A Customer Service Approach to Implementing a Best Practice at Community Health Centers

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Abstract: It is important that strategies for implementing evidence-based best practices into clinical care are developed and tested. This is particularly true for community health centers (CHCs), which are a primary source of care for low-income patients. This article focuses on a customer service approach to implementing best practices in CHCs. The approach was designed to be responsive to the tremendous demands on and limited resources of CHC staff. The CHC staff were the customers of the project while the project team played a supportive role, acting as a full-service vendor to identify and meet staff needs. Although a tobacco system was the focus of this project, it is applicable to implementing in clinical settings generally, regardless of the particular health topic.

Key words: Implementation, community health center, clinics, best practice, evidence-based, customer service.

There remains a great need to develop and test strategies for implementing evidence-based best practices into clinical care. This is particularly true for community health centers (CHCs), which are a primary source of care for low-income patients and yet often face capacity and resource limitations. This article focuses on an implementation strategy that addresses those barriers by using a customer service approach to implementing best practices in CHCs.

In 2001, as part of the Community Voices Project in Oakland, California, the Alameda Health Consortium, an association of 8 CHCs with over 30 adult, pediatric, and adolescent clinics throughout Alameda County, received a $500,000 American Legacy Foundation grant through a partnership with The W. K. Kellogg Foundation. The goal of the grant was to implement a system for documenting the tobacco use status of patients and provider advice to quit. As part of a clinical practice guideline, this system is considered a best practice.[1] Although a tobacco system was the focus of

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this project, it is important to note that it is applicable to implementing in clinical settings generally, regardless of the particular health topic.

For our implementation strategy, we chose to use a customer service approach. That choice was based on our knowledge of the tremendous demands on and limited resources of clinic staff. Key to the approach is that we defined the clinic staff, not patients, as our customers. The clinic staff were responsible for making systems changes and altering staff behavior to accommodate those changes. Therefore, the Alameda Health Consortium's role was to make it as easy as possible for them to make the necessary changes.

Our approach consisted of five interrelated components: 1) identifying the customers and their needs, 2) creating buy-in, 3) supporting systems changes, 4) building skills and capacity, and 5) monitoring and providing feedback. Individually, each component is necessary but not sufficient for full project integration and sustainability. Additionally, each component builds on and supports the others.

Identifying the Customers and their Needs

Since this approach focuses on supporting changes in clinic staff behavior, our role as implementers was to be a full-service vendor that anticipates the needs of its customers and works to meet those needs. Our first step was to identify the specific needs of the customers and the context in which the needs exist. We conducted a formal assessment of each CHC through a meeting with the medical director, clinic manager, or a key staff person. We assessed:

- the unique characteristics of each of the CHCs, such as the language needs of the patient population;
- the stressors that the CHCs were facing, particularly related to staff capacity and resources;
- the specific needs that must be addressed to support implementation;
- the operating procedures of each clinic site, such as their processes for vital signs, patient intake, and materials restocking;
- the cessation services already in place;
- who the appropriate and responsive contact person at each site would be; and
- which influential staff, such as physicians or nurse managers, had a special interest in this issue and could become our champions to encourage support from their colleagues

Again, fundamental to our implementation plan was the acknowledgment that the day-to-day reality of most clinic staff is one of limited time and limited resources. We found that clinic staff, who spent so much of their time taking care of the needs of others, responded strongly and positively when we focused on taking care of their needs.

Creating Support

Although the primary purpose of the assessments was to determine the needs and characteristics of each site, we also used the assessments to generate excitement and

build support for the project. We took part in regularly scheduled meetings of the clinic staff (e.g., medical directors, clinic managers, and Chronic Care Collaborative meetings). It was important that we did not ask them to add more meetings to their already overburdened schedules. Over four years of the project, these meetings totaled approximately 40 hours. Kick-off meetings at each site and periodic site visits, totaled an average of 10 hours per site. However, the perception of the staff was that we were there much more often. We found that it was not a matter of how much or often we actually interacted with clinic staff; rather it was how much and often we interacted with them *relative* to other projects. They had never received this level of support previously, and, again, their response was overwhelmingly positive. Additionally, the form of that interaction was key. We were supportive and responsive to their needs rather than burdensome and directive. We also used every opportunity to emphasize that change is possible.

Policy changes also played a key role in developing support. For example, in 2002, due to our partnership with the Community Health Center Network (CHCN), the management services organization for seven of our associated CHCs, those CHCs chose to make the documentation of tobacco use status the measurement for their cardiovascular quality improvement (QI) goal. They also chose to link the rates of adherence to this QI goal to financial disbursements for the sites. This had many important implications for our project. First, it meant that we were able to collaborate with CHCN on a medical records audit of the project. Second, consistent with our customer service approach, it enabled us to use the resources of our project to collaborate with the CHCs on meeting their QI goal. Last, the knowledge that they would be evaluated and rewarded for adherence created a powerful incentive for clinic staff.

Additionally, we garnered support through a customization process. We worked with a contact person at each clinic to develop a site-specific implementation plan. This customization was essential in building confidence that the project would meet the specific needs of each clinic, and it helped sustain support throughout the implementation phase. We also provided $135,000 in mini-grants that allowed the sites to experiment by developing and implementing their own complementary cessation resources for patients (e.g., one-on-one cessation counseling sessions with a health educator). Additionally, small incentives such as providing food for meetings as well as trainings for staff at multiple levels created staff enthusiasm for the project.

Supporting Systems Changes

Integrating changes into internal clinical systems was essential to creating lasting change. To support these changes, we emphasized making our project work for the clinics, rather than making the clinics work for our project. We assumed responsibility for all logistical work, including revising forms; training staff; coordinating kick-off events; and developing, translating, and disseminating health education materials in multiple languages. We gave the clinics the option of having tobacco use documentation added to their forms electronically or through the use of a self-inking stamp. Again, we customized the forms or stamps depending on the needs

and preferences of the specific site. (See Figure 1.) In keeping with our approach and appreciating the clinics' limited capacity to update their own forms, we also made any extra changes to forms that the clinics requested, including those unrelated to tobacco (e.g., adding domestic violence screening questions).

Building Skills and Capacity

Throughout the project, we provided technical assistance to increase staff skills and clinic capacity. We brought in external experts and provided on-site training for 480 clinical staff members. We collaborated with other local agencies to conduct trainings for 45 clinic staff on brief cessation counseling. We provided workshops to teach over 70 clinic staff brief health behavior counseling techniques developed by Northern California Kaiser Permanente. This greatly enhanced the sites' capacity to provide cessation services to their patients and gave them skills and tools that they could use with other health topics.

Monitoring and Providing Feedback

Ongoing monitoring played a critical role in identifying necessary mid-course corrections to improve implementation and further integrate the system. In 2002 and 2003 we collaborated with CHCN on two medical chart audits. The results of those audits were shared with the executive directors, medical directors, clinic managers, and key staff of each CHC. We gave them data that showed the changes in documentation of ask and advise rates for tobacco use for each CHC. We also gave them comparative data for their CHC and the other CHCs.

Additionally, we used the results as a management tool to identify what else we needed to do to support change. For example, the first audit showed that many sites had additional medical forms that needed revision to include prompts for documenting tobacco use and advice given. After revising many of these forms and working further to integrate the system, the second audit showed a significant increase in rates of asking patients about tobacco use at their last visit (from 59% in 2002 to 85% in 2003). However, the second audit suggested that, for the final months of implementation, we needed to reinforce the advice protocol with physicians and work with them to help them systematically document advising patients to quit. To that end, if we were to initiate the project again, we would have scheduled more meetings with physicians two or three months after we trained them. We feel that a simple 10-minute check-in at a regular meeting would have sufficed to reinforce behavior change and identify additional needs.

Looking Forward

All 30 clinics associated with the 8 CHCs now have a system in place for documenting asking and advising at each visit. It is likely that multiple factors contributed to this success, such as readiness of the sites and financial incentives and support. Given the staff response to our approach, we believe that using a customer service approach that responds to the realities and competing priorities that clinic staff face each day greatly contributed to that success.

Pediatric

HT. WT. P. R. T.

B.P. 02SAT

Tobacco exposure? ___Yes ___No ___ Advice given

School-Based Health Center

HT.________ WT.________ P.________ R.________

T.________ B.P.________ LMP. ________

Tobacco use?__Yes __No Tobacco exp?__Yes __No

___ Advice given ___Cessation referral

Adult Medicine

HT. WT. P. R. T. B.P.

02SAT LMP BCM

Tobacco use? ___Yes ___No ___Former ___Advice given

Dental

Tobacco use Exposure by________
Advised:____/____/____/____/____/____/____/____/
Refrd to Helpline/Health Educator:____/____/____/____/
Quitting: Considering Preparing Date Quit_____
1-800-NO-BUTTS/www.quitnet.com

Figure 1. Examples of Customized Vital Sign Stamps

Although the approach that we have described here may seem routine, our experience suggests that it cannot be overstated how infrequently quality improvement projects provide this level or method of support. In our health care work, we have found that direct implementation support is limited or non-existent.

The customer service approach also generally is scarce in the literature, particularly in the United States. When this approach is mentioned, it generally is related to improving patient satisfaction.[2] The Centers for Disease Control and Prevention uses the term *customer*, or, more specifically, *customer-centricity*, under their six key strategies to guide its decisions and priorities, but, again, that is directed towards the

general population.[3] We found one example that suggested employing this approach toward staff as part of a retention strategy.[4] Although it does not discuss a customer service approach, researchers from the Centre for Quality of Care Research in The Netherlands offer a useful overview of strategies to implement evidence-based practices into clinical settings.[5] They conclude with a call for testing current strategies. The most promising work that mirrors much of our experience is the Promoting Action on Research Implementation in Health Services framework initially outlined by the United Kingdom's Kitson, Harvey, and McCormack in 1998[6] and adopted, among others, by the United States Department of Veterans Affairs' Health Services Research and Development Service as part of their Quality Enhancement Research Initiative. (See guide at http://www.hsrd.research.va.gov/queri/implementation.) This framework emphasizes the need to address three factors when implementing evidence-based practice: evidence, context, and facilitation.[7] The latter, facilitation, is similar to the type of direct implementation support of our model.

Although we are encouraged by the staff response to our approach, more research must be done to develop, refine, and test this and other implementation strategies. This research can help ensure that strategies to implement best practices into clinical settings are effective. This is particularly important for CHCs that provide frontline services for so many low-income patients.

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Notes

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