**HEALTH SYSTEM CONTACT CENTERS AS THE FIRST STEP OF**

**THE PATIENT EXPERIENCE:**

**QUALITY ASSURANCE AND BEST PRACTICES AT**

**THE UPMC CONTACT CENTER**

by

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**ABSTRACT**

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As healthcare continues to shift from volume-based care models to value-based care models, providing patients with positive patient experiences has become a top priority in many health systems around the country. A positive patient experience includes placing the patient at the center of care and treating them with the utmost respect in the clinical setting, as well as in the time before and after a patient is physically seen by a provider. Health system contact centers are an often overlooked component in the patient experience. The interaction a patient has with a contact center agent is just as important as the patient-provider interaction. Contact center agents bridge the gap between the patient and the provider. They are responsible for many important tasks, including scheduling appointments and resolving billing and insurance questions. A health system’s contact center functions as an essential base and the first step in the patient experience.

Having a well-performing contact center in a health system is extremely important, as healthcare is full of options and other competitors. Thus, contact centers are necessary for patient retention and patient satisfaction of the overall health system. Contact center agents are supposed to be thoroughly trained and equipped with the tools necessary to provide patients with a seamless and straightforward experience. In reality, not all calls are easily resolved and not all patients are satisfied with the quality of their contact center experience. The Quality Assurance Department at the UPMC Consumer Contact Center evaluates randomized calls and scores them based on several metrics, including adherence to call script, hold and transfer etiquette, and appointment review. Best practices must be complied so that contact centers can successfully assure quality in customer service and so that patients can begin their hospital experience on a positive note. This analysis is of relevance to public health because of its impact on patients seeking healthcare services for better health outcomes and an overall positive healthcare experience.

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# INTRODUCTION

The patient experience has become a recent focus and area of improvement in health systems across the country. The more a patient is treated exceptionally well by the clinical and non-clinical employees who interact with them, the more positive their patient experience will be. The patient experience extends beyond the hospital setting; it also applies to a health system’s contact center, where patients can schedule or cancel appointments, resolve billing and insurance issues, get a price estimates on particular services, and address customer service related concerns.

The UPMC Consumer Contact Center is a crucial component for the patient experience. Here, the call specialists (agents) act as the first step in the patient experience. These phone calls have the potential to set the tone for a patient’s entire clinical experience and their view of the overall health system. When a call specialist can achieve everything a patient asks for and meets their expectations, the patient experience will start on a positive note and boast confidence in the patient for a continued delivery of care. With a health system as large and expansive as UPMC, quality and patient experience must be continually measured and improved. At the UPMC Consumer Contact Center, this is achieved through the Quality Assurance Program.

## UPMC OVERVIEW

UPMC is a world-renowned and nationally-ranked health system with over 30 hospitals and over 600 doctors’ offices and outpatient sites. UPMC comprises of different divisions –Health Services, Insurance Services, International, Enterprise, and Corporate. The Health Services Division is most affected by the UPMC Consumer Contact Center, as this division includes hospitals and physician groups throughout UPMC’s patient population.

## UPMC CONSUMER CONTACT CENTER

The UPMC Consumer Contact Center provides the opportunity to positively impact patients’ initial experiences at UPMC through scheduling, follow-ups, financial education, and final bill resolution. The Consumer Contact Center deals with about 3.6 million inbound and outbound calls annually. The 465 contact center specialists (levels I and II) take calls from six different lines of business – Central Scheduling, Customer Service, Consumer Referral Service, 24/7 Answering Service, Insurance Hotline, and Patient Experience (Table 1). Escalation agents, which are different from contact center specialists due to their more supervisory role, are also available to resolve vehement customer calls. The Contact Center also includes three departments – Workforce Management, Quality Assurance, and Staff Development. Each department has key responsibilities in the overall functioning of the Contact Center, including call specialist onboarding, real-time monitoring of call specialists, quality audits of call specialists’ interactions with callers, and continuous call specialist development.

Table 1. Six Contact Center Lines of Business

## UPMC CONTACT CENTER QUALITY ASSURANCE PROGRAM

The UPMC Call Center has significantly grown in the last 10 years. Starting as a pre-registry center, it now offers various services such as scheduling, customer service, and billing. With the amount of phone calls handled daily by call specialists, a standardized process to evaluate quality of the calls and call specialists’ performances has been implemented through the Quality Assurance Program. The Quality Assurance Program comprises of nine Quality Analysts (QAs) who are overseen by the Supervisor of Quality Assurance. QAs are able to work from home but are required to be in the office for initial training, meetings, and training of new hires. QAs randomly screen phone calls daily for quality assurance by filling out evaluation forms, two of which are explained in this analysis – Scheduling and Customer Service. These evaluation forms were created by UPMC and are filled out electronically by the QAs. The objective of the Quality Assurance Program is to assign the right number of resources with the right skills to the right interactions at the right times to ultimately create an exceptional customer experience.

# METHODS

## SCHEDULING QA EVALUATION FORM

Scheduling is the largest department within the UPMC Contact Center. Call specialists are provided scripts that are specific to a situation, clinical department, or service line. QAs must evaluate if call specialists followed standard call procedures, displayed exceptional customer service, and resolved the caller’s reason for calling. Evaluation sections are categorized as behavioral, procedural, or both. The scheduling evaluation form has 11 sections, each with specific actions listed under them so QAs know exactly what they are scoring. Each section also has a specific number of points a call specialist can receive based on how well they satisfied the actions listed in each section.

*1. Greeting (5 points) – Behavioral*

The section establishes the customer-call specialist relationship. Call specialists must greet the customer, thank them for calling the scheduling line, and ask how they can assist with the call. Five points are awarded for correctly adhering to the script or zero points for using a completely different or unscripted greeting.

*2. Call Management / Relationship Skills (15 points) – Behavioral*

This section assesses if call specialists have a natural yet professional conversation with the customer. Call specialists are scored on five specific actions, each worth three points if done correctly or zero points if not done correctly. First, they must address the customer with proper names or titles. They should use the customer’s actual name or refer to them as “ma’am” or “sir” rather than “hun” or “sweetie.” Second, they must exude confidence, show true interest in the caller, and accept responsibility for any wrongdoing. Third, they must show empathy. For example, a call specialist can say “I’m sorry to hear” to a customer who lost a loved one. Fourth, their pace and volume of voice should be appropriate. Call specialists should never rush the customer off the phone. Fifth, they should display service recovery such as apologizing, controlling tone, and mitigating anger or confusion on the customer’s end. It is crucial that the call specialist has strong service recovery, as it is ideal to leave the customer with a favorable impression of both the call specialist and UPMC.

*3. Professionalism / Demeanor (15 points) – Behavioral*

This section assesses the call specialist on their ability to display a professional personality while positively representing UPMC. They are scored on three actions. Two points are awarded for call specialists who use professional and understandable terminology instead of slang like “ya’ll” or hospital jargon like UPMC “Presby.” Noncompliance will result in zero points. Between one to 10 points are awarded for telephone etiquette like articulation, sincerity, avoiding long silences or pauses, and strong listening skills. Three points are awarded for displaying proper and positive representation on behalf of UPMC. Call specialists should never engage in badmouthing the health system or other employees.

*4. HIPAA (15 points) – Procedural*

HIPAA is extremely crucial to protect patient privacy. 10 points are given to call specialists who adhere to HIPAA guidelines and do not release any patient identifiers or protected health information. If call specialists release this type of information, they automatically receive zero points. Acceptable exceptions include insurance or third-party payers calling or customers requesting their medical information. Patient identifiers must be verified at that point. Five points are awarded when the call specialist reminds anyone on the other end of the call that the call is being recorded and monitored. They receive zero points if this is not mentioned clearly. This section does not need to be filled out if it was not applicable during the call; it does not affect the call specialist’s overall evaluation score.

*5. Hold Etiquette / Non-Transfer Call (8 points) – Behavioral and procedural*

This section does not need to be filled out if a transfer was not performed during the call; it does not affect the call specialist’s overall evaluation score. However, if a transfer occurs, the call specialist must ensure they are taking the correct four steps, each worth two or zero points. First, the call specialist must ask permission to put the caller on hold. Second, they must listen and wait for the caller to agree to be put on hold. Third, they must keep their hold time to three minutes or less. Fourth, they must thank the caller for holding.

*6. Transfer Etiquette (10 points) – Behavioral and procedural*

The call specialist must provide the caller with the department name and phone number in case of a disconnection and offer any further assistance before they transfer the caller. They must stay on the line until the caller is transferred, prompt the receiving party with the relevant information to complete the caller’s reason for calling, and offer the caller the option to leave a message if the receiving party does not answer within three minutes. This section does not need to be filled out if a transfer was not performed during the call; it does not affect the call specialist’s overall evaluation score.

*7. Compliance with Department Protocols (20 points) – Procedural*

In order to complete the scheduling of an appointment or the release of billing information, the call specialist must verify patient identifiers like the patient’s first and last names, relationship to patient if not the patient, date of birth, and phone numbers on file. These actions are worth a combined total of eight points. The call specialist must apply problem solving skills, efficient use of resources and software, and provide the correct information – all while following the script specific to the relevant department. These actions are worth a combined total of 12 points.

*8. Appointment (25 points) – Procedural*

Because scheduling an appointment is the reason for customers to be calling the scheduling phone line, this section is worth the most points. However, this section does not need to be filled if a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score. If this section is applicable, the call specialist must follow several steps, each worth between one and five points. Based on the customer’s needs, the call specialist must ask the appropriate questions regarding various appointment types such as same day, new patient, and return appointments. The call specialist must also review the customer’s insurance and close with thanking them for choosing UPMC.

*9. CRM (5 points) – Procedural*

Customer relationship management (CRM) allows call specialists to document their communication and interactions with customers they speak with over the phone. Call specialists must correctly fill out the CRM, so the information from the call gets routed to the correct department location. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

*10. Appointment Review / Closing Screen (8 points) – Behavioral and procedural*

Three actions make up this section. First, the call specialist must clearly acknowledge that they were able to schedule the customer’s appointment. Three points are awarded for correct action, zero for incorrect action. Second, they must ask if there is anything else they can do for the customer. If not, they should wish the customer a good day and thank them for choosing UPMC. Three points are awarded for correct action, zero for incorrect action. Third, if the customer asks for a recap of information, the call specialist should provide it. Two points are awarded for correct action, zero for incorrect action. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score. However, if the call specialist does reach this point in the call, they must continue to display a professional and polite demeanor.

*11. Consumer Referral Protocols (10 points) – Procedural*

This section is used when customers call after being referred to UPMC by another provider. Each action under this section is worth one or zero points. Actions include asking how the customer obtained the referral number, creating a CRM, and filling out customer contact information. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

Per each patient, it is crucial that call specialists have a single, successful scheduling phone call. This not only establishes a positive start to their patient experience, it also reduces the chance of the patient calling the customer service line in frustration or disappointment. If the customer service line is used, the evaluation form for customer service is similar to the scheduling one.

## CUSTOMER SERVICE QA EVALUATION FORM

Customer Service addresses post-appointment issues relating to billing, pricing, and setting up payment plans. Call specialists must verify patient name, address, email, and mobile number for every call. Similar to the scheduling evaluation form, the customer service evaluation sections can be categorized as behavioral, procedural, or both. The customer service evaluation form has 13 sections, each with specific actions listed under them so QAs know what they are exactly what they are scoring. Each section also has a specific number of points a call specialist can receive based on how well they satisfied the actions listed in each section.

*1. Greeting (5 points) – Behavioral*

This section is almost identical to the section in the scheduling evaluation. The call specialist must greet the customer, thank them for calling the customer service line, and ask how they can assist with the call. Five points are awarded for correctly adhering to the script or zero points for using a completely different or unscripted greeting.

*2. Call Management / Relationship Skills (15 points) – Behavioral*

Similar to the section in the scheduling evaluation, the call specialist must display empathy toward the caller, be genuinely interested and invested in the caller, and focus on what they can do for the caller rather than what they cannot do. This section is scored identically to the section in the scheduling evaluation – five specific actions, each worth three points if done correctly or zero points if not done correctly.

The Professionalism/Demeanor, HIPAA, Hold Etiquette/Non-Transfer Call, and Transfer Etiquette (sections three through six) sections are all identical to the corresponding sections in the scheduling evaluation. These sections do not need to be filled out if they were not applicable during the call; they do not affect the call specialist’s overall evaluation score.

*7. Compliance with Department Protocols (25 points) – Procedural*

This section is worth five more points than in the scheduling evaluation. Unlike the section in scheduling, this section accounts for the chance that an insurance company or third-party payer is calling on behalf of a patient, so the call specialist must verify a different set of patient identifiers, which includes their insurance identification number.

*8. CRM / Barrier Code Management (5 points) – Procedural*

Like the CRM section in the scheduling evaluation, this section defines the specific actions a call specialist must take to properly input a CRM. This section also takes into account Customer Barrier Code management. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

*9. UPAY (10 points) – Procedural*

This section ensures that call specialists are performing the proper collection process. Seven points are awarded when the call specialist takes the steps necessary to complete a collection or refund. Failure to do so results in zero points. Three points are awarded when the call specialist offers automatic payment deductions from the customer’s personal bank account or credit card. Failure to do so results in zero points. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

*10. Mailed Correspondence (7 points) – Procedural*

Call specialists are awarded seven points when they verify patient identification and mailing address, so any relevant mailed correspondence will be correctly delivered. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

*11. Insurance Verification (7 points) – Procedural*

A call specialist is expected to verify insurance information and eligibility and make sure that the insurance information is linked to the correct guarantor account. This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

*12. CS Escalation Protocols (Escalation Agents Only) (17 points) – Procedural*

This section is applied only when a call specialist needs to transfer the call to an escalation agent due to call specialist not being able to resolve the caller’s issue or the caller is audibly angry. The call specialist must perform nine steps, each ranging from one to five points, such as remaining positive and non-argumentative during the transfer, documenting resolutions, and completing the escalation form. This section does not need to be filled out if it was not applicable during the call; it does not affect the call specialist’s overall evaluation score.

*13. Closing (3 points) – Behavioral and procedural*

If a call specialist reaches this section, they must end the call on an upbeat note so the caller is left with a positive impression of UPMC. The call specialist must follow three steps, worth one point each. First, they must recap the call and review any action plans made. Second, they must ask if there is anything else they can do for the caller. Third, they must end with a well wish statement like “It was my pleasure to assist you today!” This section does not need to be filled out if it was not applicable during the call or a transfer occurred before reaching this section; it does not affect the call specialist’s overall evaluation score.

## CALL EVALUATION PROCESS

The nine QAs audit and evaluate 500-600 calls per month from all contact center lines of business. The Supervisor of Quality Assurance assigns QAs the names of 10 call specialists to randomly select calls to evaluate and score. The Supervisor rotates assigned call specialists to different QAs so that working relationships between QAs and call specialists stay as neutral as possible. QAs work out of software called NICE, which records 100% of incoming and outgoing calls, records computer screen scrapes where QAs can watch what the call specialists do on their computers during a call, and pulls data on QA productivity. Through NICE, QAs can listen to calls and evaluate randomly selected calls. NICE displays the following information for a QA’s reference – name of call specialist, participant number, segment start time, segment end time, segment duration, direction (i.e. incoming, outgoing), segment dialed number (i.e. line of business dialed – scheduling, customer service, etc.)

Once the QAs know their monthly assignment, they run a query in NICE for the call specialists assigned to them. From there, they can select a call from a list of calls that were recorded during that month. QAs will randomly select calls, but they also look for calls that are considered outliers – those with shorter or longer call handle times than the average of between two-and-a-half minutes and five minutes. Depending on what line of business is being dealt with, the QA uses the corresponding evaluation form and scores each call as fairly as possible. Calls that are listened to and scored are flagged in NICE by the QA to prevent repetitiveness.

A QA is expected to listen to all calls fairly and objectively. All bias must be removed. Sometimes, it is difficult for one QA to make a judgement call and give a reasonable score, so the Supervisor of Quality Assurance will help decide and confirm scoring appropriately.

The benchmark for call evaluations is 92%. As told by the Supervisor of Quality Assurance, UPMC call specialists normally receive higher than 92% on their evaluations. A decrease in score is likely because of a new QA hire who still does not have as much experience yet. If a call specialist is not satisfied with a score they received, an appeal can be made, and a meeting will be made with their supervisor to discuss, reevaluate, and rescore if necessary.

## QUALITY ANALYST INTERVIEW

While it is important to understand how the Quality Assurance Program impacts the patient experience, it is also important to understand it from a QA perspective. In order to be a QA, it is required that a person have a strong background in customer service. LL (name abbreviated to maintain confidentiality) is one of nine QAs in the Quality Assurance Program. LL has been with the UPMC Contact Center for 17 years total – stating that loyalty, its customer-oriented environment, and the option to work from home are reasons for staying at the Contact Center for this long period of time. QAs like LL are former call specialists, so they have the ideal background, experience, skills, and knowledge necessary to properly evaluate and fairly score calls. All QAs are trained in NICE and EPIC, and, incoming QAs are taught by current QAs.

LL spoke to how employees at the contact center remain motivated. UPMC provides a career ladder for contact center employees. They can have open dialogue with their supervisors to see how they can further development. The Contact Center also hosts social events across all departments such as bingo or holiday lunches to promote comradery and a friendly and conducive work environment. Every Contact Center department also has some version of a team huddle that reinforces open and equal communication for all employees, regardless of level.

According to LL, the biggest challenge as a QA is staying objective and consistent with evaluating and scoring calls. With nine QAs, a call will most likely be scored differently if evaluated by two different QAs. Thus, all QAs must all have a similar way of thinking or know a standardized way of scoring calls fairly. Additionally, because many call specialists and QAs have the option of working from home, it is more difficult to resolve problems when the problems have to be resolved remotely rather than in-person.

# LITERATURE REVIEW

Maloney et al., 1996 explains a process for evaluating and monitoring the performance quality of call center service agents/representatives, regardless of industry. The process stems from advanced cell diagnostics or private branch exchanges, which provides data to call center supervisors, who can monitor pre-recorded calls of call center agents/representatives. This process also has a monitoring schedule determined by the number of calls in a specific timeframe, a storage system to retrieve the pre-recorded calls, quality scoring, and a follow-up program. This process aims to provide training or additional training for call agents/representatives, assure quality of customer service, and maintain a reputable company image. While Maloney was published in 1996, it contains parallel features found in the call evaluation process of UPMC’s Quality Assurances Program. Today, modern technology and automation has made the evaluation process even more efficient. This advantage allows quality analysts and the supervisor to have a more standardized process for consistency and efficiency.

According to studies like Cronin et al., 2000 and Dabholkar et al., 2000, quality should be measured by direct customer judgment about an organization’s excellence rather than their expectations. The concept of zone of tolerance (ZOT) assumes that customers view service quality by a range of “desired” and “adequate” acceptance. The “desired” level represents the customer’s expectations of what can and should happen. It is consistent. The “adequate” level is the minimum level of service performance that customers consider adequate. It fluctuates based on each circumstance or interaction. ZOT applies to patient experience – call specialists should strive to match customers’ desired expectation levels to ensure the best patient experience.

## BEST PRACTICES

To ensure that patients are given the best patient experience possible starting with the Contact Center, several best practices should be acknowledged and continuously improved upon. First, engaging in effective communication applies to both external customer-call specialist relationships and internal teamwork amongst call specialists and their supervisors and across the various call center departments. Second, providing call specialists with all the resources necessary to do their jobs efficiently is crucial so that calls are resolved in a single interaction. Third, having managers and supervisors available on a consistent basis to address complaints, resolve issues, empower their employees to strive for customer service excellence, and help foster a productive work environment. Fourth, taking into consideration customer feedback should always be incorporated for improving the processes of the Contact Center.

The UPMC Quality Assurance Program includes more specific best practices regarding the evaluation process. These include remaining objective during evaluations. QAs must have a strong sense of self and know their own biases, so they can separate those from fairly evaluating the performance of call specialists. Having a strong QA-QA and QA-supervisor relationships are also crucial. With open communication and good working relationships amongst supervisors and employees regardless of level, all contact center employees will be more productive and deliver a high level of customer service, which will ultimately result in positive patient experiences.

# ANALYSIS

## QUALITATIVE ANALYSIS

The UPMC Consumer Contact Center has taken many progressive steps to establish the Quality Assurance Program. To ensure positive patient experiences, strong customer service, and a favorable view of UPMC, the scoring on the scheduling and customer service evaluation forms is fairly stringent. Most sections are based on all-or-nothing points. For example, a call specialist can lose all 10 points under Transfer Etiquette if they did not correctly follow the action steps listed under that section. That decrease in overall scoring negatively impacts the performance of that call specialist. At the same time, however, this strict scoring is beneficial to identify areas of improvement for call specialists.

## PATIENT EXPERIENCE IMPACT

Today, healthcare relies heavily on technology to provide innovative and efficient clinical services and to monitor and improve quality. However, the power of human interaction should never be underestimated or completely eliminated. This challenges health systems to find a balance between technological advances and human interaction. Patients have desired or ideal expectations and are dissatisfied if they were not met. The ZOT model can explain how a person’s desired expectation needs to be as close to their actual experience as it can possibly be for a positive patient experience and reflection of the organization. Thus, call specialists must deliver consistent call performances in order for patients to continually have positive reinforcements. The moment an adverse event or reaction occurs, the patient’s experience will be diminished, further negatively reflecting on the health system.

## LIMITATIONS

A drawback to the Quality Assurance Program is the fact that the evaluations are primarily based on human judgement, behavior, and etiquette – all of which are difficult to quantify explicitly. It is tough to define what good or standard behavior and etiquette is. Although there is some common sense behind it, a call specialist’s tone and etiquette may sound acceptable to one QA but not to another. Because the Quality Assurance Program heavily relies on human decision-making, they must rely on QAs to remain unbiased during all evaluations and make sure that they are keeping their own personal emotions and biases out of evaluations. Providing call specialists with fair scores helps to keep them on track to continue to improve and create positive patient experiences and favorable views of UPMC. Additionally, there still leaves room for human error versus if there were a more automated way of evaluating calls. But automation can also have its own internal errors, so it is difficult to say what the correct way of evaluating calls for quality should be. Thus, a proper balance of technology and human interaction needs to be maintained.

# CONCLUSION AND RECOMMENDATIONS

For more consistent call specialist performances, inter-department communication should be further analyzed. Streamlined departments can result in more uniform communication, and all Contact Center employees can be on the same page. To enhance patient experiences, a checklist could be created for patients to refer to before calling. This checklist can suggest things that callers can do for a more information and productive call like reading any fine-print and writing down questions beforehand.

Because patient experiences should be as close to their desired expectations as possible, the UPMC Contact Center – if they have not already done so – could survey their customers and ask what their desired expectations are for when they call the different business lines. Based on those responses, the Contact Center could implement ideas or change processes. The Quality Assurance Program could then adjust their evaluation forms to factor in these patient expectations.

Many measures can be taken to ensure patients are receiving the best treatments and patient experiences possible. As healthcare becomes more technologically advanced and both healthcare employees and patients rely on technology to make their lives more efficient, call centers must maintain a sense of personal connection to patients. Call specialists need to be well-trained to use the latest technology and scheduling software, but they also need to be human and align their work toward the same goal – to provide patients with positive patient experiences. Without successful scheduling, patients would not show up for appointments and healthcare providers would not have any patients to care for. Health system contact centers should be acknowledged for driving business in the competitive and ever-changing healthcare industry.

* + - * 1. **: SCHEDULING QA EVALUATION FORM**

Agent Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Segment Start Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evaluation Creation Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Segment Stop Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Direction Type Description \_\_\_\_\_\_\_\_\_\_\_\_

Segment Dials Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Can N/A Section*

**Greeting 0 / 5**

Used “Good morning/afternoon/evening, thank you for calling \_\_\_, this is [agent name]. How may I assist you today? *(5 / 0)*

**Call Management (Relationship Skills) 0 / 15**

Addressed external caller by proper name as dictated by policy *(3 / 0 / NA)*

Call Ownership *(3 / 0)*

Empathy *(3 / 0 / NA)*

Pace *(3 / 0)*

Service Recovery *(3 / 0 / NA)*

**Professionalism / Demeanor 0 / 15**

Professional terminology and demeanor *(2 / 0)*

Etiquette *(1 – 10)*

Proper Company Image *(3 / 0)*

**HIPAA\* 0 / 15**

Adhered to HIPAA guidelines; did not release protected health information (PHI) or release appointment/billing information prior to verification of patient identifiers *(10 / 0 / NA)*

Advised joining person(s) that call is being recorded and/or monitored *(5 / 0 / NA)*

**Hold Etiquette (Non-Transfer Call)\* 0 / 8**

Permission and Information *(2 / 0)*

Waited for the customer to answer before placing on hold *(2 / 0)*

Place customer on hold < 3 minutes in length *(2 / 0)*

Thanked the customer for holding (“Mr. Smith, thank you for holding”) *(2 / 0)*

**Transfer Etiquette\* 0 / 10**

Asked customer permission to be transferred *(2 / 0)*

Gave department name and number in case of a disconnect *(1 / 0 / NA)*

Offered further assistance prior to transferring the caller *(1 / 0)*

Remained on the line until transfer was completed *(4 / 0 / NA)*

Upon (warm) transfer, introduced the customer to the receiving party and/or guided the caller through the telephone prompts and thanked the caller for holding during transfer *(1 / 0 / NA)*

Gave the customer a choice of taking a messaged after 3 minutes next party is available *(1 / 0 / NA)*

**Compliance With Department Protocols 0 / 20**

Verified required patient identifiers to satisfy release of patient appointment/billing information *(5 / 0 / NA)*

Verified the secondary contact info/asked if missing/entered *(3 / 0 / NA)*

Used effective troubleshooting skills; asked appropriate questions *(2 / 0 / NA)*

Provide accurate information; utilized resources effectively *(5 / 0 / NA)*

Following departmental procedures and scripts *(5 / 0)*

**Appointment\* 0 / 25**

Accessed the correct department EPIC questionnaire and asked the appropriate clarifying questions to gain patient responses *(5 / 0 / NA)*

Added the appointment notes as directed by the specific department protocol *(3 / 0 / NA)*

NEW PATIENTS: Offered/booked appointment within 72 hours or booked appointment date requested by caller for specific departments *(1 / 0 / NA)*

NEW PATIENTS: If outside the 72-hour time frame, suggested to schedule first available date, offer to put the patient on a waitlist and sent CRM notification to the department *(1 / 0 / NA)*

Scheduled in the correct appointment type (new, return, ROB, post-op, etc.) *(3 / 0 / NA)*

Insurance question answered correctly *(3 / 0 / NA)*

Linked correct account type to scheduled appointment *(1 / 0 / NA)*

Cancel/reschedule department appointment appropriately (if for non-scheduling departments only with the same provider/visit type/appointment length) *(3 / 0 / NA)*

Used proper language of access *(5 / 0 / NA)*

**CRM\* 0 / 5**

Filled out CRM correctly *(2 / 0 / NA)*

CRM routed to correct department location *(1 / 0 / NA)*

Advised patient hat callback will be received from office in 24-48 hours *(2 / 0 / NA)*

**Appointment Review / Closing Screen\* 0 / 8**

“Your appointment has been scheduled. If you need additional information on this appointment, please visit MyUPMC.” *(3 / 0 / NA)*

“Is there anything else I can do for you today? Mr./Mrs./Ms. \_\_\_, enjoy the rest of your day. Thank you for choosing UPMC, it means a lot to us. It was my pleasure to assist you today!” *(3 / 0 / NA)*

If patient asks for any appointment information or agent to recap, provided all requested information *(2 / 0 / NA)*

**Customer Referral Protocols\* 0 / 10**

Asked how the caller obtained referral number *(1 / 0)*

Asked if call has hospital affiliation preference for physician/service referral *(1 / 0 / NA)*

Asked caller for provider information and department number if applicable *(1 / 0 / NA)*

The service/class/physician referred was appropriate for caller’s purpose of what was requested *(1 / 0 / NA)*

Hospital affiliation matches what was requested *(1 / 0 / NA)*

Provided caller with address, phone and any instructions regarding referrals *(1 / 0 / NA)*

CRM created *(1 / 0 / NA)*

Correct “smart text” used or communication reflects reason for call *(1 / 0 / NA)*

Contact information completed *(1 / 0 / NA)*

Asked caller for their zip code and included in CRM. Used default of 99999 *(1 / 0 / NA)*

* + - * 1. **: CUSTOMER SERVICE QA EVALUATION FORM**

Agent Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Segment Start Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evaluation Creation Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Segment Stop Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Direction Type Description \_\_\_\_\_\_\_\_\_\_\_\_

Segment Dials Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Can N/A Section*

**Greeting 0 / 5**

Followed proper greeting procedure *(5 / 0)*

**Call Management (Relationship Skills) 0 / 15**

Addressed external caller by proper name as dictated by policy *(3 / 0 / NA)*

Call Ownership *(3 / 0)*

Empathy *(3 / 0 / NA)*

Pace *(3 / 0)*

Service Recovery *(3 / 0 / NA)*

**Professionalism / Demeanor 0 / 15**

Professional terminology and demeanor *(2 / 0)*

Etiquette *(1 – 10)*

Proper Company Image *(3 / 0)*

**HIPAA\* 0 / 15**

Adhered to HIPAA guidelines; did not release protected health information (PHI) or release appointment/billing information prior to verification of patient identifiers *(10 / 0 / NA)*

Advised joining person(s) that call is being recorded and/or monitored *(5 / 0 / NA)*

**Hold Etiquette (Non-Transfer Call)\* 0 / 8**

Permission and Information *(2 / 0)*

Waited for the customer to answer before placing on hold *(2 / 0)*

Place customer on hold < 3 minutes in length *(2 / 0)*

Thanked the customer for holding *(2 / 0)*

**Transfer Etiquette\* 0 / 10**

Asked customer permission to be transferred *(2 / 0)*

Gave department name and number in case of a disconnect *(1 / 0 / NA)*

Offered further assistance prior to transferring the caller *(1 / 0)*

Remained on the line until transfer was completed *(4 / 0 / NA)*

Upon (warm) transfer, introduced the customer to the receiving party and/or guided the caller through the telephone prompts and thanked the caller for holding during transfer *(1 / 0 / NA)*

Gave the customer a choice of taking a message after 3 minutes next party is available *(1 / 0 / NA)*

**Compliance With Department Protocols 0 / 25**

Verified required patient identifiers to satisfy release of patient appointment/billing information *(5 / 0 / NA)*

If caller is from an insurance company, verify alternative identifiers for insurance companies/third-party payers – patient first/last name, DOB, insurance, ID *(5 / 0 / NA)*

Verified the secondary contact information (email address and cell number), if missing entered appropriate defaults *(3 / 0 / NA)*

Used effective troubleshooting skills; asked appropriate questions *(2 / 0 / NA)*

Provide accurate information; utilized resources/systems effectively *(5 / 0 / NA)*

Following departmental procedures and scripts *(5 / 0 / NA)*

**CRM / Barrier Code Management\* 0 / 5**

CRM / Barrier Code Management *(5 / 0 / NA)*

**UPAY\* 0 / 10**

Performed proper collection process *(7 / 0 / NA)*

Offered automatic payment deductions from personal account *(3 / 0 / NA)*

**Mailed Correspondence\* 0 / 7**

Verified patient ID and mailing address (or account guarantor in case of minor) prior to sending out any mailed correspondence (ex. itemized statements, paying plan agreements, UPAY receipts, FA applications, etc.) *(7 / 0 / NA)*

**Insurance Verification\* 0 / 7**

Verified insurance information with patient if coverage was listed on account (insurance ID, group number, claim number, etc.) *(2 / 0 / NA)*

Verified eligibility if new coverage provided via HDX, Navinet, Ins Rep, etc. *(2 / 0 / NA)*

Update patient demographic, guarantor account (on all service levels) and insurance registration info (when applicable*) (2 / 0 / NA)*

Linked the insurance to the correct guarantor account *(1 / 0 / NA)*

**CS Escalation Protocols (Escalation Agents Only)\* 0 / 17**

Provided their name clearly *(1 / 0 / NA)*

Displayed patience with internal representative or customer *(1 / 0 / NA)*

De-escalated representative or customer *(1 / 0 / NA)*

Positive and non-argumentative *(1 / 0 / NA)*

Informed representative or customer of what actions they will take *(1 / 0 / NA)*

Advised representative or customer how follow-up will be handled *(1 / 0 / NA)*

Documented resolution *(2 / 0 / NA)*

Educated the agent with full answers and explanations (desktop sharing) *(2 / 0 / NA)*

Completed Sharepoint Escalation form *(5 / 0 / NA)*

HIPAA Verified with internal representative all of the qualifiers identified *(2 / 0 / NA)*

**Closing\* 0 / 3**

Recapped call/transaction details; reviewed action plan *(1 / 0)*

Asked “Is there anything else I can do for you today?” *(1 / 0)*

Closed with well wish statement *(1 / 0)*

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