (eg, containing welcome letter, team philosophy, team photograph, clinician biographical cards, service hours, interpreter phone numbers, and appointment instructions) to all new members. Provide business cards with phone numbers for appointment and advice (in English, Russian, Spanish, and Vietnamese)
Emotional support	Train clinical staff how to interact with frustrated/unhappy members
	Sit while talking with patients to show greater empathy

ence (p = 0.0017). No significant change was seen in patient's satisfaction with the time it took to obtain an appointment (p = 0.134) or in the percentage of respondents who report that they received instructions or next steps at the end of the visit (p = 0.218).

Results at the team level are summarized (Table 3). Comparing the April and July overall patient satisfaction scores shows that two teams achieved a significant increase (p = 0.0236 and p = 0.0009): one team almost achieved a significant increase (p = 0.0921), and one team almost achieved a significant decrease (p = 0.07); the other teams did not show a statistically significant change in overall patient satisfaction during the first four months of the Collaborative.

Comparison with Results of KPNW Medical Office Visit (MOV) Survey

Results of the patient survey distributed by the KPNW Customer Service Collaborative teams were compared with the results of another survey, the KPNW Medical Office Visit (MOV) Survey, which is a mail survey administered by an outside vendor. Results for the second quarter of 1999 were separated into Collaborative team data and non-Collaborative team data. Whereas the Collaborative teams scored significantly higher than non-Collaborative teams on only one MOV question, the Collaborative teams scored higher on 76% of the MOV questions, a finding greater than could be expected by chance alone.

Discussion

The most important consideration in interpreting these results is that this is a mid-cycle report, not a detailed analysis of a completed project. At the end of the Collaborative, the final, complete results, including employee satisfaction data, will be analyzed in depth, permitting more sound conclusions. Our findings will be published in a subsequent issue of *The Permanente Journal*.

Aggregate results from the Collaborative surveys show promising signs of success. The substantial improvement in *Nurse/Medical Assistant Interest and Attention, Provider Listening,* and *Overall Satisfaction* is encouraging given the many improvement activities underway to address these areas. The lack of improvement in *Time to Appointment* is not surprising given that none of the Collaborative teams are addressing this area at this time. Until now, Collaborative teams have been focusing almost exclusively on aspects of the patient visit that are under the team's direct control. The amount of time it takes to obtain an appointment involves more global system issues and will be more challenging for teams to address.

Results at the team level are more difficult to interpret given small survey sample sizes. The consultants for the teams are helping to diagnose problems and to remedy the situation so that the teams will be able to continue monitoring their progress.

In addition, the teams are progressing at varying speeds. Some teams discovered a need to address team dynamics before implementing many customer service improvement activities and thus are not yet in a

Table 2. Early findings of patient surveys distributed by KPNW Customer Service Collaborative Teams

Survey question	Mean score[a] April 1999	Mean score July 1999	p value
Time to Appointment	7.91	7.79	0.1340
Nurse/Medical Assistant Interest and Attention	8.20	8.44	0.0001
Provider Listened	8.33	8.54	0.0001
Received Instructions/Next Steps[b]	96.8%	97.6%	0.218
Overall Satisfaction	8.24	8.42	0.0017

[a]Survey responses scored on a scale of 1 to 9 (9.0 = highest possible result).
[b]Received Instructions/Next Steps is a Yes/No question. Results show percentage of respondents answering "yes."

Table 3. Overall patient satisfaction results achieved by teams in April 1999 and in July 1999

Teams[a]	Mean score April 1999	Sample size	Mean score July 1999	Sample size	p value
Team 1	8.21	200	8.54	201	0.02
Team 2	8.01	245	8.14	65	0.52
Team 3	8.48	360	8.32	142	0.26
Team 4	8.31	197	8.40	189	0.60
Team 5	8.41	68	8.65	121	0.09
Team 6	7.99	211	8.53	199	0.0009
Team 7	8.57	145	7.90	40	0.06
Team 8	8.45	143	8.70	56	0.11
Team 9	7.66	181	7.42	24	0.61
Team 10	8.30	169	8.13	23	0.70
Team 11	8.49	111	8.15	100	0.07

[a]Two additional teams did not have enough surveys to be able to make this comparison.

position to significantly impact overall patient satisfaction. Other teams started strong and are already producing substantial results. Most teams are achieving results between these two extremes.

The MOV Survey results for the Collaborative teams compared with the non-Collaborative teams provide additional preliminary evidence that the improvement activities may be making a difference. Data for the third and fourth quarters of 1999 will be analyzed and compared in the same way to determine if Collaborative teams continue to score higher than non-Collaborative teams in improving customer service.

Learnings and Next Steps

Teams must function well together before a project of this magnitude can be successfully undertaken; a key learning from the Collaborative's work, therefore, is that involvement in the Collaborative can help to identify underlying dysfunctional *team dynamics*. To address the important issue of team dynamics, a portion of the agenda for the second Learning Session was devoted to team dynamics and communication. In addition, in future Collaboratives, this topic will be addressed at the initial Learning Session, and a structure for early intervention will be designed and implemented.

The *support structure* in place for each Collaborative team has been effective for some teams and not as effective for others. Two especially critical components are 1) the relationship between team and consultants and 2) the consultants' comfort with rapid-cycle measurement and improvement, team facilitation, and team coaching skills. More formalized recruitment of consultants, establishment of clear consultant expectations, and enhanced training of consultants will be incorporated into the 2000 Service Collaborative. In addition, other potential consultant staffing models will be explored. Another critical component of the Collaborative is the role of senior sponsors: Allowing teams to help define the role of their sponsor has been extremely successful.

Local distribution and collection of member satisfaction *surveys* has met with varying success among teams. Teams that recognize the value of the member feedback are the most successful in terms of collecting an adequate number of customer surveys per month with a minimum of staff and member dissatisfaction with the survey process. Teams have had difficulty moving toward alternative methods of gathering customer feedback (eg, direct interviewing and focus groups).

Use of the Customer Service Collaborative *Web site* has varied greatly among teams. Some teams regularly review the information posted on the Web site, a few use the Web site to communicate their project activities, and some teams have not used the Web site at all. The critical component in this communication-related area appears to be the role of the consultant, and a more successful approach might be to have a few select consultants assist all teams in use of the Web site.

Despite the fact that this is a midcycle report, planning is already underway for the 2000 KPNW Customer Service Collaborative. The structure of the Collaborative is continuously being evaluated for potential improvement opportunities.

Conclusion

The 1999 KPNW Customer Service Collaborative is showing early signs of success. Although many modifications are planned for the Year 2000 Collaborative, the main structure of the Customer Service Collaborative will remain. KPNW senior leadership has recently reaffirmed its endorsement of the model for moving KPNW toward an organization known for service excellence. ❖

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References

1. Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. The improvement guide: A practical approach to enhancing organizational performance. San Francisco: Jossey-Bass Publishers; 1996.(The Jossey-Bass business & management series)
2. Gerteis M, Edgeman-Levitan S, Daley J, Delbanco T, editors. Through the patient's eyes: Understanding and promoting patient-centered care. San Francisco: Jossey-Bass Publishers; 1993. (Jossey-Bass health series)

Uncited Supporting Articles

1. Issel LM, Kahn D. The economic value of caring. Health Care Manage Rev 1998 Fall;23(4):43-53.
2. Kam SM, Brooks SM. Touching the customer by understanding employees: Preliminary linkage research findings from four regions of Kaiser Permanente. Permanente J 1998;2(2):47-54.
3. Morton J. Health care redesign. Improving customer satisfaction: Emerging lessons about strategy and implementation. Manag Care Q 1995 Spring;3(2):33-42.
4. Morton J. Improving customer satisfaction: Emerging lessons about strategy and implementation, Part 2. Manag Care Q 1995 Summer;3(3):30-45.
5. Pichert JW, Miller CS, Hollo AH, Gauld-Jaeger J, Federspiel CF, Hickson GB. What health professionals can do to identify and resolve patient dissatisfaction Jt comm. J Qual Improvement 1998;24(6):303-12.
6. Sheth JN, Mittal B. The health of the health care industry: A report card from American consumers. Marketing Health Serv 1997 Winter;17(4):28-35.
7. Swenson K, Acton V. Building and delivering the Kaiser Permanente Promise. Permanente J 1998;2(1):33-6.