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Myth Busting: Using the CG-CAHPS 12-Month Survey for Quality Improvement

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Speakers

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Carla Zema

Zema (opening), Slide 1

Hello everyone and welcome to our CAHPS Webinar on Myth Busting: Using the Clinician & Group Survey or CG-CAHPS 12-Month Survey for Quality Improvement. We realize that there are a lot of myths out there and so we thought this was a great way to kind of kick off what we hope to be a series in trying to bust through some of those myths that are out there in terms of using CAHPS surveys.

My name is Carla Zema. I am a Principal with Zema Consulting and a Consultant with the CAHPS Consortium and it is my pleasure. We have such a great lineup of speakers for you.

Zema (opening), Slide 2

I want to dive right in but before I do, if you are having problems hearing from your computer speakers, there is a dial-in number that you see on your screen right now as well as an ID number. If you need that number and the slide is not up, feel free to use your Question-and-Answer feature. So there is a little Q&A icon. You can just click on that, a little window pops up and you can let someone know that you need the dial-in number. If your connection is slow or your slides aren't moving it may be your connection but you may want to try hitting F5 to refresh your screen or even logging out and logging back in. Alright, so let's get started.

Zema (opening), Slide 3

For today I am going to give you a little bit of an overview of the CAHPS surveys and a little bit of the context and the landscape for why we're having this discussion today. But really, the heart of what we want to talk about are examples from Dean Health Clinic and Massachusetts General Hospital and the Massachusetts General Physicians Organization. And they're going to talk about their experiences with using the 12-Month Survey for quality improvement.

Zema (opening), Slide 4

So we know from our pre-registration that most of you are pretty familiar with CAHPS. So I am going to go through this pretty quickly. You can download the slides. I am going to talk to you a little bit about how to do that. So if you have colleagues that you want to pass this along to and they may not be as familiar with CAHPS we put some slides in there and I think most everyone is familiar with the CAHPS program. It's funded by the Agency for Healthcare Research and Quality. We develop standardized surveys and related products all according to a set of established set of principles that have been in existence probably since about 1995. CAHPS surveys assess patients' experiences with care.

Zema (opening), Slide 5

When I refer to the CAHPS Consortium, I really mean AHRQ is the funder of the Consortium. We have two grantees at this time; RAND and Yale. Most of what you see is the CAHPS User Network and that is supported through a contract with Westat. Then we often have other government and private stakeholders as applicable. For example, CMS is a partner with us as well as NCQA and other, depending on the survey, other government and private stakeholders.

Zema (opening), Slide 6

CAHPS is a family of surveys. We're here today to talk about the Clinician & Group Survey. So the few of you that mentioned that you wanted to hear improvement strategies for the CAHPS Hospital Survey we are going to focus on the ambulatory side today. That doesn't mean you have to hang up. You might want to stick around because a lot of what we are going to talk about is transferrable but I just wanted to make sure that we are very clear that again we are looking at the ambulatory side using the Clinician & Group Survey.

Zema (opening), Slide 7

So there are several different versions of the Clinician & Group Survey. There is a 12-Month version, a Visit version and the PCMH version. They both have adult and child versions of those.

Zema (opening), Slide 8

And so I actually – sometimes we don't actually think of the PCMH as a different survey. The concept behind all CAHPS surveys is that there is a core questionnaire. So regardless of the version of the core questionnaire, you can add supplemental items and come up with a customized Clinician & Group Survey. So for us, the PCMH version is simply the 12-Month core survey with supplemental items that are specific to medical homes. So we really view the versions of the survey as having the 12-Month core or the Visit core.

Zema (opening), Slide 9

All of the core surveys have the same core measures. So we have the access measure, the provider communication measure, the office staff measure and the provider rating and they all have the same core topics.

Zema (opening), Slide 10

The only difference is, and I know you need your microscope to kind of see this slide, but this slide really – what this is really talking about is just comparing some of the differences. The main difference between the 12-Month and the Visit Survey is really the timeframe that the questions ask. So obviously the 12-Month Survey is asking about experiences in the last 12 months.

The Visit Survey is what we call a hybrid survey. It asks about access in the last 12 months and provider communication asks about the office staff for the most recent visit. That is really the main difference between the Visit version and the 12-Month. Again, the PCMH is really the 12-Month core plus additional domains and supplemental items that address medical home.

Zema (opening), Slide 11

So a lot of times – we use this slide a lot in terms of people asking us, "Well, how do I know which version to use?" We kind of go over these big buckets and I am going to touch on some of them today even though that is not really what the topic of this is about.

Zema (opening), Slide 12

So one of the first questions that we always ask is, "Well, who is using what version?" We see a lot of public reporting initiatives that use the 12-Month version. Lots of those external requirements use the 12-Month version.

I have CMS on here and I know a lot of you are kind of saying, "But wait a minute. CMS isn't a 12-Month version." That's why it has those two little asterisks by it. All CMS surveys use a 6-month timeframe but when compared to a visit, it covers a longer period of time. So we kind of consider that in the 12-month bucket even though CMS is using a 6-month timeframe.

Generally we see the Visit version is very popular mainly with practices and organizations that have been using a proprietary survey from a vendor, for example. They have been surveying for a long time before the emergence of CAHPS. They tend to be using a Visit survey. There are public reporting initiatives in Minnesota and Wisconsin that were currently using the Visit version. Minnesota has a rule out right now that is getting feedback about changing to the 12-Month version and Wisconsin is talking with its stakeholders again also about changing to the 12-Month version.

Zema (opening), Slide 13

A lot of the external requirements that I am going to talk about are available in a document that a group of us in the CAHPS Consortium, who also work on a project, Aligning Forces for Quality, that is funded by the Robert Wood Johnson Foundation. We put together this brief on external forces that are driving the implementation of the Clinician & Group Survey. So it kind of walks you through a lot of the external requirements for surveying that is going on right now.

That is available under your "Resources" icon and I will give you a little more detail of how to get that as well, but you can download that today.

Zema (opening), Slide 14

So just to kind of give you an illustration, our friends at Allina Clinic in Minnesota, we have been working with them for a very long time. They have been surveying and they are really great about kind of telling us what they are experiencing, what some of their issues are and one of the biggest struggles that they have is they have so many requirements because they are an ACO. They have the Minnesota Department of Health Statewide Initiative. They are also a Health Care Home within the State of Minnesota, which has a different requirement.

They were seeking NCQA PCMH Recognition. The arrow that is not shown here is that they also had an internal pay-for-performance initiative as well and performance incentives within their own structure. So all of these different versions can be a heavy burden on this practice. So that is just a great illustration of what practices and organizations are facing given multiple requirements.

Zema (opening), Slide 15

So I wanted to touch a little bit about some of the psychometric differences between these two versions of the survey. The Visit Survey uses a 3-point Yes-No scale. So "Yes, definitely," "Yes, somewhat," and "No," for the visit-specific questions, provider communication, and office staff. The 12-Month Survey – all of the questions are what we call frequency scale so the responses are "Never," "Sometimes," "Usually," and "Always."

Zema (opening), Slide 16

So there is a little difference between these two scales. What we find is that there is a significant, what we are going to call, ceiling effect of the Visit Survey because it is much easier to answer, "Yes, definitely," on the 3-point Yes-No scale than it is to answer, "Always," on the 4-point scale and you can see this. This is data from the 2013 Clinician & Group Database. The CAHPS Database includes national benchmarks for all of the versions of the CAHPS surveys and what you are looking at is the most recent data from the Visit Survey.

You can see in the red box – you may not be able to see the numbers, but in terms of the items that are focusing on the most recent visit and they have that three-point Yes-No scale, the 10th percentile score is 85% for provider communication and it goes to 96% to be in the 95th percentile. So there is not a whole lot of spread between the 10th percentile and the 95th percentile. Similarly, for the office staff composite, because again it is easy to endorse or to answer that "Yes, definitely." So we don't feel a large amount of variation within the top boxes of those items.

Zema (opening), Slide 17

So what are the implications for that? We see a lot of national, state, and regional reporting initiatives that are all converging around the use of the 12-Month Survey. We need greater alignment of the survey requirements to reduce the burden on respondents, to reduce the burden on health care organizations, as well as to improve comparability of survey results for reporting an improvement. Then obviously we also need to continue to research and test ways to lower cost of data collection and things like that and we are working on that.

Zema (opening), Slide 18

So again I am going to go back to the slide that I showed you a few minutes ago in terms of the factors to consider in selection and a lot of times we hear from practices, "Yeah, but how about suitability for internal improvement?" There is this perception that you can only do improvement with a Visit version. So that is really the crux of what we're here to talk about today. I want to wrap up because I know you guys are dying to hear from our speakers and so we have a great lineup of speakers today.

Zema (opening), Slide 19

We are going to hear from Linda Sparks from Dean Health Clinic and then Rick Evans and Liza Nyeko from the MGH and Massachusetts General Physicians Organization about their experiences in using the 12-Month Survey for QI. So it is myth busting because it is not true. You can do QI with the 12-Month version and they are going to tell you how.

Zema (opening), Slide 20

So I am going to first introduce Linda Sparks. Linda is the Manager of Service Excellence at Dean Clinic in Madison, Wisconsin. She came to Dean Clinic in 2007 and spent her career working in health care administration. She is responsible for planning, developing, and implementing all aspects of the patient experience including coordination, supervision, and integration of patient experience efforts and initiatives. She serves as an expert in the field of patient satisfaction and focuses on reaching the highest level of patient satisfaction through the use of both proven tactics and innovative approaches to service.

Again, we encourage you to ask questions throughout the entire webcast. We are going to have a formal Question-and-Answer session at the end. You will see a Q&A icon that will pop-up a little window and you can just hit "Submit" on that.

Zema (opening), Slide 21

Presentations will be available for download and you can hit that "Download Slides" icon and get the slides at any time.

Zema (opening), Slide 22

Again, I mentioned some of the resources that are available under the "Resources" icon and I will talk to you about the other ones that are out there in just a minute.

Zema (opening), Slide 23

So, with that I want to turn it over to Linda Sparks. Go ahead, Linda.

Linda Sparks

Sparks, Slide 24

Good afternoon. This is Linda Sparks and I am here in Madison, Wisconsin.

Sparks, Slide 25

In case you are not familiar with Dean Clinic, we are a member of SSM Healthcare. We have a large integrated health care delivery system and we actually were established in 2004.

Sparks, Slide 26

A little bit more about Dean Clinic. Again, a multi-specialty physician group. We have over 800 medical staff and a network of about 60 locations that are spread throughout southern Wisconsin.

Sparks, Slide 27

Our journey with CG-CAHPS started back in 2006. It seems like a long time ago and it seems like we have been using CG-CAHPS forever. At that time, the organization was really looking for ways to improve the patient experience. To do that, we felt we really needed a good tool to gather data so that we could measure that and track that over time. After we started using CG-CAHPS, it was within a very short period of time.

The physician community really reached out first and expressed interest in ways that they could work on increasing their individual scores. But before I talk about some of the ways that we use the CG-CAHPS data with our physician community, I am going to just go over a very specific example of how we use the CG-CAHPS data and one initiative that we had this year.

Sparks, Slide 28

The next slide, you will see a graph and it is, the numbers are very small on here, but you will see how we have measured over time and I just put since 2010 on here. The response to the questions on Clerks and Receptionists - that is part of the core survey. When I look at this, it is like, "Yes, we have made small, incremental increases quarter after quarter, but we're not satisfied with where our score is at."

So clearly we have room to grow in our patients' eyes on how the staff interacts with our patients. So this year we really tackled this. We spent a lot of the prior years working on strictly physician initiatives.

Sparks, Slide 29

One of the things that we noted, when we really dug into this data by comparing the two questions on the survey. So on the core survey question, number 25, "In the last 12 months how often were clerks and receptionists at the provider offices helpful as they should be?" The next question, "Did they treat you with courtesy and respect?"

What we found is that our patients' perception is that our staff did really well on "courteous and respectful" but they were almost 10% lower in "helpfulness." With anything else, if you want to know why patients feel the way they do about their experience, you want to go to the patients and you want to ask the patients what they consider to be helpful and what are ways that we can improve to meet their expectations and really deliver on that exceptional service experience.

Sparks, Slide 30

We have an online opinion panel. It's called Dean Listens. This was developed by our marketing department a couple of years ago. Anyone can sign up to be part of Dean Listens. Many patients are on it and sometimes it is a family member of a patient or someone who has contact with one of the Dean clinics. The purpose of Dean Listens is to really find out from our patients, through very short, direct surveys on different topics, what do they think of Dean Clinic and what are ways that we can improve? So we use this panel to ask about helpfulness.

Sparks, Slide 31

Marketing helped us do this really draft the survey that had very targeted questions on "helpfulness," what that means to our patients, and how that relates to the interaction that they have with the staff. You can see on this slide that we sent this survey out to 1,900 patients and we had just over 1,000 respond. Our patients were very honest.

Sparks, Slide 32

They gave us very good feedback on this and the things that they told us were probably something that is not really that surprising to anybody on the call, but they said to us, "You know, you have a lot of locations and we really want a consistent experience. We really want to know what to expect when we come into a Dean Clinic."

What we expect is that front-line staff – that there is always a smile on their face. They are welcoming us. They are acknowledging that we're here and we're here to serve you. Again, none of these things were things that we didn't already think about, but this really confirmed from our patients' eyes and our patients' experience that this is what they expect and this is what they are answering to when they are answering questions on the CG-CAHPS Survey. I think we have a little bit of maybe a myth that being helpful was doing something extraordinary. What our patients told us is it is not the extraordinary. It is that interaction that we have when we first come in to the clinic. So what did we do with this?

Sparks, Slide 33

The thing that we did is we took these survey results and we got them out to our staff in a number of different ways. We have an orientation on customer service expectations for all new employees and it is actually taught by our service excellence staff. We make sure that we emphasize those behaviors and we have incorporated that into that training model. We also have customer service workshops and Webinars so that we have ongoing training on customer service. Again, we have integrated this in to that.

We have gone in front of our managers, our clinic managers who supervise the staff, and we have given them this feedback and included this in action plans. Then we looked at where are we getting the lowest scores and we set up some targeted interventions. Actually working with the staff, not just the manager, but the staff on this is what our patients expect. We go there. We shadow them. We give them feedback and they're actually involved in developing the action plan to improve the patient experience.

We also work with our marketing department. They are just so creative and they have helped us put together – we have some three-minute videos that we can push out to the clinics. It actually shows people that are displaying these attributes and what it really looks like because everyone learns in a different way. For some people, really seeing it is where it really hits the mark with them.

So those are some of the things that we did with the actions. Now what we expect is that we will see results of these interventions likely starting in Q4 of this year and into next year. That is when we will see a jump in the scores from having these targeted interventions which, of course, is a little bit different than having the Visit Survey where you would see that result right away. So that is why we are very careful in what initiatives we undertake and we make sure they are very action-oriented and so that we can track what actions did we take, are we seeing the positive response or if we're not seeing the positive response when the survey results start coming in that we can take corrective action right away. I want to share with you one other way that we use the CG-CAHPS data.

Sparks, Slide 34

That is with our provider shadow coaching program. At the beginning of the presentation, I said that very shortly after starting using the CG-CAHPS Survey tool, we had providers coming to us saying, "Tell me what do I need to do? What do I need to do to increase the score?" So in 2007, and that was shortly after I came to Dean, we really started working on how do we work one-on-one with physicians because their feedback to us was, "I want to know what I need to do in that visit with the patient. What is the patient expecting of me from a service perspective?"

So in 2008 we started a shadow coaching program. We started it by observing our best-practice providers. So the providers that had the highest CG-CAHPS scores for patient satisfaction. We went and we watched and we observed them. From that, we put together a service best practice list that we have tweaked very little since that time because the service best practices are pretty universal. We saw them in action and we know that's what our patients in southern Wisconsin are looking for.

So we have now evolved that program to shadowing all new providers at about three months of employment at Dean Clinic so that everyone that comes to Dean Clinic knows early on what are the service expectations, what does this really look like in the exam room and how do I integrate those into my practice if I am not already practicing them? We have requests that come from established providers on a regular basis. Sometimes the provider's request, sometimes the medical director's request, and that is part of their performance evaluations and we do a lot of tracking on that as well.

Sparks, Slide 35

But one of the things that we use when we go into these shadows is really looking at what does the data tell us. So when we started reporting this to physicians, it was only showing their top box score. So in the first example, and this is real data, if you are the physician in this top row and your top box score is 69%, what we are hearing back from providers is, "Patients don't like me. I don't know what to do. This is a horrible score." Our providers are very data-driven. They are very concerned about the patient perspective and they want to do better.

But seeing a score of 69% can honestly be pretty demoralizing. So what we do in preparation for meeting with them is we really look at the survey results. How many patients, what percentage of patients gave them the top box score, but more importantly, what is in the sevens and eights? So if I were meeting with a provider from the top row, what I would concentrate on is, "You have 20% of your respondents reading you at a seven and eight. Now, that is not bad. There are things that we can do. There are practices that you can incorporate into your daily routine that will move those to nines. Let's concentrate on that." That gives it a whole different perspective for that provider.

You know, if I am looking at the second one, and I have 79%, well you know, that person is not too far away from the goal this year and it is a different kind of conversation because there is 12% in eights and then those are really minor tweaks. And then we can concentrate on those. So our next step for this is actually our physicians can't see this drilled down right now which is really I am finding to be a barrier. We want to make that transparent to them. Right now they are only learning that through our shadow coaches. So that is something that we are going to be working on moving forward.

Sparks, Slide 36

So those are the two things that I wanted to share with you on some of the ways that we use the CG-CAHPS data. I hope it was helpful. I appreciate the opportunity to present and at the end we will have time for questions.

Carla Zema

Evans and Nyeko, Slide 37

Great. Thanks so much, Linda. Again, I want to encourage everyone to submit their questions as we go along and we will open up and ask some of those questions at the end of the presentations. Right now I want to turn things over to Rick Evans and Liza Nyeko from Massachusetts General Hospital and Massachusetts General Physicians Organization in Boston.

First I am going to introduce Rick. Rick is the Senior Director for Service at MGH and Massachusetts General Physicians Organization in Boston where he coordinates the organization's efforts to improve the patient experience. He is also responsible for the organization's Referral Management Office, the Physician Leadership Program and the Visitor Education program. Prior to MGH, Rick served as Vice President of Support Services and Patient-Centered Care at New York's Presbyterian Hospital and also served as Vice President of Mission Services for the Bon Secours and Canterbury Partnership for Care in Hudson County, New Jersey. He also served in leadership roles in local and national non-for profit organizations moving in to health care. So he brings a wealth of experience to his role at MGH.

Liza has worked for the Center for Quality and Safety of MGH and the Physician Organization as a Manager for the past six years. In this capacity, she focused on the patient experience of care and facilitated care redesign improvement work. Prior to this, she worked in the Massachusetts Executive Office of Health and Human Services as Quality Manager for MassHealth. She has also worked at the Federal Trade Commission's Healthcare Division and the Center for Studying Health System Change which was funded by the Robert Wood Johnson initiative.

So both Rick and Liza bring an incredible diversity of expertise to their current positions. With that, I am going to turn it over to you both to talk about the experiences at MGH.

Liza Nyeko

Thank you. We appreciate the opportunity to share with you how we collect and utilize CG-CAHPS data at Massachusetts General Hospital and the Physicians Organization.

Evans and Nyeko, Slide 38

Mass General Hospital has administered CG-CAHPS since 2008. We have used the 12-Month version since implementation. In January of 2013, we converted from the 6-point scale to the 4-point scale version. This is the version consistent with national direction and was deemed beneficial in other respects.

We include adult and pediatric patients in our survey, primary care, and specialty care areas. Currently we include 14 clinical areas and 116 practices. Our vendor, Quality Data Management, or QDM, administers the surveys by phone and by internet modes. Initial contacts are made shortly after the patient visits. In addition to the core CG-CAHPS Survey, we include three open-ended questions at the end of the survey. These questions address possible improvements, providers, and staff. We collect hundreds of comments weekly on a range of issues.

Evans and Nyeko, Slide 39

We have two primary ways of accessing data internally. Our vendor, Quality Data Management, maintains an online portal which includes both data and patient comments. There are multiple ways to view the data and comments such as by clinical service, location, demographics, self-reported health status, aspects of care such as how long the patient has seen the provider and the provider type.

The vendor portal is updated weekly with all data collected to date and the lag time is really very small. MGH and MGPO users are granted single sign-on access which allows for them to analyze the data at their convenience from their individual computers. In addition to the patient portal, we also maintain an internal data repository. We receive daily feeds from our vendor of all patient comments and data and this data is collected in the data repository along with other data sources so that we can link the information and conduct a more custom analyses. These data are really used for ad hoc reporting, custom reporting as well as the ongoing quarterly and weekly reports.

Evans and Nyeko, Slide 40

So a little bit more about reporting, we disseminate, very widely across the organization, weekly comments reports. In addition, we disseminate quarterly reports at multiple levels. The summary level is intended for leadership and addresses data across clinical services. We produce a clinical service level which shows data across practices within a given clinical service and we produce reports at the practice level.

These reports include benchmarks and targets as applicable. In addition to these reports, we produce monthly dashboards which are focused on engagement areas which Rick Evans will address a little bit. We also produce leadership dashboards and ad hoc custom reporting. On an ongoing basis, we also offer tutorials to allow for users to understand how best to access their data through the online vendor portal.

Now I am going to turn it over to Rick Evans who will discuss how we utilize data and comments towards improvement.

Rick Evans

Evans and Nyeko, Slide 41

Good afternoon, everybody. This is Rick Evans. Nice to be with you all. As Liza alluded to earlier in the presentation, we have quite a few clinics here at Mass General. And so if you think about 120 practices and our service team is only four FTEs. So we have to find ways to work at scale.

So we used the CG-CAHPS data with our practices and we have developed something we call a Practice Engagement Model. I think anyone on the phone who works every day on service improvement knows that the results really improve at the local level. Service professionals like ourselves can help, can provide consultation, support, training, and other supports but ultimately it is up to the folks who are running a practice every day to really make the change.

So what we do is we enter into agreements with our clinical areas. So a clinical area, for instance, might be our Neurology area which has six or seven different practice sites. Or it might even be something much larger like our Institute for Heart Vascular and Stroke that has even more locations. We meet with their leadership, both their clinical and administrative leadership. Often that means meeting with the Chief, administrators or managers and directors, etc. We put together a service cabinet, a leadership group, for that clinical area. That cabinet, if you will, is the board of directors for service improvement for that clinical area.

So we work with that cabinet and we do what you see on this slide here. We look at data. We will identify areas that need improvement. We will select specific indicators and establish targets and we do that collaboratively. We will then do improvement planning at the practice level. So what ends up happening is each practice looks at its own data, selects indicators for improvement, sets targets that are validated by the cabinet and then produces an action plan or improvement plan which is essentially the steps that are going to be taken to reach their targets.

Those plans are then submitted to the cabinet so they are reviewed. It is not just a check-off box, I have got my plan and I'm done. It is something that the cabinets will review and actually provide feedback back to the practices. Then we spend the rest of the year, if you will, implementing best practices, monitoring improvement plan progress, looking at our results, and essentially tracking things. Then the cabinet would then recognize areas that are making progress and call in the cavalry for any area that might be struggling. We also do, through our practice engagements, a lot of training and I will talk about that I think a little bit further in the slides here.

So the bottom line is, our service team uses the data that Liza just described and we have a collaborative improvement approach with clinical area leaders.

Evans and Nyeko, Slide 42

So in terms of target setting and improvement planning at MGH and the MGPO, we do have some enterprise-wide targets. This year we chose to work on the “provider explain” question thinking that was a pretty good proxy for provider communication in general. We also established targets for the “staff helpfulness” and “staff courtesy” scores.

Like our colleagues at Dean, we see a gap between the “courtesy” and “helpfulness” scores as well. As I mentioned earlier, each practice then is looking at focus indicators so if a practice is doing their improvement plan and all three of the PO level indicators, the ones I just mentioned, are performing sub-optimally then that essentially becomes their improvement plan; they work on those three. Some of our practices are doing very well in these indicators so they are allowed to, if they are doing well, choose another indicator to work on.

Frequently chosen alternate indicators here are information about waits, information about test results, those are also questions that are frequently being worked on. So, as I said a minute ago the areas establish their targets. Those are validated by the cabinet and their improvement plans are also validated by the cabinet.

Evans and Nyeko, Slide 43

What do we have our practices doing? On the next slide you will see sort of a sampling of best practices that we have been working on here. What you will see here on the poster is a set of service expectations. So, I'm sure that most of you would agree that if you are going to achieve a rating of "always" from our patients, then the experience needs to be consistent. That is something that our colleagues at Dean just alluded to as well.

Consistency kind of leads one to looking at ways to standardize and make key processes more predictable. I don't think it is rocket science or anything genius here but we have definitely taken the patient experience and picked key touch points: checking in, checking out, hallway interactions, phone interactions, and exam room interactions. For each touch point, we have outlined some service expectations; how phones should be answered, how interactions generally should be conducted, etc., and then behaviors that would make those expectations come to life.

So we have spent a lot of time at the clinical area level and at the practice level implementing these service expectations. What does that mean? It means that we do a lot of training with management and also a lot of training with staff. But we don't train our staff unless we are training management first. I think you might agree that anyone can train staff but if they don't hear anything about it beforehand and never hear anything about it again after they are trained, you don't have any improvement effect.

So rolling out service expectations for us means telling people what they are, promoting them, communicating about them, training staff to kind of meet the expectations and training managers to properly reinforce the expectations across the board. Related to that are reward and recognition programs. So we believe that you do get a lot more with carrots than you do with sticks and we've instituted a number of recognition programs that always involve our staff in their design and they are meant to just reinforce excellent performance relative to our expectations.

We have standardized how we inform patients of waits with status boards and regular updates to patients in our waiting areas. We've instituted staff huddles. Again, I think that is probably a concept a lot of people use. One of the things our service team does is we actually issue huddle messages to everyone. So if I am a manager and I am going to have a five-minute huddle on service and I want a topic to discuss, you don't even have to think about it. You will get an email from us each week with a huddle message that you can use with your team.

We also have some service recovery programs out there and like what was mentioned by our colleague at Dean, we also train and shadow physicians on communication. We use some outside resources and we also have some internal resources. All of these best practices are meant to help people populate their improvement plans at the practice level with meaningful, evidence-based interventions. So we are trying to lead people through a process where we help them pick the right indicators, select the right target and then give them as much as we can ready-made practices to use.

Evans and Nyeko, Slide 44

This slide just outlines, the next slide, a little bit about our training. So we had enough training programs that we decided – we have a service academy. So we now have about 27 or 28 courses that we provide to both managers, leaders and to staff and it might be something like training folks on phone answering. It might be training a manager on how to communicate and do leader rounding. It might be, as Liza mentioned, basic tutorials about how to access their data from our very excellent QDM portal and it might be we have a session that is pretty popular on high, middle and low performers.

So for these practices that may have someone on their staff who has been in a bad mood for 25 years maybe we can start to train and surround that person with coaching or quite frankly over time, to help them find employment elsewhere if it is not going to work out. So we try to give training that really meets our managers' needs and helps them reinforce their goals and service targets.

Evans and Nyeko, Slide 45

Liza, maybe we would do this one collaboratively. Why did we use CG-CAHPS? I have to tell you that from our perspective, the 12-month look-back works very well. I think it is safe to assume that many of our patients who come here are definitely reflecting and providing us feedback on a number of interactions they've had with us. We have got great historical data in place. We can look at trends. We are able to see the needle move when people really do implement best practices. So this data and this survey has worked very well for us.

Liza, I don't know if you want to add to that.

Liza Nyeko

Nope, I think that is all very much on-target. The Visit-specific version really does have questions that are 12-month look-back as well so we don't see the two as entirely different at least in that respect for the access questions.

Rick Evans

Zema (closing), Slide 46

I think that is pretty much it for our section. I know we will have Q&A later.

Carla Zema

Zema (closing), Slide 47

Great. Thanks everyone and I just want to remind you that we have got lots of questions but you can still submit your questions through the "Q&A" icon. Just type your question in that window and we will continue to ask questions for as much time as we have. We know that this is one of the more important things that you value within the webcast so I want to jump right in.

I have a question for Linda. Linda, does "helpfulness" mean the same for all departments?

Linda Sparks

I'm not sure I understand. You mean the question that is asked on the survey?

Carla Zema

So when you went onto your opinion panel and you kind of were digging in deeper on what helpfulness means, did you find that there were any differences in helpfulness between departments?

Linda Sparks

We found that there was very little difference between departments and it was the consistency that patients were really looking for among sites and departments that was important to them.

Carla Zema

Great, thanks. Rick and Liza, how did MGH choose the three focus indicators?

Rick Evans

When we looked at these with our MGPO leadership, I think we wanted to reinforce team engagement in this effort. So we didn't want it to be some folks may experience this and the physicians are saying, "Well, I'm doing great. It is the support staff that aren't pulling their weight." The support staff will say, "Thanks for talking to us. Are you talking to the doctors?" So we wanted to balance it. That is why there is a provider question on there as well as the staff question. I think that has really helped us engage the entire team. In addition those are questions that we thought could use work.

Carla Zema

Great. So I want to answer a common question and I know we have several questions that came in about this. I know many of you are wondering about CMS requirements and obviously since we don't have someone from CMS here we at ARHQ as a partner with CMS however, we aren't CMS, so we leave it to CMS to answer all the questions about the requirements. There certainly are a number of different survey requirements that are coming out of CMS. So I encourage you to download the "[Forces] Driving the [Implementation] of the Clinician & Group Survey" because it kind of goes through all the different initiatives. It is not quite the same as the Hospital Survey, they say there's CMS and HCAHPS. There are quite a number of different initiatives that are coming out that are affecting the use of the Clinician & Group Survey.

Another set of questions that have kind of come in is my reference to the 6-month look-back period that CMS uses and our use of the 12 months, an interest to kind of coming to a common survey. I will just answer generally that the CAHPS Consortium is very well aware of the need to kind of move towards a national standard and we are actively evaluating that and we will have more information on that as we go along. But again, we hear that.

Zema (closing), Slide 48

I just want to remind you that if you are not getting CAHPS email updates that you can go to the ARHQ Web site and click on the little email updates in the top navigation and add yourself to the CAHPS listserv and you will get the most recent announcements. So as we come up with resolution to some of the different factors that we are looking at in terms of trying to bring standardization to these processes, you will certainly hear about it first if you are on the CAHPS listserv.

So let me jump back and this is a question for both Dean and MGH. There is lots of interest in terms of who did the shadowing and how did you identify people to do the shadowing. Let's start with Linda.

Linda Sparks

We identified staff who obviously were very service-oriented. We purposely did not choose clinical staff. We felt it was very important that their whole focus would be on service and that they wouldn't be sort of sidetracked into the clinical world. We have two full-time shadow coaches. They do other things like the workshops and the trainings in that as well. They have both worked in process improvement type roles in the past. One had done some education in the past. One had worked a lot with metrics.

We have also had some other part-time coaches over the years and it is certainly not a job for everybody. It has to have that real dedication to service, those really high communication skills, working with lots of different kinds of people. Some are very resistant to the feedback. Some are very open and being really savvy about how to deliver those messages.

Rick Evans

At Mass General, we have actually taken baby steps into this. We have a coach who is a social worker on our service team. She actually works here in our department and is also a certified coach. So she has done some work with physicians and that has been very well-received. We also have two physicians, one from our psychiatry department. I don't want that to sound scary. Another one from our palliative care team. They are both physicians who are very expert at communication and so they have also done some coaching.

Carla Zema

Great. So I want to go back to MGH for a moment. We have had a couple of questions about your service cabinet. Number one, did you include patients in them? Then can you talk more broadly about who is on the service cabinet?

Rick Evans

We have patients on some of them but we also have very active patient and family advisory councils connected with many of our cabinets. Although I have to be transparent and say this is something that we are discussing with our cabinets because we believe there should be patients on all of them. So we are on a journey with regard to that.

All of our cabinets include senior leadership from the clinical area. That might be the Clinical Chief. So there is physician leadership, administrative leadership like administrative directors. In some cases we have people who represent our training functions, people who represent our human resource function. That is very important to have someone there because we are often skirting up against some of those issues. We certainly have nursing and other clinical area leadership.

We always have a service person that is assigned to work with those groups and in some cases, we have staff-level stakeholders as well. So the mix is a little different depending on each clinical area. The key thing though is that none of the cabinets are chaired by a service person. We support them, but they are chaired by local leadership.

Carla Zema

Zema (closing), Slide 49

Great. Thanks. That is very helpful. I know several of you have asked about where you can get some of the comparative information and the benchmarks that were referred to earlier and those were all from the 2013 CG-CAHPS Database and comparative data are now available. You can see the link to the Web site in the slides. You can also go under "Resources" and find that link there.

Also, there is another resource that we have made available to you. On the CAHPS Web site, we have what we call the CAHPS Quality Improvement Guide. Since the CAHPS Web site is not currently available, we have made kind of a print version of that resource available. You can download it under "Resources" as well.

Zema (closing), Slide 50

In terms of the CAHPS Web site, we apologize greatly that the CAHPS Web site, as it was several months ago, is not currently available. ARHQ is in the process of transitioning the Web site to host that Web site internally and we apologize greatly that Web site has not been available. We are working on it. It will become available. It will be available again at the Web site that you see but in the meantime, many of you have asked, "What happens after the Webcast? Can I see the replay of this? Can I still get the resources?"

You can use your link from the registration that you used to log on today. You can come back and see the replay. You can access any of the resources. I know several of you have asked whether we could post some additional resources and we will be able to do that as well. Again, you can access the replay, all the slides, the resources just as you are doing right now after the Webcast for a period of several months. Then eventually, we will have the CAHPS Web site up and running again and hopefully this material will be available there as well.

Zema (closing), Slide 51

So I am going to continue with question-and-answer, but I know a lot of you have to leave and so I want to take this opportunity to ask you to complete an evaluation as you are listening to the final questions and answers. Information about how to contact the CAHPS User Network is there. We take your evaluations very seriously and we look for suggestions on those and your feedback is very important to us. So I am going to go ahead and open up that evaluation but I am going to continue with some questions and answers because we have got a lot. This is for both of you. I want to ask in terms of how you have used the survey for specialty practices. Let me go to MGH first.

Rick Evans
We use the survey for specialties the same way we use it for primary care. It is the data for all practices and the approach we use doesn't really differ in terms of improvement based on primary care or specialty. I don't know if that answers the question.

Carla Zema
Absolutely. The concept of the CAHPS survey is that core survey should be applicable to both primary care and specialty services but we always get questions on that so we always kind of like to hear from you guys. Linda, do you have anything to add to that?

Linda Sparks
We do exactly the same thing. We treat it the same and the data speaks the loudest and we follow the same initiatives in many cases.

Carla Zema
Great. I am going to ask this question to you both as well because I know this one has come in quite a bit as well. How do you engage providers, especially physicians? So that is oftentimes a challenge. You guys have presented great information on engaging the staff but can you talk about some of the challenges that you face in terms of engaging especially with physicians?

Let's start with Linda.

Linda Sparks
We actually have incentives tied to our five corporate goals and service is one of the five goals, so they do have compensation tied to meeting the service goal every year. But that almost sounds punitive. So we really work hard to establish our team as a resource for them and when we started shadow coaching all new providers coming into our system that was really a big move for us and it really helped to engage those providers early on that we are here to help them, we are a resource and I have really seen a change in the providers' attitude towards service since then because we are just getting off on the right foot with them. We are not being called in when things are going wrong. That is not the only time they see us.

Carla Zema
Great.

Rick Evans
I would say a very quick way to engage a physician is to give that physician their scores. So we have found that sharing those results at the provider level often very quickly engaged physicians. We have also learned though that you really have to do that correctly, which means that physicians need to understand what is this survey, why is it important, how is it part of where things are going in health care generally, how does it align with the many other things that are on our physicians' plates. But getting them their data gets their brain in the room with you very quickly.

Carla Zema
Great. So kind of as a follow-up to that comment, in essence, how old are the data by the time the physicians see them or how often do you provide feedback to them or how often do they see their scores?

Linda Sparks
We provide data on service on a quarterly basis and it is transparent across the system. It took us awhile to get there and we had to go through all of the steps that were just being discussed by our colleagues at Mass General as to the importance of it, what it really means, how you can really use it to drive initiatives and engage the patients and currently we report that quarterly.

Rick Evans
We haven't gotten there yet. Our release of data to physicians has been the historical data over the last couple of years and it has mainly been connected with our service engagements as part of their improvement plan. With an organization, and I would invite Liza to elaborate with an organization as large and complex as ours we have to think about how we are sampling and make sure we are giving providers robust data and sometimes that is hard to achieve. So we are kind of taking it on a case-by-case basis using relatively consistent template whenever we do it.

Liza Nyeko
As Rick stated, because sample sizes sometimes don't allow for dissemination of the results at the physician level as frequently as we might like, we do rely heavily on the patient comments and those comments are embraced. People really I think relate to the information that they see from patients and they are not as reliant on sample size so we are able to distribute them more frequently.

Carla Zema
Great. So is there a certain threshold that you are looking for in terms of sample size before you share with the physician?

Liza Nyeko
The literature shows that 45 completed surveys at the physician level is adequate to begin to draw conclusions so that is really what we aim for. If we do release the data with sample sizes less than 45, we issue data with all sorts of caveats attached.

Carla Zema
Great. Linda, how about at Dean?

Linda Sparks
We also use the 45 as our threshold and if a provider has less than that, it is asterisked with an explanation and then it is not transparent across the system because it is not a valid sample size. We have worked really hard at getting valid sample sizes and I think that is something that does take time to get to. We are using the mail mode right now which is a little bit different than some of the others may be using and we are hoping next year, our plan is to go to a mixed mode of mail and e-surveys together.

Carla Zema
Great. So we are still talking about physicians and their CAHPS scores, do either of you require that physicians attend coaching sessions or have some intervention as a result of their CAHPS scores?

Rick Evans
No.

Linda Sparks
Sometimes we will have a medical director recommend it to a physician and say, "I highly recommend this," and usually when a medical director recommends something, the physician will say, "Okay, I will give it a try."

Carla Zema

Great. I think that is probably in the back of everyone's mind. They want to. So I want to take a few minutes. We have a lot of questions and we weren't able to get to everyone's question. If you have a question that you have asked that is really important that we were not able to get to please feel free to resubmit your question through the CAHPS User Network and that information again that email address is CAHPS one, CAHPS with the number one, at [@] Westat dot [.] com [CAHPS1@westat.com] and we will make sure that your question gets to the respective speaker and we can get an answer for you.

I want to thank our speakers. This has been such a valuable session and I know that we never have time to get into the detail that everyone is looking for but we will follow-up with additional information that you guys have asked for and those questions that have come that are specific to CAHPS surveys and to the User Network, we can certainly follow-up with answers for you as well.

Again, I want to thank our speakers for sharing their time; Linda Sparks from Dean and Rick Evans and Liza Nyeko from MGH. Thank you again for coming to our webcast. We hope it has been useful for you and we look forward to future events with you.