

WORKING P A P E R

Improving Performance For Health Plan Customer Service

A Case Study of a Successful CAHPS Quality Improvement Intervention

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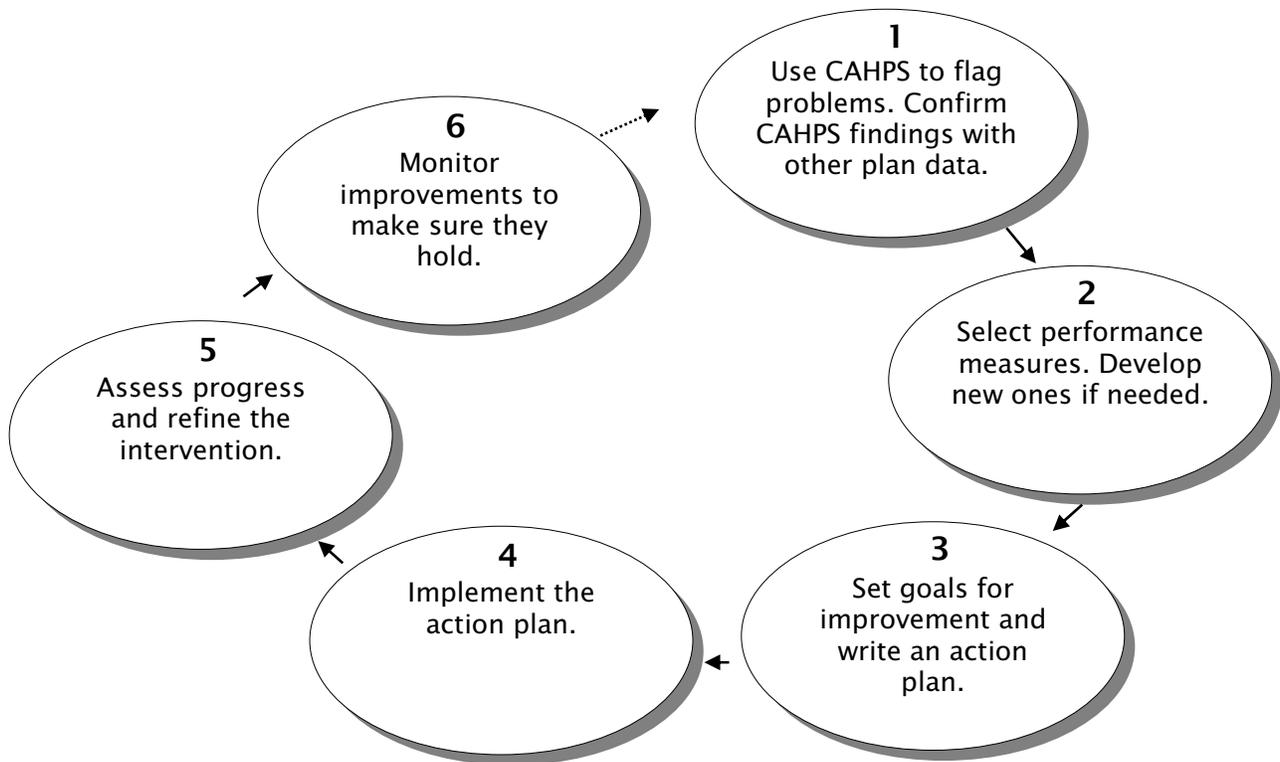
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THE CASE STUDY IN BRIEF

Introduction

This report describes the successful efforts of one full-service health plan to improve customer service for its members. Customer experience ratings provided by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which the health plan fielded annually after CAHPS began in 1995, indicated that the customer service capabilities of the health plan needed to be improved. By the late 1990s, monthly reports from the plan’s Member Services Department and surveys of the plan’s members confirmed CAHPS’s findings. This confirmation was the first step in the plan’s six-step approach to quality improvement. Figure 1 shows the six steps, which are based on the well-established Plan-Do-Study-Act (PDSA) cycle.¹

Figure 1. Six Steps to Ongoing Quality Improvement



This report begins with a summary of what the health plan did, what the results were, and what lessons were learned that may be helpful to others. The summary is organized around the six steps. For this particular quality improvement effort, the health plan went through the PDSA cycle twice—the process is intended to be iterative—until it developed a mix of intervention strategies that produced results. Following the summary is a more detailed description of the plan’s quality improvement intervention.

¹ To learn more about the PDSA approach see the Institute for Healthcare Improvement’s public website at www.QualityHealthCare.org.

The Short Story

Who?

A full-service health care benefits plan founded in the 1980s, serving 500,000 members in the northeastern region of the United States.

What?

The plan implemented a successful quality improvement intervention to improve its customer service.

Why?

Data provided by the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and data developed by the plan itself indicated that the plan's Member Services Department was unable to meet current customer service needs and support the growing needs of the plan.

When?

A quality improvement action plan was implemented in 1999. The first performance goals were reached in 2000, but quality improvement is ongoing.

Where?

The plan focused on customer service and the Member Services Department.

How?

The plan developed a multi-faceted, iterative strategy to improve several aspects of customer service and to support continuous improvement based on lessons learned.

So What?

The health plan made dramatic improvements in its customer service function. The lessons learned during the effort may be helpful to others.

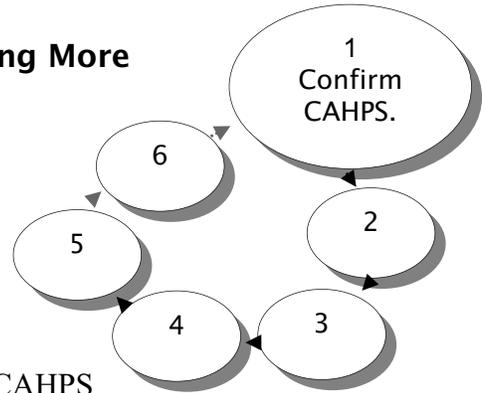
- While the CAHPS survey can signal that customer service problems exist, other surveys and assessment tools were needed in order to identify specific problems, their underlying causes, and actions for improvement.
- Operational and customer experience data are essential for ensuring that quality improvement interventions meet their objectives.
- To achieve lasting change, goal setting and quality improvement efforts need to take a systems approach.
- When implementing quality improvement actions, major changes in organization, staffing, and processes may be required.
- Organizations should expect to make mid-course corrections to their quality improvement action plans and longer-term adjustments to their goals and strategies as circumstances inside and outside the organization change.

The Steps

Step 1: Confirm CAHPS Findings by Gathering More Information

What Did the Health Plan Do?

- Continued participating in CAHPS as required for meeting National Committee on Quality Assurance (NCQA) accreditation standards.
- Gathered specific information to learn more about customer service problems identified by CAHPS survey data.
 - Conducted other member surveys to gather more information on the plan's performance in customer service and related issues.
 - Examined trends for three customer experience measures, one based on the CAHPS survey and two based on the member surveys:
 - Percent of members saying it was "not a problem" getting customer help (CAHPS measure)
 - Percent saying it was "easy" to reach a service representative
 - Average reported waiting time to reach service representative
 - Examined some operational performance measures that were based on the monthly reports from the Member Services Department.
 - Conducted employee exit interviews in 1998 and 1999 to identify staff issues.
- Benchmarked its performance on CAHPS against other regional and national plans by using Quality Compass (www.ncqa.org/Info/QualityCompass/index.htm), a comprehensive database of health plan performance data collected by the National Committee for Quality Assurance.



What Did the Plan Find Out?

Additional data from other sources confirmed what CAHPS data had suggested: the plan's customer service capabilities needed to be improved. The plan was unable to provide timely and efficient telephone service to its customers due to:

- Lack of experienced representatives to take incoming calls because of high staff turnover rate.
- The steep learning curve for new employees.

Surveys suggested that customers' experiences with the Member Services Department influenced their feelings about the plan in general and that service representatives' performance ratings improved as their length of employment increased.

Exit interviews revealed that the plan's compensation rate for service representatives was not competitive, training and educational opportunities were lacking, and workers perceived their positions as "dead-end" jobs with little or no chance for advancement.

It was clear that improvements should focus on the Member Services Department and on staff retention.

Take-Away Lessons

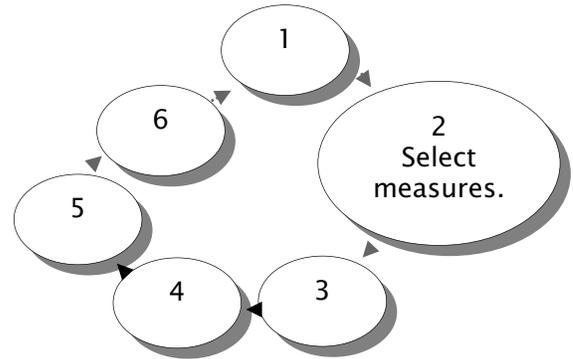


- Participate in CAHPS—it is an important, nationally recognized, monitoring and diagnostic tool.
- Use CAHPS findings to compare your plan's performance to that of other plans.
- Don't rely on CAHPS alone to diagnose performance issues specific to the health plan. CAHPS is designed to fit all health plans and may be too general to use as a stand-alone measure of customer experience. Supplement CAHPS core data with other survey and measurement tools to identify specific problems, causes, and actions for improvement. Conduct member surveys and interviews, for example.

Step 2: Select Measures. Decide What Should be Measured, Examine Data Gathered in Step 1, and Develop New Measures as Needed.

What Did the Health Plan Do?

- Focused on improving customer service, based on the CAHPS survey results showing poor customer service performance and on results from other surveys and staff exit interviews.
- In the first iteration of this step, the health plan selected the following operational measures from their monthly reports and tracked them.
 - Speed to answer customer calls
 - “Total service factor”—portion of calls answered in less than 30 seconds
 - Call abandonment rate
 - Employee turnover rate among Member Services staff
- In the second iteration of this step, the new director of the Member Services Department refined the measures so they were better aligned to the performance goal of more efficient handling of member calls.
 - Changed the main performance goal measure for service representatives from number of calls handled to increased “ready time”—the time a service representative is available to accept a call from the queue.
 - Continued to track total service factor, speed to answer customer calls, call abandonment rate, and employee turnover rate among Member Services staff



What Were the Results?

Customer service performance measures selected during the first iteration of the PDSA cycle improved during the second quarter of 1999. However, those gains were lost in the third quarter, and the health plan could not demonstrate improvement in customer service in 1999. Learning from this initial experience, it went back to the drawing board and selected measures that better represented its goal for efficient handling of calls.



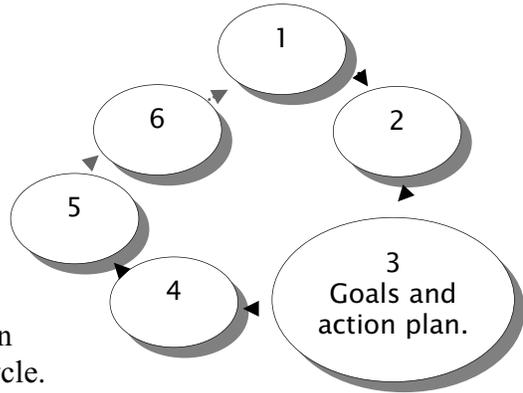
Take-Away Lessons

- Gather and examine real-time information using data from both customer experience surveys and operational processes to ensure that quality improvement interventions meet their objectives.
- Establish process measures that address the various important aspects of the process being improved, making sure that the measures are aligned with the quality improvement goals.
- Develop baseline performance data for these measures, and then measure performance on them regularly as improvement actions are implemented, to identify where progress is being made.
- Be prepared to revise measures as needed, based on experience working with them, to ensure they represent the performance goal appropriately.

Step 3: Set Goals for Improvement and Write an Action Plan

What Did the Health Plan Do?

- Set performance targets for its customer service measures based on industry standards, using 1999 performance as the baseline for measurement going forward.
- Set a goal to demonstrate customer service improvements in two consecutive quarters in 1999, for upcoming NCQA accreditation cycle.
- Expected that its increased focus on customer service and some improvements in telephone service would lead to more positive customer feedback as measured by the plan's Member Services surveys and by CAHPS surveys.
- The director of the Member Services Department developed a plan to redesign career path incentives in order to recruit and retain qualified service representatives.



Plan Has a False Start; Fails to Meet Customer Service Goals

Initial gains in customer service performance measures were made in the second quarter of 1999, but were lost in the third quarter, resulting in no improvement in customer service in 1999. The department's performance problems escalated to a point where the director's original improvement plan could not be implemented.

Back to the Drawing Board



- Leadership of the Member Services Department changed as the director, manager, and training coordinator resigned.
- The health plan created two new manager-level positions: (1) Member Services manager, and (2) Compliance manager (to handle the member appeals process), which were filled in early 2000 with experienced external candidates.
- The plan committed to continuing to administer its member satisfaction survey at least through the next accreditation cycle in 2000.
- New Member Services manager revised the goals and action plan:
 - Revisited the measures (i.e. went back to Step 2) and selected additional measures—added a focus on “ready time.”

- Revisited the action plan and developed a new plan with more detail and actions in a variety of areas/departments to address multifaceted problems.
- Commitment to the revised action plan was obtained from the plan’s Quality Improvement Committee, Service Improvement Committee, Board of Directors and executive leadership.
- Based on results of the actions in 2000, the plan’s quality improvement leaders established new customer service goals for 2001:
 - Sustain the improvements made in 2000 in Member Services telephone performance, and achieve 90 percent total service factor—the portion of calls answered in less than 30 seconds (an increase from the percentage set for 2000).
 - Continue to reinforce the department’s focus on improved service.
 - Emphasize “one-call resolution” for member issues (even though a standard measure for one-call resolution among all plans does not exist, large employers were increasingly requesting whatever information was available about calls that were resolved with one customer service call).
- Along with the new goals in 2001, the plan’s quality improvement leaders revisited the action plan and added several actions to support the progress made.

What Were the Results?



Within a few days after the new Member Services manager changed the performance goal for customer service representatives from call volume to ready time, the call waiting time dropped from several minutes to well under 30 seconds. This served as momentum for pushing forward on the additional actions and revised action plan.

Take-Away Lessons



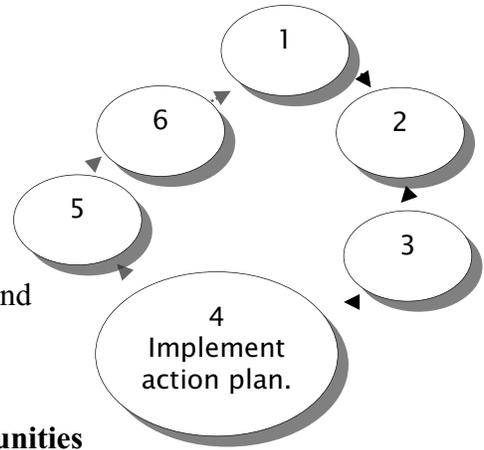
- Take a multifaceted approach to improving performance, including setting goals that address multiple aspects of the issue and pursuing a variety of improvement actions, as it is unlikely that fixing only one process within a complex system will lead to significant and sustainable improvement.
- Proactively establish goals and action plans, and adjust them as needed using experience as a guide to find the best strategies and actions.
- Bring in a new pair of eyes or an entirely new set of people to examine problems and explore ways of fixing them.
- Get commitment and active support from leadership.

Step 4: Implement the Action Plan

What Did the Health Plan Do?

Undertook several specific actions in 2000 to strengthen the customer service function:

- **Redesigned training procedures and information systems** to support the call center and a culture of “How can we work together and get better?”
- **Developed career path and promotion opportunities** for service representatives to improve retention.
- **Increased the level of staffing to meet customer demand.**
- **Empowered the decision making of the service representatives** to improve customer satisfaction. Nine service representatives were trained to use a one-time, “pay and educate” approach to resolving issues that previously would have led to complaints or appeals. For example, when an HMO member sees a specialist without first getting a primary care physician referral, the specialist’s claim for that visit will be denied. A representative may explain this policy to a member, but adjust the first such claim manually so that it is paid, while the member is on the telephone.
- **Re-energized education and training** for Member Services and Compliance staff with team meetings, online training materials, and daily and monthly newsletters.
- **Created a position for a Member Services data analyst** to facilitate shared reporting between Member Services and Compliance. The analyst developed charts that were updated with each month’s new call performance data, enabling the plan to easily track changes in performance measures over time, to recognize improvements, and to identify new trends before they evolved into established patterns.
- **Introduced an after-hours call center** that was open until midnight and on weekends, and offered a combination of services including nurse advice/triage.



What Were the Results?



By the end of 2000, a multi-faceted set of actions had been implemented and set into motion. The expectation was that its increased focus on customer service and some improvements in telephone service would lead to more positive customer feedback.

Take-Away Lessons

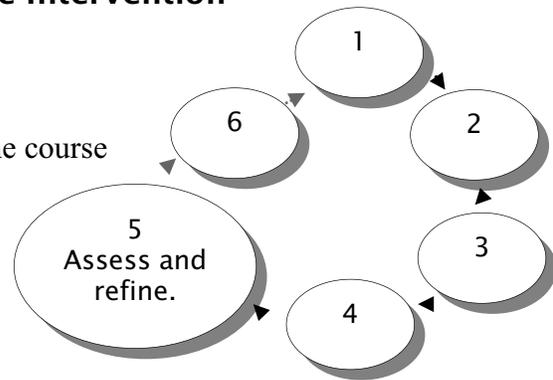


- To put in place the resources needed to bring about improvements, don't hesitate to make changes in organizational structure, staffing, or operating processes as necessary.
- Keep in mind that major changes are disruptive to organizations and individuals, so assess carefully what is "necessary" before making changes.
- Attend to the mindset of the organization and staff. Getting all involved staff "on-board" with a new concept or approach is essential for changing the performance of departments in which they work.
- Remember that the quality improvement process is iterative and continuous—don't hesitate to go back to previous steps when results aren't satisfactory.
- Use all available information to track progress toward improvement goals.
- Persevere in testing and reinforcing use of new practices and in seeking ideas and feedback from front-line staff and others with knowledge of the process being improved.

Step 5: Assess Progress and Refine the Intervention

What Did the Health Plan Do?

- Monitored performance measures over the course of the quality improvement intervention and compared them to performance goals.
- Discussed performance issues with the Service Improvement Committee after results were obtained and analyzed.
- Delivered annual performance reports to the Quality Improvement Committee and Board of Directors.
- Delivered Member Services annual report to the Service Improvement Committee, Quality Improvement Committee, and Board of Directors.
- Promoted Member Services and Compliance managers to directors in their own departments.
- Made plans to stay abreast of the changing competitive and regulatory environments.
- Took actions to enhance staff capabilities to support the progress made:
 - **Moved all Member Services reference material online** for easy access by service representatives.
 - **Reconfigured the plan's quality control contract tracking system** (the core system used in customer service, but tailored to an individual plan's needs) and implemented it in the second quarter of 2002.
 - **Established feedback reinforcement of improved performance** by celebrating with Member Services staff, who received gifts when goals were met, and by publicizing the successes throughout the organization so that individuals were appropriately recognized for their efforts.
 - **Set more ambitious performance goals for 2001**, building upon progress made in 2000.
- Developed new quality improvement projects and refined survey instruments and measurement tools.

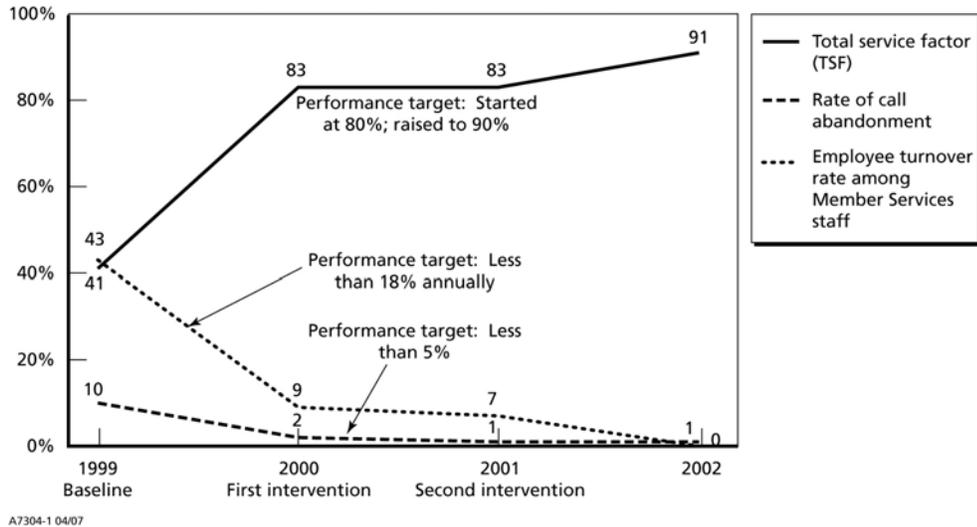




What Were the Results?

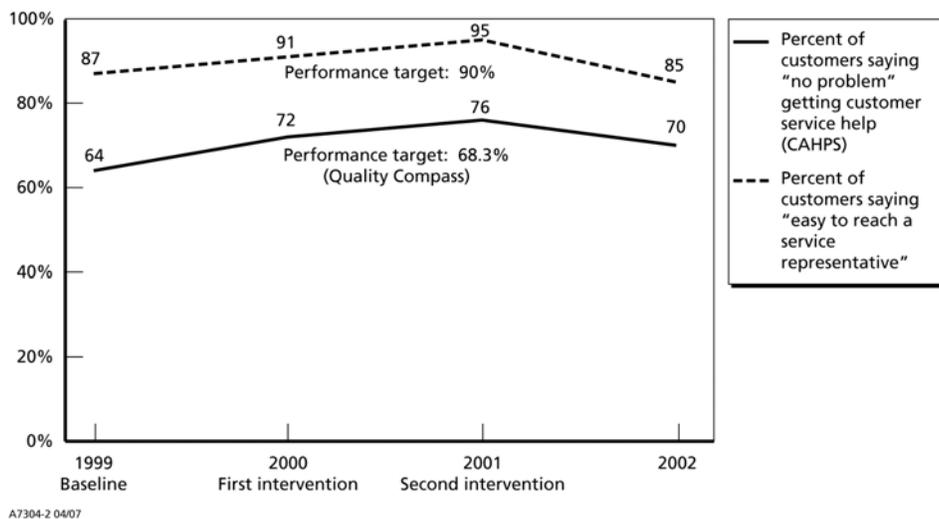
By the end of 2000, the plan had met all of its operational goals, including total service factor, call abandonment rate, and employee turnover rate among Member Services staff (see Figure 2). The plan also met its goal for average speed to answer a call.

Figure 2. The Health Plan Met Its Operational Performance Goals by the End of 2000



The plan also met its customer experience goals in 2000 (see Figure 3). Members reported that it was “not a problem” getting the help they needed when calling Member Services. Members also reported, “It was easy to get through to a Member Services representative.”

Figure 3. The Plan Met Its Customer Service Performance Goals by the End of 2000



The Service Improvement Committee agreed that actions implemented in 2000 and 2001 had improved the level of service delivered to plan members, and the intervention was recognized by the National Committee on Quality Assurance as a meaningful quality improvement approach.

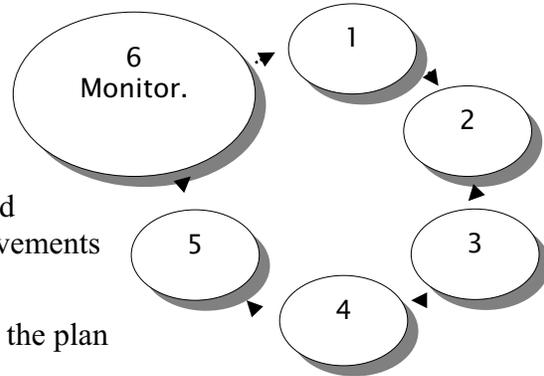
As a result of the additional actions taken in 2001, customer service continued to get better. All of the customer service goals achieved in 2000 were sustained through 2001, with the exception of total service factor (the revised 90 percent goal was not achieved until 2002).



Take-Away Lessons

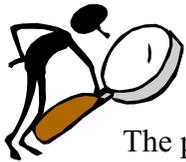
- Be patient and persevere. Some actions may show positive results immediately; others may take several quarters; and others may not work at all.
- Be prepared to identify actions or measures that are not working, identify reasons why not, and seek alternative approaches.
- As circumstances inside and outside the organization change, expect to adjust to those new circumstances by making mid-course corrections to action plans and longer-term adjustments to goals and strategies.
- Be accountable for improvement results by regularly reporting goals and progress to leadership.
- Showcase successful process improvements and document their impact on members' experience of care.

Step 6: Monitor Improvements to Make Sure They Hold



What Did the Health Plan Do?

- Continued to monitor CAHPS scores and other measures to make sure that improvements continued.
- Conducted an analysis of the challenges the plan might face in the future.
- Responded to findings of analysis by addressing potentially troublesome areas.
- Worked with vendor to dig deeper and measure specific areas of concern.



What Were the Results?

The plan held onto the gains it had made in improved customer service.

The plan was able to prepare for events that might compromise customer service. For example, the plan knew that when it sent letters to its members mandated by the Employment Retirement Income Security Act (ERISA) in the third quarter of 2002, Member Services would receive calls from members who had questions about the letters, so it added more staff.



Take-Away Lessons

- Continuously monitor indicators such as CAHPS and proprietary surveys to make sure improvements stick.
- Try to anticipate challenges that may emerge due to changes in the organization, its environment, or its members' needs.

THE CASE STUDY IN MORE DETAIL

Background

In 1995, the Agency for Healthcare Research and Quality (AHRQ) initiated the Consumer Assessment of Healthcare Providers and Systems Study (formerly the Consumer Assessment of Health Plans Study (CAHPS[®])) in order to develop survey and reporting products that provide customer feedback on health plan and provider performance, thereby helping consumers to make informed health plan choices. AHRQ initiated a second phase of CAHPS (CAHPS II) in 2002 to address the concerns of health plans and health care providers that the CAHPS survey does not provide sufficient useful information to guide quality improvement (QI) efforts, particularly in areas of importance to consumers.

As part of the CAHPS II consortium, the RAND Corporation has developed supplemental quality improvement questions for the CAHPS health plan survey that can be used to further diagnose reasons for low CAHPS scores as well as a variety of other tools to help health care organizations implement needed quality improvement interventions. (Refer to the RAND Technical Report for more information on the quality improvement supplemental items. The report is entitled, “The Development of Supplemental Quality Improvement Items for the Consumer Assessment of Healthcare Providers and Systems (CAHPS),” TR-336, Quigley, 2006.) One tool that can provide concrete and practical information on quality improvement techniques is the case example. A case example tells the story of the actions undertaken by an organization to implement a quality improvement intervention. It focuses on the experiences of the organization’s staff as they planned and carried out the intervention, and it identifies lessons from these experiences that can guide others in implementing similar quality improvement efforts.

This report presents a case example of a successful quality improvement intervention implemented by a full-service health benefits plan to strengthen its customer service function. Rated a top-10 health plan by the National Committee on Quality Assurance (NCQA) in 2002 and 2003, it has a large provider network that includes thousands of area doctors and specialists serving approximately 500,000 members. In addition to offering health insurance to private firms, the plan has also started accepting small numbers of Medicaid patients in specific service areas, and intends to add Medicare patients soon.

The plan has one major competitor in its home region, which has a smaller, less diverse service area.

Drawing on information gathered from interviews conducted with health plan staff, this case example describes the six steps of the quality improvement process through which the plan developed and implemented the intervention:

- Step 1: Confirm CAHPS Findings by Gathering More Information
- Step 2: Select Measures. Decide What Should be Measured, Examine Data Gathered in Step 1, and Develop New Measures as Needed
- Step 3: Set Goals for Improvement and Write an Action Plan
- Step 4: Implement the Action Plan
- Step 5: Assess Progress in Achieving Performance Goals and Refine the Intervention as Needed
- Step 6: Monitor the Improvements for Sustainability

The six steps are based on the well-established PDSA cycle—Plan, Do, Study Act—and are intended to be iterative. To learn more about the PDSA approach see the Institute for Healthcare Improvement’s public website at www.QualityHealthCare.org. The report concludes with lessons learned from this experience that should prove useful to other health plans in need of strengthening their customer service capabilities.

Step 1: Confirm CAHPS Findings by Gathering More Information Relevant to Areas that Need Further Study

The health plan that is the subject of this case study uses the CAHPS survey to meet NCQA accreditation standards, to comply with regulatory reporting requirements, to benchmark the plan's performance against other plans, and to market the plan to potential new members. It benchmarks its own performance on CAHPS against national and regional health maintenance organization/point of service plan averages in Quality Compass (www.ncqa.org/Info/QualityCompass/index.htm) as well as those of regional competitors across its service area. A "best in market" analysis is completed each year. Quality Compass is a comprehensive database of health plan performance data collected by

The health plan gathered together CAHPS data and all other data relevant to the quality problem.

the National Committee for Quality Assurance, a private non-profit organization founded in 1990 dedicated to improving healthcare quality. It is a tool for selecting a health plan, conducting competitor analysis, examining quality improvement, and benchmarking plan performance.

Between 1996 and 1997, the health plan, like many other growing health plans, faced a range of operational challenges. For several years, customer experience ratings provided by the CAHPS survey indicated that the plan's customer service capabilities needed to be improved. However, corporate priorities were focused on maintaining financial stability in a difficult market. By the late 1990s, the Member Services Department, originally created for a small regional health maintenance organization (HMO), was no longer able to meet the increasingly complex needs of the plan's growing membership.

In Step 1 of the quality improvement process, the health plan gathered together the CAHPS survey items and other metrics relevant to the problem from as many sources as possible. The data came from operational and cost data, other surveys, etc.

Monthly departmental reports and member surveys showed that operational measures for telephone performance were poor, and they were not improving. The

department was also having problems retaining the staff required to effectively manage the volume of calls received. By 1998, the department had the highest turnover rate (51.5 percent) within the organization. Employee exit interviews in 1998 and 1999 revealed that the plan's compensation rate for service representatives was not competitive, training and educational opportunities were lacking, and workers perceived their positions as "dead-end" jobs with little or no chance for advancement.

The plan's inability to provide timely and efficient telephone service stemmed from two interrelated issues: (1) lack of experienced representatives to take incoming calls because of the high staff turnover rate, and (2) the steep learning curve for new employees. The industry customer service standard is approximately one representative per 8,000 members. In 1999, the health plan had one representative for every 13,000 members. On average, it took nine months for a newly hired service representative with no previous experience to reach top performance within the department. Although the director of the Member Services Department had developed a plan to redesign career path incentives in order to recruit and retain qualified service representatives, by 1999 the department's problems had escalated to a point where the plan could not be implemented.

Step 2: Select Measures. Decide What Should be Measured, Examine Data Gathered in Step 1, and Develop New Measures as Needed

The next step is to examine all of the data and identify baseline performance trends, an overall picture of the problem, and to establish where there is need for improvement and what measures would best be used to track the problem and provide motivate change.

In order to assess its ongoing customer service performance, the health plan tracked several measures. Four were operational measures, based on telephone and employment statistics collected by the Member Services Department and reported monthly. Three were customer experience measures; one was based on the CAHPS survey and two were based on the plan's Member Satisfaction with Member Services survey.

The Member Satisfaction survey, as well as the plan's six additional proprietary member surveys, are developed with, and conducted by, a local research company. The plan uses information obtained from these surveys to identify opportunities to improve

quality and processes, to measure the impact of specific interventions, to provide customer experience measures for physician quality reports that are included in its pay-for-

performance incentive, and to respond to various requests for information and proposals.

The results of the Member Satisfaction survey are used to assess members' experiences on calls and to better understand customer service needs on a timelier basis than that afforded by the annual CAHPS survey.

The Member Satisfaction survey was conducted on a monthly basis with a random sample of 200 members who call the plan's Member Services department with questions or concerns. The results are used to assess members' experiences on calls and to better understand customer service needs on a timelier basis than that afforded by the annual CAHPS survey. The two sets of customer service measures are presented in

Table 1, along with performance targets and baseline performance in 1999. Performance targets were set based on industry standards.

Table 1. Targets and Baseline Performance for the Customer Service Measures

Measure	Performance Target	Baseline (1999) Performance
Operational Measures: (Industry standard)		
Speed to answer calls	Less than 30 seconds	90 seconds
Total service factor (TSF)*	Started with 80 percent; raised to 90 percent	41 percent
Call abandonment rate	Less than 5 percent	9.5 percent
Employee turnover rate among Member Services staff	Less than 18 percent annually **	43.4 percent
Customer Experience Measures:		
Percent saying “Not a problem” getting customer help ***	68.3 percent >/=90 th percentile in Quality Compass	64.6 percent
Percent saying it was “easy” to reach a service representative ****	90 percent	87 percent
Average reported waiting time to reach representative****	A decrease in member’s perception of time spent	3 minutes

* Percentage of member calls that were answered within the targeted 30 seconds.

** Turnover rate at a staffing level of one service representative per 8,000 members.

*** Based on the annual CAHPS survey.

**** Based on the health plan’s Member Experience with Member Services survey.

Analysis of the 1999 mid-year Member Satisfaction survey results showed that customers’ experience with the Member Services Department was very significantly correlated ($R^2 = 0.57$ at $p < 0.0000$) with their overall experience with the health plan. Predictors of overall member experience with the Member Services Department included: (1) confidence that the service representative would follow through on resolving the question or problem; (2) helpfulness of the service representative; (3) resolution of the question or problem; (4) number of calls made regarding the same question or problem; and (5) clarity of the service representative’s explanations. Together, these factors explained more than half of the variation in experience reported in the survey results ($R^2 = 0.58$).

In addition, the performance ratings received by the service representatives for four specific factors were correlated significantly with their length of employment at the plan. Pearson correlation scores showed statistically significant relationships between service representatives' length of service and member ratings for the following characteristics at $p < 0.05$: (1) courtesy and respect ($R^2 = 0.55$); (2) listening ($R^2 = 0.45$); (3) explaining things clearly ($R^2 = 0.38$); and (4) helpfulness ($R^2 = 0.39$). These relationships reinforced the importance of hiring, training, and retaining an adequate level of staff to handle member calls effectively.

Another part of Step 2 is to share the data and overall picture with plan leadership.

Although the health plan's customer service performance measures improved during the second quarter of 1999, the gains made in the second quarter were lost in the third quarter. As a result, the plan could not demonstrate an improvement in customer service in 1999. This sent them back to the drawing board to revisit their measures, goals and planned intervention.

In the second iteration of this step, the new manager of the Member Services Department selected measures that were better aligned to the performance goal of more efficient handling of member calls. He changed the main performance goal measure for service representatives from the number of calls handled to increased "ready time"—the time a service representative is available to accept a call from the queue. The plan continued to track the operational measures and patient experience measures.

Step 3: Set Goals for Improvement and Write an Action Plan

The plan has created a quality improvement program structure that guides all of its quality improvement efforts. Quality improvement projects may be developed based on staff-level analyses, member suggestions and survey responses, or corporate priorities as defined by senior staff. Improving customer service and achieving operational excellence have been identified as corporate goals in recent years. When customer service improvement opportunities are identified, they are brought for discussion to the Service Improvement Committee (SIC), which represents every functional area of the organization, and delegated to the appropriate SIC subcommittee for further consideration. Each

subcommittee has regular meetings and reports its progress to the entire SIC. Updates from the Member Services Department are reviewed and discussed during the SIC's monthly meetings. These discussions may lead to policy recommendations and/or the initiation of quality improvement projects. All activities are coordinated by the SIC, which provides regular reports to the Quality Improvement Committee (QIC). Ultimate responsibility for all quality improvement efforts rests with the plan's Board of Directors.

The plan focuses intensive evaluation efforts on those quality improvement projects that it expects to qualify for NCQA credit as a Quality Improvement Activity (QIA) during each accreditation cycle. QIAs must demonstrate that the plan has achieved a "meaningful" improvement in service for a "significant" portion of its membership. The plan typically prepares three QIA projects each three-year cycle in order to ensure that at least two projects will meet NCQA standards.

The health plan's customer service performance measures improved during the second quarter of 1999, but the gains made in the second quarter were lost in the third quarter. The plan could not demonstrate improvement in customer service in 1999.

In 1999, in anticipation of its upcoming NCQA accreditation cycle, the plan hoped to demonstrate near-term performance improvements (i.e., measured quarterly and sustained over two quarters) in its customer service function. Since the Member Services Department is the first point of contact for new customers, the plan expected that focusing quality improvement efforts on improving customer service telephone performance would lead to a higher level of customer experience, and ultimately an enhanced reputation and larger market share for the organization.

Although the health plan's customer service performance measures improved during the second quarter of 1999, the gains made in the second quarter were lost in the third quarter. As a result, the plan could not demonstrate an improvement in customer service in 1999. In addition, shortly before the plan's scheduled NCQA accreditation site visit in

1999, the Member Services Department director, manager, and training coordinator resigned their positions.

Despite these obstacles, the health plan's leadership decided to move forward with its goal of improving customer service, and to continue to administer the Member Satisfaction survey through the next accreditation cycle. Two new manager-level positions were created to replace the outgoing director: Member Services manager and Compliance manager (to handle the member appeals process).

The health plan in conjunction with the new Member Services manager designed a revised action plan for improving its customer service capabilities based on two principal strategies: (1) aligning performance goals for service representatives with the desired

outcome of more efficient handling of member calls; and (2) achieving and maintaining adequate staffing by resolving human resources issues that contributed to low morale and high turnover.

The Member Services Department created an incentive for service representatives to be available to answer calls when needed, regardless of the volume of calls they had already handled.

In January of 2000, the new Member Services manager revisited the measures (i.e. went back to Step 2) and selected measures that added focus on "ready time." He quickly realized that the performance target for service representatives were not aligned with the goal of more efficient handling of member calls, and he replaced the existing target

of "call volume" with a new target of "ready time." Call volume is the number of calls handled by a service representative. Ready time is the amount of time a service representative is available to accept a call from the phone queue. With a call volume performance goal, service representatives could meet their target volume early with short call times and then log off the queue, becoming inaccessible to members and increasing the call burden and the average speed to answer (ASA) calls later in the day. As a result of the call burden, fewer service representatives were available to take calls, and the ASA increased. After the performance target was changed, call volume was still measured separately (i.e., service representatives were not penalized for taking longer one the first

call to completely resolve a more complex issue on the phone), but ready time became the more important performance goal. With the focus off of call volume and the focus shifted to ready time with an emphasis on one-call resolution, the call burden decreased. The reduced call burden improved the average speed to answer, call volume, ready time, call abandonment and total service factor. Thus, the department created an incentive for service representatives to be available to answer calls when needed, regardless of the volume of calls they had already handled. Service representatives were trained and encouraged to complete as much documentation as possible while they were on the telephone in order to be ready for the next call as soon as possible. With the new goals in mind, the Member Services manager also revisited the action plan and developed a new plan with more detail and a variety of actions to address multifaceted problems.

In accordance with its standard quality improvement procedures, updates from the Member Services Department were reviewed and discussed at subsequent SIC monthly meetings, and annual progress reports were presented to the SIC and the Board of Directors. Based on the results of these reports, the department's goals and challenges for subsequent years were identified and pursued. The changes were approved by the Quality Improvement Committee, SIC, Board of Directors and executive leadership.

Based on the results of the 2000 actions, the plan's quality improvement leaders established new customer service goals for 2001. They agreed to sustain the improvements made in 2000 and aimed to achieve 90 percent total service factor as well as to emphasize "one-call resolution" for member issues. Even though a standard measure for one-call resolution among all health plans did not exist, large employers who were deciding upon various health plan benefits for their employees were increasingly requesting from health

The health plan aimed to improve its customer service by: (1) aligning performance goals for service representatives with the desired outcome of more efficient handling of member calls; and (2) achieving and maintaining adequate staffing by resolving human resources issues that contributed to low morale and high turnover.

plans whatever operational or other information was available about the number of calls that were resolved within one customer service call. These types of requests indicated to the plan the importance of one-call resolution for consumers and for purchasers.

Along with the new goals in 2001, the plan's quality improvement leaders revisited the action plan and added several actions to support the progress made.

Step 4: Implement Improvement Actions

In early 2000, both the Member Services manager and Compliance manager positions were filled by external candidates who brought substantial professional experience in their respective areas. A number of specific actions to strengthen the plan's customer service function were undertaken over the course of the year. These actions are described below in the order in which they were implemented.

January 2000

Redesigned training procedures and information systems to support a call center focus. The health plan instituted continuous training for service representatives, including regular call center staff meetings; walk-around training and call-coaching programs; and daily intranet updates that provided information about staffing questions, work schedules, recent customer complaints, etc. Although the Member Services Department was recognized as the initial point of contact for members who need to communicate with the plan, the plan's leadership acknowledged that the service representatives were not prepared to resolve every issue. Cross training with staff from other departments that interact with Member Services (e.g., Operations, Utilization Management, Pharmacy, and Legal Affairs) was initiated to improve understanding and resolution of member issues. The syndrome of "It's not our problem" was replaced with a new focus on the member's overall experience with the health plan. The new paradigm became "Are members getting our attention? How can we do that better?"

Developed career path and promotion opportunities for service representatives. In an effort to recruit and retain qualified service representatives, the health plan refined and implemented the career path strategy that had been developed under the previous Member

Services manager. In the old system, there was only one level of service representative. If the representative performed well, he or she could possibly move to the Compliance unit, which handles member appeals, but there was no opportunity to advance within the Member Services Department. To increase retention, the health plan created a career path for service representatives with three tiers, enabling existing staff to advance within the newly established departmental ranks. Advancement up the tiers results in a title change and a salary increase. A similar system was designed for the Compliance staff.

February 2000

Increased the level of staffing to meet customer demand. Proactive hiring of service representatives was implemented to meet customer demand based on the standard industry ratio of one representative per 8,000 members. Allowances were also made for normal staff attrition, and new service representatives were recruited at more competitive compensation levels.

Empowered the decision making of the service representatives. Nine service representatives received training in claims adjustments so they could provide services to members at the point of contact. These trained representatives were permitted to use a one-time, “pay and educate” approach to resolving member issues that previously would have led to complaints or appeals. For example, when an HMO member sees a specialist without first getting a primary care physician referral, the specialist’s claim for that visit will be denied. Trained service representatives would explain this referral policy to the member calling in, and adjust the first such claim manually while the member is on the telephone. Thus, the service representatives were given more responsibility for problem resolution, and the number of appeals filed by members decreased, improving the experience of all parties concerned.

Re-energized staff education and training for Member Services and Compliance staff. Service representatives were encouraged to meet in teams to discuss current member issues (e.g., “I am getting calls about this; are you getting calls about this?”). Additional training tools were developed to address needs identified by the staff. The Member Services Department’s training manual was moved online; a “Daily Update” was introduced via email to provide timely information about department activities, reminders,

and performance statistics; and the Cubicle Chronicle monthly Member Services newsletter was produced, providing additional training and information. Training was also stepped up for the Compliance staff, which received information on a number of important topics such as conflict resolution.

April 2000

Hired Member Services data analyst. A data analyst position was created to facilitate shared reporting between the Member Services and Compliance units. The analyst developed charts that were updated with each month's new call performance data, enabling the plan to easily track changes in performance measures over time, to recognize improvements, and to identify new trends before they evolved into established patterns. These improvements enabled the Member Services Department to provide quicker responses to issues of importance to call center staff and to address member "hot spots" on a timelier basis.

July 2000

Introduced After Hours call center. Previously, the Member Services call center operated during normal business hours and rolled over to an answering system at night. To improve telephone access for members, the plan introduced an After Hours call center that stayed open until midnight and offered a combination of services, including customer service and nurse advice/triage. The registered nurses in the new center also completed utilization management tasks when they were not speaking with members on the phones.

August 2000

Expanded After Hours call center. To further improve telephone access for members, the plan expanded the After Hours evening call center to include weekend coverage.

November 2000

Provided training updates. The plan provided additional training to service representatives, to ensure that consistent and appropriate information was communicated to its members, especially information related to confidentiality policies and procedures, and specific guidelines for release of information upon a member's request.

By the end of 2000, a multi-faceted set of actions had been implemented and set into motion. The expectation was that its increased focus on customer service and some improvements in telephone service would lead to more positive customer feedback.

Step 5: Assess Progress in Achieving Goals and Refine Intervention

Over the course of the quality improvement intervention, the health plan assessed its performance measures and compared them to the performance goals. Once the results were obtained and analyzed, performance issues were discussed within the SIC, and additional suggestions for improvements were made and implemented.

Additional Actions in 2001

Based on the results of the intervention in 2000, the plan's quality improvement leaders established new customer service goals for 2001. These were: (1) sustain the improvements made in Member Services' telephone performance, and achieve 90 percent total service factor; (2) continue upgrading the department's focus on improved service to members; (3) emphasize "one-call resolution" for member issues (even though a standard measure for one-call resolution across plans does not exist, large employers were increasingly requesting this information); (4) move all Member Services reference material online (i.e., into "RoboHelp," the plan's on-line help system for call representatives to use during customer service calls. RoboHelp is a help authoring tool—HAT—used by technical writers to create computer help files in various formats for easy access by phone representatives); and (5) reconfigure the plan's quality control tracking system, with a go-live date set for the second quarter of 2002. A number of other actions were undertaken in 2001 to enhance the education of Member Services staff and expand the amount of useful information that was available to them. These included providing additional training tools, including call coaching, Member Services statistics, overtime, and RoboHelp tasks; making reference tools (i.e., Benefit Interpretation Manual and Member Services Training and Reference Manual) available online; and offering additional training to ensure that consistent and appropriate information was communicated to members.

Besides assessing its progress over the course of the quality improvement intervention, the health plan also delivered annual performance reports to the QIC and the Board of Directors. Table 2 shows the performance achieved in the years following the start of the intervention in early 2000 through 2002 and 2003.

Results at Year-End 2000

As Table 2 illustrates, by year-end in 2000 the plan's operational goals were achieved for average speed to answer, total service factor, call abandonment rate, and employee turnover rate among Member Services staff. Within a few days after the performance target for service representatives was changed from call volume to ready time, the department's ASA dropped from several minutes to well under 30 seconds. By the end of the year, there was one service representative for every 7,440 members, compared to the one representative per 13,000 members at the start of the year.

Within a few days after the performance target for service representatives was changed from call volume to ready time, the department's ASA dropped from several minutes to well under 30 seconds.

The plan's customer experience goals were also achieved in 2000. The percentage of members responding that it was "not a problem" getting the help they needed when calling Customer Service" (CAHPS, Question 41) actually exceeded the Quality Compass 90th percentile mark of 68.3 percent in 2000, and the percent of members responding that "it was easy to get through to a Member Services representative," (Member Satisfaction survey) also exceeded the 90 percent performance target. The average perceived waiting time was reduced from three minutes to two minutes and the range of actual waiting time was reduced from 0-60 minutes to 0-40 minutes.

These successes were celebrated with Member Services staff, and gifts were distributed when goals were met. The quality improvement team also publicized these successes throughout the organization so that individuals were appropriately recognized for their efforts.

Table 2. Customer Service Performance Measures Tracked Over Time

Performance measures	Performance target	1999 Baseline	2000 1st inter-vention	2001 2nd inter-vention	2002	2003
<i>Operational measures:</i>	(Industry standard)					
Average speed to answer (ASA) calls	Less than 30 seconds	90 seconds	26 seconds	17 seconds	13 seconds	
Total service factor (TSF)*	Started with 80 percent; raised to 90 percent	41 %	83%	83%	91%	
Rate of call abandonment	Less than 5%	9.5 %	2.2 %	0.9%	0.8%	
Employee turnover rate among Member Services staff	Less than 18% annually**	43.4 %	8.6 %	6.7%	0%	
<i>Customer experience measures:</i>						
Percent saying “No problem” getting customer service help (CAHPS)	68.3 % (Quality Compass)	64.6 %	71.7 %	75.5%	70.1%	
Percent saying “easy to reach a service representative”	90 %	87 %	91%	95%	85%***	94%
Average waiting time to reach representative as reported by caller (range)	A decrease in member’s perception of time spent	3 minutes (0-60 minutes)	2 minutes (0-40 minutes)	2 minutes (0-30 minutes)	4 minutes (0-45)	2 minutes (0-20)

* Percentage of member calls that were answered within the targeted 30 seconds.

** Turnover rate at a staffing level of 1 service representative per 8,000 members.

*** Survey was collected in December 2002; low score was attributed to core system conversion in the third quarter of 2002, and ERISA requirement mailing around the same time, which increased call volume.

Results at Year-End 2001

As a result of the additional actions taken in 2001, the trend of customer service improvement continued through 2001. All of the customer service goals that were achieved in 2000 were sustained through 2001, with the exception of total service factor (i.e., the revised 90 percent goal was not achieved until 2002). By the end of 2001, there was one representative for every 8,478 members, and staffing increases closely followed membership growth. Morale within the department had improved, and staff turnover was reduced to 6.7 percent (and to 0 percent by 2002).

The 2001 Member Services annual report was delivered to the health plan's SIC, QIC, and Board of Directors in spring 2002. The SIC agreed that the actions implemented in 2000 and 2001 had been effective in improving the level of service delivered to plan members, and the intervention was recognized by NCQA as a meaningful and significant quality improvement action. Both the Member Services and Compliance managers were promoted to directors within their departments.

The SIC agreed that actions implemented in 2000 and 2001 had improved the level of service delivered to plan members, and the intervention was recognized by the National Committee on Quality Assurance as a meaningful quality improvement approach. Again, these successes were celebrated with Member Services staff, gifts were distributed and the quality improvement team publicized these successes throughout the organization.

Step 6: Monitor Performance for Several Time Periods to See if It Holds

In spring 2002, the plan conducted a barrier analysis to identify significant near-term changes that might affect the plan's customer service moving forward.

Having achieved and sustained many notable improvements in customer service between 2000 and 2001, the plan's new challenge was to hold these gains during the upcoming period of anticipated growth and change. The plan continued to monitor its measures. In addition, in spring 2002, the plan conducted a barrier analysis to identify significant near-term

changes that might affect the plan's customer service level moving forward. The barriers identified were:

- *Conversion of the plan's core operating (claims) system during the third quarter of 2002.* The organization needed the new system's greater capabilities in order to manage its increasingly varied product portfolio, including assignment of new identification numbers and cards to all plan members, in preparation for compliance with the Health Insurance Portability and Accountability Act requirements. However, the new system was not as user-friendly as the previous one. Claims adjustment would become more complicated, and few Member Services representatives had been trained and authorized to make these adjustments. The goal was for all representatives to be trained in claims adjustment whether or not they would use these skills on a daily basis. The overall impact of the conversion on the Member Services Department would be multifaceted. Retraining all staff members on the new system would be required to enable them to manage the learning curve during and following implementation; access member information during the "freeze" period; and handle increased call volume as members received their new ID cards and called the Member Services department with questions.
- *Employee Retirement Income Security Act of 1974 (ERISA) implementation effective in the third quarter of 2002.* This would require the plan to send more letters and explanations of benefits to members. Increased call volume was anticipated as members received the additional correspondence, and Member Services staff would have to be trained to answer their questions.
- *Introduction of new products within a short timeframe.* As members transitioned from current product lines to new products (i.e., to a Preferred Provider Organization in two states and to an Exclusive Provider Organization in one state), the volume of member calls increased and service representatives needed more information to answer members' questions.
- *State-specific issues generating increased member inquiries.* The introduction of two- and three-tier formulary pharmacy coverage, and the state Point of Service

plan riders would lead to increased call volume and require more training of the service representatives.

- *New certificates of coverage slated to replace subscriber contracts.* Again, these changes would lead to increased call volume and require additional service representative training.
- *Inconsistent products and benefits across states.* These inconsistencies would add to the difficulty in providing accurate information when members had questions on benefits.
- *The department's increased focus on one-call resolution of member issues.* Amidst all of the other changes, this focus would require training and retention of experienced representatives.

The Member Services Department had already begun to prepare for these events in 2001 by providing additional staff training and by making key information available online. Representatives were cross-trained on the new products, rather than trained to develop their expertise in single products. As the plan's new products enrolled more members, increased call volumes would be managed by a fully staffed and well-trained Member Services Department. During periods of heavy call volume, auto-attendants would be used to inform callers of off-peak calling hours and alternative communication options via the plan's website and e-mail.

The health plan used its Member Satisfaction survey to help guide these ongoing improvement actions. Although the survey was administered on an annual basis once the results had stabilized in 2002 (as opposed to the previous monthly administration), monitoring and trending continued. The quality improvement department also worked closely with the survey vendor to develop new questions that could drill down further for more specific areas of concern. For example, new questions were added about claims issues, the mandated ERISA letters, members' awareness of the After Hours call center, their access to the Internet, and the plan's website.

In some cases, the results of the Member Satisfaction survey showed that the perceptions of plan members regarding service performance were quite different from the objective numbers tracked internally by the plan. For example, when the plan's telephone system measured the average speed to answer at 11 seconds, members still reported on the survey that they waited three minutes, on average, for their calls to be answered. The plan concluded that, "It must feel longer when you are waiting."

At the end of 2004, with Member Satisfaction survey scores holding steady for some time, the plan decided to retool its proprietary surveys. Items that no longer needed to be tracked would be dropped, and others would be carried forward, perhaps in a more useful form.

As the competitive and regulatory environments continue to change, the plan intends to develop new quality improvement projects to stay abreast of the issues. For example, in the spring of 2004, the Member Services Department was reviewing its staffing model to better manage increases in call volume per membership.

Lessons Learned

This case example offers a number of useful lessons for other health plans that have identified the need to strengthen their customer service functions. These lessons, which pertain to each step in the quality improvement process, are summarized below.

Step 1: Document the Problem

The CAHPS survey is a useful—but not a perfect—tool. It provides nationally recognized, comparative measures of customer experience for all NCQA-accredited health plans that can be tracked over time. Plans can use these measures to benchmark their performance and set performance goals. CAHPS information can also be used with Quality Compass and "best in market analysis" to establish regional benchmarks that may be helpful for improving competitiveness in different markets.

The most effective way to use CAHPS information to improve customer service capabilities may be in conjunction with other survey and measurement tools that can help diagnose reasons for low CAHPS scores. Due to its "one survey fits all health plans" design, CAHPS may be too general a tool for an individual plan to use as a stand-alone

measure of customer experience. While CAHPS results can signal that customer service problems exist, additional information is required to determine specific issues, the underlying causes of problems, and appropriate improvement actions. For example, if the CAHPS survey asks, “How do you feel about X?” the plan’s survey would follow with, “Why do you feel that way about X?” Member responses can then be used to identify improvement opportunities that are relevant to a specific plan.

Step 2: Make Sure You Have the Right Metrics

Both customer experience data and operational data are essential for ensuring that quality improvement interventions meet their objectives. Health plans can document their impact on members by identifying as many process measures as possible, operationalizing the measures, establishing baseline performance, identifying areas that need improvement, and re-measuring performance after improvement actions are implemented. It is essential to select measures that are aligned with goals.

Step 3: Develop Goals for Improvement and an Action Plan

Goal setting should address system-wide problems that represent an opportunity to improve a process. It is important to use all available information to identify trends in quality of care, access, service, and financial issues that require system-wide change and to proactively set goals and develop action plans for resolving them before they get out of control. Action plans will need to be multi-faceted, as it is unlikely that fixing only one process within a broken system will lead to significant and sustainable improvement. Remember that the quality improvement process is iterative and continuous; don’t hesitate to go back to previous steps when results aren’t satisfactory. The six steps described in this report are based on the well-established PDSA cycle, which is intended to be iterative.

Step 4: Implement the Action Plan

When evidence of poor performance has been demonstrated for more than several quarters, it may be necessary to bring in a new person with a fresh perspective, if not an entirely new set of people, to examine the problem and explore ways of fixing it. When a

new Member Services manager was hired and he changed the performance goal for customer service representatives from call volume to ready time, the call waiting time went down within one week. However, other actions related to staff training, hiring, and promotion were also necessary for achieving the desired level of customer service performance. Improvements sometimes require major changes in staff, training, promotion, hiring, and other processes; don't hesitate to make these changes when needed. But keep in mind that major changes create dislocations, so assessing what is "necessary" is important.

The "mindset" of the organization is also important. Getting all staff "on-board" with a new concept or approach may be essential for changing the performance of one or more targeted departments.

Step 5: Assess Progress and Expect to Make Adjustments

Quality improvement is indeed a continuous process. Some actions may work immediately; others may take several quarters to show positive results; and still others may not work at all. Health care organizations should expect to make mid-course corrections to their action plans and longer-term adjustments to their goals and strategies as internal and external circumstances change.

Quality improvement is a continuous process. Health care organizations should expect to make mid-course corrections to action plans and adjustments to their goals and strategies as internal and external circumstances change.

Step 6: Monitor for Sustainability

Continuously monitor indicators such as CAHPS and proprietary surveys. Once performance goals have been reached in the short term, it is important to continue monitoring the improvements to make sure they are sustained over time. Also try to anticipate events in the future that could compromise customer service or otherwise threaten the gains you have worked for. As the competitive and regulatory environments continue to change, the health plan in this case study intends to develop new quality improvement projects to stay abreast of the issues.