Consumer Healthcare Priorities: What Patients Want From Their Healthcare Providers

Consumer Healthcare Study Final Report

COUNCIL OF ACCOUNTABLE PHYSICIAN PRACTICES

An affiliate of the American Medical Group Association

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EXECUTIVE SUMMARY

In 2016, the Council of Accountable Physicians Practices (CAPP), a coalition of multispecialty medical groups committed to integrated healthcare, conducted a national survey of consumers and physicians and found that most Americans are not receiving the kind of healthcare that many industry leaders believe results in better patient outcomes at a lower cost.[1] The study found that less than one-third of Americans receive advice from their doctors about increasing their activity levels, improving their eating habits, or reminders about preventative screenings they may need. When patients fail to make appointments or fill prescriptions, most are never contacted by their doctors' office and up to 40% of primary care doctors do not have access to their patients' electronic records when those patients are hospitalized or visit the emergency room. These and other findings from the 2016 study helped to identify the gaps between what many experts believe patients should be getting from their healthcare and what they are actually receiving, but the study did not address what *patients* believe is needed to improve their health outcomes.

To address the question of patient expectations and desires, CAPP commissioned a focus group study in 2017 to hear directly from consumers about what they want and need from their healthcare providers and to identify the attributes that matter most to them. The study also addressed what physicians want for their patients, regardless of cost, and how those priorities compare to what consumers think they need. The focus of the study was on the quality and delivery of clinical services and did not address healthcare costs or payment systems.

The study consisted of 11 focus groups conducted with general consumers and primary care physicians between February 25, and March 16, 2017. All consumers who participated in the study had health insurance and reflected a variety of health insurance plans and providers, including sole practitioners and large health systems. Approximately half the consumers sampled were above median income and half below. The study did not include Medicaid recipients and all participants were fluent in English. Participants included both healthy individuals and those with chronic or complex conditions (as measured by the number of doctors a patient has), and those with and without young children. Physicians included doctors working in small practices and those associated with larger health systems.

Three consumer focus groups were conducted in each of three regional markets—Arapahoe County, Colorado; Burlington County, New Jersey; and Milwaukee County, Wisconsin. Within each region, focus groups were conducted with Millennials/Generation X (26 to 50), Boomers (51 to 64), and Medicare recipients (65 to 75). Finally, two focus groups with primary care physicians were conducted in New Jersey and Wisconsin. A total of 89 consumers and 18 physicians were included in the study. All groups were held at professional focus group facilities equipped with a two-way mirror for viewing. Consumers who attended the group were served a light meal and received between $90 and $125 cash honorarium to thank them for their time. Physicians received between $250 and $350.

[1] Better Together: Patient Expectations and the Accountability Gap, Consumer Healthcare Survey Results, 2016.

To help prioritize healthcare attributes, participants were given a set of 22 cards, each labeled with a different attribute and asked to sort the cards in order of priority, with the most important attributes at the top of the stack. After sorting the cards, participants were asked to discuss how they made choices and why some attributes were more important than others. Attributes were later organized into seven clusters including the doctor-patient relationship, evidence-based medicine, coordinated care, prevention services, facilities, access, and technology.

The ranking exercise was designed to enrich the discussion and does not represent a statistical sample of consumers or physicians. Conclusions about leading attributes were based not only on the average ranking of the cluster and the number of participants who ranked each attribute very high or very low, but also how strongly participants felt about a feature and why.

Key findings from the 2017 Consumer Healthcare Priorities Study are presented below.

What Consumers Want From Their Healthcare Providers

Tier 1 Priorities

1. **A personal doctor-patient relationship.** The study found that consumers place a premium on the doctor-patient relationship and identified it as the single most important hallmark of quality care. The majority of consumers, regardless of age or health status, reported that they want a doctor who is experienced and knowledgeable, listens to their concerns, explains things clearly, and spends as much time as necessary. Out of the 89 consumers who participated in the study, 78 ranked one or more of the physician attributes as one of their top six cards. Only two individuals ranked any of these attributes as their lowest priority (bottom three cards).

2. **Evidence-Based Medicine.** While consumers place a high importance on their personal relationship with their doctors, they also expect that their medical treatment will be based on evidence and shared-decision making. This cluster included the use of treatment based on proven methods, a doctor who stays up-to-date with the current research, and a doctor who considers the patient's treatment preferences. This cluster was the most highly ranked set of attributes after the doctor/patient relationship.

3. **Coordinated Care.** The study found that consumers believe coordinated care keeps them healthy and they expect medical teams to have their current and complete medical information, regardless of where a patient receives care. Other attributes in this cluster included a primary care doctor who works with all specialists about the patient's care, and an office that follows up with patients to make sure they are getting better. The study found that coordinated care matters most to patients with chronic or complex medical conditions, including diabetes and cancer. Half the consumers who participated in the study ranked one or more of these attributes as a high priority (first six cards).

Tier 2 Priorities

4. **Quality Medical Facilities.** Results suggest that consumers view medical facilities and equipment as ancillary features, valuable but secondary to the doctor, the course of treatment, and the coordination of care. This cluster included medical offices that have the latest technology, facilities that are clean and well maintained, and hospitals that have a reputation for excellent care and safety. Consumers gave facilities an average ranking of 13 out of 22. The cleanliness of medical offices and the availability of the latest technology were the lowest ranked attributes in this cluster.

5. **Access.** The study found that consumers place a premium on accessing care when they need it but are wary of efforts to redirect them to a 24-hour nurse advice line or other alternatives to seeing their regular doctor. Attributes in this cluster included a general statement about "easily getting care and information;" access to other doctors who have the patient's medical information when the primary is unavailable; access to a 24-hour nurse advice line; and evening and weekend hours. Consumers were not asked about wait time to get an appointment with their regular doctor or wait times at their doctor's office, which may have ranked higher. Overall, consumers gave access an average ranking of 14 out of 22. Evening and weekend hours and the 24-hour nurse advice line were among of the lowest ranking attributes across all clusters. Millennials and GenX participants were more likely than were Boomers and seniors to rank access as a priority.

Tier 3 Priorities

6. **Technology.** The study found that despite an increase in the availability of online tools for managing healthcare, consumers do not place a premium on digital engagement. This cluster included access to an online portal for viewing test results, medical history, and to make appointments; the ability to submit a medical question online that will be answered by someone at the patients' doctor's office; and the primary care doctor's ability to access to hospital and emergency room records electronically. The average ranking for technology was 14 out of 22, similar to access; however more participants placed technology attributes at the bottom of their stacks and expressed strong feelings about not needing the service. Only one person out of 89 participants ranked the ability to submit medical questions online as a top priority (top three cards). Consumers were either uncomfortable with digital platforms (more common among seniors) or did not have enough interactions with the health system to make them useful (Millennials or young GenX participants, without children, who rarely visit the doctor and have no recurring prescriptions or labs).

7. **Prevention Services.** Prevention was the lowest ranking cluster among the healthcare attributes tested. Only five participants out of 89 ranked any of the attributes within this cluster as a top priority (top three cards) and 36 individuals ranked at least one of the attributes as their lowest priority (bottom three cards). The cluster included the doctor providing tools and information to help the patient improve his or her health, reminders about preventative screening, and calls when patients fail to make follow-up appointments or fill a prescription. Many participants

strongly disliked the feeling of being "managed." When asked what preventative care means to them, participants most often described reprimands about losing weight or being handed a brochure by a nurse. The participants who found value in this cluster cited personalized interactions with their doctor or their doctor's staff who helped them develop an action plan for changing health habits.

What Doctors Want for Their Patients

- **Doctors agree with consumers that the most important components of quality care are a strong doctor-patient relationship, evidence-based medicine, and coordinated care.** Like consumers, doctors believe that quality care starts with an experienced and knowledgeable physician who is willing to listen to his or her patients, can explain things clearly, and is able to spend as much time as necessary. Out of the 18 primary care physicians who participated in the study, all ranked one or more aspects of the doctor-patient relationship as a high priority (top six cards). Doctors felt strongly about the importance of spending time with their patients and many expressed frustration over the non-clinical aspects of their job that took time away from patient care, including insurance documentation and billing. Moreover, findings indicate that doctors believe patients receive the best care when treatment is based on proven treatment methods, research, and shared decision making. Evidence-based medicine was the most highly ranked set of attributes after the doctor-patient relationship. Regardless of whether they work in large health systems or small practices, the study found that doctors believe that communication between the primary care doctor, specialists, and other team members is critical for improving health outcomes. Doctors working in accountable care-type organizations were the strongest advocates for coordinated care while doctors in smaller systems were more likely to voice frustration regarding their inability to access complete information on their patients and to communicate with specialists from outside their practice.

- **Doctors place a much higher value on preventative medicine than do healthcare consumers.** Half of the doctors participating in the study ranked one or more of the prevention services attributes among their top six cards and gave the cluster an average ranking of ten out of 22. The most highly rated attribute in this cluster was the importance of providing patients with tool and information about how they can improve their health. Doctors gave this attribute an average ranking of seven while consumers ranked tools and information at 13. Some doctors were cynical about how effective preventative programs were at helping patients change behavior; but the majority still believed prevention was central to achieving improved health outcomes.

- **Doctors ranked technology, including electronic medical records and online tools for patient engagement, as the least important cluster of healthcare attributes.** None of the 18 doctors included in the study ranked any of the attributes in this area as a high priority (in the top three or top six cards). The average ranking for this cluster was 17 out of 22. Out of the 18 physicians who participated in the study, 16 ranked one or more of the technology attributes as their lowest priority (bottom three cards). Most doctors were unconvinced that the ability for patients to view test results online, make appointments, email a doctor,

or submit a medical question online improves patient care. The lowest ranking attribute in this cluster was the use of electronic medical records to keep track of patients' medications, procedures and history. EMRs had an average ranking of 19 out of 22 total attributes. Doctors were far more skeptical than were consumers about the reliability of EMRs and their ability to facilitate care coordination.

Consumers Interpretation of Common Healthcare Terminology

In addition to tracking consumer and physician priorities, the 2017 study replicated a 2007 CAPP focus group study in which common terms used in health care marketing and policy were tested to gauge whether consumers' understanding of these terms has changed over time and which terms continue to be positive or negative. [2] Results from the current study were compared with findings from 2007 to determine the ways in which consumer understanding and acceptance of terms describing integrated systems has changed over the last decade.

- **Findings suggest that consumers have a greater understanding and are more accepting of terms describing integrated care than they were ten years ago.** Coordinated care, value, team-based care, and evidence-based medicine were all rated more positively in 2017 than in 2007. Findings suggest that accountable care, which was one of the most negative terms from 2007, is now familiar to consumers and is more likely to be associated with responsible care than with defensive medicine.

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[2] "From Our Lips To Whose Ears? Consumer Reaction to Our Current Health Care Dialect." The Permanente Journal/Winter 2009/Volume 13 No. 1

Conclusions and Recommendations

Results from the 2017 study suggest that healthcare consumers are becoming increasingly sophisticated in their understanding of healthcare delivery systems and the components of quality care. Although consumers continue to place a premium on the doctor-patient relationship to define quality, the study found that consumers also understand and expect that their doctors will communicate with each other, that their medical records will be available electronically, and that their treatment will be evidence based. When presented with the set of 22 health care delivery attributes—including coordinated care, evidence-based medicine, access, prevention services, and technology—and asked to sort them in order of priority, study participants frequently complained that all the attributes were important. The language testing, which compared consumer reactions to common healthcare terms with findings from 2007, further testifies to this transition. Results suggest that consumers today have a greater understanding and more positive associations with terms describing integrated care, including evidence-based medicine, team-based care, accountable care, and value.

While the gap between how healthcare professionals define quality care and what consumers believe they need from their providers may have narrowed, there is still a disconnect. The study found that doctors place much more value on preventative services than do consumers. While doctors discussed the importance of screenings and improved health habits, consumers reported that they felt "managed" and condescended to by the standard approaches.

Finally, the study highlights a divide between policy makers' expectations of technology and the daily experiences of patients and their doctors. Tremendous attention has been paid to the value of online technology for healthcare engagement and the use of electronic medical records for facilitating care coordination. However, study results from 2016 and 2017 indicate that many consumers do not use or value online tools and doctors raise important concerns about the limitations of EMRs, including platforms that are incompatible and systems that are designed to meet billing and documentation needs rather than care coordination.

Based on study findings, we recommend the following to help guide CAPP in its marketing and communication efforts as well as policy advocacy.

1. **In communicating the value of integrated care to consumers, emphasize those attributes most recognized by consumers as hallmarks of quality care; namely care coordination and evidence-based medicine.** Whenever possible, describe coordinated care and care management as supporting the doctor/patient relationship (consumers' number one priority) rather than replacing it.

2. **Continue to use short, documentary style case studies to help consumers conceptualize the value of coordinated care.** In developing new video content, consider featuring patients with different socio-economic profiles, such as white men and people of color with professional backgrounds, to ensure that all population segments can relate to the message.

3. **When appropriate, avoid using the term "integrated care" in communicating with consumers and opt for alternative terms such as "coordinated" or "team-based" care, which communicate a similar message.** Integrated care was the least appealing term among all the language tested.

4. **Develop alternative language to replace the term "care manager" and related terms when communicating with consumers about coordinated care.** Findings from the ranking exercise suggest that the term "care manager" is associated with the impersonal management of patients. Instead, describe the outcome of such support ("making sure you're getting better") and emphasize personalized care.

5. **Look for opportunities to promote preventative health programs that incorporate personal interactions.** Consumers recognize the importance of lifestyle changes but need support to develop heathier habits. The study found that patients want interactions with caring professionals and do not value general health tips or brochures.

6. **Support public policy that aims to improve the use of EMRs for care coordination**, including policies that establish standards for data exchange across different systems, address payment incentives to foster coordination, and facilitate common expectations about how primary care and specialists will exchange information.

7. **Consider conducting an annual, CAPP-branded quantitative survey to track changes in consumer attitudes over time.** Qualitative research, such as the current study, can uncover important insights about participants' experiences and beliefs, but it has limitations. A CAPP-branded public opinion poll, conducted annually, would be a reliable way to track changes statistically and would be useful for informing communications and public policy. To ensure that poll results are robust and will be recognized by media and policy makers, adhere to the rigorous standards established by the American Association for Public Opinion Research (AAPOR) and similar organizations. Avoid using proprietary samples (which often fail to meet these standards) or vendor-branded research to ensure that the poll can be conducted consistently and independently.

8. **In developing a quantitative survey, examine consumers' reactions to the wording of the healthcare attributes as tested in the focus groups to develop a questionnaire that is as valid as possible.** Focus group results suggest that consumers often want follow-up care management and preventative services but react negatively to wording that focuses on "management" and "reminders" rather than personalized care. In addition, focus on outcomes (the benefits patients will receive), rather than methods used to achieve those outcomes, to ascertain what consumers really want.

9. **As a follow-up to the current research, consider holding a forum that includes patients, doctors, and health policy experts to discuss and possibly draft what they agree to be the ideal healthcare delivery system.** The current study was useful as a starting point for identifying patient and physician priorities but more work needs to be done to understand how these attributes translate into clinical practice and to resolve differing perspectives among health policy experts and consumers.

INTRODUCTION

The American healthcare system has undergone tremendous changes over the last ten years. With the discussion leading up to the passage of the Affordable Care Act in 2010 and recent proposals to repeal or at least change the marketplace for individual coverage, consumers—both as patients and voters—have been drawn into a national dialogue about healthcare delivery. Consumers are being asked to take a more active role in their health and healthcare choices and are navigating a multitude of service and payment options. Moreover, consumers must interpret the nuanced language of health care, which has grown more complex over time as new ways of delivery care and reimbursing providers have been implemented. As the healthcare landscape continues to evolve, understanding consumer attitudes and beliefs has become increasingly important for policy leaders, healthcare advocates, providers and health plans.

The Council of Accountable Physician Practices (CAPP), an affiliate of the American Medical Group Association, is a coalition of multispecialty medical groups united in their commitment to integrated care. As part of its ongoing work to promote the benefits of this healthcare delivery model to consumers, CAPP commissioned a series of studies beginning in 2007 to examine consumer attitudes and experiences, including the level of care Americans are receiving and their understanding of the language used to describe health policy and delivery models.

Study Purpose

In 2016, CAPP commissioned a national survey of patients and doctors and found that most Americans are not receiving the kind of healthcare that many industry leaders believe delivers better patient outcomes at a lower cost.[3] The study found that less than one-third of Americans receive advice from their doctors about increasing their activity levels, improving their eating habits, or reminders about preventative screenings. When patients fail to make an appointment or fill a prescription, most are never contacted by their doctors' office and up to 40% of primary care doctors do not have access to their patients' electronic medical records when those patients are hospitalized or visit the emergency room. These and other findings from the 2016 study helped to identify the gaps between what many experts believe patients should be getting from their healthcare and what they are actually receiving, but the study did not address what *patients* believe is needed to improve their health outcomes.

To address the question of patient expectations and desires, CAPP contracted with an independent research firm in 2017 to hear directly from consumers about what they want from their healthcare providers and to identify the attributes that matter most to them. The study also addressed what physicians want for their patients, regardless of cost, and how those priorities compare to what consumers think they need. The focus of the study was on the quality and delivery of healthcare services, not cost or payment systems.

Finally, the study replicated aspects of a 2007 CAPP focus group study in which common terms used in health care marketing and policy were tested to see if consumers understanding of these terms has changed over time and which terms

[3] Better Together: Patient Expectations and the Accountability Gap, Consumer Healthcare Survey Results, 2016.

continue to be positive or negative.[4] Results from the current study were compared with findings from 2007 to determine the ways in which consumer understanding and acceptance of terms describing integrated systems has changed over the last decade.

METHODOLOGY

A series of 11 focus groups were conducted with general consumers and primary care physicians in February and March 2017. All consumers who participated in the study had health insurance and reflected a variety of health insurance plans and providers, including sole practitioners and large health systems. Approximately half the consumers sampled were above median income and half below. The study did not include Medicaid recipients and all participants were fluent in English. Participants included both healthy individuals and those with chronic or complex conditions (as measured by the number of doctors a patient has), and those with and without young children.

Three consumer focus groups were conducted in each of three regional markets—Arapahoe County, Colorado; Burlington County, New Jersey; and Milwaukee County, Wisconsin. Within each region, focus groups were conducted with Millennials/Generation X (26 to 50), Boomers (51 to 64), and Medicare recipients (65 to 75) as presented in **Table 1**. Finally, two focus groups with primary care physicians were conducted in New Jersey and Wisconsin. Physicians included doctors working in small practices and those associated with larger health systems.

Table 1: Sampling Plan
Focus Groups Segmented by Age and County/State

	Millennials Generation X	Boomers	Medicare	Primary Physicians	Total
Colorado	1	1	1	0	3
New Jersey	1	1	1	1	3
Milwaukee	1	1	1	1	3
Total	**3**	**3**	**3**	**2**	**11**

Twelve participants were recruited for each group by a professional focus group firm in each county using databases from the research facility, resulting in eight to ten individuals attending each discussion. A total of 89 consumers and 18 physicians participated in the study. For a demographic profile of study participants, please see **Appendix B**.

The Colorado focus groups were conducted on a Saturday between 10:00 a.m. and 4:30 p.m. All other groups were held during the week in the evening at 5:30 or 7:30. The groups were held at focus group facilities, equipped with a two-way mirror for viewing. Each discussion lasted approximately two hours. All consumers who attended the groups were served a light meal and received a cash honorarium of between $90 and $125, depending on the market. Physicians received between $250 and $350.

[4] “From Our Lips To Whose Ears? Consumer Reaction to Our Current Health Care Dialect.” The Permanente Journal/Winter 2009/Volume 13 No. 1

Ranking Exercise

To help prioritize healthcare attributes, participants were given a set of 22 cards, each labeled with a different attribute and asked to sort the cards in order of priority, with the most important attributes at the top of the stack. After sorting the cards, participants were asked to discuss how they made choices and why some attributes were more important than others. Attributes were later organized into seven clusters including the doctor-patient relationship, evidence-based medicine, coordinated care, prevention services, facilities, access, and technology.

The ranking exercise was designed to enrich the discussion and does not represent a statistical sample of consumers or physicians. Instead, tallies are included as a summary of participant priorities and were combined with a qualitative analysis of the discussion to draw conclusions. Conclusions about leading attributes were based not only on the average ranking of the cluster and the number of participants who ranked each attribute very high or very low, but also how strongly participants felt about a feature and why.

DETAILED FINDINGS

The following section presents detailed findings from the focus groups, organized around the following topic areas:

- What consumers want from their healthcare providers;
- What doctors want for their patients;
- Interpretations of healthcare terminology;
- How consumers evaluate the quality of their care; and,
- The effectiveness of CAPP video messaging.

Results are presented for participants overall, followed by any observed differences by health status, age, gender, or other demographics.

What Consumers Want from Their Healthcare Providers

The primary objective of the study was to identify want consumers want from their healthcare providers and how they prioritize those attributes. Focus group participants were given a set of 22 cards, each labeled with a specific attribute, and asked to sort the cards in rank order with the top cards being the most important and the bottom cards being the least important. (For a complete list of attributes, see **Appendix A**.)

Most consumers found the exercise difficult and frequently commented "it's all important." Participants were observed organizing their top cards and their bottom cards, and spending less time sorting the cards in the middle. When discussing results, participants explained that they prioritized their cards based on what they need and want *now* from the healthcare system, not what they may need in the future.

After the focus groups were completed, attributes were organized into seven clusters including the doctor-patient relationship, evidence-based medicine, coordinated care, prevention services, facilities, access, and technology. Presented below are the seven attribute clusters, grouped into Tier 1, Tier 2, and Tier 3 priority areas. **The study found that—above all—consumers want an experienced doctor who is willing to listen, expect that their care will be based on proven methods and research, and want their doctors and specialists to communicate about their care.** Surprisingly, consumers do not place a premium on digital engagement, despite the increasing availability of online tools for managing healthcare nor do they value preventative health services. Results are summarized below followed by a more detailed discussion.

<u>Tier 1 Priorities</u>

1. **A personal doctor-patient relationship.** The study found that consumers place a premium on the doctor/patient relationship and identified it as the single most important hallmark of quality care. The majority of consumers, regardless of age or health status, reported that they want a doctor who is experienced and knowledgeable, listens to their concerns, explains things clearly, and spends as much time as necessary. On average, consumers ranked the doctor/patient cluster 5 from the list of 22 attributes including access, facilities, and technology. Out of the 89 consumers who participated in the study, 78 ranked one or more of the physician relation attribute as one of their top six cards. Only

two individuals ranked any of these attributes as their lowest priority (bottom three cards).

2. **Evidence-Based Medicine.** While consumers place a high importance on their personal relationship with their doctors, they also expect that their medical treatment will be based on evidence and shared-decision making. This cluster included the use of treatment based on proven methods, a doctor who stays up-to-date with the current research, and a doctor who considers the patient's treatment preferences. This cluster was the most highly ranked set of attributes after the doctor/patient relationship.

3. **Coordinated Care.** The study found that consumers believe coordinated care keeps them healthy and they expect medical teams to have their current and complete medical information, regardless of where a patient receives care. Other attributes in this cluster included a primary care doctor who works with all specialists about the patient's care, and an office that follows up with patients to make sure they are getting better. The study found that coordinated care matters most to patients with chronic or complex medical conditions, including diabetes and cancer. Half the consumers who participated in the study ranked one or more of these attributes as a high priority (first six cards).

<u>Tier 2 Priorities</u>

4. **Facilities.** Results suggest that consumers view medical facilities and equipment as ancillary features, valuable but secondary to the doctor, the course of treatment, and the coordination of care. This cluster included medical offices that have the latest technology, facilities that are clean and well maintained, and hospitals that have a reputation for excellent care and safety. Consumers gave facilities an average ranking of 13 out of 22. The cleanliness of medical offices and the availability of the latest technology were the lowest ranked attributes in this cluster.

5. **Access.** The study found that consumers place a premium on accessing care when they need it but are wary of efforts to redirect them to a 24-hour nurse advice line or other alternatives to seeing their regular doctor. Attributes in this cluster included a general statement about "easily getting care and information;" access to other doctors who have the patient's medical information when the primary is unavailable; access to a 24-hour nurse advice line; and evening and weekend hours. Consumers were not asked about wait times to get an appointment with their regular doctor or wait times at their doctor's office, which may have ranked higher. Overall, consumers gave access an average ranking of 14 out of 22. Evening and weekend hours and the 24-hour nurse advice line were among of the lowest ranking attributes across all clusters.

<u>Tier 3 Priorities</u>

6. **Technology.** The study found that despite an increase in the availability of online tools for managing healthcare, consumers do not place a premium on digital engagement. This cluster included access to an online portal for viewing test results, medical history, and to make appointments; the ability to submit a medical question online that will

be answered by someone at the patients' doctor's office; and the primary care doctor's ability to access to hospital and emergency room records electronically. The average ranking for technology was 14 out of 22, similar to access; however more participants placed technology attributes at the bottom of their stacks and expressed strong feelings about not needing the service. Only one person out of 89 participants ranked the ability to submit medical questions online as a top priority (top three cards). Consumers were either uncomfortable with digital platforms (more common among seniors) or did not have enough interactions with the health system to make them useful (Millennials or young GenX participants, without children, who rarely visit the doctor and have no recurring prescriptions or labs).

7. **Prevention Services.** Prevention was the lowest ranking cluster among the healthcare attributes tested. Only five participants out of 89 ranked any of the attributes within this cluster as a top priority (top three cards) and 36 individuals ranked at least one of the attributes as their lowest priority (bottom 3 cards). The cluster included the doctor providing tools and information to help the patient improve his or her health, reminders about preventative screening, and calls when patients fail to make follow-up appointments or fill a prescription. Many participants strongly disliked the feeling of being "managed." When asked what preventative care means to them, participants most often described reprimands about losing weight or being handed a brochure by a nurse. The participants who found value in this cluster described personalized interactions with their doctor or their doctor's staff who helped them develop an action plan for changing health habits.

Tallies for the cards are summarized in **Table 2**, followed by a discussion of each cluster, including the extent to which some attributes were more important than others and differences by health status, age, gender, and other demographics.

Table 2: What Consumers Want from Their Healthcare (n=89 participants)

Attribute	Number of Participants Ranked Attribute in Top 3	Number of Participants Ranked Attribute in Top 6	Average Ranking (1 = top priority)
Physician Relationship			**5**
My doctor is experienced/knowledgeable	55	76	4
My doctor listens to my concerns and explains things clearly	53	67	5
My doctor is willing to spend time	29	54	7
Evidence-Based Medicine/Shared Decisions			**9**
My doctor determines treatment on proven methods and research	9	39	8
My doctor stays up to date with research	14	35	8
My doctor considers my treatment preferences	12	28	10
Coordinated Care			**11**
Wherever I get care, my doctor has my medical info	11	32	9
My primary doctor works with all my specialists about my care	8	23	10
My doctor's office makes sure I'm getting better and follows up	7	15	13
Facilities			**13**
The hospital that my doctor works with has a good reputation	7	23	11
Medical offices have the latest technology	2	13	13
Medical facility are clean and well maintained	10	13	14
Access			**14**
I can easily get care and information when I need it	14	23	10
If my doctor is unavailable, I can see another doctor who has my medical info	7	17	12
I can call a 24-hour medical advice line	5	5	15
My doctor's office provides evening and weekend hours	0	6	17
Technology			**14**
My doctor's office has a website where I can see test results, medical history, and make appointments	11	16	13
I don't have to bring in any hospital or ER records because my doctor has them electronically	7	13	13
I can submit a medical question online and it will be answered by someone at my doctor's office	1	4	16
Prevention	**8**	**19**	**15**
My doctor gives me tools and information to improve my health	5	17	13
My doctor reminds me about preventative screenings I need	2	9	15
My primary doctor's office contacts me if I don't make a follow-up appointment or fill a prescription	3	6	17

1st Tier Priorities (Physician Relationship; Evidence-Based Medicine/Shared Decisions; Coordinated Care)

2nd Tier Priorities (Facilities; Access)

3rd Tier Priorities (Technology; Prevention)

On Doctor-Patient Relationship:

"It's all about how good my doctor is in his field and his ability to deal with me as a human being and make me feel comfortable. Everything else is a far second in my world."
—Consumer, Millennial/Gen X

On Evidence-Based Medicine:

"Nowadays, things change so quickly. New surgeries, new technologies, new medications. You can love your doctor to death and you could have him for 25 years, but if he's still working with the technology from 25 years ago, it's not best for you."
—Consumer, Boomer

On Coordinated Care:

"If you go to an office, you don't want to have to tell them everything repeating yourself. They should have records and a system where all you information is there and they don't have to ask you."
—Consumer, Millennial/Gen X

Personal Doctor-Patient Relationship

Findings suggest that consumers place a premium on their personal relationships and interactions with their doctors. These priorities were consistent across study participants, regardless of age, health status, or gender. Consumers reported that they want a doctor who listens to their needs and symptoms without rushing them or dismissing their concerns. An experienced doctor who is willing to listen and can explain things clearly was identified as critical to quality care not just because it indicates a caring relationship between a doctor and patient, but because participants believe listening and discussions lead to accurate diagnosis and improved care. All attributes in this cluster were highly rated; however, the amount of time a doctor spends with a patient was viewed as less important than the doctor's expertise and willingness to listen.

Evidence-Based Medicine/Shared Decision Making

Evidence-based medicine with shared decision making was second only to the doctor-patient relationship in its importance to consumers, regardless of the individual's age or health status. While all attributes in this cluster ranked high, findings suggest that consumers believe treatment based on proven methods and current research is even more important than a doctor's willingness to consider a patients' treatment preferences. This finding is surprising, given that shared decision making is closely aligned with a personal doctor/patient relationship—the number one priority for consumers. Results suggest that many consumers research their medical conditions online before visiting their doctor and expect their doctors to be familiar with the latest protocols. In addition, the majority of study participants did not associate evidence-based medicine with "one size fits all," impersonal care; a criticism raised in the 2007 focus groups.

Coordinated Care

While coordinated care as a cluster ranked among the Tier 1 priorities, ratings for the individual attributes within the cluster varied. Findings suggest that while consumers expect their primary care doctor to communicate with their specialists, have access to their current and complete medical information, and follow-up with them, consumers do not want to be "managed" by their healthcare providers. For the first set of focus groups in Colorado an attribute was included that read: "My doctor's office has a nurse or care manager to help me stay on track with treatments/instructions." Out of the 29 participants in Colorado, nine ranked this attribute as their lowest priority (bottom three cards). When asked why, participants responded with irritation at what they compared to being treated like a "child." Seniors and Boomers were particularly sensitive to what they perceived to be an implication of cognitive decline or other inability to manage their own care. Men were particularly sensitive to the language and a perceived criticism about their ability to manage their own care. Given the strong reaction to the wording of this attribute, the language was modified in the following way before being presented to the remaining two regions: "My doctor's office makes sure I'm getting better and follows up." In contrast to results from Colorado, only two individuals in New Jersey and one in Wisconsin ranked this newly-worded attribute as a low priority. These findings suggest that terms such as "care manager" are associated with pestering and reprimand (i.e. "nagging") while "follow-up" to make sure someone is "getting better" communicates concern for the patient and personalized care.

The most highly rated attribute in this cluster was the importance of doctors having complete medical information through electronic medical records. Only one participant out of 89 raised privacy concerns about digital and online records, a contrast to the fear surrounding this issue in 2007.

People with chronic conditions and complex medical conditions such as cancer were much more likely to prioritize coordination and care management. Patients described the complexity of having multiple doctors and tests and the importance of support for navigating treatment plans.

Facilities

Results suggest that while consumers want safe and clean medical facilities, they assume that all licensed hospitals and medical centers meet basic safety standards. Moreover, several participants explained the low ranking of this attribute cluster by reflecting that most of their medical care is not provided in a hospital setting and therefore is less important than routine care. When asked about the importance of having access to the latest medical equipment, consumers characterized it as an "extra" that would be "nice to have" but was ultimately secondary to the course of treatment and the doctor. The availability of the latest equipment along with the cleanliness of medical facilities were ranked lower than a hospital that has a good reputation for care and safety.

Access

Access, while important to consumers, was not ranked as a top priority, in part, because some attributes within this cluster were interpreted to mean patients would be redirected from their primary care doctor to other resources. Consumers in the study reported that they want to easily get care and information when they need it, but they do not value a 24-hour nurse advice line or the ability to see another doctor who has their medical information. Consumers reported that they would rather "just wait" until they could see their regular doctor and would either search online for medical answers or go to the emergency room, rather than calling a nurse. Multiple participants reported that the nurse advice line usually recommends that a patient go to the emergency room; thereby making the service redundant. (This pattern of emergency room referrals likely reflects consumers' experience in non-coordinated systems, which are less concerned with cost.)

Evening and weekend hours and the 24-hour nurse advice line were among of the lowest ranking attributes across all clusters. Out of 89 participants, 40 ranked evening and weekend hours as one of their bottom three cards and 17 similarly ranked the nurse advice line as a low priority. When asked why they did not need evening and weekend hours, participants explained that they had flexible work schedules and/or sick time they could use for appointments. These findings might be different for very low-income consumers who may not have jobs with the same benefits. Seniors were the least likely to value additional hours since most are no longer working and they have flexible schedules. The study found that access, including the nurse advice line, was a higher priority among Millennials and GenX participants who were more likely to have busy schedules and young children.

On Technology:

"I know I had the website at being one of the least ones for me…it's a valuable service and it's nice to have, but with my doctor's office, if I do a blood test and something is wrong, they're going to call me right away. I know I don't need to keep looking online."
—Consumer, Boomer

On Prevention Services:

*"**I'm** a big girl…I put my big girl pants on and make my own appointment, and fill my prescription. I don't need like a mother, that's how that reminds me."*
—Consumer, Boomer

Tier 3: Technology

The low ranking of the technology cluster was an unexpected finding, given the increasing use of online tools for managing healthcare. Findings suggest that digital tools are most valuable for consumers with chronic or complex health conditions who are also comfortable with online platforms. Although Millennials were comfortable with digital platforms, they were not more likely than older cohorts to rank online access as a priority. When asked why, these younger participants explained that they have few appointments and rarely have medical tests, so they have little need for the service. The strongest advocates for online access were consumers who were already using and experiencing the value of an online healthcare portal and had reoccurring prescriptions and/or appointments.

Tier 3: Prevention

Consumers ranked prevention lower than all other healthcare attributes and voiced some of the same concerns about prevention services that they did about having a care manager help them stay on track with treatment and instructions (under coordinated care). This cluster included the doctor providing tools and information to help the patient improve his or her health, reminders about preventative screening, and calls when patients fail to make follow-up appointments or fill a prescription. Many participants interpreted these services as impersonal and rote, whereby a healthcare system simply dictates protocols to its patients rather than engaging with them as partners in their own health. When asked what preventative care means to them, participants most often described reprimands about losing weight or being given a brochure by a nurse. This attribute cluster was unpopular even with those individuals who were active participants in their own health, did their own research, and had adopted better health habits. They simply did not view a healthcare system as being able to offer the type of support they want and need.

Consumers who found the most value in preventative services had experienced personalized interactions with their doctor or their doctor's staff who helped them develop an action plan for changing health habits.

Cost

After the card exercise was completed, participants were asked if there was anything missing from the list of attributes. Participants most often mentioned the cost of care. Generation X participants and Millennials, who were less likely to have complex medical conditions, and seniors who were on Medicare and had good coverage were both less likely than were Boomers to voice concern over the cost of care. Boomers with complex medical conditions and minimal care (high-deductible plans) expressed the greatest concern and were the most likely to describe fragmented services and express anxiety over being able to get the care they need.

On the Doctor/Patient Relationship:

"The doctor's knowledgeable and skilled. That's ultimately what medicine is. He recommends treatment based on scientific stuff, stays up to date, listens to the patient's concern and can explain things clearly, which is ultimately the goal." —Physician

On Coordinated Care:

"We can have patients who are seen in an emergency department are brought back from their overdose…and then they are back at their primary care doctor receiving the same prescription that landed them in the hospital." —Physician

What Doctors Want for Their Patients

To help identify gaps and similarities between what consumers want from their healthcare providers and what their doctors believe they need, primary care doctors in two of the three consumer markets were also asked to sort the 22 of healthcare attributes in order of importance for their patients.[5] **Overall, the study found that doctors want what consumers want from a healthcare system; namely a strong patient-physician relationship, evidence-based medicine, and coordinated care.** There were, however, differences between what doctors and their patients thought was important. Doctors place much more emphasis on the importance of preventative services than do consumers and are more skeptical about the ability of technology to improve the quality of care. Results are discussed below and summarized in **Table 3**.

Tier 1 Priorities

1. **A personal doctor-patient relationship.** The study found that doctors agree with their patients that the most important determinant of quality care is the doctor/patient relationship. Like consumers, doctors believe that quality care starts with an experienced and knowledgeable physician who is willing to listen to his or her patients' concerns, can explain things clearly, and is able to spend as much time as necessary. Out of the 18 primary care physicians who participated in the study, all ranked one or more of the doctor-patient attributes as a high priority (top six cards). On average, physicians ranked the doctor/patient cluster number four out of the list of 22 attributes. Doctors felt strongly about the importance of spending time with their patients and many expressed frustration over the non-clinical aspects of their job that took time away from patient care, including insurance documentation and billing. Doctors in smaller practices were more likely to complain that they were overwhelmed by these requirements and to report that it compromises the quality of care they are able to provide.

2. **Evidence-Based Medicine/Shared Decision Making.** The study found that doctors, like their patients, believe patients receive the best care when treatment is based on proven treatment methods, research, and shared decision making. This cluster was the most highly ranked set of attributes after the doctor-patient relationship with an average ranking of 8 out of 22. Explaining why she ranked evidence-based medicine as a top priority, one doctor said, "It's a good way to stay out of court…Doctors have to stay up to date with the current research. I have a tremendous amount of respect for people who know what's going on."

3. **Coordinated Care.** Findings suggest that doctors, whether they work in accountable care-type organizations or small practices, believe that communication between the primary care doctor, specialists, and other team members is critical for improving health outcomes, particularly when treating complex conditions. "Communication is probably the biggest flaw in American medicine," explained one doctor. "We can have patients who are seen in an emergency department are brought back from their overdose…and then they are back at their primary care doctor receiving the same prescription that landed them in the hospital." Doctors working in larger health systems were the strongest advocates

[5] Wording varied slightly to focus on the patient health. See Appendix B.

On Prevention:

"[Screeners] are important things to do. They prevent disease and they promote health. Like we've all said, though, the problem is how do we get people do them?" —Physician

On Access:

"I'm against the 24-hour access, email whenever you want…If they are going to wait until 2:00 in the morning after the late show to ask a question when they could've asked a question … when the office was open, they have to have some sense of responsibility." —Physician

On Facilities:

"Medical offices with the latest technology, I don't think that really translates into good medicine." —Physician

for coordinated care while doctors in smaller systems were more likely to voice frustration over their ability to address all aspects of care. "The main issue is still coordination of care, which is needed so [doctors] can provide the proper quality of care…I can't do everything because I don't have time," said one independent physician.

Tier 2 Priorities

4. **Prevention Services.** The study found that doctors place a much higher value on preventative services than do healthcare consumers. Half of the doctors participating in the study ranked one or more of the prevention services attributes among their top six cards and gave the cluster an average ranking of ten out of 22. The most highly rated attribute in this cluster by doctors was the importance of providing patients with tools and information about how they can improve their health. Doctors gave this attribute an average ranking of seven while consumers ranked tools and information at 13. Some doctors were cynical about how effective preventative programs were at helping patients change behavior; but the majority still believed prevention was central to achieving improved health outcomes. "Twenty seven types of cancer are now related to obesity…What do we do? We screen for it, we don't do prevention," emphasized one doctor.

5. **Access.** Findings suggest that while doctors believe patients should have access to care, they do not place a premium on the ability of patients to get care 24/7. Doctors gave this cluster an average rating of 14 out of the list of 22 attributes and only two out of 18 physicians ranked any of the attributes in this cluster among their top priorities (top three cards). Focus group participants reported that patients should be seen in a timely manner; however, doctors sounded overwhelmed at the prospect of being *personally* available on evening and weekends, particularly those doctors working in small practices. Within this cluster, the ability for patients to see another doctor was rated much higher than access to evening and weekend hours, a 24-hour advice line, and the ability to easily get care and information when they need it. Some doctors were dismissive of the idea that the majority of patients need 24-hour access to care and information, suggesting that access may be viewed as a customer service issue by some doctors. "I'm against the 24-hour access, email whenever you want…If they are going to wait until 2:00 in the morning after the late show to ask a question when they could've asked a question … when the office was open, they have to have some sense of responsibility."

Tier 3 Priorities

6. **Facilities.** The study found that while doctors want and expect clean, well-maintained medical facilities with the latest technology, they believe those features are secondary to the "people" who are providing care. Doctors rated the quality of hospitals and facilities second to last in priorities. "Medical offices with the latest technology, I don't think that really translates into good medicine," explained one doctor. None of the attributes in this cluster, including the quality of affiliated hospitals and the cleanliness of medical offices, was ranked among the top three cards.

On EMRs:

"You can go to one EMR and find everything very clearly, but if you go to another EMR you have to go through ten screens to find what you want."
—Physician

7. **Technology.** Doctors ranked technology, including electronic medical records and online tools for patient engagement, as the least important aspect of quality health care. None of the 18 doctors included in the study ranked any of the attributes in this area as a high priority (in the top three or top six cards). The average ranking for this cluster was 17 out of 22. Out of the 18 physicians who participated in the study, 16 ranked one or more of the technology attributes as their lowest priority (bottom three cards). Most doctors were unconvinced that the ability to view test results online, make appointments, email a doctor, or submit a medical question online improves patient care. Some doctors were concerned about liability and reimbursement for online consultations. Doctors working in larger health systems that have protocols for online consultation did not raise the same concerns.

   The lowest ranking attribute in this cluster was the use of electronic medical records to keep track of patients' medications, procedures and history. EMRs had an average ranking of 19 out of 22 total attributes. Doctors, while they were not opposed to electronic records, were far more skeptical than were consumers about the reliability of EMRs and their ability to facilitate care coordination. The study found that many doctors view EMRs as a tool that is only as good as the data entered and the willingness of doctors to review and apply the information. "You can go to one EMR and find everything very clearly," explained one doctor, "but if you go to another EMR you have to go through ten screens to find what you want." Another doctor said, "Technology is good but is also comes [down] to garbage in, garbage out. If we don't put information in, you're not going to get anything magic from that." "You got more information ten years ago from a specialist who wrote a one-page letter that summarized everything as opposed to a 20-page regurgitation of every test they've had for the last ten years," agreed another doctor. "You have no idea what happened, what the plan is."

   Some doctors complained that EMR systems across practices often use different platforms and cannot easily share information. "If you have all these…different technologies out there that don't communicate with each other, it doesn't help," said one doctor. Another doctor described her experience with unreliable test results. "We had a problem recently where the dot phrase from a Pennsylvania hospital was different from the dot phrase at [another hospital] and I was getting all these radiology reports that were incorrect." "It's very difficult process to EMRs to communicate with each other. Just identifying the patient. Simply identifying them as the same patient is really difficult."

   Finally, many doctors, including those working in large groups, described EMR systems as cumbersome and difficult to use because they are designed for documenting billing events and not care coordination. "There's a lot of useless documentation [in EMRs] that have been made for billing purposes, not for care," explained one doctor.

Table 3: Want Doctors Want for their Patients

Attribute	Number of Participants Ranked Attribute in Top 3	Number of Participants Ranked Attribute in Top 6	Average Ranking (1 = top priority)
Doctor/Patient Relationship			**4**
Doctors listen to their patients concerns	14	18	3
Doctors are experienced and knowledgeable	12	16	3
Doctors are able to spend time w/patients	11	13	6
Evidence-Based Medicine/Shared Decision Making			**8**
Doctors treatment based on proven methods	3	12	6
Doctors stay up to date with current research	3	9	8
Doctors consider patients' preferences	4	8	10
Coordinated Care			**9**
Primary care doctors works with specialists	1	4	9
Wherever patients get care, providers have access to their EMR	2	5	9
Nurses and care managers work to improve medical outcomes for patients	1	3	10
Prevention			**10**
Doctors and their staff provide patients with tools and information to improve their health	1	7	7
Doctors and their staff remind patients about preventative screenings they need	0	2	10
Patients are contacted by their doctor's office if they don't make a follow-up appointment or fill a prescription	0	1	13
Access			**14**
If a patient's regular doctor is unavailable, he can see another doctor who has their EMR	2	4	11
Patients have access evening/weekends	0	0	14
Patients can easily get care/information	0	0	15
Patients can call a 24-hour advice line	0	0	15
Facilities			**16**
Affiliated hospitals have a reputation for quality/safety	0	1	16
Medical offices are clean and well maintained	0	0	16
Medical offices have the latest technology	0	1	18
Technology			**17**
Patients have access to a website where they can log on, see test results, medical history, make appointments, or email their doctor	0	0	15
Patients can submit a medical question online and it will be answered by doctor's office	0	0	17
Patients don't have to manage their own medical records because physicians and nurses use EMR	0	0	19

Interpretations of Healthcare Terminology

A secondary objective of the study was to explore consumer understanding and perceptions of language used in healthcare communication. The study tested the terms "value, "accountable care," "coordinated care," "integrated care," "evidence based medicine," and "team-based care." Consumers were asked if they were familiar with the terms, to describe what the terms mean to them, and to discuss any positive or negative associations. Overall, the study found that participants generally understood the terms and found them appealing, with some nuances. Study findings were also compared with focus groups results from 2007. **Results suggest that consumers have a greater understanding and more positive associations with terms describing integrated care than they did ten years ago.** Results are summarized in **Table 4**, followed by a detailed discussion of each term.

Table 4: Appeal of Healthcare Terms
Rank Order from Most to Least Positive

Term	Positive Associations (majority opinion)	Negative Associations (minority opinion)	Comparison with 2007
Coordinated Care	• Implies communication • Working together for the benefit of patient • Organized	• Ubiquitous/over used	• Even though term was positive in 2007, there are fewer negative associations today • Consumers in 2007 said the term was unclear/bureaucratic. Rarely mentioned in 2017.
Value	• Affordable • Good care at a reasonable price • Good quality • Something that matters	• Discount; cheap • "Walmart"	• Value tested better in 2017 than it did in 2007 • Consumers are now less likely to associate value with reduced quality. Cost effectiveness is not equated with lower quality care.
Evidence-Based Medicine	• Proven medicine • Based on previous successful research • Not the "Guinea pig"	• Limits doctors from considering alternatives	• Consumers in 2017 are more assured and trusting of the term than they were in 2017. • Participants in 2007 were more skeptical and reluctant to trust a "one-size-fits-all" model • In 2007 this term was predominately negative
Team-Based Care	• Associated with coordinated care • Working as a team • Includes patient as part of team	• No individual in charge • Doesn't imply communication	• Consumers had more positive interpretations in 2017 than they did with a similar term in 2007 ("teamwork") • In 2007, team did not "resonate" with audiences and was associated with business. Today, it is associated with coordinated care.
Accountable Care	• Being responsible • Not reckless • Preventing malpractice	• Defensive medicine; "CYA" • Not about patient • Unclear who is accountable	• Consumers in 2017 were more likely to see value in accountable care than they were in 2007, as consumers were more familiar with the term and said it implied being responsible • However, the term remains ambiguous, which leads many to distrust its intended message • This term was predominately negative in 2007
Integrated Care	• Similar to coordinated • Different parts working as one • All under one roof	• Unclear • Meshed together, no real coordination • Impersonal • Sounds corporate; jargon	• Consumers find the term more appealing now than they did in 2007 and more consumers associate it with coordinated care • However, for some it continues to be unclear, bureaucratic • This term was predominately negative in 2007

On Coordinated Care:

"There's many doctors involved, they are giving you somebody that would help you coordinate all the different [treatments]."
—Consumer, Millennial/ Gen X

On Value:

"[Value] means that you're getting good care for a reasonable amount of money."
—Consumer, Senior

On Evidence-Based Medicine:

"[It means] something that's been used or studied and found to be successful."
—Consumer, Boomer

Coordinated Care

"Coordinated care" was the most highly rated of the six terms tested. The majority of participants found the term appealing because it connotes "communication" between all medical personnel involved in a patient's healthcare experience. Additionally, most participants preferred "coordinated care" over "accountable care" because it implies "everyone is one the same page," "communicating" for the benefit of the patient. One participant stated that coordinated care implies "personalized care" physicians work in tandem to customize a patient's specific medical care. Some participants see coordinated care as a system of communication in which a person's specialists "report back to the primary care doctor." A minority of participants associated the term with technology such as electronic medical records and patient online portals, which help share a patient's medical information and history. One participants stated, "The best thing is the computer, [they] see your whole picture and coordinate your care, prescriptions, and treatments. It's a great thing."

Although coordinated care was a positive term in 2007, findings suggest that consumers are more familiar with the term today and have fewer negative associations. Participants in the 2007 study were more likely to report that the term coordinated care was "unclear," "insincere," and "bureaucratic."

Value

The majority of participants found the term "value" to be highly positive as it implies that something is both "good quality" and "affordable." Many described value as "good care" at a "reasonable price." A minority of participants argued that the term has negative connotations. Only a few participants across all nine consumer focus groups argued that "value" implies a compromise or "trade off" in which patients must choose between quality care and affordable care. "You're getting what you paid for," one participant stated. In two of the nine groups, the term was reminiscent of "Walmart," a brand that they see as providing "devalued" or "cheap" services. As one participant argued, "'Discount' [can be] associated with that, which might not be good." Another participant explained, "If I go to the doctor, I don't want value. I want quality. I get value at the VA." Some participants found that the promise of finding "value" at an affordable rate was "unrealistic." One person asked, "It's a bait and switch. Why put the numbers down on paper if it doesn't exist? It baits the hook to get you [in]."

Consumers in 2017 were more likely to associate value with "good quality care" than they were in 2007. In contrast, participants were more likely in 2007 to associate value with a "cheap" product that was inferior to more expensive alternatives.

Evidence-Based Medicine

The majority of focus group participants interpreted "evidence-based medicine" to mean treatment based on "proven" methods and found the term reassuring and appealing. One participant stated that evidence-based medicine is "something that's been used or studied and found to be successful." A minority of participants had negative interpretations. A few participants reported that evidence-based medicine sounds "experimental." Additionally, some participants found the term unappealing because it is "overstating the obvious," which suggests that some consumers assume their treatment is based

On Accountable Care:

"Responsible care." —Consumer, Millennial/GenX

"[Doctors and hospitals]] pay very, very high premiums in order to maintain their malpractice coverage. They've got CYA." —Consumer, Senior

on best practices. Participants in three of the nine groups associated evidence-based medicine with "baseline" standards. One participant argued that the approach is "limited… [Doctors] might not be thinking outside the box." Additionally, a few participants were entirely unfamiliar with the term.

Compared to results from 2017, consumers appear to have more confidence in the term "evidence-based medicine" and recognize the value of treatments based on proven medical research. Participants in 2007 were more skeptical of the term's messaging and reluctant to trust a "one-size-fits-all" model.

Team-Based Care

The study found that participants closely associated "team-based care" with coordinated care. Many participants found the term appealing because it implies having all medical providers "working together as a team" to provide customized, personalized care. "It's human-based, and less corporate," said one participant. While the term is seen as generally positive, most participants preferred "coordinated care" to "team-based care." Many believe that someone should be "at the helm" to avoid having a "dysfunctional team." A primary physician or case manager, for instance, can help moderate communication and ensure that all personnel involved in providing care are well informed on the patient's medical history and treatment.

Findings suggest that consumers in 2017 are more likely than consumers in 2007 to find the term "team-based care" appealing. Overall, participants in 2017 had a better understanding of the term and often mentioned positive associations. In contrast, participants in 2007 had mixed reviews and said that the term reminded them of business or sports.

Accountable Care

The study found that the term "accountable care" continues to have both positive and negative associations for consumers. A majority of participants associated accountable care with providing "responsible" care. Some participants suggested it implies "not [being] reckless," preventing "malpractice," and avoiding potential lawsuits. "They should be accountable for what they do," one participant argued. A minority of participants were cautious of the term, interpreting accountability as a defensive position used to prove that a physician or organization has not violated professional standards. The phrase "CYA" was mentioned in multiple groups. One person explained, "[Doctors and hospitals] pay very, very high premiums in order to maintain their malpractice coverage. They've got CYA." Another participant explained, "I don't believe anybody in the medical field will be held accountable." Only a few participants were unfamiliar with the term, stating that they had "never heard of it." Others reported that the term was too ambiguous, as it does not clearly imply "who is being accountable."

A comparison of findings from 2007 to 2017 indicates that consumers today are more likely to have positive interpretations of the term. Participants in 2017 often said the term implied that physicians were practicing responsibly to prevent injury or inconvenience to their patient, not to simply avoid litigation. Despite its growing appeal, however, the term is still associated with "defensive medicine" and can be ambiguous.

On Integrated Care:

Integrated care "doesn't speak to the efficacy of the care. [It sounds like]...a big bowl of spaghetti."
—Consumer, Boomer

Integrated Care

"Integrated care" was the least positive term among all the words tested. Some participants had positive associations partly because they interpreted the term to be "similar to coordinated care" yet it is not as persuasive in swaying their opinion because it fails to capture "the communication factor." Generally, participants agreed that integrated care is unclear, and most preferred coordinated care. One participant argued that it does not clearly imply coordination. Rather it implies that physicians are simply "meshed together, like a bowl of spaghetti." Another participant stated that it implies "working together for one purpose." Others assumed that integrated care includes different types of care "all under one roof," a "one-stop-shop." Additionally, some participants believe that the difference between coordinated care and integrated care is so subtle that the two could be interchangeable. A minority of participants had negative interpretations explaining that the term could be "impersonal, "corporate," and "bureaucratic."

A comparison of findings from 2007 and 2017 suggests that consumers are today more informed about language surrounding integrated systems. Participants in 2017 were more likely than participants in 2007 to find value in the term "integrated care" and recognized it as part of coordinated care. However, the study also found that the term continues to have negative connotations. Participants in 2007 and 2017 often said the term was unclear, impersonal, and bureaucratic.

How Consumers Evaluate the Quality of Their Care

In both the 2007 and 2017 studies, participants were asked how they define quality healthcare. In the original study, consumers reported that they knew they were receiving good medical care because they had a close relationship with their physicians. In 2007, consumers rarely mentioned their doctors' technical expertise, medical training, or familiarity with current research and almost no one commented on system attributes that went beyond the doctor. In the current study, although participants still focused on the doctor-patient relationship, they were also more likely to mention attributes related to care coordination, technology, and evidence-based medicine when describing quality care. One participant described the importance of electronic medical records that were not offered by his provider: "If you go to a specialist in a big hospital, they've got top of the line everything. They've got a computer system where every doctor in that hospital can see everything that every other doctor has said about you kid in one place…That's huge when you are dealing with a lot of different things." When asked to describe quality care, another participant explained the importance of access. "Having other doctors or even nurse practitioners that you could see on a whim if you need to. I don't necessarily always need to see my doctor if I have a cold or need a prescription for a sinus infection... Being able to get in and have somebody there I trust is important." These findings suggest that consumers are increasingly looking beyond their doctor to evaluate the larger system of care.

Effectiveness of CAPP Video Messaging

Finally, the focus groups were used to test the effectiveness of six short videos, each highlighting the experience of an individual patient receiving care in an accountable system. Consumers and doctors were presented with at least one video and asked: (1) what they understood to be the main message; (2) the extent to which they found it appealing; and (3) whether they believed similar services were available in their market.

Overall, the study found that the videos were extremely appealing to consumers and were effective in communicating how coordinated care and telemedicine benefits patients. The videos focused on coordinated care were particularly appealing to consumers currently experiencing complex health problems who were not receiving the level of care depicted in the video. While only a handful of participants reported that as a result of seeing the videos they would reorganize their attribute cards from the previous exercise, several participants in every group expressed awe at the level of service provided and wanted to know either the name or location of the medical group. Findings suggest that the videos, while highly effective at explaining coordinated care and telemedicine, were less effective in differentiating multi-specialty medical groups from specialty practices or fragmented systems. Few of the focus group participants understood that the services depicted were being provided within a *single* medical group (the exception was the Billings Clinic video, which explicitly names the medical group).

The videos, originally designed for a consumer audience, were not as appealing to doctors. Many doctors interpreted the videos as a referendum on the care they were providing. Physicians from smaller practices appeared overwhelmed or intimidated as they discussed their lack of resources and support

to adopt things like medical electronic records, telecommunication, and a nurse navigator. Because the videos featured specialty practices, some primary care physicians commented that the model was not relevant or applicable to primary care. Detailed findings on consumer reactions to each video are presented below, followed by results for physicians.

Video One: Karen's Story

Video One shows the story of an older woman with ovarian cancer. The video emphasizes coordination through "teamwork" by highlighting improved technologies like electronic medical records that helps physicians share information about the patient's care. The video was shown in five consumer focus groups. Findings for Video One are presented below.

- **When asked about the video's main message, consumers generally understood it as depicting coordinated care, with particular emphasis on "coordination [through] teamwork and electronic medical records."** Overall, a majority of participants found the video appealing and "persuasive." Many commented on the value and effectiveness of having immediate and reliable access to coordinated care. As one participants stated, "The integration and working together was amazing!"

- **The majority of those who were already familiar with integrated healthcare systems, particularly those who had positive experiences and personal stories surrounding illness, were most likely to believe the message.** One participant recalled a friend's experience with cancer and described how important that level of attention and communication was for the person's wellbeing. When asked if the scenario featured in the video was believable, one participant stated, "It is real life; it happens. It does happen." Some participants who had little to no experience with coordinated systems also had a strong, positive response. "It was a great sales [pitch]…It was like, 'Wow, okay we will go there!'"

- **While the video was persuasive, it was not always relatable. Participants often commented that the video spotlighted an "ideal" scenario.** Some people suggested that Karen was an "exception" because she was already healthy and active, her son was a doctor, and she had survived long past what they perceived to be the limit for someone with as terminal an illness as ovarian cancer. "The odds were in her favor," one participants stated. Others participants could not related because the video was specific to cancer and coordination is expected. "That's the paradigm. You have a physician, you have a surgeon, you have a radiologist, and you have a dosimeter who figures out the dose of radiation. They meet as a group, and then they meet with you."

- **A minority of participants had a negative response. Some were skeptical of the message, suggesting that some places are simply "uncoordinated."** One man recounted his sister's experience with a rare cancer in which another family member had to coordinate her care. One participant found the video unappealing because the message was too confusing, switching between coordination and technology. This

suggests that some consumers may not recognize the connection between the two.

Video Two: Teresa's Story

Video Two depicts an 81-year-old woman who has suffered a heart attack after living with a heart murmur. The video highlights a structural heart program that integrates cardiology, cardiovascular surgery, and cardiac imaging in one facility. The video was shown in three consumer focus groups. Below are the findings for Video Two.

- **Findings suggest that most consumers recognized the value of "integrated medicine" after watching the video. Many participants associated the video with "teamwork," "efficiency," and "patient outcomes." Additionally, most consumers found the video appealing and persuasive.** When asked about whether elements in the video captured their interests, many participants took note of electronic medical records. One participants suggested it was an efficient way of tracking a patient's "complete and current history." Another participant argued that electronic medical records relieve patients of the burden of having to track their own paperwork. Moreover, participants frequently agreed that the video was relatable. One participant who particularly liked that video agreed with an on-camera physician's statement that that healthcare is "not there yet, but we're working on it."

- **Video Two was particularly persuasive for participants who had previously ranked coordinated care low in their deck of card. Findings suggest that the story and its visuals were effective in showcasing how coordinated care might benefit patient outcomes.** After watching and discussing the video, one woman prioritized items surrounding coordinated care to the top of her deck. "The video did change my mind on that, because I do see that as a big problem in my healthcare and having so many different problems." Some participants made little changes to their cards, but admitted that the video swayed their opinion about the importance of coordinated care. Findings suggest that although some consumers believe they do not need coordinated care, they recognized its value after watching the video. "I'm fortunate, I have very little healthcare to worry about. I'm not on any medications or anything. But when you are, yes, naturally you've got to have a lot of communication."

- **Participants recognized improved technologies, like electronic medical records and telemedicine, as valuable tools. However, participants understood that such tools are complementary rather than supplementary.** Consumers still value face-to-face interactions with their healthcare providers, and often discussed telemedicine as a "convenient" option, but not a replacement.

Video Three: Jenny's Story

Video Three depicts a teacher who had undergone bariatric surgery to manage weight and control her diabetes. The video highlights coordinated care within the Billings Clinic's bariatric program, and describes the role of a nurse navigator. Video Three was viewed in six consumer focus groups and one physician focus group. Presented below are findings for *Jenny's Story*.

- **Overall, the majority of participants described the video as depicting communication, teamwork, and collaboration among physicians within integrated healthcare systems. Positive associations with the video included "infrastructure," "listening," "investment," and "continuity."** One participants suggested that the video highlighted personalized and continuous care, "from start to finish." "They're not just going to hand me over to someone else."

- **Many consumers who were familiar with integrated healthcare systems described their own experiences with coordination care and recognized the value of having a nurse navigator.** One women likened the nurse navigator to a "case manager." "It's a great setup." Participants here often described the nurse navigator as someone who "walks you through everything" and "guides you." Recalling his own experience with his son's traumatic brain injury, another participant stated, "I've seen it work."

- **Although the video was appealing and participants recognized the value of its message, it was not very compelling particularly for those who believe this level of care is not possible outside of specialized medicine or serious illnesses like cancer.** One participant questioned whether that level of coordination was possible with all personnel involved in a patient's care, such as nurses, assistants, and administrative personnel.

- **Physicians were more likely than consumers to be skeptical of the video's message. Most physicians in the group agreed that the level of coordination, communication, and collaboration featured in the video "is not available in primary care."** One participant suggested that coordination of that caliber "is not possible outside of bariatric surgery because none of them get paid until the insurance pays for the surgery." "The team approach is not covered by insurance." Another physician believes that electronic medical records are not the solution to solving problems or curing patients. As he described, "I have one practice where I have everything, the hospital record, the specialist record and my record all combined and the cardiologist is still giving the patient two nitrates without angio[plasty], still giving him two beta blockers…It doesn't solve problems, it doesn't prevent problems."

Video Four: Jesus' Story

Video Four depicts a non-English speaking Latino man diagnosed with diabetes. The video highlights electronic medical records and preventative care. Video Four was shown in one consumer group. Below are the findings for *Jesus's Story.*

- **Overall, participants understood the video's message surrounding coordinated and integrated care. However, the study found that consumers generally had mixed opinions about the appeal of this video.** Some participants said that the video was realistic and relatable. One participant found the "family component" most appealing. "That's a good motivator [to get checked]. I should be taking better care of myself." Others recalled their own healthcare experiences. For them, the video was more accurate in detailing how coordinated care works for patients attending smaller practices and seeing fewer specialists.

- **In contrast, many other participants were unmoved by the video's main subject. Some participants even appeared uneasy and were noticeably "offended" by Jesus's story, suggesting that he was guilty of creating his own circumstances.** One participants stated, "When I watch that I think, "So you just took all that time to go see all those people for something that you should have just known to take care of yourself the whole time. 'I slept like crap, I didn't exercise, I ate bad.' It's frustrating to hear that some people need all of that to figure out… It seemed like a lot of waste to me. You did that to yourself." Other participants agreed, and suggested that the video should have showcased someone else, perhaps someone with cancer, a condition "you don't bring on yourself." These negative comments were expressed by white participants and may reflect racial bias toward viewing low-income minorities as responsible for their own misfortune. Similar comments were not raised when viewing *Jenny's Story*, which depicts a white woman.

Videos on Telemedicine

Videos five and six focused on the use of telemedicine. While their overarching theme is coordinated care, the videos make specific reference to technologies like video chats with medical teams. The videos were shown in three consumer groups and one physician group. Findings for *Emma's Story* and *Felipe's Story* are presented below.

- **The majority of participants found the videos appealing and interpreted the main message as communication through telemedicine. Participants associated "convenience" with telemedicine and being able to receive care from home.** As one participant suggested, the videos show that healthcare is embracing technological advancements.

- **Videos five and six were "positive" and aspirational, but they were not persuasive as many participants questioned the effectiveness of telemedicine in diagnosing and examining patients. Consumers all agreed that Videos five and six appear to promote telemedicine as replacing face-to-face appointments.** One participant believes that telemedicine works "in certain cases, but if you're sick, you should go in [to see a doctor]." Others argued that the videos do not explicitly suggest when telemedicine is appropriate to treat patients. "When should video skyping happen?"

- **The study found that physicians were least likely to find video either appealing or persuasive. Most physicians reported little to no experience with or desire to adopt video communication. Like many consumers, physicians believe Videos five and six appear to promote telecommunication as a replacement to traditional care.** As one participant stated, "Telemedicine is a great adjunct to your practice. It cannot replace it because you need to have at least one face-to-face contact with the patient before you can go to telemedicine."

- Finally, consumers and physicians did not believe telemedicine was being provided in their markets and saw the service as an exception to standard care.

CONCLUSIONS/RECOMMENDATIONS

Results from the 2017 study suggest that healthcare consumers are becoming increasingly sophisticated in their understanding of healthcare delivery systems and the components of quality care. Although consumers continue to place a premium on the doctor-patient relationship to define quality, the study found that consumers also understand and expect that their doctors will communicate with each other, that their medical records will be available electronically, and that their treatment will be evidence based. When presented with the set of 22 health care delivery attributes—including coordinated care, evidence-based medicine, access, prevention services, and electronic medical records—and asked to sort them in order of priority, study participants frequently complained that all the attributes were important. The language testing, which compared consumer reactions to common healthcare terms with findings from 2007, further testifies to this transition. Results suggest that consumers today have a greater understanding and more positive associations with terms describing integrated care, including evidence-based medicine, team-based care, accountable care, and value.

While the gap between how healthcare professionals define quality care and what consumers believe they need from their providers may have narrowed, there is still a disconnect. The study found that doctors place much more value on preventative services than do consumers. While doctors discussed the importance of screenings and improved health habits, consumers reported that they felt "managed" and condescended to by the standard approaches.

Finally, the study highlights a divide between policy makers' expectations of technology and the daily experiences of patients and their doctors. Tremendous attention has been paid to the value of online technology for healthcare engagement and the use of electronic medical records for facilitating care coordination. However, study results from 2016 and 2017 indicate that many consumers do not use or value online tools and doctors raise important concerns about the limitations of EMRs, including platforms that are incompatible and systems that are designed to meet billing and documentation needs rather than care coordination.

Based on study findings, we recommend the following to help guide CAPP in its marketing and communication efforts as well as policy advocacy.

1. **In communicating the value of integrated care to consumers, emphasize those attributes most recognized by consumers as hallmarks of quality care; namely care coordination and evidence-based medicine.** Whenever possible, describe coordinated care and care management as supporting the doctor/patient relationship (consumers' number one priority) rather than replacing it.

2. **Continue to use short, documentary style case studies to help consumers conceptualize the value of coordinated care.** In developing new video content, consider featuring patients with different socio-economic profiles, such as white men and people of color with professional backgrounds, to ensure that all population segments can relate to the message.

3. **When appropriate, avoid using the term "integrated care" in communicating with consumers and opt for alternative terms such as "coordinated" or "team-based" care, which communicate a similar message.** Integrated care was the least appealing term for consumers among all the language tested.

4. **Consider alternative language to replace the term "care manager" and related terms when communicating with consumers about coordinated care.** Findings from the ranking exercise suggest that the term "care manager" is associated with the impersonal management of patients. Instead, describe the outcome of such support ("making sure you're getting better") and emphasize personalized care.

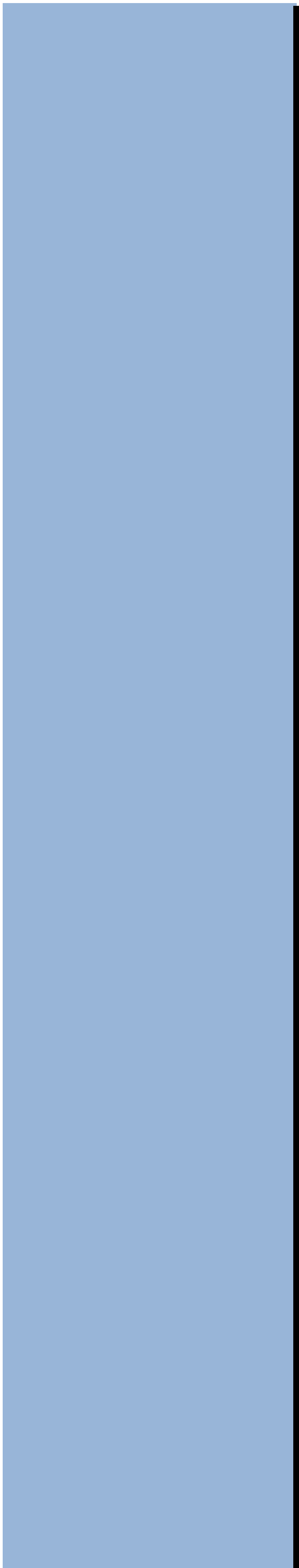
5. **Look for opportunities to promote preventative health programs that incorporate personal interactions.** Consumers recognize the importance of lifestyle changes but need support to develop heathier habits. The study found that patients want interactions with caring professionals and do not value general health tips or brochures.

6. **Support public policy that aims to improve the use of EMRs for care coordination**, including policies that establish standards for data exchange across different systems, address payment incentives to foster coordination, and facilitate common expectations about how primary care and specialists will exchange information.

7. **Consider conducting an annual, CAPP-branded quantitative survey to track changes in consumer attitudes over time.** Qualitative research, such as the current study, can uncover important insights about participants' experiences and beliefs, but it has limitations. A CAPP-branded public opinion poll, conducted annually, would be a reliable way to track changes statistically and would be useful for informing communications and public policy. To ensure that poll results are robust and will be recognized by media and policy makers, adhere to the rigorous standards established by the American Association for Public Opinion Research (AAPOR) and similar organizations. Avoid using proprietary samples (which often fail to meet these standards) or vendor-branded research to ensure that the poll can be conducted consistently and independently.

8. **In developing a quantitative survey, examine consumers' reactions to the wording of the healthcare attributes as tested in the focus groups to develop a questionnaire that is as valid as possible.** Focus group results suggest that consumers often want follow-up care management and preventative services but react negatively to wording that focuses on "management" and "reminders" rather than personalized care. In addition, focus on outcomes (the benefits patients will receive), rather than methods used to achieve those outcomes, to ascertain what consumers really want.

9. **As a follow-up to the current research, consider holding a forum that includes patients, doctors, and health policy experts to discuss and possibly draft what they agree to be the ideal healthcare delivery system.** The current study was useful as a starting point for identifying patient and physician priorities but more work needs to be done to understand how these attributes translate into clinical practice and to resolve differing perspectives among health policy experts and consumers.



Appendix A: Moderator's Guides

Healthcare Priorities Among Consumers and Physicians
Consumer Focus Groups 2017
Discussion Guide

INTRODUCTION (10 minutes)

Good Afternoon. Thank you for coming. My name is _______________. I'm with an independent research firm here to talk with you about your healthcare experiences and what you want from your health plans and providers.

GROUND RULES

Before we start the discussion, I want to go over a few things.

- We have colleagues from a local healthcare organization listening to this conversation and taking notes. We are also making an audio recording of the discussion so that we do not miss anything that you have to say.
- Everything is confidential. No one will know who said what. We don't identify people by name in any of our reports.
- I want this to be a group discussion, so feel free to respond to me and other members in the group without waiting to be called on. However, for the sake of the note-takers, please let someone finish speaking before you begin.
- There are no right or wrong answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think.
- The discussion will last approximately two hours. There is a lot I want to discuss, so at times I may move us along a bit. You can leave to use the restroom at any time.
- Do you have any questions before we begin?

PARTICIPANT INTRODUCTIONS

Let's start with a quick introduction. Please tell us your first name and where you usually go for medical care. [MODERATOR: probe beyond the name of doctor to get type of provider and insurance]

HEALTHCARE EXPERIENCES (20 minutes)

1. Do you think you are getting good medical care?

2. How do you define quality medical care? [probe beyond the doctor]

LANGUAGE TESTING [SECTION MOVED UP] (15 minutes)

3. I'd like to get your feedback on some terms that are often used in healthcare. What comes to mind when you hear ____________? [MODERATOR: Test *value*; *accountable care*; *coordinated care*; *integrated care; evidence based medicine;* and *team-based care*.]
   - What is the first thing that comes to mind when you hear that?
   - What does it mean to you?
   - Is it positive or negative?

CONSUMER HEALTHCARE PRIORITIES (45 minutes)

4. I'd like to do an exercise. I'm going to give each of you a set of index cards **[Table 1]**. Written on each card is a different feature or attribute that customers might want in a healthcare provider, such as online access to lab results. By provider, I don't just mean the doctor, but all the people and places that provide you with care. Using these cards, I want to you create your ideal healthcare experience.

   You are going to sort the cards in order of importance, putting the most important attributes at the top of the stack and the least important at the bottom. Once they are in order of priority, please number them with the top card being #1. When you are done, we will discuss your choices. Remember to sort the cards by what you want, not by what you already have. [MODERATOR: provide 5-10 minutes or until everyone is done.]

5. What were your top three cards and why are they important to you? [MODERATOR: Go around the table. If all top cards are about doctors, ask about the next three] What are your three bottom cards? Why?

6. [To the whole group] What about __________? How did that rank? [Probe for items not discussed]
   - Why was that not as important to you?

7. Is anything missing from this list of attributes that you want in a healthcare provider? [MODERATOR collect cards]

CAPP MESSAGE TESTING (up to 30 minutes)

8. Now I'm going to show you a video that describes ----------- and I want to know what you think. This video would appear on the website of an association that represents medical providers. [MODERATOR: Show CAPP video] Probe:
   - How would you summarize the main message of this video?
   - What do you think of the message? Do you agree? Is it persuasive?
   - Do you believe the information is accurate?

9. Thinking about this video and our discussion earlier, have you changed your mind in anyway about want what you want from a healthcare provider?

10. I'd like to know whether your priorities changed after watching the video. Looking back at your cards, what attribute might you prioritize differently?
    - Where did that card rate before?
    - Where would you move it?
    - What changed your mind?

CLOSING

Those are all the questions I have. Does anyone have something they would like to add? That concludes our discussion. Thank you all very much for your participation. I hope that this was an enjoyable experience.

Table 1: Provider Attributes for Testing (Printed on Cards)[6]

Accountable Care Benefits	Healthcare Attributes
Coordinated Care	I don't have to bring in any hospital or ER records because my primary doctor's office has access to them electronically
	My primary care doctor talks to and works with all my specialists about my care
	My doctor's office makes sure I'm getting better and follows up with me if necessary
24/7 Access	My doctor's office provides evening and weekend hours
	I can easily get care and information when I need it
	I can call a 24-hour medical advice line and speak to a nurse or physician who knows my medical history and conditions
	If my doctor is unavailable, I can see another doctor who has information about my medical history and conditions
Evidence Based Medicine	My doctor considers my personal preferences when we review my treatment options
	My doctor determines my treatment based on proven treatment methods and research
	My doctor stays up-to-date with current research regarding my medical conditions
Technology	I can submit a medical question online and it will be answered by someone at my doctor's office
	My doctor's office has a website where I can log on and see my test results, medical history, schedule an appointment, and/or email my doctor
	Wherever I get care, my physician has my current and complete medical information
Prevention	My doctor gives me tools and information on how I can improve my health
	My doctor reminds me about preventative screenings I need
	My primary doctor's office contacts me if I don't make a follow-up appointment or fill a prescription
Doctors	My doctor is experienced and knowledgeable
	My doctor listens to my concerns and is able to explain things clearly
	My doctor is willing to spend as much time with me as necessary
Hospitals/Facilities	Medical offices are clean and well-maintained
	Medical offices have the latest technology
	The hospital that my doctor works with has a good reputation for excellent care and safety

[6] Bedside manner and related themes regarding the patient-physician relationship are well documented. They are included here to provide a complete picture of consumer priorities.

Healthcare Priorities Among Consumers and Physicians
Physicians Focus Groups 2017
Discussion Guide

INTRODUCTION (10 minutes)

Good Afternoon. Thank you for coming. My name is ______________. I'm with an independent research firm here to talk with you about your experience providing care and to get your opinion about what good medical care looks like.

GROUND RULES

Before we start the discussion, I want to go over a few things.

- We have colleagues from a local healthcare organization listening to this conversation and taking notes. We are also making an audio recording of the discussion so that we do not miss anything that you have to say.
- Everything is confidential. No one will know who said what. We don't identify people by name in any of our reports.
- I want this to be a group discussion, so feel free to respond to me and other members in the group without waiting to be called on. However, for the sake of the note-takers, please let someone finish speaking before you begin.
- There are no right or wrong answers. You can disagree with each other, and you can change your mind. I would like you to feel comfortable saying what you think.
- The discussion will last approximately two hours. There is a lot I want to discuss, so at times I may move us along a bit. You can leave to use the restroom at any time.
- Do you have any questions before we begin?

PARTICIPANT INTRODUCTIONS

Let's start with a quick introduction. Please tell us your first name, your specialty, and where you currently provide care.

HEALTHCARE EXPERIENCES (20 minutes)

11. How do you define quality medical care? [probe beyond the doctor]

12. Based on what we discussed here, do you think your patients are getting good medical care?

LANGUAGE TESTING [SECTION MOVED UP] (15 minutes)

13. I'd like to get your feedback on some terms that are often used in healthcare. What comes to mind when you hear ____________? [MODERATOR: Test *value*; *accountable care*; *coordinated care*; *integrated care; evidence based medicine;* and *team-based care.*]
    - What is the first thing that comes to mind when you hear that?
    - What does it mean to you?
    - Is it positive or negative?

CONSUMER HEALTHCARE PRIORITIES (45 minutes)

14. I'd like to do an exercise. I'm going to give each of you a set of index cards **[Table 1]**. Written on each card is a different feature or attribute that providers might offer their patients, such as online access to lab results. By provider, I don't just mean the doctor, but the whole system of care. Using these cards, I want you to put together what you think would be the best medical care for your patients.

    Please sort the cards in order of importance, putting the most important attributes at the top of the stack and the least important at the bottom. Once they are in order of priority, please number them with the top card being #1. When you are done, we will discuss your choices. Remember, you're putting together the ideal package for your patients, not what your patients already have. [MODERATOR: provide 5-10 minutes or until everyone is done.]

15. What were your top three cards and why do you think they are important? [MODERATOR: Go around the table. [If all top cards are about doctors, ask about the next three] What are your three bottom cards? Why?

16. [To the whole group] What about __________? How did that rank? [Probe for items not discussed]
    - Why was that not as important?

17. Is anything missing from this list of attributes that you believe is an important part of quality medical care?
    [MODERATOR collect cards]

MESSAGE TESTING (30 minutes)

18. Now I'm going to show you a video that describes ----------- and I want to know what you think. This video would appear on the website of an association that represents medical providers. [MODERATOR: Show CAPP video] Probe:
    - How would you summarize the main message of this video?
    - What do you think of the message? Do you agree? Is it persuasive?
    - Do you believe the information presented is accurate?

19. Thinking about this video and our discussion earlier, have you changed your mind in anyway about how you define quality healthcare or what you want for your patients?

20. I'd like to know whether your priorities changed after watching the video. Looking back at your cards, what attribute might you prioritize differently?
    - Where did that card rate before?
    - Where would you move it?
    - What changed your mind?

CLOSING

Those are all the questions I have. Does anyone have something they would like to add? That concludes our discussion. Thank you all very much for your participation. I hope that this was an enjoyable experience.

Table 1: Provider Attributes for Testing (Printed on Cards)

Accountable Care Benefits	Healthcare Attributes
Coordinated Care	Patients don't have to manage their own medical records because physicians and nurses use electronic medical records
	Primary care doctors can talk to and work with their patients' specialists and other providers in real time or near real time
	Nurses and care managers work with doctors as part of a team to close care gap and improve medical outcomes for patients
24/7 Access	Patients have access to evening and weekend hours at their primary care doctor's office or medical group
	Patients can easily access care and information when they need it
	Patients can call a 24-hour medical advice line and speak to a nurse or physician who knows their medical history and conditions
	If a patient's regular doctor is unavailable, he or she can see another doctor who has information about their medical history and conditions
Evidence Based Medicine	Doctors consider their patients' personal preferences when reviewing their patients' treatment options
	Doctors recommend treatment based on scientific evidence and research
	Doctors stay up-to-date with current research regarding their patients' medical conditions
Technology	Patients can submit a medical question online and it will be answered by someone at the doctor's office or medical group
	Patients have access to a website where they can log on and see their test results, medical history, schedule an appointment, and/or email their doctor
	Wherever patients get care, providers have access to their current and complete medical information
Prevention	Doctors and their staff provide patients with tools and information on how they can improve their health
	Doctors and their staff remind patients about preventative screenings they need
	Patients are contacted by their doctor's office or medical group if they don't make a follow-up appointment or fill a prescription
Doctors	Doctors are experienced and knowledgeable
	Doctors listen to their patients' concerns and are able to explain things clearly
	Doctors are able to spend as much time with patients as necessary
Hospitals/Facilities	Medical offices are clean and well-maintained
	Medical offices have the latest technology
	Affiliated hospitals have a reputation for continually improving quality, care, and safety

Appendix B: Focus Group Participant Demographics

February 25, 2017 (9:30 a.m.-11:30 a.m.) Littleton, CO Group 1 Seniors						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Male	65	Caucasian	Littleton	College Grad	$75-100K	3
Male	66	Caucasian	Littleton	College Grad	$20-40K	3
Female	66	Caucasian	Littleton	Post Grad	$75-100K	3
Female	67	Caucasian	Littleton	College Grad	$75-100K	1
Male	67	Caucasian	Littleton	Some College	$40-60K	1
Male	69	Caucasian	Littleton	Post Grad	$20-40K	5
Female	72	Caucasian	Littleton	Some College	$40-60K	5
Male	70	Caucasian	Littleton	Some College	$40-60K	5+
Male	65	Caucasian	Littleton	Some College	$75-100K	2
Female	66	Caucasian	Littleton	College Grad	$40-60K	3

February 25, 2017 (12:30 p.m.-2:30 p.m.) Littleton, CO Group 2 Boomers						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Female	53	Caucasian	Littleton	HS Grad	$60-75K	3-4
Female	56	Mixed: Indian/ Caucasia	Littleton	Some College	$100-150K	5+
Male	56	Caucasian	Littleton	College Grad	$150K+	3-4
Female	57	Caucasian	Littleton	Some College	$75-100K	3-4
Male	52	Caucasian	Littleton	Some College	$75-100K	2
Male	59	Caucasian	Littleton	College Grad	$40-60K	1
Female	62	Caucasian	Littleton	College Grad	$20-40K	3
Female	64	Caucasian	Littleton	Some College	$40-60K	3
Male	64	Caucasian	Littleton	Some College	$40-60K	6
Male	59	Caucasian	Littleton	College Grad	$20-40K	3

February 25, 2017 (2:30 p.m.-4:30 p.m.) Littleton, CO Group 3 Millennials and Gen X						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Female	28	Caucasia	Littleton	Post Grad	<$20K	3-4
Female	29	Caucasia	Littleton	Some College	$40-60K	<3
Female	32	Caucasia	Littleton	Some College	$75-100K	3-4
Female	30	Caucasia	Littleton	Some College	$40-60K	3-4
Male	38	Caucasia	Littleton	Some College	$40-60K	<3
Female	44	Caucasia	Littleton	Some College	$150K+	3-4
Male	30	Caucasia	Littleton	College Grad	$100-150K	1
Male	47	Caucasia	Littleton	College Grad	$40-60K	1
Male	39	Caucasia	Littleton	Some College	$75-100K	2

March 8, 2017 (5:30 p.m.-7:30p .m.) Burlington County, NJ Group 4 Seniors						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Female	70	Caucasian	Mt. Laurel	Some College	$72-100	3
Male	66	African American	Burlington	College Grad	$100-150	2
Male	70	African American	Marlton	College Grad	$72-100	3
Female	65	Caucasian	Mt. Laurel	College Grad	$72-100	5
Female	65	African American	Willingboro	Some College	$30-60	4
Female	72	Caucasian	Mt. Laurel	HS Grad	$72-100	3
Male	67	Caucasian	Edgewater Park	Some College	$30-60	2
Male	70	Caucasian	Delran	Post Grad	$72-100	7
Male	67	Caucasian	Burlington	Some College	$60-72	3
Female	74	Caucasian	Shamong	HS Grad	$72-100	3

March 8, 2017 (7:30 p.m.-9:30 p.m.) Burlington County, NJ Group 5 Millennials and Gen X						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Male	42	Asian	Mt. Laurel	College Grad	$72-100	2
Female	31	African American/ Hispanic	Palmyra	Some College	$30-60	4
Male	28	Caucasian	Marlton	Some College	$100-150	3
Female	27	Caucasian	Delran	College Grad	$30-60	3
Male	36	Caucasian	Marlton	College Grad	$150-200	3
Male	38	Caucasian	Marlton	College Grad	$150-200	2
Female	41	Caucasian	Burlington	College Grad	$150-200	3
Male	47	Caucasian	Delran	Some College	$30-60	2
Female	27	Caucasian	Riverton	College Grad	$72-100	2
Female	43	Caucasian	Riverton	HS Grad	$72-100	3

March 9, 2017 (5:30 p.m.-7:30 p.m.) Burlington County, NJ Group 6 Boomers						
Gender	**Age**	**Ethnicity**	**City**	**Education**	**HH Income**	**Number of Doctors**
Female	55	African American	Mt. Laurel	College Grad	$60-72	3
Female	59	Caucasian	Marlton	Some College	$72-100	2
Male	53	African American	Moorestown	College Grad	$100-150	3
Male	64	Caucasian	Marlton	Some College	$72-100	3
Female	63	Caucasian	Browns Mills	Some College	$30-60	3
Male	64	Caucasian	Riverton	Post Grad	$100-150	2
Male	61	Caucasian	Mt. Laurel	Post Grad	$150-200	3
Female	54	Caucasian	Medford	College Grad	$60-72	3
Male	59	Caucasian	Delran	College Grad	$150-200	2
Female	54	Caucasian	Marlton	Some College	$100-150	6

March 9, 2017 (7:30 p.m.-9:00 p.m.) Burlington and Camden Counties, NJ Group 7 Physicians						
Gender	**Age Range**	**City**	**Type of Practice**	**Number of Physicians in Practice**	**Medical Group**	**Type of Medical Group**
Male	41-50	Marlton	FP	2-10	Elmwood Family Physicians	Single specialty
Male	51-65	Medford	IM	1	Atkinson Internal Medicine	Single specialty
Male	51-65	Browns Mills	FP	2-10	Virtua Medical Group	Multi-specialty
Male	51-65	Medford	IM	2-10	Advocare Medford Station	Single specialty
Male	51-65	Mt. Laurel	IM	2-10	Mt. Laurel Primary Care Physicians	Single specialty
Male	51-65	Moorestown	IM	2-10	Internal Medicine Physicians	Single specialty
Female	51-65	Moorestown	FP	1	Health Ward Inc.	Single specialty
Male	41-50	Stratford	FP	2-10	Rowan Family Practice	Single specialty
Male	51-65	Marlton	IM	1	Center For Adult Medicine	Single specialty
Female	51-65	Camden	IM	2-10	Penn care	Single specialty

March 15, 2017 (5:30 p.m.-7:30 p.m.) Milwaukee County, WI Group 8 Seniors						
Gender	**Age**	**Ethnicity**	**County**	**Education**	**HH Income**	**Number of Doctors**
Male	75	African American	Milwaukee, WI	Some College	$53-75K	6
Male	66	Caucasian	Milwaukee, WI	College Grad	$53-75K	3
Female	68	African American	Milwaukee, WI	HS Grad	$15-30K	1
Male	74	Caucasian	Milwaukee, WI	HS Grad	$15-30K	5
Male	65	Caucasian	Milwaukee, WI	College Grad	$100-150K	1
Female	69	Asian	Milwaukee, WI	Post Grad	$75-100K	2
Female	74	Caucasian	Milwaukee, WI	Post Grad	$30-53K	4
Female	65	Caucasian	Milwaukee, WI	Some College	Less than $15K	3
Female	68	Caucasian	Milwaukee, WI	Post Grad	$100-150K	4
Male	72	Caucasian	Milwaukee, WI	Post Grad	$53-75K	2

March 15, 2017 (7:30 p.m.-9:30 p.m.) Milwaukee County, WI Group 9 Millennials and Gen X						
Gender	**Age**	**Ethnicity**	**County**	**Education**	**HH Income**	**Number of Doctors**
Male	28	Caucasian	Milwaukee, WI	HS Grad	$30-53K	2
Male	39	Hispanic	Milwaukee, WI	HS Grad	$53-75K	5
Male	34	African American	Milwaukee, WI	Post Grad	$100-150K	2
Female	50	Hispanic	Milwaukee, WI	College Grad	$30-53K	4
Female	28	Caucasian	Milwaukee, WI	College Grad	$30-53K	2
Female	37	Caucasian	Milwaukee, WI	College Grad	$75-100K	5
Male	45	Caucasian	Milwaukee, WI	Some College	$100-150K	2
Female	29	Caucasian	Milwaukee, WI	College Grad	$53-75K	3
Female	45	Caucasian	Milwaukee, WI	Some College	$30-53K	2
Male	28	Caucasian	Milwaukee, WI	Post Grad	$100-150K	4
Male	41	Caucasian	Milwaukee, WI	College Grad	$150K+	2

March 16, 2017 (5:30 p.m.-7:30 p.m.) Milwaukee County, WI Group 10 Boomers						
Gender	**Age**	**Ethnicity**	**County**	**Education**	**HH Income**	**Number of Doctors**
Female	60	Caucasian	Milwaukee, WI	College Grad	$75-100K	2
Female	59	Hispanic/Latino	Milwaukee, WI	Post Grad	$100-150K	3
Female	53	African-American	Milwaukee, WI	Some College	$15-30K	1
Female	62	Caucasian	Milwaukee, WI	College Grad	$75-100K	1
Male	58	Caucasian	Milwaukee, WI	Some College	$30-53K	1
Male	55	Caucasian	Milwaukee, WI	Some College	$30-53K	3
Male	60	Caucasian	Milwaukee, WI	College Grad	$30-53K	2
Male	62	Caucasian	Milwaukee, WI	Post Grad	$75-100K	4
Male	62	Caucasian	Milwaukee, WI	Some College	$100-150K	3
Female	64	Caucasian	Milwaukee, WI	Some College	$53-75K	3
Female	60	Caucasian	Milwaukee, WI	College Grad	$75-100K	2

March 16, 2017 (7:30 p.m.-9:00 p.m.) Milwaukee, Racine, and Kenosha Counties, WI Group 11 Physicians						
Gender	**Age Range**	**City**	**Type of Practice**	**Number of Physicians in Practice**	**Medical Group**	**Type of Medical Group**
Male	65+	Brown Deer	FP	2-10	Rogers Memorial Hospital	Multi-Specialty Group Owned by Hospital System
Male	65+	Milwaukee	IM	Sole	Samara Clinic	Independent
Female	51-65	Franklin	FP	3	Aurora Medical Group	Multi-Specialty Group Owned by Hospital System
Male	51-65	Milwaukee	IM	3	South Center Medical Group	Single Specialty Medical Group
Male	51-65	New Berlin	IM	1	NA	Independent
Male	51-65	Milwaukee	IM	10	NA	Independent
Female	41-50	Mequon	IM	60	Madison Medical - Mequon	Multi-Specialty Group Owned by Hospital System
Male	51-65	Milwaukee	IM	15	Madison Medical - Downtown	Multi-Specialty Group Owned by Hospital System
Male	65+	Brown Deer	FP	2-10	Rogers Memorial Hospital	Multi-Specialty Group Owned by Hospital System
Male	65+	Milwaukee	IM	Sole	Samara Clinic	Independent