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Patient Service Quality and Health Maintenance Organizations: Not an Oxymoron

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PATIENT SERVICE QUALITY AND HEALTH MAINTENANCE
ORGANIZATIONS: NOT AN OXYMORON

By

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Bachelor of Science in Business Management

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2010

A thesis submitted in partial fulfillment of the requirements for the

Master of Science – Hotel Administration

William F. Harrah College of Hotel Administration

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ABSTRACT

Patient Service Quality and Health Maintenance Organizations:
Not an Oxymoron

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Today's quality movement in health care has driven the importance of patient satisfaction and experience across the industry. While the subject is of huge interest to researchers and health care companies, many struggle to identify a unified list of attributes that are applicable globally. Due to the industry's uniqueness, it becomes necessary to understand the population and specific attributes for each. In review of previous service quality research, this study presents many dimensions and attributes for application. Using existing service quality framework 5Qs, this study provides unique findings correlated to existing literature and presents actionable items.

Purpose: The purpose of this study was to provide a review of existing service quality and patient satisfaction literature in an attempt to identify common themes and trends that can affect patient satisfaction. For this study, we researched Senior Dimensions, a Medicare Advantage HMO plan in Southern Nevada. The research was to identify patient perceptions of their quality of health care and health plan.

Implications/Contribution: The findings conclude that there are several similarities between established service quality frameworks and patient satisfaction. Therefore, it is important to identify those specifically within your population. The study contributes to the service quality and patient satisfaction bodies of literature. It also provides additional value for existing theoretical models and their implementation in the health care industry.

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CHAPTER ONE

INTRODUCTION

Insanity: doing the same thing over and over again and expecting different results.

—Albert Einstein

In recent years, the perception of health care quality has shifted beyond the notion of excellent clinical care to include the patient experience and satisfaction as important indicators (Wolf, Nierderhauser, Marshburn, & LaVela, 2014). Initiated by shifts in public policy and public reporting, the patient's experience is at the forefront in determining incentives and reimbursements (Wolf et al., 2014). In shifting to a consumer-centered mindset, health care leaders across the country have increasingly acknowledged that the patient experience has become a top priority (Wolf et al., 2014). Newt Gingrich, former speaker of the House and founder of the Center for Health Transformation, has supported this notion, saying that quality will shift when there is greater transparency and consumer choice (National Committee for Quality Assurance [NCQA], 2006). He further reiterated that health care is:

. . . a stunningly inefficient system that protects and defends entire ranges of incompetent, inefficient, and destructive behaviors. It becomes imperative for improving quality, as it is an enormous ethical obligation to do the best possible job on behalf of the patient and the community. Problems with care quality reflect our failure to meet this obligation. (as cited in NCQA, 2006)

With U.S. health care expenditures in 2013 at \$2.9 trillion, or 17.4% of the national GDP, it is vital for our nation to address the state of health care using a holistic approach (Center for Medicare and Medicaid Services [CMS], 2014).

As one such approach, President Barack Obama signed into law the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively known as the Affordable Care Act, on March 23, 2010 (HHS, 2014). The bill included several initiatives aimed at strengthening health care in the United States. Among the list of initiatives were some that included the objective surrounding health care quality (Department of Health and Human Resources [HHS], 2014). As a result, several programs tied to the notions of pay-for-performance and health care quality were supported, and financial incentives were initiated to providers and health care intermediaries that could demonstrate optimal results. While pay-for-performance—a reimbursement model for meeting quality results or predetermined standards—has existed for several years, the government is now aligning payment with several initiatives to help begin a paradigm shift away from the traditional fee-for-service model. For example, the Centers for Medicare and Medicaid Services (CMS) implemented initiatives such as value-based purchasing, physician quality reporting (PQRS), and Medicare Advantage (MA) plan bonuses (CMS, 2013). By introducing these and other initiatives, the overall quality of patients' health care became an important determinant of financial rewards for health care professionals.

Moreover, Medicare Advantage (MA) plans provide monetary incentive and accreditation to health plans that can successfully meet quality results. To be considered an MA plan, the health insurer (health plan) must sign a contract with CMS to provide Part A and B coverage to Medicare beneficiaries (CMS, 2013). As a result, the health plan becomes fully responsible for managing the contracted Medicare population. Whether administered through a preferred-provider organization or a health maintenance

organization (HMO) network, the health plan is rewarded or penalized for its effectiveness in managing the patient population. Historically, HMOs, which provide patients with access to a limited, closed network of physicians, have better success at managing a population due to their gatekeeper approach (Simonet, 2005). While they may achieve better health outcomes, the perception of increased patient satisfaction has also been touted in several studies (Miller, 1992; Simonet, 2005). In connection with the National Committee for Quality Assurance (NCQA), the CMS adds and removes additional measures and modifies its rating methodology year after year.

The CMS partnered with the Agency for Healthcare Research and Quality in 2005 to develop what is known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The tool, established to measure patients' perception of their health care experience, was validated and endorsed by the National Quality Forum, which comprises several health care providers, consumer groups, professional associations, and research and quality organizations, and it was granted final approval in December 2005 (CMS, 2014). This standardized, 27-question survey tool was introduced to hospitals in 2006 and has since been implemented for providers with CMS contracts in office settings. The CAHPS survey is currently the only accredited tool for evaluating patient satisfaction and accounts for a large portion of the overall ratings for MA plans and their bonuses.

Similar to the hospitality industry, the CMS implemented a 5-star rating scale for all MA plans. As with the Forbes and Michelin star ratings, the consumer now has the ability to associate star ratings with various MA plans.

5 Stars	Excellent performance
4 Stars	Above-average performance
3 Stars	Average performance
2 Stars	Below-average performance
1 Star	Poor performance

The 5-star ratings are derived from the following sources: (a) CMS administrative data surrounding plan quality and member satisfaction, (b) CAHPS, (c) the Healthcare Effectiveness Data and Information Set (HEDIS), and (d) the Health Outcomes Survey (CMS, 2014). Beginning in 2012, if the MA plan reaches 4 out of 5 stars, it receives quality bonus payments (QBPs) from the CMS. Contrarily, beginning in 2015, the CMS will require MA plans to meet a 3-star threshold to obtain their contract and avoid penalties. CMS will initiate calls to members of the lower performing plans to recommend a higher performing plan; in other words, another insurance company with a higher star rating will be offered to the patient. In addition, many high-performing health plans are using their star ratings to drive membership and marketing initiatives. Research further drives the importance of plan quality, such as its role in predicting consumer choices (Farley et al., 2002). With roughly 30% of the traditional Medicare population enrolled in an MA plan in 2014 and a three-fold increase in MA plan membership in the last 10 years, a competitive landscape has emerged among health insurance companies (see Figure 1).

Exhibit 1

Total Medicare Private Health Plan Enrollment, 1999-2014

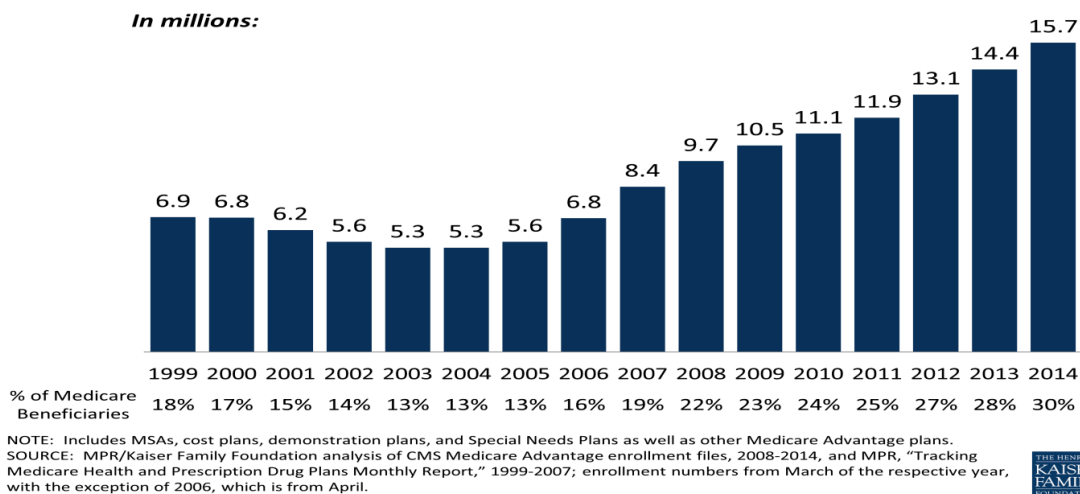


Figure 1. Medicare private plan (MA) enrollment. Adapted from “Medicare Advantage Fact Sheet” by Kaiser Family Foundation, 2014.

The health care industry has become more of a consumer-driven service, with a fundamental shift in focus to the patient experience and an introduction of public reporting. Understanding the patient experience and associated satisfaction has become fundamental to the prosperity and economic stability of the business. In an attempt to understand CAHPS, patient satisfaction, and the patient experience, the health care industry has embraced several new ideas surrounding patient-centeredness, star programs, chief experience/consumer officers, patient satisfaction surveys, and independent studies (LaVela & Gallan, 2014). Research has followed suit in pursuing the attributes that determine patient satisfaction and patient experience (Baalbaki, Ahmed, Pashtenko, & Makarem, 2008; Jackson, Chamberlin & Kroenke, 2001; LaVela, & Gallan, 2014; Naidu, 2009; Ware, Syder, Wright, & Davies, 1983; Wolf et al., 2014)

Research reiterates that high-quality services are linked to increased market share, profits, and savings (Naidu, 2009). Furthermore, service quality is profoundly and directly related to customer satisfaction, loyalty, and profitability (Wolf et al., 2014). As competition continues to grow in the industry, finding a solution to meet quality standards will become vital to long-range profitability and survival (Zineldin, 2006).

My study proposes to identify attributes that determine patient satisfaction and determinants of a successful patient experience. Moreover, the research will focus on one MA plan in Southern Nevada operating under an HMO known as Senior Dimensions. Currently, the MA plan has a 3-star rating and, more specifically, has received failing remarks in the CAHPS. With roughly 51,000 MA plan members, accounting for 50% of the MA plan members in Las Vegas, Nevada, it is vital that Senior Dimensions increase its star rating to retain its patient membership and obtain QBPs and MA plan accreditation (R. McBeath, personal communication, October 15, 2014).

In the literature, several studies exist on the determinants of customer satisfaction (Zeithaml, Leonard, & Parasuraman, 1996), patient satisfaction (Abdul, Alquraini, & Chowdhury, 2009; Badri, Attia, & Ustadi, 2008; Camgoz-Akdag & Zinedlin, 2010; Hussain & Rehman, 2012; Simonet, 2005; Zineldin, Camgoz-Akdag, & Vasicheva, 2011), and patient experience (Lang, 2012; LaVela & Gallan, 2014; Wolf et al., 2014). However, current research lacks an exploration of patient satisfaction and the experience of an MA plan operating under an HMO in the Las Vegas. While each health care landscape is vastly different, it remains important to understand the determinants of a patient population and its perception of quality. For example, the NCQA portrayed that managed care plans vary vastly in patients' care experiences and member satisfaction

ratings (Thompson et al., 1998). The results depend on the patients' subjective judgments and tolerance of surrounding quality characteristics. Therefore, it is necessary for the research to focus primarily on Senior Dimensions and its MA members. The purpose of this research is to provide attributes of a framework for developing additional tools to understand the patient population and benchmark future patient-centered initiatives.

Theoretical and Conceptual Framework

In reviewing the widely published service quality and marketing literature, the study will use the well-known and adapted version of SERVQUAL (Parasuraman, Zeithaml, & Berry, 1985) as its framework. SERVQUAL has been touted across several service industries and is a widely accepted tool in measuring service quality and customer satisfaction. While it has had limited exposure in health care compared to its use in other service industries (Alrubaiee & Alkaa'ida, 2011; Hussain & Rehman, 2012; Zineldin, Camgoz-Akdag, & Vasicheva, 2011), it has served as a benchmark in understanding service quality for several decades. In further review, several models branching from SERVQUAL will be examined for providing a framework to determine the attributes of patient satisfaction and overall experience. Well-known models such as RATER (Hussain & Rehman, 2012), GAP (Headley & Choi, 1992), and 5Qs (Zineldin, 2006) will be studied to further imply characteristics that determine patient satisfaction.

Purpose Statement

The purpose of this study is to identify key attributes that influence the patients' perception of their service quality. This research will provide the tools needed to understand the patient population of Senior Dimensions, an MA plan operating under an HMO. Due to the lack of service quality literature surrounding patient satisfaction within

an MA plan in Southern Nevada, this study was deemed necessary. This study will contribute to the body of service quality and patient satisfaction literature.

Statement of the Problem

Due to increased competition among MA plans; increased patient transparency; and pay-for-performance, quality-based payments, the notion of improved patient service quality has become imperative for MA plans such as Senior Dimensions. As mentioned before, the Senior Dimensions MA plan has received failing remarks in its CAHPS survey and must improve its results to remain a profitable MA plan in Las Vegas, Nevada.

Preview of Methodology

The research will be based on a qualitative study administered by United Healthcare on behalf of Senior Dimensions. As a subsidiary of United Healthcare, Senior Dimensions was given a research grant from United Health Group to administer a study surrounding the CAHPS survey. The study consisted of four 2-hour focus groups and 16 1-hour individual interviews with Senior Dimension patients in December 2014. In addition, a review of existing patient satisfaction, patient experience, service quality, and marketing literature will be conducted to further understand the findings. The accumulation of secondary research, combined with the empirical discoveries from the focus groups and in-depth interviews, will further assist Senior Dimensions in understanding its patients' experience within the continuum of care.

Limitations

Limitations exist due to the nature of the study, such as sample selection error, interviewer bias, acquiescence bias, and groupthink. When using a qualitative method, it

becomes difficult to generalize the findings across a population due to the overall sample size and nature of the industry. Research further implies that every health care delivery system varies in terms of patient satisfaction in each unique market (Thompson et al., 1998). Having United Healthcare find patients during the screening process may have contributed to self-serving biases and further reliability constraints on the findings. Therefore, it is important to identify these implications as limitations to the external validity of this study.

Summary

While the demand for knowledge and tools surrounding patient experience, satisfaction, and service quality are expanding, the opportunity presents itself for researchers to both better understand the dimensions and provide game-changing outcomes. The notion of patient-centered care is becoming imperative as national and industry leaders continue to drive the paradigm shift in reimbursement to quality-based payments. It is the goal of this study to provide the necessary tools to achieve actionable results, through qualitative research and a review of services marketing literature. Moreover, the research's primary objective is to identify the perceived factors of quality determinants for patients in an MA plan—Senior Dimensions in Las Vegas.

CHAPTER TWO

REVIEW OF LITERATURE

Having gained widespread acceptance across the health care industry, the constructs known as patient satisfaction and patient experience are continuing to grow within the service marketing literature. While customer satisfaction has existed in the literature for several decades (York & McCarthy, 2009), the introduction of patient experience has grown only in the last 15 years (Needham, 2012). Patient satisfaction can be defined as the patient's perception of whether his or her expectations have been met (Abdul, Alquraini, & Chowdhury, 2011; Ware, Snyder, Wright & Davies, 1983). A proliferation of surveys and definitions across the literature (Badri, Attia & Abdulla, 2008; Zineldin, 2006; Zineldin, Camgoz-Akdag, & Vasicheva, 2011) has been introduced to measure patient satisfaction. As a result, the notion of understanding patient satisfaction has grown beyond "patient satisfaction" alone to include the patient experience and overall health care quality (Ware et al., 2014). Some literature suggests that patient satisfaction helps us better understand the overall patient experience, such as aspects of the health care experience (Bleich, Ozaltin, & Murray, 2009). More specifically, the Beryl Institute (Wolf, 2010) defines the patient experience as the "sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care." This study aims to provide further understanding to the literature surrounding patient satisfaction, patient experience, service quality, and marketing.

Service Quality

Service quality originally has been defined as having two dimensions: technical and functional. However, several dimensions have been introduced to elaborate on both constructs. For service quality, technical dimensions encompass what the customers buy and whether the services fulfill their needs, while functional dimensions describe how the service products were delivered, such as customer service (Zineldin et al., 2011).

Perceived service quality is explained as the customer's judgment about the product's overall excellence based on perceptions of what is received and what is given (Zeithaml, 1988). Perceived service quality has been further explained as stemming from specific attributes or cues (Badri, Attia & Ustadi, 2008) and is considered a critical determinant of both the firm competitiveness and long-term profitability of service and manufacturing organizations (Zineldin, 2006). The literature shows there is no single definition of quality due to its complex, indistinct nature (Zineldin, 2006), implying that health care quality differs from other consumer product industries due to the lack of intellectual or technical quality (high-credence good). As a result, research suggests that not just satisfaction and loyalty may influence the overall quality of the service (Chang, Wei, & Huang, 2006; Duggirala, Rajendran, & Anatharaman, 2008; Zineldin, 2006).

Of the pioneering works in this field, Parasuraman introduced SERVQUAL, a service quality model encompassing numerous factors, such as tangibles, reliability, responsiveness, competence, courtesy, credibility, security, communication, and the customer's understanding (Parasuraman, Zeithaml, & Berry, 1985). It was further reduced to five dimensions: tangibles, reliability, responsiveness, assurance, and empathy (Duggirala, et al., 2008). Research has created several service quality models stemming

from Parasuraman's (1985) SERVQUAL model. As a result, the RATER, GAP, 5Qs, and total quality management approaches have emerged as widely published rating tools in the literature for further understanding service quality (Chang et al., 2006; Headley & Choi; 1992; Parasuraman et al., 1985; Zineldin, 2006).

Service quality in health care. The literature further implies that health care quality is inherently difficult to measure, due to its (a) intangibility, as the service is an abstract product that is not tangible; (b) heterogeneity, as the same service may have different standards due to several interchangeable variables; (c) inseparability, as services are inseparable from their original sources; and (d) perishability, as a service cannot be stored (Chang et al., 2006; Naidu, 2009). This suggests that additional aspects related to the patients' perceived health and sociodemographic variables are significant in health care quality ratings (Abdul et al., 2011; Hekkert, Cihangir, Kleefstra, van den Berg, & Kool, 2009; Jackson, Chamberlin, & Kroenke, 2001; Naidu, 2009). In addition, the literature suggests that patients' mental state may affect their perception of health care quality; for example, patients who report feeling sad may express lower satisfaction. This implies that patients' attitudes may play a role in their satisfaction results (Bleich et al., 2009; Sofaer & Firminger, 2005). While focusing on patient-centered care remains the primary goal (LaVella & Gallan, 2014; Wolf et al., 2014), it is important to include the patient's family as consumers in the health care service-scape (Duggirala et al., 2008). Several studies grounded in SERVQUAL have successfully confirmed the significance of many of the attributes outlined by the model (Badri et al., 2008; Camgoz-Akdag & Zineldin, 2010; Duggirala et al., 2008; Zineldin, 2006; Zineldin, Camgoz-Akdag, & Vasicheva, 2011). However, several critiques surrounding the largely quantitative methods suggest that the

model does not encompass the patients' experience (LaVela & Gallan, 2014; Lees, 2011; Needham, 2012; Sofaer & Firminger, 2005; Wolf et al., 2014;). Therefore, it becomes critical to identify common themes across the literature to build on a theoretical framework grounded in service marketing theory and the literature on patient satisfaction and experience.

Table 1

SERVQUAL Study.

Citation	Theoretical Framework	Purpose	Study Design	Study Findings
Zineldin, 2006	SERVQUAL-5Qs	To examine major factors affecting patients perception cumulative satisfaction in evaluating the quality of their healthcare	Survey Instrument with 48 total attributes was administered in two different cities and three separate hospitals. A total of 224 surveys were received.	5Qs provides both a structure for designing service quality measurement instrument and framework

Patient Experience

The literature defines experience as the customers' internal and subjective perceptions (indirect or direct) of a company (Teixeira et al., 2012). The customer experience becomes a holistic view that includes every aspect of the company's offerings (Teixeira et al., 2012). As previously mentioned, the Beryl Institute (Wolf, 2010) defined patient experience as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

Throughout the literature, research surrounding customer experience (Teixeira et al., 2012) and patient experience (Wolf et al., 2014) lack wide representation. However, the two support a holistic view separate from specific elements that define the customer/patient experience. The service literature presents several service elements focusing on certain aspects within service design. The overarching goal of the customer/patient experience, then, is to capture the unique and rich elements that shape the entire experience beyond individual aspects (Teixeira et al., 2012). In understanding the unique service design of the health care industry, a key component becomes ensuring that what is being measured matters most to patients. The measurement of patient experience becomes vital to provide further opportunities for better care, improve tactical decision-making, meet patients' expectations, manage health care performance, and create benchmarks (Wolf et al., 2014). Furthermore, the literature suggests that higher patient satisfaction ratings increase membership (Darden & McCarthy, 2013), loyalty (Faezipour & Ferreira, 2013; Wolf et al., 2014), financial stability (Hussain & Rehman, 2012), and word-of-mouth marketing (LaVella & Gallan, 2014; Wolf et al., 2014). It is important to understand that each health care experience is one's own, and patients vary across the continuum of care.

Several cases in the literature have overlapping notions that patient experience and satisfaction are one and the same (Needham, 2012; Ware et al, 2014). However, LaVella and Gallan (2014) refuted that notion, stating several differences between the two constructs, particularly that patient satisfaction is not the same as patient perception, thus further implying that satisfaction does not imply excellent service, only acceptable service. Satisfaction is a relative concept; therefore, what meets one person's needs may

not meet another's needs (LaVella & Gallan, 2014; Sofaer & Firminger, 2005). Although patient satisfaction is not the only measurement in quality care, patient satisfaction and its correlates remain predominant in existing quality studies. The literature has remained critical of applying patient satisfaction measures, as there is rarely any theoretical or conceptual development of patient satisfaction, as well as a lack of standardization, little reliability, and ambiguous validity measures (Sofaer & Firminger, 2005). In support, Needham (2012) stated that the focus on patient satisfaction alone is shortsighted; rather, best practices from other industries should be used to deliver a more "complete patient experience." Due to the crosscutting nature of patient experience and satisfaction, the research will identify the key attributes explained by both constructs.

Measuring patient experience. In the quest for better service design and measurement, several tools have been introduced to combat the service industry's intangible nature. Issues surrounding the measurement of a customer service experience arise: (a) the memory of an experience disappears quickly, (b) the customer experience encompasses several sub-experiences, (c) customers' recollections of an experience are multidimensional, and (d) consumers cannot accurately predict what they remember (LaTour & Carbone, 2014). All of these issues imply the need to create a memorable experience; service designers must therefore implement a set of elements that better support the customers in co-creating their desired responses (Teixeira et al., 2012). Eliminating the focus on individual aspects and shifting to their orchestration can help organizations better influence their customer/patient experiences. As prompted by the Institute of Medicine's report, *Crossing the Quality Chasm*, and public reporting through CAHPS, increased attention surrounding the measurement and improvement of overall

health care quality was introduced, resulting in patient-centered care being adopted (Badri et al., 2008; LaVela & Gallan, 2014). This further reiterates the need to understand the patient's perspectives throughout all aspects of the organization (LaVela & Gallan, 2014).

The health care literature suggests that implementing a patient-centric culture can create an ideal patient experience (Wolf et al., 2014), implying that a culture focused on high-quality care, care coordination, personalization, timeliness, integration, compassion, communication, emotional support, reliability, and responsiveness is crucial in providing quality health care (Institute of Medicine, 2001). Similar to the Institute of Medicine's framework, the Warwick patient experience framework identifies seven key concepts: the patient as an active participant, responsiveness of services, individualized approaches, lived experience, continuity of care and relationships, communication, and information and support (Staniszewska et al., 2014). Overarching themes exist across the patient experience frameworks, such as responsiveness, communication, and individualization. Responsiveness, as defined by the World Health Organization, presents a framework for patient experience through autonomy, choice, communication, confidentiality, dignity, prompt attention, and quality of basic amenities (Bleich & Murray, 2009). Needham (2012) further suggested managing the patient experience by maximizing the patient's social, mental, and physical health and wellness during care.

Satisfaction with patient experience. The patient satisfaction literature includes a vast number of quantitative and qualitative studies attempting to understand what patients' value, how they perceive service quality, and how these can be improved (Zineldin et al., 2011). Abdul et al. (2011) defined "patient satisfaction" as the degree to

which health services meet patients' wants and expectations regarding technical and interpersonal care. Satisfaction can be seen as an attitude that should be measured by quantifying all subjective assessments associated with the care experience, further implying the multidimensional nature of satisfaction (Zineldin, 2006). Badri et al. (2008) provided the following definition of patient satisfaction: "the summary of psychological state resulting when the emotion surrounding disconfirmed expectations is coupled with the patient's prior feelings about the patient experience." In conclusion, satisfaction can be seen as an emotional response (Zineldin, 2006).

With the continual changes in demographics, political policy, social perceptions of health care quality, and the health care industry as a whole, there exists a unique landscape surrounding the idea of measuring patient satisfaction (Camgoz-Akdag & Zineldin, 2010). In parallel, it becomes ever more imperative to understand the determinants of patient satisfaction, as it accounts for public reporting through CAHPS and has been linked to member loyalty, financial stability, lower malpractice costs, better health outcomes, and employee satisfaction (Needham, 2012; Sofaer & Firminger, 2006; Wolf et al., 2014; Zineldin, 2006). The industry is challenged to shift from its historical approach of services and transactions to one of customers, loyalty, and relationships (Needham, 2012).

Despite controversy surrounding patient satisfaction and service quality within literature, evidence supports the link between satisfaction and quality (Badri et al., 2008). While several studies have introduced tools based on their definitions of satisfaction, many researchers have called for an empirical cross-cultural study examining health care quality and patient satisfaction (Badri et al., 2009). In general, patient satisfaction surveys

are used to examine the patients' perspective of their health care services and provide a better way to understand patient satisfaction as a whole (Hussain & Rehman, 2012).

As a result, several models to measure patient satisfaction have been introduced. Dimensions across the studies include, but are not limited to, service quality and marketing principles rooted further in SERVQUAL (Zineldin, 2006):

- tangibility: includes physical facilities, equipment, and the appearance of an organization's personnel,
- reliability: includes the ability to execute a service accurately and as promised by the organization,
- responsiveness: includes the willingness to provide prompt service and customer assistance,
- assurance: includes how knowledge and employees' courtesy implies trust and confidence,
- empathy: describes an organization's commitment to individualized care.

Throughout the exploratory research of the patient satisfaction literature, SERVQUAL has been a fundamental framework for understanding health care quality as it relates to satisfaction (Abdul et al., 2011; Badri et al., 2008; Camgoz-Akdag & Zineldin, 2010; Duggirala et al., 2008; Zineldin, 2006; Zineldin et al., 2011). In addition, Ware et al. (1984) introduced the following dimensions: physician conduct, service availability, continuity, confidence, efficiency, and outcomes. Naidu (2009) provided the additional dimensions of core services, customization, professional credibility, competence, and communication.

Furthermore, research shows that the following communication attributes are significant in determining overall patient satisfaction: the degree that the patient is heard, remains informed, is given the ability to communicate during a visit, and is provided psychological and nontechnical information (Lang, 2012;Naidu, 2009). Non-verbal cues can also speak as loud as verbal cues (Duggirala et al., 2008). Additional common themes that exist among the studies include but are not limited to a patients' mental state (Bleich et al., 2009), overall health status (Abdul et al., 2011), nationality (Abdul et al., 2011; Weisman, Henderson, Schifrin, Romans, & Clancy, 2001), satisfaction of life (Abdul et al., 2011), and age (Hewitson, Skew, Graham, Jenkinson, & Coutler, 2014; Sofaer & Firminger, 2005;). While it is important to understand these commonalities, research suggests that socio-demographic and patient external factors further imply the need to conduct research on the specific population of interest.

Patient satisfaction within an HMO or managed care. A brief review of the literature was conducted to understand patient satisfaction within HMOs. Research implies that additional pressures on HMOs to maintain patient satisfaction become burdensome due to diminishing resources and increased demands (Simonet, 2005). Simonet (2005) also proposed several nuances within an HMO that could cause dissatisfaction. For example, the requirement to choose a primary care physician on a list of "accepted" physicians diminishes the patients' right to choose; additionally, the lack of flexibility in seeing a specialist, lack of preventive care, and partial refunds for care given by an outside provider are sources of significant dissatisfaction (Simonet, 2005). He further reiterated that patients perceive quality care as the ability to access care easily and readily when they wish (Simonet, 2005). A study conducted on CAHPS and HEDIS

scores for managed care plans shows that waiting to get an appointment longer than one week is dissatisfying among men and that primary care provider turnover is a consistently negative predictor of satisfaction, as are doctor communication and the health plan's overall rating (Weisman et al., 2001). Determinants that have been peddled in HMO surveys to measure these differences include:

- availability of specialty care,
- access to specialists,
- administrative barriers (e.g., preauthorization or referral required to access care),
- costs,
- customer service,
- communication,
- time spent with patient,
- courtesy and attention of medical staff,
- quality of follow-up and prevention programs (Simonet, 2005).

Several socioeconomic factors affect overall levels of satisfaction within the HMO as well. Simonet (2005) further said that incomes and education levels significantly influence patient satisfaction. In comparing all of the studies, several themes across socioeconomic and socio-demographic factors play an important role in overall satisfaction. In parallel, the implications of global ratings and transparency across health organizations play an instrumental role in increasing overall health care quality (Glazer, McGuire, Cao, & Zaslavsky, 2008; Sofaer & Firminger, 2005; Simonet, 2005)

Current patient satisfaction survey landscape. While the services marketing and health care literature presents several tools to measure patient satisfaction, Senior Dimensions currently uses the results from its CAHPS assessment, Press Ganey surveys, and patient satisfaction cards. Importantly, CAHPS is administered by an accredited agency at the beginning of the year, and the results from the selected sample are used to compute a portion of Senior Dimensions' star rating for the following year. The survey takes place over 60 days and is administered only once. Therefore, it is crucial to supplement it through other methodologies and provide ongoing patient satisfaction ratings before the CAHPS assessment to continually ensure optimal results. As an industry-accepted tool, Press Ganey is currently surveying Senior Dimensions' patients after each subsequent visit, thus providing some actionable results around CAHPS dimensions. While some patients may fill out the patient satisfaction cards left at the front desk, there is not currently a measurement tool in place to aggregate these results. Table 3 displays the industry's widely used survey tools, along with their dimensions and attributes.

Table 2

Industry Survey Tools

Survey	Source	Dimensions (<i>attributes</i>)
CAHPS	CAHPS, 2012	Access (<i>timely appointments, care, information</i>); communication (<i>clear explanation, respect, listened, time spent with patient</i>); courtesy (<i>helpful, respectful staff</i>); global ratings surrounding quality (<i>0–10 rating of provider and healthcare quality</i>)
Press Ganey	Press Ganey, 2014	Access (<i>timely appointments, care, information</i>); communication (<i>clear explanations, respect, listened, time spent with patient</i>); courtesy (<i>helpful, respectful staff</i>); global ratings surrounding quality (<i>0–10 rating of provider and healthcare quality</i>)
PSQ	Ware et al., 1984	Interpersonal manner (<i>concern, friendliness, courtesy, disrespect, rudeness</i>); technical quality (<i>thoroughness, accuracy, unnecessary risks, making mistakes</i>); accessibility/convenience (<i>time and effort to get to an appointment, waiting time, ease of reaching location</i>); finances (<i>reasonable costs, alternative payment arrangements, comprehensiveness of insurance coverage</i>); efficacy/outcomes (<i>helpfulness of care team in improving or maintaining health</i>); continuity (<i>seeing the same physician</i>); physical environment (<i>orderly facilities, pleasant atmosphere, clarity of directional signage</i>); availability (<i>enough providers in the area</i>)
Picker	Jenkinson, Coulter, & Brustler, 2009	Information and education (<i>communication, clear direction</i>); coordination of care; physical comfort (<i>facilities</i>); emotional support; respect for patient experiences; involvement of family and friends, continuity and transition; overall impression
General Practice Assessment Survey	Manaf, Mohd, & Abdullah, 2012	Access (<i>timely appointments</i>); technical care; communication (<i>clear, two-way communication, time with physician</i>); interpersonal care; trust; knowledge of patient (<i>understanding the patient's health history</i>); nursing care; receptionists (<i>courteous</i>); continuity of care (<i>facilitated referrals and care for patient</i>).

Research implies that, to better understand the patient's perspective of his or her experience, additional quality tools should be implemented beyond tools such as Press Ganey and CAHPS data (LaVella & Gallan, 2014; Needham, 2012; Wolf et al., 2014).

As previously stated, the shift to a patient-centric culture means that we must understand patient perceptions, as they are significant drivers of outcomes, stakeholder importance, patient choices on plan or provider, patient adherence and engagement, complaints, and, most importantly, overall health and functional outcomes (Sofaer & Firminger, 2005). As a result, the health plan can increase its global ratings through CAHPS and receive an optimal star rating. While research has questioned the notion of global ratings and plan choice, some have found them to be significant drivers (Darden & McCarthy, 2013; Glazer et al., 2008). In conclusion, further examining the patient population through exploratory, qualitative, and quantitative research models will better depict overall patient satisfaction and ensure that what is being measured is an accurate representation of what patients want (LaVella & Gallan, 2014; Sofaer & Firminger, 2005).

While measurement through survey tools is necessary, it is not always sufficient (LaVella & Gallan, 2014; Lees, 2011). The literature further suggests the need to consider whether the evaluation approaches that are employed include the right metrics and methods to further progress and improve the patient experience (LaVella & Gallan, 2014; Needham, 2012). It becomes important to understand what patients' value, how they perceive service quality, and how these can be improved (Zineldin et al., 2011).

Selected Model and Theoretical Framework

In the current literature, several dimensions, attributes, and tools have flourished in their attempts to measure patient satisfaction. As a result, a standard definition and widely adopted surveys do not exist. The literature further indicates the need to understand the patients' perception of quality within the population in question. Therefore, the study will use a mixed-method approach grounded in service marketing

theory. The study will use a framework grounded in the most recognized tool in measuring quality, SERVQUAL, adapted from Parasuraman (1985). While SERVQUAL has been used for health care quality, Zineldin (2006) called for a more comprehensive model to support health care services' uniqueness. Therefore, the 5Qs model was introduced in an attempt to strengthen SERVQUAL (Zineldin, 2006). Health care studies have tested attributes such as infrastructure, atmosphere, and interaction and found them to be reliable dimensions (Badri et al., 2008; Camgoz-Akdag & Zineldin, 2010; Zineldin, 2006). Therefore, the study will use the 5Qs dimensions below to better understand the patients' perception of their experience.

Q1: Quality of object—Measures the treatment itself, the main reason the patient is visiting a provider.

Q2: Quality of process—Measures how well health care activities are being implemented. Examples include waiting times and speed of performing health care activities. Process indicators should receive more attention in the health care industry. They can be used to pinpoint problems in service delivery and to suggest specific solutions. Frontline nurses/physicians/managers can use process indicators to monitor the activity at their facilities and guide day-to-day activities.

Q3: Quality of infrastructure—Measures the basic resources needed to perform the health care services.

Q4: Quality of interaction—Measures the quality of the information exchange. Examples are the percentages of patients who are informed about when to return for checkups and the amount of time physicians or nurses spend to understand the patients' needs.

Q5: Quality of atmosphere—The relationship and interaction process between health care workers and patients are influenced by the quality of the atmosphere in a specific environment. The atmospheric indicators should be considered very critical because of the belief that being frank and friendly can assist in driving quality of care.

Focus Groups and Individual Interviews as Instruments

The use of both qualitative and quantitative data can provide a more robust and broad perspective than one method used alone (LaVela & Gallan, 2014; Sofaer & Firminger, 2005). For the purpose of this study, the qualitative approach will be outlined further and recommendations for additional research will be given. Therefore, the study will focus on secondary research to find commonalities across the literature and propose a framework through previously administered focus groups and individual interviews. Focus groups and individual interviews have been used in research and provide an opportunity to gather in-depth understanding of patient experiences (LaVela & Gallan, 2014; Sofaer & Firminger, 2005). This approach allows researchers to gain insightful knowledge through open-ended questions that are not possible in structured quantitative studies. As a result, a richer understanding of the patients' perception and the behaviors they attach to their experiences will remain invaluable in measuring overall patient satisfaction (LaVela & Gallan, 2014). The insights gained through the focus groups and individual interviews will be valuable for suggesting additional qualitative and quantitative research at Southwest Medical Associates.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter will present the methodology used to conduct this study. It will further outline a proposed hypothesis; discuss the secondary research design, as well as its selection and measurement; and detail the administration and analysis of the study. In conclusion, it will denote the limitations and ethical considerations of the research.

To better understand patient satisfaction and the specific drivers of its star rating, Senior Dimensions, a Las Vegas-based MA HMO, agreed to allow hospitality researchers to help assimilate the data and provide recommendations based on its findings. As previously outlined, Senior Dimensions' CAHPS scores and overall star rating remain subpar. Therefore, as the health plan continues to struggle to meet patient satisfaction ratings, further research becomes imperative to assess how the patients' perspectives of their health care experience are determined.

To combat its poor patient satisfaction results, Senior Dimensions was granted research dollars to better understand the overall perceptions of its patients regarding their health care and provider network. Qualitative focus groups and individual, one-on-one interviews were conducted with Senior Dimensions patients residing in Las Vegas. The research was conducted over course of four days in December 2014.

This study will review the qualitative data provided by Senior Dimensions focus group data. As a result, the analysis will assess common trends and themes and assimilate them with the 5Qs model (Zineldin, 2006). I will identify the specific attributes patients mentioned that affect how they perceive their overall satisfaction and health care quality. According to the 5Qs model, the quality of the object, process, infrastructure, interaction,

and atmosphere are all significant drivers of overall patient satisfaction (Zineldin, 2006). Therefore, the study will review the two focus groups and individual interviews to distinguish the themes relating to the theoretical framework, as well as draw additional conclusions from the qualitative research.

Study Design

The participants were identified from Senior Dimensions' database of roughly 55,000 eligible patients. As a result, the research will allow specific relationships to be drawn across the population and further infer determinants of quality as they relate to Senior Dimensions. As previously established, the sampling framework will be Senior Dimensions, an MA plan operating under an HMO in Las Vegas, NV. The data provided will assist leadership and researchers to better understand the patients' perspective. While it implies specific findings for Senior Dimensions, the literature suggests that the findings will differ based on many external variables, if applied to another MA HMO plan. However, there may be commonalities that can be introduced for further research across service quality as it relates to health care.

Sampling Technique

The basic criteria established by United Healthcare included (to see the entire screener used for both qualitative studies, see Appendices A and B):

- individual interviews: 16 total participants plus 6–8 floaters,
- focus groups: a total of 20 participants recruited for two focus groups (i.e., recruit 10 for each, for 8–10 to show up),
- must be able to name their current health plan,
- must have been insured with their current health plan for one year or longer,

- must be between 65 and 75,
- mix of genders, ages, and ethnicities,
- must be able to articulate and be willing to answer questions,
- must answer two rating questions similarly to how that market rates, meaning previous patient survey scores for Senior Dimensions must be consistent with their rating in order to participate in the study.
 - Las Vegas: Need to rate both the health care and health plan from 6–8, meaning each participant must rate their health care and health plan on a scale of 1–10 between 6 and 8. Therefore, any participant who rated both a 6, 7, or 8 were eligible to participate in the study.
 - Q8. Using any number from 0–10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last six months?
 - Q11. Using any number from 0–10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Table 3

Rating Scale for Health Plan and Health Care

Worst health care possible						Best health care possible				
0	1	2	3	4	5	6	7	8	9	10
TERM	TERM	TERM	TERM	TERM	TERM	OK	OK	OK	TERM	TERM

Qualitative Design

The study will include 16 individual, one-on-one interviews lasting approximately 60 minutes each and two focus groups of 10 participants lasting approximately two hours each. To better understand CAHPS, guides were created focusing on specific attributes and drivers of overall quality for both the health plan and health care. Due to the one-on-one nature of the interviews, more specific questions were asked relating to specific CAHPS questions, such as:

- If your rating of health care is 8 or below, what would have to happen for you to give a rating of 9 or 10 for your health care? What would need to change?
- Rate your health plan (0–10). Tell me a little more about why you gave a rating of X for your health care. What factors went into that rating? What were you considering?
- If you needed care right away, what would you say is a reasonable time to be seen within?

In contrast, the focus group questions remained vague, in order to determine what drives the patients' perceptions of the questions. Some of the questions asked included:

- When you hear “Senior Dimensions,” what words come to mind?
- If a friend or family member asked you about your health plan, what kinds of things would you tell them?
- What do you consider to be the strengths and weaknesses of Senior Dimensions?
- What kinds of things come to mind when you hear the term “customer service”?

- Tell me about an exceptional customer service experience.
- What about when you went to your doctor's office?

The research was administered at an off-site location that was wired for sound and video. The patients were given \$100 each for their participation in the study. As mentioned earlier, the research was conducted over the course of four days in December 2014. A full schedule can be found in appendix C.

Reliability

The research conducted should infer reliability characteristics that would appear in the same fashion if the study were duplicated. However, the research design presents several issues surrounding reliability due to participant selection as well as preconceived bias associated with Senior Dimensions before the research was conducted. Additionally, biases such as groupthink and self-serving biases, may exist in the focus groups. As a result, the research may not be a complete representation of the participants' opinions surrounding the presented questions. In addition, the research presents possible issues surrounding its generalizability across the entire Senior Dimensions population. To combat these issues, recommendation for quantitative analysis will be given based on the studies findings.

Validity

Both internal and external validity are important to ensure the study's degree of generalizability. Internal validity exists to the extent that an experimental variable is truly responsible for any variance in the dependent variable. To ensure internal validity, selection and execution of study design were taken very seriously. To ensure there were no selection effects or instrumentation effects, the same sampling techniques and

interviewer were used during the study. External validity for this study is challenging, as it is only representative of a small sample of Senior Dimensions patients. To propose external validity, this study's findings should be replicated in additional research methods to ensure its generalizability across Senior Dimensions.

Data Analysis

The study used primary data, from the qualitative research conducted on behalf of Senior Dimensions. Secondary data sources, including journal publications, case studies, articles, and books, also contributed to our findings. The transcripts from our qualitative study were reviewed to identify common themes and trends. Using existing service quality framework 5Qs, as previously described, the study revealed similarities and additional attributes that align with its dimensions. It was important that the study provide specific attributes that align with existing service marketing literature, so that Senior Dimensions can identify, measure, and improve on them.

Ethical Issues

There were potential ethical issues presented with the survey design. It was important that ethical guidelines were upheld to ensure protection of all parties participating. As established by research firm Market Strategies, ethical obligations and confidentiality were upheld. Measures were put in place to ensure participant confidentiality and complete disclosure to the study's findings. All participation was voluntary, and \$100 was offered for participation in the study.

Potential Sources of Error

There were potential sources of error that needed to be avoided during the administration of the study. Due to the nature of the study, errors such as social

desirability bias, auspices bias, and interviewer bias were presented. Social desirability bias refers to how a respondent answers a question, suggesting that the respondent's answers are not reflective of who he or she is but rather who the respondent wishes to be. Auspices bias relates to potential bias that the respondent may have that is influenced by the organization conducting the study. To combat auspices bias, the moderator separated herself from the company "sponsoring" the study; however, bias still may be present in the studies findings. Interviewer bias was possible, as the moderator may have influenced the respondents' responses based on the structure, tone, and presentation of a question. To combat interviewer bias, the moderator attempted to gain responses from each participant and ensure her delivery and tone were consistent.

Additionally, administrative and sample selection errors were possible.

Administrative errors surrounding the improper administration or execution of the research task are presented. To combat administrative errors, several researchers have reviewed the findings and analysis to confirm their reliability. Sample selection error, an error caused by improper sample design or sampling procedure error was possible within the study's design. Due to the selection of participants, error can skew results and provide a misrepresentation of the Senior Dimensions population. These sources of potential error were carefully considered when generalizing results across the population of patients at Senior Dimensions.

Limitations

Within the proposed research design, several limitations are important to identify and address. With qualitative methods such as focus groups and individual interviews, certain limitations exist. Due to its nature, the study was able to capture the thoughts and

responses from only 39 patients at Senior Dimensions. With potential bias or error, the study's findings may not be replicative of the entire population. In addition, groupthink and self-serving biases also may have skewed the results, resulting in poor representation of the population interviewed.

Additional limitations exist due to the study's selection of participants. Because eligible participants were screened and selected by previously established guidelines, the population may not be representative of the entire Senior Dimensions patient population. Selection criteria included age parameters, ability to articulate questions and answers, and an overall rating of health plan and health care between 6 and 8. In addition, this study was only conducted for Senior Dimensions, a single MA plan in Las Vegas, Nevada. As a result, generalizability across different MA plans may be problematic. To infer findings across different MA plans, this study would need to be replicated in those areas.

CHAPTER FOUR

ANALYSIS

This section presents the results and analysis of two focus groups and 16 individual interviews conducted by Market Strategies, an independent research firm, on behalf of Senior Dimensions Health Plan. As previously mentioned, the focus groups and individual interviews were administered during the first week of December 2014. A total of three focus groups were administered; however, only two were representative of the Senior Dimensions population. The primary objective was to better understand the members' experiences and their perceptions of their health plan and health care.

Each focus group was administered by Market Strategies personnel and lasted approximately two hours. During each focus group, a series of questions were presented to the group to identify the positive and negative attributes about their experience with Senior Dimensions. The common themes and trends from the focus group data were analyzed to provide additional detail and further implications surrounding the patient satisfaction attributes for Senior Dimensions. As a result, future research suggestions are presented.

The analysis identified questions that specifically addressed patient satisfaction and/or the strengths and weaknesses of Senior Dimensions. The analysis reveals gaps in service quality, further aligning with our grounded service quality framework and theoretical 5Qs model. Such gaps and analysis are useful in providing insight to Senior Dimensions to improve overall patient satisfaction.

The analysis will be broken down into three sections. Section 1 provides an overview of the questions and findings from the focus group and individual interview

transcripts. Section 2 provides an analysis of the findings as they relate to the 5Qs and service quality frameworks. Lastly, Section 3 will provide additional implications and research opportunities to further patient satisfaction research at Senior Dimensions.

Qualitative Findings

Below are a series of questions that provoked attributes of patient satisfaction and determinants of overall patient experience. In addition to open-ended questions, the focus group guide also incorporated a flip chart exercise and ideation question. (The focus group guide can be found in Appendix E). Following each question, common themes and trends are listed that were identified during the analysis. With the use of mixed qualitative tools, the research provides a unique perspective from each patient participant and group.

Flip Chart Exercise 1

“Tell me all of the things you like about Senior Dimensions. What do they do well? What are the high points?” (The responses were written on a flip chart.) The common themes across both groups are listed below:

- doctors are on time and don't cancel appointments
- convenient urgent care facilities
- appointment reminder calls
- lifestyle programs and classes
- senior-focused
- affordable; no co-pay
- specialist referrals
- friends or family belong

Flip Chart Exercise 2

“Tell me all of the things that you don’t think they do well. Where does Senior Dimensions fall short? What could they do better?” (The responses were written on a flip chart.) The common themes across both groups are listed below:

- phone/customer service on-hold times
- lead time to get an appointment
- doctor compassion for patients
- patient volume per doctor
- patient–doctor communication
- PCP turnover

Each group was asked to elaborate on their responses to the flip chart exercise.

The positive and negative comments related to their findings are listed in greater detail below.

The positive responses from patients regarding what Senior Dimensions does well included:

- “When you see the doctor, there’s very little waiting time. Just a few minutes and you’re in to see him.”
- “They set up physicals for you every year with the blood work and whatever they want you to do before you come in. They call you and set it all up.”
- “I don’t have a problem with my doctor. He’s very good. He listens to me when I talk to him and spends enough time with me, so I’ve never really come against anything bad.”
- “I’ve never had a problem. At every place, everyone is nice and courteous.”

- “I had a good experience with one of the people in Southwest Medical. Every time I walk in, ‘Hello, can I help you? You were here before. I know you. What do you need today?’ It depends on the individual.”

The number of negative responses regarding what Senior Dimensions does well outweighed the positive responses. The negative comments related to what Senior Dimensions does not do well or can improve on included:

- “They always seem harried and hurried. They’re like, ‘Go, go, go.’ If they asked how you were today, I’d be impressed. It’s a personal touch.”
- “They’re watching their watch all the time. ‘No more, 10 minutes, 10 minutes.’”
- “I just want to get in and have somebody say, ‘Hi, Flora, how are you? How are you feeling? Let’s talk over your medications. I’ll sit down, and hold your hand.’ . . . I just want to know I have a caring doctor who went to a good university, is smart, and likes me. That’s all I care about.”
- “What came to mind is . . . we’re looking at a total of three months to get pain-relieving surgery.”
- “The doctor forgets to set up referrals and does not respond to phone calls.”
- “We could die before we get to see a doctor.”
- “Well, I just think they should be more understanding with you. Doctors should listen and take care of you the best way they know how.”

When asked specifically about customer service regarding their previous experiences, the following responses were similar and fell into distinct categories. Table 3 below displays these categories and specific findings for each one.

Table 4

Qualitative Summary of Findings

Show respect for me:

- Be on time, don't keep me waiting
- Remember me from previous visits
- Listen, don't act hurried, and look me in the eye instead of your computer
- Discuss/explain health issues, options, medications, and next steps in plain English without talking down
- Be compassionate
- Follow up with me
- Don't pass me off to a PA without prior discussion

Show me that I can trust and have confidence in you:

- Be thorough during exams and in paperwork
- Understand why I'm there to see you
- Be knowledgeable and up to date on latest research
- Be honest with Me about health and medications
- Don't over-medicate, prescribe medications, treatments, procedures I don't need
- Specialists should have adequate levels of experience

Be consultive and help coordinate my care:

- Make it easy to get referrals
- Offer suggestions for second opinions
- Coordinate and communicate with my other doctors
- Help me understand my options and your recommendations

In addition to the previously mentioned themes, we also found that doctor turnover and urgent care diversion can be huge dissatisfiers among patients. Comments from patients included:

- “My main problem is having a doctor I know, that I’ve seen a few years in a row, like three or four years or something like that. But they don’t have that.”
- “Southwest is a stepping stone to get on, get in, get some background, and then boom, they’re gone. I can’t tell you how many doctors I’ve had in 10 years.”

- “It seems like every time I go to the doctor . . . I get somebody I never met before. They’re good people but . . . I have to repeat my life story, basically. . . like the new doctor I just saw about five or six months ago . . . (who) said I’ll see you next time. And he just disappeared. I mean literally disappeared.”
- “I don’t want to have to start all over again with someone who doesn’t know my history.”
- “The standard answer is go to urgent care . . . but that’s not my doctor. That’s not who you need to see. And I resent a little bit having to see a physician’s assistant.”
- “When you need to see the doctor right away, you don’t want to wait a month or go to urgent care.”

Having identified several common themes among the qualitative data, we can begin to identify service gaps as they relate to SERVQUAL and, more specifically, the 5Qs. The analysis will identify attributes and dimensions that can be improved on using service-marketing techniques. As a result, additional opportunities for research and potential operational directives can be identified.

5Qs Analysis of Findings

I was able to infer potential service gaps as a result of identifying common themes and trends within my data. I identified and analyzed these gaps using the 5Qs service quality model, which has been used in previous health care studies (Zineldin, 2006). 5Qs, adapted from SERVQUAL, provides a comprehensive model to support the industry’s complexities and uniqueness. For example, the 5Qs model provides reliable dimensions such as infrastructure, atmosphere, interaction, process, and objects. Taking a closer look

at the gaps, we can begin to expand on the dimensions that are closely tied to patient satisfaction at Senior Dimensions.

Q1: Quality of the Object

Q1, as outlined by Zineldin (2006), is known as the technical service quality attribute. Q1 relates to the patients' clinical outcomes and to proper diagnosis. Therefore, the goal becomes for the quality of the treatment to leave the patient feeling a sense of well-being, security, and comfort.

Many comments were made during the study to confirm the importance of this attribute. Some included:

- “We used to have good specialists. It has gone from good to very poor.”
- “I just want a well-trained doctor who cares about me and my condition.”
- “The doctors seem so rushed that they sometimes don't take the time to address all of my concerns or questions.”
- “I'm real particular about doctors. Most people are happy to see an MD; I like board-certified doctors.”
- “No one would fill the prescription from two weeks ago for me in California. And I find that absolutely horrid.”
- “I was out of blood pressure pills, and I didn't realize I didn't have anymore. The doctor confirmed that I would have them, but [I heard] nothing after a few days. I needed my pills, so I had to run down to UMC.”

As a result, Q1 holds value in understanding the determinants of patient satisfaction. This is important, as accuracy can be measured and coached to leverage better results in the overall quality of the treatment. Although the service being delivered

has high credence, the research provides enough legs to ensure that physicians' and nurses' accuracy is critical in driving overall satisfaction.

Q2: Quality of the Process

Q2, as outlined by Zineldin (2006), measures how the services are provided, from a functional quality perspective. Therefore, waiting times to get medications, referrals, appointments, and surgeries are among the drivers of this attribute. Perceived quality here would suggest the patient is taken care of within an acceptable time frame.

The analysis provided many comments surrounding the process for patients to see or receive medical care from Senior Dimensions. Comments related to this dimension included:

- “I think the wait time is too long to get a decision.”
- “I don’t want to wait three months to see a specialist.”
- “The doctors forget to set up referrals and do not respond to phone calls.”
- “I want the results tomorrow, but it doesn’t happen—I would say, within a week.”
- “We could die before we get to see a doctor.”
- “You are on the phone forever. I avoid it and go into the office just to make an appointment.”

Among the many patient comments, the quality of the process, as defined above, supports Q2 as a reliable attribute. Due to the frequency of the comments surrounding wait times during several processes at Senior Dimensions, the analysis suggests a significant gap in service; thus, potential improvements should be evaluated and implemented.

Q3: Quality of Infrastructure

Q3, as defined by Zineldin (2006), measures the skills of the medical staff as well as the appearance and cleanliness of the buildings and staff. Perceived quality would suggest skilled medical staff and aesthetically pleasing facility and staff.

The findings suggest this was not a common theme across the qualitative research; however, some comments surrounding the skills of the medical staff were mentioned. While no specific comments were made surrounding the facility's cleanliness, research suggests its importance in driving satisfaction (Zineldin, 2006). In addition, it is widely touted that the skills of the medical staff are among the most important factors in determining overall satisfaction. Beyond that, patients desire competence, skills, and good attitudes. Comments supporting this attribute include:

- “I was thinking about the doctors that I had seen, what they did for me, and how they handled things, and I was very pleased with the doctor.”
- “If I went to see a doctor and if I didn't like him, that could make me lower my score, but that hasn't happened.”
- “It's just the attitude they've developed because they've had to take so many patients—so many more than they used to have to.”
- “Your dog is getting better treatment than you are.”

The analysis suggests that this dimension and its attributes are supported by our findings. It is important to measure this dimension to ensure consistent, high-quality service. Future recommendations for identifying the patients' perception of “high-skilled” medical staff would prove valuable for Senior Dimensions.

Q4: Quality of Interaction

Q4, as defined by Zineldin (2006), measures the adequacy of instruction regarding health, treatment, and billing, as well as whether the time spent by staff in understanding patients' needs or questions is adequate. This dimension suggests that patients are well informed regarding their health and feel that there is open and honest communication with the medical staff and supporting departments. Also, the data suggest there is transparency and full disclosure within each touch point of the patients' health care journey.

The qualitative analysis provided several examples that fit within the framework's attributes:

- “There’s a confidence level in who you’re talking to, when you go to get medical help, that’s not there when you walk into an urgent care.”
- “The doctor recommended me to an endocrinologist but felt he wasn’t qualified, and he made me an appointment with another doctor. That was good.”
- “I think, [an example is] having a doctor listen to you and take the time to listen to you.”
- “You have to have a relationship with your doctor, because then you trust him.”
- “It’s a matter of having faith in your doctor, the doctor knowing what he’s doing, and the doctor knowing you.”
- “I need a doctor that’s going to sit down and give you that extra seven minutes, because I needed it.”

- “It seems like whenever my cat has to go in for some kind of treatment—a shot or whatever—they call to see how he’s doing the next day. They don’t do that with you.”
- “I wish they would just—it just seems—stay more focused on your problem at the moment. It just seems that they’re somewhere else. They’re not really paying attention to you.”

The comments further reiterate the attribute’s importance as it relates to the patients’ satisfaction. With consistent communication and transparency, Senior Dimensions has the ability to drive satisfaction regarding the patients’ experience. As a result, patient satisfaction is influenced by receiving adequate explanations and information from health providers and supporting staff. Future proposals of service quality techniques have the potential to help combat some of the issues presented above.

Q5: Quality of the Atmosphere

Q5, as defined by Zineldin (2006), relates to the politeness and responsiveness of the medical and support staff. The atmosphere indicators should be considered important in driving satisfaction because of the belief that lack of a friendly atmosphere suggests poor quality of care (Zineldin, 2006). This dimension suggests that a friendly, inviting atmosphere is a significant driver of overall patient satisfaction.

As one of the reoccurring themes, the quality of the atmosphere can be seen as an important indicator of satisfaction for Senior Dimensions. Several comments relating to the overall atmosphere and service delivery by the staff and doctors suggest a potential service gap. For example, patient comments supporting this dimension include:

- “I just care about the doctor. I mean, as long as they’re not rude, I could care less.”
- “The very first thing you see makes a world of difference.”
- “I think if they would do something to make their employees more—how could I say it? They act like we owe them a living for being behind that desk. You walk up, they’re not friendly, they’re rushed, they’re—they need to start right there.”
- “It isn’t very hospitable.”
- “They have to have attitude education.”
- “Customer service means treating you with respect.”

As previously mentioned, the service gap presented by this dimension suggests that there is room for improvement surrounding the atmosphere at Senior Dimensions. Service training and additional research will help combat these issues and help Senior Dimensions identify the drivers causing this service gap.

5Qs, Patient Satisfaction, and Recommendations

The analysis provides substantial credibility among the patients’ remarks and the 5Qs service quality framework. In addition to the dimensions introduced by 5Qs, service quality models such as RATER, gap theory, and SERVQUAL suggest similar findings and relationships. While we revealed several gaps, our analysis suggests that Senior Dimensions should address three main gaps to combat poor satisfaction: quality of the process, quality of the atmosphere, and quality of the infrastructure.

Quality of the Process

The analysis provides an overwhelming number of patient remarks surrounding the processes of receiving and accessing care. This service gap suggests a lack of responsiveness, implying that the services are not being provided promptly. Remarks surrounding wait times on phones, waits to get appointments, waits to get prescriptions, and waits to get referrals are among the list of drivers. It will be imperative for Senior Dimensions to combat the issues surrounding this dimension to increase their patient satisfaction. Additional research providing clarity around patients' perceptions of "timely" is recommended to further support this dimension's effectiveness and the implementation of improvements.

Quality of the Atmosphere

The atmosphere dimension can be related to the lack of empathy and assurance, as established by the RATER model of service quality. The analysis provides ample findings signifying the importance of this dimension regarding the patients' overall satisfaction. The patients' remarks suggested no evidence of empathy, as well as a lack of assurance at Senior Dimensions. For example, we heard many patients say that they just wanted to be treated with respect and for the doctor and staff to truly care about their health. To combat this gap, Senior Dimensions should implement service training and a service culture in its organization that further supports the need for hospitality tools and education. Additional research is recommended on which interactions are most important to ensure validity and reliability.

Quality of the Infrastructure

The dimension of infrastructure is correlated with the tangibility of the service. Both dimensions include physical facilities, equipment, and personnel as attributes. The

nonexistent evidence of tangibility suggests a lack of infrastructure within Senior Dimensions. The remarks about doctor turnover, urgent care diversions, and lack of communication about changes prove problematic for Senior Dimensions. In resolving this service gap, it is important to retain physicians and ensure that patients can establish relationships with their doctors. In addition, should a change occur, patients should be notified and made aware so that they feel important.

In closing, the suggestion for additional research is critical for generalizing the findings of this study. A quantitative analysis is recommended to provide validity and reliability. Using the findings from this qualitative study will prove beneficial for determining dimensions and attributes to analyze.

Conclusion

Although further research is required to gain a more complete understanding of service quality as it relates to patient satisfaction, my findings indicate that existing theoretical models of service quality are advantageous within health care services. My study provokes several models that have been used to measure and evaluate service quality and their importance in driving results for health care organizations. More specifically, I identified common themes within the qualitative analysis that aligned with many of the attributes outlined by RATER and service quality framework 5Qs. Using these findings, I can infer additional research opportunities for Senior Dimensions and health care companies alike.

As competition and pay-for-performance implementation infiltrate the industry, this study can be used to provide a benchmark for measuring and understanding service quality and its effects on measuring patient satisfaction. This study provides an overview

of service quality methods and their effectiveness in identifying attributes during qualitative research methods. The study provides theoretical contribution in providing empirical findings collected through my focus group and individual interview findings and analysis. In addition, the study highlights the need for health care organizations to understand the drivers of satisfaction within their population and how you can identify, measure, and test over time.

Due to the nature of the study, several limitations exist. As a result, generalizing the results across all health care organizations proves problematic. For Senior Dimensions, it is recommended to use the study's findings and conduct additional research surrounding those attributes and dimensions to ensure validity across the entire population. Because the study provided findings from qualitative analysis only, it is imperative for additional quantitative analysis to gather a larger sample of data to validate our findings. A survey tool using my study's findings should be created and given to the patients of Senior Dimensions. Once analyzed and evaluated, additional hospitality tools should be considered for implementation at Senior Dimensions.

APPENDIX A: IN DEPTH INTERVIEW SCREENER

Basic criteria:

- Recruiting a total of 16 for IDIs plus 6-8 floaters
- Must be able to name their current health plan
- Must have been insured with current health plan for one year or longer
- Must be between 65 and 75
- Mix of gender, age, ethnicity
- Must be articulate and willing to answer questions
- Must answer two rating questions similar to how that market rates
 - **Las Vegas:** Need to answer 6-8 for both health care and health plan

RECRUIT ONLY FROM SUPPLIED SAMPLE (members of H2931-002)

Hello, I'm _____ with Market Strategies International Research, and I'm calling on behalf of Senior Dimensions about your medical insurance plan. May I please speak with [INSERT FIRST AND LAST NAME FROM SAMPLE]?

QA. Is this [INSERT FIRST AND LAST NAME FROM SAMPLE] on the line?

- 1 Yes, respondent on the line {CONTINUE}
- 2 No, ask if respondent available

3 No, respondent not available { ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE}

INTRODUCTION

I am calling today because your medical insurance plan is interested in your opinions. The information you provide will not impact your health coverage and will only be used as part of a market research study for improvement efforts. No one will call or try to sell you anything as a result of my survey today.

Q1. I'd like to spend a brief time now asking some questions about your experience with your plan. May I ask you some questions?

- 1 Yes {CONTINUE}
- 2 No {ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE}
- 3 Don't know {THANK AND TERMINATE}
- 4 Refused {TECH NOTE: ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE}

Q2. First I'd like to confirm that we have accurate information, what is the name of the company that provides your health insurance coverage? WRITE IN _____ (IF THEY SAY SENIOR DIMENSIONS or HEALTH PLAN OF NEVADA KEEP, IF THEY DON'T KNOW TERMINATE)

If they say UnitedHealthcare or UHC, ask: Which is the name of your specific plan?

- Senior Dimensions HMO {CONTINUE}
- Medicare Complete HMO [TERMINATE]
- Don't know [TERMINATE]

If they say Medicare, ask: is there an insurance company that works with Medicare to provide your medical coverage? ANSWER: _____ (IF THEY SAY SENIOR DIMENSIONS or HEALTH PLAN OF NEVADA KEEP, IF THEY DON'T KNOW TERMINATE)

Q3. How long have you been on your current plan? WRITE IN _____
If one year or more – CONTINUE

Q4. How involved are you in decisions related to health insurance coverage for your household?

- You make decisions on your own {CONTINUE}
- You make decisions with someone else in your household {CONTINUE}
- Someone else makes the decisions for your household [TERMINATE]

Q5. Which ONE of the following statements best describes what you would do if you received a survey in the mail from the Centers for Medicare & Medicaid Services, or CMS, that asked your opinion about the **quality of health care services** you received in the last 6 months. Your participation in the survey would be completely voluntary and would not affect your benefits in any way. Do you think you would . . . ? **READ**

STATEMENTS

- Definitely fill out survey {CONTINUE}
- Probably fill out survey {CONTINUE}
- Probably not fill out survey, or {TERMINATE}
- Definitely not fill our survey {TERMINATE}
- Don't know {TERMINATE}

Q6. In the last 6 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?

- __ Yes {CONTINUE}
- __ No {CONTINUE}

Q7. In the last 6 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

Yes {CONTINUE}

No {CONTINUE}

Q8. Using any number from 0 to 10, where 0 is the worst **health care** possible and 10 is the best **health care** possible, what number would you use to rate all your health care in the last 6 months?

LAS VEGAS: NEED TO ANSWER 6-8 FOR HEALTH CARE

Worst health care possible						Best health care possible				
0	1	2	3	4	5	6	7	8	9	10
TERM	TERM	TERM	TERM	TERM	TERM	OK	OK	OK	TERM	Term

Q9. In the last 6 months, did you try to get any kind of care, tests or treatment through your health plan?

Yes {CONTINUE}

No {CONTINUE}

Q10. In the last 6 months, did you try to get information or help from your health plan's customer service?

Yes {CONTINUE}

No {CONTINUE}

Q11. Using any number from 0 to 10, where 0 is the worst **health plan** possible and 10 is the best **health plan** possible, what number would you use to rate your health plan?

LAS VEGAS: NEED TO ANSWER 6-8 FOR HEALTH PLAN

Worst health care possible						Best health care possible				
0	1	2	3	4	5	6	7	8	9	10
Term	Term	Term	Term	Term	Term	OK	OK	OK	Term	Term

I have a few more questions I'd like to ask to ensure we speak to a wide range of people in our study. All the information you provide will be kept strictly confidential.

Q12. DO NOT ASK: RECORD FROM OBSERVATION OR SAMPLE: **RECRUIT A MIX**

- 1 Male
- 2 Female

Q13. Do you consider yourself to be White, African American, Hispanic or Latino, Asian, mixed race, or some other ethnic background? **RECRUIT A MIX**

IN LAS VEGAS AT LEAST 2-3 OF THE 16 TOTAL MUST BE AFRICAN AMERICAN AND 3-4 HISPANIC/LATINO

- White..... [] CONTINUE
- African American..... [] CONTINUE
- Hispanic/Latino..... [] CONTINUE
- Asian..... [] CONTINUE
- Mixed Race..... [] CONTINUE
- Other..... [] CONTINUE
- Specify: _____
- Refused..... [] TERMINATE

Q14. What is your age? (DON'T READ)

- ___ 64 and under {TERMINATE}
- ___ 65 – 75 {CONTINUE}
- ___ 76 or older {TERMINATE}

Q15. In the last 10 years, have you or any other member of your household, worked for ...?

- An architectural or engineering firm.....1 [CONTINUE]
- A physician, hospital, or medical practice2 [TERMINATE]
- An advertising agency or market research firm3 [TERMINATE]
- An automotive sales or repair facility4 [CONTINUE]
- A health, life or disability insurance company5 [TERMINATE]
- A health insurance agency or brokerage firm6 [TERMINATE]
- A pharmaceutical or medical device manufacturer6 [TERMINATE]
- (Do not read)** None of the above7 [CONTINUE]

(Do not read) Don't know/refused.....8
.....[TERMINATE]

Q16. In the last 10 years have you held a position in a company where you were involved in investigations or decisions related to employee benefits?

Yes.....[] [TERMINATE]
No.....[] CONTINUE

Q17. When, if ever, was the last time you participated in a market research discussion or interview? (RECORD ONE RESPONSE.)

Within the past 6 months.....[] (ASK 17B)
Longer than 6 months ago.....[] (GO TO Q18)
Never.....[] (GO TO Q18)

Q17b. What was the subject of the research study/ studies in which you participated?

Subject _____
Subject _____
Subject _____
Subject _____

RECRUITER: PROBE AS NEEDED. IF RELATED OR COULD BE RELATED TO HEALTH INSURANCE IN ANY WAY, DO NOT RECRUIT, PLACE ON HOLD AND LET CLIENT KNOW.

Q17. My final question is a bit different and has no right or wrong answers. Please tell me in your own words what your ideal retirement would be like. RECRUITER PROBE- ANY ASPECT IS ACCEPTABLE (FINANCIAL, SOCIAL, HEALTH, HOBBIES, ETC)

RECRUITER NOTE: MUST SPEAK CLEARLY WITH NO DIFFICULT ACCENTS. THIS QUESTION IS ASKED TO GAUGE ARTICULATION. PREFERNCE SHOULD BE GIVEN TO RESPONDENTS WHO ARE EXCITED, TALKATIVE AND ARTICULATE . HOLD FOR REVIEW IF ANY DOUBTS.

Thank you very much for your time. The information you have provided is important to Senior Dimensions as it makes improvements to better serve you.

INVITATION IN PERSON INTERVIEW

As a follow-up we would like to invite you to take part in a one on one interview with a professional market researcher at [FACILITY] at [TIME] on [DATE]. The session will last 60 minutes and you will be compensated \$XXX for your time.

You will need to arrive 25 minutes before your interview time in order to complete some paperwork prior to the discussion.

Are you willing and available able to participate in the interview?

Yes 1
.....[Collect contact
information]
No2
.....[Terminate]

We will send you some more information, including a map and directions, to confirm your participation in our study.

Please remember to bring reading glasses with you if you normally wear them to review written materials or when using a computer.

Name	_____	
Address	_____	Email
Address	_____	
Home Phone #	_____	Work Phone # _____
Cell Phone #	_____	
City	_____	State _____

APPENDIX B: FOCUS GROUP SCREENER

Basic criteria:

- Recruiting a total of 20 for 2 focus groups (*i.e.*, recruit 10 for each, for 8-10 to show)
- Must be able to name their current health plan
- Must have been insured with current health plan for one year or longer
- Must be between 65 and 75
- Mix of gender, age, ethnicity
- Must be articulate and willing to answer questions
- No more than 2 recruits per group who rated health plan lower than 6

RECRUIT ONLY FROM SUPPLIED SAMPLE (members of H2931-002)

Hello, I'm _____ with Market Strategies International Research, and I'm calling on behalf of Senior Dimensions about your medical insurance plan. May I please speak with [INSERT FIRST AND LAST NAME FROM SAMPLE]?

QA. Is this [INSERT FIRST AND LAST NAME FROM SAMPLE] on the line?

3 Yes, respondent on the line {CONTINUE}

4 No, ask if respondent available

3 No, respondent not available { ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE }

I am calling today because your medical insurance plan is interested in your opinions. The information you provide will not impact your health coverage but will only be used as part of a market research study for improvement efforts. No one will call or try to sell you anything as a result of my survey today.

Q1. I'd like to spend a brief time now asking some questions about your experience with your plan. May I ask you some questions?

1 Yes {CONTINUE}

2 No {ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE}

3 Don't know {THANK AND TERMINATE}

4 Refused {TECH NOTE: ATTEMPT TO SCHEDULE CALL BACK; IF REFUSE THANK AND TERMINATE}

Q2. First I'd like to confirm that we have accurate information, what is the name of the company that provides your health insurance coverage? WRITE IN _____ (IF THEY SAY SENIOR DIMENSIONS OR UNITEDHEALTHCARE, OR UHC – KEEP, IF THEY DON'T KNOW TERMINATE)

If they say *Medicare*, ask: is there an insurance company that works with Medicare to provide your medical coverage? ANSWER: _____
 (IF THEY SAY SENIOR DIMENSIONS OR UNITEDHEALTHCARE, OR UHC – KEEP, IF THEY DON'T KNOW TERMINATE)

Q3. How long have you been on your current plan? WRITE IN _____
If one year or more – CONTINUE

Q4. How involved are you in decisions related to health insurance coverage for your household?
 You make decisions on your own {CONTINUE}
 You make decisions with someone else in your household {CONTINUE}
 Someone else makes the decisions for your household [TERMINATE]

Q5. In the last 6 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?

Yes {CONTINUE}
 No {CONTINUE}

Q6. In the last 6 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

Yes {CONTINUE}
 No (CONTINUE)

Q7. Using any number from 0 to 10, where 0 is the worst **health care** possible and 10 is the best **health care** possible, what number would you use to rate your health plan?

LAS VEGAS: LET FALL OUT NATURALLY FOR HEALTH CARE

Worst health care possible						Best health care possible				
0	1	2	3	4	5	6	7	8	9	10
OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK

Q8. In the last 6 months, did you try to get any kind of care, tests or treatment through your health plan?

Yes {CONTINUE}
 No {CONTINUE}

Q9. In the last 6 months, did you try to get information or help from your health plan's customer service?

Yes {CONTINUE}

No {CONTINUE}

Q10. Using any number from 0 to 10, where 0 is the worst **health plan** possible and 10 is the best **health plan** possible, what number would you use to rate all your health care in the last 6 months?

LAS VEGAS: NO MORE THAN TWO RECRUITS WHO RATE HEALTH PLAN BELOW 6.

Worst health care possible						Best health care possible				
0	1	2	3	4	5	6	7	8	9	10
OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK

I have a few more questions I'd like to ask to ensure we speak to a wide range of people in our study. All the information you provide will be kept strictly confidential.

Q11. DO NOT ASK: RECORD FROM OBSERVATION OR SAMPLE: **RECRUIT A MIX**

3 Male

4 Female

Q12. Do you consider yourself to be White, African American, Hispanic or Latino, Asian, mixed race, or some other ethnic background? **RECRUIT A MIX**

IN LAS VEGAS AIM FOR 1 OF THE 10 TOTAL RECRUITED FOR EACH GROUP TO BE AFRICAN AMERICAN AND 2-3HISPANIC/LATINO

- White.....[] CONTINUE
- African American.....[] CONTINUE
- Hispanic/Latino.....[] CONTINUE
- Asian.....[] CONTINUE
- Mixed Race.....[] CONTINUE
- Other.....[] CONTINUE
- Specify: _____

Refused [] TERMINATE

Q13. What is your age? (DON'T READ)

- ___ 64 and under {TERMINATE}
- ___ 65 – 75 {CONTINUE}
- ___ 76 or older {TERMINATE}

Q14. In the last 10 years, have you or any other member of your household, worked for ...?

- An architectural or engineering firm.....1 [CONTINUE]
- A physician, hospital, or medical practice2
.....[TERMINATE]
- An advertising agency or market research firm3
.....[TERMINATE]
- An automotive sales or repair facility4 [CONTINUE]
- A health, life or disability insurance company5
.....[TERMINATE]
- A health insurance agency or brokerage firm6
.....[TERMINATE]
- A pharmaceutical or medical device manufacturer6
.....[TERMINATE]
- (Do not read)** None of the above7 [CONTINUE]
- (Do not read)** Don't know/refused.....8
.....[TERMINATE]

Q15. In the last 10 years have you held a position in a company where you were involved in investigations or decisions related to employee benefits?

- Yes [] [TERMINATE]
- No [] CONTINUE

Q16. When, if ever, was the last time you participated in a market research discussion or interview? **(RECORD ONE RESPONSE.)**

- Within the past 6 months [] **(ASK 16B)**
- Longer than 6 months ago [] **(GO TO Q17)**
- Never [] **(GO TO Q17)**

Q16b. What was the subject of the research study/ studies in which you participated?

- Subject _____
- Subject _____
- Subject _____
- Subject _____

RECRUITER: PROBE AS NEEDED. IF RELATED OR COULD BE RELATED TO HEALTH INSURANCE IN ANY WAY, DO NOT RECRUIT, PLACE ON HOLD AND LET CLIENT KNOW.

Q17. My final question is a bit different and has no right or wrong answers. Please tell me in your own words what your ideal retirement would be like. RECRUITER PROBE- ANY ASPECT IS ACCEPTABLE (FINANCIAL, SOCIAL, HEALTH, HOBBIES, ETC)

RECRUITER NOTE: MUST SPEAK CLEARLY WITH NO DIFFICULT ACCENTS. THIS QUESTION IS ASKED TO GAUGE ARTICULATION. PREFERNCE SHOULD BE GIVEN TO RESPONDENTS WHO ARE EXCITED, TALKATIVE AND ARTICULATE . HOLD FOR REVIEW IF ANY DOUBTS.

Thank you very much for your time. The information you have provided is important to Senior Dimensions as it makes improvements to better serve you.

INVITATION IN PERSON INTERVIEW

As a follow-up we would like to invite you to take part in a focus group with a professional market researcher at [FACILITY] at [TIME] on [DATE]. The session will last 2 hours and you will be compensated \$XXX for your time.

You will need to arrive 20 minutes before your scheduled time in order to check in prior to the discussion.

Are you willing and available able to participate in the focus group discussion?

Yes 1

[Collect contact information]

No2

[Terminate]

We will send you some more information, including a map and directions, to confirm your participation in our study.

Please remember to bring reading glasses with you if you normally wear them to review written materials or when using a computer.

Name _____

Address _____ Email _____

Address _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

City _____ State _____

APPENDIX C: RESEARCH SCHEDULE

Tuesday, December 2		
Start Time*	Activity	
9:30 AM	M&R IDI 1	Floater #1 = 2 hours
10:30 AM	M&R IDI 2	
11:30 AM	M&R IDI 3	
12:30 PM	Break	
1:00 PM	M&R IDI 4	Floater #3 = 2 hours
2:00 PM	M&R IDI 5	
3:00 PM	Break	
3:30 PM	M&R IDI 6	Floater #3 = 2 hours
4:30 PM	M&R IDI 7	
5:30 PM	Break	
6:00 PM	M&R IDI 8	Floater #4 = 2 hours
7:00 PM	M&R IDI 9	
Wednesday, December 3		
Start Time*	Activity	
9:30 AM	M&R IDI 10	Floater #5 = 2 hours
10:30 AM	M&R IDI 11	
11:30 AM	M&R IDI 12	
12:30 PM	Break	
1:00 PM	M&R IDI 13	Floater #6 = 2 hours
2:00 PM	M&R IDI 14	
3:00 PM	Break	
3:30 PM	M&R IDI 15	Floater #7 = 2 hours
4:30 PM	M&R IDI 16	
5:30 PM	Break	
6:00 PM – 8:00 PM	Humana Focus Group	
Thursday, December 4		
Start Time*	Activity	
9:30 AM	Senior Dimensions Focus Group #1	
11:30 AM	Break	
12:00 PM	Senior Dimensions Focus Group #1	

APPENDIX D: INTERVIEW GUIDE

Market Strategies is a research and consulting firm. My name is Dawn Hunter and I am a market researcher. So, I get the privilege of traveling to places like this and talking to people like you as part of my job.

- I first want to thank you for your participation. I realize how limited your time is, and appreciate your willingness to share your opinions.
- The interview will take about 60 minutes.
- Please know that all your responses will be held in strict confidentiality, and your name will not be disclosed as part of this study. We are very interested in your open and candid feedback. There are no right or wrong answers.
- I'll be recording our conversation to ensure that we capture your responses accurately for the report we need to create based on this research. We will not be linking your comments directly back to you.
- We have observers in a back room, and toward the end of our conversation, I will go check to see if they have any additional questions. When I come back, we'll spend another 5-10 minutes and then it will be time for you to go.
- Before we get started, do you have a cell phone that you need to turn off or put in silent mode?

Warm Up

Before we get started talking about the survey that you filled out for us when you arrived, I'd like to get some background information from you so I know a little more about your current situation.

1. Tell me a little bit about you.

Interpretation of 'Health care' vs. 'Health plan'

2. I am going to start by throwing out two terms and I want you to write down the first three words that come to your mind. Don't think too much, just write down whatever pops in first. Just three words, nothing more.
(rotate)
 - a. Health care
 - b. Health plan
3. Let's talk about what you wrote down. Why did those terms jump to your mind?
4. Now, I'd like to talk about the survey that you completed when you arrived at the facility today. One of the questions we asked you to answer was here Q12, rate your health care on a scale of 0-10. [C27] You gave it

a rating of XX. Tell me a little more about why you gave a rating of XX for health care? What factors went in to your rating? What were you considering? [Let them answer in their own words. Probe as necessary for meaning depending on what they say]

5. **If rating of health care is 8 or below**, what would have to happen for you to give a rating of 9 or 10 for your health care – what would need to change?
6. **If rating of health care is 9 or 10**, what could happen that would cause you to give a rating lower than you did today to your health care? What kinds of things would happen that might make you less satisfied with your overall health care?

Now let's talk about your 'Health plan'.

7. Another question we asked you to answer was here Q46, rate your health plan. [C28] You gave it a rating of XX. Tell me a little more about why you gave a rating of XX for health plan? [Let them answer in their own words.] What factors went in to that rating? What were you considering? Probe as necessary for meaning depending on what they say.
8. **If rating of health plan is 8 or below**, what would have to happen for you to give your health plan a rating of 9 or 10 – what would need to happen/change for you to feel like they are doing a really great job (let them answer, but redirect other than cost – try to take cost off the table).
9. **If rating of health plan is 9 or 10**, what could happen that would cause you to give a rating lower than you did today to your health plan? What kinds of things would happen that might make you less satisfied with your health plan overall?

Understanding overlap:

10. So, when you were filling this out and you rated health care, then you rated health plan, how were these two questions similar in your mind?
11. How were they different?

Differences to the screener ratings (*when appropriate*)

12. Do you remember when you received the call and you were asked to participate in this research? Do you remember that the person who invited you also asked you to rate health care and your health plan? There was a slight difference in the ratings you gave on that call and the ratings you

gave me here today (explain). Why do you think that would be? Was there something different about filling out this paper survey versus answering questions on the phone, or did something happen more recently that might have affected your ratings?

Understanding the ratings influenced by survey design:

Let's look at the survey itself now.

13. Again, let's talk about health care, and this time I want you to look at that paper survey you filled out when you arrived here today. If we look under the heading of **Your Health Care**, you can see there are other things they ask you to rate before your overall health care rating. Did you notice that when you were filling out the survey? [Did you think they belonged together?]
 - a. were you thinking about these things, or were you thinking about other areas that aren't listed here . . . *(if appropriate) like the ones we talked about earlier?*
14. Let's talk about a few of the question in this section.
 - a. When you needed care right away [Q4/ C25.1] What would you say is a reasonable time to be seen?
 - i. If you weren't able to be seen by your doctor in a situation where you needed care right away, how would you feel about being referred to Urgent Care?
 - ii. If they bring up co-pay difference – ask what if the costs were the same?
 - b. Not counting when you needed care right away, getting an appointment for your health care at a doctor's office or clinic [Q6/C24.1] What timeframe do you feel is reasonable?
 - c. Wait times in waiting room and exam room? [Q8 / C25.2] How long do you typically wait? Is that problematic? How soon would you expect to be seen?
15. How do you see the relationship between your health plan and your personal doctor?
 - a. **[Probe:** Are they totally separate – both function independently? Do they work together in a collaborative way, or is there a more formal or direct connection between the plan and the doctor? Why?]
16. Let's now talk about health plan and the paper survey. Just like before, you can see there are other things they ask you to rate under the heading of **Your Health Plan**. Did you notice that when you were filling out the survey? [Did you think they belonged together?]

17. And, when you were asked to rate **your health plan** on a 0-10 scale, were you thinking about these things, or were you thinking about other areas that aren't listed here. . . *(if appropriate) like the ones we talked about earlier?*
18. When I asked you before what went into your overall rating for health plan, you mentioned only some/none of these things. Did any of these that you didn't mention play into your rating when you filled out this form earlier today? **[Probe on each attribute]** How so/why not?
- a. Ease of getting the care, test, or treatment you thought you needed through your health plan? [Q40 /C24.2]
 - i. **[Probe for detail here.** What does this mean to you, what are you evaluating? Understand if differentiating plan vs. provider.]
 - b. Did your health plan give you any forms to fill out? [Q44]
 - i. If yes, what were those forms?
 - ii. If no, if you got a survey to complete, would you consider that from your health plan?
19. I have heard you talk [*not heard you talk much*] about the process of getting referrals when you need to see a specialist or someone other than your personal doctor for treatment. Tell me a little about how the referral process works.
- a. Probe: What works well? Challenges? [Listen for things like denials, wait times, dealing with doctor's office staff, making appts with specialists, etc]
 - b. Probe: What changes would you recommend that would make it better?
20. Now, I would like to talk a little more in-depth about customer service. When it comes to your health care and your health plan, what kinds of things come to mind when you hear the term customer service?
- a. Getting info you need from your health plan's customer service? [Q42/ C26.1] Customer service staff treating you with courtesy and respect? [Q43 /C26.2] Can you tell me about an exceptional customer service experience they have had with Senior Dimensions – something that stands out as particularly good.
 - b. What about an experience with customer service at your health plan that hasn't been quite so good . . . maybe even downright bad? Tell me about that. [Probe: wait times]
 - c. What about when you go to your doctor's office. Can you tell me about an exceptional customer service experience when you visited the doctor's office – something that stands out as particularly good?
 - d. What about an experience with customer service at your doctor's office that hasn't been quite so good . . . maybe even downright bad? Tell me about that. [Probe: wait times]

Assessment of Coordination of Care

Now, let's look at a different group of questions.

21. Let's take this one first. In the last 6 months, how often did your personal doctor have your medical records or other information about your care when you went for a visit [Q20/C29.1]. What does that mean?
 - a. You answered . . . Tell me about that, is it important? How does it impact you?
 - b. Even though it says "in the last 6 months," did experiences from longer than that timeframe come to mind? Do all of your experiences factor into that rating?

22. Looking at Q23, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them. Tell me a little more about that.
 - a. What is a reasonable timeframe?
 - b. Does it vary depending on the test?
 - c. How do you prefer to receive results? Mail, patient portal, phone call?
23. Here is another question about how frequently your personal doctor talks to you about the prescription medicines you are taking [Q25/ C29.4]. Does that happen every time you visit? How, if at all, could that be better?

24. Here is one about managing your care among different providers and services.
It reads: *In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services.* [Q31/ C29.5]
 - a. Explain to me in your own words what that means?
 - b. How many doctors do you see in an average year? Explain.
 - c. How important is that to you compared to some of the other things we have been talking about?

25. One more from this section. *How often did your personal doctor seem informed and up-to-date about the care you got from specialists* [Q38/ C29.6]
 - d. Is that different than the one we just talked about? How so or why not?

26. Tell me one or two things that your doctor (your health providers) could do to increase your overall satisfaction?

27. Tell me one or two things that your health plan could do that would increase your overall satisfaction?

Overall Perceptions vs. competition (LOWER PRIORITY SECTION – IF SHORT ON TIME)

28. Is there another company that you know of that you tend to think of as better than your current health plan? Who is that? Why are they better?
29. Is there another company that you know of that you tend to think of as worse than your current health plan? Why is that? Why are they worse?
30. In the past, have you been a member of similar plans from other health care insurance carriers? Which ones?
- e. If you had been asked to rate your health care when you were with that carrier, what rating would you have given? Why?
 - f. If you had been asked to rate your health plan when you were with that carrier, what rating would you have given? Why?

Wrap up

31. I am going to go to the back room now and see if there are additional questions. While I am gone, I'd like you to do this exercise and when I come back, we will discuss it.

[**Note:** Explain exercise: Allocate 10 pts. per attribute. Points are weight of who they are thinking about when they look at the question.]

Attribute	My doctor	My doctor's practice	My health insurer	Total Points
Getting care as soon as you thought you needed				
Getting an appointment for your health care at a doctor's office or clinic as soon as you thought you needed				
Wait times in waiting room and exam room				
Getting your medical questions answered after regular office hours				
Getting results from a blood test, x-ray, or other test as soon as you needed them				
Someone from your personal doctor's office following-up to give you results from a blood test, x-ray, or other test				

The frequency with which you and your doctor talk about all the prescription medicines you were taking	
Getting the help you needed from your personal doctor's office to manage your care among other providers and services	
Your personal doctor is informed and up-to-date about the care you got from specialists	
Ease of getting the care, test, or treatment you thought you needed through your health plan	
Getting info you need from your health plan's customer service	
Customer service staff treating you with courtesy and respect	
Ease of filling out forms from your health plan	

- 32. Discuss exercise
- 33. Ask wrap up questions
- 34. Thank and dismiss

APPENDIX E: FOCUS GROUP GUIDE

Market Strategies is a research and consulting firm. My name is Dawn Hunter and I am a market researcher. So, I get the privilege of traveling to places like this and talking to people like you as part of my job.

- I first want to thank you for your participation. I appreciate your willingness to participate in this group discussion and share your opinions.
- Our discussion will take about 2 hours total.
- We are very interested in your open and candid feedback. So, if you agree with the group, great. But, if you have had a different experience or viewpoint, please speak up. There are no right or wrong answers.
- And, while you don't have to feel obligated to answer every question, I do want everyone to participate throughout the discussion.
- I'll be recording our conversation to ensure that we capture your responses accurately for the report we need to create based on this research. We will not be linking your comments directly back to you.
- Because we are recording, however, I will ask that everyone speak clearly and one at a time. If you are sharing something important with a neighbor while someone else is talking, we will miss that on the transcript.
- We have observers in a back room, and toward the end of our conversation, I will go check to see if they have any additional questions. When I come back, we'll spend another 5-10 minutes and then it will be time for you to go.

Warm Up (15 minutes)

First, I'd like everyone to introduce themselves to the group. You are all members of the Senior Dimensions HMO health plan and we will be talking about your health plan as part of our discussion today.

20. To start us off, let's go around the table and if you would each tell us your name, how long you have been a member of Senior Dimensions, and one fun fact about you.

Health plan selection criteria (20 minutes)

21. When you hear "Senior Dimensions" what words come to mind?
 - a. If a friend or family member asked you about your health plan, what kinds of things would you tell them? Would you tell friends and family about your health plan if they didn't ask - unprompted?
 - b. What kinds of things have you heard from others about Senior Dimensions?
22. What was the main reason you selected Senior Dimensions?
 - a. Did anyone help you come to your decision? How?

- b. What else influenced your decision?
 - c. Were there other plans you considered?
23. What kind of reputation do some of the other similar plans in your area have?
(Let them name ones that they know of) If they don't mention ask: What about . . .
- a. Humana Gold Plus HMO?
 - b. Caremore® HMO
 - c. Aetna Select® HMO
24. Do any of the plans that we talked about offer things to members that are different than what Senior Dimensions does for you? [Probe beyond product design features when mentioned]
25. Are there benefits you feel should be covered by your plan that are not covered or offered?

Senior Dimensions – strengths and weaknesses (35 minutes)

26. Now that we've talked about your history with the plan and some of the other plans in the market, I want to do a brainstorming exercise where I am going to go to the flip chart and capture your thoughts just so that I don't miss anything. I'd like you to tell me all of the things that you like about being a member of Senior Dimensions. What do they do well? What are the high points? *[capture on flip chart – place on the walls of the room. Make sure to probe for things other than cost/benefit structure, ask about service features too]*
27. Okay, now I want to capture all the things that you think they don't do well. As a health plan, where does Senior Dimensions fall short? What could they do better? *[capture on flip chart – place on the walls of the room. Make sure to probe for things other than cost/benefit structure, think about service features too]*
28. Before we move on, is there anything that is missing from these two lists? Anything else that we should add as a positive or a negative to make sure we have a complete and comprehensive list? *[add any add'l comments]*
29. Now, I am going to ask you to look at what we have on the flip chart and take the pad and a pen so that you can write something down for me. First, I am going to ask you to write down two items that you think are most important that Senior Dimensions does well and should continue to do well – two that are most critical in the positive category. Next, I will want you to write down two from the other category, where they don't do well, and that you believe are most critical to improve upon. But, there is the catch – I know how important cost is to everyone. So, I am going to limit it to non-cost features. So, you **cannot** write down something that is related to out-of-pocket expenses (cross off from the list now). So, other than reducing your costs, which is extremely important . . . other than

that, what should the plan do that would also be important to you. Please do this independently, and then we will discuss as a group [*give them time to write – then tally results on the flip chart*]

35. Now, I would like to talk a little more in-depth about customer service. When it comes to your health care and your health plan, what kinds of things come to mind when you hear the term customer service?
- e. If you have had to call customer service in the last few months, did you get the information you were looking for?
 - f. Who can tell me about an exceptional customer service experience they have had with Senior Dimensions – something that stands out as particularly good.
 - g. What about an experience with customer service at your health plan that hasn't been quite so good . . . maybe even downright bad? Tell me about that. [Probe: wait times]
 - h. What about when you go to your doctor's office. Who can tell me about an exceptional customer service experience when you visited the doctor's office – something that stands out as particularly good?
 - i. What about an experience with customer service at your doctor's office that hasn't been quite so good . . . maybe even downright bad? Tell me about that. [Probe: wait times]
30. I have heard you talk [*not heard you talk much*] about the process of getting referrals when you need to see a specialist or someone other than your personal doctor for treatment.
- a. Probe: What works well? Challenges? [Listen for things like denials, wait times, dealing with doctor's office staff, making appts with specialists, etc]
 - b. Probe: What changes would you recommend that would make it better?
31. How do you see the relationship between your health plan and your personal doctor?
- a. [**Probe:** Are they totally separate – both function independently? Do they work together in a collaborative way, or is there a more formal or direct connection between the plan and the doctor? Why?]
32. When you hear the term “health care quality” what does that mean to you?
- a. What determines a quality health care experience?

Senior Dimensions – ideation (25 minutes)

33. Now, I am going to share with you a story about an experience that I had recently on a family vacation. My family was going to a resort in a neighboring state, where we had never stayed before. The drive there was rough. We got a later

start than we wanted and my 10 year old son was battling stomach problems during the drive, which made us even later. I think we pulled up sometime near midnight. When we checked in, the registrar asked how our trip over had been, I told him that my son didn't feel well and we were disappointed we arrived so late. He asked if he could give me something to make my son feel better. That was not a response I expected, but of course I said yes. He handed over a backpack that included all kinds of kid goodies and a scavenger hunt type game with the promise of a prize from one of the resort shops if my son uncovered 5 clues hidden on the premises. You might be able to guess what came next, we spent time over the next few days earnestly uncovering clues and my son proudly wore the backpack and entertained himself with other cool gear from the bag. And, at the end of the trip when we had solved the puzzle we all enjoyed a gourmet ice cream from the ice cream parlor. The reason I tell you this is that it made an impression. It created memories, it made my son feel special and it connected us emotionally to that resort. If we are thinking about staying in that area again, that VIP experience will tip the scales in favor of us returning. And, obviously, I am more than willing to tell that story of my good experience and even recommend the resort to others. Do any of you have examples of something a company did for you that made you feel special or like you'd be more willing to endorse that company? It could be something really simple, too, but that had an impact. *[let a few people share – probe on how the experience made them feel]*

So, I am going to ask you to put on your creative thinking caps and help me to come up with ideas that would create a similar experience for you as a customer of your health plan. Help me come up with ideas of things that Senior Dimensions could do to help you or create an exceptional experience for you and others like you?

34. When you were recruited to this group, each of you were asked on the phone to rate your health plan on a scale of 0 to 10 – and those ratings varied. Some of you gave X and others gave X, but very few/none gave the highest ratings of 9 or 10. Thinking about everything that you have told me today, what should Senior Dimensions do that would make you think they are a 9 or a 10 company?
 - a. Probe if needed: What are one or two things they could do different than what they do now, or new ideas, that would improve your overall satisfaction?

Wrap up (10-15 minutes)

35. I am going to go to the back room now and see if there are additional questions. While I am gone, I'd like you to do this exercise and when I come back, we will discuss it. I am passing around a sheet where I want you to write down some ideas. I want you to write down the top 5 things that you expect from your personal doctor or primary care providers, and next write down the top 5 things that you expect from specialists. You might have overlap or they could be totally different. But, write down 5 for each. When I come back we will discuss.

Top 5 things that you expect from your personal doctor/primary care providers:

- 1.
- 2.
- 3.
- 4.
- 5.

Top 5 things that you expect from specialists:

- 1.**
- 2.**
- 3.**
- 4.**
- 5.**

36. Discuss exercise

37. Ask wrap up questions

38. Thank and dismiss

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